CHAPTER 2

Overview of neuro-linguistic programming

Introduction

Have you ever seen someone who displays a skill so elegantly and gracefully that you wonder just exactly how they do it? Perhaps someone who seems to be able to deal effectively with an angry and upset person without losing their cool. Maybe someone who has excellent influencing skills and can persuade people, with integrity, to go in a direction of mutual gain. Possibly you marvel at the minor surgical skills of a colleague. It could be that your practice manager has the best planning and negotiating skills on the block. Perhaps you have a partner with a relaxed, laid-back attitude to the vicissitudes of on-call work. You may have a mentor, a person you respect immensely, and you hope that in time you can develop similar characteristics. You may ask yourself '*How do they do that?*'

And what of the people you know in other careers? The businessman who has great creative thinking skills. The trainer who can hold an audience spellbound *and* make learning fun, almost effortless. The fireman who can keep calm in the most difficult of rescue situations. The nurse who seems to exude empathy and caring to all. The tennis player with great hand–eye co-ordination. The driver of a huge articulated lorry who can reverse into seemingly impossible spaces. The accountant who can make head *and* tail of complicated financial figures. *Just how do they do that?*

You could of course put it all down to natural talent. They were probably born that way. It runs in the family. That's just the way they are, like it or lump it. It is a personality thing. Or else it took years for them to get that way, to learn that skill, and you just don't have the time anymore, nor the same starting point. Maybe it was all luck anyway. Maybe they were in the right place at the right time and that's all there is to it.

But is that really true? What if it weren't true? What if there was a way to learn skills far more easily and effectively, regardless of your starting point? What if these skills actually had a structure, and there was a process by which you could assimilate them easily? Interested? *Just how do you do that?*

I remember in my early NLP training seeing a trainer work with a demonstration subject. All her life she had felt inferior to other people – she couldn't look them in the eye, she didn't match up. She had experienced episodes of depression, and had been on treatment, yet still felt low. I watched entranced as the trainer, using verbal and non-verbal skills exquisitely, found out just precisely how this woman structured her problem state. But he did not stop there. He used extremely effective communication skills to lead her elegantly and respectfully through a process of change to a different outcome, to a different solution. And she did – *change*, that is. And over the next few months of this modular course we heard first hand her reports of continuing wellness.

I remember thinking at the time, *'Just how did he do that? How did he seem to know the right things to say? How did he structure his communication to get that result?'* Of course that was quickly followed by the thought *'I want those skills. And I want them now!'*

NLP is the study of the structure of subjective experience. Wow! What a mouthful. Just exactly what does that mean? Well, according to NLP everything that we think, say or do – our behaviours of excellence, our talents and skills, our behaviours that we wish we could change, and our troublesome problems, all of this – has an underlying, recurring pattern. An underlying template, if you will, which when brought to the surface, can be changed, rearranged, even taught to someone else. NLP is really all about having an attitude of curiosity, intense curiosity. Getting really curious about *how* people do what they do. Wondering how they manage to maintain their problem, doing it over and over again. Wondering how they can perform differently, competently, in other situations. Wondering how the skills that some people have that help them to cope well, or even excel, can be extracted and put into a format that can be easily acquired by others.

The methodology that is used to do all this is called modelling. NLP builds cognitive and behavioural models of how successful people do what they do – how they behave, how they say what they say, how they think, and how their beliefs and values fit together in an enabling way. And in this book we shall be studying how, using NLP, successful communicators can get results in medical practice. *Just how do you do that?*

A brief history of ... NLP

NLP originated in the early to middle 1970s at the University of California in Santa Cruz, when mathematician Richard Bandler and linguistics professor John Grinder become interested in how people change. Bandler had been keenly studying how Fritz Perls, a medical doctor, outstanding psychotherapist and the founder of Gestalt therapy, got results with clients. An intuitive modeller, Bandler was able not only to reproduce these results, but also to do so with ease. He asked Grinder to help him to decode the patterns of language and behaviour that Perls employed. He reputedly replied to the effect: *'Teach me **what** you are doing, and I'll tell you **how** you're doing it.'* From this initial collaboration the field of NLP developed.

Neither Bandler nor Grinder were interested in abstract theories or esoteric claims about *why* people did what they did. They wanted to build practical models of how successful people in any domain achieved results, and how they could teach these models so that others could learn easily and quickly. They focused on what people actually did, rather than on what they claimed that they did. Very soon they had discerned the linguistic patterns and behavioural techniques of Perls, and both were obtaining equally high-quality results. They decided to turn their attention to other successful therapists, as they wanted to explore other patterns of change, and this led them to Virginia Satir.

Virginia Satir was at that time the doyen of family therapy. She had a reputation for taking on difficult, complex family and relationship problems that many thought were insoluble, and solving them. What Perls did for individuals, Satir did for families. Although they were completely different personalities, Bandler and Grinder found that their underlying linguistic processes and patterns were very similar. From modelling these two therapeutic giants, the *metamodel* (see later), a specific language model for communication and change, was developed.

John Grinder and Richard Bandler also conversed with Gregory Bateson, a British anthropologist who was living and working in California at the time. From a medical perspective, Bateson was the first to propose the double-bind theory of causation in schizophrenia. He had been part of the Palo Alto group, an influential mental health research group working on the application of communication and systems theory in therapy. Interested in patterns of change, he suggested that the duo should visit Milton Erickson in Arizona.

Milton Erickson, a medical doctor, was also a trained psychiatrist *and* psychologist! The founding President of the American Society of Clinical Hypnosis, he was profoundly interested in the mechanisms of deep and lasting change. His linguistic and observational skills were legendary. He had developed the art

of conversational trance whereby, without any overt trance induction, merely talking with his patients would somehow facilitate the changes that they needed. Bandler and Grinder, in modelling his language patterns, his voice tone and his gestures, found a completely different way of using communication skills therapeutically. If Perls and Satir were masters of using very specific language, Erickson was the opposite. He was a master of artfully vague language that allowed patients to *'change in your own way'*.

From the initial modelling of these three outstanding therapists, the field of NLP has grown considerably. Bandler and Grinder, using the tools of modelling, have gone on to explore many other fields of excellence, including business, law, sport and education, to name but a few. Many other patterns have been developed. One of the key developers and innovators in the last two decades has been American trainer Robert Dilts. A student in the early days of Bandler and Grinder, he has worked extensively in the area of beliefs, producing many useful models. Interested in concepts, cognitive mapping and categorisation, he has also applied these models to health issues with intriguing results. And of course Bandler himself has continued to develop and refine his work, principally in the areas of accelerated-learning strategies and formats, making more available in less time.

This is of necessity a brief history of NLP's formation and growth. Other books will give more depth and breadth of coverage (*see* Bibliography on page 273). NLP is still an open book – it is not a complete body of knowledge. It is still growing, evolving and changing. What stands out for me is that much of the foundation on which NLP rests is *derived from a medical background*. I believe that now is the time to come full circle and bring the fruits of NLP back into the medical world, so that both our patients and we ourselves can greatly benefit.

So what really is neuro-linguistic programming?

Neuro-linguistic programming is a bit of a mouthful. How about breaking it down into its component words and examining these in a little more detail?

