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METHOD OF LEVELS THERAPY: Helping the normal change process within a person when normal change doesn't seem to be happening by itself.

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Abstract

Method of Levels (MOL) Therapy is described and applied to the case of a woman whose husband died. MOL Therapy is derived from Perceptual Control Theory. Session to session changes within the woman were quantified by means of Q Methodology and Personal Construct analyses. MOL Therapy identifies the important conditions for therapy change to occur. The case study results were supportive of the ideas of MOL Therapy.

Keywords: individual therapy; Q Methodology; Perceptual Control Theory; Personal Construct Theory; levels of awareness; internal conflicts.

Theoretical and research background

Why people enter therapy and MOL therapy

People seek therapy because they are experiencing personal problems and their normal ways of resolving problems are not working. The present case study explores a new form of individual therapy called Method of Levels Therapy (MOL Therapy). MOL Therapy is derived from Perceptual Control Theory (Powers, 1973, 1998, 1999, 2007). MOL Therapy makes it clear why and how people have trouble solving their own problems and explains the role and limits of the therapist in the helping process. A person seeking therapy help will be referred to as a patient in this case study.

Background concepts from Perceptual Control Theory.

To better explain MOL Therapy, it is necessary to introduce some concepts and terms from Perceptual Control Theory (PCT). *A control system* is the basic structural and functional unit within a person that regulates a variable of experience; each control system regulates one variable of experience. (An illustrative example is presented below.) The person enters therapy because his/her experiences are

not being satisfactorily controlled or regulated. This means that the patient's *actual* experiences (perceptions) are not closely enough matching a person's *wanted* experiences (reference perceptions). The person is experiencing some degree of upset-ness (*error signals*), which results in the experience of arousal and negative feelings/emotions, and which normally prompts the natural processes of change. The chronic and large error signals may be due to situations that are stressful and overwhelming (for example, death of someone close, sickness, divorce, natural catastrophes, etc.), which are called *disturbances* in PCT, or to internal *conflicts* among the hierarchy of control systems.

The person who enters therapy is looked upon as made up of *levels* of control systems that have a special, hierarchal relationship to each other. The levels vary from lower levels, which are more specific and concrete, to higher levels, which are more general and abstract. The higher levels of control systems provide goals for the lower levels; the lower levels provide the means by which the higher levels accomplish goals. Using the hierarchal relationship between levels of control systems concept, PCT provides a way for integrating topics that are usually treated separately in introductory textbooks (for example, sensations, perceptions, cognitions, and meta-cognitions).

The normal, inborn process of change within a person, which is called *reorganization* in PCT, usually handles problems of chronic and large error signals. Reorganization is a trial and error process that occurs when existing acquired control systems are not effectively controlling experiences. According to PCT, reorganization is responsible for all normal development and learning. Old control systems are modified, new control systems are formed, or, relationships among control systems are changed. The mechanism for reorganization within the nervous system is currently being researched and one-celled animal models are providing suggestive leads (Powers 2007).

Given that we are hierarchically organized control systems, *conflict* between control systems at the same level (defined as wanting a certain experience X while at the same time not wanting a certain experience X) can prevent reorganization from working properly. Conflict is the basic reason a person becomes unable to self-regulate, according to PCT The presence of a conflict among control systems will prevent a person from 'going up a level' which means that the person is thinking too concretely instead of more abstractly about a problem. The reason for this seems to be that reorganization follows awareness and awareness goes to the level of control systems which are experiencing the largest error signals. As a result, the person is working at a level where the conflict is acted out rather than the (higher) level which is setting conflicting goals. Reorganizing at the wrong level is not conducive to fixing the problem. It is as if the conflicting control systems are fighting each other and the person's actions are inconsistent. *In MOL therapy, a particular conflict is not considered to be the basic problem as it is in psychodynamic therapies; it is simply conflict itself, which negates action, that is debilitating.*

As an example of intrapersonal conflict, consider a person who was experiencing conflict about her work situation such as the woman in the present case study. She wanted to work where she was working for some reasons. However, she didn't want to work where she was working for different reasons. It was only after she went to a higher level of awareness during the therapy sessions that she was able to resolve this conflict. This example will be discussed in more detail later on in the case study.

The primary role of the therapist is to help patients redirect their awareness to a higher level within the hierarchy of control systems, above the level of the control systems that are in conflict, which then allows reorganization to make the necessary changes.

MOL Therapy has a specific procedure for resolving conflicts. The first step is to recognize that a conflict is present. The second step is to work with the client to define the conflict in terms of wanting and not wanting experience X. The third step is to have the person talk about each side of the conflict – what is good about each side, what is bad about each side. What often happens when this is done is that the person will be able to see both sides of the conflict simultaneously. When this happens, the

person is at a higher level and a solution to the conflict may present itself. The solution is unpredictable and the person may continue to work on the problem between the end of one session and the beginning of the next session.

The agenda of the therapist doing MOL Therapy can be summarized by three steps: (a) focus on the experience the person selects to talk about (the 'foreground topic'), (b) listen for suggestions of higher levels as the person describes the experience (the 'background topic'), and (c) have the person talk about the higher level experience (the 'background topic'), and (d) repeat the above process as many times as is necessary.

The hoped for result of the therapist following the above agenda is that the patient will become aware of higher levels. It is the higher, or more general processes, that select the lower, or more concrete ones, and decides how they will be employed. When reorganization takes place at too low a level, higher processes simply recreate the same problem in a different form.

