METHOD OF LEVELS: IS IT THE MOST PARSIMONIOUS PSYCHOLOGICAL THERAPY AVAILABLE?

EL MÉTODO DE NIVELES: ¿ES LA TERAPIA PSICOLÓGICA DISPONIBLE MÁS PARSIMONIOSA?

Warren Mansell
Reader in Clinical Psychology
University of Manchester, UK

This article was published in Spanish. This is the English version.
Link to the Spanish version: (http://revistadepsicoterapia.com/rp110-01.html).

How to reference this article:

Mansell, W. (2018). El Método de Niveles: ¿Es la terapia Psicológica disponible más parsimoniosa?. [Method of Levels: Is it the Most Parsimonious Psychological Therapy Available?]. *Revista de Psicoterapia, 29*(110), 7-15.

Abstract

In this article, I will introduce Method of Levels (MOL; Carey, 2006) therapy as one simple solution to many of the issues and complexities of mental health provision around the world. First, I will try to explain that the issues surrounding helping people with mental health problems and experiencing chronic psychological distress can be helped through three comprehensive exercises in the integration of the scientific literature: (1) to integrate psychological processes across mental health disorders; (2) to integrate psychological processes into a single core process; and (3) to integrate theories guiding psychological therapies into a unified theoretical account. Second, I will describe the principles of a theory – perceptual control theory (PCT; Powers, 1973) – that provides a unified account of psychological functioning. These principles are control, conflict and reorganisation. Third, I will explain briefly how to deliver the therapy that follows from these principles – MOL. Fourth, I will summarise evidence for the benefits of MOL and its mechanism of change. Finally, I will set forth a vision for how PCT could guide the future of mental health services.

Keywords: *Method of Levels, MOL, psychological assistance, mental health, mental health services*

Received: December 11, 2017. Accepted: January 13, 2018.

Correspondence:
E-mail: warren.mansell@manchester.ac.uk
Postal address: CeNTrUM (Centre for New Treatments and Understanding in Mental Health), Division of Psychology and Mental Health, School of Health Sciences, Faculty of Biology Medicine and Health, University of Manchester, Manchester Academic Health Science Centre, 2nd Floor Zochonis Building, Brunswick Street, Manchester, M13 9PL, UK

ISSN: 1130-5142 (Print) –2339-7950 (Online)

Resumen

En este artículo, presentaré la terapia del Método de Niveles (MOL; Carey, 2006) como una solución sencilla a muchas de las cuestiones y complejidades de las prestaciones en salud mental en todo el mundo. Primero, trataré de explicar que los problemas relacionados con la asistencia a personas que padecen problemas de salud mental y experimentan malestar psicológico crónico pueden aliviarse mediante tres prácticas generales desde la integración de la literatura científica: (1) integrar los procesos psicológicos en los trastornos de salud mental; (2) integrar los procesos psicológicos en un único proceso central; y (3) integrar las teorías que fundamentan las terapias psicológicas en un enfoque teórico unificado. En segundo lugar, describiré los principios de una teoría, la Teoría del Control Perceptual (PCT, Powers, 1973), que proporciona una explicación unificada del funcionamiento psicológico. Estos principios son: control, conflicto y reorganización. Tercero, explicaré brevemente cómo implementar la terapia derivada de estos principios — MOL. En cuarto lugar, resumiré la evidencia de los beneficios del enfoque MOL y su mecanismo de cambio. Finalmente, estableceré una visión de cómo la teoría PCT podría orientar el futuro de los servicios de salud mental.

Palabras clave: *Terapia del Método de Niveles, MOL, asistencia psicológica, salud mental, servicios de salud mental*

Three Exercises in Scientific Integration

The famous scientific doctrine of parsimony is summed up in the quote of the British 14th Century logician William of Ockham, "Entities should not be multiplied unnecessarily", or in its original Latin form, "Pluralitas non est ponenda sine necessitate". Well, what entities are unnecessarily multiplied in the field of psychopathology and mental health? I name three.