The *neuro* aspect is all about the mind and how it takes in and processes information. If you really think about it, the basic building blocks of all our experiences are composed of what we see, hear, feel, smell and taste – our five senses. Of course, to be different, and set the field apart somewhat, NLP tends to use the jargon words visual (V), auditory (A), kinaesthetic (K), olfactory (O) and gustatory (G) instead. Whatever (!), information coming from the outside world can only reach us in this way. Once inside, it passes through our various *internal filters*, such as our beliefs, values, memories and life experiences, among other things. Mostly we are unaware of this process taking place, apart from

the end result. And this is our internal representation, our internal images, sounds, feelings, smells and tastes *about* the outside event.

The *linguistic* element is all about how we use our language, how we label things, how we interpret things, and how we talk, both with others *and* with ourselves. The sixth thing that we can do inside our heads (after VAKOG) is to speak to ourselves *about* what is happening. We often have a running commentary in our mind about what is happening right now. Sometimes, perhaps in a consultation, we may pay more attention to that commentary than to our patients, sometimes to the detriment of both of us. Language, both spoken and unspoken, verbal and non-verbal, has a definite structure, and a set of rules for use, or even abuse. NLP has uncovered many useful language patterns which we shall meet in due course.

Programming is a word left over from the early days of the personal computer, which has mirrored NLP's dramatic rise in usage over the years. Patterning might be a better word. Having taken in outside information (*neuro*), talked to ourselves or others about what to do (*linguistic*), we then run a series of actions or behaviours designed to achieve our particular goal in that situation (*programming*). Our behavioural programmes may stem from the skills of excellence, doing things really well. However, we may run a pattern over and over again that leads to depression, or worse. This patterning element of NLP is the *order and sequence* of internal representations that leads to that particular behaviour – good or bad, liked or disliked, wanted or unwanted. If you know the sequence you can change the order, and thereby change the behaviour.

Universal filters

In doing all of the above, we use the universal filtering processes of *deletion*, *generalisation* and *distortion*. We delete, generalise and distort massive amounts of information which would otherwise overwhelm us. Psychologists reckon that about two million pieces of information bombard our nervous system *every second*. Yet we can only be consciously aware of about seven pieces at any one time. We have deleted the rest. If you have ever mislaid your car keys, and then found them right under your nose, that is an example of *deletion*. If you are having an enthusiastic conversation with someone and fail to hear someone else calling your name, that is another.

We take the rest of the information that remains, and generalise from it. *Generalisations* are useful short-cut rules to help us to navigate the world without having to think too much. Most doors work the same way, as do most pens, auriscopes and stethoscopes. Sometimes the rules are not so helpful. If you make one mistake and from this believe that you will never learn, that is *not*

a useful generalisation. Miss a case of meningitis and you may find yourself checking every febrile child.

What is left of the information is distorted by us in some way. The process of *distortion* involves giving labels to our experiences so that we can interpret them, make meanings out of them, evaluate them and even judge them. For example, suppose that one of your patients gives you a present to thank you for what you have done. You could think that they really appreciate you. Or, if you are cynical, you might assume that they want something more in return. You distort the experience to fit your beliefs. You are alone at the health centre at night, catching up on paperwork. You hear a noise and think that there is an intruder. You start at the shadow of a large potted plant. You find that a colleague has left his Dictaphone running and that is what is making the noise!

Figure 2.1 shows an NLP model of communication.

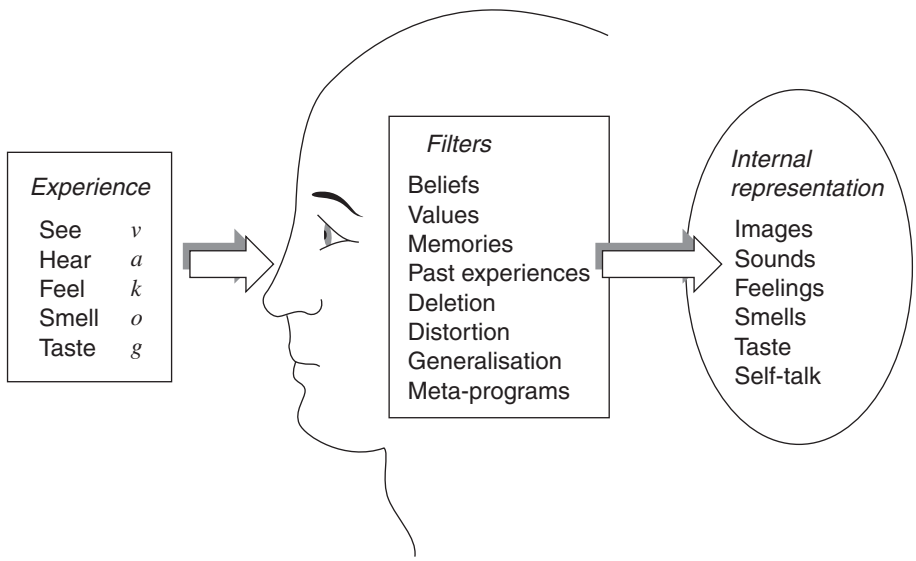

Figure 2.1: NLP communications model.

Communicating meaning

How do you say what you mean and mean what you say? Many people believe that words themselves carry all of the meaning when communicating. However, try saying the following words out loud:

'You can't do that here.'

First, imagine that you are really, really angry with someone. Get in touch with that feeling, point your finger blamingly, and then say the words emphasising '*you*'. Now shake that state off and calm yourself down.

Now imagine that someone has told you off for doing something, and you are quite incredulous about it. Put both hands out, palms up, as you say the words, emphasising *'here'* in a questioning tonality. Now shake that state off. Let me ask you, given that the words were the same each time, what conveyed the meaning?

In a classic study in the 1970s, Albert Mehrabian showed that, in face-to-face communication, only 7% of the meaning was conveyed by the actual words used. Voice tonality accounted for 38%, and physiology (our posture, gestures and facial expression) a whopping 55%! Our *non-verbal* behaviours – how we say what we say, and what we are physically doing at the time – make a major contribution to the overall meaning of our utterances. In fact, we cannot *not* communicate. Even when we say nothing at all we are still communicating something.

Cartoonists, of course, have known this forever. They use posture and gesture to convey a wide variety of meanings at a glance. Actors and actresses practise saying words like 'no' in such a way that it conveys yes, no, maybe, oh go on then, incredulity, seductiveness and myriad other meanings. So in any communication we must learn to pay attention to the non-verbal components.

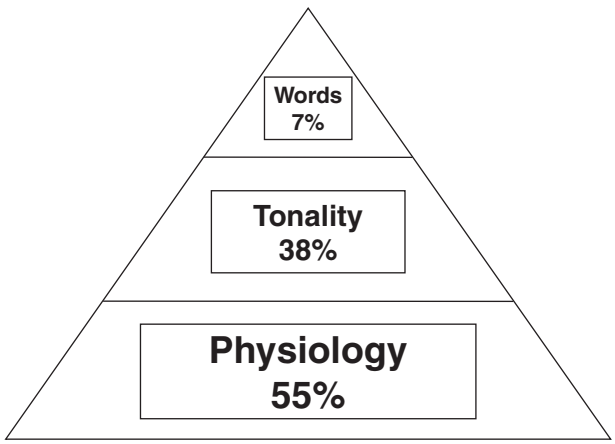

Figure 2.2: Communicating meaning.