To illustrate what 'relatively higher levels of awareness' mean in MOL Therapy, consider the following hypothetical patient statement: "I play tennis." A statement at a higher level would be one that answers the 'why' question, such as the following: "What is the function of playing tennis or what is accomplished by playing tennis?". The answer might be that tennis is a means by which the patient 'obtains exercise' or tennis could be a means by which the person 'has fun'. The perceptions of obtaining exercise and having fun would be higher level perceptions. As a person talks about playing tennis, these higher level experiences might be present and noticed. The therapist could then switch the topic of conversation to one of 'getting exercise' or 'having fun.' The next higher level would answer the question of what is the function or what is the result of having fun or getting exercise. The therapist and patient would listen for the answer.

MOL Therapy is an attempt to reduce therapy to its simplest components; the focus is on the minimal change that needs to happen within a person in order to bring about significant results. As will be cited in the treatment implications section of this paper, one can recognize that it shares some features with experiential/humanistic therapies, cognitive/behavioral therapies and psychodynamic therapies. It is unique in that it has a very powerful theoretical basis in PCT that specifies the process of change (reorganization) and specifies what is stopping the normal process of change from operating (conflict).

There is an ongoing MOL Therapy Research project among a group of Scottish Psychologists working for the National Health Service in Scotland (Carey, 2006). The present case study is the beginning of MOL Therapy research within the USA.

In MOL Therapy, a higher level is defined relatively and is the result of controlling a lower level experience. Having fun or obtaining exercise is accomplished by playing tennis. There are no fixed number of levels in MOL Therapy Other researchers have defined distinct layers of levels. , Powers arrived at 11 levels in PCT by going through a process similar to the method of levels. In MOL, the process of 'going up a level' is emphasized as being important, not the 11 levels in PCT that Powers suggests should be taken as researchable hypotheses. In similar explorations, Sachse (1990) suggests there are eight levels of processing that are defined by asking specific questions.

Q Methodology

The author of this paper (DMG) has used Q Methodology (Brown, 1980; Stephenson, 1953) to study: (a) interpersonal relationships of a person in therapy (Goldstein, 1989) and (b) self-image of a person in therapy (Goldstein & Goldstein, 2005). In the present case study, Q-Methodology was used to track the changes that take place in therapy (Ablon & Marci, 2004).

The patient was asked to Q-sort a set of 16 statements at the end of a session (Table 1).

Table 1: Items in Therapy Changes Assessment.

Item	Description
1.	I learned a new way of viewing a problem.
2.	I have corrected my understanding of the problem
3.	I have gathered more information about the problem.
4.*	I have a more positive, hopeful and less pessimistic attitude when thinking about the problem.
5.*	I have decided what I want to happen about the problem.
6.*	I have decided that solving the problem has a high priority.
7.	I have noticed that I am in conflict when it comes to this problem.
8.*	I have reworked a problem so that I can achieve it, it is more doable, and within my abilities.
9.	I am more aware of my feelings/emotions when I am addressing this problem.
10.	I have expressed and communicated my feelings/ emotions, understandings and wants when addressing the problem.
11.	I am more aware that my reactions to the problem relate to past history, or imagining than to what is actually happening now.
12.	I have noticed and stopped over-reacting or under-reacting to the problem.
13.	I have noticed that my feelings/emotions, actions or wants keep changing when it comes to the problem.
14.*	I have stopped taking a certain action (coping style).
15.*	I have started taking a certain action (coping style) which I know how to do.
16.*	I have learned a new action (coping style)

Note: item numbers with "*" showed significant linear change across sessions.

These items are derived from PCT and represent possible changes that might occur around a control loop during reorganization, which would result in Toni improving control over her life. The advantage of this approach is that it creates a uniform structure within which the client can evaluate progress in a consistent way over many sessions. A typical control system consists of three components (input, comparator/memory and output) which might undergo change in therapy.

Items 1-4 in Table 1 were conceptualized as sampling the perceptual components of control systems. It is possible that Toni may notice changes in the way she was perceiving herself, other people, her environment, etc.. The asterisk next to item 4 shows that this item actually changed over sessions. Cognitive Therapies typically involves changes in the perception components of control systems. It is interesting that item 4 relates to the issue of optimism versus pessimism which is a frequently discussed topic.

Items 5-7 in Table 1 involve the comparator/memory componet of control systems. It is possible that Toni may notice changes in what she wants, conflicts between what she wants, the importance she places on goals, etc.. The asterisk next to items 5 and 6 show that changes in these items actually took place over sessions. Psychoanalytical Therapies typically involve the comparator/memory components.

Items 13-15 all involve the action components of control systems. Note that changes in this component were noticed by the patient as denoted by the asterisks. Behavior Therapies typically emphasize these kind of changes.

Items 9-13 focus on the feelings/emotions/mood changes, which is also emphasized in Psychoanlytical Therapies.

Items 8 and 13 were attempts to identify changes in Toni which might reflect her noticing the reorganization system at work. The asterisk next to item 8 shows that it changed over sessions.

While these reasons for selecting the items in Table 1 are interesting, the reader is directed to Figure 1 in which the ways the items actually cluster are shown, as illustrated by this case study.

Learning from the present case study, I now give a pre-session questionnaire in which I ask two questions: (1) Yes or No: are some changes noticed? and (2) If Yes, what are they? If No, does the patient have any ideas of what is stopping the changes from happening. The advantage of this approach over a standard, theoretically derived set of therapy change statements is that it is more idiographic and more consistent with Humanistic Therapy approaches.

To Q-sort a set of statements, one places them in a partial rank order according to the sorting instruction (*condition of instruction*). In the present study, the condition of instruction was to sort the items so that they are MOST UNLIKE to MOST LIKE what changed or happened in the session.