The first multiplied entity is the mental health disorder. There are currently over 300 different disorders recognised internationally. Are they really different? Or more importantly, are they so different that they require different scientific models to explain them and treat them with psychological therapies? Myself and my colleagues suspected not. We followed up this suspicion with a comprehensive review, in the form of a book (Harvey, Watkins, Mansell, & Shafran, 2004). We found that most cognitive and behavioural processes that had been found to be elevated in a psychiatric disorders, were also elevated in the other disorders it had been investigated. To take one example, worry is a defining feature of generalised anxiety disorder. Yet, people with *any* psychiatric disorder show higher rates of worry than people with no psychiatric disorder. We found the same result for intrusive memories, biases in reasoning, safety-seeking behaviours –in fact we found no strong evidence that there were processes that were distinctive to a specific disorder, or even to a class of disorders. All cognitive and behavioural processes tested appear to be 'transdiagnostic'– shared across a wide range of disorders.

The second multiplied entity is the psychological process. We found a total of 12 transdiagnostic processes in our review, with a suggestion of at least half a dozen more with emerging evidence at the time. Are they really different? Or more importantly, are they so much different that we gain more from understanding them separately than understanding what they all share? Myself and my colleagues suspected not. We followed up this suspicion with a series of studies in which we attempted to assess the common features of all of these processes (Bird, Mansell, Dickens, & Tai, 2013; Patel, Mansell, & Veale, 2015; Mansell & McEvoy, 2017). We found that the people who reported engaging in one of these many processes, also reported engaging in the others. In statistical terms, this resulted in a single *latent factor* across these studies. This single factor correlated strongly with the severity of diverse mental health problems. Moreover, where we looked at what symptoms were left to explain once this factor was extracted, very little remained. We seemed to have found a single *core process* at the heart of all the processes that had been measured in previous studies.

The third and final multiplied entity is the theory guiding psychological therapy. There are hundreds of recognised psychological interventions for mental health problems, each guided by one or more apparently different psychological theories. Are they really different? Or more importantly, are their differences more important than their common principles? We suspected not. We followed up this suspicion with comprehensive reviews of the principles, components and mechanisms

of psychological change within a wide range of psychological therapies (Higginson & Mansell, 2016a; Higginson, Mansell, & Wood, 2011; Mansell, Carey, & Tai, 2015). Although these reviews were more subjective, our lasting impression was that the differences between psychotherapies were far less important than their shared elements. For example, all therapies appeared to rely on some form of emotional exposure (Carey, 2011), and conflict between goals appeared to be critical to address in order to promote well-being and mental health (Kelly, Mansell & Wood, 2015). We could identify the active ingredients of traditional therapies, but we could see no therapy that seamlessly integrated these. The client control and self-determinism at the heart of humanistic therapies appeared important, as did the recognition of conflict commonly at the heart of psychodynamic approaches. Yet we also could identify the pertinence of challenging clients to reappraise their thinking and engage with their emotion, as cognitive behavioural therapies would emphasise. Therefore, could one parsimonious theory encompass the key ingredients of effective therapy?

Perceptual Control Theory (PCT)

This is the point where PCT comes in. Although to be absolutely honest, myself and my colleagues were already aware of PCT when the above evidence was accumulating. It did not emerge as a way of explaining the above evidence. In fact, it had already been devised during the 1950s and 60s, for us to discover.

PCT proposes that life is control –and by extension– that wellbeing, mental health and freedom from chronic distress is control. The evidence that life is control is unequivocal (Carey, Mansell, & Tai, 2014). We survive on a day-to-day basis by controlling a variety of physiological variables in our bodies – body temperature, blood glucose levels, salt ion concentrations, nitrite concentrations, etc. It is commonly accepted that our body manages this through *homeostasis*. Within our brain stem, the current state of these variables (e.g. current body temperature of 35 degrees) is compared to the desired state (e.g. 37 degrees), and the difference drives an action (e.g. shivering) to restore the variable to its desired value. This goes on, in parallel, for all of the variables that are important to our immediate survival. PCT states that the same process goes on for a whole range of other variables that are *perceived (psychological) aspects of our environment.* So, for example, it may aid our survival to stay physically close to our loved ones in times of danger. To achieve this state and maintain it, we are continuously comparing our current distance (e.g. one metre away) with our desired distance (e.g. in body contact) and the difference drives our actions (e.g. moving closer) to restore these perceived aspects of our environment to their desired values. Put simply, we keep well and healthy by controlling our sense of ourselves and our environment, and we do whatever we need to do in that moment to achieve and maintain this. Importantly, we can do this automatically without awareness, and we do it all the time for many experiences – not just one. In everyday language, we call these different aspects by something

different depending on how concrete versus abstract they are, how self-determined they appear to be, and how important they are to us. Some examples of these words are targets, goals, principles, needs, values, ideals, 'shoulds', 'wants', desires, and priors. In PCT, they all operate in the same way.