What Mehrabian and others found was that the emotional content of a communication tended to be expressed non-verbally. This includes information about our deeper beliefs and values which will 'leak' spontaneously as we talk.

They will be 'given away' by tonality and gestures, *emphasis* on *certain* words, repetitive movements, etc. This occurs mostly out of conscious awareness – we usually don't know that it is happening, it is unconscious. Yet there is much valuable information here.

When we are *congruent*, aligned, our words, tonality and physiology match up. When we are *incongruent*, our words say one thing, and our tonality and physiology say another. Remember a time when you met someone and what they said seemed right yet ... later ... you felt that there was something about them – you couldn't put your finger on it ... but ... you had that recurring feeling of unease. In a mixed non-aligned message like that, the non-verbals win out each time. This is so important that we shall return to it again later.

Beliefs of excellent communicators

No matter which field of endeavour NLP has studied, time and time again the following beliefs about how to communicate effectively have always come to the fore. They are sometimes called the *presuppositions of NLP*. These are the underlying assumptions which, when acted upon, ensure that communication flows in an active, dynamic, recursive loop. They are not necessarily 'true' or 'correct' or the 'right way'. However, if you *act as if* they are true, if you try them on for size, and if you use them as a filtering lens for all your communication, then you will begin to experience exceptional results.

Everyone has their own unique model of the world

If you look again at the NLP communication model, you will see clearly that because we all have different filters, different life experiences, and different beliefs and values, then any two or more people who share the same external experience will each have a different internal representation. Your internal map – your model of what is going on 'out there' – is unique to you. So is that of your patient. In a sense, their interpretation is absolutely right – for them! So we need to give them information in a way that best fits their map, not ours.

An adolescent once told me about the excruciating pain he had from a bee sting. We got nowhere until I acknowledged that what was an irritation for most people was painful for him. Another patient was upset when he was told that his chest pain was not significant. He thought that he was being disbelieved. In fact the consultant cardiologist was only trying to reassure him that his heart was fine!

Ask yourself *'Am I communicating this in a way that fits for them?'*

Behind every behaviour is a positive intention for that person

This presupposition states that no matter what the behaviour, it is always trying to do something of positive value for *that* individual. Sometimes the behaviour itself can be a problem, but we can always find an underlying positive intention. Consider the binge drinker who drinks to escape from his personal difficulties. At the time of drinking, he feels a massive sense of relief, freedom and comfort. His behaviour is positively intended for himself *at that time*. The same is true for the anxious person who avoids the difficult social situation and now feels calm.

It is a good idea to ask yourself what could be the positive intention behind any recurring symptom or behaviour. Separate the intention *behind* the action from the action itself. Sometimes it can be difficult for a patient to give up a behaviour until the positive intention is satisfied in some other way. The classic example of this is the smoker, who smokes to relax, yet has no other way to reach that goal. Preserving the positive intention and providing other avenues for relaxing is the key.

Ask yourself *'What is the positive intention behind this behaviour?'*

The meaning of your communication is the response it gets

When two people communicate, messages are being sent and received by both parties simultaneously. Each filters the message in their own unique way. Sometimes the message sent out is received in a different way to that which was intended. You may get a response that you did not bargain on. Whatever your intentions were, the *interpreted message* was different. No one is 'wrong' in this situation – there is no blame. You simply need to accept this as feedback and put your message in a different way.

A woman in her forties started to cry when I asked about her mother's recent death. I said I was sorry if that had made her feel sad again. She said that, on the contrary, they were tears of relief, that after her long-drawn-out illness her mother was finally at peace. A woman in her fifties who was dying of cervical cancer told me she did not have the heart to tell her husband that she was too nauseated to eat the meals he had lovingly cooked. He thought that she had to eat in order to get better and that she didn't like his cooking. Explaining this to them both helped him to express his love and caring in other ways.

Ask yourself *'Are they interpreting my message in the way I intended?'*

Present behaviour is the best choice available at this moment in time

Whatever someone is doing at this point in time is generally the best response that they have available in these circumstances. That is not to excuse anyone's

behaviour, but simply to say that, given their history, their previous experiences and their current internal map, it is impossible for them to behave any differently. What we can do, of course, is to help them to update their map and expand their choices. This presupposition applies to us, too. Whatever *we* are doing as doctors today is the best we can do given the circumstances. And we can expand our choices, too, which is perhaps one of the reasons why you are reading this book.

One of my patients had been abused as a child. Now 32 years of age, having kept it secret for all this time, someone else had named the perpetrator. She was exposed and had to go to court. Memories flooded back, overwhelming her. She couldn't bear her husband to touch her. She felt like a child again, unsafe, and her husband got upset, too. We ran a simple NLP mental process, distancing the troublesome images and allowing her to be more resourceful. She was able to keep the events at arm's length as she dealt with them.

Ask yourself *'If this is their current best choice, how can I help them to expand their choices?'*

There is only feedback

Good communicators know that in every situation, what you do next moves you either towards or away from your goal. They use every response from their patient as feedback for what to do next. They have honed their *calibration* skills – their ability to 'read' people. They ensure that they only take the next step after securing agreement to the last step. If they do not obtain agreement to the next step, verbally or non-verbally, they backtrack to the previous step. They refuse to wallow in the word 'failure'. They know that this kind of thinking takes their attention off the other person. It is not that they don't make mistakes. They may make plenty of them! But they use them as feedback instead.

A patient came in and sat down. I said something that was intended to be flippant, an off-the-cuff joke that went wrong. Unfortunately, the patient became quite upset instead – not what I'd hoped for. I jumped up, pointed back to my seat and said *'You're right, that kind of behaviour is totally out of order. I apologise on his behalf.'* Then I moved my chair slightly, sat down and asked if we could start again. With the patient now bemused rather than upset, we went on to have a satisfactory consultation!

Ask yourself *'How can I utilise this response as feedback?'*

Resistance is a sign of lack of rapport

If, as an excellent communicator, you sense that you are having some difficulty getting your message across, and you recognise that you are not 'getting through'

and that they are 'resisting', this means that you have lost rapport with your patient. You need to back off and re-establish rapport before moving on (we shall deal with the specifics of rapport more fully later on).

I was telling a 40-year-old man about treatment options for his back pain and noticed a glazed, far-away look come into his eyes. I stopped speaking, adjusted my body posture to mirror him, and waited to get his attention again. When I had it, he became much more receptive to my comments.

There is a saying that *'there are no resistant patients, only inflexibly communicating doctors'*. True or not?

Ask yourself *'How can I best re-establish rapport?'*

Everyone has, or can acquire, all of the resources that they need

This is sometimes a 'challenging' one. Essentially this presupposition states that there are no unresourceful people, only unresourceful states of mind and body. Many people actually have, in other life contexts, the skill that appears to be lacking in this, the troublesome context. Finding it and bringing it to bear changes the situation. In a medical context, a prescription for medication is an external resource that is brought to bear on disease and illness.

A 43-year-old smoker who wanted to stop smoking searched his mind for an aversive past experience. As a child he hated the smell and taste of castor oil. We re-vivified that experience and with NLP anchoring techniques (see later) attached the negative feelings to cigarettes, and he stopped smoking!

