

NLPt, Salutogenesis and the Brain

Gisela Perren-Klingler

Introduction and Definitions

Neuro-linguistic psychotherapy is an offspring of NLP. The author, trained in most of the conventional psychotherapy schools from psychoanalysis to systemic and cognitive behavioural therapy, assumes that NLPt is a good unification of effective techniques in psychotherapy. Nowadays psychotherapy can offer effective treatment, this means treatment which induces change in a short period of time. Serious treatment can no longer be carried out without a concept of the brain model and a salutogenetic approach.

Salutogenesis is the attitude with which the person is not only diagnosed according to pathology (and the different diagnostic manuals, ICD 10 or DSM IV), but also according to the persons resources; one main resource is salutogenesis (Antonovsky 19) conceptualising «self coherence». This consists of «manageability» (i.e. capacity to control, be it in reality or in fantasy), «comprehensibility» (i.e. capacity to understand what has happened and is going to happen) and «meaning» (i.e. capacity to produce/create meaning in life and thereby integrate experiences). Deficiency orientation provokes an attitude in therapists in which they either fight against or move away from a problem instead of becoming creative and moving «towards» more health. The salutogenetic model lets one work indirectly, moving towards healthy parts of the patient, enhancing resources and bypassing pathology. And as the Human being is a cybernetic construction, working on resources will also change «pathology».

Neuro-physiology: It is evident that the «map is not the territory» and that we cannot not use metaphors, even if the brain seems to be «real stuff» because of its material, body bound essence. «The brain», however, is closer to reality than the concepts of unconscious mind, id, ego and superego, and just to mention one other, the psychoanalytical map. We know that brain functions are partly dependent on genetics and partly influenced by culture (Donald, M. 2000; Nisbett R.E. 2003).

The position of the observer has to be defined in order to correspond at an epistemological level to the necessary clarity. The author's position is defined by the values of the humanist enlightenment and the values pioneered by the French Revolution: «Liberté, Égalité, Fraternité» (Freedom, Equality, Brotherhood), a purely materialistic and dialectical position with a cybernetic view of the human being. These values have an immediate influence on the way one relates as a therapist to a patient or client.

The Brain, its Functions and Salutogenesis

The brain is a watery, pudding-like substance weighing little more than a kilogram, a vital organ with specific anatomical attributes and complex functions. Today, the concept in which different brain functions were localised in different areas has been revised into a concept in which activation of different neuronal networks in different locations seems to be more adapted to brain «reality».

Roughly speaking one can imagine that the brain has three parts: The cortex, the midbrain and the bridge and medulla oblongata.

The functions of the Cortex consist mainly of perception (primary and secondary), abstract and concrete thinking and conscious behaviour & belonging.

The midbrain consists of different parts: The limbic system (with the paleocortex), thalamus (link to hypothalamus and hormonal responses), hippocampus (long term memory, space perception, construction), amygdala (emotional reaction) and fornix /putamen (link between right and left hemisphere). Its functions are memory encoding, motor regulation, emotional reactions and attachment (differentiated from belonging!).

The basal part, bridge and medulla oblongata (the upper end of the spinal cord), coordinates the vital functions of the person like appetite/satiety, sleep, arterial blood pressure, cardiac frequency, body temperature and oxygen regulation (respiratory frequency). The formatio reticularis contains amongst other parts the nuclei dorso-lateralis and ventro-lateralis of the Nervus Vagus (10th nerve), where the activation through afferent and efferent parasympathetic and sympathetic fibres starts the acute stress response.

The higher the anatomy (closer to the cortex) the more sophisticated the functions become; the more sophisticated the functions the more plasticity can be found.

Salutogenetically speaking, working with/influencing the brainstem procures better Control, working with/influencing the cortex more Comprehensibility, while Meaning is a process in which cognition and emotion have to be linked, activating the midbrain.

Basic Proceedings in NLPt

The classical proceeding of NLPt always begins with what is called «rapport», a technical version of what other therapy schools call «joining», «holding», «empathy» etc. or forming a trusting contact with the patient.

1. Rapport, a concept from Messmer's «Animal Magnetism», consists of pacing the patient linguistically (in wording and in content) and physically, by mirroring body posture and typical repetitive (mostly unconscious) movements of the patient, until pacing can be changed into leading the patient in her movements. This observable, yet unconscious feedback from the patient tells the therapist that the patient has gained enough security (or working alliance) in the relationship with him and that he can now begin to approach «the problem» or start elaborating resources.

2. This is the moment where one can begin to define the problem and to formulate the objective/goal of therapy and gain informed consent. It is also in this preparatory rapport play that the therapist can find out a lot about resources, elaborate them and by that create even more security. In elaborating and maybe negotiating the «well formed outcome», be it at medium term, for a therapy goal be it at short term for the goal of the session, the patient is guided into an anticipation of his «feeling better», linguistically and using sensory representations. Respect of the patient's/client's ecology at an individual level (personal values and identity) and at a systemic level (including the familial and working systems) is essential for adequately informed consent.

