Mark Lazare writes on crisis intervention in mental health settings based on PCT – April 2012

Warren Mansell asked if I "Would maybe write a little summary" of my work. Sure. But with apologies first, I am a better counselor than a writer. Writing and typing are not my strong suits. I wrote this as I would speak to a client (with parenthetical comments to the counselors and PCT/MOL people).

Background

Circa 1990-1993 I was working on my Masters Degree in Psychology using PCT, with Tom Bourbon. My thesis covered cooperation and communication, between dyads based on PCT. Cooperation was basically being described as two or more persons, acting separately in action (their behavior or behaviour for those outside of the USA), but coordinated efforts together (Perceptions), to reach a common goal (reference) neither could achieve alone. (e.g. It is very hard to play volleyball by yourself, or if you are blind, or don't know the rules or you're in a wheelchair. For cooperation to happen, you need another, you have to be able to perceive the variable to be controlled, the ability to act, and to understand the goal).

Circa 1992 - 1997 I was still on the CSGnet, not trying to convert the non-believers, but mostly as an observer or trying to network with anyone that was actually trying to apply PCT in the real world, with real people, to solve real problems. Dag Forssell was applying PCT to the business world as a basis for Management and Leadership. But, David M. Goldstein was at that time, one of the only people actual using PCT in clinical setting with real people. MOL was born. Thanks to Tim, Mansell (yourself) and maybe a little credit to Rick Marken (but don't tell him I said so, he already thinks highly of himself) and Bill Powers, MOL really started to take off in some clinical circles.

1994-1995 I started doing crisis counseling with a company in Arizona.

1996 -2001 I started a partnership with another counselor and started providing crisis services to hospital emergency departments. It was at this time that I really started using PCT and MOL in all my interventions. Since no one else was doing it in such an intense clinical setting, I had no real reference to go with for the interventions.

2002 to 2012, I created my own company to provide crisis services to hospitals. In 2011, we provided more than 8000 crisis interventions. Approximately, 75% of the people we saw were stabilized and sent home for follow up. Of the 25% remaining, 15% went inpatient, 8% went to detox, and about 2% were involuntarily committed for mental health treatment. Of all hospital crisis providers, we had the lowest rate of persons re-entering the crisis system within 7 days of discharge. For every one person we treated that re-entered the crisis system, other providers would have 4 or 5 people re-enter the crisis system.

How (and how not) to explain PCT and MOL to other counselors

Part of the training was to expose all the counselors to my approach in crisis intervention services. At first, I would try to explain to them what PCT was and its history. The counselors' eyes would gloss over and they eventually say something to the effect of… "oh yeah, that is like William Glasser and reality therapy." "yeah, yeah I know that," and tune out.

The best approach I found was to show them how to do a crisis intervention using PCT/MOL without telling them what it was that I was doing. I could then generate a clinical epiphany in five minutes or less with MOL. Then I had their attention for the next 45 minutes, and soon they would start asking for handouts on PCT/MOL. I started putting a model (ok it was not a strict definition of "model" like Bill and Rick use) for crisis interventions down on paper. Ok, better choice of words; this became a "framework" for our crisis interventions. It was built on the foundations of Bill Powers, Tom Bourbon, Clark McPhail, Ed Ford, Goldstein, and Carey.

Examples of MOL in practice

Here is a short description of an MOL session that I like to use on counselors during our training sessions to generate a small clinical epiphany for them.

1. Q: Do you set and alarm clock to start your day? A: yes.
2. Q: Why? A: So, I get to work on time.
3. Q: Why do you want to get to work on time? A: so I don't get fired.
4. Q: Why do you want to be employed? A: I need to earn money and provide for my family.

You just keep challenging their answers with "why" questions.

5. Q: Why, don't you just take care of yourself, surely you could make more money and make it faster if you did not have morals and ethics getting in the way. A: Because I am not like that, I want to do the right thing.
6. Q: So, for you, there *is* a right and wrong, good *or* bad choice to be made, because of morals and ethics you hold. A: Yes.
7. Q: Why do you think you choose, right over wrong, or doing good vs evil or bad things in your life.? Wouldn't you agree that we all die? Therefore, we should just try to get as much out of life as we can before we die? A: No.
8. Q: Why not? A: Because, I believe in _____ and when you die if you do _____or don't do _____ in your life you will go to Heaven.
9. Q: So, if I understand you, you set your alarm clock in the morning so you can go to Heaven? A: (Long pause), (smile from subject), Yeah. Yes, I guess you are right. Wow, I never thought about it like that before (Small, epiphany).