This sorting instruction takes the following specific form:

1. Which two index cards show the changes that are MOST LIKE what happened in today's sessions? Which two cards show the changes that are MOST UNLIKE what happened? A card is assigned a value of +2 for most like or -2 for most unlike.
2. Which three cards of the remaining ones are MOST LIKE what happened? Which three cards are MOST UNLIKE what happened? Each card is assigned a value of +1 for most like or -1 for most unlike.
3. The remaining 6 cards are placed in the middle category and and assigned a value of 0.

As a concrete example of Q-sorting from the present case study, the reader can look at Table 2, which contains the Q-sort results after each session. After session 01, one can see the following distribution of items (Q-sort): she was most noticing changes in the feelings and emotions she was experiencing (items 10,13) and was not noticing any changes in the way she was perceiving the problem (items 01,02).

Case introduction

'Toni,' the woman of the present study was a self-referred, 55-year-old, white female from a Jewish, middle-class family. She is a high school graduate and has an associate's degree in Respiratory Therapy. After the initial evaluation session, the opportunity to participate in the MOL Therapy Research was offered and accepted. An Informed Consent Form was signed. Audio recording of sessions began with the second session that provided a means of reviewing a session.

Presenting complaints

Toni complained she was not functioning well in her work setting. She was distractible and forgetting to do things. She was taking an anti-depressant and anti-anxiety medication prescribed by her family doctor.

For the record, even though it is not a formal part of MOL Therapy, the DSM-IV Diagnosis for this patient was based on a standard clinical interview during the initial session and was as follows:

Axis I. 309.28 Adjustment Disorder With Mixed Anxiety and Depression
Axis II.. 799.9 Diagnosis Deferred.
Axis III. Overweight. Wears glasses. High cholesterol. Arthritis. Stomach reflux. Sleep problems.
Axis IV.Occupational problems; problems with primary support group.
Axis V. Current GAF = 60 (start); GAF = 80 (end).

History

Toni was married when she was 41 years old. Her marriage lasted for ten years. There was a history of marital problems and they had been in couples therapy. Her husband had died about four years before the first session; there were no children from the marriage. Toni had a history of alcohol abuse and was a recovering alcoholic; with a history of attending AA groups. There was no history of psychiatric hospitalization. She was working as a manager in a pharmacy. She has credentials as a respiratory therapist but had stopped working in this role after her husband died from a breathing related problem.

Assessment

In the current MOL Therapy study, Q-sorting provided an assessment procedure for what changes happened in therapy. (Ablon, & Marci, 2004) The Q-sorts after each session are shown in Table 2.

Table 2: Q-sorts of therapy change assessment (16 items of table 1) for each session

Session No.	*Item No. From Table 1*															
	01	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
SESSION01	-2	-2	0	0	-1	0	1	-1	1	2	1	-1	2	0	0	0
SESSION02	0	0	1	-2	-2	2	2	0	1	1	0	-1	0	-1	0	-1
SESSION03	2	0	1	1	-1	0	2	-1	0	1	-2	0	-1	0	0	-2
SESSION04	2	0	0	1	0	2	-2	0	0	1	1	-1	-1	0	-1	-2
SESSION05	1	0	-1	2	-2	2	-2	0	0	0	0	1	-1	-1	1	0
SESSION06	1	0	-1	2	-2	2	-2	0	0	0	0	1	-1	-1	1	0
SESSION07	1	1	2	1	0	-1	-2	2	0	0	0	-1	-2	0	-1	0
SESSION08	0	0	1	0	-2	1	2	-1	2	1	-1	0	-2	0	-1	0
SESSION09	-2	0	2	0	0	1	1	0	2	1	-1	-2	-1	-1	0	0
SESSION10	0	1	2	1	-2	0	0	0	1	2	-1	-1	-1	-2	0	0
SESSION11	0	0	1	-1	-2	1	0	-1	2	2	0	0	-2	0	1	-1
SESSION12	0	0	1	2	-2	0	1	-1	1	2	-2	0	-1	0	-1	0
SESSION13	0	0	1	0	-2	1	-2	0	2	2	0	0	1	-1	-1	-1
SESSION14	1	2	0	2	-2	0	-1	1	1	0	-1	0	-2	-1	0	0
SESSION15	1	-1	0	2	1	0	0	0	0	0	-1	-2	-1	-2	1	2
SESSI0N16	0	-1	0	1	1	2	2	0	0	-2	1	-1	-2	0	0	-1
SESSION19	-1	2	1	1	-2	-2	0	0	1	0	0	0	-1	-1	2	0
SESSION20	1	0	-2	2	0	0	-1	1	0	1	-2	-1	-1	0	2	0
SESSION21	1	0	2	-1	2	0	0	-1	0	0	1	1	-1	-2	0	-2
SESSION23	0	0	0	2	1	-2	-2	0	2	0	0	-1	-1	-1	1	1

Note: The numbers represent MOST UNLIKE (-2)…(0)…MOST LIKE (+2) what happened during each therapy session.

Case conceptualization

Toni became depressed following the death of her husband from a breathing related problem and left her career as a respiratory therapist. She then worked as a private pharmacy manager. The patient was experiencing a lot of stress, anxiety, and depression. A major source of stress was the fact that the owner of the pharmacy made negative comments about her, even though the customers liked her and spontaneously made positive remarks. In addition, Toni was scared, confused and felt guilty

because she would sometimes, impulsively, steal non-medication items from the pharmacy. Toni became aware of different parts of her self-image ('the committee') that accounted for inconsistencies in her actions. These different parts became more integrated during the course of the therapy sessions.

Course of treatment and assessment of progress

The first session in which an item was scored +2 can be seen in Table 3 and suggests what changes were happening within the patient.

