# From Technique to Accountable Therapeutic Practice

## Integrative Neuro-Linguistic Therapy and the MAPA Method

### A Critical Review and Framework for Responsible NLP-Based Practice

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**Article type:** Conceptual Review and Position Paper

## Abstract

Neuro-Linguistic Programming has developed a substantial repertoire of models concerned with language, internal representation, emotional states, beliefs, values, strategies, learning and behavioural change. Its practical appeal has often rested on procedures that are memorable, teachable and capable of producing immediate experiential effects. Nevertheless, the ability to conduct an NLP technique does not, by itself, constitute competence in therapeutic practice.

This article introduces **Integrative Neuro-Linguistic Therapy**, originally formulated in Portuguese as *Terapia Neurolinguística Integrativa*, and presents the **MAPA Method** as its organising architecture. MAPA represents four interdependent professional disciplines: **Map before intervening; Analyse before concluding; Project before promising; and Accompany before closing**. The framework places NLP-derived models within a wider process of collaborative formulation, relational responsibility, contextual enquiry, continuous consent, risk awareness, proportionate intervention, outcome monitoring, supervision and referral.

The proposal is positioned in relation to historical NLP, established European Neuro-Linguistic Psychotherapy traditions, contemporary NLP training and relevant psychotherapy literature. It acknowledges both the practical significance of NLP and the limitations of the evidence supporting broad claims made on its behalf. Integrative Neuro-Linguistic Therapy is not presented as an empirically established school of psychotherapy, a universal treatment or a substitute for legally recognised professional qualifications.

Its proposed contribution lies in the synthesis and operationalisation of responsibilities that may remain implicit or fragmented in technique-centred training contexts. MAPA is intended to prevent the premature movement from complaint to technique, to make protective function and contextual reality central to formulation, and to treat real-world follow-up as part of the intervention itself.

The article argues for the responsible development of a distinct, competency-based training pathway for professionals who intend to use NLP therapeutically. Such training should assess not only whether practitioners can perform techniques, but whether they can formulate provisionally, recognise risk, maintain consent, monitor consequences, work within scope and identify when an NLP intervention should not be used.

**Keywords:** Neuro-Linguistic Programming; Neuro-Linguistic Psychotherapy; Integrative Neuro-Linguistic Therapy; MAPA Method; case formulation; therapeutic training; ethics; supervision; outcome monitoring

# 1. Introduction: why technique is not enough

Neuro-Linguistic Programming emerged from an attempt to identify and describe patterns observed in communication, learning and therapeutic interaction. Its early developers examined the work of influential practitioners, including Virginia Satir, Fritz Perls and Milton H. Erickson, seeking to translate aspects of effective practice into structures that could be observed, taught and reproduced (Bandler & Grinder, 1975; Grinder & Bandler, 1976).

This modelling project produced a rich practical vocabulary. NLP practitioners may learn to investigate language patterns, internal imagery, dialogue, sensory distinctions, emotional states, beliefs, criteria, goals, perceptual positions, behavioural sequences and strategies. They may also learn procedures involving anchoring, reframing, metaphor, submodalities, parts, timelines, strategy redesign and hypnotic communication.

These resources can contribute to useful conversations and meaningful experiences. They may help someone recognise a previously unnoticed sequence, find language for an experience, access a resource, revise an interpretation or rehearse a different response.

Yet the capacity to produce an experience is not the same as the capacity to accompany a therapeutic process.

A practitioner may competently follow the steps of an intervention while remaining unable to determine whether it is appropriate, what risk may be present, whether sufficiently informed consent has been obtained, how the proposal relates to a formulation, what environmental conditions are maintaining the difficulty or how the effects will be reviewed after the session.

This distinction is not an argument against techniques. It is an argument for placing them within a larger architecture of responsibility.

**A technique may open a door. It is not the whole house.**

The central question in responsible therapeutic work is therefore rarely only:

“Which technique can I apply?”

A more mature question is:

**“What does this person need now, what might they be attempting to preserve, and what conditions must be present for any intervention to be proportionate, collaborative and sufficiently safe?”**

Integrative Neuro-Linguistic Therapy begins with this shift.

# 2. Scope and approach

This article is a **critical conceptual review and position paper**. It does not claim to be a systematic review, meta-analysis or exhaustive account of every publication associated with Neuro-Linguistic Programming or Neuro-Linguistic Psychotherapy.

Its purpose is to position Integrative Neuro-Linguistic Therapy and the MAPA Method within five relevant bodies of material:

- foundational and historical NLP literature;
- critical and supportive research concerning NLP and NLP-derived practice;
- established European standards for Neuro-Linguistic Psychotherapy;
- contemporary psychotherapy literature on formulation, therapeutic relationship, safety, consent, supervision, adverse effects and outcome monitoring;
- the two-volume Portuguese work *Mapas da Mudança*, in which the framework was first articulated.

Sources were selected purposively because of their relevance to the conceptual, professional and ethical questions addressed here. Priority was given to systematic reviews, meta-analyses, official institutional standards and literature directly concerned with formulation, therapeutic relationship, safety, supervision, adverse effects and outcome monitoring.

Institutional documents are used to describe published standards and training structures, not as evidence of therapeutic efficacy.

The structure of the review was also informed by published guidance on narrative and state-of-the-art reviewing, although the present article does not claim the procedures or comprehensiveness of a formal systematic review (Baethge et al., 2019; Barry et al., 2022).

The review is therefore purposive and interpretative. It seeks to clarify a problem, compare relevant traditions, define a framework and identify conditions required for its responsible development.

Three questions organise the discussion:

1. What distinguishes knowledge of NLP procedures from competence in therapeutic practice?
2. How should a MAPA-based proposal relate to established NLPt traditions and contemporary psychotherapy standards?
3. What forms of training, assessment and research would be required for Integrative Neuro-Linguistic Therapy to develop responsibly?

The article gives attention to findings that support, criticise or complicate claims made for NLP. Supportive findings are not treated as definitive validation. Critical findings are not interpreted as proof that every NLP-derived procedure is necessarily ineffective.

The more defensible conclusion is that NLP is neither a single uniform treatment nor a body of equally validated models. Claims must be examined at the level of the particular construct, intervention, practitioner, population, outcome and context.

## 2.1 Authorial position

The author is not a neutral observer of the framework presented here. He developed Integrative Neuro-Linguistic Therapy, formulated the MAPA Method and authored the books upon which the proposal is based.