Ask yourself *'Which resource can I bring to bear on this situation?'*

Mind and body are one unified system

Changing our thoughts changes our physiology, and changing our physiology changes our thoughts. In medicine, psychosomatic illness reflects one part of the link. Yet perhaps we should coin another term, *somatopsychic illness*, for the reverse. Patients who are depressed may have physical symptoms as a result, and others with chronic physical illness may become depressed. Our verbal expressions can tell one side of the story, yet much information is presented non-verbally in posture and gesture. We need to pay attention to the whole message – mind and body.

A 55-year-old man, stooped with ankylosing spondylitis, became quite depressed. A prescription for exercise not only cleared his depression, but also he became stronger and more mobile as a result.

Ask yourself *'What is the total message – mind and body – that they are communicating?'*

When you consult other NLP literature, you will find that there are several more presuppositions of NLP in addition to those that we have dealt with here. By and large, they say the same things in a slightly different way, from a slightly different viewpoint – which is fine. We all agree, though, that starting off any process of communicating with these in mind will reap dividends both for us and for our patients.

The pillars of NLP

If the beliefs of excellent communicators, the presuppositions of NLP, are the guiding principles, then the *pillars of NLP*, coined by Ian McDermott, are the operating rules in any given situation. If you pay close attention to these five rules then you will significantly increase your chances of a successful encounter. I believe that it is true to say that the whole of NLP is encapsulated within them. And *every* consultation will benefit from them. They will repay your close study a hundredfold!

1 *Your state of mind and body*
Your state is the sum total of your thoughts, emotions and feelings, and everything that is going on for you right now. We give states names, such as happy, sad, depressed, ecstatic, bored, tired, curious, fascinated, etc. You will have your own personal favourites, some of which you inhabit more frequently than others. It is vital to be in the right state for the job in hand. The right state and you flow with the task. The wrong one ... well!

And whilst you might not have recognised this yet, each state is the container for certain specific skill sets embedded within it. Being in the right state accesses the right skill most easily. Think of morning consultations after a long, tiring night on call, and three difficult cases to start with. You may find your thinking and diagnostic skills hard to access. Yet if you were fresh, and had just heard that partnership profits were up ... what a difference!

Your state is important. You need to check that it best fits the current situation, and if it doesn't, choose another. We shall deal more specifically with how to do this throughout the rest of this book.

2 *Rapport – relating to other people*
Once you are in the right state, you need to turn your attention to the other person. Rapport is also a state – one of empathic communication, a dance of mutual responsiveness. You are 'in sync' with the other person, seeing eye to eye, on their wavelength, making a felt connection. It is the state wherein mutual influence occurs. Over time, with certain patients, it may develop into deep trust.

Rapport is the *sine qua non* for effective communication. It is not necessarily about agreement, but more about *respecting* the other person's position, expressing your thoughts in ways that they can understand and act upon. You can probably recall times when rapport was lacking and meaningful communication ceased, and other times when consultations flowed. Rapport is vital life's blood to medical practice, and we shall deal with it in much greater depth and breadth later.

3 *Outcomes – what do you want?*

NLP is an outcome-focused technology. If you don't know what you want, that is exactly what you'll get … don't know. We need to be really clear about our outcomes in any particular communication situation. NLP is solution centred. Sure, we have to start with the current problem in any given consultation, but we need a direction, a target, a goal to move towards – and the action steps that will get us there. The more clearly defined the outcome, the easier it is to identify which resources are required to complete the journey – resources that we either have or can acquire.

How many times have you had a consultation during which neither you nor the patient was clear about what was really wanted? Or perhaps what was wanted just seemed rather vague, or fuzzy. How did that feel? It is very useful to have a set of criteria for a *well-formed outcome*. Because outcome setting is a major skill in NLP, and there are several aspects to it, formulating what you want in the right way is tackled in depth in Chapter 4 on gathering information.

4 *Feedback – developing sensory acuity*

Suppose that you are in the right state, have great rapport and have an outcome to work towards. How do you know that you are headed in the right direction? It is a bit like driving a car. You know your destination, but there may be several routes that you can take. And no matter which route you choose, you need to pay attention to other road users, speed limits, weather conditions and destination signs, and to drive accordingly. You drive differently in the depths of winter on snow-covered roads to the way you drive on an 'open road' in summer. Feedback like this helps you to change tack when necessary and get there in one piece.

It is the same with any other outcome. We need to open up our senses, our eyes, ears and feelings to the information that patients are displaying from moment to moment. NLP calls this developing our sensory acuity, *calibrating* to the patient's responses. Everything we need for feedback is there in front of us. We shall hone these skills further shortly.

5 *Flexibility – doing something different*

If we stay with the car metaphor a little longer, what happens if the route you have chosen has road-works or, worse still, is completely blocked? Of

course you just go home again. *No you don't!* You find another way – a detour, another route, a side road, or another form of transport altogether.

NLP calls this *behavioural flexibility* – ensuring that you have other choices, other ways to achieve your outcomes. If you believe in the 'one way fits all' type of thinking then, with this approach, some people will achieve their outcome but many others won't. NLP believes that it is more useful to have a high-quality outcome and to help that individual to get there as flexibly as possible using whatever route best fits the unique circumstances pertaining to them at that time.

So, to summarise this section, first pay attention to your own state. Ensure that it is the best one for the current situation. Then establish the depth of rapport necessary to get both your own and the other person's outcomes met. And in the setting of those outcomes, use whatever feedback you can to stay on track. If that track is closed, be flexible enough to find another one. Do this regularly and you will notice your results improving, perhaps markedly.

Logical levels of experience

The *logical levels* model (sometimes called the neurological levels model) was developed by American trainer Robert Dilts and based on Gregory Bateson's levels of learning and thinking. It is widely used in the NLP world, although some would say that it is not necessarily either a logical or a hierarchical level as first conceived. Nevertheless, as is usual with NLP, we are not concerned so much with 'truth' as with pragmatic usefulness in the real world. When applied to health, this model can give some very interesting insights about the level at which an intervention can take place and its likely effect on the rest of the system.

Although often laid out in a hierarchy, I sometimes prefer a circular approach to show that all of the levels interact as a system, influencing one another equally (*see* Figure 2.3).

Let us examine each level in turn.

Environment – where and when?