Principles for How PCT is being used for crisis interventions

I differ from Bill Powers and the rest on this one point "Behavior is the Control of Purpose," I see the clinical value of a control system is to control a purpose. I understand all science is about "How" something works, so "Behavior is the Control of Perception", is fine for science and engineering, but for philosophy and religion, it is about the "Why." So are the applied sciences, why do it this way, or why should I buy in to this_____? Why, why, why? I think to solve mental health problems, and not just manage them; it has to be about the why. Too much, and for too long, psychology has not addressed the "why" in the person; the "why, do I do the things I do?" Psychology basically has ignored the why.

Below are some basic tenets, I use in my practice:

1. Choose your words carefully. They are the only healing tools you have as a mental health clinician.

2. Mental illness should be limited to describe the entropy of a nervous system, a virus, a bacteria or a genetic condition that "caused" the mental problems such as Alzheimer's, Parkinson's, Huntington's chorea, Autism, and so on… If it is a real illness, then it has a real disease course and a common "cause" across all people. An illness is usually only manageable and rarely curable.

3. Mental disorders are mental conditions that are not in order. If everything were in-order, a disorder would not exist. Mental Disorders are highly treatable, but rarely have a common "cause" as you can see with an illness.

4. Healthy people are controlling, unhealthy people are not controlling. (This does not sound politically correct but, it will get their attention long enough for you to explain the why; the purposes: needs, wants, desires, intentions, standards, morals, ethics, and beliefs) For me I think, the "highest level" choice in a system is the choice between freewill and determinism. It is what I choose to set my beliefs with; Is it "free will" or are we all victims of "determinism" and every choice is a false choice? Some argue a spiritual level above the belief system or that it may be internal to the beliefs system. But the one choice everyone makes or chooses to be ambivalent about is the choice between freewill and determinism and that is what seems to be the basis of all beliefs. Choosing not to make a choice is still a choice. Free will and determinism are two sides of the same coin. Las Vegas is built on determinism, the choice to go there and gamble is free will.

5. In all years of my practice, seeing more than 8,000 people in crisis, only a small number (probably fewer than 20) ever seemed to be having an existential crisis. I am excluding those who said something to the effect "my life does not have meaning because, _____ does not appreciate what I did, or who I am, or because I failed to get _____, or _____ just happened and I don't have a reason to live." The person having an existential crisis is very calm. Scary calm. They will calmly discus their life and death choice as if they were choosing between what colors of shirt to pick out. Also, the existential crisis is not an event driven crisis (for example, the death of a loved one, loss of a job, business, marriage or some trauma), it seems to be more of an evaluation, of not just their life, but life in general on this planet and whether or not they even want to be a part of anything, anywhere.

6. Anxiety and Depression are good for you. (That does not make you sound like an empathic counselor but, you will get their attention long enough to explain, why.) Emotions are error signals. All pain serves a purpose. How long do you leave your hand on a hot stove? Because of pain, physical or emotional, you become aware that something is wrong and you react to avoid the pain. Depending on the level, change occurs at different speeds. At lower levels change occurs quickly; Hot stove. Quickly pull hand away. Say ouch, or M@+H3R F#@%3R. (Depending on your higher levels of principles, morals and ethics). Sometimes with great pain on any given level you reorganize. Other times it is not the amount of one error signal, it is the cumulative effect of many errors signals over time that leave behind residual error that leads to reorganization. When someone is suicidal, it is reorganization gone awry. But it is a logical attempt to eliminate intrinsic system error.

Most crisis interventions fall into the follow themes:

1. Event driven, (They didn't get something they wanted or they got something they definitely did not want. There will be a major difference between, what has just happened and their expectations)

2. Substance use or abuse, (used as coping skills, because they don't like the way they feel when sober, which is anxious and/or depressed).

