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The International Journal of Reality Therapy is directed to concepts of internal control psychology, with particular emphasis on research, theory, development, or special descriptions of the successful application of internal control systems especially as exemplified in reality therapy and choice theory.

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Permissions: Copyright held by the International Journal of Reality Therapy. No part of any article appearing in this issue may be used or reproduced in any manner whatsoever without written permission of the editor except in the case of brief quotations embodied in the article or review.
As we start the 28th year of publishing the Journal, this issue reflects its international nature. Of the twelve articles, six are from international contributors. This includes the first published articles from authors in Malaysia and Colombia, in addition to three articles from Australia and one from Canada. In addition, at least six of the articles reflect an emphasis on health-related issues.

Two of the articles reflect the thinking of individuals who experienced life-threatening or life-changing experiences and the adoption of internal control thinking that helped each on the road back toward health. Of particular interest is the article by Josephine, a pseudonym for a student in the John Dewey Academy. Readers will not only find her story compelling, but will also be interested in the accompanying article by Tom Bratter, the head of JDA.

On a different note, the articles clearly reflect the need for more data-based research on internal control psychology, as exemplified in reality therapy and choice theory. I regularly receive inquiries from two groups of individuals - one comes from students interested in available research data that they may be able to build on for their own theses or dissertations. The other comes from agencies who are seeking hard data to support funding requests from private or public agencies for their work utilizing the principles of reality therapy in their treatment of clients or their development of educational programs.

Although there seems to be a dearth of available data, that is really not the case. Although the Institute only relatively recently has placed a major emphasis on research, as exemplified by its affiliation with Loyola Marymount University, there are several sources for available research.

The first is the Resource Guide, which is an annotated bibliography of all articles from the International Journal of Reality Therapy plus abstracts of some dissertations. Vol 1 includes material from about 1980 to 1995, while Vol 2 includes material from 1996-2007.

A second source is a library search engine called EBSCO HOST. By entering the psychology data base, and then entering the search words reality therapy, or choice theory, or William Glasser, it is possible to bring up abstracts of articles from a variety of sources along with the full original article if desired. A third source is Proquest - this is the replacement for dissertation abstracts. Through this search engine, by entering the search parameters of reality therapy, choice theory, and/or William Glasser it is possible not only to bring up abstracts of dissertations done in these three areas over the past 25+ years, but it is possible to also bring up the complete original dissertation.
Forty years ago, I co-authored a book entitled Research in Counseling. In the introduction, I quoted two individuals who provide very different views on research. The first, Dugald Arbuckle, argues that counseling is much closer to philosophy than science, and therefore we cannot use scientific methods of research. He states: “One might be scientific in his attempts to evaluate what happens as a result of his counseling, what might happen if he does this instead of that, what happens if a certain variable...is introduced, and so on, but how scientific can he be in his actual relationship with the client, which after all is what counseling is.”

Raymond Bixler approached the question from a different perspective. He stated: “Until these workers can offer evidence that their techniques are more effective than placebos, we must look upon their contributions as no more than that. Faith and ad hominem arguments about the ‘worth and dignity and integrity’ of man may be temporarily persuasive but they are very poor substitutes for evidence. Such arguments are illustrative of the attempts throughout history to rebut the findings of science when these have been devastating to cherished but unwarranted positions.”

As I stated then “Each of the above suggests a framework for research. Arbuckle would look for his answers in investigations of counseling outcomes, techniques, and environments....Bixler believes that all aspects of counseling must be open to investigation if there is such a discipline, art or skill.”

Thirty years later, David Sansone raised similar questions in his article in this Journal entitled “Research, Internal Control and Choice Theory: Where’s the Beef?” It seems apparent that we have work to do.

References:
The Patterns of Reality Therapy Usage Among Malaysian Counselors

Ahmad Jazimin Jusoh, Zuria Mahmud, Noriah Mohd Ishak

The first author is in the Jabatan counseling center at Universiti Pendidikan Sultan Idris, the second and third authors are associate professors at the Universiti Kebangsaan Malaysia, all in Malaysia

The study explores the pattern of usage of Reality Therapy among Malaysian counselors. From 532 counselors who responded to The “Reality Therapy Counselor Profile Inventory (RTCPI)” (Ahmad Jazimin, 2005), 61 indicated usage of Reality Therapy. From this group, 11 counselors agreed to take part as participants in indepth interviews. Results from RTCPI show that most counselors received their information on Reality Therapy only during graduate program lectures. Interviews, document analysis of counselors’ reflections, and observations of recorded sessions indicated that counselors put more efforts in the first and second part of WDEP, that is exploring the wants and doing, but less on evaluation and planning. Counselors interviewed agreed that Reality Therapy applications are suitable in the Malaysian context.

Reality Therapy in Malaysia

Reality Therapy has been applied and taught in various countries such as United Kingdom, Germany, Australia, Slovenia, Croatia, Italy, India, Korea, Japan, New Zealand, Spain, Russia, Taiwan, Hong Kong, Singapore and Kuwait (Wubbolding, Brickell, Imhof, Kim, Lojk & Al-Rashidi, 2004). The focus of this theory which is on human motivation has enabled this theory to be applied universally. This human motivation, known as basic needs, consists of love and belonging, power, freedom, fun, and survival Glasser (1965, 1998, 2001). However, James and Gilliland (2003), and Corey (2005) mentioned that Reality Therapy is not only cognitive, but is also phenomenological, in which individual experiences of each client matters. These phenomenological elements strengthen the ability of Reality Therapy to be contextually defined, even in culturally different settings. According to Wubbolding, Al-Rashidi, Brickell, Kakitani, Kim, Lennon, Lojk, Ong, Honey, Stijacic and Tham (1998:6), when working in multicultural settings, practitioners of Reality Therapy need to be aware of their own values, skills and knowledge. They are also well advised to learn about the custom, history, sociopolitical forces, and methods of communication which are part of other cultures (Wubbolding, et al., 1998:6).

Reality Therapy, even though it has been taught in counseling programs, has not been seriously developed in Malaysia. There is currently no institution that specializes in the teaching or development of the theory (Lembaga Kaunselor, 2000). In relation to that, the amount of research that addresses the application of the theory in Malaysian counseling publications can be counted. Two works that focused on Reality Therapy are by Saedah (2004) and Ismail (2001). Saedah (2004) used a Reality Therapy approach in individual counseling to treat maladaptive behavior among adults. She found that WDEP strategies can be used to improve clients’ self concept and family adjustment. Ismail (2001) has studied the effectiveness of group therapy on a pre-resignation program. He used the Reality Therapy, Client Centered Group Counseling and Egan Model to help the participants increase the level of preparedness, self esteem and coping skills. Both these works are testimony that Reality Therapy when applied in suitable modules can be beneficial for clients of various backgrounds.

Attempts to explain the use of various counseling theories and strategies among Malaysian counselors have been done by Zakaria (2007), Zuria, Noriah and Amla (2003), Zuria and Salleh (2002), Ismail (2001), Rosnah (2001), Mohamad and Zuria (1998), and Zuria (2005). Zakaria (2007) found that out of 241 counselors sampled, more than 50% did not indicate usage of any particular theory, while the rest are more familiar with eclectic and person centered. Zakaria summarized that counselors in his sample have not fully mastered any counseling theory because of two main reasons, namely insufficient training and difficulties in adjusting the theories to the cultural context of the local clients.

Zuria (2005) highlighted that improper management of counseling services may contribute to counselors’ incompetence. Zuria (2005) presented three interesting observations regarding the application of counseling approaches among Malaysian school counselors. First, 10% of school counselors never do counseling sessions, 40% only counsel an average of one session per day, and 50% counseled more than one session per day. The 10% who never counsel are not allowed to do so because they are not fully trained. The 40% who only counsel one session per day reported time constraints as their limitation. Second, as a whole, most counselors were found to show less knowledge in using different strategies in exploring and searching for alternatives. Finally, a cyclic pattern of ineffective counselors exists. According to Zuria (2005), the cycle begins when counselors (who may be well trained
or otherwise) are given irrelevant job specs; this is followed by impacted performance from the aspects of time spent on counseling sessions and motivation to practice and sharpen their skills. Then, because school management believes that the counselors cannot handle student problems, they will not refer students to the counselors, instead they refer to other personnel who can solve the problem “quickly.” As the pattern repeats itself to form a cycle, problematic students are deprived of good counseling services, leaving them unhelped, and ending their school experiences as dropouts or juvenile delinquents.

The impact of Cultural values on therapeutic process

Another important consideration in understanding the challenges faced by Malaysian counselors in applying counseling theories is the culture. Some of the cultural elements which play a significant part in determining lifestyles and world views in Malaysia are religion, family values, and societal norms. The major religious teachings in Malaysia are Islam, Christianity, Buddhism, Hinduism and Taoism. Most religious teachings emphasize good moral behaviors which are based on relationships of humans to the Creator, the environment, and the self (Abdul Halim 2001; Mizan Adiliah et. al 2006). In Islam, some actions which are defined as negative and clearly prohibited are committing suicide, adultery, and getting drunk. Islam also teaches its’ followers to be responsible individuals whose deeds will be questioned when they die.

Family values in Malaysia highlight the importance of children respecting their elders and the expectations for children to continue the beliefs and practices of their families (Saedah 2005). Saving family ‘water face’ is a big thing in Malaysia, which means that each child is responsible for taking care of the family name by not doing anything shameful. Shameful things would mean doing anything against the religious teachings of family values. Traditionally, the Malaysian society is collectivistic, where members are supposed to look out for each other. Any wrong doings which are against religious teachings and family values will receive queer looks from society members. However, this is becoming less true now since more society members are turning into individualistic people.

The cultural values discussed above and personal desires do not necessarily coincide. Sometimes, an adult child’s decision conflicts with his parents’ wishes (for example choice of marital partner, career, or how certain events should be conducted). The difference in opinions can cause tension for both parties since the culture stresses that a child should respect his parents. These conflicts can be reasons for clients to come into counseling. Both cultural and individual interest are phenomenal experiences for the client. Since Reality Therapy focuses on responsibility for individual decisions and individual plans, counselors need to be aware of the cultural elements which may interfere with this. On the other hand, counselors who are skillful enough might be able to turn cultural values into opportunities that can help clients overcome their issues and become better people.

Main Concepts of Reality Therapy: WDEP

A main concept of Reality Therapy that has been discussed extensively is WDEP. WDEP is a short form for Wants, Doing, Evaluation and Planning. The user of WDEP needs to understand how human behaviors are driven by their basic needs which include physiology and psychological aspects of life (Glasser 1998, 2001; Wubbolding 2000). Physiological needs include food, water, air, safety, and sex, while psychological needs include power, belonging, freedom and fun. Burns, Vance, Szadokierski and Stockwell (2006) studied the reliability and validity of the instrument Student Needs Survey to measure five basic needs among students. Mottern and Mottern (2006) viewed that exploring clients’ basic needs is important in educating individuals in managing their own money. Wubbolding’s (2005) analysis on the strengths of belongingness in counseling found that counselors need to pay attention to love and belongingness because these elements play very important roles in the client’s life. Other authors such as Law (2004), Huflstetler, Mim and Thompson (2004), Atkinson (2005), Brown and Swenson (2005), Clifton (2006) and Rehak (2006) all agreed that the elements in basic needs are pivotal in human beings’ development. All these writings have been testimony to the need for counselors to explore clients’ basic needs during the early stage of the sessions.

The goal of Reality Therapy is to help clients face personal challenges more effectively and take charge of their lives (Palmatier, 1998). Counselors must practice proper skills that will enable them to help clients achieve this goal. As all counseling approaches are artful communication, counselors in Reality Therapy need to ensure that their interactions with the clients fulfill the main concepts of the therapy.

a) Exploring client’s quality world
(Wants, needs and perceptions)

Understanding a client’s quality world is most basic in reality therapy. The counselor needs to encourage clients to describe in detail what they exactly want to achieve, to be, to fulfill, or to get. To understand this, the counselor must ask a question which sounds like this “what do you want?”. An example from Wubbolding (2000);

i) What would you like to do relative to your needs?
ii) What would you like to think?
iii) What kinds of thoughts would you like to have?
iv) How would you like to feel?
v) What do you want to be like physically?
vi) What do I want that I’m getting from my family?
b) Identifying Directions (Doing)

Wubbolding (2000) suggests that sentences in identifying directions of clients must contain the question of “what are you doing?” In understanding the clients' direction, counselors must ask about the total behavior which includes emotion, cognitions, and behaviors ( Schoo (2005), Loyd (2005) and Prenzlau (2006)). According to Glasser (1990a) “focus on what they are doing now and that they are making a choice”. According to Wubbolding (2000), an example of a response to identify clients' direction would be:

**Counselor:** I have a very important question for you

**Client:** What is it?

**Counselor:** This is central to the counseling. It's extremely important. How do you know you're depressed?

**Client:** Well, I uh ... I just feel bad all the time.

**Counselor:** But how do you know you feel bad?

**Client:** I'm always down.

**Counselor:** I know I'm pressing you a little, but how do you know you feel down?

**Client:** Everything looks bleak, dark and hopeless

**Counselor:** Ok, Now you’ve said something extremely important

**Client:** I did?

Total behavior means the counselor asks clients to describe their current behavior for four components: acting, thinking, feeling, physiology, what they are doing, how they are doing it. With this move, the clients will be able to see how they are contributing to their own development and thus feel responsible of their own choice of behavior (Glasser 1998; Wubbolding 2000).

c) Evaluating Client's Actions (Evaluation)

The third step is evaluating clients' actions include commitment, total directions, and whether their wants are realistic. An example from Wubbolding (2000)

**Counselor:** Has your choice to get him to change gotten the results you wanted?

**Client:** No, nothing has changed

**Counselor:** So, working on his behavior is a dead end. This points out a basic principle that is crucial in human relations.

**Client:** What is that?

**Counselor:** Actually it's a twofold principle. You can only change your own behavior and you can't force other people to do what you want them to do. You can't force the public to buy the product.

**Client:** So I guess I'd better think about the first part of that idea.

**Counselor:** I couldn't say it any better. Do you want to work on your actions?

**Client:** Yes, I better try some different things.

d) Planning for action (Planning)

Wubbolding (1988, 2000a) suggested an effective planning should be based on criteria in SAMP C3: (S) Simple, (A) Attainable, (M) Measureable, (I) Immediate, (I) Involved, (C3) Controlled by client, Committed and Consistent. An example question from Wubbolding (2000);

**Counselor:** How about selecting one or two to start with?

**Client:** No, I need to go all the way. Getting sober is the best thing I ever did and I know I need to keep at it. But I have a lot of work to do and I've got a lot to make up for. I can do these things “one day at time”.

**Counselor:** Can you realistically work on all of these at the same time, even one day at a time?

**Client:** The theme is one day at a time. I can do it if I turn it over. But you don't seem to think I can do all of this?

**Counselor:** I think these are all necessary to work on. But I want to help you examine whether you can work on so many fronts at the same time.

**Client:** I can and I will.

The above examples will enable any researcher to understand Reality Therapy and to analyze the gaps in competency and skills of counselors claiming to use the approach.

The Current Research

This research was conducted to examine the practice of Reality Therapy from the views of Malaysian counselors. Three major questions were:

1) What are the sources of information that enable Malaysian counselors to access Reality Therapy?

2) What are the gaps in the counselor's usage of Reality Therapy in Malaysia as compared to the original model?

3) What are the cultural elements to be considered in applying RT in the Malaysian context?
**METHODOLOGY**

**Participants**

The list of counselors were obtained from two main sources, namely the National Board of Counselors and the Ministry of Education in Malaysia. 750 questionnaires were sent out, and 532 responded. Qualification of respondents on this list ranged from certification to bachelors' and masters' degree in counseling, age ranged from below 40 and above. Females were 306, males were 226. From this list, 61 gave indications of consistent reality therapy usage in their practice.

**Research Procedures**

This study employed a mixed method approach in two phases. In the first phase, an inventory was built to detect the users of reality therapy from a group of 532 practicing counselors. The counselors (61 of them) who indicated they used reality therapy were approached, and invited for indepth interviews. Finally, 11 out of 61 counselors took part as participants in the interview. Observations and document analysis were also employed in the second phase for triangulation purposes.

**Instruments**

There were four types of instruments used in this study namely a) The “Reality Therapy Counselor Profile Inventory” (RTCPI), b) Interview protocol, c) Observations form d) Document analysis form.

The RTCPI was built by the researchers based on library research and expert opinions. Readings such as Glasser (1965, 1984, 1985, 1988, 1990, 1998, 2001), James dan Gilliland (2003), Wubbolding (1988, 2000), Wubbolding and Brickell (2003) were studied to really understand the concepts and techniques of reality therapy. One of the researchers went for reality therapy training by the Association for reality therapy in Singapore, and is in constant communication with Wubbolding and the Glassers regarding the instrument. This is the first time this inventory is applied in Malaysia. Face validity, content validity, and construct validity were conducted with the help of experts who have been trained in reality therapy. The RTCPI was pilot tested for reliability. The alpha level for the reliability of this instrument is at 0.91. The quantitative data were processed by SPSS.

In the second phase, an interview protocol was built focusing on the research questions. The observation form was also built by the researcher to investigate the frequency of reality therapy responses occurring in the videotaped sessions. The document analysis form was taken from the participant responses about reality therapy. The reliability level for qualitative content analysis by Cohen's Kappa is at 0.81. This qualitative data were processed by the NVivo 2.0 program.

**RESULTS AND DISCUSSION**

**Initial finding**

Initial fieldwork of this study show that most counseling programs in the country teach reality therapy. However, this is only taught at one time, during one of the three hours lecture in the Theory and Technique class (Lembaga Kaunselor, 2000). There is no one program in the country that offers speciality in reality therapy for the whole semester. This means that the knowledge of reality therapy among counselors is very limited, unless they took their own initiative to learn this theory through other means such as workshops, and other short courses.

**Research Question 1**

What are the sources of information of reality therapy for Malaysian counselors?

To understand this, the counselors are asked to name the source of their knowledge in reality therapy. Results from the RTCPI survey show that 86.9% counselors learned reality therapy mainly from the lecture during bachelor's and master's degree programs and 63% said they had lab experiences using reality therapy. Other sources of knowledge include seminars and workshops, discussions with colleagues and experts, and from readings.

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<tr>
<th>Source of Information</th>
<th>Percentages</th>
<th>Major Activity</th>
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<tbody>
<tr>
<td>Lectures</td>
<td>86.9%</td>
<td>Description by lecturers in class</td>
</tr>
<tr>
<td>Counseling Lab</td>
<td>63.9%</td>
<td>Guided counseling sessions</td>
</tr>
<tr>
<td>Seminars &amp; Workshops</td>
<td>39.3%</td>
<td>Case presentations</td>
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<tr>
<td>Discussion with colleagues</td>
<td>42.6%</td>
<td>Discussion</td>
</tr>
<tr>
<td>Discussion with experts</td>
<td>26.2%</td>
<td>Demonstrations and videos</td>
</tr>
<tr>
<td>Own readings</td>
<td>39.3%</td>
<td>Read from reality therapy books</td>
</tr>
</tbody>
</table>

The counselors admitted that they used reality therapy, but the sources of their knowledge was very limited. None of the counselors actually obtained training from any reality therapy institute or attended one whole semester of a reality therapy course. There is no reality therapy institute or any specialized approach institute, and no program offers one approach for an entire semester, even in the master's program.

Some of the counselors interviewed said that they obtained knowledge through reading William Glasser books, and practiced according to their understanding. One participant said:
“My first book was Counseling with Choice Theory, followed by
other William Glasser’s books to understand Reality Therapy”.

Others read counseling books to learn about Reality Therapy
without further discussion with experts.

Research Question 2
What are the gaps in the counselor’s usage of Reality Therapy in Malaysia as compared to the original model?

a) Exploring Clients’ Wants

Not all counselors in this study responded in a way
indicating their knowledge of the therapy. In exploring
clients’ wants, two from eleven (2/11) counselors who
understand Reality Therapy asked:
“Ok, wants, needs and perception, This is the question that
I always ask them “what is it that you want?”

One the other hand, nine of eleven (9/11) counselors
only asked;
“What is it that you want from this session?”

Concepts such as quality world and the basic needs did
not appear as themes in the discussion and interviews.
None of the counselors mentioned the concepts of “love
and belonging”, “freedom”, “power”, or “survival” during
exploring clients’ basic needs. Only one counselor men-
tioned the word “basic needs”.

“I identify his basic needs,” (did not mention which ones).
...and they (the clients) were not sure of their basic needs.”

When clients mention what their needs are, counselors
did not try to understand the depth of these needs (clients’
quality world) and failed to connect these needs to any of
the basic needs categories listed in Reality Therapy. The
counselors will only stop at asking “what do you want?”
before furthering the session.

b) Identifying clients’ directions

Data analysis showed that all 11 counselors inter-
viewed gave indications of identifying clients’ direction,
and their efforts vary from each other. However, none
actually conducted a total behavior identification. The
responses from counselors in this research are considered
unsatisfactory because they do not fulfill Reality Therapy’s
requirements of “the total behavior”.

Examples of an acceptable counselor’s response were
obtained from two of the counselors

Counselor 1:
“You said that you want to score in the examination.
So, can you tell me what you have done?”

Counselor 3:
“You said you want your friends to understand you.
What do you do to make you friends understand you?”

On the other hand, there are more unsatisfactory
responses in this study. These are

Counselor 7:
“What job can you do, what skills you have?”

Counselor 9:
“He wanted to continue studying to a higher level but
his ability is limited, he will not get that five credits, he will
not get.”

Counselor 10:
“You mean you cannot. You are confident that you
can’t. So, why aren’t you working hard now?”

Counselor 11:
“So how are you going to get that strength that we dis-
cussed earlier? Let’s reverse and try to remember how are
you going to get that?”

Through the discussion and recorded counseling ses-
sion, this study found that counselors did not discuss the
aspect of total behavior. They went immediately to ask for
the general direction of the clients. For example the ques-
tion was “what have you done” and not followed by
questions that concern the client’s feelings, thinking, and
perspectives of his or her directions. Perhaps this short-
occurring happens because counselors in this study seem to
be satisfied with clients’ responses, or they are met with a
dead end in the interaction and give up on exploring the
clients world. Counselors in this research do not spend
time exploring clients’ doing and directions that will
enable the clients to feel responsible for their actions.
They were rushing to give answers to the clients so that
clients will immediately make decisions. Perhaps, this is a
result from not having enough time to spend on counsel-
ing sessions, or lack of skills or motivation (Zuria, 2005).

c) Evaluating clients’ actions

Almost all the counselors in this study conducted an
evaluation of clients’ actions. However, the evaluations
were not deep enough to fulfill Reality Therapy’s expecta-
tions. There were no confrontational statements as
suggested by Wubbolding (2000). According to Yaniger
(2004) evaluation should consist of clients’ wants, congru-
ence of clients’ values and behaviors, and clients’
perceptions of quality choice. All counselors in this study
have their own way of evaluating their clients’ actions.
Some counselors only evaluate how far the action matches
the goals, some evaluate wether the action is doable or not,
while others evaluate client’s commitments towards their
choice. Ten out of eleven counselors evaluate clients’ goals.
Counselor 1
Counselor: How much practice did you do?
Client: Not much..
Counselor: Haa...I thought so... . Who is your Math teacher?

Counselor 2
Counselor: If he is not an important person, why do you consider what he is saying as significant? Is it accurate?
Client: (Silence)
Evaluations should consists of confrontational statements and questions to enable clients' to self evaluate. One counselor did not give the opportunity for client's self evaluation, instead judged the client

Counselor 4
Counselor: When something happened, we accepted as fate, and we have to be realistic in life, but you sort of said that you do not want to repair the relationship (with ...)...
Client: No...no.. it's not that I don't want to, but, it's hard..
Only one counselor demonstrated an evaluation where the client was challenged to do self evaluation.
Counselor: so, you want to wait for some possibilities before you feel are motivated?
Client: for me, maybe when my parents are not around anymore, I may feel some regrets and wished that I had studied hard, maybe if that happens, I would become a very hard working person... not that I am hoping my father to die....
During the interview, participants were not able to discuss much on the aspect of evaluation. Most participants only apply the evaluation processes based on information learned during their university training. They admitted to not knowing the proper sentences to be used in the evaluation process. This perhaps is related to the lack of proper laboratory training in the theory as suggested by Zakaria (2007) or in the practice of counseling process as suggested by Zuria (2005).

d) Planning
Not all participants were able to apply “planning” according to the aspects in the SAMI2C3. The interviews, observation, and document analysis showed that counselors frequently influence clients’ choices in making decision. Counselors give suggestions, and monopolize discussions, thus limiting clients’ full participation in the planning.

In the interview, one of the counselors said:
"We give the best alternatives so he will see what is good and what's not"
Research Question 2

How suitable is the application of RT in the Malaysian context.

The majority of the participants in the interview said that the Reality Therapy approach is suitable to the Malaysian context. This conclusion is derived from the individual interviews.

Participants 3, 7 said that the theory is applicable and does not bring out any racial sensitivity.

Suitable for multicultural society like ours. I do RT in drug Rehabilitation centers. I handled sessions with Chinese, Indians, and Malay teenage and adults. Their backgrounds range from rural, urban, and various family social status..

Participant 6 saw a number of limitations in the application of RT because our society practices various religious beliefs, and the counselors must be aware of the values and background of the society members in Malaysia. Counselor 6 gave a statement on the importance of discussing the values of the clients.

"... has to follow the parents wishes, as as a son, my client voices that it is so hard for him go against his parents..." but what we discussed is if the parents have actually ask him to do something for or against the religion?. If the parents ask him to do something good, then he might want to consider the realities, but if they ask him to do something not very good, then he should be supported to follow his own thoughts. It is the religious belief of the client that overrules family values. In every race in Malaysia, there are family values which need to be changed because they are not even following the religious teachings...

This finding is congruent with views from Othman (2005) who postulates that one of the characteristics which describes a society with external locus control is that it is a challenge to implement the individual responsibility concept. The eastern culture which emphasizes close relationships, authoritative orientation, large family structure, dependency on each other, loyal, collaborative, harmonious, emotion control, and conservatism (Ho, 1985) is different from the individualistic western culture. The evaluation process becomes vital since clients always have to struggle between personal satisfaction and group harmony and demands before deciding on any alternatives. The counselor must be able to understand how the client relates to his family and society in order to assist the clients in their planning stage.

Other than family values, the counselors who are using Reality Therapy in Malaysia demonstrate interest in religious information and concerns, and how these issues impact the clients. Asking questions about clients’ quality world from their religious views, and being able to bring the discussion into the helping process appear to be common among the counselors interviewed. Due to the multicultural background of the country (Abdul Halim 2001; Tajudin 2003) counselors in Malaysia are also very accepting and open towards clients' beliefs, as seen in this study. According to participants, religious elements are taken into consideration in using RT.

Participant No. 3, for example, mentioned that the Quran teaches

"...that in Islam, an individual will not achieve his goals unless he works for it".

This is an example of how a counselor takes advantage of cultural values to help clients make decisions:

"Some clients from the Indian ethnic wanted to commit suicide, so I will ask them, does your your religion allowed this?" and they respond, "no religion in Malaysia allows people to kill themselves"... from then on, we discussed the suitability of their suicidal ideation to their cultural belief before we move on to planning for other actions.

The usage of Reality Therapy in different religions has also been discussed by Renna (1998), Linnenberg (1997, 1999), Dettrick (2003) and Perkins (2003).

CONCLUSION

Counselors in Malaysia need to improve their knowledge in various counseling skills and approaches (Zakaria, 2007), and they need to spend more time practicing various counseling approaches (Zuria, 2005). At this point, counselors only learn counseling approaches during their graduate programs, and many do not continue to seek extra training, except during counseling seminars organized by the Malaysian Counseling Association (PERKAMA). There is also no existence of any training institutes for any specialized counseling in the nation. This study found that counselors who claim to use Reality Therapy agree that Reality Therapy is applicable in Malaysia. However they have not totally mastered this approach. There is a major need for more access to specialized training to increase their skills and knowledge in Reality Therapy.
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Systems Thinking: The Key for the Creation of Truly Desired Futures

By Juan Pablo Aljure León

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HISTORY

W. Edwards Deming, Jay Forrester and Peter Senge have coincided in that systems thinking is the most important capacity needed for a group of persons to create what they really desire.

As an international consultant for over 50 years in the areas of government, education, and economics, W. Edwards Deming (1900-1993) insisted on viewing systems as one of the essential organizational capabilities for the creation of the System of Profound Knowledge that he promoted during the last few years of his life. As an expert in statistical control of quality, Dr. Deming found that the variation in the data collected depended mainly on the interdependence between resources and persons through specific processes. By means of statistical calculations, he found that one could accurately pinpoint which of the results the organizational processes control. Dr. Deming studied electrical engineering in college and physics and mathematics for his Masters degree and PhD. He also studied musical theory, played several instruments, and composed two masses. The Japanese Union of Scientists and Engineers created the Deming Prize to commemorate friendship and Dr. Deming’s contribution to the re-emergence of Japan after the Second World War in matters of quality control in industry, trade and education. Dr. Deming was the father of quality in the Twentieth Century and became famous for modeling what he taught, which his students experienced during his many years as a university professor.