This position provides substantial familiarity with the subject. It also creates the possibility of confirmation bias, selective interpretation and professional interest in future educational programmes.

For this reason, the framework should not be accepted on the authority of its originator. Its concepts, instruments, training standards and outcomes must remain open to independent criticism, research, revision and, when necessary, rejection.

# 3. Therapy, psychotherapy and professional scope

The terms *therapy* and *psychotherapy* are not legally interchangeable in every country.

In this article, **therapeutic practice** refers broadly to a structured helping process intended to address patterns of distress, limitation or reduced freedom of response. The term does not imply that every practitioner using MAPA is legally authorised to practise psychotherapy.

Where psychotherapy is regulated, Integrative Neuro-Linguistic Therapy may be practised as psychotherapy only by professionals who meet the legal and professional requirements of the relevant jurisdiction.

An INLT training certificate must not, by itself, be represented as conferring the legal status of psychologist, psychotherapist, physician, counsellor or any other regulated professional.

This distinction has direct implications for training, certification and public communication. A psychologist or legally recognised psychotherapist may integrate MAPA into clinical practice within their competence. A coach, trainer or educator may use selected MAPA principles to clarify goals, recognise limits and improve referral decisions, but should not present such work as the treatment of mental disorders when they are not authorised or qualified to provide it.

The framework must adapt to professional law. Professional law must not be rhetorically adapted to the framework.

The use of the term *therapy* in the name of the framework does not override legal definitions, protected professional titles or statutory requirements in any jurisdiction.

# 4. NLP and the development of therapeutic practice

The historical importance of NLP should not be dismissed. Its modelling orientation encouraged practitioners to examine structure rather than rely solely on abstract explanation. Its attention to language, sequence, representation and behavioural flexibility offered practical ways of exploring experience.

NLP's development was also influenced by systemic and epistemological perspectives concerned with context, feedback, relationship and the limits of any single description of reality (Bateson, 1972).

Difficulties emerged when useful observations, heuristics, metaphors and provisional hypotheses were sometimes presented as though they were established descriptions of neurological or psychological mechanisms.

Claims concerning fixed representational types, eye-accessing cues, rapid universal change, memory processes and neurological organisation often moved beyond the available evidence. Some concepts were transmitted in training settings with greater certainty than research justified.

This does not mean that historical NLP contained no safeguards. Concepts such as ecology, rapport, positive intention, calibration, outcome specification, flexibility and sensory-based feedback were present in important strands of the field.

The problem is not that responsible principles were entirely absent.

The problem is that, in some technique-centred training and application contexts, these principles may remain insufficiently integrated into an explicit therapeutic architecture involving risk, formulation, professional boundaries, contextual realities, adverse effects and longitudinal follow-up.

The expression **technique-centred NLP training context**, as used in this article, refers to this recurrent tendency. It does not describe every historical or contemporary NLP school, programme, trainer or practitioner.

Broader critical discussions have also examined both the practical contribution of NLP and the limitations of some of its explanatory claims (Tosey & Mathison, 2009).

# 5. Positioning INLT in relation to Neuro-Linguistic Psychotherapy

Any contemporary proposal for the therapeutic use of NLP must recognise that specialised psychotherapeutic training based upon NLP did not begin with Integrative Neuro-Linguistic Therapy.

A European tradition of **Neuro-Linguistic Psychotherapy**, commonly abbreviated as NLPt, has existed for several decades. The European Association for Neuro-Linguistic Psychotherapy describes NLPt as a systemic, imaginative and integrative-cognitive method of psychotherapy and publishes a metastructure for recognised training curricula based upon European NLPt traditions and European Association for Psychotherapy standards (European Association for Neuro-Linguistic Psychotherapy, n.d.).

The published EANLPt metastructure is substantially more extensive than a brief technique course. It describes a four- to five-year curriculum containing theoretical education, self-experience, peer work, individual therapy, crisis-related training, supervision, documented cases, supervised clinical work, a written thesis and a final examination. It also requires adaptation to national legislation.

The argument of this article is therefore not that therapeutic NLP training has never existed.

The more precise claim is:

**A distinct MAPA-based training pathway may be developed and evaluated while being positioned transparently in relation to established NLPt traditions, existing professionais standards and jurisdiction-specific requirements.**

Integrative Neuro-Linguistic Therapy does not claim to replace NLPt or to suggest that previous therapeutic traditions were devoid of structure, ethics or supervision.

Its proposed contribution is narrower: to articulate a formulation-centred architecture through which NLP-derived models may be selected, limited, monitored and taught with explicit attention to protective function, contextual reality, continuous consent and real-world follow-up.

INLT should therefore be understood as a potential contribution to the wider field of responsible NLP-based therapeutic practice, not as a declaration that such a field did not previously exist.

# 6. The current evidential landscape

## 6.1 NLP is not one testable intervention

The term *NLP* has been applied to a heterogeneous collection of models and activities, including:

- hypotheses about representational predicates and eye movements;
- communication practices;
- coaching methods;
- brief behavioural exercises;
- hypnotic and metaphorical procedures;
- multi-session therapeutic interventions;
- organisational and educational applications;
- integrative practices combining NLP with other approaches.

It is methodologically inadequate to ask only whether “NLP works”.

A meaningful evaluation must specify:

- which model or intervention was used;
- how it was operationalised;
- who delivered it and with what training;
- for which population;
- in comparison with what;
- over what period;
- with which outcomes;
- with what attention to treatment integrity, deterioration and adverse effects.

A study of eye-movement hypotheses cannot establish the effectiveness of a multi-year NLPt psychotherapy. Conversely, improvement during an integrative psychotherapy

containing some NLP-derived procedures cannot validate every historical claim associated with NLP.

## 6.2 Critical findings

Sturt and colleagues' systematic review examined NLP interventions in relation to health outcomes. Ten experimental studies met its inclusion criteria. The authors concluded that there was little evidence of improvement in health-related outcomes and emphasised that this conclusion reflected the limited quantity and quality of the research rather than robust evidence that no effect could exist (Sturt et al., 2012).

Witkowski's review of studies contained in an NLP research database concluded that major NLP claims had not received adequate empirical support (Witkowski, 2010). Passmore and Rowson's later critical review similarly argued that practices presented as distinctively NLP-based were poorly supported by research, particularly in coaching contexts (Passmore & Rowson, 2019).

These publications also highlight the difficulty of determining which elements are unique to NLP and which are shared with wider therapeutic and communication traditions.