This is where the next principle comes in – conflict. We need some way of organising the experiences that matter to us so that trying to experience one of them doesn't stop us from meeting a different important need. One way we do this is by arranging what matters to us in a hierarchy. PCT describes the way that increasingly more abstract and long term goals are organised higher up the hierarchy. This entails that we achieve long term goals through the way that we set lower goals. However, there is still the potential for conflict. Take the example of a client –Jane– who had the higher level goal of 'living a normal life'. She had been suffering from intrusive memories and mood swings following abuse as a teenager, but for much of her life, her way of trying to have a normal life was to 'tell myself it never happened', which in turn led her to set strategies such as to push her memories 'to the back of her mind'. She found this extremely difficult because she often encountered reminders of her abuse that made her want to do something about it. There was always part of her that wanted justice and wanted to be able to be strong to tolerate her memories, rather than deal with the challenges of continually trying to suppress them. As she grew older and had her own family, this became increasingly difficult, and she became increasingly focused on the goal of getting justice by reporting her past abuse the police and reporting her experience in detail as a witness. This entailed that her way of living a normal life was to stand up to her abuser with the help of the justice system, which in turn entailed her dealing with her trauma memories in exactly the opposite way to before – explaining to people this did truly happen, and bringing her memories of the event to the front of her mind to describe them in detail to the police, and in court.

According to PCT, the distress that Jane experienced was the loss of control that came with her conflicting goals surrounding how to deal with her trauma (see also Carey, Mansell, Tai, & Turkington, 2014). How is conflict resolved? PCT proposes that it is not simply by helping people to enact or challenge one side of the conflict – for example to provide strategies to suppress the trauma memories, or indeed to provide strategies to recall them in more detail. Both strategies (to suppress versus to recall), and both goals (to tell myself it never happened versus to tell myself it did happen) have the same ultimate purpose – to try to live a normal life. Therefore the way to resolve conflict is to help the client describe and explore both sides of the conflict, looking at it from a higher level perspective. Only from here, internally within the client, may a possible solution be found. This might be a different solution at different times for different clients. Indeed, PCT proposes that the most effective way of regaining control in these kinds of conflicts is to allow a trial-and-error learning process to occur within the client known as *reorganisation*. Because it is trial and error, it doesn't always some to the most effective solution

straight away, and the timing that this occurs is almost impossible to predict. Yet, the longer a client is helped to shift and sustain this process on to the experiences surrounding their conflicting goals from this higher level perspective, the greater the chance of 'stumbling upon' a resolution. When a person is helped to sustain their attention in this way, it may resemble what is often called exposure (Carey, 2011), and the eventual impact of elaborate exposure to the various aspects and details of a difficulty is resolution of conflict.

Method of Levels Therapy (MOL)

The above three principles –control, conflict and reorganisation– all come together in a simple intervention – MOL. They entail that what another person needs to do to help a person with a problem is to (1) help them to talk about the problem at length, in detail and in the present moment, thereby sustaining their attention to it, and (2) to notice disruptions in their speech and behaviour as they describe the problem, such that the client can shift their attention to aspects of the problem they may otherwise have missed. Disruptions are merely outside indications of possible 'background thoughts' at the edge of a client's awareness. By helping the client describe their problem, notice background thoughts and bring them to the foreground where they can put them into words, the client is expected to broaden their awareness of their problem, explore conflicts, and articulate their higher level goals, allowing more time for reorganisation to have its beneficial effects on the internal source of their difficulties.

In sum, the MOL therapist only has these two goals – to help the client describe the problem and to notice disruptions. They can try to meet these goals in any way, but, based on PCT, clearly in a way that helps the client be in control. Carey calls this helping the therapist to 'not get in the way' of the client (Carey, 2006). In practice, the MOL therapist regularly asks short, curious questions as the client is talking about their problem, many of which are focused on what might currently be in the client's awareness, or at the edge of it. This process continues as long as the client finds it helpful, and it is adapted in an ongoing way based on client feedback. The client can talk about whatever is in their mind and is not required to talk about the symptoms of their psychiatric diagnosis, if they have one. Furthermore, the parameters of MOL sessions are, as much as practically possible, also determined by the client – session length, duration, frequency, timing, and the overall number.

