

Dissociation

Perceptual control theory as an integrative framework for clinical interventions

Warren Mansell
Timothy A. Carey

Using Perceptual Control Theory (Powers, Clark, and McFarland, 1960a, b; Powers, 1973, 2005, 2008), this chapter focuses on the phenomena that are described under the umbrella of ‘dissociation’ and concentrates on defining when, how, and why, these phenomena would be significant problems.

It is widely accepted that dissociative experiences lie on a continuum with normal experiences (Ray, 1996). This chapter provides a framework for these normal processes, illuminating when they present as significant problems and how to treat them. We conclude that dissociation represents functional splits within the mind. These splits become a clinical problem when they disrupt the individual’s capacity to realize important personal goals (e.g. to maintain a social identity, to form close relationships, to keep safe).

Therapy involves helping the person to become more aware of the dissociation process and to let go of rigid ways of controlling it (e.g. social withdrawal, self-criticism). Techniques from Method of Levels cognitive therapy (Carey, 2006) are designed for this purpose, as well as established techniques. Awareness allows more *flexible* control over dissociative experiences, so that the experiences and attempts to manage them no longer inhibit pursuit of important life goals.

What are the phenomena of dissociation that need explaining?

‘Dissociation’ is usually defined as an altered state of consciousness where one experiences full or partial disruption to the normal integration of experiences (Dell and O’Neil, 2009). This may be felt as separation of consciousness from one’s feelings (emotional numbing), from one’s body (depersonalization; out-of-body experiences), or from the environment (derealization). The first author of this chapter contributed to an article establishing that dissociative experiences can be discriminated as either *compartmentalization* or *detachment*, functionally distinct processes which can occur separately (Holmes *et al.*, 2005). Examples of compartmentalization are dissociative identities, functional amnesia and somatization. Examples of detachment are states of depersonalization and derealization. This chapter will claim that both compartmentalization and detachment reflect different processes in a control system account. We ask why these experiences

might be problematic and seek to explain the ‘clinical’ features of dissociative disorders and disorders involving dissociative states, suggesting that they involve distress about the experiences and/or significant disruption to life goals.

Perceptual Control Theory (PCT)

Perceptual Control Theory (PCT) was developed by the medical physicist and control systems engineer, William T. Powers (Powers *et al.*, 1960a and b; Powers, 1973, 2005, 2008). The control theory framework has been applied to depression (Hyland, 1987), obsessive compulsive disorder (Pitman, 1987), addiction (Webb *et al.*, 2010), bipolar disorder (Mansell, 2010), and dissociative identity disorder (Johnson, 2009), as well as transdiagnostic processes (Carey, 2008; Mansell, 2005, 2012; Watkins, 2011) and used to develop highly accessible and flexible interventions (Carey, 2006; Carey *et al.*, 2009).

Propositions of PCT

Essentially, PCT continues to explain the functioning of living systems from the point where biological explanations of homeostasis leave off. A homeostatic system (Cannon, 1932) is a *negative feedback control system*. It controls a physical variable (e.g. body temperature, hormone levels, blood glucose levels) within a survivable range, generating outputs that act *against* disturbances that might change the variable. A *reference value* represents the optimal value of the variable. For example, when the glucose level in blood deviates from a safe range, the body acts to restore it to within the normal range. Eating sugary foods increases glucose concentration that requires offsetting by the release of insulin; starvation can decrease glucose concentration, needing offsetting by releasing stored sugar. This process of control occurs constantly in our bodies, mostly outside our awareness.

Human beings must engage in *behaviours* to maintain these systems. Thus, we seek out food, water, safety, and comfort. Homeostatic systems lead to the development of brains that can act to provide what the systems need to keep physical variables at reference values. In the newborn, brain systems involve crude ways of communicating that the homeostatic systems (from here they will be called ‘intrinsic’ systems) are out of balance. The growing child develops more complex brain systems that enable her to carry out behaviours to regulate reference variables and keep her intrinsic systems satisfied. For example, learning to co-ordinate limbs will eventually enable her to feed herself. Development involves processes of control that become increasingly sophisticated and flexible. This account fits broadly with our knowledge of neuroanatomy: intrinsic systems are located within the lower brain structures (e.g. the reticular formation); other structures (e.g. the thalamus, hippocampus, and amygdala) mediate between the intrinsic systems and ‘higher level’ control structures of the prefrontal and frontal lobes (Fogel, 2009).