The criticisms identify genuine problems:

- imprecise definitions;
- heterogeneous interventions;
- small samples;
- weak controls;
- inconsistent replication;
- selective interpretation;
- conflation of common helping skills with distinctive NLP mechanisms;
- claims that exceed the evidence.

They should not be dismissed merely because they are uncomfortable for the field.

## 6.3 Supportive and suggestive findings

A meta-analysis by Zaharia, Reiner and Schütz included 12 studies and reported a moderate overall effect in favour of NLP-related therapy. The authors suggested that NLPt might produce outcomes comparable with other forms of psychotherapy (Zaharia et al., 2015).

This finding deserves consideration but does not settle the matter. The included studies were heterogeneous, many were observational, samples were generally limited, and the interventions and presenting concerns varied.

The analysis may indicate a signal worthy of investigation, but it cannot validate NLPt as a uniform treatment or establish the mechanisms proposed by historical NLP theories.

The most defensible conclusion is therefore neither promotional nor dismissive:

**There is insufficient high-quality evidence to support broad claims for NLP as a universally effective therapeutic approach. There are preliminary and heterogeneous findings that justify more rigorous investigation of clearly defined NLP-derived interventions and professionally structured NLPt or INLT practice.**

## 6.4 Evidence-based practice is not technique alone

Evidence-based psychological practice involves the integration of the best available research, professional expertise and the characteristics, culture, values and preferences of the person receiving care (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006).

It is not simply the selection of a branded procedure from a list of approved techniques.

This broader understanding is compatible with MAPA, provided that each component is taken seriously:

- research must not be replaced by practitioner conviction;
- expertise must involve demonstrated competence rather than confidence alone;
- the person's values and circumstances must influence formulation and intervention;
- feedback must be capable of altering the practitioner's plan.

This position is also consistent with broader psychotherapy research emphasising relational, contextual and common therapeutic factors alongside specific procedures (Wampold & Imel, 2015).

INLT cannot become evidence-based by describing itself as integrative. It must build an evidential culture into training, supervision, documentation and research.

# 7. The competence gap

Standard NLP education can develop substantial practical ability. A practitioner may become skilled in communication, outcome framing, sensory observation, state elicitation, reframing, strategy work and the facilitation of experiential exercises.

These abilities are not identical to psychotherapeutic competence.

A practitioner may know how to perform a technique and still be unprepared to:

- recognise suicide or self-harm risk;
- identify violence, abuse or coercive control;
- distinguish anxiety-based anticipation from actual environmental danger;
- recognise severe disorganisation, substance-related risk or relevant health concerns;
- manage dependency and professional boundaries;
- formulate a complex presentation;
- repair a therapeutic rupture;
- monitor deterioration;
- identify an adverse effect;
- refer without creating abandonment;
- work within jurisdiction-specific law.

The distinction may be expressed simply:

**Procedural competence asks whether the practitioner can perform an intervention. Therapeutic judgement asks whether the intervention should be performed—with this person, at this time, for this purpose, by this practitioner and under these conditions.**

The current NLP Trainer, IN curriculum contains important foundations, including ethically and ecologically sound use of NLP, systemic work, accurate feedback, knowledge of psychological and psychotherapeutic methods, legal and ethical issues, supervision, self-experience and intervision (International Association of NLP Institutes, 2026).

Its principal structure, however, is directed towards trainer competence, group facilitation, presentation, exercise design and the organisation of learning. It is not presented as a complete psychotherapeutic qualification.

A dedicated MAPA-based pathway would therefore not negate the value of existing NLP qualifications.

It would recognise that NLP competence, trainer competence and psychotherapeutic competence overlap in certain areas but are not equivalent.

The need for additional training does not arise from an assumption that NLP practitioners are inherently irresponsible. It arises from the recognition that therapeutic work requires competencies not adequately demonstrated by procedural certification alone.

# 8. Defining Integrative Neuro-Linguistic Therapy

Conceptual precision is necessary if INLT is to be discussed, taught or evaluated.

## 8.1 Integrative Neuro-Linguistic Therapy

**Integrative Neuro-Linguistic Therapy is a formulation-centred framework developed by the author for organising the responsible therapeutic use of NLP-derived models within a broader discipline of relationship, context, safety, consent, evidence, supervision and follow-up.**

It is the overarching orientation.

It is not currently presented as:

- an empirically established school of psychotherapy;
- a replacement for NLPt;
- a universal treatment;
- a new legal profession;
- an independent licence to practise psychotherapy;
- evidence that all historical NLP theories are neurologically accurate.

## 8.2 The MAPA Method

The **MAPA Method** is the organising architecture within INLT.

MAPA means:

**Map before intervening.**
**Analyse before concluding.**
**Project before promising.**
**Accompany before closing.**

In this context, *Project* means translating desired change into a concrete, contextual and observable future direction before making promises about outcome.

MAPA is not synonymous with INLT. It is the central method through which the wider orientation organises therapeutic judgement.

## 8.3 MAPA instruments

MAPA instruments are structured aids for:

- triage and safety enquiry;
- Current State mapping;
- Desired State construction;
- provisional formulation;
- intervention selection;
- ecological and consequence review;
- progress monitoring;
- follow-up.

They are clinical and educational formulation tools.

They are **not psychometrically validated diagnostic instruments** and must not be presented as tests, diagnostic scales or substitutes for formal assessment.

## 8.4 Historical NLP models

Historical NLP models constitute one possible repertoire within INLT. They may include the Metamodel, representational processes, submodalities, anchoring, strategies, T.O.T.E., R.O.L.E., SCORE, SOAR, perceptual positions, reframing, parts work, modelling, metaphor and hypnotic language.

These models do not determine the formulation.

They are selected—or rejected—according to it.

## 8.5 The training pathway

The proposed INLT training pathway is the educational process through which practitioners would develop and demonstrate the competencies necessary to use the framework responsibly.

Completing such training would not override national law or expand the participant's underlying professional scope.

# 9. Formulation as the bridge between person and intervention

In INLT, **formulation** is the collaborative and provisional process through which a presenting concern is translated into a working understanding of how a pattern currently operates.

A formulation may include:

- the circumstances in which the pattern emerges;
- the person's attention and interpretation;
- internal imagery, language, memory and bodily response;
- emotion, action and avoidance;
- immediate protective effects;
- delayed costs;
- relevant history;
- contextual conditions;
- available resources;
- exceptions;
- risks;
- desired changes.

Formulation is not diagnosis, although diagnostic information may be relevant when it falls within the practitioner's professional competence.