Jay W. Forrester (born in 1918) is known as the father of System Dynamics, which seeks to simulate organizational and social systems with models that are full of complex variables. Dr. Forrester studied electrical engineering and specialized in applied information technologies for organizational and social systems. In the decade of the 50s, he was one of the creators of computer Random Access Memory (RAM). I had the privilege of meeting him when I traveled to Oregon for a course in systems thinking in schools, and was delighted to see his humbleness, affection and wisdom. The Creative Learning Exchange (http://clexchange.com), which has Dr. Forrester’s full support, is one of the most important organizations in the promotion of systems thinking and systems modeling in schools.

Peter M. Senge (born in 1947) is, at present, the world leader in models of learning organizations and has based his business management model on The Fifth Discipline (his most outstanding book published in the 90s decade), being systems thinking the fifth discipline and the basis for the other four disciplines that all types of organizations need to develop. Dr. Senge, together with his group of researchers and professors, promotes systems thinking as the main capability to attain fundamental solutions to the problems of all kinds of organizations, as well as to design strategies that facilitate the creation of the futures desired by a group of people, instead of resorting to quick fixes and other traps that prevent and inhibit organizational intelligence. Since I met him in the course on Foundations on Leadership in 2003 in Boston, I perceived him as being calm, humble, kind and wise. Nowadays, he promotes his ideas as a professor at MIT (Massachusetts Institute of Technology) and as the leader of SoL (Society for Organizational Learning), which started at MIT to favor organizational learning and sustainability of the planet. The Dance of Change is one of his books that could be most helpful for an organization to achieve and maintain systemic change in the long run.

DEFINITION

We can understand systems thinking as the capacity to understand the relationships between the various components that obtain desirable and undesirable results in an organizational system. In his last book The New Economics for Industry, Government, Education, Dr. Deming insists that a system only exists when its components are interrelated in the pursuit of a common aim. That is to say that, without a common aim, there would be no system, which means that there would be nothing more than a series of components that are not united or linked, and that might even be competing among themselves. Considering this definition of a system by Dr. Deming, the systems thinker perceives the patterns and structures of...
the organization throughout time, from above, without losing sight of the details of the structures, the resources and the persons that comprise it.

The systems thinker seeks to understand, rather than to blame, since he knows that blaming goes hand in hand with negative consequences for the organization and for the people. The objective of systems thinking is to understand the organizational dynamics in relation to the organization's desired future. Learning is the main objective, since, without learning, we are condemned to do and obtain the same things. Linear thinking is the opposite of systems thinking. We think in a linear manner when we seek guilty parties or, in general, when we seek the immediate cause of a certain event. It's almost as when a child says that he hit the other one because he hit him first. If one believes in the immediate causes that gave rise to the events, one will look for quick fixes, such as punishing the guilty party with penalties, indifference, isolation and criticism. The lineal thinker does not see the possible unintended consequences of his actions, nor the logical and natural limitations that other systems impose on the linear actions that are implemented. We see linear thinking on a daily basis: when a driver blocks a two-way intersection, when a passenger leaves a seat in an airplane without taking into account the passenger sitting behind him, when a parent punishes his child for his behavior, without thinking that the child may learn to punish others, when a person drives the gasoline car to the groceries store that is two blocks away, when a boss blames the salesperson for the decrease in sales, when a person takes up a specific diet for two weeks or undergoes surgery to lose weight in a short period of time, or something as simple as when a person criticizes, blames or punishes another one (spouse, student, son, neighbor), seeking temporary submissiveness. The medical model and the health system in the West, at present, is based on linear thinking because it focuses on the treatment of undesired symptoms and ignores the creation of physical and mental health as public policy issues.

The discipline of systems thinking requires the differentiation between the resulting events of the organization (company, family, city, etc.), the behavioral patterns of the system (absenteeism, participation, feelings, sales, etc.), the chosen not chosen structures of the system (resources, design of the physical space, work teams, schedules, processes, and natural laws like 24 hours in a day, genetics, etc.), and the mental models that coexist in the organization (systems of belief, models of how the world works and should work).

In the following picture, I present the iceberg as an analogy for a system where the events are what is observable above the level of the water (the tip of the iceberg), which is equivalent to one fourth of the mass of the iceberg, and the patterns, the structures and the mental models that are under the surface, supporting it and creating what is observed in the results and events.

Figure 1. Analogy of the iceberg as a system.

By 'resulting events,' in the organization, I mean every photo (instance) of every desired or undesired events of the system, such as a moment of happiness, the loss or gain of a sale, the entry or withdrawal of a student, the low or high grade on a test, or the quality of sleep on a given night. That is to say, it is the instant image of something related to the organization and, by organization, I refer to a department in a company, or a company, a set of companies in a sector, a city, a geographic sector, the educational system of a country, a block of countries, etc. It is always important to define the limits of a system, because any or everything could become a system if its components share an aim or a purpose.

By 'behavioral patterns of the system' I mean the observable behaviors that could or could not exhibit a pattern throughout time (hours, days, months, years, decades, etc.) For this, it is important to keep data records on the relevant indicators of the organization. One can record what people feel and think throughout time; the daily absences from work, number of clients per month, daily sales or income, the number of new students enrolled every year, among many other types of data that would permit clarifying organizational patterns.

By 'systemic structure,' I refer to the processes, the meetings, the work teams, the job design, the physical infrastructure (lighting, oxygenation, acoustics, ergonomics, furnishings, etc.), the schedules, the budget, the technology, the communications facilities, and the limiting structures that are not chosen, like gravity, 24 hours per day, and genetic and biological instructions of human beings, among others.

By ‘mental models,’ I refer to the set of beliefs and principles of the persons in the organization, the knowledge and understanding of the people that comprise the system, and the expectations and desired pictures that they themselves have. These mental models affect the way the organization is perceived, what one sees and observes, and what the persons in the system truly desire. If a teacher believes that all of his or her students can and will be successful, he or she will certainly have class structures and behavioral patterns between him and his students that will create 100% success. In keeping with the popular saying: “Be careful of what you want, because you might get it.” That is the power of mental models. If the husband believes that men are not designed to be sexually faithful, he will probably have extramarital sexual relationships in order to be consistent with that mental construct. If a manager thinks that he should and can control the work of the staff that reports to him so that there is proper housekeeping and quality, the organizational environment will be one of tension and mistrust, and patterns of coercion and resistance will arise, as well as absenteeism, financial losses and only partial success.

The level of leverage for the achievement of different results and events increases as we dive deeper into the water. That is to say, changes in the mental models have a greater influence on the events and results, since they generate changes in the structures and these, in turn, generate changes in the behavioral patterns of persons and in the results.

Systemic change implies changing a certain pattern, or a structure, or a certain mental model. Systemic change requires the enormous ability to think systemically, instead of blaming and seeking quick fixes.

Archetype of “Quick fixes that backfire”

Figure 2A

The main problem with quick fixes or direct changes in the events or results is that, with time, unintended consequences are generated and they worsen the original problem. For instance, a reprimand for being tardy gets that person to temporarily adjust to the scheduling rules. However, if that person continues to be pressured with disconnecting memorandums and sanctions, with time, the person could do his or her work without satisfaction and with low quality; this is an unforeseen circumstance that worsens the original problem of tardiness by adding problems of resistance and mediocrity.

The diagrams of causality are very useful to the understanding of systems. Figure 2a showed a causality diagram that represents the archetype for quick fixes that backfire.

This archetype shows a recurrent problem (budget overruns, tardiness, etc.) and a fix that is applied on each occasion, working only in the short term. The letter “s” means “similar” in direction; that is to say, when the symptom of a problem occurs, the temporary fix is made in the same direction. The “o” means “opposite” in direction; that is to say, when the temporary fix takes place, the problem symptom is reduced in the short term. In other words, the greater the problem, the greater the fix (similar in direction – “s”) and the greater the fix, the lesser the problem (opposite in direction – “o”). This gives the appearance, in the short term, of a balanced cycle, reason for which we indicate it with the letter “B” for “Balanced.” In the long term, the quick fix brings with it unforeseen consequences, which aggravate the problem. A more powerful quick fix is then applied, or it is simply used more frequently. We can call this new and broader cycle in the long-term “Reinforcement”, indicated with the letter “R” because the problem symptoms increase with time, as a result of the quick fixes. In other words, the greater the problems, the more quick fixes, and the more quick fixes, the more unforeseen consequences of the problem, which simply increase the problems. The complete cycle is one of reinforcement, because the original problem is reinforced or increased.

The quick fix is applied

Intensity of the problem

Time

The problem worsens with time

Figure 2b

In the behavior-over-time graph shown in Figure 2b, we can clearly observe an increase of the problem in the long term; although it continues to be cyclical and, apparently, in the short term (one or two cycles) it may seem as if the problem is being solved. This is why we say that the organization (family, department, company, city, etc.) falls into the trap of the pleasant sensation in the short term, despite the fact that, in the long term, everyone ends up suffering an increased problem.

A child that is repeatedly punished or rewarded with the intention of resolving his undisciplined behavior, in the long term, learns to punish or reward others, which is a worse problem; punishing or rewarding other is an even greater form of undisciplined behavior, showing the effects of the reinforcing cycle. These are children that learn to lie, bully, and, in general, to become irresponsible for their own acts and their consequences. The problem is that these unforeseen consequences are enormously far from the original intent of wanting them to learn to be responsible and successful, since what is attained is that they end up learning to be irresponsible and mediocre.

What other quick fixes do we use in companies, schools, universities and families?

All forms of coercion, no matter how sophisticated they may be, are quick fixes that seek submissiveness and indulgence by the other party and bring along unintended consequences both to relationships and productivity. I believe that this is why Dr. William Glasser, in his book Choice Theory: A New Psychology of Personal Freedom calls these quick fixes the “deadly habits” of the external control psychology. Dr. Glasser has, since the 60s, invited mankind to live a peaceful, joyful and useful life, by means of the following behaviors that bring people closer, that resolve the underlying problems, and that preserve physical and mental health: support others in their endeavors, encourage others during their tribulations, negotiate differences with others, trust others to drive out fear and create stability and safety, respect others to avoid criticism and disconnections, accept others as they are, listen to others to create empathy and learn new ideas. These seven connecting habits create an acronym, SENTRAL, to emphasize that they are the central idea behind constructive behaviors.

The systemic and fundamental solutions that help get away from this archetype of quick fixes that backfire are the following:

- Increase awareness of the mental models that are driving the system and on those that would be needed in the future.
- Reframe the problem symptoms to perceive the fundamental root causes.
- Anticipate the unforeseen and unintended consequences, and intervene with less harmful or more manageable consequences.

These solutions require data collection about the observed events of the system (symptoms, problems, outcomes) so that they can be graphed over time and analyzed for patterns.
Archetype of "shifting the burden"

Figure 3A

The archetype in Figure 3A is similar to the previous one, with the exception that the variable of long-term fundamental solutions has been added. When a quick fix is applied, the problem or the symptom is reduced, or may even disappear, which decreases the pressure to find solutions that are more fundamental. After some time, the symptom or the problem reappears and another round of fixes takes place, which frequently produces side effects that detract attention even more from the fundamental solutions. The graph showing behavior over time can be observed in Figure 3B below. It is evident that, the more quick fixes are applied (increasing over time), the less fundamental solutions will be sought. This creates a sort of addiction to quick fixes, which, when applied, they give a temporary feeling of satisfaction and relief because things appear to be working.

Figure 3B

What could we do to prevent the addiction to quick fixes?
Which structures (processes, task design, resources, etc.) are required to avoid this systemic problem?
Which mental models do we need to avoid quick fixes and to look for fundamental solutions and creations?

As an example, a student in class interrupts by talking out of turn or by disrupting others (symptom) and the teacher asks him to be quiet or to behave (fix), which inhibits the teacher from finding a long-term fundamental solution, such as having designed a specific and useful role for the student in that class. At the time that he asks him to be quiet or to behave, the student will probably do it, which the teacher perceives as a solution at the time. When he interrupts again, the teacher again asks him to be quiet or to behave, again distancing him from a fundamental systemic solution. Other students will probably also start to do the same thing (side effect), moving the teacher away even more from a fundamental systemic solution when he asks the students more and more often to behave. The teacher might even get to the point of yelling or acting coercively to reestablish order and "control" (an even stronger fix), and, eventually, some students might even disconnect themselves even more from the teacher and from their schoolwork (a stronger side effect). At this point, the teacher might not even seek fundamental solutions for the design of his class; he might even send some of the students to the Principal's office, parents could already be involved, and a student or two could already have been suspended, without realizing that the teacher has fallen into the trap of quick fixes. What could the teacher do differently to break the pattern of behavior and create new events? Which class structures could be implemented in order to avoid this trap? What changes in mental models would be required?

In a company, one can easily see how managers act as heroes, solving problems and putting out fires, in fact, more efficiently every time (increasingly more sophisticated quick fixes). However, in the long run, they end up being tired and rather unrecognized (side effect); the original problem (tardiness, poor sales, poor achievements, absences, budget overruns, etc.) has worsened, and they have gone off track from the possibility of finding fundamental long-term systemic solutions such as continuous training, effective team work design, process redesign, marketing studies, shared visioning (shared pictures of the futures among a group of people), researching and studying other models, need-satisfying meetings, and enjoyable activities.

The same thing happens in the family, in managing the family budget, in feeling close with your mate, and in child-rearing: when their attention departs from the important things and they dedicate themselves to criticizing, blaming, threatening, nagging, rewarding and punishing each other (all quick fixes), leading all to drift apart and to seek satisfaction outside of the marriage and the family (side effects). All of this reduces the possibility of finding new ways of loving each other without conditions or restrictions. True love implies loving without expecting anything in exchange for oneself or expecting the other person to change. To love is to look for the well-being of the other person. However, we often mix up power and recognition with true love.

The habits of the systems thinker

The systems thinker mainly seeks to understand the system and to act on the points with the greatest leverage. For this purpose, it is essential that the following habits be developed:

- Seek to understand the whole picture, more than certain scenes.
- Change the point of view in order to increase understanding.
- Look for interdependencies.
- Identify complex causality relationships.
- Understand and consider the ways in which mental models affect the present and future reality.
- Bring out the assumptions and subject them to testing.
- Consider the short and long-term consequences of actions.
- Find where and when the unintended consequences surface.
- Focus on the structure, not on the faults.
- Maintain the tension that stems from the controversy and the paradox, without trying to resolve it rapidly.
- Use his or her understanding of the patterns, the structures and the mental models of the system to help identify the actions with the greatest leverage.
- Monitor the results and consistently realign the actions in accordance with the needs.
- Apply the mental habits that are recommended in Habits of Mind: A Developmental Series.

CONCLUSIONS

In this article, I have covered the essential elements of systems thinking in human organizations of all types, such as companies, families, communities, cities, countries and the planet.

We have made a summary of the history of the most important thinkers and ideologists on this issue in the last century, such as W. Edwards Deming, Jay W. Forrester and Peter M. Senge. I have considered that it is important to study them, because all of them have based their ideas on knowledge built up by means of rigorous and scientific procedures and research. We have also covered the main definitions of systems thinking and what it means to think systemically. The archetypes that I have presented are among many other archetypes that try to model the dynamics of systems. The Society for Organizational Learning (www.solonline.org), The Creative Learning Exchange (clexchange.com), and The Deming Institute (www.deming.org) are some resources where you can deepen your understanding of systems thinking and dynamic modeling. Stella is a software program that you can also learn to use for dynamic modeling of systems. In www.iseesystems.com you can buy Stella and other resources for business, education and government.

I dream of a world full of loving systems thinkers that look for loving relationships and sustainable practices. These thinkers could be called “systems citizens” as was proposed by Barry Richmond, a pupil of Jay Forrester and researcher at MIT and at The Creative Learning Exchange.

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Internal Control Psychology in Chronic Disease Management: Using Choice Theory and Counselling

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ABSTRACT

This paper describes the use of internal psychology in the management of chronic disease, and the potential of methods such as reality therapy and motivational interviewing to facilitate behavioral change. A case example and tools such as SMART goal setting have been included, as well as counselling principles with reality therapy to illustrate the process that can be followed.

BACKGROUND

Professionals in many countries are challenged by an increasing preventable disease burden. Those who are at risk, particularly aging populations, often don’t feel immediately the consequences of poor lifestyle choices on their health and wellbeing. It is therefore understandable that they can lack motivation needed to make the required behavioral changes. In addition, mental health problems such as depressive behavior can make it more difficult for clients to adhere to the recommendations given to them by the health professional. People with a chronic illness can be on an emotional rollercoaster similar to those who experience loss and grief, and emotions can include denial, frustration, fear, anger, sadness, isolation and or acceptance (Baker & Stiller, 2006). It requires tactful intervention on behalf of the health professional to assist people in helping themselves.

Assessing the mental health status of the client and using counseling techniques based on internal control psychology can improve the motivation to change unhealthy behaviors. It can be expected that people who feel sad, down or miserable most of the time and/or lose interest in most of their usual activities are less likely to stick to health professionals’ lifestyle advice such as diet and regular performance of physical activity and exercise. For the health professional to move a client from a state of physical or mental illness, or being out of shape or unhappy, towards an optimal state of wellbeing, it is important to improve motivation and to reduce barriers that can have a negative impact on program adherence. Techniques such as motivational interviewing or reality therapy based on internal control psychology can be very useful to facilitate change.

CASE STUDY

Client profile

Ben is 66 years old and lives at home with his 61 year old wife. One of their children lives in the same small rural township. Up to six weeks ago, Ben was actively involved with the local CFA, the public lands committee and service club. His wife is also an active local volunteer.

Background information

Ben had a stroke six weeks ago and has recovered reasonably well. During his stay in the hospital, the speech pathologist assisted with addressing issues around swallowing and speech, and good progress has been made. The physiotherapist assisted with an exercise program and has encouraged weekly participation in an exercise class. Since he is home, district nursing is calling in on a weekly basis to check blood pressure and deliver medication.

The presenting problem

As a consequence of the stroke, Ben is unable to drive. His wife does not have a license and his son is temporarily disqualified from driving. Ben is not attending exercise classes as he does not want to rely on friends and neighbors to assist with transport. District nursing has noticed that Ben has started to drink heavily and is spending all day watching television. They asked the social worker to visit and help set a care program so as to prevent Ben from becoming socially isolated, and hopefully get him to attend exercise classes.

The assessment

Ben expressed being depressed because he was unable to get out of the house. He was asked to fill in the K10 (Carney & Freedland, 2002), which he was happy to do. He had a score of 20, which indicated that something had to be done to improve his mental health state. Although a friend and neighbors had offered to help with transport to exercise classes and social functions, he said that it was not in his nature to accept help from others. He said that he understood what the symptoms of his disease were and how he could assist in the healing process by not sitting still; however he believed that he was probably too stub-
born to accept help. Ben also answered the questions of the Flinders Model of Care and was asked to score himself for various aspects of his life. It was obvious that he was not coping and was feeling rather lonely. When he was asked to formulate a goal, Ben said that he would like to be able to drive again so that he could attend exercise classes and volunteer organizations.

When applying reality therapy techniques and motivational interviewing, he admitted that watching television all day and not adhering to any exercise at all was not helping him to regain enough mobility so that he would get back his driver's license. He set himself the goal of walking to his son's home, which was only 300 meters away. By doing so, he would not only improve his mobility, but also feel less isolated when his wife was away for her voluntary work. He said that he was hoping to improve quickly enough to be able to walk to friends who lived a little further and seek their company, which would help him to feel less depressed.

Ben was challenged about his belief that he could not accept the help of transportation by friends and neighbors. He said that it was not his nature to accept help, but the social worker asked how his current plan was helping him to get what he wanted. She asked what would make it so difficult for him to accept help from others. Ben agreed that it was all in his mind and that it did not really make sense. He decided to accept that people would take turns getting him to town.

Ben agreed to review the plan in 3 weeks time and adjust the plan if needed. Another review would take place after 6 weeks. Ben believed that adhering to the plan should get him there. He did not state at any point that he had started to drink heavily as was quoted by district nurses. Because there was no indication of such at the time of the visit, this issue was not addressed.

Outcome

Reality therapy techniques asking Ben whether what he was doing helped him to get what he wanted proved useful. Looking back is not useful, but living in the present and focusing on the future is. Positive behaviors such as accepting, respecting and trusting are valuable. As in Ben's case, facilitating internal control is important to assist people in helping them in achieving their goal. This was clear in Ben's case. Six weeks after the assessment, he stated he felt less depressed, and scored fifteen in the K10. He said that, although he had not regained his driver's license as yet, he was feeling less isolated and scored himself a six out of eight, compared to the two out of eight at the start.

The intervention and theory explained

As the term suggests, reality therapy takes place in the present moment. The past is only important if it relates to the present. Reality therapy is based on choice theory (W. Glasser, 1998) and in line with Rational Emotive Behavior Therapy (REBT) (Ellis, 1962; Ellis & Harper, 1997), motivational interviewing (Schoo, 2008a), or working with emotional intelligence (Goleman, 1998). The use of choice theory has been associated with enhanced self-management, need satisfying relationships, and mental health. Choice theory can be applied by any individual in any setting. For example, the theory is used successfully in health management, education and business, and its principles can be learned and applied by any health professional, teacher, parent or manager who is willing to do so.

Factors such as lack of control in one's life can cause enormous stress. For example, a chronic disease or an accident at work or in the car can change one's life in a most dramatic way. Physical pain and disability, reduced income, and ill treatment by representatives of the insurance agencies and the medico-legal system can cause insecurity and stress that may well be counter productive in the healing process. Traumatic onset of pain through injury can have a major impact on the individual (Turk & Okifuji, 1996). In addition, personality traits such as neuroticism and lower levels of extraversion have been associated with posttraumatic stress disorder (PSD) (Fauerbach, Lawrence, Schmidt, Munster, & Costa, 2000), which can complicate intervention. An imbalance of the hypothalamic-pituitary-adrenal axis has been implicated in PSD (Weintraub & Ruskin, 1999), and it is possible that this dysfunction can be improved by counselling. Stress can also be self-imposed through pursuing unrealistic goals. Reality therapy combined with choice theory can assist in recognizing personal needs and those of others. It assumes that goals and the way in which they will be reached can be adjusted, and that health and wellbeing can be enhanced by 'inviting' people to act and think in a manner that is in line with their needs and capabilities. As a cognitive method, the required counselling process in reality therapy may also include some education (educate = leading forth, wholeness or integrity) to facilitate positive reasoning and wholeness of body and mind.

Cognitive approaches can assist us in learning what cannot be directly changed (e.g., bodily functions and sensations) and what can be changed (e.g., thinking and acting) (W. Glasser, 2000b). As with attainment of mental health through Buddhist psychology (Walley, 1995), reality thinking can assist in choosing to live in the present moment and to make the best of it, instead of reflecting on a past that cannot be changed. Work on what can be changed within yourself, the way you think about issues and the way you act towards others (i.e., mindfulness) and accept that what cannot be changed, for instance, your genetic makeup. As Adler’s ‘Individual Psychology’ (Petersen, 2005), therapists stress clients' internal ability to control their lives. The assumption that human behavior is chosen is in contrast to Stimulus Response Theory which states behavior is directly determined by external events. Instead of using external control psychology or coercion.
(therapists know what is right for clients), reality therapists assist people in helping themselves to fulfill their present needs by making responsible choices, which help them to be in more effective control of their lives and to get more of what they want. This technique was used to help Ben make more positive choices for himself. He was asked whether watching television instead of exercising was assisting him in regaining his driver's license, and he had to admit that it was not.

Facilitating internal control and self-help is in line with the non-directive counselling method of Carl Rogers. Although reality therapists are ready to offer educational information, the pure Rogerian approach requires refraining from offering suggestions or advice. Rogers criticized psychoanalysts for underestimating people's ability to self-realize by guiding clients through seven therapeutic stages of: unblocking internal communication, taking responsibility for problems, recognizing causality, increasing mobility, owning one's feelings and living in the present moment, recognizing and accepting negative feelings, and increased independence from therapy.

After the analytic approach taught by Freud and Jung, psychiatrists such as Harry Stack Sullivan and Hans Trüb realized the importance of human relationships and communication. Although their client interaction methods were directive in comparison with that of Carl Rogers, they recognized the value of initiating change through fostering the ability to form satisfying relationships. In contrast to opinions in conventional psychology/psychiatry since Freud, in choice theory people are not excused for their deviant behavior on the basis of past events or unconscious motivations. Appealing to the responsibility of individuals and the positive choices they can make gives reality therapy more leverage to enhance effective behavior and satisfying relationships than is possible in the sphere of conventional therapy where mentally ill persons are excused for deviant behavior because of their illness. In choice theory, responsibility is defined by Glasser (1975) as 'the ability to fulfill one's needs, and to do so in a way that does not deprive others of the ability to fulfill their needs'.

Differences between reality therapy and the more conventional psychoanalytical approaches are outlined in Table 1. As can be deduced from the Table, in a reality

<table>
<thead>
<tr>
<th>Conventional</th>
<th>Reality therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental illness exists.</td>
<td>The notion of mental illness is not acknowledged.</td>
</tr>
<tr>
<td>Mental illnesses can be classified in groups. For example, neuroses and psychoses.</td>
<td>Neurosis is seen as being afraid of the reality, and psychosis as denying the reality. Crazy behaviors are people's best attempts to satisfy their needs.</td>
</tr>
<tr>
<td>Treatment differs according to the diagnostic group.</td>
<td>Treatment facilitates the fulfillment of needs in a responsible manner. The focus is on individual's quality world.</td>
</tr>
<tr>
<td>Digging in the past is important to recognize the cause of the problem.</td>
<td>The past cannot be changed. Limitations by past events are of no use. Working in the present and for the future is essential.</td>
</tr>
<tr>
<td>Once the cause of the problem has been identified, attitudes and behavioral patterns can be made more effective.</td>
<td>Specific behaviors are results of choices to meet needs in particular ways, although they may not be effective. People have the choice to adopt more effective behaviors.</td>
</tr>
<tr>
<td>Transference of attitudes of the client towards the is essential. Therapist and client can relive the events together</td>
<td>Clients are not related to as transference figures.</td>
</tr>
<tr>
<td>By reliving events, the client can get more insight in the past and replace old attitudes with new ones under analysis and guidance of the therapist.</td>
<td>Reliving the past is not relevant. It is more helpful to discover more effective attitudes and behaviors that assist in coping better at the present moment and in future.</td>
</tr>
<tr>
<td>It is even more important for the client to understand the unconscious mind than to be aware of conscious problems. Analyses of transference, dreams and free associations are therefore essential.</td>
<td>Searching for unconscious conflicts or the reasons for them is not useful.</td>
</tr>
<tr>
<td>Undesired behavior is regarded as a part of the mental illness. Until cured through therapy, the client is morally not responsible for deviant behavior.</td>
<td>The client cannot be excused for deviant behavior on the basis of unconscious motivations.</td>
</tr>
<tr>
<td>Learned helplessness.</td>
<td>Individual is the expert him/herself.</td>
</tr>
<tr>
<td>Once clients understand the roots of their problems, behavior will improve automatically.</td>
<td>Behavior is enhanced when clients find more effective attitudes and response patterns to fulfill their needs.</td>
</tr>
<tr>
<td>Enhancing desired behavior through education is regarded as less important.</td>
<td>Education is considered to be important.</td>
</tr>
</tbody>
</table>

* Extracted from Glasser (1975)
therapy setting it is not relevant to know why events happened as they did, but rather, how a specific attitude or behavior helps one to advance in life and become a better and healthier person. Valid questions are ‘how is your current plan helping you to get what you want’, ‘what is now the plan of action’, and ‘how can adherence to this plan be improved’?

Reality therapy is counselling with choice theory. It is a solution-oriented approach that requires reality thinking, canvassing the options available, and making responsible and constructive choices that assist in developing more positive response patterns of the client and, indirectly, of others around him/her. Behavioral patterns such as blaming or criticizing others, nagging, complaining, threatening or punishing, rewarding others to manipulate and control them are not very effective in fostering enduring relationships (W. Glasser & C. Glasser, 2000) or managing a chronic disease. These negative reactive response patterns belong in the externally controlled world where there are perpetrators or aggressors, rescuers, and victims who are caught within an opposing or triangular relationship, the so-called Karpman triangle (Hoogstad, 1999), and where people do not take responsibility for their own health and blame others for their problems and behavior. They need each other in order to function and face each other in a (co)dependent win or lose relationship where the perpetrator controls and the victim is helpless, and where roles can even be swapped. For instance, the victim can have the need for love and belonging met when comforted (rescued) by a remorseful aggressor. When there is enough anger, it is even possible for the victim to become the aggressor. The different dramas James Redfield (1997) describes (e.g., intimidation vs. aloofness, and aggression vs. ‘poor me’) are good examples of co-dependent relationships. A useful resource is the book written by Melody Beattie (1997) ‘Codependent no more: How to stop controlling others and start caring for yourself’. In general, co-dependent relationships are unsatisfying. There is no need to feel responsible for people’s choices, and using coercing methods to control them. At the same time, there often is no need to be victimized unless this is allowed to happen.