PCT states that ‘behaviour is the control of perception’ (Powers, 1973). Just as intrinsic systems control physiological variables (e.g. body temperature, blood glucose levels) within optimal limits, behaviour controls perceptual variables within optimal limits, so that the intrinsic systems are satisfied. For example, when a baby is cold, the discrepancy between the current body temperature and the body temperature specified by an intrinsic reference value will be detected, and the baby will engage in whatever behaviours she can to remove this discrepancy. This could involve wriggling, crying, or even dressing, depending on her developmental stage. Although the behaviours can vary, the variable that is controlled (the ‘controlled variable’) – say body temperature of 37° Celsius – is the same. From a PCT perspective, control is primary, learning is a way to achieve control, and the brain systems involved are known as *perceptual control systems*. Learning allows the person to perform flexible, goal-directed action so that exactly the right behaviour occurs at just the right time. A range of empirical, quantitative studies of animals and humans supports this account (Pellis and Bell, 2011; Bourbon and Powers, 1999; Marken, 1986; Powers, 1978).

One major clinical implication of PCT is that learning during treatment and recovery is unlikely to depend upon learning a specific behaviour that is triggered by a particular situation. It involves an internal change leading to the capacity to be more flexible in the means and processes of control.

Three propositions of PCT upon which an explanation of dissociation will be based are summarized below:

- 1 A mechanistic understanding of ‘control’ provides the foundation of development. Control involves keeping a variable within a desired range, by reducing the *error* between a *reference value* (internal standard) and an *input signal* (current perception).
- 2 Humans are born with *intrinsic systems* that maintain survival via sensing critical internal experiences (such as body temperature). *Intrinsic error* is registered when these variables deviate from the intrinsic set points (or intrinsic reference values). For example, a sensed body temperature of 25° Celsius produces intrinsic error of 12 degrees from the set point of 37° Celsius.
- 3 Intrinsic error drives the development and change of *perceptual control systems*. These systems allow a baby to learn to control her perceptions of herself and the world to reduce intrinsic error. These perceptions are learned and include, for example, being able to identify people who are safe to be close to. Intrinsic systems use the perceptual control systems as their means of affecting the environment to minimize intrinsic error (see Figure 16.1).

The next section explains how perceptual control systems develop. These five propositions will be explained in more detail in the next section.

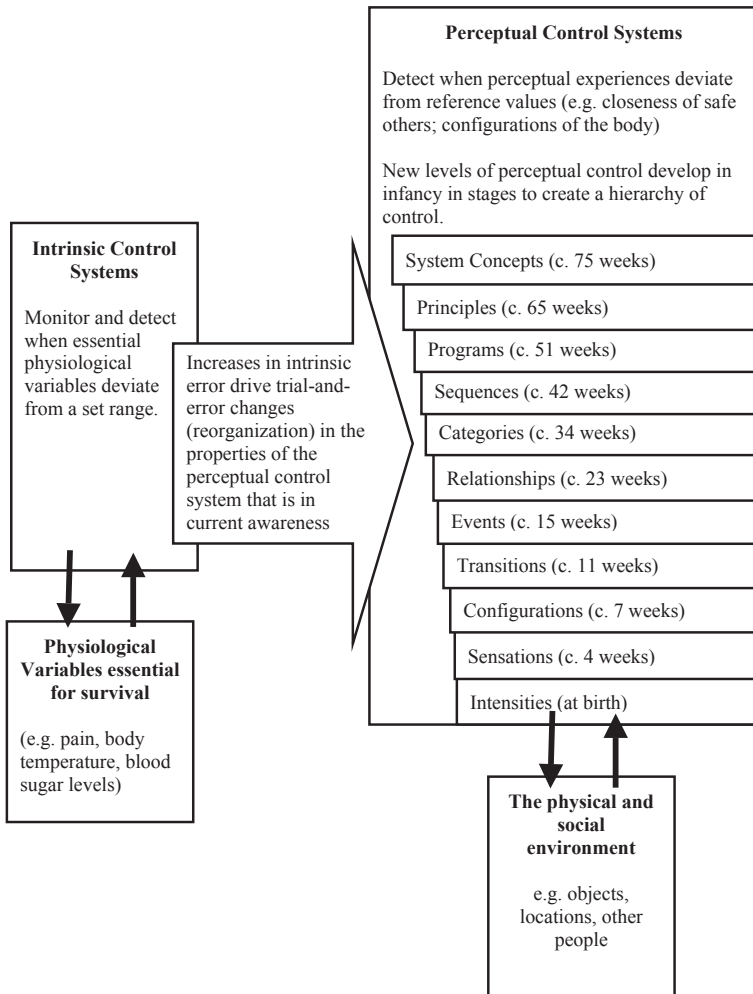


Figure 16.1 This diagram illustrates how the intrinsic systems detecting physiological changes in the body that are important to survival drive the development of increasingly sophisticated levels of perceptual control in the infant and child. This forms a hierarchy of perception of the self and others that reflects the adult's personality structure.