It is not an explanation of the whole person.

It is not a hidden theory constructed by the practitioner and imposed upon the person.

Its purpose is to create a sufficiently coherent and revisable basis for deciding what should happen next.

Contemporary case-formulation literature emphasises that formulation is intended to organise information, generate testable hypotheses and guide individualised treatment planning (Eells, 2015). Collaborative formulation may support understanding and engagement, but it can also become unhelpful or distressing when the person's meanings are not sufficiently respected (Padesky, 2020; Thrower et al., 2024).

Formulation therefore connects three questions:

**What appears to be happening?**

**What remains uncertain?**

**What intervention, non-intervention or referral is proportionate to what is currently understood?**

Without formulation, technique selection may be guided primarily by practitioner preference, familiarity or enthusiasm.

With formulation, a technique becomes one possible response to a defined and revisable hypothesis.

**A map is useful when it organises enquiry. It becomes harmful when it silences the territory.**

# 10. The MAPA Method

MAPA should not be understood as four rigid stages through which every person must pass in the same order.

Its four movements are recurring professional responsibilities. A practitioner may return to each of them as new information emerges.

MAPA is therefore less a protocol than a discipline of therapeutic prudence.

## 10.1 Map before intervening

People frequently arrive with global descriptions:

“I have anxiety.”

“I am insecure.”

“I cannot say no.”

“I procrastinate.”

“I sabotage myself.”

“I cannot stop working.”

These statements may communicate genuine suffering, but they do not yet reveal how the difficulty functions.

Mapping moves from identity and abstraction towards a sequence that can be observed collaboratively.

The practitioner may investigate:

- the situation in which the pattern occurs;
- the apparent trigger;
- what happened in observable reality;
- where attention moved;
- what meaning was attributed to the event;
- which image, memory, internal statement or sensation appeared;
- what happened emotionally and physically;
- what the person did, avoided or attempted to control;
- what immediate relief or protection followed;
- what cost emerged later;
- which resources became inaccessible;
- what the environment contributed;
- when the pattern occurred less intensely.

Instead of concluding that someone “is insecure”, a map might show:

When invited to contribute in the presence of senior colleagues, the person predicts that an imperfect response will reveal incompetence. They imagine critical expressions, experience tension and shame, rehearse several possible answers and delay speaking until the

opportunity has passed. Remaining silent reduces exposure temporarily but later increases regret and self-criticism.

This description does not define the person.

It makes a sequence visible.

Mapping protects against the premature conversion of suffering into identity. It also reveals several possible points of intervention rather than forcing the difficulty into the practitioner's preferred technique.

### The map must remain recognisable to the person

A formulation becomes problematic when it is intellectually elegant but unrecognisable to the person whose life it describes.

The person must be able to say:

"That resembles what happens."

"This part is missing."

"That interpretation is not mine."

"You are treating a real danger as though it existed only in my mind."

"The pattern works differently in another context."

Mapping is not complete when the practitioner is satisfied.

It is sufficiently useful when it improves shared understanding without pretending to explain the person completely.

## 10.2 Analyse before concluding

Mapping describes a sequence. Analysis considers what might be maintaining it, what purpose it may be serving and what remains unknown.

INLT treats formulation as provisional. A hypothesis should be sufficiently coherent to guide the next step and sufficiently flexible to be corrected.

This protects the person from confident but premature statements such as:

"You are afraid of success."

"This is resistance."

"You are attracting this."

"Your unconscious is sabotaging you."

"You have a limiting belief."

Any of these ideas might occasionally contribute to enquiry. None should be imposed as unquestionable truth.

### Internal process and external reality

A central INLT distinction is the relationship between:

- the person's representation of events;
- the conditions that are actually occurring around them.

Someone may anticipate criticism because of earlier experiences. They may also work in an objectively humiliating environment.

Someone may experience guilt when establishing a boundary. They may also depend financially upon the person to whom the boundary would be addressed.

Someone may remain vigilant because of learned threat prediction. They may also be living with violence or coercive control.

Someone may be exhausted because of rigid performance criteria. They may also have a medical condition, severe sleep deprivation, caregiving responsibilities or an objectively unsustainable workload.

The statement "the map is not the territory" must never be used to imply that only the map matters.

**Sometimes the territory is dangerous.**

## What is the pattern attempting to preserve?

The organising question of INLT is:

**What is this person attempting to preserve?**

A pattern may be attempting to preserve:

- safety;
- dignity;
- attachment;
- belonging;
- predictability;
- competence;
- loyalty;
- identity;
- responsibility;
- moral coherence;
- relief from overwhelming emotion.

This question develops the traditional NLP notion of positive intention while treating it with greater precision.

The term *positive intention* can become misleading when it is treated as a literal truth about every behaviour or when it appears to place a positive label upon harmful experiences. In some contexts, **protective function**, **perceived necessity** or **need being preserved** are more accurate formulations.

The intention may be understandable.

The strategy may remain costly.

The need may be legitimate.

The behaviour may need to change.

Understanding does not mean justification. Respecting a function does not require maintaining the pattern.

It means that a viable alternative must preserve something important more effectively and with less cost.

## 10.3 Project before promising

Many therapeutic goals are initially expressed as the absence of an unwanted state:

“I want to stop feeling anxious.”

“I want to eliminate guilt.”

“I want to remove this fear.”

“I never want to feel this way again.”

These wishes deserve respect, but they do not yet describe a future response.

Projecting means asking:

**“What would you like to be able to do when this situation occurs again?”**

The person who fears meetings may wish to make one relevant contribution while allowing some nervousness to remain.

The person who agrees automatically to every request may wish to pause, consult their availability and respond without abandoning either the relationship or themselves.

The exhausted professional may wish to distinguish a genuine emergency from the mere existence of unfinished work.

The person facing a conflict of loyalty may wish to consider an opportunity without automatically interpreting growth as betrayal.

The Desired State is therefore not an idealised identity. It is a sufficiently concrete, contextual and observable direction.

### Change is not emotional eradication

Fear may communicate risk.

Guilt may indicate a moral or relational concern.

Sadness may accompany loss.

Anger may signal violation.

Ambivalence may be an appropriate response to a consequential choice.

The aim may be to help the person:

- recognise a state earlier;
- distinguish emotion from instruction;
- tolerate manageable discomfort;
- create a pause;
- access support;
- revise an inaccurate prediction;
- respond in accordance with chosen values;

- recover more quickly;
- protect themselves more effectively.