Co-dependent behavior has been associated with poor communication, dependency, low self-worth, weak boundaries, denial, care taking, lack of trust, controlling, anger, sex problems, repression and obsession (Beattie, 1997). For instance, co-dependent people tend to talk about others and believe that their own opinions are not relevant. They lack fun in life because they take things personally, seek constant approval, let people hurt them, feel responsible for other people’s problems, and have feelings of pity, guilt, anger or anxiety. In addition, they tend to not trust themselves or others, worry constantly, and may feel hopeless, trapped and depressed. Consequently, they may become emotionally, mentally and physically ill, become withdrawn or violent, and addicted to substances or sexual relationships when they rather need to be touched, hugged, nurtured and loved (Beattie, 1997).

Although positive responses are more satisfying (W. Glasser & C. Glasser, 2000), from time to time most people use negative responses that are used in a co-dependent world (Beattie, 1997). Negative response patterns are based on a win/win approach whereas positive responses allow others to learn and get stronger. Behaviors such as accepting and respecting, listening, negotiating, trusting, supporting and encouraging (W. Glasser & C. Glasser, 2000) allow getting what the person wants without denying others what they want. These positive response behaviors facilitate personal development in a spiralling ongoing circular motion that goes from strength to strength. The latter process assists in the fulfilment of needs and the experience of meaningful lives of the people who choose to operate in this relationship model.

In relation to needs fulfilment, the hierarchy of needs Abraham Maslow postulated in the 1950s and 60's was a break from existing schools at the time, i.e., psycho-analysis (e.g., Freud, Jung) and behaviorism (e.g., Watson, Skinner). In essence, in the humanistic view of Maslow, human behavior is not seen as being solely dependent on the unconscious mind, instincts or a learned set of actions, but rather on the fulfillment of different needs (Maslow, 1968, 1970, 1971). According to Maslow, needs at the lower end of the scale need to be alleviated first (i.e., physiology, safety, love, esteem) before the higher need for self-actualization can be filled. Physiological needs are the most basic ones and include the need for air, water, food, procreation and rest or sleep. The need to be safe (without threat) is next, followed by the need for love, belonging and to be accepted by family, friends, colleagues and other people. The need for esteem has two aspects: (i) self-esteem due to the ability of performing certain tasks; and (ii) the positive interest and acknowledgment from peers and others that comes with it. The esteem need/desire to be admired has been recognized as a power need (Gwynne, 1997). Lastly, the need for self-actualization has been defined by Robert Gwynne (Gwynne, 1997) as “the desire to become more and more what one is, to become everything that one is capable of becoming”. This will to self-actualize can lead to the fulfillment of spiritual needs such as knowledge/wisdom, peace and oneness (Gwynne, 1997) once people have everything they desired for. The perceived difference of what people want and what they have got drives them to action, as illustrated in the case of Ben.

Initially, Glasser (1975) distinguished a few basic psychological and psychological needs that motivate persons to fulfill them. Physiological needs included food, warmth and rest, whereas the two basic psychologic needs were: (i) to love and be loved; and (ii) the perception of worthiness to oneself and to others. In later publications, the needs were expanded to five, including the physiological need to survive (W. Glasser, 1985). Needs are seen as common to all creatures, whereas wants are unique to each person.
(Wubbolding, 1988). When people are not receiving what they really want, they become frustrated. This perceived imbalance is likely to initiate action to get what they have set for themselves. Behavioral patterns or actions are the result of fulfilling needs and wants in a manner that is chosen by the individual. The resulting actions include deeds, thoughts, feelings and emotions, and physiological processes in the body. However, some behavioral patterns are not as effective as others and can cause stress, pain and problems such as illness in both the person who performed the actions and others who have to live with the consequences of these actions.

Depressing behavior is an example of a less effective behavior. Although 'depression', pain and disability are common problems in people with an chronic illness such as osteoarthritis (Van Baar, Dekker, Lemmens, Oostendorp, & Bijlsma, 1998), behaviors can be changed. Being depressed is in choice theory not regarded as a fixed state of mind, but a chosen action, for instance, when people are not prepared to accept a situation. Hence the use of the verb 'depressing' rather than words as 'depression' or 'depressed'. People may choose to depress themselves in order to restrain anger, to call for help or to prevent undertaking something that may fail. Depressing is not an effective form of behaving, because it immobilizes and hurts. It provides control at the price of experiencing misery. The development of physical symptoms such as through arthritis may stop the need to depress oneself (W. Glasser, 1998).

In reality therapy, raising awareness of personal needs and wants, and choosing effective behaviors in a responsible manner to fulfill these needs are considered to be essential. In Buddhist terms, this 'responsibility' can be seen as 'mindfulness', and as an opportunity rather than an obligation (Walsch, 1995). It is our freedom to make choices, to see them as opportunities to act in a responsible manner, to become a healthier person, and to contribute to a better society.

Improving behavioral patterns through reality therapy requires a methodological approach through counseling or self-evaluation, and action in a responsible and persistent manner. It requires identification of the problem, evaluation of the effect of certain actions, design of an action plan, sincere commitment to the plan, and monitoring the effect of the action plan. Although it can be helpful to analyze what values/trait people have learned to put behind their screen, why people are attracted to each other (or not), how it may have affected their way of acting and why it brought them in a particular predicament (Skynner & Cleese, 1993), it is important to move on from that and to self-evaluate the effectiveness of chosen response patterns. Reality therapists will encourage clients to initiate choices that assist them in meeting their needs without depriving others from meeting theirs. The reality therapist will assist in readjusting the action plan as need-
ed. This process demands skills such as listening, refram- ing to ensure that the problem is understood, respecting, sharing, being creative, using humor when appropriate, not accepting excuses, refraining from arguments or criti- cism, and not giving up (W. Glasser, 2000b; Wubbolding, 1988, 2000). For example, the counsellor may ask a client who is depressing herself, whether this negative behavior is giving her the results she was hoping for. More positive response patterns can then be explored and tested on their effectiveness.

The reality therapist may attempt to get an impression of clients' private picture album of their ideal world and the intensity of their basic needs. Frustrations due to discrepancies between these personal factors and the real world are essentially the impetus for their thoughts and actions. In addition, the therapist may want to assess clients' beliefs and knowledge since this information can assist in determining whether thoughts and actions are based on specific beliefs, poor knowledge, or both. Beliefs and knowledge are the two filters in the choice theory that play a role in filtering incoming information. The information that is detected through the senses is colored by personal beliefs or attitudes, experiences and knowledge. It will be compared against personal pictures of the ideal (quality) world people have in their mind and their needs. The difference in what people want to have and what they actually receive is the basis for people's total behavior (thinking, acting, feeling, and physiology or bodily functioning). Although the strength of the basic needs cannot be changed, education and counselling may assist in reality thinking and evaluating whether some of the images of people's so-called ideal world are realistic, and the way they opt to respond is effective in getting what they want.

The process of counseling in a reality therapy setting contains several aspects that need to be addressed correctly in order to find out what the problem is, why this problem is affecting the person the way it does, what can be done about it to reduce or eliminate the impact of this problem on someone's life, and how committed this person is to stick to the plan and make it work. Important aspects of a counseling sessions are (Devine, 2001; Sommers-Flanagan & Sommers-Flanagan, 2004; Wubbolding, 1988, 2000):

1. Creating the right ambience is most important to put people, who can be very stressed about the particular problems they are facing, at ease. For example, a quiet room, a comfortable chair, a cup of tea, sitting on an equal level and being receptive to what people have to say are important ingredients that facilitate the sharing of information during a counseling session.

2. Listening to what people have to say. Ask open-ended questions that cannot be answered with 'yes' or 'no'. Appropriate sentences start with the words 'why', 'when', 'where', 'who' and 'how'. For instance, why did you decide to see me? Although it is impor-
tant for the counsellor to remain neutral, being curious and ignorant can assist in understanding the problem of the client. Ignorance in this context is defined as a state of acted unawareness on behalf of the counsellor, which provides the opportunity for the client to describe the relevant issues in detail. Valid questions can be ‘how do I know when this situation occurs’ or ‘what did you think exactly when that happened’. It is possible that people get sidetracked and go off in directions that are not relevant to their problem. It is perfectly alright to lead them back to the relevant issues in a non-offensive manner.

3. Without any judgment on behalf of the counsellor, picking up people’s opinions and what is important to them (values) can be done by asking, for instance, ‘what concerns you most about this situation’, or ‘why do you dislike ...?’ Personal values and judgments color one’s life and it can be important for the counsellor to give clients the opportunity to test theirs on their validity.

4. Framing or structuring the information by using techniques such as reframing (presenting alternative frames of reference) and deframing (testing existing frames of reference). Without exercising any judgment, these techniques are useful for the counsellor to piece the facts (assertions) together to stories (frames) that are either rejected or accepted by the client as valid (Ampersand Australia). The facts (e.g., observations, events, thoughts) can be positive or negative and can be linked together to stories (e.g., ideas, beliefs, conclusions) that are correct or incorrect. Facts and stories reflect what is going on in the personal quality world, or the private picture album of how things are meant to be to the individual in the ideal world.

5. Asking the miracle question and verifying if that is the desired outcome. For example, ‘suppose you wake up tomorrow and all these problems have been resolved, what will you do differently?’

6. Identifying the underlying need(s). For instance, a need to have fun when life is boring, or a need to be free when others manipulate you. Sometimes people constantly blame others for their failures, misfortunes and unfulfilled needs.

7. Provide opportunities for clients to self-evaluate by placing the self on the scales and weighing up personal needs against what is perceived to be received in reality. Establish whether there is a discrepancy between the two, and explore whether this perceived difference between what one has and doesn’t have explains chosen behavioral patterns.

8. Explore the systems of values and the preparedness of changing the personal picture album so that some of the pictures that individuals have of their golden quality world can be exchanged for more realistic ones ‘of how things should be’. Although it is possible for the client to find behavioral patterns that are more satisfying by learning from past situations, providing additional education can be an important tool to facilitate change.

9. Designing a plan that leads to fulfilling needs in a responsible way, based on positive thoughts and actions. The plan needs to be adhered to in order to be effective. Constant monitoring and adjusting can be useful to obtain lasting results. It needs to be kept in mind that people will only change their behaviors when there is something in for them, not because the counsellor wants them to change.

Useful examples of clinical case management can be found in the many reality therapy books that are available (N. Glasser, 1989; W. Glasser, 1975, 1985, 1994, 1998, 2000a, 2000b, 2001, 2003; W. Glasser & C. Glasser, 2000; Wubbolding, 1988, 2000), particularly the more recent ones. In addition to reality therapy, various forms of physical and/or mental activity and exercise can assist in maximising results.

Using outcome measures and providing tools to improve behavior

The use of valid and reliable tools can assist the therapist in finding out whether clients use less effective strategies. The Hospital Depression and Anxiety Scale or the K10 (Carney & Freedland, 2002) are scales that can be used in clinical practice settings to measure the severity of the condition and to measure improvement. There are even shorter tools (two questions) that can provide an indication, but care needs to be taken with the interpretation of the results. The two questions of this tool are ‘During the past month have you been bothered by: (i) feeling down, depressed or hopeless?; and (ii) little interest or pleasure in doing things?’ In case both questions are answered positively, the person could choose to depress. When both are negative, the person is most likely not choosing to depress (Arroll, Khin, & Kerse, 2003).

Although prevention is better than treatment, realistic thinking and doing can be valuable tools that assist treatment of many conditions. For example, people with asthma can benefit from personalized care and learning to control their emotions, in addition to receiving standardized medical care and education. This mind-body focused model of health care is, for example, practiced at the Parkland Memorial Hospital and community health centers in Texas as explained by David Smith and Ron Anderson (Flowers, Grubin, & Meryman-Brunner, 1993) or exemplified in the Flinders Model of Care theory (Battersby et al., 2007). Meeting needs in more positive ways and escaping the negative effects of the spiralling
physiological cycle of stress may assist in achieving higher levels of well-being.

It is generally recognized that there are many factors that can contribute to the development of different illnesses. For example, factors can be genetic, environmental or psychological. There may even be a great deal of overlap between the different factors since behavioral patterns such as depressing behavior (Pert, 1997) can lead to stress and the development of disease. Experiments by Hans Selye (1956) demonstrated that alarm reactions in stressful situations could be provoked by emotions such as fear, anxiety, anger, guilt or depression as well as physical stress (e.g., trauma) and chemicals (e.g., pollution and the use of alcohol, nicotine, caffeine, sugar and excessive fats). The physical responses of stress on the physiology can be self-perpetuating due to the production of different substances by the brains, adrenal glands, sympathetic nervous system and liver, and the effect they have on blood pressure and ongoing stress. Physical inactivity appears to have a negative effect on this cycle because the substances produced are not metabolized and continue to have a negative effect on the body. In fact, there are practitioners who prefer to counsel their clients while walking, or who suggest tasks that require outdoor activities (Burns, 1998).

Motivational interviewing and reality therapy can be applied in settings ranging from ‘in the clinic’ to at home or via telephone. The skills required for motivational interviewing and reality therapy are comparable and are well described (W. Glasser, 2000a; W. Miller & Rollnick, 2002; W. R. Miller, Moyers, Ernst, & Amrhein, 2003; Schoo, 2008). The techniques are not only practiced by health professionals such as psychologists and social workers, but also by physiotherapists, dieticians, medical practitioners and nurses. The effects are immediate and just two treatments can be sufficient to boost motivation. However, the effect sizes diminish over time (from d = 0.77 at post-intervention to d = 0.30 at 6-12 months) (Hettema, Steele, & Miller, 2005). A follow-up session every six months can increase the effectiveness of the intervention. Useful tools for motivational interviewing are:

1 Making a decisional balance list of benefits (for) and costs (against) for making change or for not making change (Table 2);
2 Putting together a change plan worksheet and identify the desirable changes, the reasons for changing, the required steps, the support needed of others, what determines success, enablers and barriers that need to be considered, and a back-up plan;
3 Working with the readiness ruler (for example, readiness to regularly perform physical activity and adhering diet guidelines); and
4 Knowing what is to be expected from the intervention.

Table 2. Identifying benefits and costs of changing behavior by using a decisional balance list.

<table>
<thead>
<tr>
<th>Decision</th>
<th>Benefits (for)</th>
<th>Costs (against)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changing</td>
<td>..................</td>
<td>..................</td>
</tr>
<tr>
<td>Not changing</td>
<td>..................</td>
<td>..................</td>
</tr>
</tbody>
</table>

Counselors that use techniques based on internal control psychology (e.g., motivational interviewing or reality therapy) are likely to emphasize clients’ perceptions of the consequences of their behaviors instead of using a clinician’s model causality (Brunette & Drake, 2007). SMART goal setting (Specific, Measurable, Achievable, Realistic and Timely) can be used to progress with small steps and within agreed timeframes. People with chronic illness can benefit from target practice enhancement facilitated by the health professional (Glasgow et al., 2002; Thoesen Coleman & Newton, 2005). This may include:

1 Client and health professional agree together on one topic that is appropriate for the session (e.g., regular exercise);
2 Health professional to identify what the client wants to know about the topic;
3 Health professional to provide the requested information;
4 Health professional to identify client’s disease concerns, the desired outcome and the steps required to reach that outcome, and the possible barriers that may be encountered;
5 Health professional to provide additional information as needed;
6 Client and health professional to agree on goals and action plan;
7 Health professional to provide clarification of goals and action plan, and to encourage the client to use a personal action plan worksheet;
8 Health professional to establish the confidence of the client in carrying out the agreed action plan on a scale from zero to 10, and to identify what needs to take place to increase confidence in case it rates less than seven;
9 Health professional and client to evaluate and refine the plan; and
10 Health professional and client to agree on another relevant topic (one added at the time, e.g. diet). Etc.

It is important to facilitate ownership of the process so that adherence is enhanced. Reason why interventional programs such as the Flinders model can fail is due to health professionals not letting go of their tendency to do things for people and to tell them what to do (Pill, Rees.
Stott, & Rollnick, 1999) rather than giving people the opportunity to help themselves and to have ownership of their goals, how small they may be.

IN CONCLUSION

Applying interventional methods such as reality therapy that are based on internal control psychology can assist in the management of chronic diseases by addressing factors that affect mental and physical wellbeing. As with motivational interviewing, reality therapy can be used by health professionals to assist clients in taking responsibility for their choices and helping themselves by adopting and maintaining a lifestyle with positive habits and areas of social relations, physical activity and exercise, and diet.

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ABSTRACT

The Continuum of Healthy Communication was created to visually present the connection between relationships, Glasser's Seven Deadly and Seven Caring Habits, and emotional vs rational reasoning. These three dimensions are discussed in a narrative fashion. Specific mention is made of the importance of healthy relationships and of how relationship satisfaction and dissatisfaction are connected to Old Brain and New Brain thinking processes. This chart has been used by the author to facilitate personal growth in high school students and parents, as well as to effectively support pre-service instruction in a faculty of education program in central Canada.

Reality therapy, as a therapeutic model, has been referred to as "an oldie but a goody" and as such, is an extremely useful counseling tool to support today's guidance counselor. William Glasser's approach, with the concepts of choice theory and reality therapy, burgeoned forward in reaction to behaviorism in the 1950's and 60's and is based on humanistic, existential and cognitive-behavioral traditions (Finnerty, 2008). Glasser’s Reality Therapy took form in 1965 and is, arguably, the granddaddy of all cognitive approaches. At the turn of the century, Glasser (1998) reconceptualized his control theory and published these ideas in his book *Choice Theory: A New Psychology of Personal Freedom*. Glasser's concepts are the basis for my counseling practice. By studying Choice
Theory and Reality Therapy, I have personally come to see the world in a more meaningful way that makes sense of the human condition.

Fundamental to choice theory are the following presuppositions: all we do is behave; we choose our behavior; and we are biologically driven to fulfill the basic needs of survival, fun, freedom, power, and love and belonging. In his model, Glasser stresses the vitality of relationships and therefore places greater emphasis on the significance of love and belonging over other needs. He also emphasizes what he refers to as total behavior and how we, as human beings, are creative in trying to realize our quality world. However, we are sometimes misguided in connecting with and fulfilling our quality world pictures. This is where effective counseling helps. By supporting clients in connecting to their wants and helping them choose appropriate actions and thoughts, clients can be steered in the direction of connecting with their quality world pictures and choosing behaviors that will help them fulfill their needs (Glasser, 1998).

The Continuum of Healthy Communication chart (see figure 1) recasts one piece of Glasser’s seminal work visually for educators and guidance counselors in an easy to understand and useful way. The chart is a compilation of others’ work. During one of my many web searches in 2005, I came across a website that had placed the habits on a scale going from negative to positive. This website, which can no longer be found in order to give credit to the author, was the impetus for the chart. The Continuum of Healthy Communication was created to relate healthy habits to emotions. The chart provides a visual representation of the continuum of healthy communication in relationships and the connection to thinking and feeling.

The primary concept that relationships are critical to self is fundamental to Choice Theory. In relationships, we try to get what we want. Sometimes we may lose sight of the fact that what we really want are quality relationships, not control. When our mind is quieted and not thinking about activities and making future plans, it reverts to thinking about the quality of the relationships that we have with others (Goleman, 2006). Relationships are vital to sustaining us as human beings; without them, we cannot thrive (Glasser, 1998).

When I was a guidance counselor in a small high school, I had this chart posted on the wall. I used the chart daily, to explain to students and their parent(s) how to relate to loved ones. Students usually connected well with the message. When working on family issues with students, they understood the need to relate, but often felt powerless to change their family. Once students learned that the only person they could change was themselves, they understood the model and the connection to working on being the best person they could be.

Parents, on the other hand, usually wanted answers about how they could better manage their teenager; they were looking to assert more control. When I first started my counseling career, I would give parents information and advice on how to do just that. I would explain the many facets of managing behavior through a discourse on the behavioral approach. I would even provide booklets and strategies on how to control an adolescent’s behavior. This method made me very uncomfortable, because in my heart I knew that this was not the best way to support families. As well, many of the parents who were asking for assistance had no problem asserting control. The adolescents in their homes were choosing to opt out and act out to remove themselves from an external control environment created by rigid and authoritarian parenting styles. I agree that parents need to “manage” their adolescents effectively and set limits, but sometimes parents were looking for ways to “turn it up a notch” and gain more external control over their sons or daughters. This was antithetical to what they needed to do. The parents had lost sight of the power inherent in relationships.

Parents often wanted things to change at home, but some thought that they were not the ones who needed to change. This is the power of the message I bring, because through the continuum of healthy communication I explain what healthy communication is without any discussion about who or what needs to change. In a more anxious meeting with parents, I would start by explaining what I have been talking to their son or daughter about and then I would teach what I taught their adolescent — the chart. Using this approach is an indirect and less threatening way of presenting the information. The parent and student would choose to accept, reject, or seek clarification and a deeper understanding about healthy communication.

I put together this Continuum of Healthy Communication to support my work with students and parents. Then, when I started to teach in the Faculty of Education at Brandon University, I began to use the chart to present an alternative to the behavioral approach to manage student behavior in schools. Now, I introduce the chart to explain how to work with exceptional students using techniques that are not behavioral. In Manitoba, Canada, educational programming for students who are exceptional is founded on the behavioral approach. In my university courses I teach pre-service teachers to do a functional behavioral analysis. I introduce The Continuum of Healthy Communication and a gentle teaching approach to complement my instruction on the behavioral approach. I use choice theory and its application to relationships because it is not based upon having power over someone. It fosters developing and maintaining quality relationships with all students, including those at risk. Pre-service teachers who hear me talk about the continuum in class, like parents and high school students who heard me talk in my guidance office, will also be exposed to these.
I cannot take credit for the ideas contained within the chart. However, I think that I have presented them in a format that is palatable to the lay person unfamiliar with Choice Theory. Once I have presented this chart, more often than not, people ask for more information on what we have been discussing. I gladly point them in the direction of Choice Theory and Reality Therapy. Glasser places great emphasis on quality relationships and how, when a client comes for help, there is always some unsatisfying relationship as a core concern. I support this belief and try to impart as much of Choice Theory as I can into my university courses.

At the top of the chart is the notion that we have choice and influence over our action, feeling, thinking, and physiology. Total behavior and how we interact with our environment is a keystone concept of Choice Theory. We behave purposefully in our best attempt to have satisfying relationships. According to Glasser, we steer ourselves with our thoughts and actions and are moved by our emotions and physiology. As counselors working with clients, we are encouraged to focus on thinking and to active doing. Change for the clients occurs by having them do something that will move them closer to what they want.

Counselors and teachers struggle to have students transform their intentions into action. I quip to pre-service teachers, when discussing the change process, that “talk is cheap; it is what the student will do that matters.” We can spend a great deal of time talking, helping students become more aware of their physiology and identify stressful feelings and thoughts, but this means very little if change has not resulted in choosing more adaptive behavior. It is harmful to make clients conscious of negative events and feelings and then not do anything but discuss them. Some students will spend energy and time vacillating between thinking and choosing action, even when they are aware that what they are doing is not working. Change is hard for students; good or bad, change is hard.

Contained within the continuum are the polarities of emotions-managing-reasoning and reasoning-managing-emotions. What I have tried to do here is incorporate my work as a Crisis Prevention Institute (CPI) instructor into the model. Although the CPI language would be somewhat different, “primitive” brain for Old Brain and “rational” brain for New Brain, I believe the terms are virtually synonymous (Crisis Prevention Institute, 2008). In Glasser's brain-based terms, the Old Brain is the emotional, feeling part of our brain and the New Brain is the rational, thinking part of our brain. Choice theory is predicated on the idea that we need to make rational choices in the New Brain. The Old Brain and the New Brain are integrated and constantly exchanging information back and forth, but each part has its specialized function.

The New Brain can override the Old Brain's emotional responses, but not easily (Goleman, 2006). Our best thinking occurs when we are relaxed, and reasoning through the New Brain. When our reasoning manages our emotions, we are able to reduce our emotional defenses, and think clearly and rationally. When under stress, the emotions part of the brain will take over and direct our actions, unless the thinking brain stops this from occurring. For example, Old Brain feelings are responsible for triggering our fight or flight response through our need to survive.

On the dissatisfied relationship end of the continuum when we emote negatively, the Old Brain becomes more engaged. When this occurs, we are moving away from choice theory and toward external control. We are in reality are moving toward “survival mode” in an attempt to control the person(s) on the other end of the dissatisfying relationship. Put another way, when extremely unsatisfied with our relationships, we revert to emoting in survival mode; it is our best effort to reduce anxiety and restore stasis. In this state, our feelings are managing our thinking. We are beginning to see others as objects and trying to control them as such. In the extreme, we use angering and depressing in our best attempt to get compliance and external control over the other person(s). When we are dissatisfied with our relationships, we begin to objectify others and see them in an “I—It” relationship.

On the other end of the continuum, when satisfied with our relationships, we are not anxious or driven by Old Brain emotions. The rational New Brain is directing events. In satisfying relationships, we are relaxed, happy, and more able to think clearly and be aware of those around us. Satisfying relationships create more mindful behavior, joy, happiness, and an even temperament (Buddhism Teacher, 2008). We are empowered to become aware of our thoughts, actions, and motivations in satisfying relationships. We feel intimately connected and satisfied with our relationships. We see others as extensions of self; the “I—Thou” relationship flourishes (Buber, 1958).

In between the poles of relationship dissatisfaction and relationship satisfaction are the habits that we use to get the relationships that we want. The caring habits are more pro-social and supportive than the seven deadly habits, as they are on the right side of the continuum. We use caring habits because they will lead us in the direction of relationship satisfaction (Glasser, 2003). The more we use the habits of supporting, encouraging, listening, accepting, trusting, respecting, and negotiating, the more we will live happy, mindful and equanimous lives. These positive habits are based upon the idea of moving away from control and toward having people choose to be with us in a comfortable way. The caring habits are the externalize expression of our desired internal needs. We seek to internalize relationships and be listened to, supported, encouraged, respected, accepted, trusted, and negotiate with. Therefore, we must give what we most desire in order to have healthy relationships. This is another exam
ple as seeing people as extensions of self, as opposed to objects to be acted upon. When we are reasoning to manage our emotions, we are reasoning thoughtfully and engaging others thoughtfully.

The seven deadly habits are further down the other end of the continuum in the direction of relationship dissatisfaction. Here, when we are emoting to manage our reasoning and are thinking in the primitive part of our brain, we treat people as objects to be acted upon and employ criticizing, blaming, complaining, nagging, threatening, punishing, and rewarding to control as a means to an end (William Glasser Institute - choice theory, 2008). The seven deadly habits translate into power and control over others.

When we examine the two sets of habits more carefully, we see that the caring habits bring us closer to relating in a healthy way with someone. All of the caring habits forge strong relationship skills with individuals. However, the caring habits do not give power or control over the individual. The deadly habits may cause the person who is acting on the other to attain what he or she wants, but this will not work to develop a better relationship. From a behavioral perspective, the seven deadly habits may work to elicit the desired behavior. However, a byproduct is that the deadly habits estrange the individual from meaningful relationships. We are genetically programmed to love and be loved. However, because the seven deadly habits are used to gain external control over others at the expense of relationship, those who subscribe to this process will be dissatisfied in the end, and over time may turn to more emoting in order to get what we believe they want. This can lead to more extreme attempts to control by angering and depressing. Violence occurs when angering and depressing no longer adequately serve to externally control the behavior of others.

Students, parents, and pre-service teachers do not easily see the significance of why we choose caring habits over deadly habits. In fact, pre-service teachers very correctly point out that many of their classroom management models are behavioral and are built around punishment and rewards. Teachers have legitimate power over students. When working as a guidance counselor, the idea of rewarding to control was often discussed by students and parents. This happens in society all the time. Rewarding to control is about power over another. When we are giving someone something in an attempt to increase a desired behavior, we are rewarding to control.

During counseling sessions, parents, who often started out by wanting to “get their kid under control” did not eas-

ly see the strength inherent in the caring habits until they were asked the question “what do you want?” Ultimately, parents then understand that what they really want is a better relationship with their sons or daughters. At this point, they would understand and would move away from external control. They had begun to see their adolescents, not as objects upon which they wanted to act, but as extensions of self. They chose to move towards listening respectfully with their hearts and minds open. They were empowering their sons or daughters to be apart of the change process.