3. It is only now that the NLPt therapist can consider models to achieve the defined goal, which techniques to use and to find the most adapted model and technique to leverage the desired/convened outcome with the least effort and pain possible. It is for this part that all the different techniques of NLPt are trained.

4. At the end of each session the therapist and the patient have to have evidence that they have done valuable work together: The therapist can observe (and not feel!) a clinical physiology, which is different from the problem physiology at the beginning; the patient has to feel better, see clearer etc. and be motivated to do some homework (neuronal sprouting). The seriousness of this motivation can also be observed («calibrated») by the therapist and is confirmed in the next session.

The Brain, Salutogenesis and NLPt

Neuro-linguistic psychotherapy addresses in its proceedings all three parts of the brain and can utilise the three aspects of salutogenesis:

1. The first step of rapport addresses the brain stem: Security gives a sense of control («manageability» = control) and calms the autonomic (sympathetic and parasympathetic) functions. The basis for any efficient psychotherapeutic intervention, rapport, pacing and leading has to be sought in addressing the brain stem. «Chatting» about resources plays an important role because when the resources of the patient are mobilised this produces an increased sense of «competence» or control. The physiology changes according to the resources, from negative (the «problem physiology») to positive (the «resource physiology»). One can also observe the biological effects, such as calming down of the vital functions, breathing and pulse rate.

2. This is the moment where the therapist can safely address the cortical functions by asking the patient about her problem and how she would like it to change. This process mainly addresses the cortical functions, conscious description of the problem and the desired outcome. Of course physiology and emotions (autonomic, brain stem and amygdala activity) go with it and this helps the therapist to calibrate when the problem and the possible solutions are addressed. In that part comprehensibility for patient and therapist is better mobilised if one uses «Clean language» (Grove, David, 1998). This process of conscientization (Freire), in which the patient recognises the metaphors of her «dis-ease», is a first step in the change process. This again influences the brain stem. Cognition, memory and emotions (midbrain) are activated during the specific therapeutic change techniques.

3. Finally, the midbrain is specifically activated when, at the end of a session, the patient understands, reframes and begins to give some meaning to an old and hopefully a new behaviour and is somehow reconciled with herself and her surroundings. This activation of the midbrain is central in motivating the patient to do her homework as defined earlier: Homework is essential in order to fix change by enhancing dendrite sprouting (the process, which will

fix the newly acquired behaviours and insights at a neuronal level). This is the only way to reach solid, sustainable and enduring changes that will slowly become automatic.

Of course it goes without saying that in step 1, when security and control are installed, emotions calm down (midbrain, amygdala) and that verbal communication cannot function without activating the cortex. The activation of one brain part allows the other brain parts to «vibrate» due to the multiple interconnections; activation of one network activates to some extent all the others.

Illustration: A Case History

A 38 years old female contacted me by letter. She had suffered from tinnitus for the past 6 years. Her last hope was to have hypnotherapy and she had found my address through the Swiss Medical Association for hypnotherapy. She had already passed through different hands ranging from her General Practitioner, the local neurologist, the otorhinolaryngologist to some national specialists and some psychiatrists.

She presented herself well dressed, pale and with a shrunk-like body posture. She began to describe her problem to me immediately.

1. Rapport, Brain Stem Work/ Control: Although I prefer to enter into contact with a new patient through other topics than the problem, it was evident that I had to accept this offer for rapport and pace her by listening and asking about her problem. Her description of the tinnitus was impressive: «This big noise», which wakes her up at night because it is so loud, which bothers her the whole day and which gives her only little rest. After about 10 minutes of describing the problem and her physiology getting worse and worse I wanted to mobilise her internal feedback mechanisms and to diagnose whether she had some dissociative disorder.

I asked her how she felt: «Lousy», she replied. I now proposed an «exercise» to ease her evident stress. In a specific breathing exercise (Perren-Klingler, 1998) I paced and lead her into a calm breathing, her pulse rate went down, hands became warm and dry and her face physiology changed. After about 10 minutes of leading her breathing I asked her how she now felt. Starting to pay attention to herself, she noted with astonishment and surprise: «Good... and it is has gone», she said. I asked her if she could bring «it» (her «noise») back. Her breathing changed

immediately, she pulled in her head and neck and in a distorted position with an immediate poor physiology pointing to her left ear said: «Here it is again». So I began her breathing again until her physiology returned to the good. This was her first experience of being able to control, albeit under my guidance.

2. Confrontation, Psychoeducation, comprehensibility, working with the Cortex: I now began to explain the mechanism to her. She breathes in a distorted body position, this produces a hyperventilation effect with a high pulse rate, cold and sweaty hands, a dizzy head etc. and like that she is able to sustain her tinnitus. She asked me whether I thought she did it on purpose, to which I could easily say «No». «So you believe me that I hear it?» «Yes, of course» I replied, «However let's be clear, if I concentrate on my ears, listen inside and stop breathing (me imitating her body position) I also hear sounds in my ears...». Surprise again – «So I am not crazy?» «No, and moreover you can control it and that will be your homework». I explained the exercise to her, her body position for the exercise and gave the instruction that she will have to do the exercise twice a day for 15 minutes. We exercised until she was able to do the breathing independently and in an adequate way.