3. Affective disorders, (They are anxious or depressed because they are not getting something they wanted or they have to deal with something they definitely did not want, or they have no goal or purpose, or finally, what they are doing is not working). They either can't see or focus on controlled variable (perception), they have poor goals or no goals (references), or they don't know what to do or not do (output/behavior).

4. Relationship problems, (They either don't have any friends or family, or they do.)

The PCT/MOL techniques I used to treat the disorders are about:

1. Rapport/Openings (Based on the work of Clark Mcphail, and Miller, Hintz, and Couch)
   a) *"Opening refers to the activity of two or more persons moving from a condition of behavioral independence to one of Inter-dependence. It is thus the first necessary activity two persons must perform successfully if they are to do anything else together. (1975:479)"*
   b) With PCT, establishing rapport is based on a control system model of cooperation. The start of a crisis intervention is very important.
      i) Tell the person, who you are, who called you, why they called (identify the problem as others see it), and tell them that you can help.
      ii) They may open up right away, telling you what happened and why.
      iii) They may tell you, "you don't know me, you can't help me, or you won't understand." To which the counselor responds: "I know that the problem is probably one of two things –

      (1) "Something happened you did not want" or

      (2) "Something you wanted did not happen" or "a little bit of both".

      "Which one is it?" They will probably tell you which one and start telling you what happened and why.

      iv) If they need more convincing that you understand their problem and you can help, tell them that: "Suicidal thoughts and attempts are normal behaviors when a person feels (unresolved error signals) they have lost control of their life, when they lost purpose (reference) in their life or when nothing they do (behavior) ever seems to work (effect the controlled variable)."
      v) Ask for their cooperation. "If you allow me to, I can help you." Or "I can help you, but I will need you cooperation"

vi) The person will open up, if you can tell them the above and then starting asking the open ended questions that can't be answered as, "Yes", "No", or "I don't know."

2. Reframing the perceptions, (It is not a good thing or a bad thing, it is only an event. What you do about it determines and defines the value of the event; that is in your control).
3. Setting realistic goals, (It may be self evident, but drive the point home. Well, if you want to be unhappy, set really high and very difficult goals for yourself, so you can constantly be disappointed in yourself. Also, if you really want to be miserable, spend all your time trying to control other people or events outside of your control.)
4. Reorganization – (you may not always find out what works, but you find out quickly what doesn't)
   a) Managing Perceptions of rehab and recovery. Count successes not just failures. Being sober for 49 days and relapsing on the 50th day, does not mean on day 51 you only have one day of sobriety. It does not mean you are failure, loser or weak. If, you go to a store with a $100 bill and purchase a two dollar item, you would want 98% of that 100 dollar bill back. Likewise of the last 50 days you have been sober 98% of the time. Relapses do happen, but by "managing perceptions" of the event, they will happen less often and less intensely.
   b) Managing expectations of rehab and recovery. Success is not always measured in absolutes, but in progress toward a goal. (Make the goals realistic, short term at first, then longer and longer term goals.)
   c) Managing behaviour though education is about better coping skills, – Replace negative coping skills with positive coping skills (They used to be called vices and virtues long ago.) Positive and Negative Coping Skills.
   d) Managing emotions – In crisis, one point to make about emotions is that they are transitory. "How you feel now is not how you will always feel".
      i) Anxiety and depression are not something anyone suffers from; they are not a victim of emotions. Emotions are created by the person, and thus solvable (error signals/emotions are byproducts from the lack of control), because of:
         (1) inaccurate perceptions,
         (2) extreme/unrealistic goals or no goals at all, or
         (3) difficulty with coping skills.

The short of it is: you are diagnosing where the breakdown of control happened, in a level or on several levels. Next, is the "problem" going to be found in the Perceptions, the Goals, and/or the Behaviors that are not completely intact on any given level, so to speak? (Perceptions: Is the glass ½ empty or ½ full? Expectations: Do I have the right glass, should I use a bigger or smaller Glass? Feelings/error: Am I even thirsty? Or Behavior: Should I drink out of a glass, use a sippy cup, or a straw?)

When two or more are gathered … "control" is a double entendre.