Table 3: First Session In Which An Item Was Scored +2

Session	Item scored +2 for first time
1	13: My feelings, actions, or wants keep changing.
	10 : I have expressed my feelings, understandings and wants
2	6: I have decided that solving the problem has a high priority.
	7: I have noticed that I am in conflict.
3	1: I learned a new way of viewing a problem.
4	No new items scored +2.
5	4: I am more hopeful and less pessimistic.
6	No new items scored +2
7	3: I have gathered more information.
8	9: I am more aware of my feelings/emotions
9 – 13	No new items scored +2
14	2: I have corrected my understanding of the problem
15:	16: I have learned a new action (coping style).
16-18	No new items scored +2
19	15: I have started taking a certain action which I know how to do.
21	5: I have decided what I want to happen.
22,23	No new items scored +2

It is interesting to note that in session 2, Toni was becoming aware of internal conflict. Work on conflicts starts early in MOL Therapy.

Items 11, 12 and 14 were never scored +2. It seems likely that other forms of therapy might encourage patients to notice these changes. For example, psychodynamic therapy might result in the patient noticing aspects of past history and fantasy (item 11). The results in Table 3 give a pretty good picture of the course of therapy. What follows is a more technical analysis of the data which the reader unfamiliar with factor and cluster analysis can probably skip and jump to the section on complicating factors.

It would be nice to have something like a learning curve for the changes in therapy. The following is an attempt to do this. To study the within-person changes across sessions in more detail, the Q-sorts for the five successive blocks of four sessions each were combined (session block variable: sessions1-4, 5-8, 9-12, 13-16 and 17-20). Thus, each combined Q-sort is a description of the changes which were noticed in a particular block. It then becomes clearer when there were changes from one block to the other.

The five Q-sorts, one per block of sessions, were factor analyzed (with SPSS Software (2002); the extraction method was Principal Component Analysis; the rotation method was Equamax with Kaiser Normalization; the Anderson-Rubin method of generating factor scores was chosen). It was found that the session block variable loaded on a component that included item 5 (loading was .893), item 6 (-.976), and item 15 (.934); the session block variable also loaded on a second component that included items 4 (.854), item 8 (.765), item 14 (-.709) and item 16 (.869). If the session block variable did not load on any component in the factor analysis, then this would have shown that there were no learning changes.

As seen in Table 1 by looking at the item numbers with an asterisk next to them, the patient became more optimistic (item 4), knew that she wanted to solve the problem and made a specific goal (items 5 and 6) and took appropriate actions to achieve the goal (items 8, 14, 15, and 16). These are the changes that Toni noticed over sessions.

I had avoided applying MOL Therapy to the topic of the 'the committee' within the patient, which she was aware of and sometimes brought up. This topic was avoided because of the fear of 'opening a can of worms' if she were suffering from a dissociative disorder. The patient also avoided talking about the committee with me for fear of being perceived as a multiple personality. DMG did bring up the topic of 'the committee' during the later sessions. This turned out to have a very good result and moved Toni's level of awareness to a higher level. She could describe the changes that were happening in the committee members.

Toni actually became aware of a level above the committee that in PCT is called the *observer self*. The observer self was aware of all of the members of the committee. Toni reported feeling calm and mature when taking the view of the observer self. She was unable to describe the observer self in any further detail. The observer self seemed closer to her 'true self.'.

Factor and Cluster Analysis of Q-sorts

The Q-sorts of Table 2 were factor analyzed, in a similar manner as described above for blocks of sessions, in order to condense the 20 Q-sorts into related categories. The result was that 6 factors were obtained with the following session Q-sorts loading on each factor: sessions 3, 8 and 12 on factor 1; sessions 4, 5 and 6 on factor 2; sessions 1, 2, 9, 11 and 13 on factor 3; sessions 7, 10, 14, 16, and 17 on factor 4; sessions 15, 18, and 20 and on factor 5; session 19 on factor 6. Thus, the 20 Q-sorts were reduced to 6 Q-sorts which were similar.

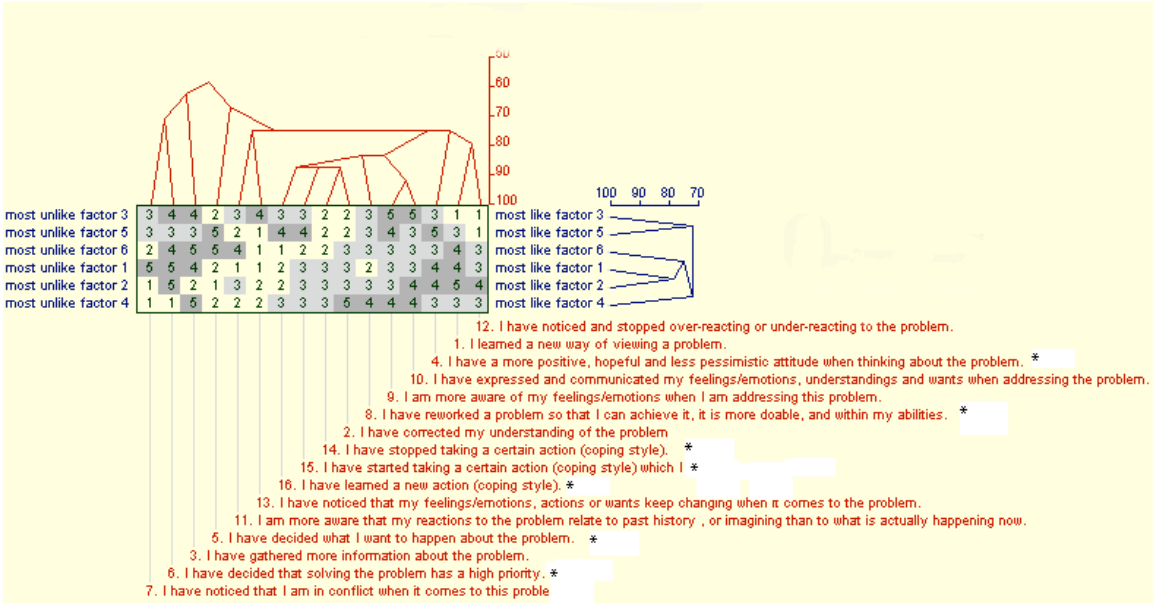
Cluster analysis was used to analyze the 16 statements and 6 Q-sorts. The Rep IV Software (2005) was used. The results are shown in Figure 1.