3. Giving a first meaning (emotions midbrain) through the definition of a well-formed outcome: I asked her whether this would be a possible goal for our work together: She would learn how to manage her ears and become able to make them quiet. She agreed happily. I told her that I thought she could succeed in about 5 sessions with me and that that all depended on her regularity in doing her homework. She understood and agreed (comprehensibility and control). I gave her my phone number and an appointment in two months.

She came back after the two months and had been able to control her tinnitus. She had no longer been disturbed by it in her sleep. She did, however, look very «worn out» and depressed.

I explained why she should take an antidepressant drug (an SSRI, influential on different brain levels), and negotiated her consent (cortex). She would have to take it for a whole year (explaining the relapse prevention effect of the duration of medication). I also controlled her breathing homework, which she did perfectly well and I instructed her

to do some daily sport. She talked about biking, walking and swimming and we convened that she would do one of these sports for at least one hour daily – at the least 4 times a week. I did psychoeducation about stress and its management and its influence on depressive moods. With that I mainly addressed her cortex, giving not just comprehensibility and control but also meaning, because she became conscious that she was on the way to curing herself.

I also explained to her different attentional styles: Listening to the inside when one is depressed and to the outside when one feels well.

I began specific resource work, eliciting different sensorial situations where she is competent – as a mother, as a professional, doing sports – and anchoring them (tonified conditioned reflex, working with the brain stem). I gave her another appointment in six months.

In her third session, six months later, she looked well and when I asked her how life was, she straightened up and said: «I can hear / listen very well, the cars on the road outside the window, your voice (outside attention); and I can also hear the silence in my head». She continued, saying that the tinnitus was sometimes there but it did not disturb or agitate her anymore. She had been able to discover that this was just a signal notifying her about too much stress and that if she listened to it, it would become her friend – or a feedback mechanism. Here, for the first time, she told me about her husband, who had been depressed for 15 years because of a drawn-out legal proceeding.

I told her that first of all she had to protect herself from his depression and that she had to do that through a «resource diary». I reactivated her resources from the last session and then instructed her that every night she had to ask herself about the best moment in her day and pass it through all her senses, as if she was living it again – as we had done just now. Then she would have to mark it with a word in a little diary in order to tell about it next time.

Resource work activates all three brain parts: Emotional (amygdala) «the best moment of the day»; cognitive (cortex) through eliciting the sensorial memory and fixing its physiology in an anchor (brain stem). The daily exercise was meant to make her dendrites sprout and automatise the resource procedures.

To the last session, six months later, she came with a completely different body tonicity and I was easily able to stop her antidepressant medication.

I asked what she had learned with me, she said: «I have learned how to listen well, how to manage my stress and how to step back from my husband's depression, sometimes I can seduce him to do sport with me». She was looking forward to the winter season with lots of skiing (superb physiology) and she enjoyed being with her adolescent daughter much more. She had changed her tonicity in her

work as an aesthetician and masseur.

Comment

At that moment in which I was able to notice that she was associated, i.e. did not have a dissociative disorder, I refrained from taking a complete clinical history and concentrated on the patient's resources. Even having had a thought pass through my head that there might be a couple problem I refrained from asking about systemic complications in the first session. This couple problem became clear only in the third session. However, the patient did have the feeling that she was able to deal with her husband's depression once she felt better. Our negotiated therapy outcome was that she would have a quiet head and be able to manage her stress. This means that I had not asked for her consent to enter into her systemic problems and it proved unnecessary.

Once she became well she began talking about her feeling guilty for not having been attentive enough to her adolescent daughter. Instead of entering into that problem, it was possible to enhance her pleasure with her daughter and probably more effective in the long run than adventuring into interpretation of her feeling guilty.

Therapy was easy because the patient was motivated. After perceiving her hopelessness in the first session, however, (six years of symptomatology is long!) it would have been easy to become contaminated by it. The approach through her body, by breathing, was a direct way to show her concretely her (and the therapist's) ability to control, giving back her hope immediately. Assuming that psychotherapy always works with/for the future, I only worked in the present. This way I was able to refrain from going back to eventual past causes of her tinnitus, thus avoiding the psychodynamic interpretative essays.

I also interpreted her depressed mood exclusively in the sense of a reactive depression through exhaustion/lack of sleep.

As we know today, stress management (breathing exercise and regular sports) is essential in every psychic condition. It was enough to show the patient this to be effective for her symptom. As we also know that relapse prevention in depression depends on the capacity of the patient to manage her stress and by that her rumination the patient's central topic has been addressed.

She might cease to do her breathing exercise she will, however, know how to do it when she needs it again – be it because of the tinnitus or feeling low and ruminating. So she has been able to model healthy behaviour and, having exercised it for a year under the therapist's control (even with only five sessions), she has achieved comprehensibility and control. The meaning for the span of her therapy

was her learning and feeling resourceful and better.

Larger-scale meaning will be an ongoing task in her life as a professional woman, a mother and a wife of a depressed husband. For that she has probably acquired some supplementary tools.

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