This is the selected context and the time frame. Here you will have the places and any other people involved in the action. For instance, this could be your consulting room or health centre, or anywhere else you care to imagine that is pertinent to the situation under consideration. You can compare and contrast environments *where* you have a problem and ones *where* you don't. You

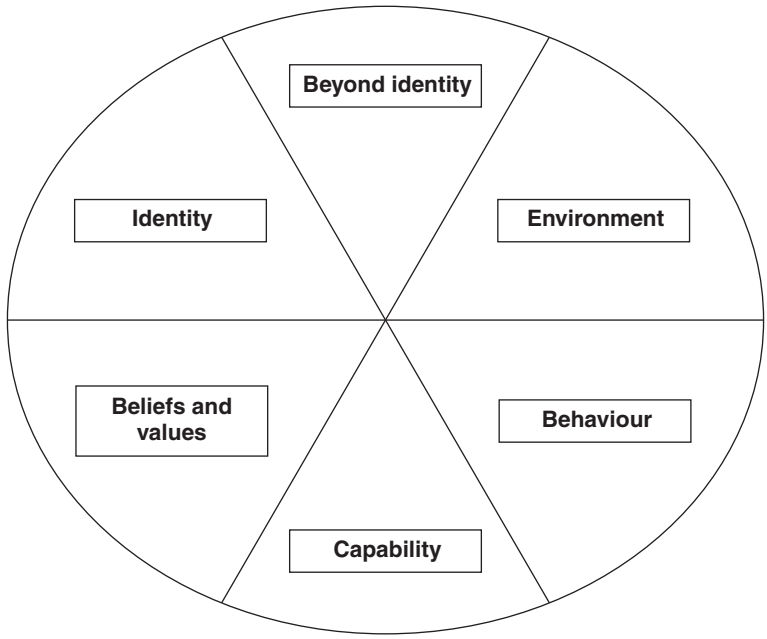

Figure 2.3: Logical levels ('Beyond identity' courtesy of Ian McDermott).

might feel pressurised in your work environment and relaxed at home, or you might feel pressurised at work only *when* you are on call.

Behaviours – what?

These are the things that you actually *do* in that environment – how you walk, talk, breathe, move, and your posture and gestures, the very things that an external observer of the situation could comment on. You can compare and contrast your behaviours in different environments, as described above. *What* you do may be a troublesome behaviour, one that you want to change. However, changing behaviour *per se* is more intimately connected to changing at the other levels.

Capability – how?

Capabilities are the skills that you bring to bear in that environment. They answer the question *'How are you doing that?'* The skills can be mental skills, such as making a hypothesis or a diagnosis, which involve internal thinking strategies. They may also be physical skills such as performing minor operations

or cardiac resuscitation. Your practice manager will display many organisational skills in the day-to-day running of your practice. Business people call these *competencies.*

We can apply this to disease and illness. For example, we could view depression as a series of thinking skills leading to feeling down. How might you think instead? Thinking in this way about illness can open up new avenues for exploration.

Beliefs and values – why?

If values are the things that are really important to us, *why* we do what we do, then our beliefs are the operational rules that express our values in action. You can think of them as guiding principles for our daily lives and deeds, letting us know what we can and can't do. When people say *'Actions speak louder than words'*, they are drawing attention to the fact that what we *say* we believe and value may be different from the underlying reality of what we *do*. Our deeply held beliefs may, more often than not, be below the level of our normal conscious awareness.

Beliefs and values also operate at an organisational level. You may not have considered that, whether you know it or not, your practice partnership operates out of shared beliefs and values, some of which are aligned together while others are not. How does this apply to the rest of the NHS? What about your family? What other organisations do you belong to?

When patients come with behaviours that limit them or cause illness, the solution may actually be at this level rather than the others. If health, which is a values-based word, is low down in their hierarchy of importance, it will be difficult to get them to sign up to healthy behaviours. However, profound change can occur when you make an intervention at this level.

Identity – who?

Your identity is your sense of self, *who* you are at the deepest level. It encompasses your core beliefs and values and expresses itself in why you are called to do what you are doing. Usually this sense of self is very robust and resilient, and change tends to occur slowly and in an evolutionary way. Change can occur more quickly when people explore their sense of purpose, their vision and life's calling in more depth.

Occasionally, however, after severe physical or psychological trauma we can lose this sense of self for a time, and this can be very troubling – a deeply felt anomie. Prolonged meditation and fasting without adequate preparation can also have this effect. Dissociative identity disorder is an example of differing identities being present in the same individual but with little or no internal

connection. This can follow very severe childhood abuse. It is a rarity in general practice.

Organisations also have an identity, which reflects the business culture to which they belong. Manufacturing companies have a completely different ethos and feel compared with the creative whiz-kids in marketing.

Beyond identity – who else?

This level is all about connection – *c*onnection to other people, and connection to religion and spirituality. It is about who you are in the world and how you relate to others – your patients, partners and the wider community. And not only you, but also your practice has a place in the community, and you may have a vision of how you want that connection to be. In a sense we have come full circle, stepping back into the environment that we started in.

Language of the levels

It is often useful to map out the language that patients use to describe their problems in terms of the *logical levels*. This can give you a better idea not only of the various facets involved but also of the particular level at which an intervention might be more successful. Table 2.1 lists some examples of patients' statements showing which level they fit.

Table 2.1: Examples of patients' statements in relation to their identity

	Identity		
	I am an alcoholic	*I am a cancer victim*	*I am a smoker*
Beliefs	Drinking helps people to cope with life's problems	No one survives this kind of illness	Smokers are more sociable people
Capability	I can drink a bottle of whisky a day easily	I don't know if I have the strength to go on	It's the only way I can really relax
Behaviour	I like chatting to my drinking buddies	Chemotherapy makes me sick	I spend £30 a week on cigarettes
Environment	The Rose and Crown is my favourite pub	I want to die at home	We have a smoking area at work

You can use this to explore the levels of solutions as well. A patient complaining about stress might go on holiday for two weeks – a change of *environment*. He could do something different, such as take up jogging – a new *behaviour*. He

might learn some new thinking skills, such as meditation, so that he is *capable* of relaxing at will. He could adopt the *beliefs* of successful communicators, and influence his boss to change working practices. Learning from all of his experiences so far he might find a new role (*identity*) as the company's 'stress buster'. There is no one right solution that fits all cases, yet some solutions (*meditation – capability*) will provide longer-term beneficial effects than others (*holiday – environment*).

Let me be quite clear about this. All of the levels interact with each other, and all of the levels can provide the means for a solution. Because they are part of a system, change at one level may lead to changes at all levels. Sometimes these collateral changes will be too small to notice, but sometimes a small change will cause a huge ripple effect. The trick is to find the one small change that gives most leverage for your patient.

The structure of subjective experience

How do you know the difference between something that you are going to do next week and something you did last week? What is the difference between thinking about your summer holiday of last year and the one that you are planning to go on this year or next year? Think of something you definitely did *yesterday*, you're certain of it. Now think of something you could have done but didn't do yesterday. How do you know the difference? (Hint: think of your mental pictures, sounds and feelings).

Think of something that you believe in 100%, such as 'breathing is good for you'. Now think of something that you are not sure of, such as what you might have for tea next Friday. What is the difference? Think of a good, happy, pleasant memory. Now think of one that is a bit unpleasant. What is the difference?

Experience has a *structure*. Whether we know it consciously yet or not, our brains code our experiences in such a way that we can retrieve them without getting them mixed up. We have codes for past, present and future, certainty and uncertainty, real and unreal, good and bad, like and dislike, belief and disbelief. We code all of these things by organising our internal pictures, sounds and feelings in particular ways.

Exercise 2: Exploring mental perspectives

Think of a *really good pleasant memory from the past*, perhaps a time when you achieved something of importance at work, in sport, etc., maybe a *memorable* holiday, a place you visited, a *dramatic* sunset. Perhaps a time when you

were *having fun*, with family, friends or relations. When you have the memory now, think about the following.