Figure 1: Cluster analysis of Toni's Items and Q-sort Factors
The Q-sort scores (-2…0…+2) were converted to a 1 to 5 scale for this analysis.

The columns in Figure 1 represent different statements. Note the way the statements group together. There are three clusters of items as follows. One is 7, 6*, 3, 5*, 11, 13. A second is 16*, 15*, 14*, 2, 8*, 9, 10. A third is 4*, 1, 12. Note that the asterisks mean that linear change was evident across sessions. The first cluster involves deciding or wanting. The second involves actions. The third cluster is a more general perception change.

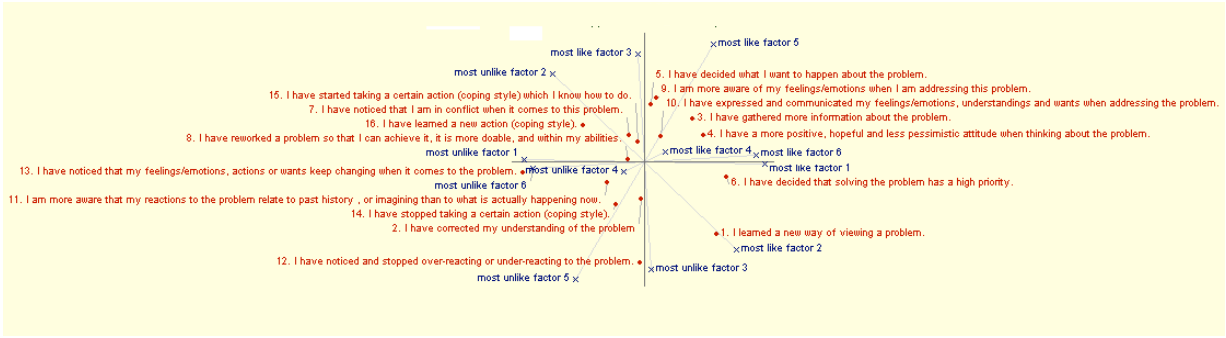
The rows in Figure 1 are types of sessions. Observe how the 6 Q-sort sessions group together. There seem to be two clusters of factors as follows. One cluster is 3, 5. A second cluster is 6, 1, 2, 4.

Note that the asterisks refer to items for which there is a linear change over sessions.



One can observe in Figure 2 the following relationships between statements and factors.

Figure 2: Principal grid factor analysis for Toni's data.



Note that the Y-axis shows Cluster 3,5 and the X-axis shows Cluster 6,1,4.

As seen in Figure 2, the positive pole of the first cluster (X-axis) is defined by factors 1, 6, and 4. The positive pole of the second cluster (Y-axis) is identified with factor 3 and factor 5. Factor 2 is confounded between clusters 1 and 2. These results correspond to the cluster results for sessions in Figure 1.

The statement which is most associated with the positive pole of the first cluster (X-axis) can be seen to be statement 6 (I have decided that solving the problem has a high priority). The negative pole is associated with statement 13 (I have noticed that my feelings/emotions, actions or wants keep changing when it comes to the problem.)

The statements which are most associated with the positive pole of the second cluster (Y-axis) are statements 5 (I have decided what I want to happen about the problem.) and 9 (I am more aware of my feelings/emotions when I am addressing this problem.) The negative pole is most closely associated with statement 12 (I have noticed and stopped over-reacting or under-reacting to the problem.)

Using the information in Table 3, please note that the first cluster in the above analysis (X-axis) happens early (session 2) in therapy while the second cluster (Y-axis) happens later in therapy (session 21) . This is consistent with the observation that there were changes within the patient as

therapy sessions proceeded, with the items undergoing significant change shown in Table 1 and Figure 1 by an asterisk.

Complicating factors

I had to modify my usual way of doing therapy, which is eclectic, in order to be consistent with the MOL Therapy process. The hardest thing for me was to modify my tendency to problem solve or to get Toni to problem solve on specific goals based on the presenting symptoms. In MOL Therapy, the goal is to help people change where their awareness is directed within the hierarchy. Once they place awareness appropriately, they will make needed changes in a way that is meaningful and lasting.