Control happens in two basic forms between people, coercion or cooperation. (Positive Reinforcement*, Negative Reinforcement* and Punishment* are all coercive as I explain them to clients in terms of control).

1. These concepts can be simply explained to the patient or lay person by giving every day examples. Positive Reinforcement, Negative Reinforcement does not mean good or bad reinforcement. Think of it as adding or subtracting something you do (or have control over) to make someone do something.

   a) Positive Reinforcement – Giving something to someone, they either do or don't want, so they will do what you want. (In PCT terms, injecting a disturbance to a controlled variable)

      (1) Positive Reinforcement – "I will give you $20 dollars to take out the trash."
      Q: Will you do it? A: Sure. (But I only do it for the money, not for you.)

      (2) Positive Reinforcement could also be, "I will harass, scream and nag you, until you take out the trash.
      Q: Will you do it? A: Sure (But I won't like it and I won't like you either)

   b) Negative Reinforcement – Taking something away from someone so they will do what you want. (In PCT terms, reducing a disturbance to a controlled variable needed for collective action.)

      (1) You offer only conditional help. I will only stop the pain if you _____ (fill in the blank for your terms and conditions). Whatever adversity you are suffering from, I won't help you unless I get something out of it. You don't help me, I won't help you. I will do this for you, if you do ___ for me.

      (2) I am taking away, my time, attention, love or sex out of our relationship until you do what I want. All things you want that I could give, you won't get until, I get what I want.

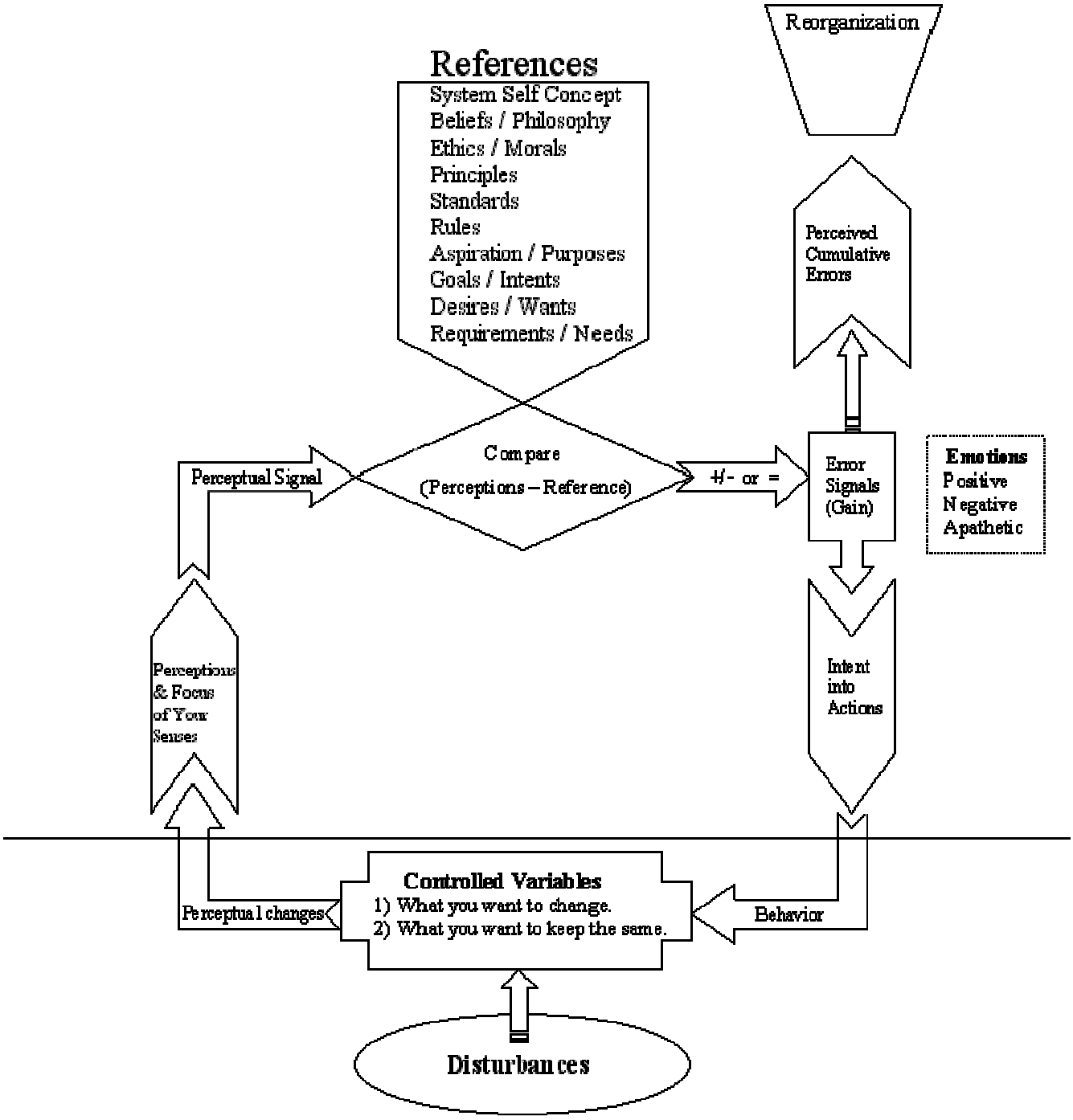
   c) Punishment – If you do ____ I will get back at you by doing _____. Punishment is retaliation.

      (In PCT terms, punishment is injecting a disturbance onto a person's controlled variable or to attack any of the person's references, without respect for any present or future collective action, to stop them for disturbing your controlled variables).

Positive Reinforcement, Negative Reinforcement and Punishment are all coercive. Relationships built on coercion are doomed to fail. A person will subjugate their will to another for only so long before a conflict will arise and, quite possibly, a violent one. Cooperation is best described as two or more people coming together for mutual benefits, to achieve something none could do alone. Long-term healthy relationships are built on cooperation. The Question to ask is: "Are your personal relationships based on coercive control or cooperative control?"

[Editor's Note:** Mark Lazare seems to make less use of disruptions and present-focus questions than Tim Carey utilizes in the most recent descriptions of MOL yet the fact that the questioning is driven by PCT is direct, explicit and clear; Mark also focuses on what can be controlled – now! The relative importance of these different features of MOL will be important to study in the future. He also uses the term 'reinforcement' which should be understood as having its origins in behaviourism and is distinct from learning principles in PCT (seehttp://www.pctweb.org/PCTUnderstanding.pdf. See the concept of 'arbtrary control' for another way of explaining the above (e.g. Powers, 1973; Mansell, 2005)]*

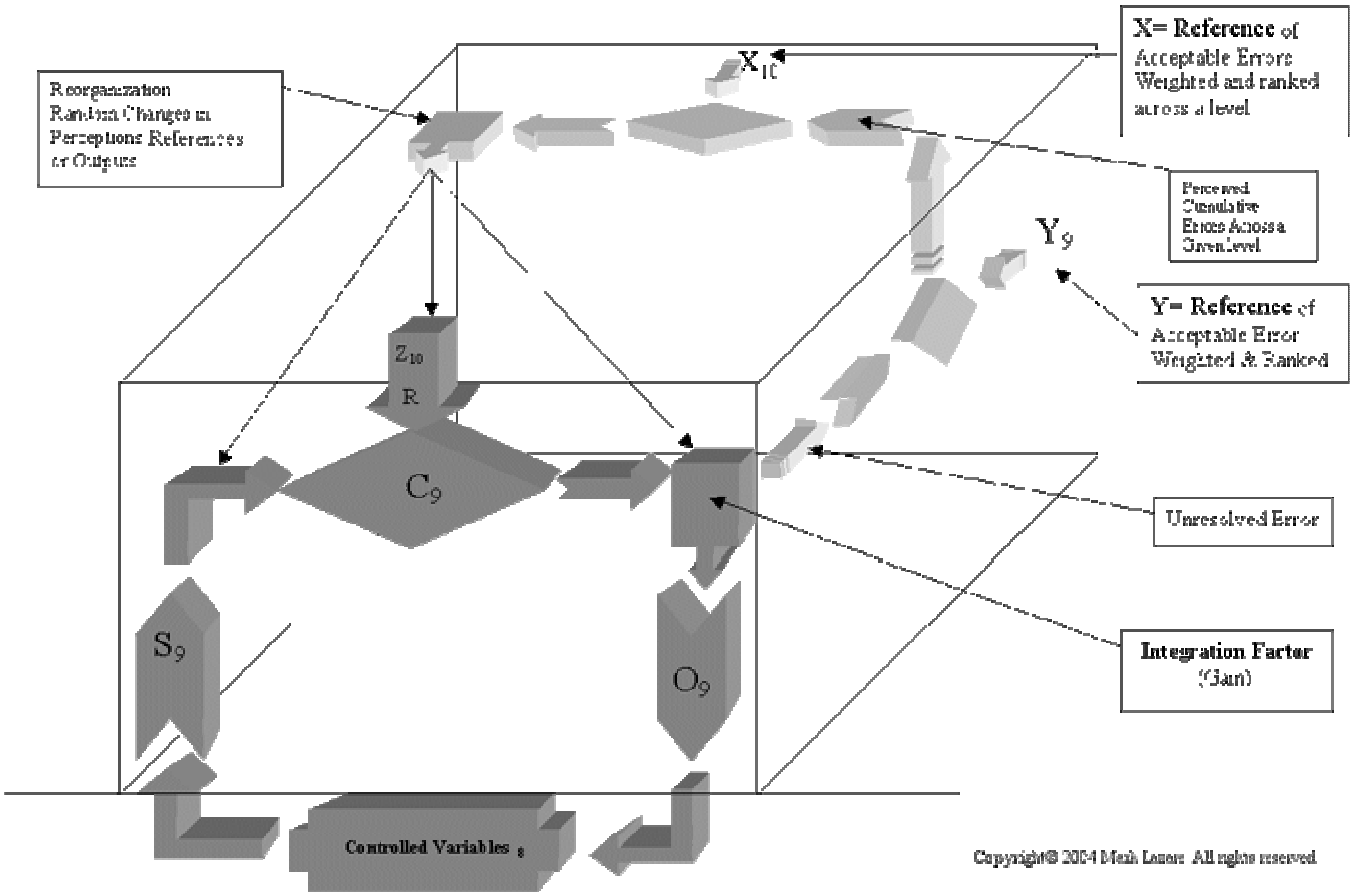
Behavior is the Control of Purpose



A Model of Reorganization Across Levels

The depiction of the reorganization process (see diagram overleaf) starts with the:

1. Integration factor (related to gain) that has left
2. Unresolved error in an active system.
3. The unresolved error is then compared to an intrinsic fixed reference (Y) of acceptable error within a level that is weighted and ranked for a given control process.
4. If there is a significant difference in the unresolved errors across for given control process it will be sensed by the next higher level. Once the higher level is "aware" of the error….
5. That cumulative error signal is then compared to a fixed reference (X) Reference of Acceptable Errors Weighted and ranked across a level or series of control processes.
6. If there is a significant difference in the cumulative errors across a given level or series of control processes it will result in Reorganization.
7. Reorganization is Random Changes in Perceptions References or Outputs of the next lower level,
8. Thus reducing or increasing unresolved error in an active system.
9. Repeat steps 3-7 until the unresolved error in less than (Y) the intrinsic fixed reference of acceptable error within a level for a given control process.



First, Y_9 is the reference that is compared to the integration factor's residual error. Each controlled activity has an acceptable level of error. We routinely accept less than perfect. Also, we accept relatively greater error on each higher level (X) or conversely we expect tighter control on each lower level. No living system has an error signal as a constant zero, and certainly not zero error, at every level.

As you go up the hierarchy you must build in greater level of "acceptable error across a level" (X) or you would be in constant reorganization (crisis).

Think about some of these questions:

- Is what you are doing working?
- Is what you are doing getting you what you want?
- Is what you are doing making you happy or content?
- If the answer to all the above is no, then right, wrong or indifferent, you will have to do something different.

Change how or what you perceive, change your expectation, or change what you are doing. Changing any one of these will change how you feel about the situation. Reduce the acceptable level of residual error (Y) and error across a given level (X). And, yes, I believe both are variable between people, but may be constant or innate for an individual…. But, how to choose what to change is a guess or a random act of reorganization.