Visual

- Create a mental picture of the event. If you can't yet see it clearly, just pretend that you can. A glimpse is enough.
- Is it in colour or black and white?
- Is it close or far away?
- Is it a movie or a still framed photograph?
- Where do you see it in your visual field? Up, down, left, right or straight ahead?
- Is it fuzzy or in sharp focus?
- Are you inside it, seeing it as it is happening (associated), or outside it, watching yourself from a distance (dissociated)?
- Is it framed or unbounded, with single or multiple images, two-dimensional or three-dimensional?

Auditory

- Now listen to the sounds of the experience. If you can't yet hear them clearly, just pretend that you can.
- Is the volume loud or soft?
- Does it come from close by or far away? Which direction? Up, down, left or right? Point to it.
- Is it surround sound or more easily heard in one ear? Which ear?
- Is it clear or muffled, soft or harsh, high or low pitched?

Kinaesthetic

- How does this experience feel in your body? Pay attention to the feeling.
- Where is the feeling located? Put your hand on it.
- How intense is it? Is it high or low? Does it feel light or heavy?
- Does it start in one place and move to another? Does it move quickly or slowly?
- Is it hot or cold? It is continuous or discontinuous?

Well done, you have begun to find out more about the building blocks of all experiences. You can *repeat the exploration* with a neutral or less than positive experience for comparison, although not your worst memories! Use something of mild to moderate intensity only.

If visual, auditory and kinaesthetic are the *modalities* of experience, then the subdivisions that you have been exploring are the *submodalities*, the actual building blocks themselves. No matter what we experience, our brain codes this

with a particular sorting code, a combination if you will, that locks it away for easy retrieval. If you experimented with the less than good memories as well, you will have noticed that your brain has coded them in a different way. Comparing in this way is called *contrastive analysis* – finding out the points where things differ. You can try this out with like and dislike, certainty and doubt, belief and disbelief, past and future.

Why is this so important? What are the benefits of knowing the structure of experience in this way? What if you could change the structure and thereby change the meaning of the experience? Would that be useful? And how could you begin to apply this now?

Let us do another thought experiment.

Exercise 3: Changing perceptions

Think back to the pleasant experience in the last exercise. We are going to change the submodalities of that experience and notice what happens. After each shift, put the memory back the same way before experimenting with the next shift.

Visual

- Turn the brightness of your mental image up and notice what happens. Now turn it way down. What happens now? Now put it back to the original way.
- Bring the image really close. Then push it way into the distance. What happens? Put it back.
- Continue in this way.
- Make it much larger. Now make it tiny.
- Make it more colourful. Now drain all of the colour away.
- Change the location. If it was up right, put it down left, etc.
- If you are 'inside' (associated), step outside and see yourself over there. If you are 'outside' (dissociated), step inside and pull the image all around you.
- Adjust the image until it gives you the best feeling possible.

Auditory

- Listen again to the sounds.
- Turn the volume up and notice what happens. Now turn it way down.
- Bring the sound closer. Now push it away into the distance.
- Make it 'surround' sound. Now have it come from a point source.
- If it was louder in the left ear, change it to the right ear.
- Now adjust the sounds to give you the best feeling possible.

Congratulations, you have just changed an experience for the better by altering its structure through sub-modality shifts.

Now do the same for the previously less than good experience, finishing up with the changes which let you experience it more comfortably.

In this exercise you have found out just which submodalities affect your experience most, those which can enhance your good memories even more, and those which reduce the intensity of less than good memories. You may also have found that certain ones are *critical* or *driver* submodalities. Changing one of them in one direction also spontaneously changes others. For example, bringing your image closer may have brightened it up and made it more colourful at the same time. Knowing these drivers can help you to change any experience quickly.

Many people find that they can enhance good memories by stepping inside them (associated), making them bigger, brighter, more colourful and closer. At the same time you can turn up the volume of the sound, bringing it closer and making it 'surround' sound. Notice where the feelings start in your body, intensify them and loop them round to start again and again.

You can also markedly reduce the intensity of negative feelings associated with less than good memories. Step outside the image, seeing yourself over there (dissociated). Shrink it down into a small, still-frame, black-and-white photograph away in the distance. Turn the volume of the sound down until it is inaudible. Reverse the feelings back into a tiny area from which they came.

I wonder if you can think of certain patients, coming to mind now, who might benefit from experiencing things anew in this way, as well as yourself.

If you have not already done these exercises, I suggest that you *go back and do them now*. They may seem a bit 'off the wall', quite different from anything you have done before. Yet it is very important that you have the experience. You are the only one who will miss out if you don't (do the exercises, that is). The exercises in this book build on one another. Not only *you will benefit*, but your patients will, too.

Association and dissociation

We have mentioned these in passing several times already. They are two of our brain's most fundamental coding mechanisms and operate on every experience that we have. So what are they, and what effect do they have?

Association means that you are fully *inside* the experience, having a first-hand awareness. You are 'all there', looking out through your own eyes, hearing

with your own ears, and feeling the feelings that are intimately connected with the experience. You are fully engaged emotionally, mentally and physically. This applies to events that are happening right now as well as being associated with past memories and future imaginings.

Dissociation, on the other hand, means that you have '*stepped out*' of the experience and distanced yourself in some way. You see yourself over there, somewhat detached, like an observer. You may be hearing what you are thinking *about* the event, like a running commentary. Your feelings will be disengaged. You may feel something *about* the event, but not the feelings *of* the event itself. You can have this perspective about past memories and future imaginings as well.

Think of a patient who was telling you about a past unpleasant event and then became upset and tearful. They are back inside that memory reliving it as if it was happening now, feeling the discomfort once again. Remember how when someone is telling you about a past success that they had they seem to light up and feel excited, bubbling with energy. You catch that excited feeling and feel good, too. Think of a future event that you are really looking forward to, so much so that you feel good right now. These experiences are typical of varying degrees of association.

Think of a patient who was telling you about a harrowing experience. Yet they remain 'deadpan', with little expression and a somewhat monotone voice, describing it as if it had happened to someone else. Remember a time when you were consulting, trying out a new approach, a different way of doing things. As you were doing it you commented to yourself about your performance, criticising your apparent ineptitude. Think of a time when you were making strategic plans for the future, taking into account different perspectives. These experiences are typical of varying degrees of dissociation.

In and of themselves, association and dissociation are neither good nor bad. Yet each is useful with different types of experience. Look at the following patterns of possibility with regard to positive and negative events. Do you recognise anyone? Patients, colleagues, family or friends? Yourself?

Associating with both positive and negative

When you feel good, it's great. When you feel bad, it's awful. Life can be a bit of an emotional roller-coaster. You feel all feelings intensely, and it's difficult to step back and get some perspective on the situation. Sometimes you can't see the wood for the trees.

Dissociating from both positive and negative

You can easily handle difficult circumstances by distancing yourself. However, you have the same strategy for events that should be happy. You may feel like a spectator – not really engaged. A bit like a 'Mr Spock', you may feel that life is passing you by.

Associating with negative, dissociating from positive

Life seems painful most of the time. Happy events are fleeting, ephemeral, and you can't hold on to them. You may not even notice them slipping by. Episodic misery is punctuated by bouts of neutrality. The future may look bleak, and you may ask yourself if it's all worth the effort.

Associating with positive, dissociating from negative

You have lots of choice. You can feel really good about something if you want to. You can distance yourself from negative events and find some positive aspects to take away from them. Your future seems bright, and you are confident that you can handle whatever happens.

A cautionary word. Beware! Dissociation is a good way to handle painful events that are happening now. However, keeping the disconnection in the longer term is not such a good idea. Keep the events dissociated only until you have learned from them what you need to, and can integrate this into your everyday life.

You will find many suggestions throughout this book for you and your patients to associate and dissociate in helpful ways. Be patient!

Anchoring

Does the name Pavlov ring any bells? He was the Russian psychologist who conditioned dogs to salivate in response to the sound of a bell. He waited until they were hungry, salivating for the food that they saw in front of them, and then rang a bell at the peak intensity of the experience. After doing this several times, he found that ringing the bell without any food being present could make the dogs salivate again. This is called *associative conditioning*, whereby the natural salivatory response to *seeing* food was paired to a completely different stimulus, the *sound* of a bell. NLP calls this *anchoring,* whereby a particular trigger can fire off a particular response.

Anchors occur all around us – they are everywhere. They occur in every representational system – visual, auditory, kinaesthetic, olfactory and gustatory. This trigger can be something external in the environment, or something internal in our mind and body. Anchors happen automatically, outwith our conscious thinking processes, like knee-jerk reflexes. Just think, how do you respond to the sound of an ambulance siren? A flashing blue light? The sound of a cardiac arrest bleep? The feel of a scalpel in your hand? The smell of hospital disinfectant? The taste of post-consultation coffee?

What feelings do the memories of all these things generate in you right now? Box 2.1 lists some other examples in all of the representational systems.

Box 2.1: Common anchors

Visual
The face of a 'heartsink' patient!
The entrance to your health centre
Blue sky and sunny day, or grey sky and rain
A photograph from a great holiday

Auditory
Your name
The voice of a 'heartsink' patient!
Your favourite music
The sound of skidding tyres

Kinaesthetic
The feel of your consulting-room chair
Rubber gloves
The touch of a clammy, shocked patient
A massage

Olfactory and gustatory
The smell of coffee
The local bakery
The smell of ether
The taste of your favourite food

Anchors are universal, and they are used universally. Look at adverts in the various GP and medical magazines. The advertisers are attempting to pair their product to a particular induced feeling, a particular emotional state. Listen to the music that accompanies adverts on the television. It is there to change your state to make you more receptive to what they want you to buy. Smells are the 'express train to the brain' because they have a direct one-step connection to our emotional centres. The smell of newly laid tar takes me right back to being a child. I used to love that smell, and would get down on my hands and knees to sniff even more. Yes, I confess, I'm an addict.

Recall how your mother used to call your name in a particular tone of voice, and you knew that you were in trouble! How different when someone you love

says it in *that* special way. How do you react when a patient who you hardly know calls you by your first name? It's the same name each time, an anchor for your identity, who you are, yet the different voice tones evoke differing responses. Auditory anchors tend to be mostly out of conscious awareness, and we may respond completely automatically, for good or ill, without knowing why.

What is a phobia? This usually occurs when an intensely negative feeling is paired with an external stimulus, usually a visual one. Simple phobias, such as fears of spiders, dogs, etc., are examples of one-trial learning. Often a single event is enough to set up a lifetime's fear – a very powerful visual–kinaesthetic link. Sometimes even just *imagining* being in the presence of the stimulus is enough to trigger the response. It has become hard-wired to our internal circuitry. NLP has techniques for dealing with simple phobias and other more complex psychological traumas.

Kinaesthetic anchoring, or touching, is also very powerful. If someone is in an intense state, if you touch them in a particular way in a particular place (e.g. on the arm or shoulder), that touch may become a trigger for that state. Touching again, in the same place, in the same way, can reactivate the feelings. This is great if it is a joyous state, but not so great if it is one of sadness or grief. So be careful how you touch people when they are in the grip of powerful negative emotions. Of course, you can deliberately set up touch anchors for yourself and your patients for really good, positive states. And you can deliberately use anchors for these powerful states to neutralise negative states. More on this later.

Anchors in health and disease

Phobias can begin with one intense emotional traumatic episode. However, many anchors are set up by repetition, over time, of mild to moderately intense states. This accumulative effect, out of conscious awareness, can cause certain anchors to run our lives. Just think of the number and variety of states that you go through each day as you respond to patients, phone calls, road traffic, meetings, music, food, coffee, etc.

Yet anchors can also, almost imperceptibly over time, damage our health. States such as depression, anxiety, anger, hostility and helplessness have all been shown to cause physiological and chemical changes that can lead to further disease and illness, shortening life expectancy. These states are negative anchors. The growing field of psychoneuroimmunology shows how our very thoughts can affect our immune system for better or worse. Some allergies may have a stimulus–response cause and effect on the immune system that can be modified by anchoring techniques. We can think about anchors at the various logical levels.

Many negative anchors are *environmental* responses. Chemotherapy-induced nausea and vomiting have a conditioned element to them which can be reduced by desensitisation techniques, as can certain allergies.

Our posture is a potent physiological anchor for certain *behaviours*. Depression has a characteristic posture which further anchors the state. That is why exercise, which significantly changes posture, can be helpful. Try it for yourself. Any time you feel down, dance for 15 minutes to upbeat music. Your state will definitely change quickly.

The *capability* level is all about our thinking styles and strategies. Worry, anxiety and panic are usually caused by associating into imagined future negative consequences and feeling the feelings now. The images trigger the response. Learning to dissociate can change the response.

Beliefs and *values* act as frames for experience which can lead to self-fulfilling prophecies. Negative beliefs such as 'Nobody gets better from cancer' can trigger profound immunological responses derived from 'learned helplessness'. Changing the frame changes the response.

At the *identity* level, the various roles that we play in life can trigger differing effects. The so-called 'sick role', where the secondary gain derived keeps the problem going, is another ill-health anchor.

Anchors are pervasive. Yet looking at disease and illness through this type of lens can open up many more opportunities for lasting, health-improving change. Keep this in mind as you read on.

Achieving what you want

NLP is an outcome-focused, solution-oriented behavioural technology. We look towards *outcomes*, rather than simply identifying problems to move away from. Think of a particular challenging situation and ask yourself the questions in Box 2.2 in turn.

Box 2.2: Identifying problems and outcomes

Problem frame	*Outcome frame*
Why is this a problem?	What do I really want here?
Why does this always happen to me?	How will I know when I have that?
What is my worst experience with it so far?	What can I learn from the situation?
Who is to blame for it?	

Why have I failed to resolve it?	What am I assuming about it?
What does that mean about me?	What else is possible here?
What should I do about it?	What resources do I already have which I can bring to bear?
Who ought to solve it for me?	What example is there of something like this that I have previously succeeded with?
What if it can't be solved?	What is the next step?

Which set of questions are the most useful ones to ask? Which ones leave you feeling more resourceful, that something can be done, that there is a potential solution? Yes, people do have problems. And yes, we do need to start from where they are at before moving on. We shall explore the setting of outcomes in more detail in Chapter 4 on gathering information.

However, there are three things that need to be in place before we can even begin to move in the direction of getting our goals met:

- *motivation* – we believe that the goal is achievable and worthwhile. We *want* to get there
- *means* – we know which resources we need to achieve it. We know *how* to get there
- *opportunity* – we can deal with any interference. We have a *chance* to get there.