Table 4 Q-sort of MOL Therapy Test Items

Item	WTP Time 1	WTP Time 2	DMG
025 The therapist had many suggestions about how I could solve my problems	1	1	1
023 The therapist gave me useful suggestions about how to act when I feel bad	2	2	3
001 I found that my own ideas were inferior to the therapist's ideas about my problems	3	6	4
012 In the session, I was told or shown that my unpleasant thoughts are incorrect	3	4	2
006 I was told of the real meanings of my thoughts and feelings	4	3	5
024 I was encouraged by the therapist to behave and think in a more realistic way	4	4	7
008 The therapist seemed to have more insights into my problems than I did	5	5	4
013 The therapist suggested new viewpoints toward my problems to try out	5	3	5
019 I began to understand the method that the therapist was using	5	9	9
005 I was reminded by the therapist of the social norms that apply to my actions	6	5	3
011 The therapist showed me that my present problems come from past experiences	6	5	5
002 When I was con- fused, the therapist explained things so I understood them better	7	7	7
007 I was often unable to answer questions that the therapist asked	7	7	6
014 The therapist helped me by using his knowledge of other people	7	6	6
016 I do not remember any specific questions the therapist asked	8	8	9
020 I was shown by the therapist that my desires or goals contradict each other	8	7	7
003 The therapist did not always seem to be interested in what I was saying	9	9	8
010 The therapist communicated almost entirely by asking questions	9	9	8
018 The subject under discussion seemed to keep changing	9	8	10
009 When I asked for advice, the therapist refused to give it to me	10	11	10
015 The therapist spoke less than I did during the session	10	10	9
017 I was helped to see both sides of conflicting wishes and intentions	11	10	11
021 I felt that it was up to me to resolve my problems	11	13	13
022 The therapist made me more aware of how I felt and thought during the session	12	11	12
004 The therapist brought my attention back to fleeting thoughts I mentioned	13	12	11

Note: The Q-sort instruction was: Rank the items form MOST UNLIKE an MOL Therapy session (score1) to MOST LIKE an MOL Therapy session (score 13). WTP refers to William T. Powers, the creator of MOL Therapy. The high test-retest correlation shows that he is consistent with himself from time to time. The high inter-observer reliability between WTP and DMG shows that I have the same understanding of the MOL Therapy process as WTP.

In Table 4, there is a set of statements that can be used to describe MOL Therapy in terms of a Q-sort. The items MOST LIKE MOL were: items 4, 22, 21 and 17. The items MOST UNLIKE MOL were: items 23, 25, 01, 12, 6, 24, 8 and 13. This Q-sort can be used after a session by the therapist or an observer to provide a check on the way the therapist conducted the session. It also provides an operational definition of MOL Therapy.

To provide reliability information, the set of statements in Table 4 was Q-sorted. A test-retest correlation coefficient of r =.91, p <.001 was obtained by WTP (the creator of MOL Therapy) and an inter-observer reliability was r =.89, p <.001 between DMG and WTP.

Managed care considerations

The number of sessions (23) is consistent with the shorter-term therapy of managed care. This patient and other patients experiencing MOL Therapy have commented on how fast things seem to move. While MOL Therapy is at the earlier stages of empirical validation, it is similar to other, established shorter-term therapies.

Follow-up

Toni was very pleased with the progress. She described MOL Therapy as ‘fast-track’ therapy, which was intended as a positive comment; her prior therapy experiences were the basis for this judgment. Her family described the changes as ‘a miracle’ because she made significant changes in her life that she had been unwilling or unable to make before therapy. She was ‘forgetting’ to take her antidepressant and anti-anxiety medication. Toni was concerned that she might forget the process we used during the therapy. She was reassured that she could call and reschedule at any time if that became necessary. By the end of the treatment series, she had returned to work as a respiration therapist and felt valued by her employers and coworkers.

Toni completed the Revised Reactions Session Scale on the last day of therapy, which was about two months after the previous session and the results are shown in Table 5. As can be seen by item 24, she found the sessions ’Extremely Helpful.’

A longer-term follow-up was undertaken in 10/06, eight months after the end of therapy. Toni was working full-time in a hospital setting rather than working part-time for an agency. On a New Pre-Session Change Questionnaire that I created, she indicates that she has noticed significant changes in herself as follows:. She is speaking up more for herself with people in an appropriate way (for example, with her mother and with co-workers). It became clear during the session that she retained the skill of beng able to go back and forth between foreground and background levels of cognitive activity and that this helped her to cope. The problem with stealing no longer seems to be present and in fact Toni cited an incident in which she returned some money that was paid to her by mistake.

As part of the follow-up, some formal psychological tests were given, including the SCL-90-R, which is widely used as a therapy outcome measure. She came out with T-scores all below T-50 (the mean score). She indicates she is not experiencing a great deal of distress on the 90 items of the SCL-90-R.

The MCMI-III was also given. This is a self-report test which consists of 175 statements to which a person answers ‘True’ or ‘False.’ She came out with a high BR Score on the Drug Dependence Scale,

which probably reflects past history and not current behavior. She came out with high BR Scores on the Personality Scales of Narcissistic, and Antisocial. She is aware of these features of her personality are and may want to do something about them in future therapy sessions, since they interfere with her everyday social interactions in a negative way.

Table 5: Revised Session Reactions Scale

Item	1	2	3	4	5
1. Seeing things from another person's perspective.			X		
2. Pressured or controlled.	X				
3. Definition of problems for me to work on.				X	
4. Deprived or uncared-for	X				
5.Insight into self; made new connections about myself.					X
6. More distanced.		X			
7. Supported.					X
8. Insight into others: made new connections about other people.				X	
9. Relieved.					X
10. Stuck/lack of progress.	X				
11. Close to therapist.				X	
12. Understood.					X
13. Criticized.	X				
14. More aware or clearer about other people.				X	
15. Distressed.	X				
16. More aware of clearer about self.					X
17. Positive beliefs about others.			X		
18. Involved in therapy.				X	
19. Misunderstood.	X				
20. Positive beliefs about self.				X	
21. Distracted or confused.	X				
22. Progress towards knowing what to do about problems.				X	
23. Confidence in positive changes and hopefulness at ability to make changes.				X	
24. Overall sessions helpfulness.	Extremely Helpful.				

Date: 02/04/2006
Sessions: 05/26/2005 to 02/04/2006 (23 sessions)

1=Not at all; 2=Slightly; 3=Somewhat; 4=Pretty much; 5=Very much.

Treatment implications of this case

MOL Therapy is based on a clear concept of what is important in order for a person to change in therapy. The person must go to a higher level of awareness . The person must resolve internal conflicts that block the normal process of trial and error change (reorganization) from taking place. These ideas are derived from Perceptual Control Theory (PCT).

According to PCT, the 'right' level of awareness is a higher one than the patient is functioning at when he/she starts therapy. The reason for this is that PCT teaches us that the higher levels of control systems set the goals for the lower levels. If a person makes changes at the lower levels, this will simply result in the higher levels undoing or modifying the change. Thus, a form of symptom substitution will take place, PCT implies. This feature of MOL is similar to psychodynamic forms of therapy but provides a rationale for why symptom substitution is likely to happen.

The idea that higher levels of control systems set the goals for the lower levels of control systems also provides an explanation of why therapist suggestions and interpretations are likely to be resisted. The therapist is unlikely to know enough about the higher level of control systems to know what sort of changes would be consistent with them. Thus, the patient is likely to resist or defend against suggestions or interpretations made by the therapist. This provides an explanation of why patient noncompliance takes place and why patients sometimes act in 'defensive' ways.

In order to notice higher levels of awareness, the person must focus awareness on the experiences that are happening right there in the therapy session, no matter what the person is talking about. Whether the person is talking about a past trauma, talking about a dream, or talking about a future event, the important thing is for the person to notice and describe the experience that happens as the person talks about these things. The focus on present time experience is similar to client-centered, humanistic and experiential forms of therapy.

However, the reason for the focus on present time experience is that the person may become aware of the imagined perceptions ('background topics') that, according to PCT, result from the activities of higher-level control system. In MOL Therapy, the therapist is encouraged to not become too involved in the content of what the person is describing at the moment. The reason is that the therapist wants to notice imagined perceptions that are a sign of higher levels ('disruptions' in the conversation can be noticed.) This is a hard thing for the patient to accept and for the therapist to do. The patient may think that the therapist is not interested in the topic and doesn't care. The therapist may want to help the patient solve a problem the patient is describing and get stuck at the lower level, just like the patient.

The MOL therapist must prepare the patient for topic switching by explaining that following the background thought is very likely to lead to a topic that has more relevance to the real problem. Most therapeutic approaches involve some form of redefining the problem. In MOL Therapy, the form this redefinition takes is based on the hierarchy within the patient, the way that the patient is organized.

The therapist may come to realize that the patient is in conflict, which leads the person to want and not want a certain experience. This blocks the movement of awareness to higher levels. PCT teaches us that conflict is caused by a control system receiving different goals from higher level systems. There is a specific procedure in MOL Therapy for helping a person resolve such internal conflicts that was described in the introduction to the case study. When a person can simultaneously see both sides of the conflict, a solution will often suggest itself. This is a specific technique that a therapist must learn in order to do MOL Therapy. Thus MOL Therapy is similar to psychodynamic therapy in the emphasis on the importance of working with conflicts. It is different in that the existence of a conflict per se rather than the specific content of the conflict is the issue. Conflict resolution in MOL allows a person to move to a higher level of awareness.

In the present case study, the life situation changes in the patient were completely initiated by the patient. They were not the result of a suggestion or interpretation by the therapist. For example, she decided to change her work situation on her own. It is reasonable to assume that this required her to satisfactorily work through the trauma of her husband dying from a breathing related problem, which understandably, made it hard for her to work with patients who had breathing problems.

As a second example of patient-initiated change, she decided to stop the medications on her own, in consultation with the prescribing doctor. Apparently, she no longer needed the medication to cope with anxious and depressed states. In PCT, the trial-and-error process of reorganization is thought of as resulting in reduced error signals within the hierarchy of control systems that trigger arousal and negative feelings/emotions. The therapist was pleasantly surprised by the announcement of these specific changes. Apparently, the reorganization had taken placebetween therapy sessions, once awareness was in the right place.

Given the nature of reorganization, a therapist may have to accept that specific changes within a person are unpredictable. This means that the therapist has limited control over what, when or how

person changes occur. The therapist can help the patient start the change process, but the way the patient is organized determines the specific changes that occur and when they occur. The therapist must be patient, respectful and not try to artificially rush or direct the reorganization process. It is helpful to have an attitude of confidence in the normal process of change so that the patient can have confidence in it.

The MOL Therapy picture of the normal process of change raises serious questions about the current approach to therapy. The standard approach starts with diagnoses based on the outsider point of view. The therapist develops specific treatment goals based on the diagnoses, and then applies specific treatment interventions intended to bring about specific changes. All of the above is supposed to take place as quickly as possible.

In contrast to the above approach, the treatment goals in MOL Therapy are more general and could be phrased as follows:

Goal 1: the patient will talk about the topics that are stressful (‘problems for the patient’, not ‘for society’ and not for ‘significant others.’).
Goal 2: The patient will raise awareness to higher levels when thinking about problems that will result in learning about the self.
Goal 3: The patient will resolve any goal conflicts that block the-awareness-raising goal.

The general intervention strategies in MOL therapy are as follows:

Strategy 1: Help a person to be aware of what he/she experiences as a stressful topic is being discussed.
Strategy 2: Help a person to be aware of higher level experiences when a topic is being discussed.
Strategy 3: Ask a person to switch topics and talk about the higher level experience.
Strategy 4: Help a person resolve conflicts that are present during strategies 1-3.

