REFERENCES


Table of Contents

Lawrence Litwack .................. Editor's Comment 2

Edward E. Ford .................. Case Examples of the Therapeutic Process in Family Therapy 3

Russell S. Mattimore-Knudson ....... Using Reality Therapy as a Judicial Officer in a Residence Hall Situation 11

Stella Lybrand Norman ............... Evaluating Counselors' or Students' Knowledge and Use of Reality Therapy 15

Arlin V. Peterson .................. Pathogram: A Visual Aid to Obtain Focus and Commitment 18

Gerald D. Parr

Linda S. Barnard .................. A Reality Therapy Staff Development Model 23

Irene Mehnert

Robert Drummond

John Banmen .................. Reality Therapy Research Review 28

Guidelines to Contributors Inside Back Cover
CASE EXAMPLES OF THE THERAPEUTIC PROCESS IN FAMILY THERAPY

Edward E. Ford*

This article is a selection from the chapter entitled Reality Therapy in Family Therapy by Edward E. Ford in the book Family Counseling and Therapy by Arthur M. Horne and Merle M. Ohlsen, published by Peacock Publishing Co., Itasca, Ill. 1982. A reprint of the entire chapter entitled A Summary Of Reality Therapy is available through Edward Ford, 10209 N. 56th St., Scottsdale, Arizona 85253 at $1 per copy. A Spanish edition is also available. Mr. Ford is a faculty member of the Institute for Reality Therapy.

When we teach reality therapy, we explain it in eight steps. These were originally described in The Identity Society. Glasser has since developed them more fully in a recent explanation: What Are You Doing? It is important to remember that the steps of reality therapy will be the same when used by any certified reality therapist, but the application may vary slightly depending on the therapist. I refer to how I use reality therapy. The book What Are You Doing? is a collection of case histories by 24 certified reality therapists and shows different ways reality therapists use the same techniques. But the basic concepts, including the steps, are always the same.

The first part of Step One is “make friends.” This is often the most misunderstood step of reality therapy. Students hear this, agree with the idea and then want to move on to the “action part” of therapy. But a therapist’s ability to deal with the client depends heavily upon this first, critical step. And it is an “action step.”

Clients or patients must believe that anyone trying to work effectively with them is a caring person who cares especially about them. In What Are You Doing? for example, Lee Silverstein’s client Kit, describes the numerous ways her therapist attempted to come into her life. “Some days we would have lunch, some days Lee would involve me with some of the paperwork he was doing in the office . . . some days we would get into his car and ride to a record shop or bookstore . . . he always gave me something to take home to read . . . and each week . . . an assignment to do something.”

“Making friends” can be very tough and demanding, requiring a great deal of patience, acceptance, and a sense of humor. It is rarely the same from one client to another. In the same book Ann Lutter describes how she made friends with an acting-out, drug-abusing teenager. She never passed judgment on the child’s behavior, not even her colorful choice of words, or her (to her parents) radical opinions, but listened to the girl express her values and her analysis of the situation and then proceeded. Lutter says that by applying her client’s attitudes, not the therapist’s, they were able to find practical, realistic solutions to the problems.
This constant showing of caring will become apparent as the steps are explained, but there are some specific ways of working with the client that are important to learn. We treat with respect what the client has to say. We do not necessarily agree but we respect the opinion, as Lutter did in the case above. When the client contradicts him or herself (as is often the case with members of a family), it is best for the therapist to accept the responsibility for clearing up the contradiction by saying, for example, “I don’t understand” or “I’m a little confused.”

We try to avoid increasing clients’ frustration which comes from the lack of confidence in knowing how to handle their lives. It is important that the therapist does not put pressure on clients to come up with new behaviors before they are ready as this increases their failure image. The less upset the clients are, the easier it is to develop the confidence to work out problems.

We are not afraid to become real people to our clients. To do this we show a warm, friendly personality rather than a cold, detached, sometimes called “professional” approach. When a client begins to believe that someone in this world really does care about him or her, this, says Glasser, is when therapy begins.

The second part of Step One is to find out from the clients what they want. If we’re going to help people we must start dealing with them from where they are, not from where we the counselors think they are. We never tell them what we think they should want. Often I have asked a married couple “Do you want to work at this marriage?” Or a child “Do you want to get along better with your mother?” This establishes soon in the therapeutic session where the client is. Getting them to examine what they want and where their priorities are helps them to see that they must start taking responsibility for their actions. A good technique to use while doing this is to summarize during the session. A brief summary of what the client has said he or she wants helps the client to know that you are listening and makes it easier for both to focus in on what the client wants. It helps keep the perspective. This technique is explained by Gary Applegate in What Are You Doing?

Specific questions help the client clarify what he or she wants in counseling and can also be of great importance to the therapist. For example, is the client ready to handle what he wants? Sometimes a person who wants to work at a marriage must first work at putting his or her life in order. Sometimes what we want isn’t possible. For example, a parent may want to be closer to a child but finds that the child does not want to reconcile with the parent. Or a person who wants to work at a marriage finds the spouse indifferent or unwilling to cooperate. An absentee parent may find his remarried ex-wife has moved across town or out of town, thus making frequent access to his children difficult. Then it is best for clients to look at other areas of their lives over which they have some control.

Another aspect of this step is to ask the client what they want from you, the counselor. “How do you see me helping you?” you may ask. This important question helps to clarify in the client’s mind the role of the counselor. This clears the air of unrealistic ideas of just what a counselor can do. I once had a distraught husband say “1 want you to straighten out my wife.” When I asked, “Do you really believe I can do it?”, he replied, counselor can do provides an honest relationship and saves many a mis-

**Step Two of reality therapy is to help the clients examine what they are doing.** It is a necessary step to accepting responsibility. The clients take a almost always want to talk about other areas of their lives: what their various aches and pains, their inability to find work, or how much they are like their mothers were or are. Somehow people seem to sense that when they talk about what they are doing, they are talking about something over responsibility.

The critical point for the therapist to keep in mind is to focus in on specifically what the client is doing. In my experience as a teacher of therapists, failure to effect such a focus is the single biggest mistake rarely see their behavior as having anything to do with the problem. They see the world, not themselves, as having to change. Or they see themselves when I ask a couple to be specific about when they last spent time doing we haven’t had much time lately with my mother being sick and my wife went to the mountains last summer,” “I have been feeling so depressed lately,” “we Wednesday.” None of these responses answers my questions. Thus it is doing.

The reality therapist avoids asking people why they are doing what they are doing or feeling the way they do. This “why” question moves clients away from looking at their behavior and sets the counselor up for a no-win response. Clients very likely will claim the world has to change or place the blames on things they can’t control. If the counselor asks why and then agrees with a client, the client will continue with the same behavior. If the counselor argues with the client about the poor excuse, then there is a good chance that the fragile client-counselor relationship which should be strengthening, will get worse.

Another area to stay away from is the negative past. Clients are desperately seeking relief from pain. Whatever the counselor talks about is going to be perceived by the client as important to the client’s eventually finding some degree of happiness. Recalling past traumas or events can bring about feelings of pain and reinforces the client’s lack of confidence. The client knows how to fight, depress, or use drugs. We can’t undo the which is to use the past as an excuse for present behavior. Talking about the therapy takes place. “My Dad was this way and I’m this way and I’ll never
They often respond “you don’t understand, let me tell you about . . .”

They will come up with every excuse they can think of to avoid the one thing necessary for them to do in order for their lives to get better. They will want to draw out what has happened to them, what their spouse is doing, how their kids are behaving, that it isn’t really their problem, that they are just in here to tell you about their child. “It’s the child that’s having the problem,” they’ll say. “I’ve tried everything.” They have made excuses for years and if they do not make a value judgment they will never assume responsibility for what they are doing.

Besides what a person is doing, the value judgment may also include a decision about what they want. “Do you really want to quit school?” “How will you support yourself?” “Can a girl of 14 find a job in today’s labor market?” “Are you willing to live with the hassle the police will give you since at your age you are likely to be picked up?” This kind of questioning can lead to planning which often helps the client to evaluate whether they think they want is a good thing to want. The therapist, remember, is not making the judgment, but the questions are important because they lead the client into a better evaluation of the consequences of what he or she wants.

We all make value judgments about people based on what we have true of how we perceive ourselves. Sometimes we believe we are inept but ourselves and our ability changes. Sometimes I will ask clients who have a day, never repeating anything. Within a few weeks, they often change their opinion or themselves for the better.

Perceptions can be a critical part of an unresolved conflict and getting a value judgment of their perception is an important consideration when judgment of their parents or teachers, although possibly or at least partially justified, is hard to accept. I’ll say, “from what you are saying, your father sounds like someone who beats his wife, never works, drinks all the time, and has never done a thing for you children.” This often gets the response, “Oh, he’s not that bad.” Then I’ll follow with, “Well, what’s good about him?” or “Tell me what he does that is good?” In this way asking for a value judgment from clients about their perceptions can have an “awakening” effect. They begin to realize, perhaps for the first time, that they do have choices to make, regardless of what others say or do. In What Are You Doing? Barnes Boffey talks about families in a falling-apart relationship crisis, by asking her “Would you have chosen for the relationship to continue? Do you want to see it end?” She then goes on to say that for “the first time Mary sensed she had a choice about the matter. She was acting as though she were a helpless drifter waiting for the fates to buffet her around, but she had her first choice . . . and by doing so could now begin to take an active part in finishing the relationship and making choices about how things turned out . . . by coming for help at the very beginning of this stressful time she was able to make rational choices and save herself a lot of pain.”

Once the clients have made the value judgments that what they were doing is hurting them and they want something better for themselves, you move to Step Four of reality therapy which is to help them make a plan to do better. Plan making is where the skill, knowledge of human resources and personal experience of the counselor comes in. Therapists can draw on their experiences in helping people and take an active part in making suggestions. The weaker the client, the more the therapist will be needed to help in formulating a plan. In the beginning sometimes the therapist has to make the plan but needs the client’s approval — that is, affirmation that the client thinks he or she can do it (value judgment and commitment). The sign of confidence building is when the client begins to make his or her own plans. Gary Applegate in his chapter in What Are You Doing? demonstrates successful plan making with a married couple and shows some helpful techniques. One is to send clients home with a filled out “plan sheet,” keeping a copy for himself “so there is no problem determining
Plan making is a necessary skill to good counseling and there are elements the therapist can learn which help develop this. First, remember that the plan should be small both in terms of what is done (a couple might take a walk in the evening or a child might do homework in only one subject) and the time frame in which it is done (try the plan for 20 minutes a day for 3 days and call me). If a plan is too large, it is too easy to fail and this serves to confirm in the client’s eyes that he or she is a failure. It is more important at first for the client to feel success than to accomplish a lot. To allow a person to say, for example, “I will be cheerful and pleasant from now on” is to set him up for failure. It is better to say, “I will remain calm for the next 20 minutes.” Most of us can handle that and in doing so, we build confidence that we can extend the time to an hour, a half day, or whatever is necessary.

Second, the plan should be specific, considering such elements as what, where, how, how many, when and with whom. Probably the second biggest mistake next to making the plan too large is not making it specific enough, not focusing. The plan must be something the client will do, not stop doing. For example, “I will greet my husband pleasantly when he wakes up in the morning and give him a kiss” and not “I will try not to nag at my husband when he wakes up.” It must also depend on what the client does — not others. For example, “I will wash my wife’s car every Saturday if she washes my clothes” is not a satisfactory plan, but “I will wash my wife’s car every Saturday regardless of what she does” might be a good plan. A plan should be something a person does without any conditions.

Plans should also be something that can begin as soon as possible. The longer one waits to put a plan into effect, the less likely the client is to do it. I find that couples or members of a family accomplish the plan best if they start the same evening. It helps if the plan is easy to repeat each day. There is nothing wrong with a big plan once in a while, such as taking a weekend trip, but it doesn’t help a family or couples form the daily patterns of behavior necessary for happy family living.

Plan making is a very creative skill for it demands of a therapist not only a wide range of experience from which to draw, but the creativity to come up with something if a plan has failed. When this happens, the therapist has to trust his or her ability to think of another plan. My son, Nelson, is a gunsmith. Sometimes he receives guns that require that he make a part himself although he has little or no knowledge of the original part. He has found that when he is working on a gun and having problems, if he puts it aside and works on an easier gun, he can return to the troublesome gun later and come up with enough ideas to repair it. Counseling is not unlike this. If I am working with a client and I run up against a difficulty I can’t seem to figure out, I just relax and chat with him or her about pleasant subjects. Eventually, an idea comes to me and we are able to return to the difficulty and resolve it.

One final word about plan making. After a plan has been made, it helps to solidify the plan by returning to the value judgment step. Ask the client whether the plan is a good one, and if it will work. This way the client takes ownership of the plan. The job of the therapist is not to tell the client what to do but rather to suggest alternatives to help the client work out a better way of behaving on his or her own. This way the client realizes the plan is his or her plan. Ask a question like, “Is the plan reasonable or excessive?” It helps them to become more conscious of just what they are doing. Sometimes, it even helps to get them to repeat the plan so that you can be sure they understand it. Again, the value in summarizing.

Step Five is to get a commitment to the plan. Ask the client if he or she will do it. You are now helping the client to take responsibility for the plan. This is a critical stage in plan making for it shifts the responsibility to the clients. They are taking possession of the plans just as they previously took possession of their behavior through making a value judgment of what they were doing.

The counselor should be a part of the commitment process. I use a plan sheet which we both sign. This shows specifically what the plan is and shows them I am interested in them and what they are going to do. If the client likes me as a person, this commitment further solidifies the relationship and gives the client confidence. “My therapist really does believe that I can do this.” Often, I ask my clients to call me the next day and let me know how the plan went. If they don’t call, I call them.

Step Six of reality therapy is to accept no excuses. It might be called the treadmill step. How easily we all get caught and mired in excuses. They come up constantly during a therapeutic session. It is fascinating to me to notice how clients often slip into another area of thought the minute the counselor asks a question that carries with it implied responsibility.

Excuses can come anytime but are frequent both when I am attempting to help them make value judgments, and during plan making. “I’ve already tried that, it doesn’t work,” or “We’d love to spend more time with our daughter but my wife has started this new business and I’ve been so depressed lately.” Even before making a commitment they begin to break down and look for a way out. I’ll hear, “Oh, I can’t spend time with you Tuesday evening, I promised my mother I’d take her to the market,” or “I really don’t know whether this is all worth it or not.”

A good way to lower the excuse level is to ask for a value judgment every time you hear an excuse. Making the excuse is the evidence that the client hasn’t fully understood the value judgment he or she has made. I’ll say, “What’s more important to you, your daily visits to your mother, your job, your golf, or your marriage? Do you want to work at getting along with your child or do you want to give up?” The return to the value judgment is very valuable in getting the therapy session back on course.

Step Seven of reality therapy recognizes and respects that we don’t function well when we are hurt. It states, “Don’t punish but don’t interfere with reasonable or minimally painful consequences. Don’t criticize.” It is important not to create any more pressure on the client (punishment) than the client already is experiencing (usually a lot). Punishment is an external attempt to force a person to change but it doesn’t teach the way to change. It almost always causes change but rarely in the direction the punishing person desires. It can cause a whole series of ineffective behaviors ranging
from apathy to violence. Although Glasser says “don’t punish,” he does believe people should suffer reasonable consequences when they break rules. When a person wants to change, he or she can then be taught how to act more responsibly. Punitive action generally makes things worse, sometimes adding more problems. For example, the natural consequence of driving too fast is to lose one’s driving privileges. When the parent reacts with anger or punishment, not only is nothing learned but the child now suffers what he or she perceives as the loss of parental love, which makes it more difficult for him to resolve the driving problems as now there is an added burden, namely reconciliation with loved ones.

Don’t criticize is another part of Step Seven. This means no criticism from either the therapist or the client. Try not to allow the clients to criticize themselves unless it is part of a judgment and is tied to a plan to correct the problem. Even then don’t accept the criticism, but deal with it. For example, when a client says “I’m just no good, I never do anything right,” your reply might be “I don’t think I can agree with that. You go to work every day on time, and from what you say, do a good job. You’re here trying to work out problems with your wife and two children, which shows a willingness not seen in everyone. Your wife says she’s willing to work at the marriage which shows she cares for you. You must be doing something right.” If a client is self critical and does not use this to lead to a good plan it becomes reinforcing to the client’s feelings of the lack of self-worth.

It is equally important that the therapist never criticize the client. If I were to say to a client, for example, “I don’t think I can accept what you are doing” it could be very frustrating to the client, particularly if in the client’s mind there is not another alternative apparent. If the therapist is critical without suggesting a better way of doing something, he or she is raising the concern of the client. A better way to handle the above statement after saying “I don’t think I can accept what you are doing” would be to follow it immediately with “I think I can suggest a better way, let’s talk about it.” The client then has an option and is assured of help in doing better. You are now teaching a better way to handle problems in cooperation with another person. This both solidifies your relationship and helps build confidence.

The final and Eighth Step of reality therapy is to never give up. No matter what the client does or says, your attitude should always indicate you will continue to persist long after the client wants you to give up. It is when your clients really believe you are not going to give up that some, perhaps, for the first time, begin to work at rebuilding their lives. They know they are no longer alone.

### USING REALITY THERAPY AS A JUDICIAL OFFICER IN A RESIDENCE HALL SITUATION

**Russell S. Mattimore-Knudson**

*Dr. Mattimore-Knudson was formerly a residence hall counselor at Northern Illinois University, DeKalb, Illinois. He is currently in private practice.*

#### Introduction

Since the conceptualization of Reality Therapy (Glasser, 1965), dozens of studies have been done showing its ability to effectively treat a variety of human problems and disorders pertaining to both the young and old. These include the rearing of children (Ford and Englund, 1977; Glasser, 1965-1969), delinquency (Cox, 1979; Glasser, 1965, 1969, 1972, 1981), paranoia and schizophrenia (Brink, 1981), acute brain syndrome (Henker, 1979), independent living skills for the elderly (Klein, Frank & Jacobs, 1980), dementia (Hanley, McGuire & Boyd, 1981), school guidance methods (Paterson & Sikler, 1974), communication and decision skills for supervisors in education and business (Schaughency, 1977; Karrass, & Glasser, 1980), and others (Bassin, Bratter & Rachin, 1976).

While these have demonstrated the viability and versatility of Reality Therapy as a therapeutic model, there are many other areas of human interaction that Reality Therapy can be applied to and shown to be useful. One of these is the area of college and university residence hall living, particularly the judicial area.

Based on a search of the literature from 1965 to the present, it was discovered that nothing has been published on the use of Reality Therapy as a general counseling method in a college or university residence hall situation, or as a method to help students in college or university residence halls deal with rules and regulations imposed upon them by the administration. This lack prompted the following discussion.

It is hoped that the results shed light on the use of Reality Therapy as a means to help students who violate residence hall and university or college rules and regulations realize they have the ability to change for the better and at the same time satisfy their needs within the rules and regulations that surround them and were not created by them.

The population of this study consisted of 164 undergraduate students between 18 and 23 years of age. Of these, 54 were business majors, while the rest represented majors across the university; 100 were freshman, 55 were sophomores, 5 were juniors, and 4 were seniors. Further, these students all resided in the same residence hall at Northern Illinois University; a hall of 1000 students.

One hundred sixty four students were seen by the author (a Residence Hall Advisor with many responsibilities working with students, one of which was working as the hall judicial officer) for a variety of violations such as drinking in a public place, smoking marijuana in the hall, making excessive noise, and failing to evacuate the building during a fire alarm.
Every student was seen privately and individually in the author's office, located in the Hall for 8 to 35 minutes.

None of the students “volunteered” for counseling but were referred to the judicial officer via a written citation that was issued to the student by a Resident Assistant or Residence Hall Advisor who observed the student violating a rule. These students were also seen within a two day period after they were cited for violating a rule or regulation.

Reality Therapy proved to be an effective therapeutic model to help students realize they could satisfy their needs in an acceptable way within the judicial system at Northern Illinois University. It further proved to be a means to help them accept responsibility for their actions as residents in the Hall, and to learn that they possessed the ability to change and to become, within limits, whatever they wanted. It was discovered, however, that the eight steps of Reality Therapy could not be applied in their usual manner. Shortly after the study began, it was discovered that steps 2, 3, and 6 could be directly applied as described by Glasser (1981), but that steps 1, 4, 5, 7, and 8 required alteration, condensation, or elimination. Four barriers or conditions were discovered to account for this. The first was the fact that none of the 164 students came to counseling voluntarily. The second barrier was the students' perception that the role of the Hall judicial officer was prosecutor and persecutor. The third barrier was the students' perception that the university judicial system was overly unfair, punitive, and that of a prosecutor and persecutor. Furthermore, the Hall judicial officer was viewed by the students as an extension of the university judicial system. And, although all of these substantially affected the application of Reality Therapy in this situation, the fourth barrier — the nature of the Hall judicial officer position — was probably the most significant.

When a person feels forced especially in a judicial situation where a rule has been violated and a consequence is being applied, making friends is difficult — especially if it is between the judicial officer and the offender. Although none of the 164 students seen was incorrigible or a habitual offender, making friends with them was a formidable task. If they did not come to counseling, they could be evicted from the hall, and, if the circumstance was serious enough, expelled from the university. Some claimed that counseling was a waste of their time. The fact none of the students wanted to be there, and the fact they perceived the entire judicial system as unfair and authoritarian including the role of the hall judicial officer, made it virtually impossible to make friends. During all the sessions, each of the students were asked questions about their interests and needs, but none of these questions generated sufficient information to cancel out their perceptions of the judicial officers role as an extension of the judicial system which they hated. If each of these students could have been seen several times for several hours, perhaps a suitable involvement could have been established. As it was, however, the fourth barrier, or the nature of the judicial officer position in the Hall, did not allow more than 35 minutes maximum with a student and many times not more than 10 minutes.

Therefore, while the effort to make friends with each student was made during the counseling sessions, greater focus was placed on steps 2, 3, and 6 which could be applied directly without change. This was because the students were aware of what they were doing, whether or not it was helping them stay out of trouble, and that excuses were unacceptable. The way in which they were approached in view of these three steps was to simply ask them about the nature of their violation, whether or not they wanted to remain living in the Hall and attending the university, and whether or not they knew the rules governing student activities at the university. Exploring answers to these questions, and suggesting alternatives for change so they could meet their needs without having to see the hall judicial officer again worked very well. None of the 164 students expressed feelings that they were being “patronized” or advised against their wishes. It is unknown to what further extent Reality Therapy helped these individuals, however, because to date there has not been any follow-up. Only 4 of the 164 returned for another “forced” counseling session because of violating another university rule.

Although no written plans were used, verbal plans and commitments were frequently used. If the number of students returning is any indication of how well it worked, it worked very well. Just as a person makes a written plan in Reality Therapy, these students made verbal plans to change. As they were “do” plans in Reality Therapy and not “stop” plans, most of the 164 students made verbal plans to “do better” and committed themselves to do better.

Although steps 1, 4, and 5 had to be changed in order to fit the situation in this residence hall, Reality Therapy as a method still could be used, was used, and worked. Steps 7 and 8 were also applied, but in this situation step 8 wasn’t applicable. Step 7 worked well in the sense each student was asked about the rules of the university and about the consequences when they were violated. If a student did not know the rules and the consequences for violating them, they were informed of them.

As a teaching model, Reality Therapy worked well in this situation because many of the 164 students who were seen did not know how to behave, in order to fulfill their needs for freedom and independence. Most of them were freshman and away from home for the first time. Most of them also had never lived in a dormitory situation before, and did not know how to act appropriately while living in it. Furthermore, they had never experienced a university judicial system before and living according to its rules. For all of them, attending Northern Illinois University was a new experience, and they had to learn how to live within it in order to satisfy their needs without denying the needs of others. Working with these 164 students, even if it was for one session seemed to help them learn as they
REFERENCES


Ford, E.E. and Englund, S.

Glasser, W.

Hanley, I.G., McGuire, R.J. “Acute Brain Syndromes.”

Klein, S.; Frank, P.

Schaughency, B.S. “Living Skills in Geriatric Inpatients.”

Karrass, C.


Newly Released

Reality Therapy Bibliography

by

Dr. John Banmen, Assoc. Professor

University of British Columbia

Certified Reality Therapist

Published by: The Institute For Reality Therapy

A 41 page annotated bibliography of reality therapy program evaluation, books, and research studies.


Cost: $5.00 - includes handling and mailing.

EVALUATING COUNSELORS’ OR STUDENTS’ KNOWLEDGE AND USE OF REALITY THERAPY

Stella Lybrand Norman*

*Ms. Norman is a certified reality therapist.

As a supervisor of a satellite counseling office with three counselors from various counseling backgrounds and differing years of experience, and three practicum students from three different colleges, it was difficult to evaluate counseling sessions. Everyone spoke their own “psychologese,” even though Reality Therapy is the basic form of counseling the Crossroads Drug Abuse Program uses. A common language, and with that a single set of criteria for evaluation of counseling sessions, was needed so that evaluations could be as concrete as possible rather than subjective, and could be done by students or counselors on themselves, by a supervisor, or by co-facilitators.

An assessment instrument, “Reality Therapy Evaluation Checklist,” was devised to meet that need. This checklist is divided into two parts. Part I - Techniques to assess the use of the eight steps of Reality Therapy and Part II - Competencies to assess Knowledge, Ability, Self-assessment, Personal Congruence, and Confrontation.

The following are the instructions for the scale, Part I - Involvement and Evaluating Present Behaviors, Part II - Confrontation, and an answer sheet to cover those areas. There are no right or wrong answers. Each step is evaluated individually. By doing this, counselors are better able to understand their ability to use each step.

INSTRUCTIONS

This checklist is intended as a training device to direct attention to specific areas of knowledge, abilities and/or strengths/weaknesses, and characteristics that are considered to be essential in conducting Reality Therapy (RT).

The checklist has several uses. It may be completed by a student or counselor for the purpose of self-evaluation, by a supervisor, or by observers who wish to learn more about RT. It is suggested that all parties fill out separate checklists, and compare them as a basis for evaluation and training. If the observers can be seen by the client, the checklist should be completed following the session. If the observers can not be seen by the client, completion of the checklist during the session would be better.

The scale below from 1 through 6 is to be used for evaluation of the performance of a counselor for a particular session. An answer sheet is provided for this checklist. Please circle the appropriate responses for numbers 1 through 17 and letters A through E for the overall evaluation.
REALITY THERAPY EVALUATION CHECKLIST

1. Decidedly lacking in competence. Counselor is sufficiently uninformed or inexperienced that s/he must confer with his/her supervisor for additional training.

2. Lacking in competence. Counselor will probably improve with additional information or experience. S/he may wish to confer with his/her supervisor or the supervisor may wish to confer with the counselor.

3. Competent. Counselor is qualified to function with minimal supervision.

4. Decidedly competent. Conferring with colleagues rather than supervisors is indicated.

5. Insufficient information. The competency is appropriate to the session, but information is unavailable or inadequate to evaluate the competency.

6. Not applicable. The competency is not appropriate to this particular session.

PART I. REALITY THERAPY TECHNIQUE

INvolvement

Involvement is the process whereby the counselor makes friends with the client. The following are some of the ways this was done.

- shaking hands (1) yes no
- smiling at client (2) yes no
- leaning forward (3) yes no
- making eye contact (4) yes no
- attentively listening to client (5) yes no
- finding things in common and spending time sharing them (6) yes no
- asking the client what s/he does for fun and sharing what you do (7) yes no
- finding out what the client wants (8) yes no
- using personal pronouns "I" and "me" (9) yes no
- being warm and friendly rather than cool (10) yes no
- Other-how (Write out on answer sheet) (11) yes no

The counselor became involved with the client and was very real to the client. (A) 1 2 3 4 5 6

EVALUATING PRESENT BEHAVIOR

Evaluating present behavior is the process whereby the counselor assists the client in making a value judgment on his/her behavior. The following are some of the ways that this was accomplished.

- finding out if what the client is doing is helping (12) yes no
- asking for the client's value judgment (13) yes no
- getting the client to make the value judgment (14) yes no
- reviewing the problem very specifically and then finding out if what s/he is doing is helping (15) yes no
- helping the client see that s/he can make choices about what s/he is doing (16) yes no
- Other-how (Write out on answer sheet) (17) yes no

The client made a value judgment on his/her behavior. (B) 1 2 3 4 5 6

PART II. COMPETENCIES

CONFRONTATION

The counselor is able to utilize the technique of confrontation for the purpose of:

- keeping the client's attention on the problem being explored (C) 1 2 3 4 5 6
- assisting the client in understanding the apparent contradiction between statements and behavior (D) 1 2 3 4 5 6
- assisting the client to look at other areas of his/her life (E) 1 2 3 4 5 6

REALITY THERAPY EVALUATION CHECKLIST ANSWER SHEET

Counselor ______________________ How used: ( ) Self-assessment
Client Name/Number ______________________ ( ) Supervisor
Date ______________________ ( ) Observer
When clients seem to have an understanding of the pathways, the first instruction regarding the pathogram is for clients to determine which pathway they think they spend the most time and energy trying to fulfill. We ask clients to draw a vertical line which will be the highest line in the graph to represent this pathway. Next, we ask clients to consider the pathway they spent the least amount of time and energy on, and to draw a vertical line which will be the shortest line on the graph to represent this pathway. Finally, we ask clients to fill in the other lines. We tell clients we are interested in relationships in the diagram.

When clients have completed the pathogram, we ask them to reflect on it and respond to the following questions.

1. What have you learned about yourself?
2. What do you like about what you see?
3. What do you dislike about what you see?
4. What could you change?
5. Do you want to change?
6. How would you do that?
7. Will you do it?
8. When will you begin?

The Pathogram and questions provide a wealth of information for clients to think about. Also, the clients’ pathogram serves to reinforce or contradict the therapist’s perceptions of the clients’ world. The accuracy of the pathogram is in the eye of the beholder. The conversation that follows is usually very interesting and quite potent for clients. Helpers may use the pathograms in any setting to assist clients in satisfying basic needs. Some variations in the use of pathograms include instructing clients to:

1. Draw a pathogram as you are, then draw a pathogram as you would like to be. The differences (perceptual errors) become the goals for therapy.
2. In marriage counseling, we ask each partner to draw a pathogram for himself or herself and for his or her partner. Perceptions are checked, with similarities and differences the focus of discussion.
3. In family counseling, each member capable of drawing a pathogram draws one for himself or herself and each other member of the family. Perceptions are checked, with similarities and differences discussed.
4. In school, teachers and/or students may draw pathograms for particular classrooms to determine classroom climate.
5. Teachers and school counselors may use the pathograms to assist students with adjustment skills.

Sample Pathograms

The sampling of pathograms presented in figures 1 and 2 illustrates the types of profiles you might expect to see from various clients. We stated earlier that figure 1 depicts a workaholic client.
The profile conveys very clearly the imbalance of time and energy spent in activities to realize worth and recognition as a result of high work related achievement. Workaholic clients will often rationalize and state, “but I enjoy my job, I like what I do.” When confronted with this rationale, we explain that while they may derive much pleasure from work, we consider fun to be child-like behavior totally unrelated to work. Also, we ask them if spending all that time on work related activities is producing the results they want. Usually they will say yes and no. They like the job success, but not what it is doing to their private life. Marriage and family relations are frequently strained. We discuss their values and priorities in depth before considering making plans for behavioral change. Once clients indicate they want to do something different to achieve more balance in their lives we will help formulate a behavior plan for change. In this case we would begin by assisting clients to develop a plan to have more fun. We would encourage them to have some individual or private fun and also to do something fun with significant others, e.g. spouse, children, or close friends. Our counseling at this point would follow the regular Reality Therapy process.

Other clients will have voids in other pathways. The bored housewife or the suicidal person, for example, will not perceive many options in their life. One strategy with them would be to help them make choices to increase their sense of freedom.

Figure 2 portrays an acting out problem student.

The problem student does not spend much time doing those things that earn much love or sense of belonging. Problem students frequently have given up attempting appropriate behavior so they aren't looking for alternatives. They spend much time doing those things they perceive as fun or that get them some degree of recognition. Pathograms have helped problem students realize the ineffectiveness of their behavior. Students seem to like the notion of making plans that will change the height of the lines on the pathogram. Our job as Reality therapists is to help the students make better choices and develop realistic plans for behavioral change.

The ideal profile would reflect a balance of time and energy spent on each pathway. During any period of time in a client's life the pathogram may be skewed toward one pathway. You would expect to spend more time having fun on vacation in comparison to the end of a semester if you are a college professor.

Results

Our experience has been that clients enjoy drawing their pathogram. Also, pathograms have proven to be useful in assisting clients to pinpoint a specific area of their lives that they wish to change. The visual graph seems to motivate clients to commit time and energy to doing something to make their lives better. Clients seem to do better when doing something to increase a pathway line compared to trying to stop doing something to decrease the line. Clients appear to better understand the concept of balance.
in their lives. Also, they realize they are in control of how they use their time and energy.

We like the pathograms because it gives the clients responsibility for their own diagnosis and provides a terminology frame of reference for discussion. Also, the pathograms provide us with a behavioral baseline (where the client is at), helps us focus on where the client wants to go (therapy goals), how to get there (the plan), and finally pathograms seem to strengthen the clients commitment to the Reality Therapy Process.

BIBLIOGRAPHY

Dusay, J., 
Glasser, W., 
Glasser, W., 

A REALITY THERAPY STAFF DEVELOPMENT MODEL

Linda S. Barnard*  
Irene Mehnert*  
Robert Drummond*

*Dr. Barnard is Executive Vice President for the Institute for Occupational Services, Sacramento, California.
*Dr. Mehnert was formerly Director of the University of Maine-Orono Teacher Corps Youth Advocacy Project and now lives in Bloomington, Minnesota.
*Dr. Drummond is Professor of Education at the University of North Florida in Jacksonville.

Much has been written about the use of Reality Therapy with clients in a variety of settings (Glasser, 1965; 1968; Karrass & Glasser, 1980; Ford, 1974; N. Glasser, 1980). While the emphasis has centered on how Reality Therapy can effectively be used as a treatment approach, another dimension which may be equally important is the effect Reality Therapy training has upon the staff who receive it. Wubbolding (1979) and Edlewich (1980) applied Reality Therapy to professionals to combat burn-out, demonstrating the use of Reality Therapy as an intervention tool with staff. However, beyond the range of intervention lies the scope of potential benefits of Reality Therapy training as a staff development mechanism. Certainly Reality Therapy has been shown to be an effective approach in therapy, but the positive impact upon staff who learn the concepts and skills has been largely ignored. The purpose of this article is to describe a model for staff development that was used and tested at the Maine Youth Center in South Portland, Maine.

Teaching staff in an institution how to apply Reality Therapy affects them as well as the clients they serve. Many of the staff who are employed by institutions have neither the training nor background to provide “help” to their clients, leaving the “therapy” to the professional staff. In most cases, the staff who have the most direct contact with the clients are the least able to perform treatment; they primarily provide maintenance functions. Studies have shown that training/re-education can result in positive changes among staff persons toward a more internal locus of control (Dua, 1970; