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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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Editor's Comments
Larry Litwack

This issue marks the completion of 27 years of publication for the International Journal of Reality Therapy. Originally started in 1981 as the Journal of Reality Therapy, the title was changed in 1997 to reflect the growing international contributions by the international reality therapy community. This issue continues in that pattern with the articles by Adrian Schoo from Australia and the research article by Jong-un Kim from Korea.

Readers may also note that the editorial board has been replaced by an advisory board. Reviewers will continue to be used to maintain the status of the Journal as a peer-reviewed publication. However, I have decided to create an advisory board to help determine the future status of the Journal. Some of the questions I hope to pose to the advisory board will be:

1) How can the Journal be maintained as the principle publication promoting the research into and the practice of reality therapy and choice theory?

2) Although the Journal is an independent publication, how can ties with the William Glasser Institute and the international community be maintained in ways that respect the autonomy of all concerned?

3) How do we go about finding someone to assume the role of the Journal editor that will maintain the integrity and autonomy of the Journal and that has the professional background and credentials to continue the status of the Journal as a universally accepted independent outlet for research and practice of RT/CT?

4) Are there ways that the Journal can be expanded, revised, and/or changed to make the Journal more useful to readers and researchers?

I would also like to express my appreciation to the William Glasser Institute for resuming our relationship in making the Journal available to Institute members. I believe that this will be a win-win situation for all concerned.

For Institute members who have not seen the recent issues from 2006 and 2007, please note that the back issues are all available at a reduced cost. Readers can either order through the Journal website journalofrealitytherapy.com or they can contact me at llitwack@aol.com

Addendum to research listings in Vol. XXVII, No. 1:
The Effect of a R/T Group Counseling Program on The Internet Addiction Level and Self-Esteem of Internet Addiction University Students

Jong-Un Kim

The author is an assistant professor at Dong-A University in Busan, South Korea

ABSTRACT

The present study examined the effect of a R/T group counseling program derived from choice theory and control theory of reality therapy theory for group counseling on the Internet addiction level and self-esteem of Internet addiction University students. Participants in the treatment group attended the R/T group counseling program that was held 2 sessions per week for 5 consecutive weeks, whereas participants in the control group received no treatment. The findings indicated that the treatment program effectively reduced addiction level and self-esteem of Internet addiction University students. At the same time, the results revealed the significant effects of the R/T group counseling program on the dependent variables.

INTRODUCTION

Cyber space is a virtual space in which we communicate with other people on the network due to the wide distribution of computers. Cyber space has appeared as a new environment basically different from the physical space in which we live.

However, the advancement of Internet technology not only brings benefits, but also negative results. Of these negative aspects, excessive Internet use is increasing dramatically. Typical Internet behaviors included revolving around the PC rooms, participating in chat rooms, checking e-mailbox too many times, playing online games, and surfing pornographic contents.

Internet addiction is described as an impulse control disorder that does not involve use of an intoxicating drug and is very similar to pathological gambling (Young, 1996). Internet addiction is called Addiction Disorder, Pathological Internet Use, Excessive Internet Use, and Compulsive Internet Use.

Young (1996) carried out the earliest empirical study on excessive Internet use. According to Young (1999), Internet Addiction is a broad term covering a wide variety of behaviors and impulse control problems. She categorized Internet addiction by five specific subtypes of Internet addiction such as cyber-sexual addiction (compulsive use of adult chat rooms or cyber-porn), cyber-relationship addiction (over-involvement in online relationships), net compulsions (compulsive online gambling, shopping, and obsessive online trading), information overload (compulsive web surfing or database searches), and computer addiction (obsessive computer game including Doom, Myst, Solitaire etc.).

Internet addiction is a more common problem in our society as Internet users are increasing. The Internet has positive aspects including informative, convenient, resourceful and fun, but for the addicts, these benefits become detriments. There are various opinions on Internet addiction. A common saying is that if someone is addicted to anything and it is knowledge, this case is not addiction (Mental Health Net, 1997). Others such as Young and other psychologists, however, think that the excessive Internet use can become hazardous to one's mental and physical health. An addiction may interfere with normal, adaptive functioning. So if someone is addicted, his or her functioning is maladaptive.

South Korea is one of the most wired countries in the world. The number of Internet users has skyrocketed and is nearly 75% of the entire population as of 2004 (Korea Ministry of Information and Communication, 2004). In fact, ninety percent of homes connect to Internet by cheap costs, high-speed broadband. Online gaming is a professional sport, and social life for the young revolves around the PC room. Obviously, these numbers means that Internet has become an important vehicle of Korean life today. With such ease of access, the Internet has become an integral part of our lives (Huang & Alessi, 1997).

Some studies postulated that excessive Internet use is more likely to pose to college students as a population group (Korea Ministry of Information and Communication, 2004; Korea Agency for Digital Opportunity & Promotion, 2004; Lee, 2002). This population is deemed to be vulnerable because of the accessibility and the Internet and the flexibility of their schedules (Moore, 1995). That is, college students are vulnerable to Internet addiction because of many factors such as difficulty adapting to life away from home and underlying psychological problems, including depression or social anxiety. Thus, college students with quite a lot of discretionary time on their hands and adjusting to the new schedule on university campus are susceptible. Young (1996) points out the several dynamics that make university campuses ripe for Internet overuse. These includes free Internet access, huge blocks of unstructured time, newly experienced freedom from parental intervention, no monitoring of what they express online, full encouragement from faculty mem-
 University is a training center for adulthood and an individual must be responsible for oneself. But there are college students spending way too much time online, probably to the detriment of their school works and other activities.

Korea Ministry of Information and Communication implemented a survey of Internet addiction in 2004. They surveyed 2,600 ranging from elementary level to adults. This study used a Korean Internet Addiction Scale from Korea Agency for Digital Opportunity & Promotion (KADO). Of these, 4.8% were classified as Internet addiction disorder. Of Internet users, 7.9% were college students, the highest level. Lee (2002) recruited 3,000 ranging from elementary school level to college students. Approximately 4.8% of the respondents were classed as Internet addiction disorder. Of these Internet addiction disorder, college students were 36.7%, the highest level as well.

They spent at least two hours a day online, usually playing games or chatting. They even showed signs of actual addiction, like an inability to stop themselves from using computers, rising levels of tolerance that drive them to seek ever longer sessions online, and withdrawal symptoms like anger and craving when prevented from logging on (Lee, 2002).

To address the problem, the Korean government has built a network of 140 Internet addiction counseling centers, in addition to treatment programs at almost 100 hospitals and, most recently, the Internet Rescue camp, which started summer in 2007 (The New York Times, Nov. 18, 2007).

It is important that counselors recognize the signs and symptoms of Internet addiction. This includes not only determining the amount of time spent on the Internet, but also whether Internet usage has negatively disrupted any major areas of the client’s life (e.g., recreational, social, occupational, legal, financial, physical or mental). Also, 21st century counselors need to be familiar with the signs of Internet addiction and some of the emerging treatment strategies.

Griffiths (2000) has argued that the Internet is largely being used only as a medium to carry out these behaviors in the majority of the cases. Namely, the Internet would be acting as a medium, and not a causal factor (Shaffer, Hall, & Vander Bilt, 2000). Some of the factors that had been found to be associated with Internet addiction disorder are self-control ability, self-esteem, mental hygiene, self-efficacy, depression, anxiety, and loneliness, etc (Baek, 2005). Armstrong, Phillips and Saling (2000) investigated the extent to which sensation seeking and low self-esteem predicted heavier Internet use, using the Internet Related Problem Scale. Results said that self-esteem was a better predictor of ‘Internet Addiction’ compared to impulsivity. Individuals with low self-esteem seem to spend more time online.

In Korean studies on the correlation between Internet addiction and self-esteem, Jeon (2005) investigated the effect of the extent of Internet use, depression and self-esteem from 800 adolescent surveyed. As a result, the extent of Internet use increases depression and it decreases self-esteem. You (2006) analyzed the effect of Internet addiction on 400 elementary school students’ self esteem and depression. The relationship between Internet addiction and self-esteem indicates a statistically significant negative slope (r= -.284, p < .01). In other words, the higher Internet addiction is, the lower self-esteem is. Other studies have looked at the relationship between ‘Internet addiction’ and self-esteem (Lee, 2007; Kim, 2007; Park, 2007; Widyanto & McMurran, 2004).

Goldberg and Young offer some ways Internet users who believe they are addicted can help themselves. First, Goldberg (1996) feel that Internet addicts should recognize patterns of overuse and be aware of the basic symptoms. A key signal to this could be time spent at the computer, but also time spent thinking about the Internet or in activities related to the Internet. The next step is to identify underlying problems (Young, 1999). Similar to other kinds of addicts, Internet addicts must ask themselves what is causing them to escape from everyday life. The third step is to devise and act out a plan to work through the problem, rather than escape it. Young argued that escaping from the problem through the Internet does not make the problem solving. It usually only intensifies the problem. Final step is that the addicts try to take steps to solve the addiction itself. Young suggested a gradual decline in use, until a sensible amount of time is reached (Murray, 1996).

Four-step treatment for Internet addicts proposed by Goldberg and Young is similar to a WDEP model in Reality Therapy. The WDEP model summarizes some procedures to explore of clients’ direction and self-responsibility in life in the practice of Reality Therapy (Wubbolding, 2000; Corey, 1996). WDEP refers to W=wants, D=direction and doing, E=evaluation, and P=planning and commitment. After rapport has been established, counselors based on Reality Therapy explore clients’ wants, needs, and perception. Wubbolding (2000) postulated that choice theory based on WDEP is very useful in helping clients to establish a healthy recovery method by exploring with them how they can meet their basic needs by questioning their doing, wants, self-evaluation, and plans as well as choosing more effective behaviors. Counselors who focused on the rationale of Reality therapy encourage clients to explore behavior and evaluate how effectively they are getting what they want. Clients make some plans that will lead to change and commit to plans. The core component of Reality Therapy is to ask clients the following questions?

What are you doing now?
What did you actually do this past week or month?
What stopped you from doing what you want to do?
What will you do tomorrow or in the future?
Reality therapy has been used widely as a treatment for addictive disorder (e.g., drugs, sex, food, work). Glasser (1985) has used Choice Theory to explain addiction. Lewis & Carlson (2003) has recently taken advantage of Reality Therapy for a core addiction recovery tool. Howatt (2003) developed a core addiction recovery tool based on Choice Theory figuring out that Choice Theory can serve as a core addiction recovery tool.

Reality therapy is designed to help individuals control their behavior and make new and difficult choices, in their lives. It is based on choice theory, which assumes that people are responsible for their lives and for what they do, feel, and think.

It is difficult to directly change our feeling or physiology separately from our doing or thinking. Nevertheless, we are able to change what we do or think despite how we feel. Thus, the key to changing behavior lies in choosing to change our acting and thinking.

By having clients commit to change their Internet addiction and explore their total behavior, he could bring about changes in their Internet abuse and stick to those plans. In doing so, he would not accept excuses from clients. Rather, he worked hard to help them take control over their Internet addiction behavior.

Reality therapy seems to be of value for counselors who deal with persons with Internet addiction. Regardless of the kind of addiction, a universal variable is that persons who demonstrate addiction behavior should make the rational choice to achieve their wants. Thus, Choice Theory in Reality Therapy can be used as an Internet addiction recovery way and provide a pathway to make effective choices.

Group counseling appears to be the predominant modality for treating addiction (Fisher & Harrison, 1997). The support, confrontation, and insight gained from other individuals experiencing similar cognition and emotions facilitate therapeutic recovery. Millions of recovering addicts have experienced success from attending 12-step support group (e.g., Alcoholics Anonymous, Narcotics Anonymous, Overeaters Anonymous, etc.). Internet addicts may experience similar success in attending a group designed specifically for individuals excessively using the Internet. A number of these support groups have already been established in the United States.

Reality therapy is well suited to individual counseling, group counseling, and marriage counseling (Corey, 1996). Group counseling is an effective method by which to apply the procedures of Reality Therapy. The group process can be powerful in helping clients implement their plans with their commitments. The clients and group members are encouraged to write down specific behavioral contracts and read them in front of the group. Involvement with other members in a meaningful way is an inducement to stick by the commitments made. The use of co-leaders is frequent and has been found to be a valuable adjunct in Reality Therapy group counseling (Glasser & Zunin, 1973).

In Korea, for the past few years, group counseling programs for University students who have used excessively Internet or who were Internet addiction are rare (Kim, 2004). Especially, a group counseling program based on Reality Therapy and Choice Theory is very rare. Kim (2007) developed a Reality Therapy group counseling program as an Internet addiction recovery tool for college students in Korea. The purpose of the present study is to implement this program and examine the effectiveness. Two main research questions follow: (a) Does the R/T group counseling program for Internet addiction college students reduce significantly their Internet addiction level? (b) Does the R/T group counseling program for Internet addiction college students enhance significantly their self-esteem?

RESEARCH METHOD

Participants

The subjects for this study were 276 University students who were at D University in Busan metropolitan city. After the pretest, twenty-five participants were volunteers among thirty-two Internet addicts who had shown Internet addiction disorder. Demographic information of the participants follows. The participants consisted of twenty males and five females, twelve were sophomore, eight junior, and five senior. The average of their age was 24.2. They were randomly assigned into two groups, thirteen for the experimental group and twelve for the control group, respectively. In the experimental group, there were ten males and three females. Twelve were in the control group, of whom ten were male and two female.

Instruments

K-Internet Addiction Scale (K-IAS). K-Internet Addiction Scale used in this study was the Korean version developed by Korea Agency for Digital Opportunity & Promotion (KADO) (2004). In this study comparisons could be made for the effectiveness of R/T group counseling program. This study used a 40-item self-report questionnaire on which participants rate themselves on Internet use using a 4-point Likert scale ranging from (1 = not at all) to (4 = very true). K-IAS was totaled for an overall effectiveness score and can be used as seven subscales: Disturbance of Adaptive Function (D-scale), Disturbance of Reality Testing (R-scale), Addictive Automatic Thought (A-scale), Withdrawal (W-scale), Virtual Interpersonal Relationship (V-scale), Deviate Behavior (B-scale), and Tolerance (T-scale). Each of the subscales consists of 3 to 9 items. The seven subscales are weighted on 3-36 scale and combined for a composite scale of 40-160 for total effectiveness.
In a study by KADO (2002), internal consistency coefficients was .96 as measured by Cronbach's. In the present study, Cronbach's was .93.

Coopersmith's Self-Esteem Inventory (CSEI). The Self-Esteem Scale was measured with a 10-item Self-Esteem Scale of Coopersmith (1981). Participants respond to a 4-point Likert scale (1 = not at all true of me, 4 = very true of me). The possible scores range from 10 (low self-esteem) to 40 (high self-esteem). In a study by Chang (2003), internal consistency reliability coefficients of the CSEI was .88 as measured by Cronbach's. In this study, Cronbach's was .87.

Description and some practical guidelines of the R/T group counseling program

The R/T group counseling program is a plan for ten group sessions dealing with Internet addiction University students. This program was evaluated and supervised by specialists certificated by the Korea Counseling Association. Each session lasts 60 to 90 minutes in length. Procedure of each session includes an introduction of session goal, teaching, activities, homework assignment, and sharing.

Although each session has been carefully planned, circumstances from the previous session or issues that could arise might suggest to group leaders that the plan should be altered. Namely, group leaders need to be flexible.

Group leaders must be flexible and know when it is advisable to deviate from the proposed session plan. Time is frequently the enemy of the group leader. Group sessions have a time limitation in terms of both the length of time for a session and the number of planned sessions. Thus, the group leader should not try to plan for more topics than could be covered in a group session. The size of group and the quality of interaction often suggest the number of topics that can be discussed in a given session.

The group preparation can be divided into four sections:

State what the session is expected to accomplish, namely, purpose, or objectives

Check the material that will be used and what needs to be collected prior to the session. Materials, including blank paper, topic-oriented games, posters, construction paper, a chalkboard and chalk, crayons, scissors, or an overhead projector or a video, might be used during the sessions.

Detail the strategies including what the group leader plans to say to the group, group activities, topics for discussion, homework assignments, and a brief summary of what was accomplished.

Evaluate the group experience both in terms of individual growth and the extent to which the group, as a whole, accomplished its objective.

Procedure

A quasi-experimental pretest-posttest control group design was completed. Prior to the initial commencement of the R/T group counseling program, all participants signed an informed consent agreement and completed a demographic information questionnaire. Subsequent to the completion of the pretest assessment, the treatment group participated in the R/T group counseling program that would be held two sessions per week for five consecutive weeks. The control group received no treatment. After completion of the program, both the treatment and the control group completed the posttest assessment.

Data Analysis

The data collected were analyzed by independent samples t-test in an effort to examine the initial differences between the treatment and control groups on the pretests. Means, standard deviations, and estimated marginal means of the treatment group and the control group were calculated. An analysis of covariance (ANCOVA) was conducted for the analyses of research questions, because this procedure increases the statistical power (Keppel, 1991). ANCOVA was performed with the pretest measures of Korea-Internet Addiction Scale (K-IAS) and Coopersmith's Self-Esteem Inventory (CSEI) as the dependent variables.

RESULTS

Independent samples t tests found significant differences that two groups were not statistically equivalent on two variables including Addictive Automatic Thought and Tolerance of K-IAS. As two groups were not equivalent before the intervention, in an effort to increase the statistical power, ANCOVA was conducted. The results of this study are reported in Tables 1-4.

Research Question 1

Does the R/T group counseling program for Internet addiction college students reduce significantly their Internet addiction level? Means and standard deviations for the pretest and posttest of K-IAS are presented in Table 1. To examine the difference of the main effect of treatment in the K-IAS between the experimental and the controlled group. ANCOVA was conducted with means of the posttest measure as the dependent variables and the pretest measure on K-IAS as the covariates.

As exhibited in Table 2, ANCOVA was significant, resulting in the rejection of Null Hypothesis in K-IAS scores, $F(1, 22)=172.308$, $p<0.001$. In subscales of K-IAS, D-scale is $F(1, 22)=76.140$, $p<0.001$, R-scale, $F(1, 22)=13.651$, $p<0.01$, A-scale, $F(1, 22)=10.911$, $p<0.01$, W-scale, $F(1, 22)=6.095$, $p<0.05$, V-scale, $F(1, 22)=18.568$, $p<0.001$, B-scale, $F(1, 22)=19.330$, $p<0.001$, T-scale, $F(1,
22)=15.499, p<0.01 respectively. On each of the dimensions of the subscales of K-IAS, after the treatment of the R/T group counseling program, the treatment group demonstrated significantly even lower Internet addiction than did the control group.

**Research Question 2**

Does the R/T group counseling program for Internet addiction college students enhance significantly their self-esteem? Means and standard deviations for the pretreatment, immediate post treatment measure and estimated marginal means of CSEI appeared in Table 3. To reveal the difference of the main effect of the R/T group counseling program in the self-esteem scale between the experimental and the controlled group, ANCOVA was conducted with means of the posttest measure as the dependent variables and the pretest measure in self-esteem as the covariates.

As shown in Table 4, for Research Question 2, ANCOVA was significant, resulting in the rejection of Null Hypothesis in CSEI score, \( F(1, 22)=40.927, p<0.001 \). On the dimension of CSEI, after the treatment of the R/T group counseling program, the experimental group exhibited significantly higher self-esteem than did the control group.

In all, the findings of this study indicate that the R/T group counseling program for Internet addiction college students was an effective intervention for reducing their Internet addiction disorder and enhancing their self-esteem especially related to Internet addiction disorder. All of the null hypotheses tested were rejected in flavor of the experimental group.

<table>
<thead>
<tr>
<th>Scale</th>
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<th>Pretest M</th>
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<td>8.58</td>
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Note. D = Disturbance of Adaptive Function; R = Disturbance of Reality Testing; A = Addictive Automatic Thought; W = Withdrawal; V = Virtual Interpersonal Relationship; B = Deviate Behavior; T = Tolerance.
Table 2. The results of ANCOVA on K-IAS

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Note. D = Disturbance of Adaptive Function; R = Disturbance of Reality Testing; A = Addictive Automatic Thought; W = Withdrawal; V = Virtual Interpersonal Relationship B = Deviate Behavior; T = Tolerance.
*p < .05. **p < .01. ***p < .001.

Table 3. Means and Standard Deviations and Estimated Marginal Means of CSEI by Group

<table>
<thead>
<tr>
<th>Scale</th>
<th>Group</th>
<th>Pretest</th>
<th>Posttest</th>
<th>Estimated Marginal</th>
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Note. CSEI = Coopersmith’s Self-Esteem Inventory.
DISCUSSION AND CONCLUSION

In general, many counselors who specialized in the treatment of addiction such as drug, alcohol, gambling, sex, and even Internet take advantage of individual, group, and family counseling with a heavy emphasis on the rational choice. Many studies on addiction recovery treatment have proved that group counseling is the predominant modality. Reality therapy, especially, is well suited to group counseling. In other words, the focus of Internet addiction treatment is not on Internet use, but on his or her decision-making and responsibility for dealing with situations in his or her life.

In South Korea, as Young (1996) argued earlier, some studies indicated that excessive Internet use is more likely to pose to college students as a population group. That is why this population is deemed to be vulnerable because of the accessibility and of the Internet and the flexibility of their schedules. College students, also, are vulnerable to Internet addiction because of many factors such as difficulty adapting to life away from home and underlying psychological problems, including depression or social anxiety.

University is a training center for adulthood and an individual must be responsible for oneself. Counselors and University administrators should treat Internet addiction University students for their recovery. Answering this requirement of the age, Kim (2007) developed a Reality Therapy group counseling program as an Internet addiction recovery tool for Internet addiction University students in Korea. The purpose of the present study was to implement this program and examine the effectiveness.

The data collected immediately after the delivery of the treatment of the R/T group counseling program revealed that the participants who participated in the experimental group demonstrated significant lower Internet addiction level than did participants in the controlled group. Exposing the experimental group to the R/T group counseling program significantly reduced their Internet addiction usage. This may be linked to the fact that exposing the experimental group to R/T group counseling program enables them to aware of their doing and wants, and to plan and implement plan. Also, self-evaluation for the implementation and the choice of more effective behaviors help them improve responsibility.

This conclusion also supports Abbott’s (1980) suggestion that the focus of treatment was not on Internet use, but on his or her decision-making and the responsibility for dealing with situations in his or her life that would be more helpful.

In Korean studies on the correlation between Internet addiction and self-esteem, Jeon (2005) and You (2006) prove that the extent of Internet use increases depression and it decreases self-esteem. Other studies have looked at the relationship between Internet addiction and self-esteem (Lee, 2007; Kim, 2007; Park, 2007; Widyanto & McMurran, 2004). These results mean that the higher Internet addiction is, the lower self-esteem is. In accordance with these results, Internet addiction University students need to enhance their self-esteem. Moreover, group work was more effective to help clients to enhance self-awareness and self-esteem (Lee, 2002).

The experimental group experience psychological support from the counselor and other clients. Namely, the R/T group counseling program that was used in this study includes observation of demonstration, role-play, behavioral practice, explanation, feedback, reinforcement, encouragement, and assignment of behavioral tasks related to Internet excessive usage. In the posttest Immediate after the treatment, participants who participated in the R/T group counseling program exhibited higher self-esteem than did participants who received no treatment. Exposing the experimental group to a wide variety of group activities, such as psychological support from the other group members as well as group leader, role-play with peers and challenging their sense of shame, significantly affect their self-esteem. These results lend support to a vast literature on this subject (Jeon, 2007; You, 2007; Lee, 2007; Kim, 2007; Park, 2007).

In all, the R/T group counseling program is very effective to improve Internet addiction level of Internet addiction University students and enhance their self-esteem related to Internet use. These conclusions also support that Reality therapy has been used widely as treatment for addiction.

<table>
<thead>
<tr>
<th>Table 4. The results of ANCOVA of CSEI</th>
</tr>
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<tbody>
<tr>
<td>Scale</td>
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<td>-------</td>
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</tbody>
</table>

Note. CSEI = Coopersmith’s Self-Esteem Inventory.
REFERENCES


The author may be reached at jongun22@donga.ac.kr
## Appendix: Description of R/T group counseling program

<table>
<thead>
<tr>
<th>SESSION</th>
<th>OBJECTIVE</th>
<th>PROCEDURE</th>
</tr>
</thead>
</table>
| 1. | Introduce group leader, group members, group rules and set goal | • Ice-breaking: introduce themselves and one reason they are in the group  
• Discuss purpose of the group  
• Make a contract on group norms such as confidentiality, commitment, treat each other with respect members, and so on.  
• Play matching game |
| 2. | Introduce five basic needs to the group and help the group members understand more about Internet addiction | • Briefly restate the purpose and rules of the group  
• Explain five basic needs and explore what needs have been missed  
• Complete the Internet Addiction Checklist  
• Explore the factors of the Internet addiction in terms of basic needs |
| 3. | Introduce choice theory and time management techniques | • Explain choice theory  
• Teach the group to use time management techniques  
• Homework assignment: Apply time management techniques |
| 4. | Introduce 'Total Behaviors' and explore alternative activities | • Review confidentiality and follow up on the homework assignment  
• Explain ‘Total Behaviors’ with toy cars or copies of car picture  
• Encourage the group to establish an alternative acting  
• Present clients’ alternative acting to the group |
| 5. | Explain WDEP to the group and practice the process of WDEP | • Introduce WDEP and practice the process of WDEP  
• Encourage the group members to use WDEP in the situation of Internet abuse  
• Homework assignment: Apply WDEP to the real world |
| 6. | Recognize Internet usage pattern and their addiction triggers | • Follow up on the homework assignment  
• Identify your usage pattern with some question: What days of the week do you typically log online?; What time of day do you usually begin?; How long do you stay on during a typical session?; Where do you usually use the computer?  
• Ponder your own feeling when you head for the computer and share Internet addiction trigger  
• Homework assignment and review the session |
| 7. | Help the group make a concrete plan to do better | • Review the group rules and follow up on the homework assignment  
• Complete time plan form  
• Present it to the whole group |
| 8. | Help the group make a verbal or written contract | • Make an oral or written contract with group members  
• Encourage the group to commit to plans  
• Homework assignment and remind the group of only two more session |
| 9. | Help the group make positive reminder cards and use these cards in real world | • Review the purpose of group and follow up on the homework assignment  
• Make positive reminder cards and encourage the group to use in their real life  
• Discuss examples of Internet excessive use and major benefit of reducing online time  
• Homework assignment: Apply positive reminder cards  
• Remind the group that the next session will be the last meeting |
| 10. | Discuss the goals and extent to which they have been achieved and have a group celebration | • Follow up on the homework assignment  
• Review significant accomplishments of the group and circle whip  
• Thank the group for the hard they did and its cooperation  
• Complete a group evaluation sheet  
• Remind the group that even though the group experience has ended, confidentiality is still expected and important  
• A light, healthy refreshment can be offered the end the group session |
Confrontational Psychotherapy: 
A Compassionate and Potent Therapeutic Orientation for Gifted Adolescents Who are Self-Destructive and Engage in Dangerous Behavior

Thomas E. Bratter, Danielle Esparat, Andrea Kaufman, Lisa Sinsheimer

All authors are from the John Dewey Academy, Great Barrington, Massachusetts. The first author is the founder of JDA.

ABSTRACT

Confrontational psychotherapy (CP) has been considered as “cruel and unusual” treatment. This criticism is partially correct; confrontation is painful. What is disregarded, however, is that for any treatment population that engages in extreme, self-destructive, and sometimes death-defying behavior and is not amenable to traditional approaches, Confrontational psychotherapy is a most responsible and caring psychotherapeutic approach.

The Goal of Confrontation is Awareness

Confrontation exists in every human transaction. Any question, no matter how benign, is also a confrontation by virtue of the process of reflection and reaction. Confrontation is thus synonymous with awareness. Using the language of interpretation, Freud was in fact, confrontational in his insistence on bringing unconscious forces into consciousness. Confrontation disturbs homeostasis. To use a metaphor from nature: without wind, leaves do not move; more intense winds are required to stir leaves weighted down by rain or snow. Confrontational Psychotherapy (CP) can appear more extreme than other forms of psychotherapy, but we contend that—properly practiced—it is also vastly more effective. In communicating with reticent and self-destructive adolescents, confrontation techniques are considerably more able to pierce formidable defense systems that produce massive resistance to change. These teens have insulated themselves in protective and self-righteous cocoons, often aided inadvertently by well-meaning conventional mental health practitioners who arm them with excuses in the form of a multitude of misapplied diagnostic labels.

In this article, we limit our discussion to the application of Confrontational Psychotherapy in cases of self-destructive behaviors by bright, out-of-control adolescents. We will demonstrate why CP is a crucial tool in effective treatment for this particular population and debunk the notion that CP is ‘cruel and unusual punishment’.

Confrontational Psychotherapy: A Heroic Treatment Approach

Debate about the goal of psychotherapy is valid: insight, adjustment to the status quo, understanding, feelings, growth, etc. In working with teenagers who are at-risk to destroy themselves and have ruined educational, social, and professional options, there is one primary goal at the outset of treatment: PRESERVING LIFE AND MINIMIZING SERIOUS CONSEQUENCES. The symbolic ticking time bomb of escalating dangerous behaviors must be stopped before permanent damage or death ensues. Other therapeutic methods simply do not penetrate what Alcoholics Anonymous aptly labels “stinking thinking.”

Truly effective Confrontational Psychotherapy must include other techniques such as Cognitive Behavior Therapy and Dialectical Behavior Therapy. Working with adults, Linehan et al. (2006) conclude, “dialectical behavior therapy appears to be uniquely effective [at reducing] suicide attempts” (p. 757). Though research on the effectiveness of DBT on adolescents is limited, preliminary findings suggest that DBT is a promising treatment for suicidal and parasuicidal teens (Rathus & Miller, 2002).

Many mental health practitioners confuse Confrontational Psychotherapy with Attack Therapy. Lieberman, Yalom, & Miles (1973) define a casualty of CP whose participation in an encounter group precipitated psychological distress and/or “more maladjusted mechanisms of defense” (p. 171). They also examine the relative effectiveness of various leadership styles. Their findings are important because they confirm the effectiveness of the confrontational charismatic leader in group psychotherapy. Most psychotherapists erroneously assume this “scientific study” condemns confrontation. Lieberman, et al. (1973) states, however, that participants in groups conducted by charismatic leaders “showed the most extensive changes in...values and attitudes” (p. 251).

This trio fails to note that the charismatic leaders they studied were members of Synanon, an ex-addict-run residential treatment program that later disintegrated into a cult. These ex-addicts lacked academic training and discipline. We note at least two major differences between recovering addicts and credentialed professionals doing similar work. First: Recovering persons are zealous because they believe passionately that the approach that saved them can save everyone. The need to proselytize affects their judgment and infects their efforts. Second: Since ex-addict leaders lack academic training, they do not factor in the effects of psychodynamic issues like transfer-
ence and countertransference. This trio concludes (with no data) that such leaders are more likely to abuse power. Lieberman, Yalom, & Miles (1973) concede, however, that charismatic leaders using confrontation as their primary therapeutic orientation are effective. Unfortunately, in the wake of the Synanon of the 1970s came the proliferation of encounter groups with untrained and inexperienced leaders. This particular study came out of valid concerns on the part of academically trained psychotherapists. Miller, Benefield & Tonigan (1993) conclude that confrontation is counterproductive because they believe this approach tends to lead to argument and conflict. Judiciously implemented CP actually stimulates a more honest and candid recognition of reality, which creates less conflict for the individual.

Using CP, therapists at The John Dewey Academy have conclusively proven that pathological beliefs and dysfunctional behaviors can be modified in the short term and that improvement persists after treatment ends. JDA students can transcend their pasts. Patterson (1966) proposes that individuals “cannot...control conditions [by] which [they are] confronted, but can control [personal] responses such as choices and actions” (p. 466). Explicit is the concept of CHANGE—i.e., unlearning (rejecting dysfunctional acts and attitudes) while simultaneously learning more responsible and productive ways to respond to the challenges of living. Confrontational Psychotherapy stresses personal choice, demanding the development of integrity and responsibility.

What of the ‘Bipolar Child’ and the ‘Dual Diagnosis’? We believe these concepts do in fact have limited utility in helping us understand the complexities of the mind; but they are overused by a mental health establishment overwhelmed by troubled teens. There has been an increase, for example, in the diagnosis of Bipolar Affective Disorder. Many of our students arrive with this label; upon graduation, they leave medication-free and clearly NOT the victims of any chemical imbalance.

There are six primary uses of Confrontational Psychotherapy:

1. To expedite behavioral change.
2. To force accountability for attitudes and acts.
3. To understand the relationship between current behaviors and future consequences and payoffs.
4. To learn more appropriate responses.
5. To mobilize personal talents to succeed.
6. To discover a directionality and in so doing justify one’s existence to oneself.

The John Dewey Academy’s treatment approach utilizes a compassionate confrontational-existential-cognitive-behavioral orientation. When used constructively, CP catalyzes resilience and mental toughness—i.e., learning from errors in judgment to become responsible, positive, and productive. Bratter (1972) describes the treatment thrust of a group orientation:

Using a confrontation-teaching-interpretative-reasoning approach, the group demonstrates to the [member] the irresponsible and self-defeating aspects of...behavior [and]...he begins to understand the consequences of his acts and attempts to become more responsible to himself, others, and society. Emphasis is placed on the eigenwelt (the relation to one’s self)—i.e., the immediate experience. The individual must acknowledge his perceptions of the conflict, the problem, his irresponsibility, etc...

The individual, gaining the candid opinions and admonishments of...peers regarding the more destructive elements of...behavior, considers a new orientation and behavior (p. 309).

In a group setting, members relate to peers whose input provides the catalytic conditions necessary for self-exploration and change. Rather than receiving sympathy and comfort—which inadvertently prolong homeostasis and paradoxically result in the student feeling misunderstood and even more alone and depressed—confrontation forces teens to face reality. Complicating the problem is that not every gifted teenager who engages in self-destructive behavior has the ego strength and desire to improve: CP does not work for all. During the intake interview and periodically thereafter, John Dewey students and families are warned that, despite the Academy’s success rate of 100% of graduates attending excellent four-year colleges, this therapeutic approach is not effective for all adolescents. Our screening is an important element of the process; we seek to admit only those students who are appropriate for the program. In order to provide an effective checks and balances system against countertransference acting out, our practice of CP is a team effort.

Compassionate Confrontation: Clinical Dynamics

Based on his clinical experience, the senior author rejected psychoanalysis and client-centered therapy as irrelevant and ineffective approaches for use with acting-out, alienated, and bright adolescents. He chose Reality Therapy, a milder form of confrontation, as his primary orientation, believing it to be more effective. Three tenets of Reality Therapy form the core of confrontation:

1. To create a treatment environment that encourages the adolescent to evaluate his or her behavior.
2. To force the youth to accept responsibility for his or her conscious choices.
3. To provide support for constructive and creative change.

Forty years ago, William Glasser was criticized for being simplistic. He viewed individuals as either responsi-
ble or irresponsible. Subsequently, Glasser has been proven right with this population. Until gifted and unconvincing, teens take control of their lives, they will refuse to change. Undaunted by criticism, Glasser (1998) stresses vindicated teens take control of their lives, they will refuse 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).

There are two primary kinds of confrontation. The most direct involves a third party rendering a behavior assessment so the confronted knows the specifics of an inappropriate attitude or act. The psychotherapist demands the best, rather than conceding that the perpetrator is either a victim or incapable of constructive and creative change. The second form of confrontation is to encourage the confronted to become his or her own contronster by evaluating the impact of his or her behaviors. "Does what you do today help you achieve your intermediate and long-term goals?" "Do you have self-respect?" "Are you happy?" The most effective confrontation is to ask questions so that the teen comes to a more independent understanding of his or her behaviors, thus increasing the chances of an independent decision to change. Such a dialogue results in a proactive, less passive individual. Garner (1970) urges therapists to inquire, "What do you think or feel about what I told you?" (p. 231).

Two 1972 definitions of confrontation remain relevant. Carkhuff and Berenson's concept (1972) provides a positive description of confrontation as a tool to help the person-in-treatment understand

his strengths and resources...It is a challenge to...become integrated...It is directed at discrepancies...between what the client says and does...and between illusion and reality...It implies a constructive attack upon an unhealthy confederation of...illusions, fantasies, and life avoidance techniques in order to create a reintegration at a higher level of health (p. 171).

Van Stone and Gilbert (1972) describe peer confrontation in which

Each member...is presented with candid personal facts regarding...behavior or attitude recognized by the group as being self-defeating or dishonest. If the member under scrutiny attempts to explain away or deny any observation, he is confronted. Intellectual insight or gentle self-interpreta-
tion are denied as an escape from responsibility for current behavior. Honesty, trust in the group, realistic self-assessment, appropriate emotional release, and changed behavior...are rewarding by sympathetic counsel and encouragement from fellow members... (p. 585).

The emphasis is on "people instead of pills..." The members are...concerned with each other, [but] are uncompromising in their demands (p. 584).

Confrontation can only be effective in the context of a positive treatment alliance. The therapist needs to accept the burden to create a special relationship. Bratter (1975) labels genuine care, of which confrontation is a basic element, to be the "responsible therapeutic Eros" when he asserts,

Angry, alienated, self-destructive adolescents equate the degree of caring by the psychotherapist with the loudness of the therapeutic protest and intensity of therapeutic anger expressed. The acting-out teenager needs and wants...assurance that another...cares enough...to become involved and help him/her...Ex-addict...workers...have devised a term, "responsible concern," which implies...[to] get involved...and, if necessary, intervene directly to prevent him/her from harming [him/herself]...They view themselves as "my brother's keeper." Alcoholics Anonymous, in comparison, has adopted a less active-directive approach. A twelfth step worker...will respond for help twenty-four hours a day, seven days a week but will not...impose him/herself in the drinker's life and try to force the alcoholic to remain abstinent. The analyst, in contrast, remains objective, passive, detached, and uninvolved (p. 100).

Bernstein (1972) "attributes many treatment failures to the prohibition against compassionate behavior on the part of psychoanalysts. Therapists often misread...the counter-transference prohibition and feel afraid [to have...feeling]...Thus instead of feeling compassion to "help me! they feel coldness, objectivity, and withdrawal" (p. 121). Most talk therapies caution the therapist, rightfully so, about the dangers of over-involvement. Most schools of psychotherapeutic thought suggest the therapist avoid answering legitimate questions such as "Are you married?" or "Have you used drugs?" If so, which ones?" The professional response is to avoid relating. Graduate schools recommend asking, "Why is this information important to you?" hoping, of course, that the patient will yield to a change of subject. Hostile, suspicious, alienated, and challenging adolescents frequently demand an answer—or lose respect for the therapist. Effective therapy is a dialogue, not a monologue. Inevitably, there are intrusive questions on both sides of the equation. Although we accept that certain treatment boundaries must be maintained, we assert that lack of in-depth attention to this dynamic has resulted in both over-rigid and over-porous therapists. Surely we can do better in this regard.

**Pre-1968: Prolonged Innocence: Boys Will Be Boys, Girls Will Be Girls**

Glasser's work at the Ventura School for Girls occurred during a more innocent era. His reality of the late 1950s and early 1960s was one of racial tensions and sexual boundaries. Thus, Glasser's view of confrontation reflects those days rather than the reality of the new millennium. Glasser was a responsible revolutionary who was one of the first to challenge traditional psychoanalytic thought. While he disapproved of confrontation, he knew...
of its effectiveness; Alex Bassin, one of Glasser's most loyal supporters, co-authored the proposal for funding Daytop Village. Bassin was a mentor of the senior author and introduced him to Glasser in 1963. Glasser knows that The John Dewey Academy is effective, having visited three times and read numerous articles published by members of the JDA faculty.

Keniston (1971, 1968 & 1965) warns of a new breed of alienated youth, but his works were initially dismissed because readers thought he was only discussing Yale students. Friedenberg (1957) predicts that adult values would be adopted by teens, but neglects to warn that adolescent values would filter down to influence children. One has only to observe the ever-younger ages of children entering psychiatric and psychological treatment to realize that this has, in fact, occurred.

With the wider societal changes of the 1960s in America came vastly increased pressures on youth to confront issues such as sex and drugs that had previously been limited to the adult population. Unfortunately, teenagers lack the maturity and long-term vision to help them assess these issues thoughtfully and responsibly.

Post-1968: The “New Breed” of Adolescents

During the early 1960s, Freud's psychoanalysis and Rogers' client-centered therapy were two dominating therapeutic orientations. Both approaches used a “gentler” form of confrontation. For a brief period, Reality Therapy and other cognitive-behavioral-existential reality-based orientations were effective with this challenging treatment population of teenagers before they became suspicious, unconvincing, and resistant to previous forms of therapy.

In retrospect, the now infamous 'generation gap' led to teenagers mistrusting adults, an attitude that evolved into societal reality. It was as though adolescent mutants developed thicker therapeutic skins that were far more impermeable than their sweet and innocent counterparts of the late 1950s and early 1960s. These changes required more powerful and intensive treatment approaches.

Without warning, 1968 galvanized society. The idea of a gradual growth and assimilation into adulthood was destroyed, releasing a torrent of rebellion. Nihilistic rage predominated for a period and had a lasting effect on the lives of teenagers to come. The quest for freedom, emancipation from families, and escape from societal restraints assumed endemic proportions.

In today's world, children lose innocence before they appreciate its value. 'Playing doctor' has been replaced by oral sex beginning in middle school, followed in short order by sexual intercourse. Drug experimentation often begins in middle school as well. Children crave adult status, while adults seem to want more childish pursuits of late. During the third millennium, the distinction between responsible and irresponsible behavior has blurred. Further exacerbating this problem, the intense peer pressure faced by teens to perform destructive, defiant, and dangerous acts has attained pandemic proportions both in high schools and on college campuses. It is now the rule rather than the exception for teenagers to experiment with drugs and sex rather than to abstain. Thus, the age-old adolescent imperative to test limits, to question, and to reject authority has assumed a new and much more dangerous aspect. Assessment has also become more subjective because it more often reflects the values of the clinician making the diagnosis. Glasser (1998) contends that, “training programs have an ethical responsibility to provide information and opportunities for counselors to confront...cultural biases that may perpetuate racist attitudes and behavior” (p. 64).

Experimentation with drugs and sex has become a “rite of initiation” into adolescence. Today, youth who abstain comprise the minority—hence, they are different. “Well-adjusted” adolescents do not become addicted to psychoactive substances, self-mutilate, binge and purge, or engage in physical violence—but they can write pessimistic and “dark” poetry, may play and listen to gloomy music, sometimes glorify celebrities dead by suicide, fantasize about aberrant acts, and periodically engage in very dramatic behaviors.

Confrontation: A Failure

When Meredith arrived at The John Dewey Academy as a sixteen year old “ne'er-do-well,” she was a dependent, insecure, and terrified product of a New York City prep school. This adolescent had twin goals: to be sophisticated and popular. She had perfected the art of saying what others wanted to hear. She was a master manipulator whose glibness resulted in her skating by with decent grades and without adults confronting her on her destructive behaviors, even after she was asked to leave two different private schools for a variety of infractions that included selling cocaine to her friends in order to appear cool and be liked.

Meredith arrived at The John Dewey Academy confused, conflicted, and with no sense of identity. She was a chameleon, devoid of substance. She followed the crowd and never questioned whether her decisions made sense.

Her story provides an example of both the benefits and the limitations of confrontation. Her treatment at The John Dewey Academy resulted in dramatic improvement. Confrontation, however, has thus far not preventing her from smoking cigarettes and using alcohol socially.

Meredith was lucky that The John Dewey Academy rejects DSM-IV labels; in another program, she would have been labeled Borderline and Dysthymic and would...
have been prescribed psychotropic medications. Instead, we viewed Meredith as irresponsible and suffering from a failure of identity. By graduation, Meredith had developed a secure sense of self, integrity, and a strong work ethic. These changes turned out to be crucial during her first year in college, when Meredith's mother (also a smoker) was diagnosed with metastatic lung cancer. Although Meredith was no longer a student at JDA, she voluntarily maintained a relationship with the school and the senior author both out of appreciation and out of a sense that she could count on the Dewey brand of caring confrontation as she encountered the challenges of her freshman year. These affectionate post-treatment contacts are common for JDA graduates, who know they can depend on JDA staff and fellow graduates to be real. Sadly, CP has failed to convince Meredith to reject nicotine and alcohol. While the following confrontations are harsh and inevitably will invite some to criticize and condemn the senior author, it needs to be noted that he not only wrote a twenty-two page letter of recommendation for her college application but also has remained in contact with her since her graduation from JDA in 2006.

When Meredith first mentioned that her mother was scheduled for tests to determine whether she had cancer due to prolonged and excessive smoking, the rhetorical questions asked her included, “Are you crazy? Your mother has lung cancer. I predict she will be dead within the year! If you love her, as you claim to do, you owe it to your mother to assure her that you have learned from her misguided decision to smoke. All studies prove conclusively that smoking causes cancer. By giving her this assurance, you will make it easier for your mother to die in peace.” In denial, Meredith responded that her mother did not have cancer because she is as responsible as you are. Think about how your peers, her friends, feel. Or don’t you give a damn? Are you rotten to the core? .. You [will] sacrifice your “tucked-up” needs? Think about how dirty, disgusting, and manipulated Jill feels. In no way do I excuse what will it be next, a shot of dope, a burglary when you need some money? Are you prepared to sacrifice everything for the symbolic fix—this time it’s a piece of ass, a profoundly deceitful and a predator who preys on weaker individuals.

Two weeks before her mother's death, Meredith called upset. Her alcoholic father mentioned he had had several drinks. Meredith wanted advice about what she could say or do. “You know what you need to do,” the senior author screamed, “but you won’t. You need to make a commitment to stop smoking and drinking if he will pledge to do the same.” The confrontation was then escalated. “It is an unjust obscenity that soon Abbey will be deprived of a mother and may lose her father because you are so stupid, selfish, and stubborn. You refuse to stop, though you know carcinogens cause cancer.

While confrontation has failed to end Meredith’s nicotine habit, she has made the Dean’s List and been an active student leader at college.

Written Confrontations: Upping the Therapeutic Ante

In order to maximize the therapeutic effect of a verbal confrontation, one can follow it up with a written version. Supplying a confrontation in written form provides numerous advantages:

1. A written confrontation creates a permanent record that can be re-read and discussed post hoc.
2. This document can be sent to significant others not only to appraise them of concerns but also to include them on the treatment team.
3. A written document minimizes misunderstandings.
4. The written work functions as a mirror that reflects reality and does not allow for distortion.
5. The confrontation can be prepared thoughtfully, with no interruptions, and will therefore contain more precise language.
6. The effort inherent in writing provides more evidence of the sincere concern of the confronter.
7. The communication serves as a clinical record.

The following is an example of a written confrontation that has yielded awesome results. On his eighteenth birthday, the recipient was taken by ambulance to an Emergency Room because he overdosed on methadone. He is lucky to have survived.

Though twenty-one years old, Paul stayed an extra year at The John Dewey Academy as a consequence for his refusal to work, grow, and change. During his final year at JDA, the senior author wrote,

I do not regret I gave you the benefit of the doubt by not only trusting but also permitting you to take a course at Williams College. I showed good faith which is much more than you did... What I do regret, however, is that for the duration of your stay at The John Dewey Academy you have remained profoundly deceitful and a predator who preys on weaker individuals.

Time to recognize you for what you are. You [will] sacrifice everything for the symbolic fix—this time it’s a piece of ass, what will it be next, a shot of dope, a burglary when you need some money? Are you prepared to sacrifice everything because you want what you want when you want it and you don’t give a damn whom you betray as long as you can gratify your “fucked-up” needs? Think about how dirty, disgusting, and manipulated Jill feels. In no way do I excuse her because she is as responsible as you are. Think about how devastated and frightened your parents are. They began to dare to dream that maybe finally—their son had learned his lesson and really changed. Think about how your peers, who trusted, admired, respected, and even loved you, must feel. Or don’t you give a damn? Are you rotten to the core?...
Obviously, you have destroyed your dream to attend MIT. Obviously, I refuse to recommend you to any college of quality because I cannot do so in good conscience. Since one of the consequences Jill received for being stupid is to remain an extra year, at this juncture I question whether this makes any sense for you, Or are you beyond the point of no return? Honestly, I expect more shit to emerge which probably will seal your fate and result in your expulsion. You wonder why periodically you erupt in rage. Obviously, you are so damned narcissistic that you become consumed by fury when someone disappoints you or deprives you of your sense of entitlement. As long as you cling to your dope fiend attitudes, your prognosis is pessimistic—there is no damn hope that you ever will permit yourself to succeed, though this time you came close. Think about it, again you “pissed” away another year and $56,000 of your parents’ money. I hope that digging your grave forced you to see yourself as a cruel, vicious dope fiend whom you must murder if there is to be any hope for your future. Do you ever want to marry? What kind of a father do you think you will be? How long do you think you can be a criminal without being incarcerated? What kind of a person do you want to be? When you die or are murdered, do you want to know you have lived a bogus and wasted life or do you want to die with self-respect knowing you have justified your existence to yourself?

The real tragedy is that you have been blessed and born with awesome talent which you abuse. My fear is that you will quit—actually, that is not accurate; you never started or tried. I don’t know what to write because I have worked with dope fiends for a quarter of a century. I know damn well that until they “hit bottom” and feel the shame, the disgust, the guilt, and the self-hatred, there is no chance. I have attended funerals of monsters who refused to join humanity and have had too damn many chances which you have not heeded.

Like the old Delta Airlines advertisement, “We’re ready when you are!” But are you ready or do you need to sink deeper into your private cesspool? The only way...to find salvation is...to purge yourself 100% of the poison and shit which flows through your arteries. Do you have the guts, the desire, the strength to reclaim your life from the stinking sewer?

Paul attended an Ivy League college from which he graduated salutatorian and Phi Beta Kappa. He won four leadership awards at his graduation. He was admitted by one of the three most prestigious law schools in the country and has been offered a job after he graduates by a most prestigious law firm.

Paul returns periodically to The John Dewey Academy, has maintained contact with the senior author since his graduation in 2003, and has delivered the alumnus address at the Academy’s last two graduation ceremonies.

Critics Confuse Compassionate Confrontation with Attack Therapy

Bratter and Sinsheimer (2007) assert that CP forces the confronted to recognize masochistic and sadistic acts which rejects minimizing and glorifying of behavior, or pretending that magically one day a cure will happen. Critics contend [that] confrontation is controversial, countertherapeutic, and cruel punishment which often brutalizes the confronted. Critics of Confrontational Psychotherapy need to remember Dewey students have engaged in dangerous, sometimes death-defying behaviors which demand heroic and desperate interventions. Unless the therapist can persuade at-risk youth to stop acting out, crises can escalate and produce devastating and permanent consequences. Critics who do not fully appreciate the extent of destructive and dangerous behavior label this treatment process to be “attack therapy.” These critics are right, but for the wrong reasons. Unless CP can remove malignant attitudes and acts, Dewey students will be consumed by a magnitude of at-risk behaviors which will produce severe consequences such as hospitalization, incarceration, and/or premature death. Undeniably, CP forces students to recognize masochistic and sadistic acts which rejects minimizing and glorifying of behavior, or pretending that magically one day they will awaken cured. Dewey students have engaged in extreme, self-destructive, stupid, immature, irresponsible, illicit, dangerous, and sadistic behavior. They have toxic attitudes of entitlement and reduce others to objects to satisfy [their] narcissistic needs. Confrontational Psychotherapy penetrates denial, distortion, and dysfunctional attitudes (p. 108).

Opponents fail to understand the clinical challenges involved in treating these adolescents. When treated skillfully and for the right reasons, the confronted feels the concern of the confrontational therapist, who not only demands the termination of life-defying behaviors but also refuses to accept anything less than the best. Although perhaps difficult to hear at the beginning of treatment—when self-esteem is at its nadir—the message, “you can do much better” is both therapeutic and prima facie evidence of genuine care. When the intent is positive, caring confrontation becomes the ultimate expression of what Breggin (1997) terms “empathetic love.” To love and be loved, Breggin contends, “is...to feel empowered—to feel in control of one’s...spiritual state” (p. 78).

Compassionate confrontation obliterates defensive avoidance. Prior to stumbling into The John Dewey Academy, JDA students were untreatable, uneducable, unreliable, unmanageable, unruly, uncivilized, untrustworthy, unlovable, unworthy, unwanted, undisciplined, unfaithful, unpredictable, unhappy, unlawful, unstable, and unsuccessful. While often viewed as unmotivated, even by themselves, they are in reality unconvincing. The burden to convince them to change falls upon the therapist.

As with all treatment procedures, abuses of power are a potential risk. If the intent of the confronter is humiliation, pain and intimidation, this is a perversion of CP. Similarities exist, however, between the psychotherapist who confronts, the radiologist who x-rays, the surgeon
who operates, and the psychiatrist who prescribes. Each of these procedures is subject to abuse in the quest to attack disease and dysfunction. The surgeon, radiologist, and psychiatrist do more physical and permanent damage under the guise of medical treatment than does the therapist who confronts. Interestingly, the medical profession escapes criticism because its ends justify its means. CP can be compared to laser surgery which, when skillfully and judiciously used, attacks and eradicates malignant cells. Similar to laser surgery, however, when abuses occur (mostly caused by disappointment, frustration, and anger), confrontation becomes a counter-therapeutic technique.

**Cruel and Unusual Punishment: Questions Remaining**

The therapist who knows an adolescent is at extreme risk to destroy by engaging in dangerous behavior yet refuses to intervene by confronting is guilty of malpractice.

What is worse? To prescribe psychotropics which have not been well-studied in children and adolescents, or to confront a teenager in his or her own vernacular? Rejecting the medical model has incurred the wrath of the powerful pharmaceutical industry. Combining research with common sense, Breggin (1991) asserts that teenagers suffer from a “psychospiritual crisis,” usually surrounding issues of basic identity and shame, and typically with feelings of outrage...By refusing to diagnose or to label people who already feel rejected and humiliated, we welcome them back to the human community and promote humane, respectful, and loving attitudes toward them” (p. 46). Ought we assume that negative behaviors can be cured by prescribing a myriad of psychotropic medicines, or to use Confrontational Psychotherapy to affect positive change?

Pharmacology does not work with these teens because the cause of deceitful and cruel acts is most often an attitude, NOT a chemical imbalance. Medication cannot change attitudes, which is why the recidivism rate of traditional psychiatry remains high.

Which is more destructive: to attribute irresponsible, dysfunctional, deceitful, dangerous, and lazy behaviors to a never-proven metabolic disorder; or to demand that the youth makes more rational, responsible, and realistic decisions? To conclude an adolescent suffers from ADHD, which describes characteristics that often resemble those of gifted students, and thereby condemn the student to a lifetime of stimulant medications? To assume that a teenager is dominated by unconscious and preconscious dynamics, or to hold the kid accountable for poor conscious choices? To have low expectations that result in a false sense of success, or to have high expectations that may initially create frustration but that catalyze genuine improvement? To pretend that masochistic and sadistic acts will be self-correcting, or to confront and demand improved behavior? To create a professional mental patient with psychiatric hospitalizations, or to listen more carefully when an adolescent discusses fears about suicide?

The John Dewey Academy refuses to apologize for being unrelenting and uncompromising by escalating expectations to demand personal growth. We submit that the ends justify the means for this effective therapeutic approach with gifted, acting-out, unconvinced adolescents who engage in dangerous behaviors.

**A Psychoanalyst Views Confrontation - William Glasser**

As a psychiatrist and psychoanalyst, I have spent my professional life helping others in the pursuit of understanding. Theory tells us that understanding is a necessary basis for change, and that without analysis we are doomed to repeat our mistakes.

I believe in that theory, but in our society, it is often twisted into an excuse for bad behavior and dysfunctional relationships. It can be particularly dangerous when applied to adolescents.

I first began to understand the misuse of psychoanalytic concepts in our society during my first visit to the John Dewey Academy in July of 2002. Sent there by an educational consultant who described the Dewey approach as “controversial,” I sat in on a therapeutic group of which the focus was a brilliant college dropout. He had returned to high school at JDA in order to determine why he flamed out so spectacularly during his freshman year at a prestigious liberal arts college.

That day in July, he was the focus of the group because he had once again handled a cooking responsibility poorly. As I sat listening to his self-pitying excuses about why he was incapable of cooking rice, the scales fell from my eyes. He talked at length about his powerful desire to be responsible, about his wish to be a better brother to his younger sibling, and about all the painful reasons he could not seem to do either. He was articulate and clearly not mentally ill in any conventional sense; and he seemed to believe that his wish to change, coupled with all the evidence of his pain over his failures, would make things different—or at least allow him to continue pretending that he was doing something about his problems.

As I listened, I found myself increasingly excited by the “real” nature of the dialogue in the group. Initially, I wondered if the minor crime of burned rice really warranted all the time and focus it was afforded; but as the group progressed, I understood why this was so. The group process teased apart the various elements of the situation and laid bare this boy’s excuses and evasions. Repeatedly, he voiced self-pitying justifications for his failures. Repeatedly, the group exposed his dishonesty and laziness in very explicit terms. It was clear that others would not join him in pretending that he was incapable of cooking rice. Implicit in their refusal to believe his excuses was the
assertion of his basic intelligence and competence. Thus the confrontations had two purposes, both rooted in reality: they exposed the reality of his behavior and the reality of his potential, all in the same moment.

Confrontation, I have come to understand, is necessary to pierce the armor of denial and rationalization with which these dysfunctional souls are wont to surround themselves. Facing the truth is the first step towards long-lasting change. Our society abounds in methods for avoiding reality: these include drugs, alcohol, self-mutilation, eating disorders, and Internet addictions of various types, among others. Confrontation works because it attacks avoidance; sadly, other forms of therapy are often unwittingly twisted into the service of this avoidance.

That “boy of a thousand excuses” was confronted repeatedly and candidly about his irresponsibility, and his behavior changed quite rapidly. Perhaps the change was initially due to his desire to stop hearing the confrontations—but as he began to reap the benefits of his improved behaviors, he established a sort of positive feedback loop, and the improvements snowballed.

That first group I attended made me think about the psychoanalytic approach to treating alcoholism in the 1950s: endless talk and analysis, accompanied by continued problem drinking and escalating life problems. Of course, true analytic understanding can come only after the patient eschews alcohol and begins to take a clear, hard look at him- or herself. The boy who was burning the rice clearly would have been happy to talk the issue to death that day; but his talking seemed only in the service of his pathology. Only the confrontations of his peers resulted in actual change.

Analysts are trained to be endlessly patient in the quest of understanding. Psychoanalytic treatments last for years—often many years. But in the new millennium, with adolescents exposed earlier and earlier to adult dangers, I believe we do not have the leisure of devoting years to a psychotherapeutic technique which often fails to yield behavioral changes. I would argue that analytic understanding alone is the wrong approach. Further, such understanding is often misused in the service of resistance to change.

Was there a role for analytic understanding in that college dropout’s recovery? Yes, there clearly was. But just as with the alcoholic in analysis, he had to face some facts and make some changes before he could benefit from understanding the underlying issues.

I have further observed that therapists who confront dysfunction and name it unsparingly are actually quite supportive—and the recipient of the confrontation is often relieved by the truth-telling. In fact, confrontations are often seen as proof of care—and, I believe, accurately so.

Critics who describe confrontational therapy as too “harsh” are actually missing the point. When delivered with care, even the harshest sounding confrontation results in the student feeling better as well as doing better. Caring confrontation also generally results in a closer relationship between confronter and confronted. The message is simple: “I care enough about you to tell you the hard truth, even if it hurts in the short term.”

Since that July day in 2002, I have spent many hours and days at the John Dewey Academy and have had the opportunity to see, over and over again, the benefits of confrontational therapy. I have also run into considerable prejudice within the mental health community with regards to the idea of CP. Most of this prejudice stems from a basic misunderstanding of the technique and a lack of skill in employing it.

My approach to clinical work has changed significantly as a result of my exposure to the dynamics and benefits of CP. In looking beyond my own practice, though, I have seen repeated evidence of the need for more truth-telling throughout our society. Theatrical confessions, breast beating recitations of guilt, and other forms of avoiding reality pervade modern life; they are corroding our definitions of integrity and honesty, and we are all the poorer for this development.

A Student Experiences Confrontation

At fourteen, Debby started seeing psychiatrists who exacerbated problems by ascribing them to chemical imbalances. This made her feel as though they were beyond her control. Debby became ensnared in the ‘no-win, no-exit’ labyrinth created by psychiatrists. She felt different and viewed herself as psychologically damaged. Misguided and erroneous psychiatric interpretations produced profound demoralization and depression: she felt unable to extricate herself from inadequacy, failure, and shame, which produced feelings of unworthiness.

Debby felt in control when she hurt herself. Her parents hospitalized her for eight weeks when they discovered she was self-mutilating. She was diagnosed with major depression and prescribed Effexor, Resperidal, and a bevy of sleeping pills, none of which worked. There are two DSM-IV diagnoses that concede the potential damage caused by misused psychotropic medications:

(995.2) “Adverse Reactions to Medication.”
(333.90) “Iatrogenically Induced Akathesia Associated with SSRI Antidepressant Treatment.”


Iatrogenic symptoms may originate from a pathology-oriented belief system through which therapists interpret, reinterpret, or labeled clients’ personal characteristics, life script, or distress. Clients may be socialized into therapy through a language system that emphasizes pejorative labels and suggests that therapists hold specialized knowledge...
that, in truth, they may or may not possess. Therapists may give clients the implicit or explicit message that something is wrong or flawed with them, which...may contribute to negative treatment effects (p. 247).

These two psychologists contend, furthermore, that the degree and potential range of negative treatment outcomes may not be readily apparent to therapists whose intentions are clearly aimed at ameliorating clients’ distress. However, the presence of negative treatment effects are too pervasive and the unfortunate consequences that sometimes result from treatment are too powerful to deny or dismiss cavalierly (p. 253).

Knowing the hospital and medication were ineffective, Debby’s parents referred her to The John Dewey Academy. During her intake interview at JDA, she was confronted about her dysfunctional behavior. Because she remained intransigent and refused to change, the senior author wrote her a letter deliberately precipitating a crisis. She impulsively left the Academy. The senior author’s treatment task in writing the letter was straightforward: to eradicate Debby’s infantile and attention-seeking behavior while simultaneously affirming his belief in her potential:

You stand at the crossroads of your existence. The decision you make, in retrospect, will prove to be the most important one of your life. This choice will have profound consequences and payoffs: "Does Debby want to become an autonomous PERSON who has self-respect or remain a PATIENT?"

You agreed not to play suicidal games and not to self-mutilate. Do not purge because it will be the symbolic strike three which will end the ball game. Stated simply, Debby, I refuse to permit you to...[engage in any] further type of self-destructive behavior. The John Dewey Academy has zero tolerance. When you were interviewed, I was brutally candid describing our mission. You agreed to attend because the healthy part of you wants to have a positive and productive future...

What concerns me is you gain attention when you act crazy and sick. The John Dewey Academy is the wrong place for this behavior. Those who choose to play these stupid games belong in a HOSPITAL. Should you continue your attention-seeking antics: the histrionics, the hysterics, the anxiety attacks; we will conclude you choose to remain "sick"...so you will be expelled.

After forty years waging war against...dysfunctional and destructive behavior...I believe it is a product of conscious choice. While perhaps an over-simplification, what...you did prior to attending The John Dewey Academy is irrelevant. We cannot re-write our pasts; but we...can learn from previous mistakes. Should you choose to remain at The John Dewey Academy, we will help you to diminish your infantile narcissism and learn more positive and productive ways to gain attention and approval. I will confront harshly your malignant attitudes and acts because you need to unlearn before you can learn how to become assertive. You are your own worst enemy. The treatment “mission impossible” is to symbolically kill that self-created monster to permit the healthy human to grow strong and sane. I warn you this will be painful and scary; but until you change, your prognosis remains pessimistic! For...too long you have invested your energy into cultivating a “sick persona”...you [need] to change. Either GROW or GO! This is your choice, but it will be my decision. Time is a precious commodity which you squander.

I do not doubt you are endowed with superior intelligence. I demand you prove to yourself that you can succeed at those positive activities you deem important.

Message sent; hopefully understood and heeded. Wishing you the very best, I remain:

IN THE STRUGGLE TOGETHER,

Debby refused to respond to CP. She was sent to a six-week wilderness program to help her realize that her behavior was intolerable. Positive expectations change the transaction from a pathogenetic to a salutogenic orientation—eventually. Debby not only assumed responsibility for her acts and attitudes but also took control of her life. She writes:

“I am a psychiatric casualty. I failed to respond to traditional psychotherapy and two months hospitalization. Initially, I rejected Confrontational Psychotherapy. I had been convinced by psychiatrists that I was beyond help. Before I attended The John Dewey Academy, no therapist told me ‘to grow up,’ ‘accept responsibility’ for my conscious choices, and ‘stop whining.’ Psychiatrists told me that medication would cure my symptoms and suggested I wait patiently until the right combination of medications was found.

Confrontation differs from other therapies because it has a dual approach. I benefited because I was confronted by the truth about my poor decisions and crazy thinking. When individuals confront each other, the person making the confrontation gains integrity and self-confidence. He or she also internalizes proactive beliefs by helping another to help him- or herself to improve.

I know that confronting or being confronted often is painful. I recall often feeling forced to confront my fear to change, but I had little choice; I was forced by CP to view how damaging my behaviors were. In retrospect, I feel embarrassed because I was so unaware of the consequences of my decisions. I was terrified to confront reality and probably would have avoided it indefinitely had I not been confronted. I never doubted that people cared about me, but it would be dishonest to write that I appreciated being confronted. There were times when I hated the confronter, but deep down I knew the confrontations I received were realistic.

Once I made a commitment to transcend my craziness, I assumed the role of confronter myself. Every time I confront, I remind myself about the self-imposed hell in which I chose to live. I still am a work in progress, but I know I never will permit myself to return to the delusions and self-hatred of my past.
I do not doubt that confrontation helped me salvage and save my life. I tremble when I think of who and what I would be today had I not been confronted. I might have committed suicide or still be in a hospital.”

Having graduated from a prestigious liberal arts college, Debby is currently seeking a Ph.D. in clinical psychology.

**Rejection of Psychotropic Medicine at The John Dewey Academy**

JDA rejects claims of psychopharmacologists and neuropsychiatrists that intrapsychic problems are caused by biologically-based disorders and chemical imbalances. Although we recognize the possibility of such disorders in certain individuals, the incidence of these among dysfunctional, bright adolescents is much lower than conventional treatment approaches suggest. Feelings of depression, pain, shame, inadequacy, and fear—which are often reality based—that overwhelm adolescents are more often caused by conscious, dysfunctional, dishonest, destructive decisions than by biological aberrations.

Breggin excoriates pharmacologic researchers and the FDA for accepting self-serving, flawed, and deliberately dishonest studies financed by corporations with economic interests in the results. Angell (2000), Bodenheimer & Korn (2000), Friedberg, Saffran, Stinson, Nelson & Bennett (1999), and Krimsky & Rothenberg (1998) protest the correlation between the pharmaceutical industry’s financial impact and research outcomes. Physicians and psychiatrists are aware of this unholy (perhaps even criminal) alliance, which they disregard by continuing to prescribe medicines that have not been proven effective or safe. This—not Confrontational Psychotherapy—is “cruel and unusual punishment” and may result in class action lawsuits for malpractice.

Breggin (1991) debunks the justifications for medication:

In the world of modern psychiatry, claims can become truth, hopes can become achievements, and propaganda is taken as science. Nowhere is this more obvious than in psychiatric pretensions concerning the genetics, biology, and physical treatment of depression and mania...Bio-psychiatric research is based too often on distortions, incomplete information, and sometimes outright fraud—at the expense of reason and science.

There are no known biological causes of depression.
There is no known genetic link in depression.
There is no...drug treatment for depression.
The same is true for mania: no biology, no genetics, and little or no rational basis for endangering the brain with drugs.
The biomythology of depression denies the obvious causes of depression in the lives of most people who become depressed...

To treat a depressed person as a biochemically defective mechanism, and to blunt or damage the brain of the suffering individual, many biopsychiatrists approach the patient with an especially dehumanizing view. Out of this perspective grow extreme treatments like electroshock (pp. 182-183).

Most psychiatric practitioners and researchers agree with Offson et al. (2006a) that “there has been a sharp increase in antipsychotic treatment among children and adolescents in office-based medical practice” (p. 679). This psychiatric team cautions that for second generation antipsychotic medications, there is a “pressing need to increase and extend the experimental evaluation of these medications in children and adolescents” (p. 684). All journals which are financed by significant advertising by pharmaceutical corporations should require authors to disclose whether they own stock in those corporations.

Offson et al. (2006b) conclude that “antidepressant drug treatment was not significantly associated with suicide attempts in adults aged 19-64” (p. 865). However, they also state that “there may be an association between antidepressant drug treatment and suicide attempts and completed suicide in severely depressed children and adolescents in the Medicaid program after hospital discharge” (p. 872, emphasis added). Leon et al. (2006) “do not rule out the possibility of suicidal thoughts or non-lethal suicide attempts among youths taking antidepressants” (p. 1057, emphasis added).

Significantly, an editorial (2006) which purports to redefine Bipolar Disorder contends that “increasingly sophisticated neuroimaging and genetic research have deepened our understanding of the neurobiology of bipolar disorders as one involving complex disturbances in relationships, linking environment, genes, neural systems, and behavior” (p. 1135). BUT, two sentences later, this editorial seems to contradict its original hypothesis:

Although the understanding of the pathophysiology of bipolar disorders remains limited, preliminary findings from recent neuroimaging studies have indicated persistent dysfunctions specific to bipolar disorder within neural systems underlying mood and cognition (p. 1135, emphasis added).

The insistence that depression is a single entity with a particular biological underpinning ignores the impact of toxic acts and attitudes. In contrast, feelings of pain, shame, inadequacy, and fear that overwhelm adolescents often are caused by conscious, dysfunctional, dishonest, and destructive decisions, not by biological aberrations. When asked why they feel depressed or shameful, adolescents often can provide realistic explanations. The John Dewey Academy asserts that personality and affective disorders rarely are cured by medicinal approaches. There is no pill that teaches self-respect and cures noxious narcissism, dishonesty, and anti-social attitudes. Therefore, we eschew the use of psychotropic medications at JDA and view drug-free as a viable treatment goal.
Breggin (1996) renders a polemic against the brain dysfunction assumption by exposing its counter-therapeuti
c message:

The biopsychiatric approach...reinforce[s] the patient's worst feelings and attitudes. The patient...feels helpless—at the mercy of forces beyond his or her control. The patient often feels like an object or thing that can do nothing more than react helplessly to internal and external threats. In the extreme, the individual suffers from delusions and hallucinations about being influenced and manipulated by imaginary others and outside unknown forces. Often the patient feels mentally defective. Unfortunately, the bio-psychiatrist's approach will encourage the patient to think and act like a helpless victim of overwhelming forces, namely genetic and biochemical abnormalities. The doctor "takes over" and pre-
scribes physical agents supposed to counteract the genetic and biochemical influences. This further reinforces the patient's self-destructive helplessness (p. 4).

In The Boston Globe, Goldberg (2007) reports that beginning January 1, 2008,

Annual checkups for...nearly half [a] million Massachusetts children on Medicaid will carry a new requirement. Doctors must offer simple questionnaires to detect warning signs of possible mental health problems, from autism in toddlers to depression in teens...Skeptics warn that more children could end on heavy duty medications...they really do not need (p. 3, emphasis added).

It is clear what the impact of this law is likely to be. Frighteningly, overburdened delivery of care systems find themselves depending increasingly on medications because of the lure of the 'quick fix, even though the fixes are neither quick nor effective in the long run. Despite the FDA's refusal to grant approval to doctors to prescribe anti-depressants to children and youth, "Big Pharma" and an overburdened and under-funded mental health indus-

tries are interested in "better living through chemistry," although their motivations are different. Psychiatric resi-
dents no longer are trained to do "talk therapy; instead, they are taught every disorder has a biochemical basis, though this theory never has been proved. Frighteningly, the trend is towards medicating children at younger and younger ages, although we do not understand the effects of psychotropic medications on the developing brain.

We ask: What is more "cruel and unusual punishment"? To confront or to prescribe medication of unproven efficacy and safety?

The Scandals of the FDA and Congress

Few psychiatrists doubt the corrupting and corrosive power of the pharmaceutical industry, which uses massive funds to influence research findings. Medical researchers know that future funding is contingent upon positive find-
ings; if they wish to receive financial support, their results need to be positive. In short, research outcomes are influ-

enced by money. There is little doubt that the massive and powerful pharmaceutical cartel has bribed key researchers and politicians. The FDA has breached its mandate to pro-
tect the consumer because this government agency has not exercised "due diligence." How can the FDA justify not demanding that negative studies become part of the pub-
lic domain?

In addition, some Senators and Congressmen accept sizeable contributions from the medical industry. At the very least, when medical legislation is discussed, these recipients need to recuse themselves due to a "conflict of interest." How these politicians have escaped censure, impeachment, and in extreme cases prosecution needs to be explained.

The FDA has also remained strangely silent about the steroid and growth hormone controversy. Congress joins this shameful conspiracy when it limits its investigation of steroids to professional athletes and in so doing ignores the pandemic of abuse by adolescent athletes who take harmful performance enhancing drugs. Escaping scrutiny and censure are colleges and high schools that admit and work with athletes whose size and strength can be attributed to these substances (Celizic, 2004). A most prestigious college—respected for its academics rather than its athletics—has, for example, recently admitted a young man who has grown from a 5'11", 130 pound freshman to a 6'5", 190 pound senior. These data were in a newspaper article sent to the Dean of Admissions.

While perhaps only tangentially relevant, when they violate the Hippocratic Oath to "Do no harm" by prescrib-
ing dangerous and/or unproven medications, psychiatrists engage in shameful and illicit activities.

Who is more "cruel and unusual": those who confront by communicating "You are in control of your life" and "You can do much better," or those who join a conspiracy of silence, prescribing psychotropic medications that they know are harmful and ineffective?

CONCLUSION

The Reputations of Colleges That Admit JDA Graduates Validate the Effectiveness of Confrontational Psychotherapy

Since the Academy's inception in 1984, less than ten percent of JDA graduates recidivate, seek psychotherapy, or need pharmacological intervention. These raw data warrant more scientific examination.

Prior to attending The John Dewey Academy, most students had mediocre grades and inconsistent academic records. Many functioned more than one grade level below their age, so they need intensive, individualized instruction to remedy educational deficits. More than a third of John Dewey graduates make Dean's List in college. Since the first class graduated in 1987, all graduates have attended four-year colleges. Similar to elite prep
schools, The John Dewey Academy wants to be judged by the reputations of the colleges that admit its graduates. Former students have made the Dean's List at: Barnard, Bates, Binghamton, Carleton, Colby, Columbia (College & University), Connecticut College, Cornell, George Washington, Georgetown, Haverford, Hobart, Holy Cross, Mount Holyoke, Muhlenberg, NYU (College of Arts and Sciences & Tisch School for the Performing Arts), Oberlin, Ohio Wesleyan University, RPI, Rochester University, Spelman College, Skidmore, Syracuse University (Visual and Performing Arts & Newhouse School of Communications), Trinity, Tufts, Union, the Universities of Chicago, Hartford, & Massachusetts; Vassar, Wellesley, and Williams.

The John Dewey class of 2008 has been admitted to Brandeis University, Columbia, Goucher, Oberlin, Sarah Lawrence, and the University of Chicago. The only student not admitted via Early Decision has been deferred by Amherst.

Acceptances by these colleges of quality make The John Dewey Academy indistinguishable from the most elite prep schools in the country. This validates the effectiveness of compassionate confrontation; the same students who distinguish themselves as student leaders at college once were viewed as psychiatric casualties.

The results achieved by The John Dewey Academy, which utilizes Confrontational Psychotherapy, warrants further investigation and research. Polcin (2003) suggests that when the goal of confrontation is to enhance growth, it is experienced to be positive and produces positive results. There needs to be further inquiry into the effectiveness of CP with different treatment populations in different settings.

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Motivational Interviewing in the Prevention and Management of Chronic Disease: Improving Physical Activity and Exercise in Line with Choice Theory

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ABSTRACT
Discusses the relationship between motivational interviewing and choice theory in working with chronically ill clients/patients

BACKGROUND
The prevention and management of preventable chronic disease poses challenging problems for many countries due to aging populations. There are many factors associated with the development of chronic disease, for example, lack of physical activity and exercise. Generally, as people age, they become physically less active. Physical inactivity has been associated with obesity, and obesity with cardiovascular disease, diabetes, and osteoarthritis (Cooper et al., 1998; Sui et al., 2007). In addition, chronic disease such as osteoarthritis has been associated with pain, disability and depression (Van Baar, Dekker, Lemmens, Oostendorp, & Bijlsma, 1998) (note that this is the term generally used in the literature).

The health and quality of life benefits of physical activity and exercise are well established, including in people with depression or anxiety (Babyak et al., 2000; Biddle, Fox, & Boutcher, 2000; Byrne & Byrne, 1993; Lawler & Hopker, 2001; Scully, Kremer, Meade, Graham, & Dudgeon, 1998), or those with chronic diseases such as cardiovascular problems or osteoarthritis (Morris & Schoo, 2004). Physical inactivity, depression, and anxiety are common problems. Risk factor data in the Greater Green Triangle region in Victoria and South Australia indicate that most people aged 25-74 were not sufficiently physically active at the time of the surveys (Heistaro, Vaughan, & Schoo, 2007); 7.7-8.7% of the cohorts were moderately to severely depressed while 9.1-10.7% were experiencing anxiety problems (Bunker, Kao-Philpot, & Reddy, 2007). Rates were worse in 45-65 year age groups with up to 19.5% showing signs of depression and 15.7% signs of anxiety. Despite the benefits of physical activity and exercise on mental health, one of the problems is that many perceived their physical fitness as "reasonable", "reasonably good" or even "very good". This means that there may not necessarily have been a perceived need or motivation to become physically more active (Heistaro, Vaughan, & Schoo, 2007).

One of the problems that health professionals face is that clients mostly don't immediately feel the consequences of poor lifestyle choices on their health and well being. Therefore, one can understand that they can lack the required motivation to change some of their behaviors. This problem can be compounded by mental unwellbeing (i.e., depressive behavior) which makes it more difficult to abide by the recommendations given to them in the understanding that this advice will be adhered to. Regardless the cause of the chronic condition, people who have a chronic illness can be on an emotional rollercoaster similar to those who experience loss and grief. Emotions can include denial, frustration, fear, anger, sadness, isolation and/or acceptance (Baker & Stiller, 2006).

In order for health professionals to move clients from a state of physical or mental illness, or being out of shape or unhappy, towards an optimal state of wellbeing (see Figure 1), it is important to minimize barriers to program adherence and maximize motivation. Assessing mental health status and using counseling techniques such as motivational interviewing that improve clients' motivation to change can be very useful to facilitate behavioral change. This can be important because it is reasonable to expect 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 adhere to healthy behaviors such as physical activity and exercise. There are various valid and reliable tools to measure depression, for example the K10 (Cairney, Veldhuizen, Wade, Kurydak, & Streiner, 2007). These tools can be easily applied in clinical practice and justify referral to a counselor if needed.

Physically ill ↔ Out of shape ↔ Physically healthy
(pathology) (health)

Mentally ill ↔ Unhappy ↔ Mentally healthy/happy

Figure 1. The continua of physical and mental health according to Glasser (2003)

Motivational interviewing and changing behavior

Motivational interviewing is a "client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (W. Miller & Rollnick, 2002). In terms of CT, motivational interviewing can assist in creating discrepancy in the comparing place...
between what is wanted and what is perceived to be received. This discrepancy facilitates change by assisting clients to discover inconsistencies between what they are currently doing and their core values and sense of self (Markland, Ryan, Tobin, & Rollnick, 2005). Although some may be of the opinion that motivational interviewing lacks the framework that CT has, it has been used effectively in many studies that examined modification of lifestyle behaviors, including physical activity (Hardcastle, Taylor, Bailey, & Castle, 2007). The principles of motivational interviewing are:

1. Express empathy
2. Develop discrepancy
3. Avoid argumentation
4. Roll with resistance
5. Support self-efficacy

Characteristics of motivational interviewing:
1. Client centered
2. Non-judgmental
3. Expressing empathy
4. Building trust
5. Being collaborative
6. Reflective listening
7. Increasing discrepancy
8. Exploring ambivalence
9. Reducing resistance
10. Increasing readiness
11. Eliciting change talk
12. Increasing self-efficacy

Motivational interviewing fits in well with acceptance and client-centered counseling according to 'theory of critical conditions for change', 'cognitive dissonance theory', health belief models (does one think that one is at risk), 'trans-theoretical model of change', 'self-perception theory', self-determination and the innate ability to sort things out (Ryan & Deci, 2000), and love and caring habits that respect the growth of others (Markland, Ryan, Tobin, & Rollnick, 2005; W. Miller, 1999). Motivational interviewing detects ambivalence, increases change talk (i.e., desire, ability, reasons, need, commitment) of the client, and decreases resistance to change (Figure 2).

**Ambivalence** (promoted by empathy)

(direction is influenced by positively reinforcing client’s speech)

**Desire → Ability → Reasons → Need → Commitment → Change**

Markland et al. (2005) placed the characteristics of motivational interviewing in three domains when utilizing the self-determination theory. The underlying assumptions are that: (i) involvement leads to relatedness; (ii) structure leads to competence; and (iii) autonomy support leads to autonomy (Figure 3).

| Involvement → Express empathy → Relatedness |
| Explore client’s concerns | Demonstrate understanding | Avoid judgment or blame |
| Structure → Clear and neutral information → Competence |
| Agree on appropriate goals | Provide positive feedback | Support self-efficacy |
| Autonomy support → Avoid coercion → Autonomy |
| Roll with resistance | Explore options | Encourage change talk |
| Client decides what and how to change |

**Figure 3.** How motivational interviewing fits within in the framework provided by the self-determination theory (Markland, Ryan, Tobin, & Rollnick, 2005).

Motivational interviewing is practiced by health professionals such as psychologists, social workers, nurses, medical practitioners, physiotherapists and dieticians. The method can be applied in settings ranging from ‘in the clinic’ to at home or via telephone. Although effects are immediate and two treatments can be sufficient, effect sizes diminish over time (from $d = 0.77$ at post-intervention to $d = 0.30$ at 6-12 months) (Hetterna, Steele, & Miller, 2005) and 6-monthly follow-up sessions are likely to increase the effectiveness of motivational interviewing in the management of chronic diseases.

The skills required for the interviewing process are not dissimilar to reality therapy (Glasser, 2000b) and other counseling methods, and are well described by Miller et al. (2003). Useful tools for motivational interviewing are:

1. Decisional balance list on pros (benefits) and cons (costs) for making change or not making change (Table 1);
2. Change plan worksheet (identify the desirable changes, reasons, steps, support of others, realization of success, enablers and barriers, back-up plan);
3. Readiness ruler (this could be applied to physical activity and diet);
4. Expectation (what is wanted from the intervention)
SMART goal setting (Specific, Measurable, Achievable, Realistic and Timely) can help to keep advancing with small steps and within agreed timeframes. Counselors that use motivational interviewing generally emphasize clients’ perceptions of the consequences of their behaviors instead of using a clinician’s model causality (Brunette & Drake, 2007). Target practice enhancement of people with chronic illness facilitated by health professionals (Glasgow et al., 2002; Thoenes Coleman & Newton, 2005) includes:

1. Agree together (client and health professional) on one topic appropriate for the session (e.g., increasing level of physical activity);
2. Identify what client wants to know about the topic;
3. Provide the requested information;
4. Identify disease concerns, desired outcome, required steps to reach that outcome, and the barriers that may arise;
5. Provide additional information if needed;
6. Agree on goals and action plan needed to address clients’ concerns;
7. Provide clarification of goals and action plan, and utilize personal action plan worksheet;
8. Identify client’s confidence in ability to carry out the agreed action plan on a scale from zero to 10. In case confidence rates less than seven, identify what needs to happen to make it higher;
9. Evaluate and refine the plan; and
10. Agree on one other relevant topic (e.g., diet). Etc.

**Motivational interviewing and choice theory**

Motivational interviewing is in line with Choice Theory (Glasser, 2000a). Exploiting the differences between clients’ perceived pros and cons of changing behavior and enhancing ownership of the interventional program can assist clients in moving towards sustained adherence to healthy behaviors such as physical activity and exercise. Physical activity is defined as any skeletal muscle activity that results in energy expenditure, and exercise as planned, structured, repetitive movement designed to improve or maintain some component of physical fitness (Casperen, Powell, & Christenson, 1985). Both, physical activity and exercise have been associated with health benefits (Andersen et al., 1999; Dunn et al., 1999) so health professionals can let clients discover what is acceptable to them after they have explored the pros and cons of improving these behaviors. Some like swimming, some dislike it; some like gardening while others do not have a garden; some want routine whereas others like change; some like undertaking activities in company of others and others prefer to be on their own. It is the task of the counselor to enhance ownership in clients’ plans to adopt and sustain these behaviors. Reality therapists may want to use other methods that are available to them within the choice theory in addition to these techniques to enhance outcomes. They are equipped to contribute to much needed lifestyle modification programs and/or research for the benefit of public health and well being.

**REFERENCES**


Choosing to Love:
The Essentials of Loving (Presents and Problems)

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ABSTRACT

There are problems as well as presents in the process of loving. All loving behavior is total behavior. Loving compensates for the movement from one behavior to another. The total behavior of loving is reflected in the pictures chosen for the quality world. Loving is an act of sacrifice. Perfect loving is predicated upon acts of perfect sacrifice. Perfect sacrifice is to give and not to receive, (for)giving is enough. Perfect loving seeks perfection within perfection. To love is to give up that which one wishes to keep while finding joy in the giving. Loving is manifested through total behavior. Loving behavior sets the parameters for defining loving. This article discusses perfection of loving behaviors.

Two Plants - One Flower

A transformation from twoness into oneness is a reasonable expected outcome of loving. A sense of sweetness is concomitant to loving. Happiness is expressed in a loving relationship. Loving is not just a change in one or two people, but the transformation of both. Loving provides the parameters for creating a new reality. The behavior of being in love is a process. This process includes meeting basic needs. To truly be in love, one can perceive a loss of freedom but cannot continue in loving without meeting this need in the relationship. The increase in choice is required for empowering lovers. To truly love is to place the other in a position of power. The power that one gives to another when he or she admits to requiring the presence of another to feel complete is empowering. To love requires the sacrifice of meeting power or freedom needs (Glasser, 1984). Fun is essential to loving – each enjoys the process. Love and belonging is a joining to the other who is in fact accepted as one who adds to a sense of oneness. At times, the parameters of love must be stretched in order to develop loving. Loving occurs on both the physical and spiritual levels. The spiritual level is stretched to encompass both levels. The more one stretches the parameters, the more faith in loving each develops.

Each partner must have enough faith in the other to believe that the stretching does not end the love, but nurtures the loving. During the process of stretching, each becomes more aware of how much in love each is. The process of stretching energizes the desire to develop more effective loving behaviors. In order to effectively stretch, sacrifice is necessary. Love always demands sacrifice. One must sacrifice for the fulfillment of other needs. This is especially true for the needs of power and freedom. Those who are in love gladly give of their power and freedom in order to gain love and belonging. The measure of love is how much you give in the relationship. Loving partners give and give and desire to keep on giving.

Giving increases your involvement. To choose to think and act incomplete without the selected significant other is an empowering process. One’s level of involvement can be determined by measuring the extent of energy expended to maintain the relationship. To reduce the energy expended to continue the behavior of in-loving is a direct reflection of the choice to remove shared quality world pictures. In this instance, it is not the quantity, but the quality of our pictures. Each of us place need fulfilling, relationship building pictures in our quality world. The pictures in the quality world assist us to build and sustain relationships. Quality pictures are needed to build quality loving relationships. According to Ford and England (1979), “Whatever may be true about the art of loving as an abstract formulation, when you come right down to building permanent love relationships between people, the single most decisive factor is the quality of the activity they share in their daily lives (p. 15).” Quality activities develop loving relationships. Out of the loving relationship we choose to develop quality pictures.

As a counselor, friend or therapist, one’s role is to assist those who present relationship issues with ways to build more loving quality world pictures. Sharing time and pictures is not enough. It is the content of the pictures that determine love or in love with a significant person. If we share these pictures, we share time. Sharing time is not enough. Over time, one can become accustomed to doing and being with someone. These behaviors alone do not build a loving relationship. It is shared commitment that builds the loving relationship. You can share rituals on a regular basis and as a result you can develop together pictures with this other. The very act of being in love requires that the pictures be more than rituals. Being in love requires that the pictures be supremely need fulfilling. Relationships end when we refuse to allocate quality time – we are out of time for each other. It takes time to build and rebuild relationships. It is easier to give up.
understand that perfection is a goal. Patient loving manages the feedback loop. Basic needs are met without the good cheer. A patience love understands that perfect love one to manipulate time. It allows one to wait and be of constraint of now or later. The present of patience allows is acceptable.

Five presents

The five presents of perfect love are purgation, perception, praise, patience and perfection. Purgation is the present of forgiveness. Forgiveness purifies and purges the factors related to negative relationship building. Forgiveness should not be confused with forgetfulness. One may remember and forgive. Forgiveness is refreshing. It allows those involved to start again. In each relationship, one or both partners may err. To err is human, to purgate is to love. It, forgiveness, is the first and foremost gift of loving. Those who are in love forgive and forgive, and forgive to strengthen the relationship.

Perception is the present of insight. Perception provides the participants with the ability to sense at an intuitive level. That is, to see that which is not present (physical) but using the ability to sense that which is invisible (spirit) and to be driven to act as if it were visibly present. Loving insight strengthens the ability to understand the strengths of the significant other. In understanding strengths, one affirms the worthiness of others.

Praise is the present of affirmation. The present of praise allows one to see worth in one’s self and one’s partner. Praising partners possess the ability to praise and appreciate the significant others’ gifts and abilities. Those who love with praise can perceive strengths in their significant other. Constant warranted praise reaffirms the choice to be significant to one another.

Patience is the present of understanding. Understanding is a process of filtering information and reframing it into a clearer, clean picture. Patience lovers understand that perfection is a goal. Patient loving manages the feedback loop. Basic needs are met without the constraint of now or later. The present of patience allows one to manipulate time. It allows one to wait and be of good cheer. A patience love understands that perfect love takes time. Patient in loving is in a hurry but does not rush is acceptable.

The final present of perfect loving is perfection. Perfection is the present of wholeness. It is wholeness and completeness. The present of perfection is visibly manifested in the successful loving relationship. To seek perfection is to expect success in the relationship. Perfection is a refusal to accept failure, as a perfect love is quality loving. It is the consummation of total loving behaviors. It is each partner seeking perfection within the imperfection (Mickel and Hall, 2006) of human behavior. Perfection moves loving beyond the mental and physical to loving as spiritual acting.

The five presents are manifest through need fulfilling loving behaviors. In the act of spiritual love, we allow ourselves to be loved, while choosing behaviors that we perceive as acceptable to the one(s) we wish to love us. That is, we influence others to form pictures of us that are perceived as need fulfilling. In the search for the perfect love, we shape our behaviors to meet what we perceive as our expectations. These presents exist within the loving system. The loving system exists within us all. We can choose to activate and use this system or to move to another behavior. A role assumed by the therapist is to work to empower those who wish to use the loving system.

Five problems

Just as there are presents in loving relationships (Mickel and Hall, 2006), there are also problems. Need fulfilling behavior is unmanaged when we have more problems than presents. This is an imbalance, a lack of homeostasis. We choose to describe five problems in the love relationship. They are best described as prejudice; pseudo; permissive; pride; and possessive love. We act irresponsibly when we are unable to give and receive loving presents.

The problem of prejudice loving, consist of making judgments without a sound epistemological foundation. Prejudice is based on incomplete information/involvement. Prejudice loving involves jumping to conclusions about the relationship and the components within the relationship. It is manifest in a lack of discernment. There is minimum reality testing while invention and fantasy are the primary motivators for making choices. The valuing filter in the perceptual system does not consider means, only ends. Means are preexisting within ends (Washington, 1986).

The problem behaviors of pseudo loving, mistrust liking for love. It is confusing infatuation for intimacy. It is also misunderstanding lust for loving. I love you only so long as you make me feel good. The moment you make me feel bad or unhappy, I question my love for you. This is a pseudo or surface love. Pseudo loving is love without depth. Any issue can shake its foundation because it is not built on a well formed base. Pseudo loving presents as a desire for commitment without being committed. It is in
the final analysis, a one way relationship. Pseudo or false love has many of the visibly present signs of a true loving relationship. It is a mile wide but only an inch deep. It results in a failure of the behaviors needed when one works at loving. It presents as a false expectancy that love answers all questions. Pseudo loving is also a nonspiritual form of loving. It can be expressed as narcissism. This is, loving without spiritual discipline. External physical discipline may be present. Inner discipline based on internal deliberate effort is absent. Pseudo loving involves the promotion of oneself to the exclusion of the others except when it benefits one's self. I will love if there is something in it for me. It is an empty shell that echoes what sounds like love but is in the final analysis noise. False loving is the antithesis of unselfish loving.

A problem of permissive loving is that it seems to be loving and belonging without structure. Structure, for our purpose, consists of mutually agreed upon boundaries. Permissive loving results in a relationship where anything goes. Boundaries are porous and the relationship seems to have few if any rules. The commitment to the relationship is consistently in question. A consistent question is do you really love me? If you do, why don't you behave in a manner consistent with my perceptions? This includes taking the position that loving does not require each party to relinquish some power. In this relationship, permission is not required in order to act. Love in and of itself does not give permission to act in certain ways. Permissive loving is loving based on fear of loss. It is based on a belief that if one party complains or requests compliance, and the other does not acquiesce, then one will lose love. Love does not require sacrifice; it only requires the façade of loving.

A problem of prideful loving includes acts that can be termed selfish. Selfish acts are I focused. The very actions of loving are dependent upon what I contribute to the relationship. This problem is manifested as fear without sufficient rationale. Past experiences with love, help to shape current definition of loving. In prideful loving, the negative experiences take precedence. The past can influence perception which influences your behaviors. Selfishness is pride in the conquest. Selfishness is manifest in pride. Pride engenders a belief in the sense that you are nothing without me. The relationship is exemplified in the trophy possession. I love you only so long as others think you are worthy of love and possession. Loving manifested as pride is focused on the external. Prideful loving's focus is to love for reasons outside of the relationship. This is the type of loving that can be altered in the face of a strong opposition or conflict. Its strength is individualization. It is the I in loving rather than the we.

A problem of possessive loving is manifested as ownership of another. Possessive love is to place one self and one's wants before the others. I can only love you after I love me. It is manifested and acted out in jealousy. Possession is acted out through communicating that this person belongs to me. The possessor has an expectation that the other acts and is treated like a possession. It is understood that "you are mine." Loving is viewed through how action impact the perception of ownership. Possessive loving is expressed in acts of jealousy. It indicates that the possessor is not in control of self and acts out insecurities in the relationship. Possessive love is based on affective emotions. When possessive behaviors are challenged, anger results. According to the Dalai Lama (1999), "When we become angry, we stop being compassionate, loving, generous, forgiving, tolerant and patient altogether" (p. 95). The act of possession taints the positive relations that are built around sharing. One may also build a relationship on negative, hurtful behavior. These behaviors are used to punish. In the act of forgiveness, one does not use the event to castigate or punish the offending party. Negative events are used to provide a foundation for change. It is the failure to share on a consistent basis. Possessive loving consists of suffering. Problems are manifest in imperfection within perfection.

**Perfection within imperfection**

The search for perfection within imperfection considering the five problems reveals the principles of polarity and complementarity (Mickel, 2005) relating that within every problem exists a solution. For each of the problems there is a solution, a present if you will. According to the principle of polarity (Three Initiates, 1988), "Everything is dual; everything has poles; everything has its pair of opposites; like and unlike are the same; opposites are identical in nature, but different in degree; extremes meet; all truths are but half-truths; all paradoxes may be reconciled," (p. 125).

Loving exists on two levels, the physical and the spiritual (Mickel, 2004). These levels are reflective of the ancient laws of complementarity and polarity. The law of complementarity is significant to choosing to be in love. One can experience love without loving, but one cannot have loving without love. Each person contributes to pictures that complements the other. The leading and complementing half need only to connect the individual pictures to make them complete. Complementarity is necessary for balance. True love in action releases how you structure your pictures to allow socially constructed images to be developed to make perfect the one you love.

Perfect love conquers fear that is manifested as insecurity and jealousy. We must be willing to return to those pictures of loving to recall our love and belonging behaviors. These are the pictures in our quality world. Love is a transformative process. It moves one from unable to two who are able. Those who truly love can do anything. They stretch the perceptual boundaries of both time and space. Total love is to love self (and hence others) wholly and universally.

The presents to problems continuum represents one of
many ways to focus on the loving relationship as need fulfilling. The loving relationship results when one utilizes the presents to overcome problems. In order to change problems into presents, one must be willing to change perceptions. According to Ford (1983), “Critical to the success of this endeavor is the ability to look for those behaviors in our partners that either reinforce our existing positive perceptions or change our negative perceptions to positive ones” (p. 44). Our perceptions (pictures) must be balanced or we perceive a sense of frustration and can use non loving behaviors to match pictures which meet our needs in the here and now but can be disconnecting/non relationship connecting. It has as its outcome the strengthening of healthy healing loving relationships.

The authors believe that perfect love exists. The actions of loving are in the final analysis the reach for this perfect love. It requires faith in the successful outcome of loving. These expectations are manifested in mind, body and spirit. We choose behaviors based upon our perceptual system (knowledge and values) interpretation of what it requires to build an intimate relationship. These behaviors are expressed through our total behaviors. The power of loving is perfectly manifested through the healing process. Healing love is never selfish. One is always comfortable within the parameters of healing love. The essential of in loving is choosing presents over problems.

CONCLUSION

In order to be successful and balanced, we all need love. The definitions of love take several forms and each may be expressed differently. There are three common types of love. They are eros, philia and agape. Eros is the term used to discuss romantic love. Philia is reciprocal loving. Each can be presented as quality loving. In order for in loving to be quality, it must be agapic. This form of loving is necessary to share both time and pictures. Agapic loving is that which is given without expectation of receiving. It is not predicated on the behavior for the recipient. According to Felder (1989), “Agapic caring presumes that the beneficiary of the love receives it whether or not it is deserved by conventional standards” (p. 71). Agape is an understanding, redeeming love which does not seek love in return (Washington, 1986). Whatever the form or function loving relationships take, love is necessary to a healthy life (Glasser, 2003).

Loving is operationalized through acting, thinking, feeling and physical aspects (total behavior) of a shared quality world. In the shared quality world, there are usually many more shared pictures than we use. As we live our life, we accumulate our loving pictures. These pictures prepare us for our perception of in loving. The accumulation of more pictures than we currently need (negative entropy) is necessary for those moments when loving is threatened. It is the building of a reserve in the quality world. These moments include disagreements, selfishness, loss, pain and problems. In terms of love and belonging, each of us can acquire any number of pictures. The more we believe it, the truer it is. The world of loving is socially constructed around what we believe. Loving relationships are the perfect model of the concept of constructivism.

The question is what type of love exists? One can transition from in loving behaviors to love behavior. When one encounters problems in the relationship, one can move from agape loving to philia. Here, the relationship is based on reciprocity. The loving system will always seek homeostasis. This is a balance of love within or outside of the relationship. Ideally, the system will seek balance in a healthy need fulfilling manner. If the balance is unhealthy, intervention is necessary. Whether or not the love system is healthy or ill, balance will be the outcome. The system will not judge the behaviors but acts to achieve balance. It is up to the perceptual system to interject judgment into the type of balance achieved. Self evaluating will determine through the valuing filter if the behavior is healthy.

When one is in love, one acts lovingly. According to Glasser (1965, p. 10), “To either love or allow ourselves to be loved is not enough, we must do both.” Love is and isn’t at the same time. It is everything and nothing. It is the all but it fails to meet the any. Love is the joining of extremes. It is a union of opposites. It is both presents and problems. This evidences a commitment to the process and practice of loving. The most significant practice of acting lovingly is to be open to love. Those who love are connected beyond space and time. Loving is a total behavior. The feeling, thinking and physical aspects of loving are evidenced through our behaviors. These are the visibly present manifestation of the spirit of loving. Total behavior infused with spirituality is wholistic.

Spiritual loving is the transformative component of perfect loving. Perfect love has no beginning and no end. One cannot remember the moment of transformation to perfect love, that is when it began nor can one predict its end. Perfect loving is timeless, no beginning and no end. Perfect loving includes mind, body and spirit. The total behavior of loving includes thinking, feeling, physiology and doing. It is the love that is both convergent and triangular in the practice. Spiritual loving is need fulfilling. Spiritual loving is pure love. This is the love that is beyond the physical and the mental. It’s love based on the existence of the perfect within the imperfect. The struggle toward perfectibility is the physical attempting to be congruent with the spiritual. The spiritual is that which lasts forever, while the physical is temporary and limited. Spiritual love is loving without boundaries. Its residual exists on this plane, but it is in reality on a higher plane. It raises the level of consciousness of the participants. It widens the sphere of influence and concern.

One must choose to be aware of the other’s behavior as well as the choices made in an attempt to control others. All behavior is our best attempt to control our perception.
Perception which is focused allows us to focus this control in a need fulfilling way. Perfect loving is comprised of complementary loving relationships that seem to provide a perfect model. Loving and belonging is evidenced by total behaviors. It is the basic need that connects each one with another. The more interconnected one is with another, the more involved they are. Involvement is expressed in the process of communing. Communing is the coming together of those with like minds. Communing is the operationalization of faith in the loving relationship. This coming together reflects consubstantiation. Consubstantiation means that we are of the same substance and therefore we can commune with each other utilizing intuitive knowing. Intuitive knowing is required to express faithful loving. According to Ford and Englund (1986), “Faith is the veneration, love, and trust you give to the source of ultimate meaning of your life” (p. 127).

Choosing to love perfectly requires that each of the needs be fulfilled. In addition to fulfilling the needs, the authors posit that special attention should be paid to loving as a form of wellness. Wellness leads to loving perfectly. Perfection requires focus on loving. To be perfect in loving, one must aspire to be perfect in behavior. To be perfect in behavior, one must focus on total commitment to self as well as to the other. In the final analysis, loving is two plants into one flower.
Choice Theory as a Model of Adult Development

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ABSTRACT

Choice Theory is popularly recognized as a basis for the practice of Reality Therapy, Quality Education and Lead Management. There seems to be little thought given, however, to Choice Theory as a broader model for human development. This lack of perspective is surprising given the Institute's training emphasis on application of Choice Theory in practitioners' lives, as well as vocations. While some attempts have been made to expand the Basic Needs concept, through suggestions of additional Needs, there has been no real attempt to use Choice Theory as a frame for understanding human development through the lifespan.

Development is understood as occurring within individuals who may be designated as more fully or less fully developed. Development in these individuals is contrasted and compared with other developed individuals. Although this is not intended to be an exhaustive thesis, by any means, Choice Theory is presented as an idea with richer veins to be mined, especially in the developmental area.

Choice Theory as a Model of Adult Development

The ideas in this paper are predicated on the author's understanding of Choice Theory, an internal control psychology formulated by Dr. William Glasser (1998) that states that all human behavior is motivated by five Basic Needs - the physiological Need of survival and four psychological Needs that may be represented by the terms, love/belonging/acceptance, power/recognition/achievement, freedom/independence/choice and fun/learning/excitement. Choice Theory is the product of consideration and research applied to Control Theory (Glasser, 1984), itself a product of Behavior: The Control of Perception Psychology (Glasser, 1981), an offshoot of William T. Powers' Perceptual Control Theory (Powers, 1973).

Powers (1973) suggested that subjective perception is the only reality for any individual and that all behavior was motivated by the need to control individual perceptions and, hence, reality. Glasser originally embraced Powers' idea of perceptual control as a theoretical framework for his Reality Therapy, suggesting in Behavior: The Control of Perception (BCP) psychology, a model similar to Powers' Perceptual Control Theory (PCT). Glasser later posited that Basic Needs were the motivators for behavior and the individuals parted ways, Glasser to reformulate BCP into Control Theory, later to become Choice Theory, and Powers to refine his PCT, believing that there was no logical foundation to create Basic Needs when PCT explained behavior without them.

This paper is an attempt to understand Choice Theory in relation to the concept of adult development. While this paper is not necessarily meant to set forth an exhaustive theoretical frame, it is hoped that the discussion will stimulate research in this direction.

Development Through the Lifespan

Human beings continue to develop throughout their lifespan. Development is here defined as the ability to progressively make good choices to meet Basic Needs. Choices are defined as "good" if they move individuals closer to meeting their Basic Needs in ways that do not harm them or others. Choices are defined as "bad" (or less effective) if they do not move individuals closer to meeting their Basic Needs or if the choices harm the individual making the choices or harm others.

Choices begin to be made in infancy and continue through the physiological developmental stages of childhood, adolescence, young, middle and older adulthood. As individuals age, they may or may not become consciously aware of their Basic Needs. Individuals may or may not develop strategies to satisfy their Basic Needs. All individuals will, however, progress from relying on others to satisfy their Needs to making conscious choices about their behaviors that satisfy their own Basic Needs. This progression, from others satisfying Needs to self satisfying Needs is development.

Development is not sequential but is progressive. Individuals do not pass through various stages of development but do become progressively better at making choices to meet their Needs. This progression is noted by a lessening of motivation to fulfill the Need. While all Basic Needs motivate us to meet their genetic level of satisfaction, it will be noted that Needs satisfaction, itself, is in constant flux. That is to say, just because an individual engages in Needs satisfying behaviors at one moment in time does not mean that Needs satisfaction is temporally static. As individuals change within their relationships and relational environments, Needs satisfaction will fluctuate. E.g., if one's Needs are primarily met through one's marriage and employment, Needs satisfaction may diminish if the spouse dies or leaves or if one is terminated from one's job.
As individuals age and move into different life roles, the ways in which they meet their Basic Needs vary. In childhood, Basic Needs are met primarily through relationships with parents. In adolescence, Basic Needs are met through relationships with peers, and in young adulthood, Needs are met through relationships with "significant others" and individuals in vocational and academic settings. In middle adulthood, Basic Needs are met through employment relationships and in older adulthood, relationships with "significant others" and friends fulfill required Needs. Basic Needs do not change but life roles change, based on choices made to fulfill immediate Basic Needs requirements. As roles change, the ways in which Basic Needs are met change.

More and Less Fully Developed Choice Individuation

A more fully developed individual will seek ways to compensate for the lack of Needs satisfaction caused by these life events through finding other ways to fulfill the Needs by making good choices. A less fully developed individual may make bad choices in attempts to fulfill the Needs "void" caused by changing relationships, e.g. loss of spouse and co-workers, and relational environments, home and work life. The term, void, is used to denote the difference between the satisfied and unsatisfied Needs levels. Basic Needs are always met at some level. Individuals are compelled to achieve some level of Needs satisfaction to continue operational functioning. The methods for obtaining Needs satisfaction may be bad choices, but choices will be made in an attempt to meet basic needs. e.g., individuals may choose to depress in response to the hypothetical situation given above, i.e., the loss of a spouse and employment. This is a bad choice but it is the best choice the individual can create at the moment. A good choice in the hypothetical would be to develop or rely on a support group and work toward seeking other employment. The more developed individual would choose thinking and behaviors that more fully help meet Basic Needs satisfaction. The less developed individual would choose actions and cognition that less fully meet Basic Needs.

The pejorative nature of the more and less fully developed individual's definitions is acknowledged. From a biopsychological perspective, development is about the ability to meet Basic Needs. Simply meeting Basic Needs, however, does not imply development. Applying criteria of harm to self or others in defining "good" and "bad" choices are based on sociocultural perspectives that differentiate between human development and simple change.

Psychopathic and antisocial behaviors designed to meet Basic Needs are no more or less developed than prosocial strategies for Needs fulfillment. They are simply different ways to achieve Needs satisfaction. Perhaps "other developed" would be a more appropriate term for individuals in this category, while "less fully developed" remains applicable for individuals who make choices that move them no closer to greater Needs satisfaction but who meet Needs on a survival level, i.e., the minimal level required to prevent Basic Needs frustration.

Sex, Race and SES

Sex, race and socioeconomic status (SES) are irrelevant factors in fulfilling Basic Needs in so far as all individuals have access to environmental and relational vectors for Needs fulfillment. This is not to deny that limited opportunities may exist for individuals based on race, gender and SES. Limited opportunity, however, does not prevent individuals from making good choices to meet basic Needs, regardless of the environmental or social richness. This is seen on a survival level with organisms that exist in environments "at the edge" of biological sustainability (for examples refer to Gould & Gould, 1989). While these organisms may not "develop" in the manner in which the term is here being used, the analogy serves. Life finds a way to exist, whether it be biological life or psychological life, and both may flourish in the cruelest of environments. Even in a society that represses opportunities based on discriminatory ideologies, opportunities exist for individuals to develop. Indeed, if Needs fulfillment is based on attainment of pictures in the Quality World and pictures in the Quality World are based on individual cognition, then individuals may fulfill Basic Needs in whatever environment they find themselves. Aspirations are contingent upon previous, individual experience. One cannot imagine what is unknown to one's experience and, therefore, one cannot develop a picture of Needs fulfillment based on what has not previously existed in the form of environmental stimuli. Individuals may become more fully developed in whatever environment they exist.

Gender Bias in Needs Fulfillment

Male and female proclivities are subjective descriptors. Humans are integrated beings. Both "male" and "female" aspects are human traits expressed as behaviors aimed at fulfilling internal motivators. Sociocultural modeling may provide individuals with clues of how to go about fulfilling Basic Needs but individual choice is the final arbiter of behavioral expression.

Recognizing Total Behavior in the Function of Boredom

With age, "tastes" may change. Those things which fulfilled Basic Needs in the past still fulfill Basic Needs in the present but the degree to which fulfillment is met may vary. One indication that behaviors that previously fulfilled Basic Needs may be waning is the feeling of "boredom." Boredom is an indication that pictures in the Quality World are losing efficacy as motivators of behavior. These phenomena (phenomena because emotions are viewed as the effect of constellations of influences) may also account for the "seven year itch." The popular notion
of the desire to move from one relationship to another every seven years. Fisher (1989) suggested that it was actually a “four year itch,” four years being the requisite time for a child to be conceived, born and reared to a self-sustaining age. The biological advantages for a “four year itch” are assumed to be increased genetic diversity (Fisher, 2004), an evolutionary advantage, and sustained Basic Needs fulfillment at a high level of satisfaction. While the “itch” may be biological in nature, the manner in which this is handled is mediated by sociocultural expectation. Sociocultural norms, values and mores will influence individual choices in Basic Needs fulfillment in more fully developed individuals. Such influences are not always congruent with efficient Needs satisfaction and may actually interfere with Basic Needs fulfillment. Puritanical ideologies may find themselves at odds with biological imperatives, creating psychological disturbances. These disturbances are dilemmas that may be solved by more fully developed individuals through self-reflection and alternative choice recognition. Regardless of resolution or non-resolution of psychological dilemmas, boredom may serve as an identifiable affective precursor to biological imperatives. This relationship between affective, physiological and cognitive states with behavioral functioning defines the concept of Total Behavior.

Antisocial and psychopathic individuals, as has been noted, do not employ less fully developed strategies for Needs satisfaction. They employ other strategies for Needs satisfaction. Cheating is an evolutionary stable strategy (Szamadó, 2000; Colman & Wilson, 1997). Promiscuity is another method to ensure genetic continuity and variability. While these behaviors may not be socioculturally acceptable, they are sociobiologically viable.

Definition of Midlife Event

More fully developed individuals may develop self-reflection skills that allow them to move from fulfilling Needs on an unconscious level to fulfilling Needs on a conscious level. This shift from unconscious to conscious fulfillment of Basic Needs may precipitate a “midlife crisis” in some individuals, although not necessarily in all individuals and not necessarily in mid-life. This particular “midlife” event may be due to a picture in the Quality World demanding, as it were, satisfaction. After many years of fulfilling Basic Needs on a survival level, the internal drives exert themselves in an effort to more fully achieve satisfaction. The Total Behavior created to fulfill the repressed pictures in the Quality World, i.e., the underfulfilled genetic drives, may force choices, but the force is internal and the external expression is always a conscious decision to action. Jung (1933) noted that “the achievements which society rewards are won at a cost of diminution of personality. Many – far too many – aspects of life which should also have been experienced lie in the lumber-room among dusty memories. Sometimes, even, they are glowing coals under grey ashes” (p.104). Boredom, which may predict a midlife event, could be an indication that the coals are, indeed, smoldering beneath a layer of socioculturally repressive ash.

Evidence suggests that even in other developed individuals, including psychopathic individuals, some sort of midlife event occurs that brings about a decrease in criminal behavior, behavior designed to meet Basic Needs. According to Hare (1993), criminal activity remains high in psychopaths until about the age of forty, when a decline occurs. The decline is more pronounced in nonviolent offenders than in violent offenders. While it is unlikely, given knowledge of psychopathy, that these individuals become more self-reflective, it is possible that previous pictures in the Quality World begin to fade, as they do in more and less fully developed individuals and other strategies are employed to achieve Needs satisfaction. This same phenomenon is seen in antisocial individuals at about the age of fifty years (Troisi, 2007).

Mental Health in Development

The individual that is being called “more fully developed” tends to exhibit a greater degree of mental health. Note that the “less fully developed” individual is still mentally healthy. If there does not exist a pathological cause for the individual’s behavior, e.g., depressing, then the individual is not mentally ill (Glasser, 2005). Mental illness is only used to denote a brain illness with a pathogenic origin. Depressing is a cognitive behavioral choice, as are all of the “personality disorders” listed in the DSM-IV-TR. Alzheimer’s is a pathological illness caused by amyloid, senile plaques and neurofibillary tangles in the human brain. Individuals who choose thinking and actions that lead to greater Needs satisfaction move away from cognitive behavioral choices such as depressing, because they do not meet Needs satisfaction beyond the survival level. Individuals with Alzheimer’s cannot make cognitive behavioral choices to reverse the effects of that disease. The greater the degree of mental health, the greater an individual’s facility with making good choices and, therefore, the greater an individual’s developmental ease.

Spiral Nature of Development

This model of development may be viewed as an upward spiral where choices about Need satisfaction must be made throughout the life cycle but choices are made at higher levels of development. As has been stated, “higher levels of development” refers to good choices that lead to sustainable Needs satisfaction. As has also been stated, Needs satisfaction is a dynamic variable. While more fully developed individuals may make more sustainable choices, e.g., developing a support group to deal with loss of other relationships, they may also make less sustainable choices immediately to satisfy Basic Needs, e.g., hiring a prostitute. Both choices lead to Basic Needs fulfillment.
but development of a support group is the more sustainable choice for fulfilling an individual's Needs.

This ability to make more and less sustainable choices indicates the "Snakes and Ladders" nature of adult development. While progress is made up the spiraling ladder of development through making sustainable and good choices, and learning from these choices, regression is possible when encountering a "snake" of a problem that is outside the usual domain of one's life experience. Bad choices may be made and an individual may "slide" down the progression spiral. Since development is non-sequential, however, knowledge gained from all choices, both good and bad, provides an individual access to a previous position on the "board of life" without having to re-climb the stairs of experience. Knowledge once learned need not be re-learned.

Knowledge may or may not be transferable to other life situations. Non-transferable knowledge is knowledge that an individual does not transfer from one setting to another. The knowledge is situated in the context of one meaningful life event. When met with a similar life event in a variable context, the previous knowledge does not seem applicable to the current situation. Choices may be made that do not meet Basic Needs in as facile or Needs fulfilling a manner as could be due to the non-transference of relevant knowledge. A "slide" occurs. New situational knowledge is gained. The individual, when faced with the same choice, can then draw on the previous, experiential knowledge and make a more fully developed choice. More fully developed individuals may be more adept at transference of cognition to different life situations, developing a "suitcase" full of behavioral strategies to deal with life events (R. Wubbolding, personal communication, October 13, 2007).

**Affects as Indicators of Needs Fulfillment**

The more fully developed individual is the "happy" individual. It is the individual who defines life and relationships as joyful and ultimately fulfilling. Happiness is here distinguished from pleasure. True happiness often requires an individual to make choices that are painful in the short-term but that lead to long-term joy or happiness. An individual may make choices that are good for long-term Needs fulfillment but that cause immediate or short-term Needs denial. During the period between short-term Needs denial and long-term Needs fulfillment, one will suffer.

Just as happiness defines Needs fulfillment, misery defines Needs denial. The more fully developed individual will make good choices that lead to long-term, or sustainable, Needs fulfillment. Less fully developed individuals may make choices that provide for immediate Needs satisfaction at the expense of long-term Needs fulfillment.

Consideration of long- and short-term choices demands recognition of the possibility of suffering. The ability to suffer may be a blessing or a curse. The more fully developed individual who has a great capacity for suffering will find that capacity to endure suffering as a boon when having to make Needs denying choices to fulfill long-term Needs satisfaction and when struggling to make choices that only nominally meet Basic Needs requirements. These nominal choices illustrate the spiral nature of the development in even more fully developed individuals. The less fully developed individual may find the same capacity to endure suffering as a curse that leads, not to resolution in the attainment of Needs through good choices, but to a non-motivating misery.

Hare (1993) notes that psychopathic, i.e., other developed, individuals have a lowered affect that may be biologically induced:

In effect, the elements needed for the development of psychopathy — including a profound inability to experience empathy and the complete range of emotions, including fear — are provided in part by nature and possibly by some unknown biological influences on the developing fetus and neonate (p.173).

Because of lowered affect, psychopathic and antisocial individuals may require greater stimuli to register the experience of Needs fulfillment (Troisi, 2007). This may explain why a greater threshold of fear is exhibited by psychopathic individuals. Less fear allows for more intense interaction, thus providing the more intense sensation required for Needs satisfaction.

Other developed individuals are also less affected by standard punishments for criminal behaviors. Such punitive measures seemingly have little or no effect on the behavioral strategies of psychopaths in Basic Needs fulfillment. Psychopaths may, at some point, suffer due to minimal Needs satisfaction but it is not due to the meager punishments meted out in most correctional systems. Indeed, the very appellation of "correctional" applies to projections of what prosocial individuals believe would deter other prosocial individuals, both more and less fully developed, from behaviors that violate sociocultural norms. Other developed individuals may actually find "correctional" measures to be stimulating and Needs fulfilling, hence, they have no reason to change their behavior.

**Spirituality**

Although some have proposed that the Basic Needs be expanded to include spirituality (Litwack, 2007), spirituality, itself, satisfies other psychological Needs. This, in and of itself, precludes spirituality from being a Basic Need. If Needs were satisfied by each other, then there would be no motivation for behavior. The very genetic presence of the other satisfying Needs would suppress the behavioral imperative.