Some people may want to get there, but may not know how to, or may not believe that they have a chance to do so. We can help them with the means and the opportunity. Others may know how to, and have the chance to, but they just don't want to! It can sometimes be comfortable staying as we are, letting someone else (e.g. the doctor) sweat about providing the motivation. Robert Dilts has put together the following general model for change.

We start from our *present state* – where we are right now, the problem as formulated. We then set up our *desired state* – our potential solution, our goal, where we want to end up. In order to get there, two things must happen. First, we must remove any *interference* that prevents us from reaching our target. Secondly, we must add the necessary *resources*. Remember that this all happens within the framework of the patient's existing *beliefs* about him- or herself and the world. Finally we must add *ecology* – the study of consequences, what will happen if the goal is actually met or not.

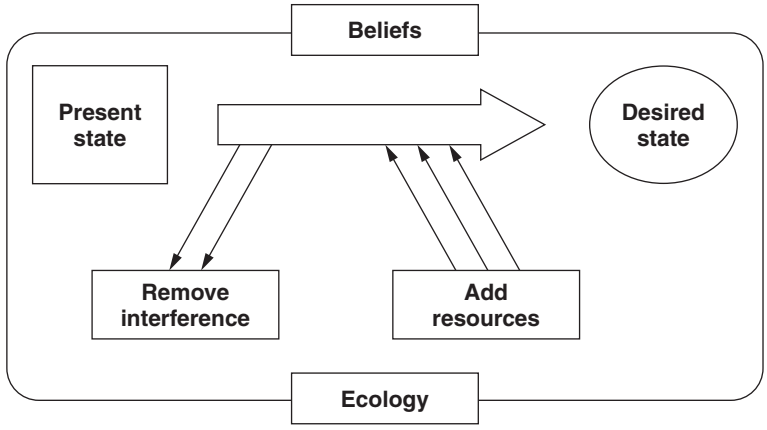

Figure 2.4: NLP model of change.

Over the next few chapters we shall find numerous ways not only to deal with the possible types of interference, but also to add resources at the appropriate *logical level*.

Consulting with NLP

We are going to draw this chapter to a close by having a look at a flow diagram (*see* Figure 2.5) which gives a useful overview of how you can use NLP to promote change within the consultation. This is a model that has been used extensively in business and education with excellent results, and is now being utilised with equal vigour in therapeutic and health contexts. It is a model which sits very comfortably with all of the other models of the medical consultation to date. And in fact all of your current skills and favourite approaches can be nested within it. The beauty of the NLP approach is that it *adds* to the choices which you already have. You don't have to give up anything. The rest of this book will put the meat on to the skeleton's bones.

The main aspects of each stage are summarised below. We shall cover them in depth in succeeding chapters.

1 *Your state* – your own state of mind and body – how you are in yourself before you start – is so important that we shall devote an entire section to this in Chapter 3 on initiating the consultation. And of course your state at the end of each consultation, and between consultations, is worth paying attention to as well.

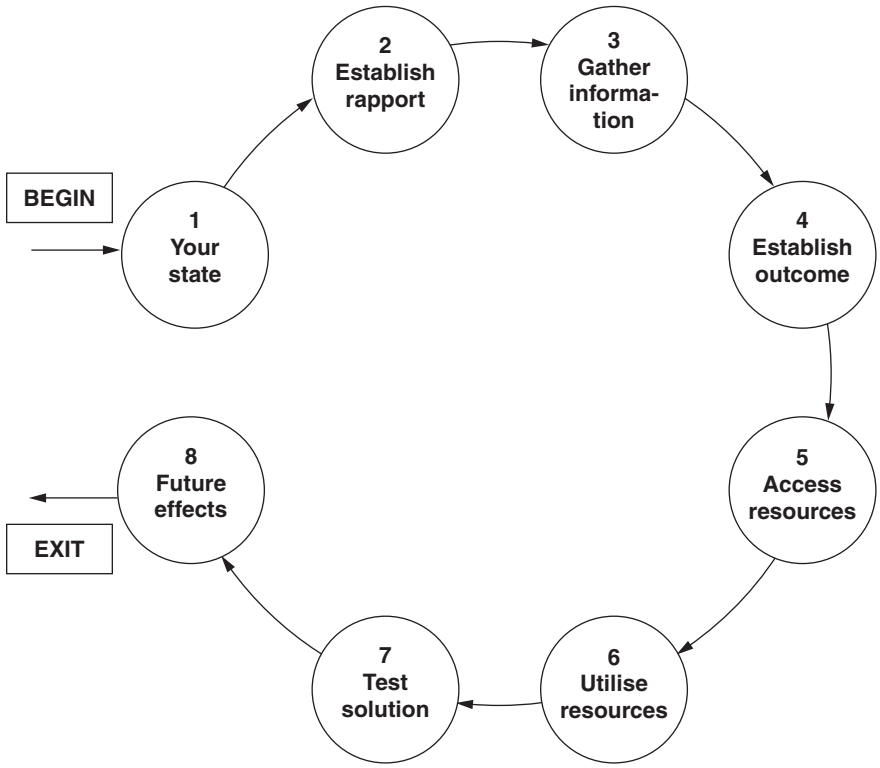

Figure 2.5: Consulting with NLP (adapted from Ian McDermott).

2 *Rapport* – this is vital to any flowing consultation. Rapport needs to be maintained throughout the consulting process, at *every* stage. And not only the current consultation – it can be built up and deepened over a series of consultations.
3 *Gathering information* – high-quality information about how this person structures their experience of illness and disease will allow you to find the levers for effective change. We need to pay particular attention to patients' health beliefs and expectations and, of course, to both their verbal and non-verbal communications.
4 *Outcomes* – you must find out what your patients really want for this situation – their outcomes – and what you want, too! Both can be dovetailed together. Specific outcomes can be set for achievement over one consultation or, by a process of review, over several consultations.
5 *Access resources* – what does this particular person need now in order to best get what they want? Which resources fit the bill? Perhaps they simply

need more information, or a particular kind of intervention, or maybe onward referral.

6 *Utilise resources* – no matter what resources are potentially available, they need to be brought to bear on the current situation. You must use your explanation and planning skills to give this information sensitively in a way that best fits the patient's unique worldview. There are myriad ways to do this, and you will find examples in every chapter.

7 *Test solution* – have you and your patient successfully achieved your outcomes? Has there been a significant difference in the patient's condition? Matching up where we want to go with the evidence that we have actually got there means that what we have done has worked. If it hasn't, you need to know that, too, so that you can do something different.

8 *Future effects* – whatever you do in the consulting room, the proof of the pudding is in the external world of future actions and behaviours. Does the patient actually take their prescribed medication? Has their behaviour really changed? Are they doing things differently? You will find out one way or the other on their return.

These are the eight stages that NLP has used over the years with excellent results. In the real world, all of these stages flow into one another, and may loop recursively back on themselves prior to successfully concluding. You may complete them all in a single consultation, or you may find that they spread out over several consultations, each aspect coming to the fore at the appropriate time. As we explore each phase of the consultation in the succeeding chapters, you can use this flow diagram as a framework in which to connect the detailed skills.