### Ecology must include the real world

Ecological review cannot be confined to internal congruence.

It must also consider:

- physical and mental health;
- financial conditions;
- culture;
- family and community;
- power differences;
- dependency;
- discrimination;
- legal realities;
- safety;
- access to support;
- the likely reactions of other people;
- the practitioner's professional scope.

A person should not be encouraged to confront an abusive individual merely because assertiveness has been identified as a desired resource.

Someone should not be invited to disclose sensitive information without considering foreseeable consequences.

A change may be psychologically imaginable and still be socially, physically or economically unsafe.

Projecting before promising is therefore a discipline of consequence.

## 10.4 Accompany before closing

A session may feel powerful and still produce little durable change.

Someone may cry, feel relief, alter an internal image, access confidence, formulate a decision or understand an important pattern.

These experiences may be meaningful.

They are not, by themselves, proof of therapeutic outcome.

The more important questions arise when the person returns to everyday life:

- Did they recognise the sequence earlier?
- Was a pause possible?
- Did the pattern become less intense, shorter or less frequent?
- Was recovery faster?
- Did the intervention produce an unforeseen consequence?

- Was the planned step too large?
- Did the work increase shame, confusion, avoidance or dependency?
- Was another form of support required?

A recurrence does not automatically demonstrate failure.

It may reveal an overlooked context, insufficient resources, exhaustion, external danger, an incomplete formulation or a step that was too demanding.

### Feedback as part of the intervention

Research into routine outcome monitoring and progress feedback suggests that average benefits are generally modest and depend heavily upon implementation, context and whether feedback actually influences clinical decisions. These approaches may be especially useful in identifying people whose progress is not proceeding as expected (McAleavey et al., 2024; de Jong, 2025).

INLT should not reduce a person to a score. It should nevertheless establish disciplined ways of learning whether the work is helping.

Monitoring may include:

- person-defined indicators;
- changes in functioning;
- frequency, intensity and duration of the pattern;
- recovery time;
- observable behaviour;
- relational consequences;
- access to resources;
- therapeutic-alliance feedback;
- unwanted or adverse effects;
- need for referral or additional care.

The person must be able to say:

“This did not help.”

“I felt pressured.”

“I understood it, but nothing changed outside the session.”

“The exercise was too intense.”

“I need another form of support.”

Such feedback is not proof of resistance or insufficient commitment.

It is information about the process.

# 11. Technique as a formulation-linked experiment

Within INLT, a technique is not selected because it is dramatic, familiar or commercially attractive.

It is selected because a provisional formulation suggests that it may help explore or modify a particular part of a pattern.

For example:

- Metamodel questions may clarify vague predictions, omissions or assumed meanings.
- Submodality exploration may examine how the sensory qualities of a representation relate to emotional intensity.
- Anchoring may support access to a resource but cannot replace protection, medical care or social support.
- Reframing may expand meaning but must not invalidate grief, injustice or danger.
- Perceptual positions may increase perspective but should not be used to demand empathy for an aggressor.
- Parts work may help organise ambivalence, provided that metaphorical parts are not mistaken for literal separate personalities.
- SCORE may broaden formulation across symptoms, perceived causes, outcomes, resources and effects.
- Strategy models may clarify sequences without reducing the person to a mechanical programme.
- Hypnotic language may support attention and experiential learning but requires consent, competence, monitoring and appropriate closure.

The proposal can be framed collaboratively:

"Given what we currently understand, this exercise may help us explore this part of the sequence. I will explain what it involves. You may decline, pause or ask to proceed differently, and we will review what happens afterwards."

The technique becomes a **formulation-linked experiment**, not an act of professional authority.

# 12. Safety, consent and relational responsibility

## 12.1 Safety before depth

Therapeutic maturity includes the ability to recognise when not to proceed.

Before emotionally intensive work, the practitioner may need to consider:

- risk of self-harm or suicide;
- violence, abuse or coercion;
- severe disorganisation;
- impaired contact with reality;

- dissociative vulnerability;
- substance-related risk;
- relevant physical symptoms;
- extreme exhaustion or sleep deprivation;
- current medical, psychological or psychiatric care;
- available support;
- emergency resources;
- professional competence and legal scope.

Guidelines concerning self-harm emphasise individual psychosocial assessment, safeguarding, contextual understanding, continuity of care, appropriately trained professionals and collaborative safety planning. They do not support replacing assessment with a generic technique or a simplistic risk category (National Institute for Health and Care Excellence, 2022).

In some situations, the most responsible intervention is not an NLP exercise but:

- stabilisation;
- direct safety planning;
- medical evaluation;
- psychological or psychiatric assessment;
- activation of a support network;
- legal or social assistance;
- consultation or supervision;
- referral;
- emergency care.

Referral is not therapeutic failure.

Stopping is not abandonment.

## 12.2 Continuous consent

Consent is not a single administrative event.

Someone may initially agree to an exercise and later discover that it feels intrusive, confusing or too intense. They retain the right to:

- ask for an explanation;
- refuse;
- pause;
- change direction;
- request a different pace;
- withdraw consent;
- report discomfort;

- ask for another kind of support.

Before an intervention, the practitioner should explain:

- what is being proposed;
- why it is being considered;
- what it may involve;
- what discomforts may occur;
- what alternatives exist;
- that participation is voluntary;
- that the procedure can be stopped;
- how the experience will be reviewed.

This is particularly important in hypnosis, memory-oriented procedures, imagery, dissociation, emotional intensification and methods in which the practitioner possesses strong symbolic authority.

## 12.3 Rapport is not compliance

Rapport must never become a method for obtaining obedience.

A person who disagrees, hesitates or refuses may be protecting a boundary, recognising a mismatch, communicating insufficient safety or correcting an inaccurate formulation.

The task is not to overcome every objection.

It is to understand what the objection communicates.

## 12.4 Rupture and repair

Even experienced practitioners misunderstand people. They may proceed too quickly, interpret inaccurately or fail to recognise cultural, contextual or relational meaning.

Therapeutic competence includes the ability to notice and repair such moments.

Meta-analytic research has found an association between successful alliance-rupture repair and therapeutic outcome (Eubanks et al., 2018). More broadly, the quality of the therapeutic alliance is consistently associated with psychotherapy outcomes across different traditions (Flückiger et al., 2018).

An accountable practitioner can say:

“I may have concluded too quickly.”

“That interpretation does not appear to fit your experience.”

“Something changed between us when I proposed that.”

“Please help me understand what I missed.”

Repair is not a loss of professional authority.