As spirituality is a Needs satisfier, however, it is possible that it represents a developmental construct. If spirituality is viewed as a "way of knowing" or a "way of making meaning" that incorporates a concept of some-
thing greater than the individual, it is possible that spirituality represents choices that include global consciousness decision making, i.e. the awareness of the social ramifications of individual choices. While more fully developed individuals will make choices that satisfy Basic Needs and do not harm self or others, more spiritually developed individuals make choices that positively impact society. Kohlberg suggested similar stages of self-transcendence in his theory of moral development (stages 6 and 7), as did Fowler in his “universalizing” stage of faith, and Maslow in his concept of “peak experiences” (Bee & Bjorklund, 2004). While this ability to choose socially constructive alternatives is not viewed as a developmental stage in the proposed Choice Theory model, it is acknowledged as an aspect of the more fully developed individual, who does not make socially positive choices.

Limitations of Choice Theory as a Model of Human Development

Basic Needs Theory is based on the idea that the Needs are genetically encoded. To date, no evidence exists for a genetic blueprint for Basic Needs. The lack of evidence for the Needs, however, does not negate their existence. Whether there exists a freedom gene, or any other specific gene solely tied to any Basic Need, is questionable, despite the fact that genetic heritability of personality is given much credence in certain schools of personality psychology (Penke, Denissen, & Miller, 2007). While personality traits have long been seen as heritable by these schools, the idea of Basic Needs as a construct in personality formation has been largely ignored.

While Brown and Swenson (2005) developed a Contextual Needs Assessment instrument to assess the relative strengths of Basic Needs – an exercise that recognized the genetic basis of Basic Needs through the inference that Basic Needs are common to all human beings - Minatrea and O’Phelan (2000) correlated the Basic Needs with the Myers-Briggs Typology Indicator, suggesting that Basic Needs may, indeed, be related to personality. Such studies have been few and far between.

It is suggested in this paper that clusters of genes are activated and/or repressed based on environmental influences during the life cycle and this activation and/or repression leads to psychological predispositions referred to as Basic Needs, the configurations of which define human personality. This scenario, if valid, lends further credence to the developmental nature of this theory since activation and/or repression of genes usually occurs during discrete periods in the developmental life cycle.

While studies to validate this thesis have yet to be presented, it is suggested that discussions of this nature may serve to stimulate such research and expand the dimensions of Choice Theory as a model of human adult development.

REFERENCES


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ABSTRACT

Looks at the relationship between emotional intelligence and choice theory in the work world, with particular emphasis on the implications on health and productivity.

Most of us have a managing or leading role of some sort, whether at home, in community life, or at work. Also, as a professional, one can be leading through professional expertise and not necessarily because of one’s place in the organizational hierarchy. There is an increasing awareness of the role of leadership and team development in organizational development, for example in health care where change is needed to manage the chronic disease burden (Dunbar et al., 2007) and utilizing and retaining a dwindling workforce (Schoo, Stagnitti, Mercer, & Dunbar, 2005). This is forcing leaders and their teams to work as smart as they can with resources that are available to them.

Positive leadership has been associated with outcomes that include happy relationships, teamwork, learning, recognition, staff retention, and health and wellbeing. There is evidence that emotionally intelligent leaders in workplaces are able to bring about these positive outcomes because they are attuned to the emotions that move people around them (Goleman, Boyatzis, & McKee, 2002). In this sense, emotion can be defined as aroused energy that takes a direction (Hunt, 2004a) (Latin: e = from, movere = to move). Valerie Hunt regards emotion as the metronome of life (Hunt, 2004b). Although emotion can be a feeling state (e.g., fear, anger, joy, hate or sorrow) associated with action, its energy is, according to Hunt, directed to action, to behave (Hunt, 2004b). As mentioned in an earlier publication (Schoo, 2005), Pert (Flowers, Grubin, & Meryman-Brunner, 1993) regards emotions as a bridge that connects the mental and physical realities (p. 187), and sees neuropeptides as the physical representations of these emotions. Negative thoughts and emotions such as excitement and anger have been found to increase gut motility, cancer risk and arterial plaque formation which can lead to a heart infarct (Pert, 1997), whereas positive emotions seem to do the opposite.

Leaders and Their Teams: Learning to Improve Performance with Emotional Intelligence and Using Choice Theory

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Emotional intelligence and choice theory

Frustration is a term often used when one is barred from reaching one’s goal. In choice theory (CT) (Glasser, 1998, 2000), frustration is the discrepancy between what is wanted and that which is perceived to be received. The perceived imbalance motivates people to get what they want (or to leave). Emotional intelligence (EI) is about being aware of your own needs and those of others and working with both the best you can. It is about priming positive attitudes and behaviors, and as such, Goleman and colleagues coined the term ‘primal leader’ for leaders that use EI. This is in line with CT where ‘lead managers’ support their team members in fulfilling their needs by making responsible choices (Glasser, 1994). Goleman and colleagues (2002) define EI as being intelligent about emotions, and note “The extent to which one is able to manage oneself and the relationships with others is influenced by EI”. CT assumes that we need to be internally motivated and that good relationships are the core of mental health and happiness. It also assumes that people have the ability to make responsible choices to obtain what they want. Both EI and CT are based on internal control psychology. The discrepancy between the ideal me (quality world) and who I perceive myself to be in reality (perceived world) fires the motivation to change. Also, both, EI and CT recognize the needs of others, promote empathy and healthy relationships, and see meeting needs of others as an opportunity rather than an obligation.

Needs and responsibilities

Maslow, in his humanistic view, based human behavior on the fulfillment of needs rather than it being solely dependent on the unconscious mind, instincts or a learned set of actions (Maslow, 1968, 1970, 1971). According to him, 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. There are two aspects to the need for esteem: (i) self-esteem that is based on the ability to perform specific tasks; and (ii) self-esteem that is based on the positive interest and acknowledgment from peers and others. Robert Gwynne (1997) defined the need for self-actualization as “the desire to become more and more what one is, to become everything that one is capable of becoming”. Maslow’s needs are not unlike those suggested by Glasser (Schoo, 2005).

Although needs may differ in intensity from person to person depending on factors such as personality and generational differences, they are similar for everyone (Glasser, 1975; Maslow, 1968, 1971) whereas ‘wants’ are
personal to the individual (Glasser, 2003; Maslow, 1970). Common needs include the need for survival, power, fun, belonging and freedom (Glasser, 2003), and relate to workplace issues such as remuneration, job responsibility, team spirit and autonomy. Self-actualization (Gwynne, 1997), inner-vision and inner-divinity (Schoo, 2005) are seen as higher needs that need no immediate fulfillment whereas the need for survival can warrant urgent attention when being hungry. Therefore, in fulfilling higher needs, people's behaviors may be more relaxed, flexible and effective, and work environments are likely to be more pleasant than in situations where people have to struggle to fulfill their external necessities to live.

Desirable values, behaviors and competencies

EI recognizes personal and social competencies, each having an awareness aspect and an ability aspect. As such, it is desirable for leaders and those they lead to have self-awareness as well as social awareness. Similarly, to be able to manage themselves (self-management) as well as to have social skills that assist in managing relationships. Awareness includes: Self-awareness of emotions and feelings, recognizing strengths and weaknesses accurately (incl. personality type and communication style), knowing what one is capable of doing with confidence, sensitivity towards values, concern and feelings of others (empathy), awareness of organizational agenda and climate and decision-making, and understanding patient, client or customer requirements (needs, wants) (Goleman, Boyatzis, & McKee, 2002).

Desirable managerial competencies include: being able to control one's own emotions, being transparent and trustworthy, wanting to perform well, taking action and using opportunities, being flexible to changes or in surmounting problems, focusing on the positives, inspiring – leading and motivating with vision, employing a variety of methods to sway others, developing others by providing constructive criticism and assistance (responsible behavior), initiating, managing and leading change, resolving conflict, networking, and working together with others – team development (Goleman, Boyatzis, & McKee, 2002). Spencer and colleagues (2005) mapped desirable professional competencies and suggested a framework to compare standards across health professions, with an emphasis on allied health. The competencies shown in Tables 1 and 2 are generic and not only applicable in the work situation.

<table>
<thead>
<tr>
<th>Values</th>
<th>Behaviors</th>
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<tbody>
<tr>
<td>Personal leadership* [1]</td>
<td>Application of knowledge</td>
</tr>
<tr>
<td>Commitment to excellence* [2]</td>
<td>Display understanding</td>
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<tr>
<td>Professional practice* [3]</td>
<td>Applied skills and techniques</td>
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<tr>
<td>Vision, environmental awareness, political acumen* [4]</td>
<td>Use of initiative</td>
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<tr>
<td>Systems thinking</td>
<td>Use of technology</td>
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<tr>
<td>Courage</td>
<td>Critical reasoning* [5]</td>
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<tr>
<td>Integrity and trust</td>
<td>Flexible approach</td>
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<tr>
<td>Resilience</td>
<td>Use of concepts</td>
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<td>Empathy</td>
<td>Pattern recognition</td>
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<td>Self-confidence</td>
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*1) Includes: Personal power, reality/choice theory, self-awareness and self-actualization, personal development, developing capacity for self-regulation

1) i.e., quality and improvement focus

3) Includes: Client service aspects, philosophy of care and ethics

4) Includes: 'Purpose' items, e.g. understanding changing environment, institutional culture plus strategic leadership focus, valuing leadership style and presence

5) Includes: Pattern recognition, data analysis, use of concepts, theory building

Table 1. Desirable values and behaviors.

<table>
<thead>
<tr>
<th>Values</th>
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<tbody>
<tr>
<td>Emotional intelligence</td>
<td>Power, influence and persuasion</td>
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<tr>
<td>Personal/self management** [1]</td>
<td>Problem solving</td>
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<tr>
<td>Written communication</td>
<td>Planning, implementation, evaluation</td>
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<tr>
<td>Giving and receiving feedback</td>
<td>Negotiation skills</td>
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<tr>
<td>Motivating, developing others** [3]</td>
<td>Networking skills</td>
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<tr>
<td>Building consensus</td>
<td>Making good decisions</td>
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<tr>
<td>Interpersonal communication skills</td>
<td>Managing change</td>
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<tr>
<td>Managing difficult conversations</td>
<td>Data analysis</td>
</tr>
<tr>
<td>Working with diverse populations and needs</td>
<td>Knowledge, improvement management</td>
</tr>
<tr>
<td>Building effective teams</td>
<td>Theory building</td>
</tr>
<tr>
<td>Teamwork</td>
<td>Building positive environments</td>
</tr>
</tbody>
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**1) Includes: Managing time, energy, stress and coping, and work-life balance

2) Up, down, horizontal

3) Includes: Mentoring, coaching

Why EI and CT in the workplace are so important

Psychosocial environmental conditions such as work overload, high organizational tension, career limitations and high personal constraints have been associated with illness and absenteeism (Woo, Yap, Oh, & Long, 1999), yet these conditions can be addressed by good management. Emotions and behaviors experienced and/or encountered by managers and their staff may include fear and anxiety, insecurity, defensive or irrational behavior, anger, aggres-
sion, arrogance and controlling behavior. As mentioned at the start of the paper, negative thoughts and emotions appear to increase gut motility, cancer risk and arterial plaque formation while positive emotions seem to achieve the opposite (Pert, 1997). Stress increases (nor)adrenaline and cortisol production and decreases the ability to learn while it is present. In addition, prolonged stress has been associated with atrophy of the hippocampus, a part of the limbic system associated with emotions (Magarinos & McEwena, 1995). Emotional distress at work is a predictor of back pain disability and absenteeism in those who have experienced back pain before (Brage, Sandanger, & Nygard, 2007). Leaders (and other team members for that matter) should be equipped to create and maintain a work environment that is conducive to feeling safe, relaxed, interested and motivated in order to be able to function effectively. Unfortunately, this is not always the case, and issues that can be resolved by management have been associated with people's intention-to-stay at an organization (Stagnitti, Schoo, Reid, & Dunbar, 2006). It has been said that people join companies and leave managers (Buckingham & Coffman, 1999) and in this lies a challenge for those who lead to make a difference.

Leadership styles

From early on, leadership style studies discriminated two basic styles of leadership, relationship-oriented (democratic) versus task-oriented (autocratic). Although later studies have added more styles and combinations (Waller, Smith, & Warnock, 1989), there still is a dichotomy noticeable when authors write about complex adaptive and traditional systems (Mackey, 2007), lead management and boss management (Glasser, 1994), or creating resonance or dissonance (Goleman, Boyatzis, & McKee, 2002). Following from this binary approach, Goleman and colleagues described four leadership styles that have been associated with creating resonance (being emotionally on the same wavelength, or in synch). These styles are visionary, coaching, affiliative and democratic. The two styles that have been associated with dissonance (e.g., collective distress and unhappiness) are pacesetting and commanding. Although the latter two styles can be used in specific conditions, they need very careful monitoring.

In short, visionary leadership moves people to shared dreams and can be used when direction is required or changes demand a new vision. Coaching connects people's needs with the goals of organization and improves performance by building on people's capabilities. An affiliative style connects individuals and creates harmony. Team building is useful for motivating in times of stress. A democratic style encourages participation, input and commitment, and builds ownership or agreement. Pacesetting can be used when meeting challenging and exciting goals, and obtaining quality outcomes from an able and motivated team. Unfortunately, the style can be poorly executed and frequently leads to poor results. Finally, commanding provides clear direction during emergencies and, therefore, can reduce fear. Although it can be used in crisis situations to initiate a turnaround or when dealing with difficult employees, according to Goleman and colleagues (2002) it is often misused with a highly negative impact on work climate.

Lead managers and primal leaders

Leaders that use CT base their management on internal control psychology. They tend to use caring habits (listening, supporting, encouraging, negotiating, respecting, accepting and trusting) instead of negative habits (blaming, criticizing, complaining, threatening, punishing, nagging, rewarding to control) (Glasser, 1998). Leaders and their teams that use internal control methods to fulfill their needs are likely to recognize the needs of others, have a win-win method of dealing with problems, investigate to appreciate a particular problem, foster confidence in others, recognize input of others, accept others for who and what they are, live in the present moment while looking ahead, ask rather than demand, communicate and depend on cooperation, do not use others but are concerned with them, and do not blame others but get on with the job. In using Stephen Covey's terminology (Covey, 1998), they tend to use proactive language instead of reactive (e.g., let's canvass options available to us) to obtain results. For example, lead managers tend to ask "What happened?" instead of "Who did it?" (see Table 3).

The list of qualities associated with lead management versus boss management resemble those of complex adaptive systems versus traditional systems as described by Mackey (2007) in a publication on leadership and complexity. Complex adaptive systems are open and responsive, are adaptable and offer alternatives, are collaborative and engaging, value people and listen, and help others. Traditional systems value positions, structures and rules; they control, resist change and repeat the past, and disengage.

Lead managers are likely to be emotionally intelligent and in control of their own total behavior. The six Ls that lead managers tend to use are leading, loving (empathy), listening, learning, limiting (e.g., by focusing on the goals and objectives of the organization) and leveling; these are important tools in the tool box of a lead manager. In EI, Goleman and colleagues (Goleman, Boyatzis, & McKee, 2002) maintain that a key task of leaders is to "prime good feelings" in the people they lead. This in turn creates resonance and contributes to a positive work environment in which people work best. Therefore, they argue that basically the primal job of a leader is emotional and that the primal leadership model is congruent with neurology (Goleman, Boyatzis, & McKee, 2002). Not only do the moods of leaders affect those who they lead, EI leaders inspire, motivate and arouse enthusiasm and commitment. Mental efficiency and flexibility in thinking is enhanced when people feel good (Isen, 1999).
Team building

Team building is an ongoing process. It requires constant attention of the leader and positive input by using EI or, in CT terms, the use of caring habits and the six L’s. After all, in working with teams, it is not important how the leader sees it but how the team sees it. As with personal self-awareness, the self-awareness of group or team is in place when members are aware of each other’s emotions as well as those of the entire group or team. It is important for leaders to realize that self-awareness of an entire team can be lifted by only one emotionally intelligent person (Goleman, Boyatzis, & McKee, 2002). In EI, empathy is regarded as a basic relationship skill and empathic teams are good in establishing mutually beneficial relationships with other groups or teams (Goleman, Boyatzis, & McKee, 2002).

Teamwork in health care management

Teams in health care management may include assistants as well as expert professionals from different disciplines that have common purpose and goal performance, possess complementary skills and keep themselves mutually accountable (Katzenbach & Smith, 1993). There must be a motive for a team to want to work together and to function effectively, an awareness that collaboration is more effective than working alone, a dependence for members on each other to reach the agreed goal, joint accountability within an organization or community, and competent leadership (Herrman, Trauer, Warnock, & Professional Liaison Committee Project, 2002; Reilly & Jones, 1974; Rush & Shelden, 1996; P. A. Spencer & Coye, 1988). This requires team members to trust and respect each other, to accept program protocols, to understand the procedures, to take part in team development, to remain flexible and to be able to let go or accept particular roles (Antoniadis & Videlock, 1991; Rush & Shelden, 1996). This is particularly important when teamwork around clients advances from multidisciplinary (separate disciplinary treatment plans) to interdisciplinary (shared plan and monitoring of progress) or transdisciplinary (crossing professional boundaries) modes of service delivery. The latter form of teamwork requires integration, collective thinking and the highest degree of trust where professional boundaries may start blurring (Sands & Angell, 2002).

Learning to improve

In developing and improving leadership, EI and CT have a similar approach. First, there needs to be a clear vision, one needs to wonder who one ideally wants to be (quality world) before assessing who one really is by assessing strengths and deficiencies via self-assessment and assessment by others (perceived world). This is likely to enhance the needed motivation to change. Then, determine how strengths (capacities) can be improved and deficiencies can be reduced (comparing place & making a plan) and start practicing new thoughts, actions and feel-

Table 3. Lead managing versus boss managing.

<table>
<thead>
<tr>
<th>Lead managers &amp; team players*</th>
<th>Boss managers &amp; individualists*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>We</strong></td>
<td>I</td>
</tr>
<tr>
<td>Ask and model (e.g., “Let’s go”)</td>
<td>Demand and command (e.g., “Go”)</td>
</tr>
<tr>
<td>Lead by internal control</td>
<td>Exert external control</td>
</tr>
<tr>
<td>Compare with their own potential</td>
<td>Compare themselves with others</td>
</tr>
<tr>
<td>Show how it is done</td>
<td>Know how it is done</td>
</tr>
<tr>
<td>Admit mistakes</td>
<td>Cover up mistakes</td>
</tr>
<tr>
<td>Look for solutions (what to do to fix)</td>
<td>Blame others for problems (who …)</td>
</tr>
<tr>
<td>Appreciates</td>
<td>Take things and people for granted</td>
</tr>
<tr>
<td>Accept others</td>
<td>Judge others</td>
</tr>
<tr>
<td>Trust</td>
<td>Distrust</td>
</tr>
<tr>
<td>Communicate</td>
<td>Build walls</td>
</tr>
<tr>
<td>Do more than their work</td>
<td>Only there to work</td>
</tr>
<tr>
<td>Look at today as well as the future</td>
<td>See today</td>
</tr>
<tr>
<td>Identify and treat causes</td>
<td>Treat symptoms</td>
</tr>
<tr>
<td>Coach others</td>
<td>Drive/manipulate others</td>
</tr>
<tr>
<td>Use cooperation</td>
<td>Use authority</td>
</tr>
<tr>
<td>Inspire enthusiasm, create confidence</td>
<td>Inspire fear</td>
</tr>
<tr>
<td>Develop people</td>
<td>Use people</td>
</tr>
<tr>
<td>Work hard for the team to produce</td>
<td>Work hard to produce</td>
</tr>
<tr>
<td>Make time for things that count</td>
<td>Never have enough time</td>
</tr>
<tr>
<td>Concerned with people</td>
<td>Concerned with things</td>
</tr>
<tr>
<td>Seek to understand</td>
<td>Seek to be understood</td>
</tr>
<tr>
<td>Team players know where they stand</td>
<td>People know where the boss stands</td>
</tr>
<tr>
<td>Give credit to the team</td>
<td>Take the credit</td>
</tr>
<tr>
<td>Win-win approach to conflicts</td>
<td>Win-lose approach to conflicts</td>
</tr>
<tr>
<td>Use caring habits (see in text)</td>
<td>Use deadly habits (see in text)*</td>
</tr>
</tbody>
</table>

ings (new behavior). Finally, create supportive and trusting relationships that facilitate learning, for example, through honest feedback (maintain and evaluate whether new behavior is effective). New behavior needs to be practiced continually by visualization (mental preparation), performing the visualized behavior in reality, and maintaining performance (Goleman, Boyatzis, & McKee, 2002). The continuous practice will assist in forming new neural pathways (Zull, 2002).

In planning personal or organizational changes or other challenging projects, the steps described above are very similar to those described by National Health Service Modernisation Agency (2005) in the United Kingdom. What is needed is a motive to change, clear shared vision, the capacity for change, and actionable steps. Poor motivation has been associated with a slow start, poor vision with false starts, poor capacity for change with frustration and anxiety, and poor actionable first steps with uncoordinated efforts. Therefore, engage superiors to get their active support and ensure that the required resources are available to carry out changes. Projects can be complex and visible, they often require strategic planning and giving consideration to approaches that are available. While it is likely to involve dealing with conflict, it demands maintaining EI and a healthy work climate. Focus on the learning rather than achievement, and regard the process of learning as a project outcome. When setting goals for learning new behavior and/or planning change, it is important to have ownership of these goals and to build on strengths, although these strengths may not need to be so prominent (Goleman, Boyatzis, & McKee, 2002). Plans need to be flexible, doable and in line with personal learning style. A stepwise approach can be very useful to master components of a plan. Remember SMART goal setting (Specific, Measurable, Achievable, Realistic, Timely).

The following examples illustrate how behaviors and competencies in relation to EI can be improved by practice (Goleman, Boyatzis, & McKee, 2002). In learning to control negative emotions, people can set themselves a set of actions that include listening to what the person has to say, barring oneself from interrupting and jumping to conclusions, and preventing negative emotions taking over by asking more questions to clarify the issue. In improving a skill such as presenting in front of an audience, one could seek advice from a preferred presenter, then prepare a short presentation, practice with a trusted person, audio or video record the presentation, evaluate the presentation on effectiveness and look for opportunities to talk and practice, and evaluate feedback from audience.

In conclusion, motivation and persistence is needed to learn and improve on leading with EI. Accurate awareness of personal strengths and deficiencies (against the ideal self) enhances the motivation to change (perceived discrepancy). As in motivational interviewing and CT (Schoo, 2008), awareness of discrepancy between the two is likely to assist in wanting to change. Self-learning ‘change’ is a lifelong activity of self-assessing strengths and deficiencies, and mastering or perfecting thoughts, actions, and feelings by living EI and CT. Lead managers will benefit from having more tools in their toolbox to manage. They are well equipped in relation to EI but could benefit from having more leadership styles available to them that may suit the strengths they have and the situations they are in, therefore making their leadership more effective. Also, lead managers may benefit from the advances made in EI to evaluate the effectiveness of their behavior and that of others.

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Frequently Asked Questions and Not So Brief Answers: Part II

Robert E. Wubbolding, John Brickell

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ABSTRACT:

This article presents detailed answers for two questions often asked of teachers and practitioners of choice theory and reality therapy: What is the role of the past in the practice of reality therapy; Does choice theory and reality therapy give adequate attention to the outside world? The answers presume a working knowledge of choice theory and reality therapy, as well as previous study, reading or training in the principles of reality therapy.

In a previous discussion (Wubbolding & Brickell, 2007), we provided responses for frequently asked questions such as, “What is the difference between choice theory and reality therapy?”, “What is the WDEP system?”, “What is the suitcase of behavior?”, “Does reality therapy deal with feelings and emotions?”, “How does reality therapy differ from cognitive therapy?” and “What is the meaning of the phrase, ‘current reality’?”

In the current article, we present answers for two controversial questions often presented as objections to the theory and practice of reality therapy. Accurate answers to these objections are crucial to a comprehensive understanding and practice of reality therapy as well as useful for colleagues who sometimes find reality therapy a rigid and incomplete system. In our view, some objections are, in fact, based on a caricature, i.e., an inaccurate picture of reality therapy. On the other hand, some objections are rooted in misunderstandings or a narrow interpretation of the principles of reality therapy. For instance, in discussing whether reality therapy deals with emotions, Wubbolding & Brickell (2000) state, “It is quite justifiable to discuss each aspect of total behavior, not merely actions or thinking. Feelings are seen as important but they are analogous to the lights on the dashboard on the car” (p. 64). Feelings and emotions indicate a healthy or unhealthy life direction. When the lights ignite, they convey a message to the driver. Two more relevant questions are presented and addressed below.

Question #1

What is the role of the past in the practice of reality therapy? This question emerges regularly during training sessions and often ignites extensive discussion. The past obviously has an enormous influence on almost every facet of our lives. It impacts our attitudes, values, beliefs, tastes, aspirations, behavior, health and wellbeing, and much more. However, we emphasize the use of the word influence, rather than the words determine or cause. As Glasser contends (1965): “We are the sum total of our past experiences, but we don’t need to be a victim of them unless we choose to be”. Although this statement needs a lot of unpacking, it nevertheless provides a major stance regarding the reality therapy approach to dealing with the past that can be applied to many client/life issues. However, there are exceptions such as cases of trauma and abuse that may require specialist intervention by a qualified professional (as discussed further in this article), and a few other issues that may necessitate a review of past behaviors or life events (again discussed further in this article).

Also, for the purposes of clarity, it is important to note that we ask about the past; as in “tell me about what happened the last time you spoke to your son” or “is that the tone of voice you’ve always used when speaking to young people?” Or even, “Is what you’ve been doing helping?” But these questions refer to the recent past, that we perceive to be connected to the present situation or to unsatisfying relationships. Reality therapists believe that such questions about the more recent past reveal patterns of total behavior or other relevant information. These questions heighten clients’ awareness of their more recent behavior, so that they can evaluate future alternative choices resulting in a better today and tomorrow.

Participants in training sessions who have had exposure to other methods are often troubled by a hurried explanation of the “D” question: “What are you doing?” The conventional and accurate answer emphasizes precision in that the what implies the suggestion that therapists facilitate a discussion of precise facts, i.e., what is happening in the client’s life. Discussion of doing includes a description of actions, thinking, and feelings. Wubbolding (2008) states, “Feelings of anger, shame, resentment and guilt send a message that a client is not headed in the right direction. On the other hand, feelings of joy, altruism, comfort and compassion often indicate that the client is headed in a healthy direction” (p. 385). Are implies that the discussion should stay focused on current behaviors. Instructors often state, “The past is over, there is nothing that can be done about it. Let’s talk only about your present life direction, current behaviors and choices.” Glasser (1980a) states, “Always the emphasis is on the present-
—what you are doing now and what you plan to do in the future. This does not deny that problems may be rooted in the past” (p. 49). He also states, “Focus on the present and avoid discussing the past because all human problems are caused by present unsatisfying relationships” (2005a). Wubbolding (2000a) elaborates on this principle: “Past successes provide useful data as a basis for future effective choices, but endless discussion of past misery is less fruitful. Reloading past, out-of-control behaviors serves only to increase clients’ perception of the importance of problems over which they have no current control.” During the first certification week held in Kuwait in May 1998, Saddiqa N. M. Hussain put it succinctly: ‘The past is a springboard, not a hammock. You don’t drown by falling in the water. You drown by staying in it.’ “ (p. 107). You imply focusing on the client’s controllable behavior, not on external uncontrollable people, things, events in general, their environment, or their outside world. Doing means the conversation should center on actions and thinking, i.e., the behavior over which we have the most direct control without denying feelings and emotions.

While discussion of present behavior as the focus of interaction is an accurate reality therapy principle, it is incomplete and requires close scrutiny. A more expansive view of the principle involves the following considerations.

1. As with any theory and methodology including choice theory and reality therapy, a blind and rigid adherence to the principles takes their real life use into a realm in which clients and students become secondary, if not irrelevant. Rather than a puristic and unthinking view of theory and practice, it is more useful to expand the principles and apply them to the specific needs of clients and students.

2. Many agencies require a social history of clients. In fact, one of the best predictors of future behavior is past performance. When asked by someone for a loan of $1,000, any sensible reality therapist would seek a history of the loan seeker. Does the loan seeker have a history of failure to repay loans? Or is the request based on a solid credit record? A reality therapist hiring an associate would want to know if the applicant has a history of child abuse, or prison time for dishonest behavior. Teachers who boast, “I don’t read the records or the previous teachers’ comments” make a serious mistake. They not only show disdain for other professionals’ measured judgments, they also can make themselves unaware of such health issues as students’ asthma, epilepsy, diabetes or serious allergies as well as delinquent or possibly dangerous tendencies. Knowledge and preparedness need not lead to the self-fulfilling prophecy.

3. It has always been a point of some instructors to teach that discussion of past successful behaviors could provide encouragement, evidence of possible future improvement and a prelude to evaluation and planning. Clients come to believe, “If I did something successful in the past, I can do it again and even improve on it.”

4. Clearly, a discussion of past behaviors is useful if they impinge on the present. A history of irresponsible behavior such as criminal actions, violent choices, and others relates to the present. Reality therapists can ask, “Do you want to continue the same behavior that has brought you to this current crisis?” On the other hand, exceptions to problems and past appropriate choices can serve as evidence for future effective need satisfaction.

5. Even though the action component of an experience is past, the emotional and cognitive effects can continue to be present. An adult who was abused as a child sometimes experiences emotional turmoil for many years. The past experience also lingers in the cognitive memory and is reflected in such self-talk statements as, “I can’t relate to people of the opposite sex.” A soldier experiencing the tragedy and horror of combat sometimes experiences the emotional and cognitive after-effects for decades. Thus, even though the action component of the experience resides in the past, the experience is quite present. Consequently, dealing with post traumatic stress requires more than the simplistic implied injunction, “Improve your relationships and your PTSD will vanish.”

Indeed, the effective and ethical treatment of past trauma, including abuse and PTSD necessitates specialized training and qualification that is not inherent in the reality therapy certification program. However, the necessity to repeatedly relive past traumas is not a requirement for successful treatment. The advent of relatively recent psycho-neurological techniques (Griffin & Tyrrell, 2003; Morter, 1998; Shapiro, 2004; Smith & Sumida, 2003; Williams 2002;) minimize, and in many cases, neutralize the psycho-physiological impact of past traumas and memories, has demonstrated that effective trauma treatment can be remarkably short-term and does not necessitate repeatedly revisiting past traumatic events.

Additionally, Ellsworth (2007) states, “...when using reality therapy a counselor does not have clients relive the abuse and trauma. Two exceptions of reviewing the past exist when, (1) a client has not told the story before and been supported, or (2) a client wants to verbalize the story in order to deal with shame issues” (p.16).

Sometimes a discussion of past behavior enables the counselor to gain the client’s confidence and improve the therapeutic relationship. The artful use of reality therapy also provides a tool for leading clients to better human relationships.
6. At times, clients insist on discussing their past. Even if the therapist sees such a discussion as unnecessary, it can be useful in establishing and maintaining a relationship with the client. The skilled reality therapist leads clients to a better place but needs to start with clients where they are. Counselors facilitate the counseling relationship when they assist clients with their agenda, not with the therapist's agenda. Moreover, with some clients, the goals are limited to helping them feel good. Many older people wish to discuss "the good old days"; they have pleasant memories, and have humorous tales to tell, and the best therapist is often the person who listens to their stories and appreciates them. This "reminiscence therapy" allows the person to once again be the center of attention, satisfy a need for belonging, focus on successful behaviors rather than on current limitations, and enjoy the encounter with a counselor or a friend.

Consequently, the skillful reality therapist strikes a balance between an unending discussion of past experiences and dismissing them as non-therapeutic. It is of little use to imply that the endless repetition of past experiences, especially past misery, is the epitome of counseling. Clients, in fact, feel disempowered if they come to the belief that resolution of current pain somehow results from the rehearsing of past unhappy experiences. On the other hand, dismissing or minimizing the past as completely irrelevant and meaningless can demean the important life experiences of clients. Moreover, past action-experiences, e.g., trauma, often have long-lasting cognitive and emotional consequences. The past is not only prelude. The past is present.

Emphasizing the present without diminishing the importance of past experiences sends a subtle message to clients, a meta-communication that there is hope, that life can be better, and that "proper planning produces proud performance" (Wubbolding, 2006).

Question #2

Does choice theory and reality therapy give adequate attention to the external world? What role does clients' and students' life environment play in theory and practice?

The answer to the first question is "yes" and "no". From the early days of reality therapy, behavior has been viewed as chosen. In describing the helper's role, Glasser (1965) implied that even mental patients have the power of choice. "Our job is to help the patient help himself to fulfill his needs right now" (p. 46). More recently, Wubbolding (2000b) states that behavior as a choice is emphasized in Glasser's significant work, Control Theory (1985). Because of the central place of choice in the theory Glasser changed the name of the theory to "choice theory" (1998, 2005b).

Because of the centrality of free choice in choice theory and reality therapy, some have concluded that the external world is irrelevant or easily managed if we would only learn choice theory, attend a focus group or read a book on this topic. Murdock (2004) states, "Reality therapy does not seem to take these phenomena into account. Glasser would probably say that going along with the crowd is more a result of a failure to wake up and make choices than to any magical power of social forces" (p. 273). While not agreeing with this criticism, Wubbolding (2008) cautions users of reality therapy, "Dismissing the influence of other factors gives the counselor tunnel vision and may result in therapy being less successful than it would have been with a wider view" (p. 390).

Consequently, the following considerations provide an alternative perspective on choice theory and reality therapy.

1. Originally, even before the use of the term "control theory", the justifying theory for reality therapy was called "behavior, the control of perception" (Glasser, 1980b). The interaction between behavior and the external world determined perceptions. Consequently, the external world and its responses exert an enormous influence on how people see the world, what they want, and how they perceive their needs will be met. It is entirely true, however, that in practice some reality therapy practitioners too casually dismiss the influence of the outer world.

2. The external or outer world consists in family, friends, neighborhood, school, country, and culture. A person growing up in Seoul, Korea or Johannesburg, South Africa has a worldview very different from a person in suburban Chicago or El Paso. These individuals see their choices from quite different perspectives.

3. The impact of the external world might even be harmful. A person raised in an abusive family, a neighborhood saturated with crime and gangs or, on the other hand, in a nurturing family with a mother and father in the home experiences a wide variety of memories, feelings, self-talk as well as radically different viewpoints regarding their choices.

Therefore, implementing choice theory and reality therapy is an artful process that takes into consideration the worldview of clients and students as well as empowering them by opening choices and presenting alternatives.

SUMMARY

The advanced use of choice theory and reality therapy allows the helper to discuss the past when necessary, acknowledge students' and clients' outer world, listen to their pain, give their "real world" its proper due and help them acknowledge that no matter how serious their limitations, they still retain the power of at least some choice.
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**ABSTRACT**

It is not unusual to find students in the elementary school setting who may or may not have a specific diagnosis, yet still struggle with social and emotional issues. This article presents an after-school program that serves to meet the needs of these children while employing the elements of Choice Theory.

**INTRODUCTION**

We began by posing ourselves this question: How could Glasser’s principles apply to an after-school group trying to meet the needs of at-risk students? As purported in Glasser’s Control Theory (1984), the basic needs are to survive, belong, have power, be free and have fun. Using Choice Theory works well in the school setting (Fox 1997). We elected to zero in on belong, fun, freedom and power. Secret Agents (Mayes 1996) is designed to be utilized with grades 4 through 8 in a small group setting or as an after-school program. Members are deemed “agents” who perform various missions related to acts of kindness. Accepted missions are usually accomplished anonymously and then reported on at the next meeting. Agents agree to take on responsibility for the success of each mission as well as keep their identities a secret. Progression through the ranks of secret agent-hood is attained by earning mission points.

**How We Started**

While poring through various counselor resource catalogs, we found the Secret Agents kit authored by Susan Mayes. It sounded fun and the price was reasonable. It appealed to us because it simultaneously focused on individual responsibility and group cohesion.

It arrived shortly and we immediately began to form our Secret Agents’ Club. Some of the students had already been referred to us for counseling services while others were chosen because we felt they displayed at-risk behaviors such as involvement in peer conflicts, were victims of bullying, or lacked social skills. Glasser (1992) stated that cooperative learning works well because students gain power. In our group, we also began to witness that cooperative learning and doing projects together created a sense of belonging and fun. The power of fun transcends all age groups (Fox 2003).

**How It Works**

We meet weekly in the counseling office for an hour. Agents were given black folders at the first meeting and asked to invent a code name. The counselors chose code names as well. The counseling office became known as “Headquarters.” This gave the counselors an opportunity to further employ Glasser’s concepts of doing the unexpected, using humor, being our usual enthusiastic selves, not giving up as well as sharing ourselves (Wubbolding, 1993). When the students inquired why they were chosen specifically, we informed them that the qualities they possessed would benefit our school via this program. We needed a “spy” in each classroom as well as students who were able to respect the confidentiality and integrity of the program. We emphasized the “ripple in the pond” effect—how their actions would affect the greater good while improving our school’s emotional climate. A point Glasser (1969) emphasizes is that students learn the mechanics of democratic society by having a voice in both the curriculum and rules of their school. In our Secret Agents Club, members are encouraged to inculate the practices of responsible democracy by suggesting project ideas and voting on them. A main factor of our success has been that students are brought into leadership positions and everyone’s opinion is thoughtfully considered.

Popular spy tunes can be heard on the CD player as agents report to Headquarters. Our main group project first semester has been to design a series of colorful posters reflecting the importance of kindness, friendship, tolerance, and diversity. Meanwhile, students were still completing their individual missions which included such tasks as teacher appreciation, helping hands, gossip stopping, making new friends, etc. Upon completion of the posters, the Secret Agents Club met on a weekend at school to hang all the posters during a “covert operation” and enjoy pizza and sodas as a reward for their devotion and individual work and accomplishments. Parties, celebrations and agent promotions throughout the year helped solidify the group and individual need for love and to feel...
worthwhile (1975). Points are awarded for individual missions completed and on occasion, agents progress to the next rank. To date, we have had one agent progress all the way to a 5-star secret agent. Others became very inspired by her model of leadership and enthusiasm. Currently, we have two 4-star agents, a few 3-star agents, and two 2-star agents.

Always focusing on the next group project while keeping School Improvement Goals in mind and incorporating the curriculum standards, the Secret Agents have decided to work cooperatively on writing anonymous but creative thank-you cards and letters of gratitude to the school staff members.

CONCLUSION

What We’ve Learned

While this program is not a panacea for all students, we found that when given the opportunity to participate in a fun yet structured program they self-actualized through their commitment to individual missions and the group at expected peer maturation level.

To our delight, we found that they bonded with others they hadn’t expected to and seemed to enjoy watching us have fun too. Our need for fun and belonging and to feel worthwhile—that we could make a difference in the world around us—were the driving forces behind our Secret Agents Club (Glasser, 1998). As he so eloquently stated, “It takes a lot of effort to get along well with each other, and the best way to begin to do so is to have fun learning together. Laughing and learning are the foundation of all successful long-term relationships.” We at Secret Agents Headquarters couldn’t agree more.

REFERENCES


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e) Manuscripts should be prepared in accordance with the Publication Manual of the American Psychological Association, Fifth Edition.

f) Each manuscript should be accompanied by an abstract that is a maximum of 960 characters and spaces (which is approximately 120 words). A good abstract concisely summarizes the content and directs present and future readers to the article.

g) Manuscripts are received with the understanding they are not under simultaneous consideration by any other publication. The Journal will not be responsible in the event a manuscript is lost; and once published, manuscripts may not be published elsewhere without written permission from the editor of The Journal.

h) When a manuscript is received by the editor, it is referred to two members of the review board. Reviewers are asked to consider these questions:

1. Has the subject been covered adequately in The Journal so the publishing this manuscript would be redundant?

2. Is the manuscript on a problem or topic of sufficient importance in demonstrating Reality Therapy to warrant its publication?

3. Is the content of the manuscript scientifically accurate and philosophically sound?

4. Does the manuscript contain any false or misleading statements?

5. Does the manuscript have readability, i.e., is it clearly written, succinct, and easily understood?

6. Will the manuscript require a great deal of revising to make it acceptable?

i) All accepted manuscripts are subject to copy editing.