- Perceptual control systems develop as a *hierarchy*. Their sequential growth can be observed as periods of regression and leaps during the first two years of life – infants show periods of increased distress (regression) that predict the acquisition of a new skill (leap). Within PCT, this leap is considered to be evidence of the arrival of a new perceptual level – the ability to perceive

more complex environmental variables – that permits increased interaction with the environment and improved control – e.g. recognition of patterns and sitting upright (holding the body in a specific arrangement) are seen to develop in tandem (Van den Riijt and Plooij, 2003).

- 5 The *reference values* of perceptual control systems are past perceptions that are stored in a distributed memory throughout the perceptual hierarchy.
- 6 A key skill a baby learns during development is how to reduce *conflict* between perceptual systems so that intrinsic needs are met.
- 7 Conflict is reduced by a learning process known as *reorganization* involving internal trial-and-error changes to perceptual control systems when intrinsic error increases.
- 8 This adaptive development occurs through interpersonal environments. These environments help the child to develop ways of regulating multiple conflicting goals. They promote development of a new system controlling a different class of perception at a deeper (more abstract or complex) level. This allows the child to regulate the conflicted systems. Helpful interpersonal environments involve: safety, containment, acceptance of a wide range of behaviours, limited attempts to control what the child is learning, and playful recognition that new ideas and behaviours, however unusual or odd, are part of life and the learning process. These environments contrast with those proposed to be linked with later dissociation, i.e. attempts by the caregiver to suppress, manipulate, or ignore the emotional needs of the child, often because they trigger memories of loss and trauma in the caregiver (Fearon and Mansell, 2001).

Development of hierarchies

According to PCT, perception is controlled. ‘Perception’ is formed from the way signals from our senses are transformed into further signals as they pass through our nervous system. The functional anatomy of the nervous system shows that there are two major branches to and from the senses (see also Powers, 1973) – an external branch detecting and controlling sensing of the outside world, and an internal branch detecting and controlling perceptions of internal bodily states. Phenomenological accounts show that people can control perceptions of the world – independently of the world – imagery, imagination, planning and inner speech. To understand how this wide range of experiences can be controlled, the PCT model has a hierarchical structure with a functional basis. While the idea of a hierarchy in psychology, psychiatry, and neuroscience is not new (Hughlings Jackson, 1882; Kortlandt, 1955; Selfridge, 1959), the structure of the perceptual hierarchy in PCT is unique, and expressed in functional terms.

Powers (1973, 1992) specified eleven levels of perception developing from conception, each new layer providing a new way of regulating the reference values of the level below. The primatologist Frans Plooij (1984) recorded developmental stages of infant chimpanzees and found that they progressed, after a

period of regression where they were more distressed, through discrete skills stages. At each stage following the regression period they could control a new kind of perception. For example, newborn chimpanzees find their mother's nipple by ascending a gradient of warmth until they reach their 'target' and satisfy their need for food. At this age they cannot tolerate being removed from the nipple and become distressed if they are removed. At a later stage, they regulate their search for the mother's nipple as part of a larger set of controlled perceptions, as they explore their environment. The work that Plooij (1984) began has been elaborated around PCT and forms a framework for understanding developmental stages of human children: the development of a new 'skill' is the capacity to control a more sophisticated perception. Van den Riijt and Plooij (2003) explain how at around 11 weeks a child learns to perceive and control smooth transitions: they observed a reduction in the jerky movements of previous weeks and development of smoother coordination of limbs. Each new class of skill (a leap) is preceded by periods of regression (fussiness, distress) as the new level of control is initially trialed by the infant. There is increasing evidence from developmental research to support Plooij's account (Sadurni and Burriel, 2010).

Development of the perceptual hierarchy in PCT provides increasingly abstract levels, each new level being defined and grounded by the levels below. For example, one can pursue a *principle*, such as 'to be honest' through the way that one engages in a range of *programs*. The perception of honesty could be achieved by 'speaking true statements', 'being open with feelings', and 'sharing information'. It is proposed that the complex hierarchies we develop as adults are the personality structure of goals that we build in order to keep our intrinsic needs met in the long term. For most adults, these highest level goals, around self-identity and the kind of world we want to live in, end up transcending the intrinsic systems much of the time as people settle into supportive communities and a regular routine of activities. However, periodically, when intrinsic systems are challenged (e.g. a death in the family; a trauma), the personality structure will need to change to adapt and regain control. The process of change is known as *reorganization*, which will be covered later.

Memory and imagination in a perceptual hierarchy

Powers's (1973) work describes how *memory* involves a wide range of psychological processes that could be considered to be forms of 'dissociation'. Our suggestion is that these are helpful processes that allow people to fulfill their goals when they are controlled *flexibly*. But when they are used *rigidly* to serve one set of goals without regard to others, they indicate *conflict*. This stifles goal progress, and may mean that intrinsic needs are not met, the individual becomes increasingly compartmentalized and separate sections of their mental processes drift out of control.

Figure 16.2 illustrates how a hierarchy can be compartmentalized in a flexible and adaptive manner. There is evidence from social psychology that effective

functioning in social contexts involves having multiple identities (Kessler and McRae, 1982); this is particularly effective when identities are ‘integrated’ with one another (Thoits, 1983). For example, people describe being a ‘different person’ when they are at work from when with their friends. Within a PCT model, an overarching level of control regulates different aspects of the self according to context. Although different ‘selves’ are compartmentalized for all of us, awareness and control of these social-selves ensures that ‘vertical splits’ in the hierarchy do not conflict. The different selves are adaptive, allowing individuals to achieve constant results in variable social environments. People are successful at work *and* when socializing because they have flexibility to alter their behaviour.

Powers (1973) describes how levels lower down the hierarchy can become disengaged from levels above to allow a person to control perceptions of themselves and the world ‘as if’ they are occurring right now. This explanation

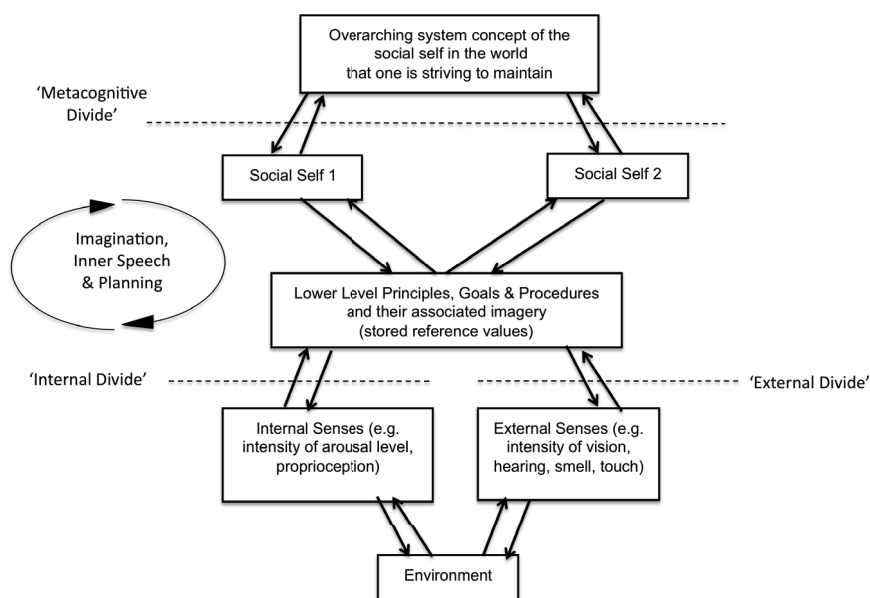


Figure 16.2 Dissociation involving flexible, adaptive control. Different compartmentalized social selves are used flexibly in different social contexts through the awareness provided by an overarching concept of the self in the world. Detachment is used to disengage effectively from current feelings and the current environment, when this facilitates imagination, problem-solving, and planning with respect to personal goals. Re-engagement with the internal and external environment in order to implement planned goals is controllable. Intrinsic needs generally remain fulfilled but, when environmental challenges create sudden changes, reorganization of this hierarchy will occur until control is regained.

is used to account for planning, rehearsing, imagining, day-dreaming, and so on. We propose that it is a form of detachment, that this time involves horizontal, rather than vertical, splitting of the hierarchy. For example, while driving we can visualize what we want to eat for dinner; a prisoner can imagine ways to escape or imagine life outside captivity; someone with social phobia can visualize the embarrassment of public speaking. Powers (1973) provides more detail but essentially this relies on taking memories from past experiences and using them as substitutes for the current experience. For example, being inspired by another person may work this way – we recall a person in our own lives, or in a fictional story, who reflects the principles we hold, and carry out acts that make us more like that person. Using this capacity, future goals can be planned through simulation of the real event. At a higher level, verbal thoughts can be substituted for more abstract goals (e.g. ‘to be successful’; ‘to be loyal’). When the individual is ready to implement their plan (a program in PCT), the higher levels re-engage the lower levels and action in the outside world proceeds – for example, we decide to keep a secret to be loyal to a friend. The brain’s capacity to dissociate in this way produces a diversity of mental skills, allowing goals to be achieved more smoothly, and also disruptions to control are pre-empted and managed. We can plan all kinds of future actions in situations we are not currently experiencing, all at the same time as seeing through current goals. Thus, compartmentalization is a functional mechanism that may be essential and ubiquitous to the human psyche.

We propose that detachment can also be functional. A control hierarchy is a *latent* structure that operates outside awareness, just like the concept of a schema. The fact that complex goal structures of this kind operate outside awareness is now commonly accepted, following a wide range of experimental research (Bargh and Morsella, 2008). Nevertheless, at any one time, a proportion of these structures will be in the spotlight of awareness. We propose that when compartmentalization is affecting the content of current awareness, this phenomenological shift is felt as detachment. Essentially, compartmentalization represents the fact that mental structures are separated and may not be in awareness at the present time whereas detachment describes the phenomenological experience within current awareness. This can be explained using two examples – one where compartmentalization is present but not having an impact within current awareness, one where compartmentalization causes detachment. Many clients describe a ‘side of themselves’ that they hide from others or try to suppress. It may be a more fearful, vulnerable and critical side of themselves. When this compartmentalized side is not relevant to the situation – for example, no obvious threats are present – little effort is required to keep it outside awareness, and no detachment is experienced. In a threatening environment, this side is relevant to the goals of the situation and becomes activated. This may be experienced as feelings and thoughts intruding into awareness. The client may struggle to suppress these experiences, and consequently feel detachment such as emotional numbing or even an out-of-body experience. This example illustrates that detachment can emerge because of compartmentalized self-structures (e.g. different self-identities switching within

awareness). Evidence suggests detachment can also be triggered by factors such as acute trauma (Putnam, 1985). Thus, detachment and compartmentalization are closely related but distinct processes.

Our model distinguishes between functional and dysfunctional features of detachment. For example, a new doctor tries to suppress feelings of horror at a serious injury, experiencing this as emotional numbing. If she also finds herself numbing her emotions in close relationships *and* she desperately wants a relationship, this will be a problem. Here it is not detachment *per se* that is problematic. The *conflict* with other life goals makes the detachment a problem. The conflict might be worse if the doctor regarded her emotional awareness as an indication of how affectionate she is – in therapy she might report her emotional numbing as indicating that she is ‘cruel and heartless’. Using PCT we have explanations of the process itself and of why it might be a problem.

The development of loss of control in a compartmentalized mind

Figure 16.3 illustrates how a perceptual hierarchy can reach a dysfunctional state characterized by chronic separation of its parts, conflict between them, and ultimately loss of control of normal functioning. Figure 16.3 represents one extreme of a continuum, the other extreme is represented by Figure 16.2. Most individuals can be represented by a combination of both figures; therapy aims to transform processes in Figure 16.3 into those in Figure 16.2. In Figure 16.3, the individual experiences intrinsic error because basic biological needs have not been met. The focus is on short-term, rigid and/or extreme methods of control (known as arbitrary control; Mansell, 2005, 2012; Powers, 1973). This leads to actions that merely maintain or increase conflict. For example, blocking out emotions can increase a sense of control in the short term. But then emotional states cannot be used for functional reasons – such as signaling danger or prompting assertive action. The arbitrary control strategy is met by a rebound effect when goals depending upon emotion for their execution regain prominence. The doctor suppresses her emotions and can deal with horrific injuries but loses her ability to maintain close relationships. The key to recovery lies in developing and reorganizing systems regulating the conflicting selves.

Clinical implications

Here we describe how PCT can be used to understand dissociation in clinical practice, inform why existing therapeutic strategies work, and develop a novel approach to therapy for dissociation.

Case formulation

Here is a clinical example illustrating Figure 16.3. Marjorie, a 35-year-old woman, has received various diagnoses, including bipolar disorder, borderline

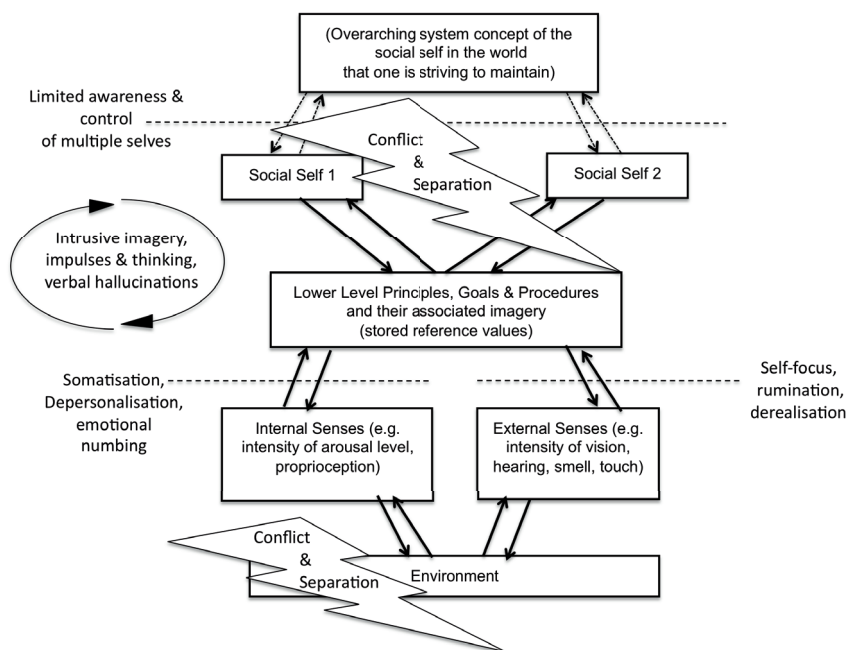


Figure 16.3 **Dissociation involving chronic loss of control.** Different compartmentalized social selves compete and conflict with little awareness, acceptance, or acknowledgement of one another or any overarching self concept. Detachment is implemented by one social self in an attempt to rigidly control the competing self, and the process is often felt as uncontrollable. Intrinsic needs generally remain unfulfilled, and attempts to reorganize this hierarchy are met by rigid and extreme attempts to prevent change. The person remains unable to regain control when challenged by sudden changes in the environment.

personality disorder, and schizoaffective disorder. She described at least two different ‘social-selves’. Her ‘anxious self’ would withdraw from the world, ruminate, and criticize herself. In this mental state she was in touch with her feelings, kept safe, and ‘real’. Yet the anxiety was often unbearable. Marjorie’s ‘tough self’ would not experience negative emotions, and was strong. In this state she felt ‘unreal’ and often got into fights or psychotic or manic states. Both sides of the ‘self’ (involving vertical splits in the hierarchy) had developed to protect her (the overarching goal at the top of Figure 16.3), yet neither was sustainable. She was in conflict over which side of herself to present and oscillated uncontrollably between them. Each side was associated with a different ‘horizontal splitting’ (a form of detachment) of the hierarchy at any one time. The ‘anxious

self' was consumed by imagined scenarios and feelings and yet separated from the physical world. In contrast, the 'tough self' was engaged with the physical world but cut off from internal sensations and emotions. Owing to the extreme advantages *and* risks of each of the sides of herself, Marjorie found it hard to identify 'dissociative' processes that were helpful to her (e.g. imagination, planning as shown in Figure 16.2). The experience of dissociation was instead experienced as an uncontrollable threat.

Theoretical rationale

The principles of PCT have direct clinical implications. Since compartmentalization and detachment may be functional and adaptive processes, dissociation would not automatically be identified as the problem. A clinician practicing within a PCT framework is interested in the *distress* associated with the behaviours and symptoms the person describes rather than the behaviours and symptoms themselves. The focus is on identifying aspects of the individual's life that are not controlled as well as the individual would like them to be – essentially their important goals. The clinician explores the distress experienced: how long has the person been distressed, are they distressed more at some times than others, what reduces the distress, how does it manifest in their body, are there associated images and thoughts, etcetera.

The PCT clinician is alert to indications of conflict within the individual, such as struggling or fighting with themselves, feeling torn between alternatives, being in a dilemma, and feeling stuck. Systematic and specific questioning helps highlight the conflict and expand the individual's awareness so that they are able to appreciate both sides. An optimistic attitude underpins this clinical work through appreciation of the robust and constructive nature of reorganization. Reorganization is the mechanism that produces the changes in control systems necessary for the individual to feel less distressed and more in control. The individual does not need advice about how to behave differently but benefits from sensitive and curious questioning. Through in-depth questioning around both sides of the conflict and careful attention to thoughts occurring during the questioning, the clinician helps the individual's awareness move *from the distress* that is currently in focus to *higher-level systems* that are the source of distress. With sustained attention to higher-level systems, reorganization will occur and bring relief and a sense of contentment and satisfaction. PCT utilizes a therapy known as Method of Levels (MOL; Carey, 2006, 2008) to facilitate this process. MOL uses questioning (1) to help the client to keep talking and (2) to notice disruptions and present-moment processes as they emerge. Questions include enquiries about changes in affect, body language, eye movement, and those that redirect attention to processes such as fleeting thoughts, imagery, and conflict in goals. Examples of MOL are provided below.

Due to the trial-and-error nature of the reorganizing process the first solutions generated may not be the best. The individual may feel some things are worse

than they were before. This is analogous to periods of regression experienced by infants prior to developing new control abilities (cf. Plooij, 1984). The therapist assists the distressed individual to continue exploring their conflict until they find a satisfactory solution.

Interventions

Because MOL uses the client's own frame of reference, we are not constrained by the assumptions or terminology of the therapist. In the following vignette we see how questions targeted at helping the client talk about their problems, noticing disruptions and exploring conflict can cover a wealth of approaches within traditional therapies. Look out for the following:

- appraisals of detachment experiences
- formulating different 'self-states'
- use of different cognitive and behavioural processes
- managing risky or out-of-control states

We have coded 'C' for client and 'T' for therapist, with each utterance numbered as C1, T1, C2, T2, etc.

- C1: *I numb myself to everything when I get stressed out – it's my only way of coping.*
- T1: *Tell me more about what 'numbing' yourself involves?*
- C2: *I switch off, cut off my feelings, my emotional pain – it is scary at times. It worries me!*
- T2: *Describing it like that, how does it sound to you?*
- C3: *Sounds desperate, not how I want to be. But what else can I do?*
- T3: *How do you want to be when you are stressed out?*
- C4: *Calm, but in touch with my feelings.*
- T4: *How does that sound?*
- C5: *[look of shock] Sounds like I would get walked over, manipulated by people. Can't see it working.*
- T5: *What happened there, when you said that?*
- C6: *I got a thought of what people would do to me if I was just calm – nasty.*
- T6: *You've told me about numbing yourself as one option and being calm but in touch with your feelings as another option. How are these looking right now?*
- C7: *Both look bad. Either I am cut off, tough, lose a sense of who I am and drink to keep it going, or I keep in touch with my feelings but get abused by people. I can't win.*
- T7: *What is it about being in touch with feelings and getting abused?*
- C8: *What do you mean?*
- T8: *Does one follow the other, do they happen at the same time, or what?*

- C9: *Never really thought of that. They seem the same thing – if I open up to my feelings I open myself up to other people.*
- T9: *How does that sound?*
- C10: *Doesn't sound quite true actually. Mmmm...*
- T10: *What's with the 'Mmmm'?*
- C11: *I thought when I open up here and show my feelings – just some of them – you don't take advantage.*
- T11: *How does that work?*
- C12: *Well, I feel in control of what I open up to, and I know that I can numb them out if I want, but I don't.*
- T12: *Right. What is it about control that's important?*
- C13: *That's all I want really – to feel in control – especially when I am stressed out. I don't feel in control when I numb myself out – things can get a lot worse in that state. I need another way to be in control with people who might harm me, some way to be less vulnerable [smiles].*
- T13: *What's making you smile?*
- C14: *Ah, oh, I just saw myself working as a caterer, years ago, before things got bad. I was in control then, but I could tell people how I felt. I got respect.*
- T14: *How clear is this picture?*
- C15: *I see this time when I dealt with a nasty customer. I'm really animated. The image is clear until I get angry then it seems to fade. I did get my way with him but I can't remember how.*
- T15: *What are you thinking now as you have this image?*
- C16: *That there's another way of being, of dealing with stress, by being in touch with how I feel. Don't want to be a really angry person – that would make me as bad as them.*
- T16: *How angry do you think is about right?*
- C17: *That's an odd question. Is there a right amount of anger? I had never really thought there was. Do you mind if I think about that?*
- T17: *Are you OK there if we leave it there for today then?*

Here, the therapist is helping the client to talk about her problem and tracking any disruptions that are linked to her current experiences – often involving themes of conflict. Traditional therapies might explain parts of this session in various ways. A cognitive approach might emphasize exploring appraisals of dissociated states. A cognitive analytic approach might regard this session as formulating different self-states. A metacognitive processes approach might identify the regulation of worry, emotion suppression, and alcohol use. We might prioritize risk assessment and developing better coping strategies. In the vignette, a new strategy becomes apparent in C12 – bringing a memory of coping in a different way to mind. This could be construed as an imagery restructuring procedure – familiar to schema therapists. Interventions designed directly for dissociation, such as 'grounding' using a physical object, may help the client to maintain control when emotions

and thoughts seem out of control. While we do not use such techniques in MOL, their utility might be explained by PCT.

For Marjorie, therapy involved monitoring her thoughts, feelings, behaviours, memories, and social contexts with which they could be identified. Basic formulations were developed of the kinds of actions that would bring a specific social self into awareness. For example, emotion suppression tended to enhance the ‘tough self’ whereas worry tended to encourage the ‘anxious self’. The therapist was curious as to the perceived goals of each self in current awareness, and how they related to overarching goals. Marjorie became increasingly able to articulate her own needs and her values for living, and consider how to achieve them.

The questioning was guided by the assumption that the process Marjorie described could be part of a helpful way of relating to the self and the world (as in Figure 16.2). For example, mental imagery was used as a way of problem-solving imagined scenarios, so they became less frightening. Emotions were discussed as potential signals for action rather than threats to be suppressed. The therapist would enquire as to the usefulness of these strategies in achieving Marjorie’s overarching goals to feel safe and feel connected to other people.

The clinician needs to be alert to any preconceived ideas they might have about the nature of the ideal solution. Solutions can be unexpected and even seem mundane. The individual’s experience is the crucial test; small shifts in perspective can bring about big changes in outlook and attitude. Standardized questionnaires, for example, are not always sensitive to changes experienced through subtle cognitive realignments. For example, Marjorie suddenly said, ‘You know, my tough self and anxious self don’t need to be fighting. Maybe they’ve both got something to offer.’ This seems obvious, and tempting to suggest to Marjorie, but until she has reorganized her way to this insight, it will not make sense to her. Afterwards, she might wonder why she didn’t think of it ages ago. People achieve insights, realizations, and epiphanies in their own time. According to PCT, attempts to steer this process through suggestions and strategies may distract and slow down the reorganizing processes.

Conclusions

We provided an account of dissociation, making ‘control’ central to whether dissociative processes are helpful or problematic. The perceptual control hierarchy is served by multi-layered memory stores, and serves basic biological needs. Chronic conflict within this hierarchy is the hallmark of ‘disordered’ dissociation. Clinical interventions facilitate the client’s awareness of these dissociative processes alongside the wealth of experiences in their lives, and their deepest values – the ‘higher-level systems’. Questioning using Method of Levels helps clients navigate awareness towards these life goals. Reorganization produces changes that make clients more adaptive – contrasting with inflexible strategies (e.g. chronic avoidance, suppression of emotions) that maintain distress. A future

direction is to explain the perceptual changes during dissociation using PCT and to build working models to test this account.

Further Resources

If you want to use this approach and learn more about this therapy, the resources we would suggest are:

- Carey, T. A. (2006). *Method of Levels: How to Do Psychotherapy without Getting in the Way*. Living Control Systems Publishing. Available at <http://tinyurl.com/MethodOfLevels>
- Mansell, W., Carey, T. A. and Tai, S. J. (2012). *A Transdiagnostic CBT Using Method of Levels Therapy: Distinctive Features*. Routledge: Hove.
- Mansell, W. & Hodson, S. (2009). Imagery and Memories of the Social Self in People with Bipolar Disorders: Empirical Evidence, Phenomenology, Theory and Therapy. In L. Stopa (ed), *Imagery and the Threatened Self: Perspectives on Mental Imagery and the Self in Cognitive Therapy*. London, UK: Routledge.
- www.PCTWeb.org. This website provides an introduction and links to the research and applications of Perceptual Control Theory.
- www.youtube.com/user/InsightCBT. This YouTube channel hosts an array of videos introducing and explaining Method of Levels.