It is a more responsible use of authority.

# 13. Model, metaphor, technique and evidence

INLT requires explicit epistemic distinctions.

## Model

A model organises observation. It may be useful without being a complete or literal description of psychological reality.

## Metaphor

A metaphor offers a way of speaking about experience. Terms such as *parts*, *maps*, *levels* and *programmes* may support reflection without representing anatomical or neurological entities.

## Technique

A technique is a structured procedure intended to influence attention, experience, meaning or behaviour.

Its usefulness depends on indication, competence, consent, context, relationship and follow-up.

## Evidence

Evidence concerns the quality and consistency of the information supporting a claim.

Different claims require different forms of support:

- a person's report may show that an experience felt helpful;
- a case study may illustrate a process;
- an observational study may identify an association;
- a controlled study may contribute to causal inference;
- replication and synthesis may increase confidence;
- an emotionally powerful session does not establish universal efficacy.

These distinctions have practical implications:

- representational systems may guide enquiry without classifying people into fixed visual, auditory or kinaesthetic types;
- eye movements should not be treated as reliable methods of mind-reading or deception detection;
- submodalities may be used descriptively without being presented as neurological switches;
- Neurological Levels may organise questions without being described as literal levels of the brain;
- parts may be treated metaphorically without implying separate personalities;
- reframing may widen perspective without denying pain, injustice or danger;

- dissociation may be used cautiously without becoming avoidance of reality.

The value of an NLP model lies in the quality of the enquiry and experience it supports—not in the confidence with which a metaphor is mistaken for scientific fact.

# 14. What INLT does not claim

Integrative Neuro-Linguistic Therapy does not claim:

- that all historical NLP theories are scientifically established;
- that NLP offers a universal treatment for psychological suffering;
- that MAPA has already been empirically validated as a complete therapy;
- that MAPA instruments are diagnostic or psychometric tests;
- that completing an INLT course automatically authorises psychotherapy practice;
- that INLT replaces NLPt, psychology, psychiatry, medicine or specialised care;
- that every difficulty can be resolved by changing language, internal representation or emotional state;
- that rapid subjective impact necessarily predicts durable therapeutic change;
- that contextual, social, medical or legal realities can be reduced to a person's internal map.

These limitations are not peripheral qualifications.

They are part of the framework itself.

# 15. The specific contribution of MAPA

MAPA does not claim to have invented therapeutic alliance, informed consent, supervision, risk assessment, ecological thinking, case formulation or outcome monitoring.

Its proposed originality lies in bringing these responsibilities into a concise and teachable decision architecture designed specifically for the use of NLP-derived models.

Its distinctive contribution consists of five interrelated movements:

1. preventing the direct transition from complaint to technique;
2. making the possible protective function of a pattern central to formulation;
3. requiring internal representation and external reality to be considered together;
4. linking intervention choice to provisional formulation, consent and proportionality;
5. treating real-world follow-up as part of the intervention rather than an optional addition.

MAPA is therefore best understood as a **meta-framework for therapeutic judgement**.

It does not prescribe which technique must be used.

It organises the questions that must be addressed before, during and after any technique is considered.

| Dimension | Selected technique-centred NLP training contexts | Established NLPt | Proposed INLT–MAPA contribution |
|---|---|---|---|
| Primary emphasis | Learning and applying NLP models and procedures | Practising NLP within an established psychotherapeutic training pathway | Organising intervention through explicit formulation and follow-up |
| Formulation | May be implicit or vary by programme | Present according to training tradition and practitioner | Made explicit through MAPA and its instruments |
| Protective function | Often explored as positive intention | May be included within systemic and integrative work | Becomes a central, ethically qualified formulation question |
| External context | Variable | Included according to professional training | Explicitly considered alongside internal representation |
| Consent | May be associated with agreement to an exercise | Governed by psychotherapeutic standards | Treated as continuous and revisable |
| Intervention choice | May be influenced by technique availability | Based upon psychotherapeutic judgement | Explicitly linked to formulation, risk, proportionality and alternatives |
| Follow-up | May include future pacing and subjective confirmation | Included within clinical care | Real-world transfer and consequences form a distinct MAPA responsibility |
| Competence | Ability to demonstrate methods | Multi-year psychotherapeutic development | Assessment of judgement, safety, monitoring and appropriate non-intervention |

The first column describes tendencies that may occur in selected technique-centred NLP training and application contexts. It should not be interpreted as a description of NLP as a whole or of every NLP school, trainer or practitioner.

# 16. Why a dedicated MAPA-based training pathway is needed

The existence of advanced NLP qualifications does not, by itself, resolve the question of competence for therapeutic work.

The need for a MAPA-based pathway arises not because NLP practitioners should be presumed irresponsible, but because therapeutic practice requires additional competencies:

- collaborative formulation;
- recognition of risk;
- professional boundaries;
- contextual analysis;
- continuous consent;
- management of non-response;
- monitoring of deterioration and adverse effects;
- supervision;
- appropriate referral;
- the ability to decide that an NLP technique is not indicated.

A dedicated pathway should complement—not replace—established NLPt, psychology, psychotherapy, medical and mental-health education.

## 16.1 Differentiated professional routes

A responsible international training structure should distinguish at least three possible routes.

### Regulated or legally authorised professionals

Psychologists, psychotherapists, physicians and other professionals legally authorised to provide clinical or psychotherapeutic services may integrate INLT within their existing scope, subject to relevant competence, supervision and regulation.

### Coaches, educators and other helping professionals

Non-clinical practitioners may study selected MAPA principles for communication, goal clarification, formulation awareness, boundaries, safety recognition and referral within non-clinical settings.

Their certificate must not imply authority to diagnose or treat mental disorders when they are not authorised to do so.

### Personal and professional development

A foundation programme may teach MAPA as a framework for reflection and responsible communication without qualifying participants to provide therapy.

These distinctions must be visible in curriculum, assessment, certificate titles, public communication, scope statements and supervision requirements.

# 17. Principles for curriculum development and assessment

A future INLT curriculum should be competency-based rather than attendance-based.

Its principal domains should include:

- foundations and critical literacy;
- therapeutic relationship;
- ethics, law and professional scope;
- triage, safety and referral;
- MAPA formulation;
- therapeutic language and meaning;
- experiential interventions;
- trauma, grief, health and contextual reality;
- outcome monitoring and adverse effects;
- supervision and assessed practice.

Historical NLP models may be studied, but every method should be taught alongside:

- its proposed purpose;
- indications;
- limitations;
- consent requirements;
- possible risks;
- alternatives;
- criteria for follow-up.

Training must also establish that:

- trauma is not merely an unpleasant internal image;
- grief is not a failure to reframe;
- violence should not be converted into a compulsory growth opportunity;
- depression is not simply deficient state management;
- illness is not evidence of incorrect belief;
- anxiety may coexist with genuine danger;
- some presentations require specialised assessment and evidence-based care.

Psychological interventions may be followed by deterioration, dependency, shame, dropout or other unwanted events. Adverse effects should therefore be actively considered and monitored rather than assumed to be absent (Klein et al., 2024).

Supervision should examine formulation, intervention choice, relationship, practitioner assumptions, rescue impulses, preferred techniques, errors, adverse events, non-response and referral. Current evidence concerning supervision is promising but remains methodologically limited, supporting structured use without implying that every form of supervision is equally effective (Schreyer et al., 2025).

The proposed use of reflective journals, intervision and case review is also compatible with traditions of reflective professional practice in which competence develops through examination of action, uncertainty and professional judgement (Schön, 1983).

## 17.1 Assessment

Attendance alone should not establish therapeutic competence.

Assessment should include:

- knowledge of MAPA, ethics, risk, evidence and scope;
- observed practice;
- written formulation;
- ethical reasoning;
- reflective practice;
- supervision and intervision;
- ability to receive and integrate feedback.

Candidates should demonstrate the ability to:

1. establish a collaborative frame;
2. clarify the person's language;
3. map a concrete sequence;
4. maintain provisional hypotheses;
5. identify relevant safety concerns;
6. explain a proposed intervention;
7. obtain and maintain consent;
8. notice distress or incongruence;
9. adapt or stop;
10. invite feedback;
11. close safely;
12. formulate a proportionate next step.

A case report containing only successful technique demonstrations is insufficient.

Certification language should state explicitly that the qualification:

- confirms completion of a defined training pathway;
- does not itself confer a statutory licence;
- must be used within applicable law;
- does not authorise practice beyond the participant's professional scope;
- requires appropriate supervision where therapeutic work is undertaken.

Detailed Practitioner and Master curricula, including entrance requirements, minimum hours, assessment rubrics, supervision expectations and proposed certificate wording, should

be presented in separate institutional documents rather than embedded in full within this conceptual article.

# 18. A research programme for INLT

INLT should not seek credibility through stronger rhetoric.

It should seek credibility through clearer definitions, transparent data and willingness to revise itself.

Initial investigation may examine:

- whether INLT, MAPA, MAPA instruments and historical NLP models are conceptually distinguishable;
- whether MAPA instruments are comprehensible and usable;
- whether resulting formulations are recognisable to the people concerned;
- whether training increases attention to context, safety and referral;
- whether participants become less likely to select techniques prematurely;
- whether MAPA-based training improves formulation quality and ethical reasoning;
- whether practitioners identify non-response and unwanted effects more effectively.

MAPA instruments should initially be studied as formulation and educational tools. Psychometric claims should not be made unless appropriate validation has been completed.

Research should examine not only improvement but also:

- deterioration;
- emotional destabilisation;
- invalidation;
- memory confusion;
- shame;
- dependency;
- boundary violations;
- delayed referral;
- practitioner overconfidence;
- misinterpretation of external danger.

Whenever possible, investigation should involve researchers who are not financially or professionally invested in INLT training.

Negative, mixed and inconclusive findings should be publishable.

**A framework that cannot tolerate unfavourable evidence is not yet ready to call itself responsible.**

# 19. The foundations in *Mapas da Mudança*

The initial foundations of INLT and MAPA were published in Portuguese in the two-volume work *Mapas da Mudança*.

## Volume I — *Pessoa, linguagem e processo*

The first volume develops the conceptual architecture:

- technique is not therapy;
- the person is not the presenting problem;
- no single map is sufficient;
- formulation precedes intervention;
- safety and context matter;
- Current State and Desired State must be distinguished;
- NLP models are lenses rather than total explanations;
- health, grief, ethics, science and professional limits require explicit consideration.

## Volume II — *Técnicas, instrumentos e acompanhamento*

The second volume organises the practical infrastructure:

- triage;
- contract and safety;
- MAPA formulation instruments;
- Current State mapping;
- SCORE and SOAR;
- language models;
- state and resource work;
- technique consultation sheets;
- intervention-selection matrices;
- health, grief and limits;
- follow-up in everyday life.

The relationship between the volumes is deliberate.

The first asks how to think responsibly before intervening.

The second asks how to select, conduct and accompany interventions without turning them into automatic protocols.

The books represent the first articulation of the framework, not its final scientific validation.

# 20. Limitations

Several limitations must be recognised.

First, this article is a purposive conceptual review, not an exhaustive systematic review. Relevant sources may have been omitted.

Second, INLT is an emerging proposal developed by the author. It has not been established as an empirically supported psychotherapy.

Third, MAPA has not been evaluated as a complete treatment package.

Fourth, MAPA instruments are not validated diagnostic or psychometric measures.

Fifth, many principles included in the framework—formulation, collaboration, alliance, consent, safety, supervision and monitoring—are shared with broader psychotherapy traditions. The originality claimed is primarily architectural and operational, not the invention of every component.

Sixth, the relationship between INLT and established NLPt traditions requires continuing dialogue. No single institutional description can represent every NLPt school, practitioner or training culture.

Seventh, implementation will vary according to law, culture, professional regulation and service context. No international certificate should presume equivalent rights of practice across countries.

Eighth, the author developed the framework and may participate in future training programmes. This interest must remain transparent.

# 21. Conclusion: the next development is not another technique

The therapeutic future of NLP will not be secured by accumulating additional procedures or intensifying promises of rapid transformation.

Its development depends upon greater maturity in the conditions under which existing resources are selected, limited and used.

NLP has contributed a creative practical language for examining subjective experience, communication, attention, representation, meaning and behavioural sequence.

Some historical claims remain weakly supported or unsupported.

Some procedures overlap with wider therapeutic traditions.

Some findings are promising but methodologically insufficient.

These realities should be acknowledged without promotional denial and without indiscriminate dismissal.

Integrative Neuro-Linguistic Therapy proposes that the therapeutic use of NLP should be organised through an explicit architecture of responsibility.