The Continuum of Healthy Communication is a wonderful tool to help students, parents, and future teachers connect to Choice Theory. By producing this chart, I have attempted to express the connection between relationships and communication as an element of Choice Theory. It is my intention to help people understand how to engage in healthy communication that will foster satisfying relationships and create a happy and mindful way of being. I have used this chart in my own high school counselling and university teaching practice with great satisfaction and it is my hope that readers will find this chart useful in their own practice.

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Counseling: Working with Different Personalities and Behaviors to Improve and Maintain Mental and Physical Well-being

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ABSTRACT

The manner in which people choose to behave is unique to the person. A range of factors can be found in the literature that have been associated with the way people respond in different situations. They include education, learned behavior (e.g., hardiness), environment, state of health as well as attitudes, tendencies, archetypes, temperaments, and personality and or body types (Cataldo, 2001; Jung, 1921; Kretschmer, 1948; Soderstrom, Dolbier, Leiferman, & Steinhardt, 2000; Wilber, 2000). Temperaments are natural dispositions based on individual eccentricities of physical and mental organization that influence the way in which people tend to think, feel, and act (i.e., personality types), whereas personality type can be defined as ‘the expression of the individual’s interaction with his environment’ (Hurley & Dobson, 1991). The purpose of this paper is to draw attention to these behavioral factors, as well as to nutrition as a factor that could influence the capacity to change. Finally, some common psychological models of behavior and an algorithm are described to assist the counselor in achieving change.

Uniqueness of behavior

The unique ways individuals interact with their environment can be grouped in accordance to favored paradigms. Hippocrates and Galen distinguished four temperaments, namely: sanguine, choleric, melancholy, and phlegmatic (Federspil & Sicolo, 1994; LaHaye, 1984). These temperaments have also been described as those of an artisan (e.g., promoter, implementer, operator, performer), rationalist (e.g., organizer, inventor, strategist), idealist (e.g., advocate, facilitator, mentor, diplomat) and guardian (e.g., traditionalist, supervisor, protector), respectively (Keirsey & Bates, 1984). In contrast, Jung (1921) distinguished six functional manners of communicating with the environment which are widely used as a part of the Myers-Briggs type indicator. According to Jungian psychology (Hall & Nordby, 1973), the paired manners of taking in (process of perceiving or becoming aware) and construing reality (decision-making process) are ‘sensation or intuition’ (the senses versus the unconscious) and ‘thinking or feeling’ (thinking versus values and standards for making judgments). The first one (becoming aware) depends on incoming stimuli, whereas the latter (decision-making) is rational and requires making judgments. The two manners of acting in response to ‘becoming aware’ and ‘making judgments’ (basic orientation to life) are being ‘extravert or introvert’ (outer world focus versus inner world focus). (Jung, 1921). In the Myers-Briggs, the lifestyle attitudes ‘judging or perceiving’ (outcome orientated versus process orientated) were added (Keirsey & Bates, 1984).

Although some individuals show no preference of the manner in which they communicate with their environment, most people have developed one side at cost of the other in each of the pairs. For example, males tend to develop the analytic thinking aspect and women the emotional feeling (Jung, 1921). For people to have opposing types of personality can be very useful. Sensing types benefit from intuitive types (e.g., future, creativity, enthusiasm), intuitive types benefit from sensing types (e.g., present moment, realism, facts, experience), thinking types benefit from feeling types (e.g., to conciliate and negotiate, know how others feel), and feeling types benefit from thinking types (e.g., to analyze and organize, to stand firm). Using the Myers-Briggs classification, Keirsey and Bates (1984) see artisans as people who are sensitive and who are good perceivers, rationalists as those who have developed their thinking and intuition, idealists as those who use their feelings and who are intuitive and guardians as those who are sensitive and judge. More typologies, or different interpretations of those of presented in the Myers-Briggs, have been described by Ross (2003) and others.

Personality types can be seen as tools that can be utilized to function in life. Each of us has been given one or more of types to use. Perhaps these are the ‘talents’ given to us and it is our task to rise above the strength and weaknesses of them and to add more tools (‘talents’) to our toolbox. Almaas (Glouberman, 2005) sees the personality as a mimicker of the soul (the soul being individual consciousness), and the personality as a collapsed version of the soul due to its delusions or fixations. Consequently, behavioral responses will be enhanced when individuals are totally free of the collapsed mind (synonymous for enlightenment).
Body typology

In the East as well as the West, three body types have been identified that have been associated with specific personality characteristics and mental diseases. In Ayurvedic medicine, three body types (doshas) are distinguished, namely, Vata, Pitta and Kapha (Chopra, 2001). Although some people may have many characteristics of one dosha, it is normal to have characteristics of all doshas. In brief, Vata types have thin bodies. They have fast and unsettled minds and behave in a lively way, particularly when they are under stress. They can be anxious and excited. Others may perceive the Vata type as impulsive (Chopra, 2001). Pitta types have medium sized bodies. They tend to be orderly and strong-minded, and can become angry and curt in stressful situations (Chopra, 2001). Finally, Kapha types have heavy bodies, but tend to be easy going. They remain steady and calm. Although they are perceived as being relaxed, they shy away and become silent under pressure (Chopra, 2001). The ancient typology is not dissimilar from the three constitutional groups proposed by Ernest Kretschmer in the early 1900s (the tall and thin asthenic type, the muscular athletic type and the plump pyknic type) (Kretschmer, 1948). The types were shown to differ in physical parameters such as chest circumference, head circumference and height, and proneness to mental diseases. Kretschmer’s research showed that the asthenic type is tall and thin and tends to be introverted and prone to developing schizophrenia. The athletic type is muscular, whereas the pyknic plump. The pyknic type is more likely to be extraverted and prone to developing bi-polar disorder (Kretschmer, 1948). As with the doshas, many people have characteristics of more than one body type.

There is accumulating evidence that body and mind, or rather the physical and the non-physical, are intrinsically connected. As recognized in Chinese Medicine, one is a reflection of the other, and dysfunction of one is related to a dysfunction of the other. For instance, pain and disability have been associated with psychological factors such as depression or distress (Badcock, Lewis, Hay, McCarney, & Croft, 2002; Buckley et al., 1999; Cataldo, 2001; Ektor-Anderson, Isaesson, Lindgren, & Orbaek, 1999; Ericsson et al., 2002; Manninen, Heliövaara, Rihimäki, & Mäkelä, 1997; Ormel et al., 1997; Penninx et al., 1996; van der Windt, Croft, & Penninx, 2002), whereas psychological factors and behavioral traits have been associated with problems such as headache (D. A. Marcus, 2000), back and neck pain (Linton, 2000), functional gastrointestinal problems (Tanum & Malt, 2001) and stroke-related death (Carney & Freedland, 2002; May et al., 2002). In mind-body focused healthcare, it is important to be aware of the presence of common negative emotions such as fear, anxiety, anger, hostility and sadness, because of their effect on mental and physical health. For example, people with depressive behavior are four times more likely to have a heart attack than others who do not depress (Lotufo, Chae, Ajani, & et al, 2000).

Observing physical and non-physical features clients exhibit can complement the assessment and subsequent treatment. These features include general appearance, body shape, body language, voice, physiognomy (e.g., facial lines that show sadness or cheerfulness), use of language, beliefs and knowledge, and may be indicative for personality type, self-worth, mood or negative response patterns. In the East, practitioners have used facial diagnosis for many centuries (Kushi, 1983). Although this area needs more research, specific features such as vertex baldness (top of the head) (Lotufo, Chae, Ajani, & et al, 2000) and earlobe creases have shown to be strongly associated with cardiovascular disease, particularly creases that are present bilaterally (Elliott & Powell, 1996).

Food for enhancing mental health and well-being

It is widely accepted that a well-balanced diet enhances physical function and health. Restoring nutritional imbalances have been associated with reductions in severity of illnesses and even complete recoveries (Werbach, 1993). The relationship between nutrition and mental health is less known and accepted. Studies show that the quality of food intake can have an impact on how a person feels and thinks. For example, depressive behavior has been associated with a deficiency in Omega-3 (Tiemeyer, Van Tuijl, Hofman, Kiliaan, & Breteler, 2003) and vitamin D (Hoogendijk et al., 2008). Correct nutrition can enhance mood and emotional stability, and improve intellectual capacity and memory (Holford, 2003).

In his book, Holford describes the five brain foods that are important to maintain optimum mental health, namely, balanced glucose consumption, and an adequate intake of essential fats, phospholipids, amino acids and intelligent nutrients. Glucose is the energy source of the brain. Complex carbohydrates have a low glycemic index and provide a more evenly distributed source of energy than the ups and downs caused by digesting refined foods (simple sugars) with a high glycemic index. A balanced carbohydrate consumption can minimize symptoms such as fatigue, poor concentration and memory, irritability, depressive behavior, sleep disturbance, blurred vision, dizziness, sweating and digestive problems (Holford, 2003). The use of sugar substitutes such as aspartame is not recommended, particularly for people who exhibit depressive behavior. Aspartame has been associated with nausea, memory problems, increased depressive behavior and temper in those who exhibit this mood disorder, and nightmares and poor memory in a control group of health individuals (Walton et al., 1993). Findings show that the use of the natural sweetener stevioside, found in the Stevia Rebaudiana Bertoni plant, is a better alternative for those who wish to add sweetness to foods (Jeppesen, Gregersen, Alstrup, & Hermansen, 2002; Jeppesen, Gregersen, Poulsen, & Hermansen, 2000).
The transference of messages in the central nervous system requires essential fats (seeds/nuts, fish), phospholipids (egg, meat), amino acids (protein), and vitamins and minerals to assist the formation of neurotransmitters that can be sent effectively from sending stations to receiving stations. Neurotransmitters such as serotonin can influence moods and induce feelings of happiness (Holford, 2003). It is therefore important to ensure that diet contains these five essential ingredients to enhance the function of the brain. Holford developed a checklist to find out if symptoms can be related to each of these five areas.

1. Poor concentration. lack of energy, drowsiness, dizziness, irritability, and craving for carbohydrates, sweet foods, alcohol, coffee, tea, tobacco or chocolate can indicate that there is a glucose imbalance.

2. Dry or rough skin, eczema, poor concentration or memory, water retention, eye problems (dryness, itchiness or watery), chronic inflammatory conditions may be a result of a deficiency of essential fats (omega-3 and omega-6). Eating the wrong fats (fried foods, chips) can aggravate these conditions.

3. Forgetfulness, poor concentration and memory, learning difficulties, and depressive behavior have been associated with insufficient intake of phospholipids. Phospholipids can be found in lecithin, nuts, fish, egg and soy products.

4. Anxiety, irritability, tiredness, lack of motivation, depressive behavior, poor concentration or memory, low blood pressure, delayed hair and nail growth, feelings of hunger or indigestion can be caused by an amino acid deficiency. Amino acid rich foods include pulses, tofu, nuts, grains, fish, egg, dairy and meat.

5. Anxiety, irritability, depressive behavior, muscle cramps and white fingernail marks have been related to a lack of vitamins and/or minerals. Holford calls these “intelligent nutrients”. They can be found in fresh fruit and vegetables, and supplements. Factors such as smoking, drinking alcohol and stress can deplete the reserves of some of these nutrients.

It is possible that specific food combinations can aid digestion and subsequent absorption of nutrients. Some foods need to stay in the stomach for much longer than others. For example, there will be a big difference between melon and cheese. Ingestion of both at the same time may not be beneficial and may cause bloating and other problems. Also, it is possible that people with different blood (D’Adamo & Whitney, 2001) or body types (Chopra, 2001) require different ratios of particular foods to stay healthy.

Choosing positive actions and how to maintain them

When experiencing difficulties such as unhappiness, relationships problems, obesity and/ or ill-health, it is common to have good intentions to start a set of actions that are likely to enhance health and wellbeing, although it can prove extremely difficult to maintain these positive actions. Social support and counseling, for example reality therapy, can assist in empowering people, in thinking realistically, taking responsibility for their own lives, and adhering to a particular program they set themselves to do. Reality therapy has been applied in the management of arthritis (Maisiak, Austin, & Heck, 1995), and could be a suitable cognitive behavioral method to be used in conjunction with the framework of specific psychological models of behavior. From a choice theory point of view, intentions and the actions that are based on these intentions can be associated with meeting specific needs, for example, changing diet and increasing physical activity in order to lose weight and feel invigorated/powerful, or to prevent diabetes or a heart attack and increase the chance of survival, or singing and smiling to have more fun. Needs satisfying relationships form a basis for good health.

Fostering internal motivation and choosing caring habits such as listening, supporting, encouraging, negotiating, respecting, accepting and trusting can assist in achieving agreed goals and maintaining programs that meet needs for survival, power, fun, love and belonging and freedom (Glasser, 2001), or in Maslow's context, lead to self-actualization (defined as “the desire to become more and more what one is, to become everything that one is capable of becoming” (Norwood, 2004)).

Whatever actions are initiated and maintained, they should benefit the person who performs them and should not be performed at detriment of others. This is referred to as responsibility, taking responsibility for one's health and that of others in the context of opportunity rather than obligation. Using choice theory (Glasser, 1998, 2003) together with models such as the health belief model, transtheoretical theory of stages of change or the social learning theory may increase the likelihood of successful behavioral change.

Common psychological models of behavior and the step-model

In the Transtheoretical Model of Stages of Change, change of behavior is dependent on the personal readiness for that particular change to occur (Prochaska & Velicer, 1997). This readiness may depend on whether the desired behavior or outcome matches what is in one's perceived quality world or whether there is a perceived susceptibility to a disease, as in the health belief model (Egger, Spark, Lawson, & Donovan, 1999). The stages of change in this transtheoretical model help to identify the cognitive and behavioral processes that accompany various stages while trying to achieve change (e.g., weight reduction, quit smoking, fitness training), and include precontemplation, contemplation, preparation, action, and maintenance in a sequential manner. This process of stages of change is not
always linear, but can be cyclic in the event of individuals making more than one attempt to change their behavior. Each stage of change during each cycle is unique. Different cognitions are thought to be relevant for each of the stages the model has (Horne & Weinman, 1998; Norman & Conner, 1996), but low self-efficacy is regarded as a salient cognitive barrier to program adherence. Although the principles of this model have been applied to exercise (B. H. Marcus, Rossi, Selby, Niaura, & Abrams, 1992; Prochaska & Marcus, 1994), criticisms of the stage models (and social cognitive models) include that they do not provide an adequate answer for the continuation of motivation in order to maintain exercise behavior (Horne & Weinman, 1998).

The Social Cognitive Theory is also known as the Perceived Self-Efficacy Theory or the Social Learning Theory. Instead of a one-way relationship from the environment on the individual, Bandura recognizes through his theory the interaction between the individual on the one hand and the environment on the other (Bandura, 1986, 1997). Individuals learn through observation of their own experiences and the ones of others. They, subsequently, select through interpretation the desired course of action. Judgments of what can be achieved with particular skills are reported to be more important than the actual skills themselves. Factors such as outcome expectancy and confidence in personal ability (self-efficacy) are components of perceived personal control in the social cognitive theory. In other words, the theory takes into account the mutual influence of perceived personal control, environmental events, and behavior. As for the initiation of action in choice theory, the difference between the actual personal achievement and the personal goal (standard) facilitates self-change through self-initiated reactions (Bandura, 1986, 1997).

Multi-component models such as the 'step-model' include the training of specific skills in order to assist the person's self-regulatory ability. The model was developed to facilitate behavioral change and ongoing self-management (Van der Burg & Verhulst, 1996, 1997). Each step may require a different (educational) intervention strategy, based on individual needs, in order to maximize coping skills. Steps include being receptive to the information (opening up), understanding the information, willing to act on basis of this information (factors include attitude, social influence, and self-efficacy), ability to perform the required tasks, performing the required activities, and persisting to perform. The level of belief in one's personal ability to perform specific tasks is a predictor of motivation and behavior. Perceived personal ability to perform may be low in people who have an external locus of control. Personal self-efficacy beliefs can be improved through performance mastery, modeling, reinterpretation of physiological symptoms, and persuasion. In this theory, a subsequent higher level of self-efficacy leads to improved thinking patterns, motivation, behaviors and emotional well being. Values of particular objects or outcomes such as a good health status, better looks, or feeling better can work as incentives. Threats to these personally valued outcomes and the belief in one's capability to change can facilitate behavioral changes (Egger, Spark, Lawson, & Donovan, 1999).

Long-term behavior change is a complex issue, which requires simple short-term goal setting and breaking down the desired behavior into manageable components (Fox, Breuer, & Wright, 1997; Oettingen, Honig, & Gollwitzer, 2000; Oettingen, Pak, & Schnetter, 2001). Self observation during the program, judgment whether goals that were planned have been achieved, and rewarding oneself when goals have been attained are necessary to control one's behavior. Accomplishment is enhanced when goals are kept small, and when they are manageable and readjusted at regular times in order to keep up the challenge. Although it is important to have long-term goals, the chance of achieving them is greater when many small short-term goals are positioned along the way. Goal attainment is a rewarding activity for most people. To increase the chance of success of modifying someone's behavior one could ask the following questions (Lorig, 1996):

- Why is it so difficult to adhere to the program?
- Is there evidence that adherence will enhance health and wellbeing?
- Does the client believe that adherence to the program will help?
- Are problem and action plan clearly understood?
- Does the client have the required skills to carry out the program?
- Is there a confidence in client's capability of addressing the problem?
- Is there the willingness to adhere to the program?
- Is adherence to the program punishing?
- Is there an advantage to not perform the program?
- Is the required behavior too complex or is poor memory an issue?
- Does the client have the mental capacity to learn and/or the physical capacity to perform?

Education on lifestyle issues and the use of cognitive behavioral intervention such as reality therapy, in the form of individual or group counseling, can help to discover the relevance of specific treatment methods, identify possible barriers to program adherence, raise program outcome expectation, expectations of personal success, setting realistic goals, determining appropriate strategies, initiating goal directed actions, monitoring performance, evaluating outcomes and readjusting the program as needed (Oettingen, Pak, & Schnetter, 2001; Zimmerman, 1998).

Figure 1 shows an algorithm (flow chart) that can be helpful to identify appropriate actions that are needed to optimize program adherence (Lorig, 1996).

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IN CONCLUSION

Interprofessional client management and the use of cognitive behavioral intervention can be very useful to address problems that impinge on mental and physical wellbeing effectively and efficiently, including adopting and maintaining a lifestyle with positive dietary habits.
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Application of Choice Theory with a Student Whose Parent is Incarcerated: A Qualitative Case Study

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ABSTRACT

Substantial numbers of persons are incarcerated in countries around the world. Many prisoners are parents, and incarceration prevents them from functioning as the primary caregivers for their children. Children of prisoners are said to experience academic, behavioral, and social problems in school. The problems are often partly related to parent-child disconnection due to the parent's incarceration or the factors that predate the incarceration. In this brief paper, the phenomenon of children of prisoners is reviewed and the children's school-related challenges are described. In addition, we present a qualitative case study to illustrate how choice theory, and its principles of connecting habits, can be employed as an ideal therapeutic model to improve the psychosocial functioning of children of prisoners.

Approximately 2.2 million persons are incarcerated in the United States, 1.5 million in China, and .9 million in Russia (King's College London, 2007). Many of these prisoners are parents of minor children. For example, in 1999, it was estimated that approximately 1.5 million children of prisoners (COP) resided in the United States (Mumola, 2000). These children have a greater probability of experiencing psychosocial and school-related difficulties (Poehlman, 2005; Shillingford & Edwards, 2008).

Functioning of COP

Limited research is available that describes the functioning of COP. Nonetheless, the available data suggest disruption in parent-child relationships as a result of parental incarceration negatively affects many children (Poehlman, 2005). These children often experience feelings of shame, social stigma, loss of financial support, weakened ties to parents, poor school performance, increased delinquency, and increased risk of abuse or neglect (Travis, Cincotta Mcbride, & Solomon, 2005). Some COP even experience long-term effects such as negative perceptions of police and the legal system, increased dependency, decreased ability to manage future stress or trauma, disruption of development, and intergenerational recurrence of criminal behavior (Travis, Cincotta Mcbride, & Solomon, 2005).

It is important to note that not all COP are negatively affected, as some COP are resilient and can thrive and experience successful psychosocial functioning despite their parent's incarceration. Moreover, not all COP are affected to the same degree. Among a host of other reasons, the effect depends on whether the mother or father is incarcerated, whether both parents are incarcerated, whether the parent resided with the child prior to the incarceration, the age of child at the time of the incarceration, the remaining caregiver's (or caregivers' such as grandparents) parenting skills, the type of supportive services the child receives at school, and the length of incarceration or parent-child disconnection (Edwards & Ray, 2008).

Loss of Connections

The connections young children make with their first caregivers influence their development, psychosocial functioning, ability to make appropriate choices, and their success in school (Poehlmann, 2005). COP whose connections to their parents are unexpectedly or forcefully disrupted or severed will likely be deprived of a consistent relationship with one of the caregivers biologically and socially charged with modeling good choices and appropriate relationships (Edwards & Ray, 2008). Further, the children will have fewer opportunities to learn how to develop positive connections to others. The children may begin to question parental authority and experience difficulty trusting adults and peers (Edwards, 2006; Travis, Cincotta Mcbride, & Solomon, 2005). The effect of parental incarceration is particularly pernicious when mothers are imprisoned. Children whose mothers are prisoners experience parent-child disconnections that often result in severe depression, anxiety, and/or aggressive and other antisocial behavior (Dalley, 2002).

As a function of their developmental history of parent-child separation, disruption, and disconnection, COP may have difficulty making appropriate choices and developing positive habits. Although their remaining caregiver(s) can model positive habits and relationships, early childhood is a period when children learn how to relate appropriately to others and the absence of a mother or father may hinder the child's relationship-building skills (Poehlmann, 2005).
Relevance of Choice Theory

Since the cornerstone of choice theory is that all human behavior is a function of personal choice, COP can be taught how to choose behaviors that foster positive relationships and engage in behaviors that will get them what they want without unfavorable consequences. They can learn to avoid the seven deadly habits that damage relationships (Glasser, 1998): criticizing, complaining, blaming, threatening, nagging, punishing, and rewarding to control. In addition, they can be taught to mobilize the seven positive habits that lead to connected relationships: accepting, respecting, listening, supporting, trusting, encouraging, and negotiating differences. The case study in the next section illustrates how the first author used principles of choice theory to improve the psychosocial functioning of a pre-adolescent boy whose father is incarcerated.

A Qualitative Case Study

A is a fifth-grade African American student who resides with his mother and three siblings. His father has been incarcerated for the past five years due to drug-related charges. A was referred to me, the school counselor, by the school principal because of A's frequent fighting with schoolmates and use of profanity with teachers.

Upon the initial meeting with me, A appeared angry. He stomped into the counseling office and initially refused to speak. After building rapport with him, I asked him to talk about his feelings and he eventually mentioned that everyone was against him and no one understood what he was going through. I asked him to explain what he meant and he shared that he was always getting into trouble at school and home despite trying to behave properly. He indicated he believed his mom was too tired and stressed to have much free time with him. He also revealed that his father was in prison and thus was unavailable to help him, his mother, and his siblings. One striking statement that A made during that first visit was “I have no choice but to be angry, nothing is working out right.”

Behavioral Themes

During our initial two meetings, A and I explored some of the incidents that were reported about his behaviors. We were able to identify some of his persistent, ineffective choices and behaviors that led to unwanted consequences. For example, he often got into trouble and was disciplined because he frequently belittled other students on the school bus (criticizing). His physical education teacher indicated that A “harassed” female peers on the playground by calling them derogatory names. This teacher further noted that there were times when other students complained of A threatening them if they did not allow him to play with them. His classroom teacher expressed concern about A's lack of effort and refusal to complete in-class assignments. A indicated that “the work is too hard, they’re making too much noise” (complaining). Additionally, A frequently did not complete homework assignments and he blamed his mother by making statements such as “my mom is not home to help me so I couldn’t do it” (blaming). Taken together, these behavioral themes indicated A was not making appropriate choices when interacting with other persons and was not doing well in school.

Case Conceptualization and Hypotheses

A and I discussed and processed each behavior (negative habit) to clarify the reasons why they were occurring. We discovered that A's anger and difficulty managing his anger caused some of his problems at school. He was angry at his father for making ineffective choices and his lack of availability. He was also angry at his peers because they teased and denigrated him about of his father's incarceration. As we addressed the incarceration, A was able to convey that he did not want to become a prisoner like his father and that he wanted to make better choices by controlling his anger and coping with his father's absence from his life. He recognized that his negative habits were inappropriate and ineffective because he did not get what he truly wanted – a better relationship with his family and connected, caring relationships with friends and school staff. We established that A was disconnected from his social network. In addition, his behaviors were conscious choices and that he had the power to control these choices.

After the first two sessions, I decided that choice theory was the appropriate theory-driven approach to apply when working with A given his social disconnection and his obvious ability to make more positive choices. I hypothesized that the abrupt and unpleasant separation from his father and the subsequent effects of his father's incarceration were implicated in A's problems establishing and maintaining positive interpersonal relationships. Based on these hypotheses, choice theory, with its emphasis on disconnectedness as the source of many human problems, seemed to be the ideal theoretical lens to conceptualize A's situation and design therapeutic strategies.

Choice Theory Strategies

A and I discussed the relevant components of choice theory. We evaluated different scenarios when he made negative choices and reflected on how each choice affected him. We also discussed his father's incarceration and choices that his father made that ultimately caused his incarceration. We decided that a behavior contract should be developed. The goal of the contract was to empower A to make more positive choices. This contract included A meeting with me for about 15 minutes each week for four weeks. He also agreed to participate in a small counseling group for six consecutive weeks and a mentor program with another adult staff member.
Individual and Small Group Support

Each week, A and I worked on different positive habits through role-play, modeling, and homework assignments. For example, we discussed a situation when a friend did not want to play a particular game that A wanted to play. We role played listening and respecting the perspective of his friend. I also taught him how to negotiate differences by discussing other options such as playing the game his friend wished to play and then the two friends could play a game that A wanted to play. A and I were able to use this strategy to help him make choices to improve his relationships with peers and school staff. As A connected with me and other school staff, he became more effective at making prosocial choices.

Furthermore, I began a small counseling group to help A learn to more effectively generalize positive behaviors to different people and contexts. The group included four other students with social skill deficiencies and anger control issues. These students frequently made poor choices, manifested one of more of the seven negative habits, and exhibited diminished awareness or use of the seven positive habits.

Group meetings began with each student sharing a feeling he or she experienced that week. Students learned to listen without interrupting when others shared. I showed the students how to encourage each other by linking their similar experiences. I was able to build connections with these students by supporting them and by accepting their stories in a non-judgmental way. As each student situation was different, the initial phase of the group brought some disconcerting moments such as when group members indicated the following: “well at least you have a father” and “why are you here anyway, you [are] just looking for attention from Ms. S.” I was able to help them recognize their differences and accept each other as valuable persons.

The WDEP Scale

It was important for me to consistently remind students that their behaviors involved personal choices that resulted in positive or negative consequences. They learned how to use the WDEP scale (Wubbolding, 2007) to make choices that resulted in positive outcomes. In this scale, the W refers to “what do you want”, D designates “what are you doing about it”, E is “evaluation”, and P refers to mobilizing the “plan” (Wubbolding, 2007). We were able to use the scale to construct different scenarios and develop and discuss choices that advanced favorable outcomes. For example, a group member shared that she wanted (W) to play with her friends when she got home from school. What she did (D) was to complete much of her homework in the after-school care program. Based on her evaluation (E), her plan (P) allowed her ample time to play with her friends when she arrived at home.

Mentors

To provide students with an additional support network and secure connections to other persons at the school, each student was paired with an adult mentor (e.g., the school social worker). The mentors were encouraged to discuss behavior choices with their students and to facilitate use of the seven positive habits. For example, a student indicated to her mentor “I am going to choose to have a good day today because I want my mother to be happy.” Another student noted that “I am going to choose to have a good day because I want to do well in school.” Students were then instructed to state what they were doing to ensure a good day, to self-evaluate the effectiveness of their choices and behaviors, and to systematically plan at least two options to ensure the good day.

Results

To determine the results of this therapeutic approach, students developed a signal with me so that when our paths crossed on the school campus prior to our group meeting, they would give a thumbs up for “good-choice-day” and thumbs down for a “not-good-choice-day.” We were able to discuss in group sessions each week the number of “thumbs-up-days” and “thumbs-down-days” and what role their choices made in the outcome. We also explored how they used the WDEP scale to make more positive, prosocial choices.

Generally, all students made behavioral improvements. In particular, by learning to apply the principles of choice theory, A distracted his classmates less frequently and rarely made fun of their mistakes. He also stopped fighting with them. Although he still experienced some conflicts with other students, his psychosocial functioning improved by employing the WDEP scale and various combinations of the choice theory’s positive habits.

CONCLUSION

Although some COP experience favorable psychosocial and school functioning, others may feel abandoned, disconnected, and stigmatized. These feelings may be partly responsible for the children’s psychological distress, mistrust of others, and difficult school functioning. Children who distrust others have difficulty developing a sense of connectedness to important members of their social network such as classmates and school staff. Choice theory is relevant to the experiences of COP because it provides a conceptual lens from which to understand their experiences and it offers a framework to guide the implementation of school-based therapeutic services. Moreover, it provides an empowering message to these students that they have control over the choices they make, even when the adults in their lives do not make positive choices.
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Machination, Medication, and Mutilation

Josephine

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ABSTRACT

A personal narrative of the journey of a self-mutilator from negative to positive behavior.

I was never one of those kids. You know—the really crazy ones. The ones who lurk in the corners between the lockers and the staircase, the ones you hear about from parents, the ones you stay away from. Sometimes they come to school sporting hospital admission bracelets from their wild nights or their stints in rehab. Many have scars lining their arms and wear dark clothing. They carry razor blades and safety pins. They growl at people, they say “f*ck the world,” they put their pain on display and dare people to ask them what happened. Fortunately, their openness about their suffering, however abrasive, allows them to ask for and receive help. It’s the quiet ones, the liars, the ones who slip through the cracks that are in the most danger.

I was a quiet one, your average student. Charming and pleasant, I made a lot of friends and navigated all of my academics and extra curriculars with ease. I was a vocal coach for little kids and a respected employee. I was considered a well-adjusted, bright teenager right up until the day I was rushed to the Emergency Room at the end of my sophomore year.

It wasn’t vicious high school cliques or a traumatic prom experience that led me to that cold, sterile room in the ER. While high school exacerbated the frustration and anger, the real problem was me. For years, I had hated every inch of the image I projected, and clung to desperation and hope that I would somehow change. I hated myself and my life, and felt I needed to punish myself. I cut my legs viciously, trying to extract meaning from my life and deal with the misery that coincided with deep self-hatred. My self-inflicted wounds have yet to heal entirely, and have left deep, ugly scars that are unable to be corrected by surgery. Now, over a year later, I have come to a crossroads in my life. Scarred by years of self-imposed misery and suffering, and moving forward to create a new life, I have to ask myself: what was it all for? How can anyone possibly get over something like this? How did I?

According to helpguide.org, more than two million people in the United States self-injure, and about one percent of the population has intentionally hurt themselves to cope with an overwhelming situation. More alarming, Dr. McVey-Noble suggests in When Your Child is Cutting that fourteen percent of students confirm engaging in self-injurious behavior at some point (p. 23). She writes that researcher Amanda Favazza divides self-injury into four categories: impulsive, major, stereotypic, and compulsive. According to the authors at helpguide.org, the most common type of self-injury is impulsive, intentional injury to one’s body with the objective of hurting oneself to cope with an emotionally distressing situation. This includes cutting, burning, skin-picking, hair pulling, hitting or banging, and in more severe cases, bone breaking and amputation. McVey-Noble suggests that the overwhelming majority of self-injurers are female, “although we think that this number may be low, because males may underreport this symptom in treatment or psychiatric settings, viewing it as behavior more commonly associated with females.” (p. 23)

I can handle damage. I can’t handle endings. In November of my freshman year I sat alone in my room, writing furiously in my notebook, trying to justify my actions. Summer had ended, along with most of my friendships from middle school, and I felt completely alone. I gingerly ran my hand across my legs, wincing slightly at the touch. A wave of remorse flowed through my body and thoughts of regret flashed through my mind. I quickly pushed the feeling aside, telling myself I was being ridiculous. It was too late. I wasn’t allowed to regret cutting; it made sense to me. Dragging a blade across my skin seemed so much easier to deal with than anger or sadness or fear. It was simple. Cut, clean up, move on. When emotions were swerving out of control, hurting myself brought me back to neutral. I would endure the pain until I felt nothing at all. Sadness didn’t exist. Nothing existed but the dull throb in my leg. I saw no reason to stop. In fact, I thought I should be credited for having found a way to survive by expressing my emotions through physical injury.

McVey-Noble suggests that one of the most common reasons for self-injury is an inability to cope with intense emotions. When being barraged by feelings of self-hatred, guilt, loneliness, anger, or sadness, cutting serves as a way to process these emotions (p. 29). Tracy Alderman, author of Scarred Soul, suspects that adolescents and adults who hurt themselves never developed the ability to release emotions. When emotions intensify, there will be an explosion. If a child is raised with adults who are emotionally inept, she never learns how to deal with emotions. That
In this situation, simply crying may not be enough to release the huge collection of grief, and a more drastic solution seems warranted. Appropriate expression of emotions must be taught just like any other skill, and, unfortunately for kids like me, without a lot of knowledge or practice, there are a lot of explosions (p. 31).

I have often been told my cutting may have served as coping mechanism; this in a sense is the easiest way to approach self-injury. Before coming to the John Dewey Academy, the therapeutic boarding school I currently attend, every therapist I had encountered clung to this concept, distributing massive lists of “coping mechanisms” that are supposed to help self-injurers replace their destructive behavior with more productive actions. The alternative “coping mechanisms” range from reading a book to drawing red lines on the arm to satisfy the desire to see blood. These “coping skills” enraged me beyond comprehension. When I was fuming or miserable, I could not possibly think of anything I’d rather not do than reading a book, taking a shower, or doing any of the other hokey solutions provided. When I felt like I wanted to hurt myself, I was full of impulsive, destructive energy. I needed action. Sitting on my bed reading quietly was not exactly the best alternative. Besides, even if those coping skills had proved to be a helpful alternative, I wasn’t actually dealing with my life or what was bothering me. It was simply another distraction, another way to run away from what I was feeling instead of really dealing with my feelings. Some of the more “extreme” ones included snapping a rubber band, holding ice until it melts, or using other types of satiation techniques; I found these hilariously ridiculous. Replacing self-injury with a lesser form of self-injury is still, believe it or not, self-injury. I could not heal if I continued to hurt myself, no matter how much “less damaging” it was. Besides, cutting as a coping skill was just the tip of the iceberg; it was the desires behind it, the dark secrets, and the feelings that led me to hurt myself that needed to be addressed.

That’s the great thing about being numb, someone once told me, because when you’re numb, nothing can hurt you. I strove to be numb, to shut down all feeling so I could be invincible. I grew up in an environment where emotions were messy and shameful, a sign of weakness. I hated to feel. Strength, to me, was endurance, and anything to the contrary was a sign of pitiful weakness. I stuffed down all of my emotions so I could be numb. Numbness was safe to me, and when emotions would surge up, my chest filled with fury and I lost control. I felt weak, which was unacceptable. In those moments, things seemed to slow down and words formed in my head, playing over and over. My mantra, I want to destroy, I need to destroy. I’d grit my teeth, I’d ball my fists. And I’d let it all explode. If there were nothing else to hurt myself with, I would slam my fists into my body until I couldn’t move anymore. I wanted to punish, destroy, kill all feeling in my body so I could be as shut off as everyone else around me. I felt like I was inherently bad, wrong, pathetic, and I hated myself for not being good enough.

“People who engage in self-inflicted violence are often overly critical of themselves,” Alderman explains. “The internal criticism facilitates their acts of self-injury. Criticism—internal or external—leads to feelings of shame and blame, which lead in turn to self-punishment (p. 46).” Every time I made a mistake I believed I deserved punishment. I abused myself so no one else could. Without punishing myself, I felt guilty, because I believed I deserved it. I scoffed at my emotions, and when they would spill out, fear clawed at me: I hated not being in control.

Cutting myself was the ultimate sign of control. When I cut, I was in charge. No one else could hurt me the way that I did, and I loved the intoxicating rush of adrenaline and reassurance that I had done justice; I had gotten what I believed I deserved. Control, Alderman writes, “is an essential component in each of our lives, and perceiving that we have control is indisputably important to our mental health (50).” She continues:

On a very primitive level, [self-inflicted violence] replicates the sense of control we had when we were children; it is a way to control our physical being... Many episodes of SIV are triggered by feelings of lack of control. By planning and carrying out acts of self-harm, you are, in a sense, structuring your life by controlling your emotional states. (50)

At home, I was terrified of losing control. I came from a picture-perfect family in the suburbs, where the lawn was always green and the neighbors were always smiling. In fact, we were all smiling, always, because that’s the way it was “supposed” to be. Nobody cried or got angry, at least not in front of me. The idea of displaying emotion in front of the members of my family was horrifying to me, and I did everything in my power to prevent it. I shut down and vowed never to be weak. I maintained my apathetic image by exploding in the solitude of my bedroom. Once I closed the door gently behind me, fury and tears would pour out and I would begin the process of terminating all emotion. I cut until I felt nothing. I wrestled with emotion until I won, and re-emerged smiling, so as not to give myself away.

Despite my fear of being discovered, part of me wanted everyone to know. I wanted to be noticed. More than that, I wanted to be saved. I didn’t think I could do it on my own, and I wanted someone to save me without having to do the work. I was desperate but lazy. Part of me wanted to shock people, to watch their reactions as I revealed my cuts to the world. Had I indulged in that desire, I would not be in the position I am in. I craved more than just pain and control; I craved what Steven Levenkron describes this as “negative attention”: 
She is damaging herself in full view of the world. When others around her find out what she is doing to herself, they become frightened for her, sometimes angry at her, while expressing their worry and helplessness to her. This intense focus and attention is gratifying in its own way, despite the fact that anger, worry, and fear are what we call negative attention. She also feels more powerful when she commands this type of attention. (111)

I have known teenagers who deliberately hurt themselves only to gain negative attention when they felt they were sick of being ignored. Unfortunately, negative attention is the most unsatisfying drug. The rush of feeling powerful is fleeting and insatiable, and leaves a sour taste of emptiness and loneliness behind. And sometimes that can never be shaken.

What's wrong with what I'm doing? I used to ask myself. At least I've found a way to survive, to manage things. I function in society. I get good grades, and nothing can hurt me. What's the problem? Although I believed this, part of me was scared for my life. The problem ran deeper than my external appearance or performance in school. I was not invincible; I was addicted. I felt an intoxicating rush each time I hurt myself, and I craved more. A small slash didn't satisfy me anymore—as I continued to cut myself, I needed deeper and deeper wounds to feel better. Just can't figure out how to live. I wrote, shortly before I was rushed to the emergency room. I was panicking. My control was diminishing and I was a slave to a scalpel. Both feared and desired death. In a chillingly detached journal entry, I described the way I felt shortly before I went too far, and the part of me that cared was drifting away. I was too afraid to tell my parents I was in trouble. I was so detached from reality that I feared "getting in trouble" more than saving my life. I didn't know if she could see me, but I could see her. Unable to watch anymore, I closed my eyes and drifted off to sleep. I was awakened by the ambulance GPS system blaring, a loud voice indicating a wrong turn. We turned around and pulled into a long driveway leading up to a large white house. I thought it was beautiful. Two EMTs opened the doors and carefully unloaded the gurney. And so it began: the emotional whirlwind of hospitals, therapy, medication, doctors, and surgeons. And, of course, the one nagging question: what? Somehow I'd made it this far; where is the hell do I go from here?

Strapped to a gurney on my way to a psychiatric hospital, I watched my mother's Subaru through the window of the ambulance. I could just barely make out her face. Ridden with guilt, shock, and panic, she stared blankly ahead. I didn't know if she could see me, but I could see her. Unable to watch anymore, I closed my eyes and drifted off to sleep. I was awakened by the ambulance GPS system blaring, a loud voice indicating a wrong turn. We turned around and pulled into a long driveway leading up to a large white house. I thought it was beautiful. Two EMTs opened the doors and carefully unloaded the gurney. And so it began: the emotional whirlwind of hospitals, therapy, medication, doctors, and surgeons. And, of course, the one nagging question: now what? Somehow I'd made it this far; where is the hell do I go from here?

Unfortunately for my distraught mother and father, that question would never fully be answered. I went many places from that ambulance, many of which made things worse. My parents arrived at a solution nearly half a year later, and by then, it was almost too late. Regardless of the location, however, recovery is really the answer, the next step. Numb, confused, and lost, recovery and hard work was not the answer I wanted to hear. I still wanted someone to save me. I wanted an easy answer, an easy pill. A quick fix. Escape was all I knew, and recovery was the opposite. There are many ways to ask for help in a healthy way; I did not know any of them. Recovering from serious self-injury is impossible to do alone. I needed all the help I could get, though I resisted almost every single form of it.

Being hospitalized probably saved my life. I do not know what would have happened had I been left to my own devices. I had fallen in love with cutting and I was unable (and unwilling) to keep myself safe or healthy. It
had replaced everything important in my life, and consumed all of my thoughts, time, and energy. The hospital, physically and metaphorically, served as little more than a band-aid. I was sleep-deprived so they drugged me to sleep. I was underweight so they fed me. I was unstable so they medicated me. They took care of my every need because I simply couldn’t do so for myself. Interestingly enough, my cure coincided with the day my insurance ran out. Three weeks later, I had color in my cheeks and a spring in my step, but my mind remained dark and obsessive. I was discharged from the hospital and began a summer of intensive therapy.

The “intensive therapy” program turned out to be a total joke. We played hangman, cards, and other inane therapeutic games. I manipulated my therapists into believing I was perfectly fine, that everything was a big mix up, and I graduated the program weeks earlier than they had anticipated. Sadly enough, the combination of intensive therapy and psychotropic medicine are the most commonly prescribed methods to deal with self-destructive behavior; but only if the self-injurer is willing to reap the benefits of it. As a stubborn, intelligent, self-righteous teenager, I was defiant and unwilling to accept help. I thought the program was a joke, and thus rejected its therapeutic approach. Traditional therapy as a whole seemed theoretically helpful, though I had a hard time grasping the concept. In Cutting, Levenkron writes about the merits of therapy:

Psychotherapy is an opportunity for learning about healthy relationships: the relationship between the therapist and the patient teaches the self-harmer new ways of relating to herself and others. What is missing in the world of the self-mutilator is trust and healthy attachment to other people; these emotional building blocks can be developed within the therapeutic relationship. (185)

Traditional therapy was easy for me to fake progress in by using my charisma and cordiality to appear better and healthier. Therapists are not trained to confront dishonesty or to supportively force them to live a healthier lifestyle. I had no respect for my therapists, because I could manipulate them. I could switch personalities instantly. When I needed to be charming and charismatic and polite, I was. My dishonesty rendered traditional therapy useless. I needed someone who wouldn’t let me put up a façade. Soft-spoken therapists and “I feel” statements could not make me change. I needed reality, because if I had continued what I was doing, there wouldn’t have been a reality. I needed something new and outrageous to shake things up, to show me I wasn’t the one in charge.

"You fucking asshole!" Tom bellowed. "You are totally fucking bogus and everybody knows it." I sat in the group therapy session, staring wide-eyed at my sixty-nine-year-old therapist. Each kid in the group watched me as I fumbled to find a smooth response. Lost for words, I stammered that I was unhappy, to which he responded, "So change! If you want to drown in a pool of your own self-pity tears, then get your sorry ass out of here. You possess the power to change. You have to justify your existence to yourself. What is frightening is that you are forced to make one of the most important decisions of your life and you have only been here four hours. If you want to gain self-respect and be successful, then stay. But if you want to bullshit yourself and everyone else, do us a favor and leave." He was a lunatic. He was unconventional. He was abusive. And I needed him. Sweet-talking therapists could never make me change. He terrified me, but I needed him to whip me into shape. I gulped and shook his hand, not really knowing what I was in for. I soon found out that Tom’s speech was not out of the ordinary. This therapeutic boarding school is based on “confrontational therapy,” described by Dr. Thomas E. Bratter himself, the aforementioned Tom, the founder of the school:

Undeniably, confrontation psychotherapy is painful because it forces (the student) to view (his or herself) realistically and does not permit either minimization, glorification of behavior, or pretend that magically one day he will be cured...I submit that “attack therapy” is the most precious and tangible proof of love and concern—i.e., to demand that the person terminate self-destructive and sadistic acts while concurrently improving.

This style of therapy scared the shit out of me. Shortly after I shook Tom’s hand, I missed my sweet-talking therapist and her stupid worksheets. It was hard. It was scary. And I wanted no part of it. Fortunately for me, Tom and the students saw a glimmer of potential beneath my enormous layers of lies and masks, and wouldn’t let me leave without a fight. I wanted to believe that there was really nothing wrong with me at all. Tom and my fellow classmates would have none of that.

The school has twenty-five kids, each dealing with his or her own self-destructive habits. The students are mature and brilliant, and the community is based on kids helping each other. This was new to me. I could not manipulate kids who had done the exact same things. Students at John Dewey confront each other when individuals are not taking care of themselves or their lives. This method taught me to examine all aspects of my life, not just my explicitly self-destructive behavior. The friendships among the community of students are powerful, and I realized that the more I was open about the way I actually thought and felt, the more I was embraced into the community. It was unlike anything I had ever seen before. From the moment I walked in, every single person knew what I had hid from everyone for years. When I came, I was still very guarded and unwilling to show anyone who I really was. Growing and learning with a few other students made me feel safe and supported, defining the general slogan of the school, “in the struggle together.” For the first time in my life, it wasn’t about struggling alone, or hiding in the darkness of my room, or beating myself up to make things feel right.
again. There was someone there, always, and it was a whole hell of a lot easier when there was someone to lean on.

Ironically, I followed common steps to recovery used in traditional therapy, just in a much more unconventional and unorganized way. Alderman explains the four concrete steps to getting over self-injury: deciding to stop, changing the behaviors, developing a support system, changing the thoughts, and expressing emotions (129-143).

Deciding to stop was one of the hardest steps for me to take. Even as the ambulance whirred down the suburban streets of Connecticut en route to the hospital, I was unsure whether I really wanted to stop hurting myself. I longed to cut again, and even though I knew that I couldn’t hide any longer, I didn’t feel a strong desire to stop. “The first [question you need to ask yourself],” Alderman writes, “is, why do you want to give up SIV (128)?” This question should have a simple answer. I had resolved to stop cutting months before going to the hospital, but I could never keep it up for more than a few weeks. I discovered that I couldn’t stop for anyone else. I couldn’t stop because my boyfriend wanted me to, or my therapist, or my best friend. I needed to really want to stop destroying my body.

The second step of the long process is to change the behaviors. Ridding myself of all sharp objects was not only useless but also impossible. I could devise a way to hurt myself in any circumstance. I could throw out everything sharp in my house, but I could never escape from myself. Breaking the habit, though, was an important component. Instead of slinking off to my room when I was overwhelmed, I attempted to talk to my friends about how I was feeling. Weeks went by where I couldn’t even articulate how I felt exactly. I just sat and stammered, trying to come to terms with the concept of being open with others. A large part of my recovery was what Alderman refers to the breaking of the “ritual.” She gives the example of a patient who cut herself every day at night in her bathroom. To help stop, she threw away all of her razor blades and spent that time somewhere other than her house or spent time with a friend. Breaking up the ritual can help avoid the situation entirely (135). For me, choosing to spend time with people instead of sitting alone threw a wrench in the situation entirely (135). For me, choosing to spend time with people instead of sitting alone threw a wrench in the situation entirely (135).

I don’t know how long it’s going to take for me to accept that the secret’s out. They all know. They all know. Telling people how I actually felt about myself horrified me. After years of hiding everything, I couldn’t imagine telling anyone about how I thought or felt; it didn’t fit my image of being put-together and “fine.” I was carrying so much tension, so many bottled up thoughts and feelings, that I was due for an explosion. Little by little, floods of shame, sadness, regret, and embarrassment came over me. I had to face years of unexpressed emotions without my typical coping skill to help me sort through them. With that, however, came a sense of support and care. It struck me that I no longer had to carry such a huge weight on my shoulders alone. I held back tears when anyone would say I was no longer alone. Each time someone said that, images of lonely nights of shallow breathing and bloodstained paper towels flashed through my head. I had always chosen to be alone when I needed someone the most. “Most individuals engage in SIV when they are alone,” Alderman writes, “by creating and using a solid support system and participating in activities with others, your feelings of isolation and alienation decrease. Also, when others are present, you make it less likely that you will harm yourself (136). It was hard for me to say or understand, but I needed someone. For once, I admitted to needing help, and this time I asked for it.

I hate myself and I want to die. I need to destroy. I am worthless, stupid, and unworthy. Each day these thoughts would run through my head and fuel my desire to destroy myself. They would come in floods and I did nothing to stop them. I clung to cutting because it was all I knew, and letting go of it scared me. I needed to make my new life of strength and hard work better than a lonely life of secrecy and destruction. I needed to look at things realistically and question the validity of my thoughts. For example, my mantra, I want to destroy, was often an overreaction. I wanted to destroy myself after every small error, even if it wasn’t my fault. I had to take a step back and ask myself if cutting myself over a bad grade on a math test was worthy of months of despair and first aid, or if it made me a terrible unworthy person to have flaws. The more I examined my thought processes, the more I realized the degree to which I overreacted. There was really only one solution; I needed to stop it. Stop tearing myself apart in my head and look at reality. I had to rid myself of all the dark thoughts and feelings in my head. For weeks, each time a destructive thought entered my head, I wrote it down and told my closest friend. She didn’t have to reply, and I didn’t expect her to. I just needed to let it out. I needed to let everything out so it wouldn’t explode.

What are you feeling? How do you feel about this? These phrases made me want to vomit. Not only did I not want to have feelings, I did not want to talk about them either. As usual, my instincts were incorrect. Talking about feelings was exactly what I needed to do. Alderman suggests that most self-injurers do not understand emotions or how to express them (141). All I can say is that she’s right. As a formerly emotionally-retarded human being, I know how hard it is to learn this skill later in life than most. “The first step in learning how to alter your emotions is learning to identify what you are feeling,” Alderman explains. “Once you’ve begun to identify your feelings, the simplest way to change them is by expressing them (143).” She also says that many people do not know the difference between thoughts and feelings, and have difficulty expressing them in a non-physical manner (142). I begrudgingly accepted that, as an emotionally sensitive human being, I needed to express the things I felt in order
to be stable. I had always viewed strength as tolerance. Because of my belief that suffering through the pain without doing anything about it was respectable, and those who cried were weak and inferior. I had to allow myself to feel things and accept them instead of trying my hardest to stifle them in order to change it.

Well I relapsed like a month ago...I guess since my New Year’s resolution failed, I’ll try from age 15. I will not cut myself after I turn 15...I want to be able to say I was young and stupid and 14. That was not the first time something like that appeared in my notebook. I tried quitting for my boyfriend. I tried quitting out of fear and shame, I tried quitting because I was sick of dealing with the wounds I inflicted. I tried quitting when I came to therapeutic boarding school. Each time, something snapped inside of me that made cutting seem worth it to me, putting temporary release over long-term health. I didn’t cut myself, though; instead, I burned myself and broke bones. I didn’t think I’d ever be able to really stop, because the urges were so overwhelming. Even after coming to John Dewey, I hurt myself when I felt overwhelmed or scared. I did so in much smaller ways, but I was acting on the same feeling. I told myself that since I wasn’t hurting myself to the same degree I had been, it was okay. Even after I stopped, the urge to cut myself remained. “Though some self mutilators recover,” Levenkron explains, “others find the behavior persistent. Even with effective treatment, they could be described as chronically recovering as opposed to recovered [...] the behavior and temptation to do it again will persist for an indefinite period of time (237).”

I am recovering. Things will never be perfect, I will never be able to always say exactly the right thing, and I still struggle sometimes with some of the basic things. But it was all worth it. The hospital, the outpatient therapy, and all the rest of my unsuccessful therapeutic endeavors, all leading up to the “fuck yous.” I am transforming from a miserable, lost, self-effacing, hospital patient to a hard-working, honest, caring person. Not only that, but I like myself. I go out of my way to say what I’m feeling, because to me, that’s what strength is. For me, handling hardship by leaning on others and examining the truth is the ultimate symbol of strength. I still struggle to deal with emotions; my initial instinct is still to run in the other direction when faced with an emotionally intimidating situation. This time, though, I force myself to move in the other direction. I have deep dependable relationships and a sense of security and support I had never had before. I am far from fully recovered. I am still recovering from physical damage. I am still trying to fully answer the question for myself: how do I get over this? I am still scared sometimes. But as I progress through each step of the process, and continue to learn, I can finally say: I’m glad it’s over—but I’m still not over it.

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I treat talented, troubled, troublesome, and tortured teens. These adolescents are alienated, angry, and act-out, so they need a structured, safe, and supportive environment to contain and control annihilative and sometimes death-defying acts. For me, psychotherapy becomes a war. Unless the psychotherapist is prepared to confront and attack by using any desperate and heroic ethical intervention necessary to destroy anti-social and self-destructive attitudes and acts, it is malpractice to become therapeutically involved. Unless the treatment agent accepts the awesome psychotherapeutic responsibility of annihilating ALL malignant material, like a cancer, that malignancy will metastasize and produce disastrous consequences. I view every adolescent as guilty until proven innocent. Fortunately, more than three decades ago, much to the chagrin of Glasser, I adopted a new treatment identity—i.e., gun fighter rather than the traditional therapist. For example, when parents were unable to prohibit driving or, in extreme cases, confiscate a car which the substance abuser drove at excessive speeds while intoxicated, I put sugar and salt in the engine, which destroyed the car. I contacted drug dealers, furthermore, to threaten them that if they did not stop selling drugs to my kids, I would dispatch someone to break their legs. I informed them that I had worked with mafia families who had voluntarily offered this kind of intervention. Wisely, I informed drug dealers that my job was to protect MY kids, not to incarcerate them. Several times, I persuaded my kids to speak with enforcement agents to introduce an undercover agent to the dealer. This undercover police officer would introduce a second who would introduce a third who would make the arrest. My intent was to protect my kid, the informer, because if his identity were discovered he could have been killed. One time, an agent refused to honor the agreement. I immediately interrupted by inquiring, “Do you think I am so damned stupid to believe the shit you are saying? Well, little girl, let me tell you I am not amused because you try to insult my intelligence. Do you really think I am that dumb or that you are so damned slick? I have worked with your kind of kid longer than your parents have been alive! Do you have a reaction or a comment or do you want to leave? John Dewey is a voluntary school. All our graduates attend college. What is fucked up is that you will be admitted by a more prestigious college from John Dewey than from your former school! I warn you that, should you decide to stay and we decide to admit you, John Dewey will be the most stressful, terrifying, and painful experience you ever will have. If you want to play idiot games, remain a cute child.

The Intake Interview: Defining the Helping Relationship

During the intake interview with Josephine, an attractive and socially sophisticated adolescent, the sixteen-year-old tried to mesmerize and seduce me into believing that she was fine and that her problems would be self-correcting. Josephine attempted to convince me that she did not need residential placement. What this sixteen-year-old child did not know is that I have buried kids whom I loved and had the dubious honor of delivering eulogies for four. These experiences radicalized me.

Immediately, I loved this female’s potential and the clinical challenges she presented—i.e., not being amenable to any treatment. I knew the stakes, as with most John Dewey students, were high. Either she would become a miraculous winner or remain a tragic loser. John Dewey students are doomed. Given their awesomely superior innate and intuitive intelligence, they can never be normal. Stated simply, they are too damned gifted in many ways. I enjoy playing this potentially deadly game with her because she was good—no, great! Josephine is articulate. Josephine is very likeable—no, loveable.

I permitted her to talk uninterrupted. She thought my smile was approval, but was wrong. I smiled because I knew she felt in control of the session as she had been with all psychiatrists. She gained pseudo-confidence because the number of doctors she had seduced was impressive. She was treatment savvy because she had said the right words, but for the wrong reasons. I permitted this sham to last five or ten minutes by pretending to be impressed.

I changed my posture from slumping to sitting erect. I interrupted by inquiring, “Do you think I am so damned stupid to believe the shit you are saying? Well, little girl, let me tell you I am not amused because you try to insult my intelligence. Do you really think I am that dumb or that you are so damned slick? I have worked with your kind of kid longer than your parents have been alive! Do you have a reaction or a comment or do you want to leave? John Dewey is a voluntary school. All our graduates attend college. What is fucked up is that you will be admitted by a more prestigious college from John Dewey than from your former school! I warn you that, should you decide to stay and we decide to admit you, John Dewey will be the most stressful, terrifying, and painful experience you ever will have. If you want to play idiot games, remain a cute child.
or do not want to attend a great college, this ‘ain’t’ [sic] the right place; but if you want to have real options when you grow up, then we are the best damn place in the world!” Even before responding, I knew that Josephine now realized who was in charge. Much to her parent’s surprise, the little girl said meekly, “I want to stay.” What a major victory for me. Rather than gloat or become confident I taunted her, “Why should we admit you?” In a matter of minutes, Josephine knew the “ole” man would be a formidable foe, which intrigued her for all the wrong reasons. I was prepared to wage war for the right reasons.

**Josephine: A Reality Therapy Diagnosis.**

Josephine appeared for an outpatient session. The psychiatrist, alarmed by her bleeding, called an ambulance to transport her to the Emergency Room. Eventually, she was taken to the pediatric ward, where she was placed on one-to-one suicide watch. Josephine was transferred to another facility for psychiatric inpatient treatment. There are explicit reports from the emergency room, which describe the severity of personal attacks. When released from the psychiatric ward, she was given the benign diagnosis of Mood Disorder. Incredibly, the psychiatric institution ignored the diagnosis of suicidal ideation. Visually, these extreme scars need no explanation. How can any psychiatrist diagnose an individual who mangles herself as having only a Mood Disorder? The DSM-IV, most assuredly, does not include serious self-mutilation in its diagnostic criteria for Mood Disorder!

With little effort, Josephine can create the illusion of “having it all.” Externally, any grandfather or father would yearn to have Josephine as their daughter or daughter-in-law. But they would be wrong! Underneath the sweet and superficial smile, which camouflages hemorrhaging, is a lonely, confused, conflicted little girl who tortures herself physically.

After being hospitalized, predictably, Josephine was prescribed Lamactil, Klonopin, Seroquel, and Wellbutrin in an age that embraces the slogan probably proposed by a public relations specialist employed by big pharma—i.e., “better living through chemistry.” When one learns, furthermore, that she has been hospitalized, there remains disbelief as to the seriousness of her condition. And finally, when one sees self-inflicted wounds on her legs, there are feelings of intense disgust. Three John Dewey Academy females have seen her legs: A psychiatrist, a psychologist, and a recovering self-mutilator whose self-inflicted wounds are ugly. Each reports that these wounds are grotesque and gruesome. While beyond the purview of this article, at this juncture, two plastic surgeons question whether surgery will be effective. A physical therapist fears that there is permanent nerve and muscle damage. The damage was so severe that Josephine needed crutches to walk and extensive physical therapy. While hospitalized, Josephine reports she was warned that this extreme kind of self-mutilation could be life threatening! Mood disorder, indeed! She did escape, however, the favorite diagnosis “Adjustment Reaction to Adolescence.”

**The John Dewey Academy: A College Preparatory/Therapeutic School**

Bratter (1993) writes that The John Dewey Academy is unique because its primary identity is as a school that provides individual, family, and group therapy for gifted adolescents who enter with negative self-concepts that Bratter et al. (2006 & b), (2003), and Bratter (1989) describe. Most students are impulsive, with histories of extremely destructive and dangerous acting out patterns that generated these negative self-concepts. They need to establish stable identities while concurrently learning how to form positive interpersonal relationships.

The John Dewey Academy’s therapeutic orientation is existential-confrontational. Students are forced not only to accept accountability for dysfunctional attitudes and acts but also to improve in a stressful, unrelenting, and uncompromising environment that demands educational excellence and personal integrity. Dewey nurtures the psychological, moral, and spiritual growth of students by creating conditions conducive to the (re)gaining of self respect and integrity. The community insists that members become positive and productive by resolving intrapsychic and interpersonal problems while concurrently learning how to form mature interpersonal relationships. In a group setting that has escalating expectations for improvement, members relate to peers who offer insight and suggestions which provide the catalytic conditions necessary for self-exploration and change. Positive peer pressure is the primary and potent psychotherapeutic approach, which stresses empowerment. Students are persons, not patients. They are perpetrators, not victims. The treatment goal is to nurture psychological and moral growth. Gifted, creative, alienated, self-destructive, and angry adolescents respond positively to confrontation.

**The Rejection of Psychotropic Medication**

Breggin and Glasser (2003) were the first to reject the trend to medicate when they pronounced taking pills under medical supervision communicates the anti-therapeutic message “something is wrong with your brain, and you need a potent medication to function as ‘normal.’” A decade and a half before others, Breggin (1991) attacked not only the biological theory of depression but also the use of older antidepressants to treat this “biochemical disease”:

For years the dominant biological theory of depression, ...was derived from speculations on how and why medications...alleviate depression. One of the earlier groups of antidepressants, the monoamine oxidase inhibitors (MAOIs)...tends to increase the levels of available norepinephrine in the central nervous system...It was hypothesized that depression might result from the opposite-too little norepinephrine. Later studies showed some so-called
depressants may cause an increase in the availability of another neurotransmitter, serotonin. So the theory was enlarged: some forms of depression may be due to too little serotonin...Eventually the theory was punched full of holes by contradictory evidence. For example, some drugs that mimicked these biochemical effects did not seem to alleviate depression, and others that are thought to sometimes relieve depression have a wholly different biochemical mechanism. Furthermore, the supposed efficacy of the antidepressants...is much in doubt. (pp. 141-142)

Biological psychiatry assumes mental illness is caused by a chemical imbalance in the brain. Pharmacological solutions create the comforting illusion that disease can be controlled easily and cheaply by pills. Breggin excoriates pharmacologic researchers and the FDA for uncritically accepting self-serving and flawed studies financed by pharmaceutical corporations for their economic behalf.

Breggin was among the first to contend the myth of a biochemical disorder is precisely that—a malicious myth. Frighteningly, his second contention—that the only chemical disorder is the ingestion of psychotropic poisons that cause imbalances—has been ignored until recently (Breggin 2008a & b). Refusing to be silenced and often in the forefront of the fray, Breggin (2005) continued to confront the FDA when he criticized the agency for refusing to heed warnings of the increased harm posed by the SSRI antidepressants. He had exposed these risks more than a decade earlier.

Finally confirming conclusions that Breggin had documented since 1991, in 2003, the British equivalent of the Food and Drug Administration, the Medicines and Healthcare Products Regulatory Agency, notified the medical community that they must cease prescribing most SSRI antidepressants for the treatment of depression in children due to a combination of lack of efficacy and an increased risk of suicidality.

A year earlier, Connor (2004) commented, “The FDA released a statement regarding...Paxil for pediatric depression...[There] is a statement...that three well-controlled trials in pediatric patients with major depressive disorder failed to show that...Paxil was more effective than placebo. As far as I know these studies never have been published” (p. 127).

Brent (2004) observed that the “problem is exacerbated when studies are financed and directed by the pharmaceutical industry when there is a great disincentive to publish negative results...The FDA should require that these data be made public in a timely manner” (p. 127).

Whittington et al. (2004) warned that children and adolescents are at risk to attempt suicide: “The possibility that a drug might increase that risk without clear evidence of benefit, should in our view discourage its use...A possible increased risk of suicidal ideation, serious adverse events, or both, although small, cannot be ignored” (p. 1344).

As Breggin often has noted, a quid pro quo exists: If researchers want to receive funding, research needs to justify dispensing medication. Psychiatric journals, subsidized by advertising from Big Pharma, know survival depends on this money. An editorial in The Lancet (2004), a respected and trusted British medical journal, concluded that research regarding selective serotonin reuptake inhibitor use “in childhood depression is one of confusion, manipulation, and institutional failure. Although published evidence was inconsistent...use of SSRIs to treat childhood depression by pharmaceutical companies and clinicians world-wide continues” (p. 1335).

Breggin has concluded that, while causing suicidality, the drugs do nothing to prevent it. Tiirhonen et al. (2006) confirmed Breggin’s contention, stating, “Despite extensive research, it has not been possible to demonstrate that the use of any antidepressant medication decreases the risk of suicide” (p.1358).

There can be no justification for the federal policy to pander to the corporations. Connor (2004) protested, “How can we practice in the best interests of child and adolescent patients if negative trial data are withheld from the scientific journals and only positive studies are published?” (p. 127).

The John Dewey Academy adheres to the same guiding principles as Breggin’s critique of biological psychiatry—i.e., drugs do more harm than good, and individuals need to learn to determine the course for their lives in more ethical and self-fulfilling ways. Psychopharmacologists’ and biological psychiatrists’ claim that intrapsychic problems are caused by metabolic disorders, genetic imbalances, and cellular deficiencies are refuted by The John Dewey Academy. Feelings of depression, pain, shame, inadequacy, and fear that overwhelm adolescents are caused by conscious dysfunctional, dishonest, destructive, and dangerous decisions, not by biological aberrations. When asked why they feel depressed or ashamed, students provide realistic explanations. The John Dewey Academy asserts that personality and affective disorders are rarely cured by medicinal approaches; no pill can teach self-respect or cure noxious narcissism, dishonesty, and anti-social attitudes. No psychotropic mood or mind-altering medication, therefore, is prescribed at John Dewey. Drug- and psychotropic medicine-free are viable treatment goals.

Breggin (1996) rolls against the brain dysfunction assumption by exposing its counter-therapeutic message:

The biopsychiatric approach...reinforces...the patient’s worst feelings and attitudes. The patient...feels helpless—at the mercy of forces beyond his or her control. Often the patient feels mentally defective. Unfortunately, the biopsychiatrist’s approach will encourage the patient to think and act like a helpless victim of overwhelming forces, namely genetic and biochemical abnormalities. This further reinforces the patient’s self-destructive helplessness (p. 4).

Breggin discusses the roles of empathy and love in the psychotherapeutic process. To love and be loved, Breggin (1997) contends, “is... to feel empowered—to feel in control of one’s... spiritual state” (p. 78).
Breggin urged that psychotherapy attempt to empower those who seek help to become persons who "are active forces in their... lives." Rightfully, Breggin (1997) suggested that the sense of helplessness needs to be resolved:

Behind emotional psychological helplessness lies a subjective judgment about our... capacity to handle ourselves and our lives. As a healing person, nothing is more crucial than encouraging people to overcome ... feelings of helplessness. Helplessness reflects a judgment... that nothing can be done. The alternative to helplessness is a feeling of self determination and mastery; the sense of taking control over one's ... feelings and thoughts, and giving direction to one's life (pp. 72-73).

What makes "giving up" or quitting so debilitating is "when a feeling of helplessness... increases, because the individual may lose control in reaction to a seemingly slight frustration”(p. 73).

In philosophical terms, they have autonomy and are capable of self-determination... Because human beings must exercise free will... to survive and to prosper, they need... personal freedom... Approaches to deeply disturbed human beings should... respect their autonomy, independence and freedom... Empowerment involves self-understanding, moral encouragement through a caring relationship, and guidance toward... autonomous and loving principles of life... Deeply disturbed people should be viewed as... struggling to survive and to grow--as persons in conflict with themselves and with [others]. Healing comes through a combination of self-development and beneficial relationships (pp. 2-3, 7).

Breggin (1991) correctly identified this therapeutic challenge when he proposed that each person needs to "choose whether or not to overcome any hardship or oppression inflicted by the family, society, or psychiatry. Human beings retain... free will... Indeed, without the exercise of that flickering will, there is no hope... that is the helper's role, to encourage every hint of self-determination" (p. 45).

Teenagers suffer from what Breggin (1991) has labeled a psychospiritual crisis, usually surrounding issues of basic identity, shame, and, typically, overwhelming feelings of outrage:

By refusing to diagnose or to label people who... feel rejected and humiliated, we welcome them back to the human community and promote humane, respectful, and loving attitudes toward them” (pp. 45-46).

**Toward a Rational and Effective Treatment Approach: Compassionate Confrontation**

While Glasser may disagree, three guiding principles of reality therapy form the core of compassionate confrontation. First: To encourage the youngster to evaluate behavior. Second: To force the youth to accept responsibility for conscious choices. Third: To help the teenager make a commitment to change constructively and creatively. Reality Therapy has been erroneously criticized as simplistic and superficial. One of the first advocates of this approach to therapy, Glasser viewed persons to be either responsible or irresponsible. Until gifted, deceitful, and masochistic teens can be convinced to take control of their lives, these youngsters will refuse to change. Breggin (1991) correctly identifies the correlation of choice to treatment outcome when he writes "every individual must choose whether or not to overcome any hardship or oppression inflicted by the family, society, or psychiatry--indeed, [it is] the helper's role to encourage... self-determination” (p. 45).

No one denies that confrontation psychotherapy, at times, can generate much personal pain. Van Stone & Gilbert (1972) describe this pain generated by a self-help confrontation group as a psychotherapeutic orientation when these two psychiatrists write:

Each member... is... confronted with candid, personal facts regarding every observable behavior or attitude recognized by the group as being self-defeating or dishonest. If the member... attempts to explain or deny any observation, [she is] ridiculed, browbeaten, shouted down, and insulted [when peers]... hammer away at the distorted ideas that he offers in support of his damaging behavior patterns. Intellectual insight or genetic self-interpretations are derided as an escape from responsibility for current behavior. Honesty, trust in the group, realistic self-assessment, appropriate emotional release, and changed behavior... are rewarded by sympathetic counsel and encouragement from... members (p. 585).

Sifneos (1991) warns the therapist who uses confrontation to be cautious but optimistic that this treatment orientation:

will [stimulate]... self-understanding... be beneficial to the patient. He must... be convinced that the patient [can], withstand considerable stress... [Effective] confrontation must be based on the therapist's observation about a series of paradoxical behavioral patterns, contradictory statements, [self-destructive acts], and by arousing the patient's feelings, it must motivate him to look at himself from a different point of view (pp. 374, 382).

Psychotherapy with gifted, manipulative adolescents who engage in deceitful, destructive, and dangerous behavior has two sequential phases. First: To unlearn and reject malignant attitudes and acts. Second: To learn how to become honest, responsible, and value self-respect as the **summum bonum**.

Carkhuff & Berenson's (1972) four-decade-old definition remains relevant:

Confrontation helps the confronted understand: his strengths and resources, [and]... self-destructive behavior... it is directed at discrepancies... between what the client says and does... and between illusion and reality... it implies a constructive attack upon... unhealthy... illusions, fantasies, and life avoidance techniques... to create a reintegration at a higher level of health” (p. 171).

Complicating this seventeen-year-old's commitment to change is the fact that she knew her sentence at Dewey would be two and a half years, which for any adolescent feels like an eternity. Thus, there was no inducement to change quickly. Fortunately, I am impatient, so I escalated confrontations. What happened is that Josephine slowly began to trust, respect, and, yes, even like me.
After three months, I suggested that Josephine consider showing her scars to her parents. I knew secrecy would retard the recovery process. Being concerned about parental shock and overreaction when they saw the wounds, I demanded that two female Dewey staff attend. The Dean of Students and our consulting psychiatrist were there. When asked if I wanted to witness, I declined. I did not want to be a voyeur and, more important, I did not want to see the wounds. Josephine revealed her scars to the two Dewey staff members and to one of our students, a recovering self-mutilator. This act probably signaled that Josephine had determined she wanted to change. Theespctacy of silence had been shattered. Two months later, to my surprise, Josephine volunteered to show ugly and graphic color photographs of her infected wounds (which she had previously put on a website for self-mutilators) to the John Dewey community. I tried to discourage her, but she persisted. Though never seeing the pictures, I feared these self-inflicted mutilations would disturb peers. Josephine fetched the pictures, which she circulated. This ghoulish act lasted for an hour! My reaction when viewing these photographs? I was horrified that any intelligent person could intentionally hurt herself. These self-inflicted lacerations were more brutal than had she been attacked by a sadistic criminal mutilator. She had brutalized herself with an extreme self-hatred and vengeance. Josephine cleverly hid these extreme slashes from the world. Josephine had severed some muscle. She had acquired a scalpel with which to cut herself. The *piece de resistance* was that she inserted a needle to ascertain how deep the numbness was. The three inch needle broke and remained embedded in her leg. Her mother opposed removing the needle, but I prevailed. As I expected, it was simple surgery. These lesions are the ugliest and deepest that I have seen in a career which approaches the half century mark. I cannot explain the desperate pain caused by self-hatred acts. No person has such a high tolerance of pain to endure self-inflicted suffering. Josephine, indeed, was fortunate to survive this ordeal. Had Josephine been unlucky, she could have severed an artery, had her leg amputated from a class A infection, or died!

This adolescent's recovery has been facilitated by another self-mutilator who wore short sleeves to reveal ugly purple slashes. What needs to be noted is that others made significant contributions to Josephine's rehabilitation. Without peer input, this process would have taken longer or, more frighteningly, never happened. My role has been not only to confront but also to elicit and coordinate peer help.

**CONCLUSION:**

**A Happy Ending**

While there is tangible and compelling evidence that Josephine has miraculously transformed herself, I am reluctant to concede these changes are permanent. This seventeen-year-old confronts others and in so doing confronts herself. She has become a respected, trusted, admired moral leader. If a gun were placed to my head and I was ordered to give a prognosis, I would respond that Josephine's prognosis has tentatively been modified to guardedly optimistic. I am in no hurry to celebrate because it is premature. I am in a clinical no-win quandary. If I trust prematurely and am wrong, I forfeit therapeutic integrity, but if I withhold approval I can retard damage the treatment alliance. I intend to proceed slowly. If forced to wager today, however, I would bet huge sums that this young self-mutilator will graduate from a more prestigious college than most of her physicians whom, I contend, violated the Hippocratic Oath because they did harm by not only refusing to confront deliberate deceit but also prescribing potent psychotropic medicine when there was no evidence of the existence of a chemical imbalance! Simply stated, there is no psychotropic medicine that cures deliberate deceit or produces self-respect.

When I feel comfortable that Josephine is on solid ground, I will suggest she send copies of her article to those physicians who worked with this remarkable adolescent. My intent is not to wound or gloat, but rather to educate them.

Finally, I extend my appreciation to Jason Rosenfeld, who will hopefully be attending Columbia College next year, for his help in editing this letter.

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Choice Theory, Metacognition, and A Life Experience:
Self-Integrity Following Change

Patrick M. Hillis

The author, a graduate of Syracuse University, Suny-Buffalo, Suny-Bridgeport, and Elmira College, has an extensive background working with special needs individuals.

ABSTRACT

Psychological changes following a traumatic physiological experience were described. The psychological changes included an enhanced metacognitive awareness of negative self-talk and an integration of conflicting cognitions. Choice Theory is explained as an underlying framework utilized during the processing of the psychological and physiological changes which accompanied the traumatic experience.

The Experience

During the morning of December 31, 2007, roughly eight inches of snow had fallen, followed by a rapid environmental warming. As I had done hundreds of times, over many years, I started up the snow blower and began to remove snow from the long driveway and walkways of my residence. What I quickly discovered was that the snow had become unusually sticky, due to the warm air. This caused the snow blower to clog every few feet. In fact, I cannot remember a snow blower clogging that often. I had to stop and unclog the chute probably 30 times during the more than one hour I was snow blowing. I utilized two previously effective methods to unclog the chute: a stick and my hand. Although the hand method is not recommended, all the snow blowers I had ever worked with were all equip with an automatic-mechanism shutoff which caused all blades to immediately stop rotating when my hands were removed from the throttle. Thus, prior experience had informed me that there was little danger. However, the frustration level associated with cleaning out the chute an unprecedented number of times led to a new outcome.

At approximately 10:45am, when I was within a few feet of finishing all the snow removal, my irritation level had reached a point where I just wanted to be done and yet the chute clogged again. Instead of taking my hands off the throttle and moving to the side of the machine to clear out the chute, I attempted to save time and instead leaned forward, over the machine. My right hand was removing snow and my left hand remained on the throttle. What happened next took at most one second.

The Choices Following the Experience

The first choice was to remove my right hand from the chute as quickly, and as forcefully, as possible. However, this choice may have been more of a reflex than a thought. The next choice was to look at my ski glove to determine if I could assess the damage without first looking at my bare hand. The ski glove was intact, except for the end of the middle finger which was missing. I then quickly removed the glove to find that approximately one inch of the end of my middle finger had been removed and the bone between the first and second knuckle had a compound fracture. Moreover, the ring finger also had a compound fracture between the first and second knuckle.

Following the brief, initial assessment of the damage, I then chose to look in the snow blower for the end of my middle finger and could not find it. My next choice was to inform a family member that I needed to be taken to the hospital. As I walked toward the house, I can clearly remember thinking to myself, as I again looked at my fingers, “Ok, this is your reality now and you will not look back on this with regret.”

When we arrived at the hospital, I was immediately admitted. During the one and a half hours of waiting in the emergency department for the hand surgeon to arrive, I was able to more fully assess my situation. The initial focus of my assessment was the extent of the damage. From the appearance, I assumed that I would no longer have my middle finger from the second knuckle up and that I may lose the end of the my ring finger. Based on this assessment, I began to think about worst-case scenarios; not from a negative perspective, but from a problem-solving perspective involving what I could do given the physical limitations I may now have.

The first life area considered during this problem-solving process was employment. The main question was, “How long would it be before I could work?” This question was not amenable to an informed answer until the surgery was completed. However, because I worked from my home, except for regularly scheduled community-based meetings, I believed that I would be able to immediately continue with many of my responsibilities, most of which were based on the ability to write and type. Being right handed, the answer to the writing question was not apparent. There were two possibilities: a. I would be able to write with my right hand, or b. I would have to learn to write with my left hand. Only time would answer this question. Also, although I knew I would be able to type with my left hand and the remaining fingers on my right hand, I
did not know what effect this would have on the speed of my typing. Again, time would answer this question. With the problem-solving assessment pertaining to my employment complete, there was no need to further consider it.

Education was another life area considered during the problem-solving process in the emergency department. I required two courses to graduate in June with a Master of Science in General Education, with one of those courses being the Master's thesis. It was clear that I would not be able to take two courses in the twelve-week Winter term and simultaneously fulfill my employment obligations. Thus, the best option was to take the thesis course because I had already completed the first draft of my thesis. The final course would have to be taken in the Spring term, just before graduation. With the problem-solving assessment relating to education complete, there was no need to further consider it.

For recreation, social, and spiritual reasons, one of my favorite activities is hand drumming. I am a member of a community drumming group in Ithaca, New York, and my ability to continue to drum was certainly worthy of consideration during the emergency department problem-solving process. The options were: a. I would still be able to drum with both hands, or b. I would only be able to drum with my left hand. Again, the answer to this question would have to wait until after I healed, thus there was no need to further consider it.

Although there were several other life areas assessed during the emergency department problem-solving process which are not described in this article, it may be useful to share two of the main thoughts that were repeated during this problem-solving time: a. the situation could be much worse; and b. there are millions, if not billions, of people in the world who have to live with much more profound challenges than what I am, and will be, experiencing. These were sincere thoughts reinforced by more than 18 years of professional experience working with people with disabilities, including developmental disabilities, mental-health disabilities, physical disabilities, and traumatic-brain injury.

The surgeon eventually arrived and performed the surgery in the emergency department with local anesthetic and the results were mostly excellent. He was able to save the remaining length of the middle finger and all of the ring finger. Moreover, as the weeks passed, I learned to write with my right hand again and drum with both hands, without a noticeable difference in ability. However, during the rehabilitation process, it was discovered that the Experience led to an inability to flex my middle finger at the second knuckle. The success rate of the surgical procedure to correct this situation is low, so I chose to live with the inability to flex this finger.

The weeks following the Experience involved many opportunities to make choices. One choice I made was to not accept assistance from anyone if I could do something myself, even if it took several times longer than normal to complete. After many years of facilitating the independence of people diagnosed with disabilities, I saw my situation as an opportunity to temporarily experience a disabling condition from the perspective of a person who lives independently. In other words, I wanted to walk my talk. This walk included doing laundry, showering, grocery shopping, working, dressing, putting on my sneakers and tying the laces, making food, and doing the dishes. Although I rescheduled employment-related meetings the week following the Experience to allow the bones to initially heal with minimal interference, I stil worked that week by answering and making phone calls, answering and sending emails, and typing all required documents. For four weeks, I typed only with my left hand while the bones of my right fingers healed. This led to a large increase in the amount of time spent for employment purposes, as well as for revisions to my Master's thesis. However, I did not fall behind at work and the quality of my work remained consistent. Also, I completed my thesis on time and passed with distinction. In fact, during Commencement, my thesis won The Outstanding Graduate Thesis Prize.

Throughout the many weeks of healing, there were the daily challenges involving how long it took to complete even the simplest task and how much energy it took to get through a day. At times, frustration and fatigue would reach a point where I would have to lie down and sleep for several hours, even in the middle of the afternoon. It was during these times of exhaustion, that I began to realize that many people with disabilities have overcome obstacles and achieved life victories that may be as profound as some of the greatest of human accomplishments. Moreover, my condition was improving and soon would be resolved, but many people with disabilities continue to be challenged for the remainder of their lives. This recognition led to an awe-inspiring revelation which conveyed the tremendous strength which many disabled people must possess to just get out of bed each day. I found that my respect and admiration for the people I currently served, who had sustained traumatic brain injuries, moved to a level equal to the most respected and admired people I had ever met. This was certainly a serendipitous gift which the Experience had facilitated.

Choice Theory, Metacognition, and Self-Integrity

As the above narrative demonstrates, there were many opportunities to make choices pertaining to how I would allow the outcome from the Experience to affect various aspects of my life. William Glasser (1998a) describes a similar process in his book, Choice Theory: A New Psychology of Personal Freedom, when he wrote, “Choice Theory is an internal control psychology; it explains why and how we make the choices that determine the course of our lives” (p. 7). Although I did not know it at the time.
I may have been utilizing Choice Theory during some of the decisions I made following the Experience. However, is it possible to utilize Choice Theory without being formally introduced to its theoretical concepts and procedures? In Glasser's (1999b) book entitled, *The Quality School: Managing Students Without Coercion*, he alludes to this possibility when he wrote, “successful teachers and administrators, whether they are aware of it or not, use Choice Theory” (p. 58).

Since it may have been possible that I unknowingly utilized Choice Theory following the Experience, is there evidence to suggest this occurred? To provide this evidence, the previously described decision to accept my new physiological reality and thus, to not look back on the Experience with regret, will be utilized. Glasser (1998a) appears to suggest this type of acceptance and lack of regret when he wrote: (a) “When you focus on the past, all you are doing is revisiting the misery” (p. 130); (b) “What’s done is done; to keep this failure alive is divisive…” (p. 211); (c) “Regardless of what happened to us, Choice Theory does not focus on the past as the cause of our present difficulties” (p. 231); and (d) “What happened in the past that was painful has a great deal to do with what we are today, but revisiting this painful past can contribute little or nothing to what we need to do now” (p. 334).

To further explore the implications of accepting and not regretting the Experience, the emotions labeled “guilt” and “blame” may provide some insight. Guilt is an emotion that is potentially associated with nonacceptance and regret, and may occur when a person blames themselves for past outcomes which appear to be undesirable. Thus, the choice to accept my new reality and to not look back on the Experience with regret may have led to a minimization of guilt and blame. Glasser (1998a) includes guilt and blame as issues addressed within Choice Theory when he wrote: (a) “Freedom from the undeserved guilt that floods the external control world we live in is a huge benefit of learning the use of Choice Theory” (p. 18); (b) “Can [a person] do anything to undo what happened? Will it do any good to blame…? It’s enough that [a person] lived through what happened to [them] once. [They] don’t need to go back through it again” (p. 225); (c) “Many clients want to stay in the past. They are afraid to deal with the present problem and are happy to escape into the past to find someone to blame” (p. 231); and (d) “To blame is much easier than to choose to change” (p. 232).

Thus far, I have primarily described the ideal cognitions and emotions which were associated with my choices following the Experience. However, there were times when I became overwhelmed with my new circumstances and would momentarily begin negative self-talk which would include something like, “You are an imbecile. How could you have done such a stupid thing.” This type of negative self-talk was especially prevalent and intense when the day-after-day struggle of completing tasks at a slow rate, and addressing the care of my fingers (e.g., daily bandaging, daily exercises), became too much for me to handle in a calm and positive manner. Although these reactions at first appeared to be of little value, I began to become acutely sensitive to these moments of negative self-talk and eventually learned how to rapidly stop them in an intentional way. This may have been possible because I believed, more than in previous moments of my life, that this negative self-talk involved useless and destructive energy, and that if I was going to heal to my full capacity, I could not allow this self-talk to remain in my consciousness. In other words, I was developing a refined ability to discontinue negative-thought patterns mostly through an urgent awareness that this was the healthiest choice. Glasser (1998a) alludes to the existence of, and choice to create negative thought patterns, with their accompanying negative emotions, when he wrote, “we choose everything we do, including the misery we feel” (p. 3). Additionally, Glasser (1998a) wrote, “success in any endeavor is directly proportional to how well the people who are involved in it get along with each other” (p. 21), and Glasser (1998b) wrote, “Among the most destructive of all our coercive practices is our overuse of personal criticism” (p. 75). These latter two quotes may not appear to be relevant to an exploration of negative self-talk. However, their relevance may become apparent by describing how metacognition became an interpretive theme during moments of negative self-talk.

During the moments of perceived negative self-talk following the Experience, I began to have a heightened awareness of something I had perceived many times in the past: that there may be an observer to my actions (i.e., the Self) and a participant of those actions (i.e., the self), within a single conscious awareness. This observer-participant dichotomy may contribute to an awareness of thinking about thinking; an ability known as metacognition. Furthermore, metacognition presents the possibility of a perceived relationship between the metacognitive aspects of consciousness. This relationship may involve the Self observing and judging the thoughts and actions of the self. It is this relationship of observation and judgement by the Self toward the self which may involve criticism (i.e., negative self-talk) and which provides the relevance to the above written quotes by Glasser (1998a) and Glasser (1998b).

As indicated above, the existence of the metacognitive nature of consciousness was not new to my awareness. However, following the Experience, the realization of how separate these two metacognitive aspects could appear, may have been unique. Through this discovery, it became apparent that the Self may become an incessant antagonist of the self. This awareness, and the intensity of some of the negative self-talk I observed following the Experience, led to a belief that I may have been at a crossroads in my life. I could reconcile much of the negative self-talk which had been recently taking place at an unprecedented inten-
positive or I could allow the Self and the self to further separate through continued self-hatred; a separation which I can only guess would have led toward a negative mental-health outcome. Glasser (1998a) suggests such an outcome when he wrote, “Even though it is unusual, we can actually remove every single person from our quality worlds except ourselves. No matter how we picture ourselves, we can’t take ourselves out…To take ourselves out would mean we don’t exist” (p. 53). Thus, Glasser may be hinting at what I was intuitively experiencing, although I was not utilizing the concept of a quality world (i.e., the most valued and important perceived aspects of one’s life), nor was I thinking about the potential of the Self or the self becoming nonexistent. However, if the metacognitive dynamics of consciousness became unremitting antagonists through severe and consistent criticism, then perhaps the Self and the self may lose their ability to be aware of each other in any meaningful way. This may lead to a kind of split, perhaps similar to the split seen in dissociative-type disorders. Although I have no evidence for this belief other than the above described subjective awareness, it may be worth searching the psychological and psychiatric literature for similar hypotheses.

As may be apparent from the content of this article, I was able to resolve a substantial portion of the negative self-talk, thus facilitating the unity of the Self and the self. In fact, I believe this present unity has led me to a new level of self-integrity (i.e., the Self and the self coexisting in relative harmony) which may be unprecedented within my life. Glasser (1998b) appears to provide a partial explanation for this process which led to increased self-integrity when he wrote:

> what actually initiates all behavioral change is the pain associated with the difference between what the student wants from his or her quality world and what is going on in the real world. The greater and more sudden this difference, the more urgent and energetic the change in behavior will be. (p. 77)

Thus, it is plausible that the sudden and painful physiological change which was the Experience, and the concomitant challenges associated with that change, may have created such a profound discrepancy between what I believed was important to me (e.g., employment, education) and my ability to continue to successfully engage in these life aspects, that I was somehow able to focus my mental energies in ways not previously possible. This focus may have been a key factor in my ability to resolve much of the negative self-talk and thus, to develop a new sense of self-integrity.

Given the possibility of a self-integrated consciousness, does Choice Theory contribute toward understanding the benefits of such a consciousness? Glasser (1998a) may have described a potential benefit when he wrote, “As she learns to help herself, she begins to put a strong picture of herself into her own quality world. She is now planting the seeds of personal freedom.” (p. 57). This quote provides both a Choice Theory description of self-integrity (i.e., placing a strong picture of yourself within your own quality world) and a potential benefit of self-integration (i.e., personal freedom). What this potential personal freedom may entail, I am only beginning to experience. However, I believe it includes an increase in self-esteem and an increase in confidence, as evidenced by my noticeably enhanced ability to verbally share and present during Choice Theory class (i.e., my first class on-campus since the Experience) on a level of assuredness and confidence that I cannot remember having in any previous class in my entire academic career. Also, as previously indicated, I have noticed a definite decrease in my negative self-talk to a point where I sometimes believe it may no longer be a possibility within my consciousness. However, there are days when the stress of life becomes high and negative self-talk follows. During these moments, though, I am able to quickly notice the negative self-talk and rapidly discontinue it.

### Moving Forward with Choice Theory

This article is based on a paper I wrote less than two weeks before graduating with a Master of Science in General Education from Elmira College on June 01, 2008. The paper was required for my final course entitled, Choice Theory, with the instructor being Marjorie Van Vleet, who is named within Glasser’s book, *Choice Theory*, as his contact person in Corning, New York, when that city was preparing for their attempt to become the first Quality Community. Thus, I had become familiar with Choice Theory through class discussions, activities, and reading both *Choice Theory* and *The Quality School*. Given that new knowledge of Glasser’s theory, what follows are some ideas I generated pertaining to how Choice Theory may be able to assist me with moving forward, as I continue to address contingencies related to my increased awareness of metacognitive processes, as well as my acceptance of my altered physiology.

As previously written, the perceived metacognitive relationship between the Self and the self has noticeably improved. Although I believe I have developed strategies which will allow this relationship to continue to improve, Glasser (1998a) provides another strategy, which I will place within my repertoire of ways to enhance this relationship, when he wrote:

> To prevent fight or flight, which is the beginning of the end of any relationship, whenever they have a problem, they ask themselves, if I say or do this right now, will it bring us closer together or will we end up further apart?" (p. 173).

This unifying question will be utilized during moments of negative self-talk and during moments which may indicate that negative self-talk may be possible.

In addition to providing a strategy which may assist with addressing the metacognitive aspects of consciousness, Choice Theory also presents a holistic and integrated
model of human functioning called Total Behavior. Glasser (1998a) described this when he wrote, “All behavior is total behavior and is made up of four inseparable components: acting, thinking, feeling, and physiology” (p. 335). This integrated perspective presents a potential method of understanding and approaching life situations from an expansive point of view. For example, one activity I enjoy is weight lifting. Due to my middle finger no longer being able to flex and my ring finger having limited movement in the first knuckle, I could have believed (i.e., thinking aspect of Total Behavior) that I would no longer be able to lift (i.e., action part of Total Behavior) the heavy weight required to maintain a strong body (i.e., physiological aspect of Total Behavior) because I would no longer be able to grip the weights; specifically, I would no longer be able to grip the weights utilized to strengthen the upper back and shoulder muscles. Without a strong upper back and shoulders, it would be difficult to continue to maintain strong chest muscles without jeopardizing the strength balance between these opposing muscle groups. Thus, my ability to lift heavy weights, with a balanced result, was in question. However, because I did not accept that there was nothing I could do, my thinking led to action which led to obtaining hand grips which allow both hands to grip a weight bar by wrapping a strap around the bar which is also attached to my wrists. This has allowed me to lift heavy weights again. Moreover, this combination of thought, leading to action, leading to physiological changes, has been accompanied by emotions (i.e., feeling aspect of Total Behavior) which may be described as empowerment and elation.

Along with the concept of Total Behavior, another hallmark of Choice Theory is that “We are driven by five genetic needs: survival, love and belonging, power, freedom, and fun... [and] We can satisfy these needs only by satisfying a picture or pictures in our quality worlds” (Glasser, 1998a, p. 335). Thus, the genetic needs appear to be related to the quality world which Glasser (1998b) described when he wrote, “It is called the quality world because it contains our best or highest-quality pictures or perceptions of the people, things, and situations that we have learned feel especially good in the real world” (p. 63). Consequently, by becoming more aware of the contents of my quality world and how my quality world may lead to the fulfillment of my needs, I may be able to more fully and productively approach circumstances related to the outcomes of the Experience. For example, I am currently changing careers from human services to education, where I will be a certified secondary-school biology teacher, and subsequently plan to apply to doctorate programs in education or educational psychology after achieving secondary-school tenure. As a teacher, there is the possibility that I may meet fellow educators who have not been informed about human differences to the same extent as my colleagues within human services. This lack of information may lead these colleagues to misinterpret my

status as an equally valuable human being because of the physiological difference resulting from the Experience. This situation may present a momentary challenge to my perception of being accepted and thus may briefly affect my need to belong. However, if I realize that my quality world does not include people who would negatively judge me for this physiological difference, then my acceptance by these people may have little or no effect on my need to belong. Moreover, I would prevent a reciprocal process of negative judgement by realizing that their opinions may only be misinterpretations based on insufficient information. I would then implement a professional, yet cordial, interaction with these people. By maintaining a professional relationship with people who do not include in my quality world, I would be able to productively relate with them while simultaneously remaining free from their misinformed opinions, thus satisfying my need for freedom. Also, by believing that the opinions of these people are only misinterpretations, I would be free to continue to accept myself and move toward greater levels of self-love which would satisfy my need for love. In fact, this way of cognitively processing reality may be circular and self-reinforcing as increased levels of self-love and self-acceptance lead to increased levels of freedom from the influence of the misinformed opinions, which again may to lead to increased levels of self-love and self-acceptance. Through this process, new levels of self-love and self-acceptance may continue to be achieved.

**CONCLUSION**

This article presented a self-discovery process following physiological trauma. The initial process was compared with aspects of William Glasser's, Choice Theory. Additionally, Choice Theory-based strategies were described which may guide the self-discovery process, moving forward. A serendipitous result of the Experience is that metacognitive awareness increased and a higher level of self-integrity was achieved. Although this article presented some indication of the thinking which occurred following the Experience, it may be difficult to fully express many of the thoughts and how these thoughts may have contributed to the enhanced self-integrity. To more fully explicate these thoughts, the words of William Ernest Henley (1875), as written within the poem, *Invictus* (i.e., Latin for “unconquered”) are offered:

Out of the night that covers me,  
Black as the Pit from pole to pole,  
I thank whatever Gods may be  
For my unconquerable soul.  
In the fell clutch of Circumstance  
I have not winced nor cried aloud.  
Under the bludgeonings of Chance  
My head is bloody, but unbowed.
Beyond this place of wrath and tears
Looms but the Horror of the shade,
And yet the menace of the years
Finds, and shall find me, unafraid.

It matters not how strait the gate,
How charged with punishments the scroll,
I am the master of my fate;
I am the captain of my soul.

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Choice Theory and Emotional Dependency

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ABSTRACT

This article focuses on emotional dependency and how it develops, using Choice Theory as its theoretical base. It is proposed that in order to prevent this type of dependency, children need to be brought up in an environment of unconditional love and acceptance so they develop a strong identity with clear boundaries. In discussing the impact of emotional dependency on relationships, the Karpman Triangle is used to explain the destructive behavior choices that dependent players make. A detailed account of the techniques the Reality Therapy counselor can use to help clients become interdependent is provided.

Choice theory says that human beings are internally motivated. However, the world around us is almost entirely adheres to the opposite belief; that we are externally motivated. The belief in external motivation includes the notion that people are able to cause others to behave in a certain way. It endorses the idea that it is possible to control others. Yet, attempts to control others nearly always lead to the use of coercive methods, as control is based on trying to make other persons behave in a manner that is often against their wishes. Some individuals even resort to verbal and physical violence, as well as other types of abuse. They do not only exercise this kind of control in relationships with important people in their lives, but they behave in similar ways with other people with whom they come into contact. It is not difficult to see that coercive methods are destructive to relationships.

It is also important to mention that a number of individuals exercise control by attempting to obtain the approval of others. This is nearly always achieved by trying to please or solve other people’s problems. These rescuing behaviors lead to the denial of those other people’s own wants, which actually results in just as much unhappiness as that caused by individuals who use force as a means of control.

I believe that the desire to control others excessively usually stems from a dependency the individual has on those other people. I am not talking about the kind of dependency that babies and children have with their parents or other adults for emotional and physical care, or the kind of people who are very ill or totally incapable of moving about who also need to be looked after and therefore are dependent on their environment.

Rather, in this article I wish to discuss individuals who are emotionally dependent as well as those who are mutually dependent, which is often referred to as 'co-dependent'. This is because, from my observations, emotionally dependent people often form relationships with other people who are equally dependent.

What is emotional dependency?

Emotionally dependent individuals rely on other people for emotional security and stability. They might also be dependent on possessions, looks and achievements. Whatever they depend on, they believe that the gap they experience internally can only be resolved by someone or something outside themselves. Emotionally dependent individuals appear to lack an adequate sense of self or strong identity, and they perceive this as an emptiness or gap which they can’t put into words and don’t understand.

Their reasoning might go something like this:

I am what others think of me.
I own, therefore I am.
I achieve, therefore I am.
Other people approve of me, therefore I am.
I have the perfect body and hairdo, therefore I am.
I help others, therefore I am.
I earn a lot of money, therefore I am.
I am successful in my job, therefore I am.

There is absolutely nothing wrong with being successful, taking care of oneself, achieving, having a good job and a nice place to live, and being recognized and acknowledged by others. The dependency is evident in the second part of that thought – ‘therefore I am’ – where the identity of the dependent individual is only complete and whole when certain conditions as described above have been met. If those conditions have not been met, that person’s thinking becomes ‘I am not’.

What is identity?

The word identity can be defined as the state of being oneself and not another. It implies separateness. Birth is the first step towards becoming a separate being. Then, in time,
a baby develops a sense of self and an identity is formed.

It occurred to me that as a baby enters the world as a separate being when it is born, it also needs to be able to connect to survive. However, we are only able to connect if we know and understand what it means to separate, and we are only able to separate if we know what it means to connect. Through her actions, the baby’s mother guides this process of separation and connection.

I believe that awareness of the dual relationship between connection and separation is necessary to understand the concept of boundaries. Each identity has boundaries. They denote the difference between one person and another: between one identity and another. This is ‘you’ and this is ‘me’.

The word boundary implies a division. Many people find it difficult to accept that there are boundaries between people because they believe we are all connected. However, our boundaries signal messages to the world around us about who we are, and what our values and beliefs are. Values and beliefs as well as knowledge of what we want to do with our lives form part of the most inner area of our quality world or the “what we want most world”. The more awareness we have about this most inner core of our quality world, the better we will be able to give information about ourselves to the important people in our lives as well as others, and the stronger our boundaries will be.

It follows then that the stronger individuals’ boundaries or signals are, the better their connection with other people will be.

This is because individuals with strong boundaries are interdependent while people whose boundaries are vague are most likely dependent, meaning their relationships are co-dependent. In other words, if individuals have vague boundaries, this leads them to overlap their boundaries with others.

I believe that vague boundaries come into existence very early in a child’s life. The reason is that the process of separation and connection is disrupted by the behavior of the parents, particularly the mother. After all, the baby spent nine months in its mother’s womb. It is mostly the mother’s responsibility to guide the process of separation and connection.

If the mother is unclear about her own identity and dependent on important people in her life, including her partner, she will most likely become dependent on her child as well. The child in turn will exhibit similar behaviors, as there is no clear distinction between separation and connection.

For example, if the mother of the child is insecure and hesitant about her decisions in caring for her baby, the baby will sense this. The mother might also be overprotective and the tone of her voice could indicate that she is unsure about herself. What this kind of behavior points to is that the mother lacks trust in herself, which will also be evident in the way she approaches other people. The sad consequence of such a mother’s actions is that her baby will not develop trust in itself or indeed in other people.

As the child gets older, the messages it received in early infancy continue. They can be of a very subtle and manipulative nature. For example, the dependent mother might say to her three year old child who is going to stay overnight at her grandparents’ house, ‘I hope you’re not going to miss us when you’re away tonight. Do you think that you’re big enough to do that? I’ll miss you a lot and I won’t be able to read you a story when you go to bed.’ The child will most likely reply that it doesn’t really want to go. The response is not surprising, considering that the child has been groomed to develop emotional dependency from the day it was born. I believe that:

Emotional dependence implies a lack of boundaries and the inability to send clear signals, which leads to emotional fusion and neediness.

It follows that the child is not able to form an adequate sense of self as it is never acknowledged as a person in its own right. Its mother’s love is conditional. The only recognition the child receives is when it acts according to its mother’s demands. Furthermore, because the mother’s relationship with her partner is likely to be co-dependent, the behavior choices the father makes when relating to his child will further enforce dependency in the child.

It is not surprising that such a child will grow up into an adult who is faced with a catch 22 situation on a daily basis. His or her reasoning might be:

‘If I become the real me, nobody will like me, accept me and recognize me. I won’t be happy!’

If I remain the false me so that I’m liked, accepted and recognized, I’m denying who I really am. I won’t be happy!’

I believe that the approach of parents when interacting or discussing incidents with their children must be founded on a strong emphasis of recognition. Recognition is acknowledgement of the child’s being, the child’s personality and basic needs as well as the child’s input into situations. Recognition is being listened to and heard.

Children whose parents resort to conditional love never receive the recognition they need to develop an adequate sense of self. When these children become adults, they are unsure about their identity. As a result, the behaviors they choose to satisfy their needs are based on an unfulfilled childhood wish to get the recognition they never received as a child. Yet, because the behaviors they choose to satisfy their basic needs are colored by the desire to be recognized, it is not difficult to see that they are ineffective.

In my experience, emotionally dependent individuals struggle enormously to satisfy their needs for love and belonging. They don’t know how to connect with people
and they are incapable of closeness with others.

It is not surprising that due to this lack of closeness they also have difficulty satisfying their other needs, particularly their need for power. This is because part of what gives people a sense of power is recognition. In this way, the need to obtain recognition from others one way or another becomes the main drive of people who are emotionally dependent.

Yet, dependent individuals have not acquired the effective behaviors they need to satisfy their need for power, largely because the choices they make involve all or some of the disconnecting habits they learned as a child. Disconnecting habits are BLAMING, COMPLAINING, NAGGING, PUNISHING, THREATENING, CRITICIZING AND REWARDING IN ORDER TO CONTROL. When taken to their extreme, they involve violence and all types of abuse.

People who resort to these behaviors are persecutors. Persecutors are just one of the three groups of people who play a role in destructive relationships. Below is a diagram known as the 'Karpman Triangle', which attempts to show the relationship each of these groups has to the other:

**Karpman Triangle**

- **Persecutor**
  - **Rescuer**
  - **Victim**

As you can see, persecutors form the first group at the top of the triangle. Persecutors torment people, including by resorting to extreme control to ensure the important people in their lives continue in the relationship. However, for persecutors to be able to persecute, they need a victim. In this way, persecutors and victims are dependent on each other. Domestic violence is an example of a situation that demonstrates the dependent relationship between a persecutor and victim.

Victims are the second group. They are the receivers of the ill treatment dished out by persecutors. They believe they have no choices over their circumstances because they perceive themselves as powerless. Victims want other people to feel pity for them, and they long for attention. Victims keep important people in a relationship with them by playing 'poor me'. Interestingly, I believe that all persecutors began as victims, but at one point decided to become a persecutor to be the 'top dog'.

The third group is rescuers. Rescuers fix the problems of other people. The purpose of their behavior is to 'secure' their relationships by making other people dependent on them. That way, the resucer feels safe enough to in turn depend on those people. Rescuers often perceive themselves to be really 'nice' people. However, they are not aware that their behavior sends a message to other people that they are incapable of getting by without a resuer. Rescuers are also unaware that their behavior indicates neediness because they are co-dependent. Thus, the resucer and victim are just as dependent on each other, as persecutors and victims are.

It is also important to note that individuals often move from one group to another, for example victims might also persecute some of the time, and persecutors might become rescuers.

The behaviors of the three groups described in the Karpman Triangle are all based on fear. Fear is the opposite of love and trust, and relationships based on fear rather than love and trust don't work because the behavior of "fearing" dominates decision making. It follows then that the games played by the groups in the Karpman Triangle are harmful, i.e. because they are based in fear rather than love and trust.

These games can be played by just two people or by a larger group such as a family. They can be found in any workplace or organization, and they can be observed in many different cultures.

One of my clients referred a French tourist to me for counseling who was very distressed. It emerged that she came to Australia to escape her partner who lived in Paris because he was persecuting her. She thought that getting away as far as possible from this man on a one-way ticket would automatically fix her problems. However, she was 'emotionally fused' with him and as a result only felt incomplete and desperate. She was also confused and didn't understand why on the one hand she wanted to be as far away as possible from him, and on the other wanted badly to see him and be near him.

During our conversation, the woman worked out that apart from being a victim, she was a resucer and a people pleaser. Often rescuers are pleasers. They please others to receive approval, which makes them feel whole. However, this need to please also indicates neediness which in turn shows they are dependent.

I have observed that pleasers offset their excessive pleasing by rebelling. Rebelling is an attempt to be free from others who pleasers perceive as having a great deal of control over them because those others decide whether to give the recognition and approval the pleaser needs. Rebelling also satisfies pleasers' need for freedom.

*The intensity of the rebelling is related to the intensity of the desire to please, which in turn is related to the extent of the perceived power of others.*

Attempts by pleasers to please and to offset this pleasing by rebelling do not work. In fact, they cause new problems and this is what happened to my client. While she realized after some counseling that her escape to Australia was a way of rebelling, and also that purchasing a one-way ticket had not helped her get away from her partner because she remained emotionally tied to him, her rebellious behavior had caused her new problems: her visa was only valid for
three more weeks and she had little money left.

We only had a short period, but during that time I helped my client learn strategies to begin to step out of the Karpman Triangle and I taught her more effective behaviors. She soon found herself a job to earn the money to buy a return ticket. Upon her return to France she finished the relationship with her partner, and sought further help at my advice.

The French woman wrote to me during that time, and said that on a daily basis she was now giving herself the recognition she so desperately wanted all her life and never received as a child. She grew up in an environment of conditional love in which the only way she could receive love as a child was by acting and responding according to her mother’s demands.

I taught her to focus inwards and to look for the solutions inside rather than outside herself. In other words, I encouraged her to reclaim her lost center of self. She began to change her self-talk. She said this was hard work, but that she was determined to succeed.

Although my client’s mother was not violent, what she did was just as damaging as those parents who threaten, punish or resort to emotional abuse. Some parents do resort to violence and other types of abuse, while on other occasions they become rescuers as the Karpman Triangle explains.

Equally as harmful are the parents who act overly nice to their child giving them everything they want and never setting limits. In such relationships, boundaries are absent. Through my work, I have observed that underlying this kind of behavior once again is fear. The parents who do not signal boundaries are scared that if they set limits, they will lose the love of the child. However, by putting their need to receive their child’s love first, such parents are ignoring their own wants and needs, or in other words, they are ignoring their own identity.

I once asked a client, a sixteen year old boy, what he wanted more than anything else from his mother and father. He replied that he wanted structure. I asked him what he meant, ‘What I mean by structure is limits,’ he told me. I continued to ask him what it would mean if there were limits in his home environment. He was close to tears when he answered, ‘Then I would finally know that they love me’. The boy had picked up that he was not being loved for himself, but that his parents loved him for their own sake. Once again, what lies beneath this scenario is the boy’s desire for unconditional love and acceptance, and ultimately for recognition.

Unconditional love and acceptance

When children receive unconditional love and acceptance, they learn that they are always loved and recognized for the person they are. They learn that their parents rightly focus on their behavior when the choices they make are unsafe or interfere with the rights of other people.

I believe that there needs to be a distinction between a person and the behavior that person uses. Children are born with genetic needs that they are driven to satisfy from the very beginning. The learning process is in how they do this. The first ‘how’ is about creating need satisfying behaviors that are effective. The second very big ‘how’ concerns discovering that other people also have needs, The most challenging ‘how’ is to develop behaviors that both satisfy needs but in ways that do not interfere with the rights of other people to do the same. This implies an ability to get along with others.

This type of learning takes time. I believe that the reason why there is so much misery in the world is that many adults never acquired these skills. As a result, they are unable to model adequate behaviors to their children.

To overcome this lack of ability to get along with others, people need to incorporate the principles of internal control psychology or choice theory. As already mentioned, what is mostly practiced is external control, which is based on the belief that we can control others and that they can control us.

In a ‘choice theory home’, parents would have a strong sense of self and well developed self-awareness, which they would have gained partly through their knowledge of choice theory. Consequently, they would have strong boundaries and they would give unconditional love and acceptance to their children.

These parents would feel good about themselves and would see themselves as being in control of their lives as well as capable of satisfying their basic needs while maintaining a good balance between them. Their strong identity would be reflected in their behavior toward their children. This in turn would facilitate their children’s learning to form their own identity.

Through the father and mother’s unconditional love and acceptance and the ensuing quality of the interaction with their children, the children would learn to relate to other people. The parents would model the connecting habits of listening, supporting, encouraging, accepting, respecting, trusting as well as practice negotiating skills with their children when disagreements arise.

As a result, the atmosphere in a choice theory home would be one of safety in which all family members are accepted for who they are. Only in that type of environment would children be able to explore their own needs, become aware of the needs of others as well as develop an increased understanding of others, a sense of compassion and the ability to empathize. In short, they would become interdependent.

Emotional dependency and reality therapy

Dependent individuals nearly always practice disconnecting habits. As mentioned, they include blaming,
complaining, bagging, punishing, threatening, criticizing and rewarding to control others. Usually, only when these people's relationships have been ruined by the above behaviors do they look for help and support as a last resort.

The question I would like to answer now is what can a practicing reality therapy trained counselor do to help such clients understand that their behavior is not very helpful and teach them to replace these deadly habits with connecting behaviors?

First, it is important to be aware that no matter what the counselor and clients focus on during the first visit, the counselor must practice these habits at all times. By doing so, the counselor creates a safe and trusting environment and models good relationships. Gradually, clients will learn to replace harmful behaviors with helpful ones.

One option is for the counselor to make a connection between the deadly habits and the Karpman Triangle. In my practice, I teach my clients the Karpman Triangle to enable them to evaluate whether any of their behaviors reflect the three groups in the triangle. Discussions around this issue may well involve more than one session.

The deadly habits refer to behavior choices. Behavior choices form part of choice theory, and the reality therapy counselor nearly always teaches clients choice theory, or at least parts of it. This depends on the case and the type of client.

I always explain the scales and the concepts behind it using a physical set to demonstrate my point. In my experience, there are no better tools to explain that the behavior choices clients have been making are their best attempts to close the gap between what they want and what they perceive they are getting.

In the lives of victims, the scales are permanently tipping and no matter what they do, nothing changes. This is because they have not realized that the want on their scales is always focused on what they want from other people. This way of behaving guarantees misery because they are totally focused on the behavior of others over whom they have no control. This leads to a perception that they are utterly powerless when others don't give them what they want. It does not occur to them to ask themselves what they can do, how they can approach a situation and what their choices might be. In other words, victims hardly ever put themselves on the scales.

I was involved in a program for around six to eight adolescent boys and girls who had been expelled from their schools many times. Their home environments were all abusive and some of them had appeared before the Youth Court. I developed a very good relationship with them, particularly when they realized I was not there to change them, criticize them or tell them what to do. Rather, I was interested in them and in what they wanted from the program.

Fortunately, funds were available to extend the program several times. I was asked by the coordinator to submit the contents of my program to her, which I did, although I hardly ever implemented what I had planned. Instead I asked the group what they wanted to discuss. However, whatever their requests were, I incorporated choice theory into our sessions so they would learn some new tools. They were so interested in one aspect of choice theory, the scales, that we discussed it each of the 24 times we met.

I believe this is because these young people had been victims all their lives. What the scales did was explain to them their situation and how they were thinking and acting. Through this, they slowly began to understand they had options. Some of them began to make different choices in their lives. What I learned from this group was that I could not wish for a better tool to explain the behavior of 'victiming' than the scales.

In my work I also use the scales to talk about the recognition desired by emotionally dependent clients. I help them realize that because the wish to be recognized was never fulfilled when they were younger, over time it became their script. A script involves a specific way of thinking and acting and can be compared to a road map. It is how clients approach events and situations they are unable to handle.

Examples of childhood scripts or road maps are: 'If I am a very good girl, people will be good to me', 'If I am a very good boy, people will love me', 'It's all my fault', 'I don't care', 'It's not fair', 'I will never do anything right', 'I am not important', 'The world is out to get me', 'If I do what my parents want, they will be happy with me' or 'I am bad, my parents are good'. In short, they are a child's best attempt to get by in difficult situations.

I always ask my clients what the purpose of such thinking was. Their replies are always roughly the same. They inform me that there was no pay-off, just misery. However, when I question them further, they become aware that the purpose of their thinking was to give themselves a sense of control over what was happening in their lives.

If their script read that everything was their fault, they often concluded that all they had to do was not make any mistakes and everything would improve. This never worked, of course. First, the behavior of people in their environment did not change no matter what they did or did not do. Second, everyone makes mistakes; they are opportunities to learn by. However, in their situations these people interpreted mistakes as failure which diminished their self-esteem. In many cases, this led to perfectionism or the tendency to overcompensate.

Unless such people are able to resolve these issues, they continue to act out their scripts into adulthood. I explain to such clients that the way out of this is to write a new and effective script. They need to find better choices and become aware that they are in total control of their thinking and acting.
With help, they begin to realize that the answer to their problems lies in the way they think or the way they talk to themselves as well as in pondering their identity. The question they must ask themselves is, ‘Who am I’ as Dr. Glasser put it so succinctly in The Choice Theory Manager.

This question urges clients to consider how they can become the person they want to be. It causes them to consider what kind of behaviors such a person would use, what their values and beliefs would be, what they would and would not do, how they would support, respect and recognize themselves, and how they would develop trust.

These are some of the questions I put to my clients in this position who are then able to see that there is a way to overcome their misery that involves a journey of self-discovery over time in which they need to take responsibility for their actions and thoughts. Often, however, dependent clients struggle with responsibility. Some believe that other people are responsible for the problems while others carry the difficulties of the entire world on their shoulders.

The strategy I use with such clients is to ask them to imagine one or more brightly colored bags. The first one is labeled ‘My responsibilities’ while the labels that are given to the other bags depends on what the client wants. They might want a bag each for their partner, child, parent or employer or they might have just one bag for ‘Other people’. Next, we discuss what it is that belongs in the client’s responsibility bag and what doesn’t, which takes some time. After that, we talk about how the use of the bags might impact on the client’s future behaviors. For example, what would life be like for them if they were only responsible for their own behavior?

I remember that one of my clients commented that the exercise of the bags helped her realize that her thinking had been “faulty” for many years. After that, she was able to begin to make changes that allowed her to see herself in a different light. In the end, she became her own best friend and treating herself the way she wanted to be treated by others. She gave herself what she so desperately wanted and needed as a child. It is at that point that she became truly interdependent.

I have found the above techniques very useful, but this list is by no means conclusive. The technique I use or do not use at the time depends entirely on the kind of client with whom I am working. I have found that nearly all clients struggle with one or more difficult and harmful relationships. But I strongly believe that people can change. I explain that to my clients; that we are a team and that together we can work it out. It is essential that the environment the counselor creates is one of trust. Only then can interdependency develop and flourish.

In finishing, I would like to quote Rabbi Mendel who explains the meaning of interdependency better than anyone:

“If I am I because I am I
And you are you because you are you
Then I am and you are
But if I am I because you are you and
And you are you because I am I
Then I am not and you are not.”

REFERENCES

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ABSTRACT

This paper discusses combining Animal Assisted Therapy (AAT) with Choice Theory (CT) or Reality Therapy (RT). Counselors seek methods to facilitate a positive therapeutic relationship or Therapeutic Alliance (TA), and this study incorporates a unique method. Animal Assisted Therapy (AAT), to enhance and expedite this stage. Additionally, therapists search for supportive means to move individuals into engagement and commitment to the counseling relationship. This article discusses how one four-legged-therapist and one two-legged therapist facilitated this. Although there have been several studies measuring correlation between AAT and physical health (Anderson, Reid, & Jennings, 1992; Dembicki & Anderson, 1996); this empirical study evaluates the relationship between AAT and individuals participating in mental health counseling. The study shows the outcome of using CT or RT and AAT with group members addicted to drugs, in an inpatient setting.

CT (Glasser, 1969, 1998; Wubbolding, 2000) provides the theoretical framework for this study and, more specifically, the facilitation of the counseling session's initial stage, building the relationship as discussed in Reality Therapy's Cycle of Counseling. Counselors question ways to facilitate a positive therapeutic relationship or Therapeutic Alliance (TA), and this study incorporates a unique method. Animal Assisted Therapy (AAT), to enhance and expedite this stage. Therapists search for effective means to move individuals into engagement and commitment to the counseling relationship. This process appears more complex with individuals whose lives involve impediments such as trust, abandonment, addictions, legal, educational, physical, and career, to name a few (Glasser, 2000). The aforementioned provides the rationale for the research project presented in this document.

Literature Review

This paper highlights two areas of literature: the philosophy and use of Choice Theory/Reality Therapy and the power of AAT in increasing individuals' physical and mental health. There appear to be numerous articles and texts addressing the aforementioned; however, when linking both concepts together, literature appears nonexistent.
a Reality Therapist would mostly concentrate upon actions and thoughts, while not ignoring feelings and physiology. Choice Theory/RT (Glasser, 1998; Wubbolding, 1986, 2000) uses a suitcase metaphor to describe this concept, with the handle representing action and the main suitcase consisting of thoughts, feeling, and physiology. When individuals change their “doing” behaviors by metaphorically picking up their suitcase handle, the rest of their behaviors will follow (e.g., thoughts, feelings, physiology).

**Relationship.** Total behaviors either impede or facilitate the development and maintenance of effective relationships. Furthermore, CT authors (Glasser, 1965, 1998; Wubbolding, 2000) suggest that individuals demonstrating effective control of their lives also appear to have healthy quality relationships. Individuals place symbolically these relationships in their QW and access these memories when the need arises.

Some individuals do not have access to information or experiences to make an evaluation about how their behaviors affect their relationships (Wubbolding, 2000). For example, individuals raised in violent homes (Glasser, 1998) may not be able to distinguish between neutral and threatening events. Individuals with an early childhood history of drugs (Glasser, 1995, 1998), physical and mental abuse (Glasser, 1998), or inconsistent parenting (Glasser, 1998) in their home, may not know or understand “acceptable or normal” behavior. Behaviors may be chosen to meet a short-term sense of happiness over long-term goals in a person’s QW (Glasser, 1995, 1998; Wubbolding, 2000), such as freedom (divorce, loss of children, or jail), power (loss of self-esteem, education, or job), belonging (loss of family, children, or friendships), and survival (poor health, loss of housing, money, or death).

RT indicates the relationship between the client and the therapist as a critical component in counseling (Glasser, 1965, 1998; Wubbolding, 1986; 2000). In addition, individuals entering counseling must place the therapist in their QW for effective change to occur (Glasser, 1965). This is a powerful and critical key in working with individuals in evaluating their needs profile, wants, perceptions, and total behaviors. Expanding upon this significant key, variables found in the counseling relationship resulting in individuals improving due to counseling, the following additional literature extends the previous review beyond CT references.

**Therapeutic Alliance**

Authors refer to this process as circulatory (Briggs, 2006; Critis-Christoph. et al., 1991; Critis-Christoph., & Connolly Gibbons, 2003; Flores, 2004). Clients bring their interpersonal experiences into the counseling relationship; additionally, the counselor presents his or her own history (e.g., education, training, experiences, interpersonal attachments, values) into the counseling relationship. In fact, several researchers (Critis-Christoph. et al., 1991, Harvath & Symonds, 1991; Henry, 1998; Lambert, 1992; Martin, Garske, & Davis, 2000; Orlinsky, Grawe, & Parks, 1994; Wampold, 2001) advocate that the therapeutic alliance accounts for much of the variance (12% - 54%) in explaining treatment outcomes in contrast to counseling theory or techniques. Indeed, two large separate studies (Krupnick, et al., 1996; Orlinsky, Ronnestad, & Wilutzki, 2003) conclude that the strength and quality of therapeutic alliance is an antecedent to positive treatment outcome. Given that, the therapeutic alliance appears to be such an important ingredient in facilitating positive counseling outcomes that counselors need to measure consistently this variable (Bachelor & Horvath, 1999; Norcross, 2000). Based upon the client’s perception of the counseling effectiveness, the therapist makes appropriate adjustments (Duncan, Miller, & Sparks, 2004); thereby increasing the counseling effectiveness.

A particularly demanding population challenging the counselor’s ability to provide and moderate the therapeutic alliance involves those abusing or addicted to substances (Miller, Rollnick, & Conford, 2002). This is the population used in this research. Several authors (Beck, Wright, Newman, & Liese, 1993; Connors, DiClemente, Carroll, Longabaugh, & Donovan, 1997) maintain the strength of the therapeutic alliance appears just as significant and worth monitoring when working with individuals with a history of substance abuse or addictions. This imperative variable emerges in early work by Chafetz, et al. (1962) and more recently by Meier, Donnall, McElduff, Barrowc1ough, & Heller (2006). When looking at the variance between one single empathic counseling session with individuals addicted to alcohol, Chafetz, et al. (1962) concludes one compassionate session increases the chances ten times that the person will seek additional treatment and strengthens (almost fifty times) the individual’s commitment level for treatment.

**Animal Assisted Therapy (AAT)**

This section reviews the definition of AAT and its research and application. The International Delta Society (2004) certifies and defines Animal Assisted Therapy. Individual(s) participating in AAT are working toward specific treatment goals; the handler may or may not be a therapist. Handlers and their animals function as partners in working with individuals in a variety of ways. (Hunt, Hart, & Gomulkiewiez, 1992). Keeping this in mind, the following literature reviews the use and effectiveness of AAT.

Focusing on AAT and exploring the related literature reveals four broad categories, 1) meta-analysis, 2) empirical type studies, 3) case studies or more qualitative type studies, and 4) personal type studies. Three meta-analyses exist reviewing AAT studies (Barba, 1995; Garrity & Stallones, 1998; Gerbasi, 2004). The most recent meta-analyses by Gerbasi (2004) review 128 studies using animals in different types of healing or rehabilitative inter-
ventions. In scrutinizing for the most reliable studies (e.g., empirical design, random samples, blind review of data, research goals) Gerbasi (2004) determines only Zisselman, Rovner, & Ferrie (1996) meets the aforementioned criteria; therefore, lending credence to the need for quantitative research measuring the association between AAT and curative outcomes.

Looking at less robust AAT research, even though they do not meet the Gerbasi's (2004) strict criteria, there are still numerous substantive studies. Some of the most vigorous studies reveal a positive correlation between the presence of an animal and its effect upon physiological indicators. In early work, Anderson, et al., (1992) conclude a positive association between animals and biochemistry (cholesterol and triglycerides levels lowered). Odendaal's (1999) proves neuroendocrine levels appear significantly affected with the human-animal interaction. Lastly, numerous studies measuring the association between animals and autonomic responses, consistently support significant results in lowering blood pressure and heart rates (Allen, 2003; Allen, Blascovich, Tomaka, & Kelsey, 2001; Allen, Shykoff, & Izzo, 2001; Baun, Bergstrom, Langston, & Thoma, 1984; Friedmann, Katcher, Lynch, & Thomas, 1980; Harris, Rinehart, & Gerstman, 1993; Nagengast, Baun, Leibowitz, & Megel, 1993; Nagengast, Baun, Megel, & Leibowizt, 1997; Odendaal, 2000). A second focus in the literature reviews AAT and psychological variables. AAT appears to positively influence self-esteem (Terpin, 2004; Walsh & Mertin, 1996), reduce stress (Allen, Blascovich, et al, 2001; Allen, Shykoff, et al, 2002), and improve behavior (Merriam-Arduini, 2000; Strimple, 2003; Terpin, 2004).

A third concentration of literature analyzes the human-animal interaction with two specific age populations. The literature reveals early studies analyzing the human-animal interaction with the aging in nursing homes and supervised living environments. When introducing an animal into the lives of the aging, numerous significant advantages appear from improving physical health (Dembicki & Anderson, 1996), to increasing eye coordination (Edwards & Beck, 2002), and improving physical activity (Corson & Corson, 1978; Taylor, Maser, Yee, & Gonzalez, 1993). Studies also conclude progress in pro-social interactions (Churchill, Safaou, McCabe, & Baun, 1999; Fick, 1993; Walsh, Mertin, Verlander, & Pollard, 1995) and reduction of stress (Barak, Savorai, Mavashev, & Beni, 2001).

Looking at the opposite age spectrum, the inclusion of animals during child and adolescent treatment reflects positive improvements in cognitive functioning, mental health, and relationships. Studies reveal progress in cognitive abilities (Nathanson & de Faria, 1994), and language skills (Nathanson, 1989). Numerous studies measure improvements in children's mental health when utilizing an animal, although these are not inclusive. However, some of the more recent and more noteworthy include the following: reducing anxiety during treatment (Allen, Blascovic, & Mendes, 2002; Nagengast, et al., 1993; Reichert, 1994; Woolverton, 1993), increasing attention spans (Nathanson, 1989), and improving empathic abilities (Ascione, 1992; Melson, Peet, & Sparks, 1992). Furthermore, children appear to improve in their relationships and increase their ability to form attachments when introducing an animal into the setting (Melson, 1990; Paul, 2000; Terpin, 2004; Vidovic, Stetic, & Bratko, 1999). Lastly, animals can enhance a child's ability to express unconditional acceptance (Bardill & Hutchinson, 1997).

To conclude the literature review of AAT with the general population, this paper directs the reader to studies advocating negative risk or no effect on participants. Brodie, Biley, and Shewring (2002) speak in their article about the negative consequences, costs, individuals disliking animals, phobias, and cultural inhibitions. Additionally, individuals need to consider complications that are more serious. These include allergies (Barba, 1995; Schantz, 1990) and infections from animals or zoonoses (Schantz, 1990). The most serious concern includes bites (Schantz, 1990), supporting the need for handlers and their partners to be certified and participate in re-certification on a routine basis. Finally, two studies (Miller & Lago, 1990; Stallones, Marx, Garrity, & Johnson, 1990) found no changes in the well-being of older adults, when AAT became a part of the milieu.

Shifting to AAT with individuals participating in substance abuse services, there appears to be only two forerunners to this project: A descriptive study (Pace, 1996) and a qualitative study (Campbell-Berg, 2000). Pace (1996) studied three female adolescents abusing substances and the changes in their self-concept and their role changes after using AAT. The second project (Campbell-Berg, 2000) used a qualitative method to study a 21-day residential treatment program for individuals with addiction disorders. The researcher included 6 to 8 individuals from the program and completed four group sessions. Group members could play fetch with the AAT dog, a German shepherd. The data originated for this study from responses to fifteen questions. The results concluded participants experienced an increase in positive attitude, helpfulness, trust, communication, and a decrease in fear and anxiety. These two studies did not allow for a control group, consisted of only a few participants, and used no assessment instruments; however, the results were positive for both projects.

Although not an empirical study, Pichot & Coulter (2006) write about their positive experiences using AAT with a substance abuse program in Colorado. Some of their observations about the clients and animal interaction include increase in comfort level, shifts in communication to positive talk about the dog instead of drug stories, and a decrease in anxiety and depression. Until this study, there appears to be no control outcome studies measuring AAT and the effect upon treatment with individuals
addicted to substances.

To summarize the literature section, the relationship between the counselor and the client appear significant in the progress of treatment (Beck, et al., 1993; Connors, et al., 1996). Choice Theory or RT supports this notion and includes rapport building in their Cycle of Counseling (Wubbolding, 1986, 2000).

Study

This section discusses three categories within the methodology, 1) research questions, 2) research design, and lastly 3) assessment instruments. This study contributes to the literature evaluating the use of AAT’s influence upon the counselor and client relationship in a group-counseling context with members experiencing a history of substance abuse or addiction. The research design questions the hypotheses. Does AAT make a difference in the therapeutic alliance when treating individuals abusing or addicted to substances in a group counseling modality using CT or RT as the counseling theory?

Research Design

To measure the above question, the researcher randomly assigned twenty-four individuals to either the control group or the experimental group. The participating individuals met the criteria for substance dependency and currently resided in a residential treatment facility. Prior to an individual’s involvement in the group process or meeting the therapist, several steps occurred. First, individuals participated in a screening along with taking the PET Attitude Scale (PAS) developed by Templer, Salter, Dickey, Baldwin, and Veleber (1981).

To keep the (AAT) variable as the only difference between the two groups, the therapist employed CT philosophy (Glasser, 2000), or RT (Glasser, 1998, Wubbolding, 1988, 2000), techniques, and the same topics were presented for both groups. While both groups worked on recovery issues with the same human therapist, the experimental group also worked with a four-legged therapist, Mitzi Ann. Both the therapist/handler and the 7-year-old Beagle mix dog, Mitzi Ann, held international certification with Delta Pet Partner. At the time of the research, Mitzi Ann had completed numerous training series (11) and had provided over 84 clock hours of therapy in a variety of settings. The doctoral level therapist used for both groups (first author of this article) also holds a license as a Professional Clinical Counselor and three certifications (National Board Certified Counselor, National Certified Addictions Counselor II and Certified Alcohol and Drug Counselor) and, at the time of the research, brought twenty years post-masters experience to the setting. Additionally, the therapist had completed training in Reality Therapy (basic week), conducted workshops and taught a graduate level course focusing on Reality Therapy, and lastly, in 2000 published an article discussing Reality Therapy (Minatrea & O’Phelan).

Assessment Tools

The researcher administered the following assessment tools to participants in order to compare outcomes (Helping Alliance Questionnaire (HAQ-II) (Luborsky, et al., 1996), Pet Attitude Scale (PAS) (Templer, et al., 1981), Session Rating Scale (SRS) (Duncan, Miller, Reynolds, et al., 2004), and blood pressure monitoring). The researchers filmed all sessions in both groups. Later, after the completion of the sessions, the second author of this paper randomly selected eight sessions from both groups, copied fifteen minutes from each meeting on a separate DVD. Then, six independent reviewers observed the DVD measuring for differences in the group outside AAT.

Results

This section presents information summarized from the data collected from the participants and the independent reviewers. Table 1 shows the means and standard deviations of the variables. A series of one-way analyses of variance (ANOVA) computed the difference between the group incorporating AAT and the group without AAT. Additionally, these analyses evaluated the mean HAQ-II ratings, for each group. The results found significant differences between clients in AAT groups and traditional groups. In terms of the clients’ perceptions of the working alliance, a significant difference was found between mean HAQ-II ratings, F (1, 229) 25.44, p < .001. 2 = .100, with those in the AAT groups reporting a more positive opinion of the working alliance. A review of the effect sizes calculated for each variable suggests that the addition of AAT therapy contributed most to the differences observed for mean HAQ-II ratings.

Table 1.

Means, Standard Deviations, and ANOVA for Effects of Animal Assisted Therapy

<table>
<thead>
<tr>
<th>Variable</th>
<th>Animal-Assisted</th>
<th>Traditional</th>
<th>ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAQ-II Rating</td>
<td>122.07</td>
<td>104.52</td>
<td>25.44</td>
</tr>
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Note: "p < .05

Discussion

Increasing the counselor and client relationship can affect a sense of caring or compassion, commitment to counseling process, and treatment goals. This study shows that AAT influences positively the counselor and client relationship with group participants who are addicted to drugs. The group using AAT appears more attached to the counseling process, places a higher value on the experience, and exhibits less stress during the process.
Redefer & Goodman, 1989), and other cognitive challenges (Nathanson & de Faria, 1994). Mitzi Ann currently works successfully with numerous individuals who have communication disorders and autism spectrum disorder.

Teaching problem solving concepts. Using AAT provides a tangible method for demonstrating shaping behaviors toward goals. Individuals can see the importance of the concept of progress not perfection, and the “never giving up” when learning a new trick with an animal or in their own lives.

The authors of this paper recognize that not everyone is enthusiastic about involving an animal in therapy. There are some concerns, cautions, and drawbacks when using a dog, cat, or other animal in the counseling session.

Drawbacks

This paper previously mentioned a few concerns with using any animal in a therapeutic setting, for example infections or bites (Schantz, 1990). Additionally, the authors of this paper express concern for those just bringing their family pet to the office. The regulatory process for certification of handlers and their animal provides protection for the animal and the community they will be serving. The team needs to obtain certification for working with different age groups and settings.

A second concern involves those fearful of animals or allergic to their dandruff (Barba, 1995). Counselors need to use alternative ways to engage participants allergic or fearful of animals, in order not to exclude individuals when conducting group type activities. An aging man in a community day care facility wanted desperately to pet, love, and be a part of Mitzi Ann’s tricks; however, his allergies precluded such interaction. The modification included Mitzi Ann’s picture on his walker, and a stuffed beagle dog for him to carry on his walker, thus he felt a sense of belonging with the rest of the group during Mitzi Ann’s visits.

A third concern relating to this study involves the setting and sample. The individuals were residents in a medium size town and low income; consequently, the reader needs to consider these variables when generalizing to other populations.

SUMMARY

Recently, researchers appear to place more emphasis on the relationship between the counselor and the therapists, the strength of this rapport, and the impact of this connection (Krupnick, et al., 1996; Orlinsky, et al., 2003). CT stresses the importance of this relationship; indeed, CT indicates that clients must put the counselor in their QW to influence change (Glasser, 1965). During this study, the counselor used CT or RT as the foundation for the interactions and techniques. Additionally, the authors compare the two groups for the relationship between involving an animal in a group counseling setting and a group without a dog in the setting. The group with the dog expressed more positive association to their group. “The Mitzi Ann Group,” strengthened the quality of the counselor and client relationship, and enhanced participants’ engagement. Counselors working in other mental health settings may find it useful to include AAT as a counseling modality.

REFERENCES


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Using Reality Therapy to Influence Health Behaviors: Childhood Obesity

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ABSTRACT

This article identifies the health epidemic of childhood obesity and how one might use CT/RT to combat obesity on an individual level by affecting health behaviors. The significance of childhood obesity is assessed, including its prevalence and health implications. How one could use CT/RT in conjunction with education in order to internalize the ideals of healthy living and influence the individual control of health behaviors is discussed.

Introduction to childhood obesity

Childhood obesity is seen as one of the worst current health epidemics in our country. The percentage of obese children has more than tripled in the past forty years. "Data from two NHANES (National Health and Nutrition Examination Surveys) surveys (1976-1980 and 2003-2004) show that the prevalence of overweight is increasing: for children aged 2-5 years, prevalence increased from 5.0% to 13.9%; for those aged 6-166 years, prevalence increased from 6.5% to 18.8%; and for those aged 12-19 years, prevalence increased from 5.0% to 17.4%" (Overweight Prevalence). The significance of these statistics merits the inclusion of this critical health issue in the government program Healthy People 2010, which has listed "Overweight and Obesity" as one of its leading health indicators.

Childhood Obesity Defined

Childhood overweight and obesity is generally defined using body mass index (BMI), which is a measure of weight/height. The terms overweight and obese at this stage of development are used interchangeably, and are defined as greater than or equal to the 95th percentile of BMI. "At risk" for overweight is within the 85th-95th percentile. The child and adolescent population is extremely vulnerable, and being overweight at this stage of development is a great risk factor for being overweight later in life and developing serious health conditions.

Health Implications

Some of the serious health consequences associated with childhood obesity include the conditions that can develop immediately, such as type II diabetes, hypertension, hepatic disease and orthopedic complications, which can become long term conditions. There are also health consequences that will develop over a longer time period, such as atherosclerosis, arthritis, liver fibrosis/cirrhosis, and colorectal cancer (Elssie and Gunner, 2004). These are very serious health consequences, and some of the important reasons why it is so vital to reduce childhood obesity.

Childhood obesity is a significant emerging health issue in the United States. An article from the National Institutes of Health states that "obesity in kids is now epidemic in the United States. The number of children who are overweight has doubled in the last two to three decades; currently one child in five is overweight" (Torgan, 2002). Due to the prevalence of childhood obesity, as well as its associated health risks, morbidity, and national cost, it is a major health issue.

"Overweight adolescents have a 70% chance of becoming an overweight or obese adult" (Torgan, 2002). This increases their chance of developing obesity-related diseases such as cardiovascular disease or type II diabetes. These are significant health implications, being that cardiovascular disease is the number one cause of death in America and type II diabetes is number five (Heart Disease). As the percentage of obese children increase, so will the percentage of obese adults. This will considerably decrease the health of our nation as a whole.

Obesity does not only affect physiological health, but also greatly affects psychological health. Many studies have linked childhood obesity with depression. One particular study published in Pediatrics concludes that "there is a significant statistical association between adolescent obesity and depression" (Sjoberg, Nilsson and Leppert, 2005). This study also linked obesity with experiences of shame in adolescents. The depression and shame that obese children and adolescents are experiencing is leading to a greatly decreased quality of life. In a research study in JAMA (2003), it was found that in regard to quality of life scores, "obese children and adolescents reported significant impairment not only in total scale score, but also in all domains – physical, psychosocial, emotional, social, and school functioning –in comparison with healthy children and adolescents" (Schwimmer, Burwinkle and Varni, 2003). From this same study, it was found that "severely obese children and adolescents have lower health-related
QOL (quality of life) that children and adolescents who are healthy and similar QOL as those diagnosed as having cancer”. This shows that the quality of life in obese children and adolescents is considerably harmed, and this must be taken into consideration in the child’s overall health.

Choice Theory and Reality Therapy

Childhood obesity has become a major issue in America today, and it is likely that it will be encountered in many settings. When considering ways of combating this trend, choice theory and reality therapy can be useful in controlling the behavioral aspects of obesity and the choices that contribute to this health concern.

An important first step is the give children the necessary information to take control of their health. Education about nutrition and physical activity and their effect on overweight and obesity is an important first step toward using choice theory and reality therapy. This is because it is only after children have the knowledge base that they are able to take responsibility for their individual behavior. Baseline knowledge is imperative in understanding the scope of obesity, its health consequences, and how nutrition and physical activity can assist in taking control of one’s health. In CT/RT terms, we are increasing information in children’s perceived world. The goal is that this information will help them realize that they can choose healthier behaviors.

Choice theory

Choice theory explains why we behave the way we do. Our behavior is guided by an intrinsic motivation to fulfill five basic needs: survival, love and belonging, power, freedom and fun. These basic needs make up our quality world, which we attempt to keep in balance with our perceived world through our psychological and physiological behavior. All individuals have control over their own behavior. All of these are important concepts in using CT to control health behaviors, with a particular focus on combating childhood obesity through behavioral change.

When working with children, first explain the concepts behind choice theory. A greater understanding of why they choose their behaviors will help them gain control of these behaviors. Also, empowerment comes from placing the responsibility for control on the individual. Choice theory can also be used to internalize the ideals of healthy behavior. Explain the five basic needs and how obesity might affect an individual’s ability to satisfy these needs.

- Survival: Health implications related to obesity are critical and life-threatening.
- Love and Belonging: Loved ones are concerned for child’s health. Stigmas related to obesity can affect the child’s relationships.
- Power: Individuals can lose autonomy due to poor health.
- Freedom: Health problems can provide limitations on the activities that an individual is able to do. This may contribute to an individual being dependent on others.
- Fun: Obesity can restrict an individual’s ability to participate in fun activities.

As much research indicates, childhood obesity shows a substantial relationship with depressive symptoms. This is because obesity limits individuals’ ability to meet all of their basic needs. Their scales are unbalanced, and as a result their behavior is depressive. Discovering how obesity affects individuals’ ability to fulfill their basic needs can be the key to influencing behavior change.

Reality Therapy

Reality therapy can be used to help create a quality world based around healthy behavior and making a plan that integrates this healthy behavior and leads to better healthy living choices. The WDEP (Wants, Doing, Self-Evaluation, Plan) model can assist in moving forward toward incorporating healthier behaviors.

First, identify children’s wants based on their quality world. With the knowledge of how overweight and obesity occurs and how it can affect their lives, they will understand how the health consequences of this health condition would affect their quality world. When looking to meet their basic needs, they must maintain healthy behaviors.

Recognize particular behaviors that are healthy that will assist children in maintaining their quality world. Good nutrition and physical activity will assist children in having good health, and that will assist them in satisfying their basic needs. Be specific in behaviors that are particularly helpful or harmful to their health. Also, be sure to reiterate that children have control over these behaviors, and therefore control over their living a healthy life.

Assist children in evaluating their own current health behavior. Are they making the right choices? How are their choices affecting their quality world? Can they improve in any way? Allowing children to answer these questions on their own, and self-evaluating will further them in their understanding and internalizing that they are the only ones that can control their own individual behavior. Their self-evaluation will be motivation to change behaviors.

Finally, children can develop plans to move forward and integrate healthier practices into their lives. Encourage children to make realistic goals for themselves. The most important part of building a plan is making it easy to follow through. Important steps include creating a time line for action, identifying particular checkpoints, and integrating a form of self-evaluation. The ability to assess progress is important because it allows the plan’s participants to know if the plan is working for them. If it is, then
the behavior change is occurring, if not, then they know they must try something else and not move forward with a plan that does not work for them.

**Constraints on using Choice Theory and Reality Therapy with children**

An important consideration in using CT/RT with children is their parents. Although we can help children understand that ultimately they have control over their behavior, parents can also have a considerable effect. When using CT/RT with children, it is important to consider the role of the parents. Encourage parents to be involved with the process. Explain CT/RT to them, and give them a greater understanding of how this type of counseling could assist their child in making healthier choices and having a better health outcome.

**Appendix A**

**Quality World**

<table>
<thead>
<tr>
<th>Survival</th>
<th>Love &amp; Belonging</th>
<th>Power</th>
<th>Freedom</th>
<th>Fun</th>
</tr>
</thead>
</table>

How does my current behavior affect my.......?

**Survival**

Love and Belonging

Power

Freedom

Fun

Am I In Balance?

**Appendix B**

**Wants**

What is most important to me?

What do I need in order to have a balanced quality world?

**REFERENCES**


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