A comparison of therapy and the game of pick-up-sticks can help to make the above points in a different way. At the start of the game (therapy), the sticks are thrown on the table. Let us set up the situation so that the therapistknows about the sticks only from the patient’s description of them. Goal 1 would result in the person describing the ‘top stick’ in as much detail as possible. Goal 2 would be accomplished when the person describes the stick or sticks that are in the immediate ‘background’ of the top stick. Goal 3 might be a discussion with the therapist to resolve conflicts that stop a patient from taking action and picking a stick. Therapist suggestions that are about sticks ‘deeper’ in the pile would not be very helpful, even if the suggestions are correct. The patient would likely ignore or resist them. The organization of the sticks determines what the sequence of steps should be.

Here is another metaphor that helps to explain the process of MOL Therapy. A person doing MOL Therapy is like a person walking up stairs backwards. The person must first focus on the step where he/she stands (foreground topic). Then the person must find the step that is just above the present one with one foot and carefully lift the other foot to the higher step (background topic). In that the person is ‘going up a level’ backwards, the person is not sure of how many steps there are to the ‘top.’ Also, the person would not be ready to go to a level higher than the immediate next one, if the therapist should suggest it, even if it is a correct one. The ‘background’ topic becomes the ‘foreground’ topic and the process repeats itself..

Readers familiar with Mahrer’s Experiential Therapy might notice interesting comparisons with MOL Therapy. (Gontovnick, 2004; Mahrer, 2002). Just as with Experiential Therapy, each MOL Therapy sessions stands by itself, and the focus is on self learning. Strategy 1 and 2 in MOL Therapy correspond to the first two steps in Experiential Therapy. In MOL Therapy, discussing the past history (step 3 in Mahrer’s therapy) and future situations (step 4 in Mahrer’s therapy) is not emphasized as separate topics but could occur as part of MOL Therapy strategy 1 or 2. However, there is no MOL Therapy strategy 4 in Experiential Therapy.

Readers familiar with Cognitive Behavior Therapy (Leahy, 2003) may be reminded of schema-focusing (for example, vertical descent), emotional processing (for example, accessing the emotion) or putting things in perspective (for example, looking at it from the balcony) techniques.

An advantage of MOL Therapy over existing therapies is that it is based on PCT that provides a unifying, simplifying, theoretical framework for selecting techniques and a conceptual analysis of what stops the normal process of change from happening.

Given the uncertainties of the therapy process, it is helpful to have a colleague with whom the case can be discussed.

In summary

The MOL Therapy approach is described by the Q-sort in Table 4. As explained previously, it has points of similarity with experiential, cognitive-behavioral and psychodynamic therapy approaches. However, MOL Therapy is not simply another eclectic blend. It is the result of applying PCT, which contains ideas about the normal process of change within each person. Reorganization, which leads to all normal learning and development according to PCT, can be supported and facilitated, even if it cannot by directly manipulated by the therapist. The MOL Therapy approach does require the therapist to take a more realistic and humble attitude towards the role of therapist.

Recommendations to clinicians and students

MOL Therapy is worth learning and doing, even for experienced clinicians; see Carey (2006) for further learning about MOL. It is eye opening to realize that much of what we do in therapy may not be necessary, and may even be counterproductive, for change to happen in the person. Be warned, however, trying the MOL Therapy approach may require the therapist to resolve some internal conflicts about how to do therapy.

MOL Therapy needs further research studies to define who it works for and for what kind of problems. Some of this research is taking place by Carey (2006). DMG has carried out several case studies other than the one reported. Three cases were clearly positive including the present one, two cases are still underway, and two cases terminated before much progress happened.

MOL Therapy is based on PCT, which Mansell (2005) has described as providing an integrative framework for clinical work. It is strongly suggested that the clinician and student would find it worthwhile to study the PCT approach (Powers, 1973, 1998, 1999 and 2007).

It is possible to practice the scientist/practioner model within a regular clinical setting. Q Methodology and Construct Therapy Analyses can help in this clinical research enterprise. In any future studies, DMG will assess the reactions to a session at the beginning of the next session, because significant reorganization continues to take place after a therapy session. It is hoped that with future clinical case studies, MOL Therapy can join the ranks of empirically supported therapies and the research can contribute to a better understanding of the therapy process. If the minimal therapist interventions in MOL can result in significant person changes, one wonders whether the effective components in other therapies might not be doing the same thing. Or, are there additional person changes that happen with minimal interventions plus other interventions?

Digital, audio recording of therapy sessions is valuable and provides an opportunity for the therapist to review the session and evaluate how things went. It could also be used as a means of helping a patient to listen to parts of a previous session.

Conclusions

MOL Therapy provides a clear conception of how to facilitate the change process in a person who enters therapy. The therapist should help a person move awareness to a higher level and should help a person resolve internal conflicts that are obstacles to accomplishing this.

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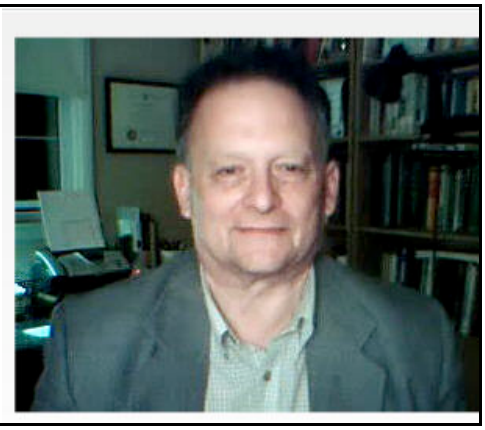

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