That architecture is MAPA:

**Map before intervening.**
Because a complaint is not yet a formulation.

**Analyse before concluding.**
Because an attractive explanation is not necessarily accurate.

**Project before promising.**
Because change must be translated into a life that can actually be lived.

**Accompany before closing.**
Because an intervention must encounter the real world before success can responsibly be declared.

The purpose is not to increase the practitioner's power over the person.

It is to improve the quality of judgement surrounding intervention.

A person should not be required to submit to a technique, deny a legitimate danger, abandon their history or suppress an important need in order to appear transformed.

The central question remains:

**What is this person attempting to preserve—and how might change become possible without requiring them to abandon what remains humanly important?**

That question marks the movement from applying techniques to accompanying people.

It also provides the strongest reason for dedicated, supervised, evidence-literate and competency-based training in Integrative Neuro-Linguistic Therapy.

# Declarations

## Authorial position and potential interests

The author developed Integrative Neuro-Linguistic Therapy and the MAPA Method and authored the two-volume work upon which the framework is based. He may participate in future educational programmes related to the approach.

The framework should therefore be evaluated on the coherence of its arguments, the transparency of its limitations and the quality of future independent research rather than on authorial authority.

## Funding

No external funding was received for the preparation of this article.

## Empirical data

No new empirical data were generated or analysed for this article.

## Ethical approval

Ethical approval was not required because this article does not report research involving human participants or identifiable clinical material.

# References

American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271–285. https://doi.org/10.1037/0003-066X.61.4.271

Baethge, C., Goldbeck-Wood, S., & Mertens, S. (2019). SANRA—a scale for the quality assessment of narrative review articles. *Research Integrity and Peer Review, 4*, Article 5. https://doi.org/10.1186/s41073-019-0064-8

Bandler, R., & Grinder, J. (1975). *The structure of magic I: A book about language and therapy*. Science and Behavior Books.

Barry, E. S., Merkebu, J., & Varpio, L. (2022). State-of-the-art literature review methodology: A six-step approach for knowledge synthesis. *Perspectives on Medical Education, 11*, 281–288. https://doi.org/10.1007/s40037-022-00725-9

Bateson, G. (1972). *Steps to an ecology of mind*. Chandler.

de Jong, K. (2025). Using progress feedback to enhance treatment outcomes: A review of the evidence and recommendations for implementation. *Administration and Policy in Mental Health and Mental Health Services Research, 52*(1), 210–222. https://doi.org/10.1007/s10488-024-01381-3

Eells, T. D. (2015). *Psychotherapy case formulation*. American Psychological Association.

Eubanks, C. F., Muran, J. C., & Safran, J. D. (2018). Alliance rupture repair: A meta-analysis. *Psychotherapy, 55*(4), 508–519. https://doi.org/10.1037/pst0000185

European Association for Neuro-Linguistic Psychotherapy. (n.d.). *Metastructure of training curriculums for Neurolinguistic Psychotherapy*. EANLPt. Retrieved 11 July 2026 from https://www.eanlpt.org/About-Us

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy, 55*(4), 316–340. https://doi.org/10.1037/pst0000172

Grinder, J., & Bandler, R. (1976). *The structure of magic II: A book about communication and change*. Science and Behavior Books.

International Association of NLP Institutes. (2026). *IN standards and curriculum for "NLP Trainer, IN"*. https://www.nlp-institutes.net/pdf/NLP-Trainer.pdf

Klein, J. P., Rozental, A., Sürig, S., & Moritz, S. (2024). Adverse events of psychological interventions: Definitions, assessment, current state of the research and implications for research and clinical practice. *Psychotherapy and Psychosomatics, 93*(5), 308–315. https://doi.org/10.1159/000540212

McAleavey, A. A., de Jong, K., Nissen-Lie, H. A., Boswell, J. F., Moltu, C., & Lutz, W. (2024). Routine outcome monitoring and clinical feedback in psychotherapy: Recent advances and future directions. *Administration and Policy in Mental Health and Mental Health Services Research, 51*(3), 291–305. https://doi.org/10.1007/s10488-024-01351-9

National Institute for Health and Care Excellence. (2022). *Self-harm: Assessment, management and preventing recurrence* (NICE Guideline NG225).

Padesky, C. A. (2020). Collaborative case conceptualization: Client knows best. *Cognitive and Behavioral Practice, 27*, 392–404. https://doi.org/10.1016/j.cbpra.2020.06.003

Passmore, J., & Rowson, T. S. (2019). Neuro-Linguistic Programming: A critical review of NLP research and the application of NLP in coaching. *International Coaching Psychology Review, 14*(1), 57–69. https://doi.org/10.53841/bpsicpr.2019.14.1.57

Percia, A. (2026a). *Mapas da mudança: Volume I — Pessoa, linguagem e processo*. Edição do Autor.

Percia, A. (2026b). *Mapas da mudança: Volume II — Técnicas, instrumentos e acompanhamento*. Edição do Autor.

Schön, D. A. (1983). *The reflective practitioner: How professionals think in action*. Basic Books.

Schreyer, B., Leithner, C., Eilers, R., Gossmann, K., & Rosner, R. (2025). The effects of clinical supervision on supervisees and patient outcomes in psychotherapy: A systematic review and meta-analysis. *Frontiers in Psychiatry, 16*, Article 1705578. https://doi.org/10.3389/fpsyt.2025.1705578

Sturt, J., Ali, S., Robertson, W., Metcalfe, D., Grove, A., Bourne, C., & Bridle, C. (2012). Neurolinguistic programming: A systematic review of the effects on health outcomes. *British Journal of General Practice, 62*(604), e757–e764. https://doi.org/10.3399/bjgp12X658287

Thrower, N. E., Berry, K., Johnston, I., & Morris, L. (2024). Understanding the factors that contribute to creating a collaborative psychological formulation: A qualitative systematic review. *Clinical Psychology & Psychotherapy, 31*(3), e2998. https://doi.org/10.1002/cpp.2998

Tosey, P., & Mathison, J. (2009). *Neuro-Linguistic Programming: A critical appreciation for managers and developers*. Palgrave Macmillan.

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.). Routledge.

Witkowski, T. (2010). Thirty-five years of research on Neuro-Linguistic Programming: NLP Research Data Base—state of the art or pseudoscientific decoration? *Polish Psychological Bulletin, 41*(2), 58–66. https://doi.org/10.2478/v10059-010-0008-0

Zaharia, C., Reiner, M., & Schütz, P. (2015). Evidence-based Neuro Linguistic Psychotherapy: A meta-analysis. *Psychiatria Danubina, 27*(4), 355–363.