MOL therapy simultaneously validates and challenges the major forms of psychotherapy – psychodynamic, humanistic, cognitive and behavioural. Like psychodynamic therapies, MOL sees internal conflict as at the heart of psychological distress; however, in order to address it the therapist does not provide any interpretations, nor utilise the therapeutic relationship in any direct way. Like humanistic therapies, MOL attempts to bring out the self-determined goals of the client; however, in order to do this most effectively and efficiently, the therapist may regularly interrupts and questions the client. Like cognitive therapies, MOL strives

to help the client gain wider perspectives on their problems; however, it does not use explicit formulations, tools, techniques or reality-testing methods to do so. Like behavioural therapies, MOL helps people to sit with difficult experiences in the present moment; however, there is no attempt to change behaviour or plan exposure exercises.

Research and Practice of Method of Levels

Either because of, or despite, the above features of MOL, it is a highly distinctive therapy. In a recent study we compared MOL with six other therapies – gestalt therapy, CBT, person-centred therapy, transactional analysis, existential therapy, and rational emotive behaviour therapy (Macintyre, Brown & Mansell, 2017). We found that MOL therapy had more open and closed questions, and more questions about non-verbal behaviour than the other therapies, and very few other types of therapist utterance (e.g. interpretation, direct guidance, personal disclosure, confrontation). The MOL therapy had more therapist utterances overall, and yet over the whole session, the client spoke over twice as much as the therapist, which was again greater than the other therapies. Each of these features clearly matches with how I have described the principles of MOL earlier.

The evidence for the effects of MOL are reviewed elsewhere (e.g. Carey, 2008; Alsawy, Mansell, McEvoy, Carey, & Tai, 2014). In sum, on average, patients show large effect sizes in their reductions in symptoms and distress during therapy and at follow-up. Maybe more importantly, qualitative reports of patients indicate how much they value being able to control their own appointments, control their topic of conversation, and the overall insights they gain despite the 'hard work' at times of facing questions about difficult experiences. Whilst no randomised controlled trials have been published on Method of Levels, there are reasons to believe that it is more efficient than other forms of therapy, at least when patients are given the opportunity to book their own appointments. In a study of MOL within secondary care in remote Australia, the beneficial effects of the therapy *per session* of therapy attended were greater than a range of benchmarked studies (Carey, Stiles, & Tai, 2013). This property of MOL makes it particularly suitable for contexts where flexibility is necessary because of the constraints of the environment. Examples of such contexts in which we are evaluating MOL are: inpatient psychiatric wards (Sara Tai, Vyv Huddy), schools (Susan McCormack, Ana Churchman, Kirsty Hughes, Louise Mansell), early intervention in psychosis services (Rob Griffiths), prisons (Vyv Huddy), and Death Row (Susan McCormack).

We are also accumulating evidence of the mechanism of change in MOL. For example, in one study of 18 clients receiving MOL, we gave them the opportunity to watch a video of their session and tell us every two minutes what was helpful over that short period of the session. We found that talking freely and being in control were associated with high ratings of helpfulness, over and above those of the therapeutic relationship (Cocklin, Mansell, Emsley, McEvoy, Preston, Comiskey,

& Tai, 2017). We have also developed a coding scheme to assess whether clients show the shifts and focus in awareness towards their conflicts and higher order goals that PCT predicts would facilitate change. The scheme, known as the Depth and Duration of Awareness Coding Scheme (DDACS; Higginson & Mansell, 2016b), has proved to be a helpful tool, albeit with the obvious limitation that an observer can never truly know what a client is aware of at any one time. It can be used to illustrate the path of the client's awareness, and indeed appears to pick up a sustained focus on conflict, elaboration of high-level, self-definitional goals, and moments of change that could result from reorganisation. An online video of this scheme is available from the Further Resources section below.

Summary

I have explained the strong conceptual rationale for a universal, integrative, and coherent therapy as opposed to the status quo of a multiplicity of different theories to inform numerous techniques for a large number of different psychiatric disorders. I have explained why I think that PCT rises to this challenge, and why and how MOL follows from this theory. The simplicity of MOL is its strength because it allows the therapist the focus on following only two goals, leaving all other elements of therapy to be controlled by the client. In the context of the chronic and extreme lack of control that people with mental health problems have had to suffer in much of their lives, we owe it to them to build a space to reclaim control of their lives, step by step. Our work on evaluating and disseminating MOL is in its infancy but, as you might imagine, we have high hopes for this scientifically robust and parsimonious approach to facilitating psychological change.

Further Resources

In addition to the academic references cited above, the following will be useful to anyone wanting to know more about the transdiagnostic approach to psychotherapy using Method of Levels.

www.methodoflevels.com.au – the main link for resources on MOL including manuals, testimonials and videos.

Mansell, W., Carey, T. A., & Tai, S. J. (2015). *Principles-based counselling and psychotherapy: A Method of Levels approach.* London, UK: Routledge. This is the most recent therapy manual for MOL.

https://www.myownworstenemy.org/podcast/getting-my-head-shrunk/ - a frank and open introduction to MOL by a professional service user – Danny Whittaker – including an 80-minute session of MOL.

References

Alsawy, S., Mansell, W., Carey, T. A., McEvoy, P., & Tai, S. J. (2014). Science and practice of transdiagnostic CBT: a Perceptual Control Theory (PCT) approach. *International Journal of Cognitive Therapy, 7*(4), 334-359.

Bird, T., Mansell, W., Dickens, C., & Tai, S. J. (2013). Is there a core process across depression and anxiety? *Cognitive Therapy and Research, 37*, 307-323.

Carey, T. A. (2008). Perceptual control theory and the method of levels: Further contributions to a transdiagnostic perspective. *International Journal of Cognitive Therapy, 1*(3), 237-255.

Carey, T. A. (2011). Exposure and reorganization: the what and how of effective psychotherapy. *Clinical Psychology Review, 31,* 236-248.

Carey, T. A., Mansell, W., & Tai, S. J. (2014). A biopsychosocial model based on negative feedback and control. *Frontiers in Human Neuroscience, 8*, 94.

Carey, T. A., Mansell, W., Tai, S. J., & Turkington, D. (2014). Conflicted control systems: the neural architecture of trauma. *The Lancet Psychiatry, 1*(4), 316-318.

Carey, T. A., Tai, S. J., & Stiles, W. B. (2013). Effective and Efficient: Using Patient-led Appointment Scheduling in Routine Mental Health Practice in Remote Australia. *Professional Psychology: Research and Practice, 44*(6), 405-414.

Cocklin, A. A., Mansell, W., Emsley, R., McEvoy, P., Preston, C., Comiskey, J., & Tai, S. (2017). Client Perceptions of Helpfulness in Therapy: a Novel Video-Rating Methodology for Examining Process Variables at Brief Intervals During a Single Session. *Behavioural and Cognitive psychotherapy, 45*(6), 647-660.

Harvey, A., Watkins, E., Mansell, W., & Shafran, R. (2004). *Cognitive-behavioral Processes across Psychological Disorders: A Transdiagnostic Approach to Research and Treatment.* Oxford, UK: OUP.

Higginson, S., & Mansell, W. (2016a). A systematic review of independent-rater, within session measures of therapeutic change: The importance of awareness and transformation. doi: 10.13140/RG.2.1.3280.9041

Higginson, S., & Mansell, W. (2016b). The Depth and Duration of Awareness Coding Scheme (D-DACS) Manual. doi: 10.13140/RG.2.1.2494.4725

Higginson, S., Mansell, W., & Wood, A. M. (2011). An integrative mechanistic account of psychological distress, therapeutic change and recovery: The perceptual control theory approach. *Clinical Psychology Review, 31*(2), 249-259.

Kelly, R. E., Mansell, W., & Wood, A. M. (2015). Goal conflict and well-being: A review and hierarchical model of goal conflict, ambivalence, self-discrepancy and self-concordance. *Personality and Individual Differences, 85,* 212-229.

Macintyre, V., Brown, H., & Mansell, W. (2017). Coding the common and distinctive components of diverse therapies. *Paper presented at the Annual Scientific Conference of the British Association for Behavioural and Cognitive Psychotherapies, University of Manchester.*

Mansell, W., Carey, T. A., & Tai, S. J. (2015). *Principles-based counselling and psychotherapy: A Method of Levels approach.* New York, NY: Routledge.

Mansell, W., & McEvoy, P. M. (2017). A test of the core process account of psychopathology in a heterogenous clinical sample of anxiety and depression: A case of the blind men and the elephant? *Journal of Anxiety Disorders, 46,* 4-10.

Patel, T., Mansell, W., & Veale, D. (2015). The Cognitive Behavioural Processes Questionnaire: A preliminary analysis within student, mixed clinical and community samples, and the identification of a core transdiagnostic process. *Cognitive Therapy and Research, 39*(2), 193-203.

Powers, W. T. (1973). *Behavior: The control of perception.* NuevaYork, NY: Hawthorne.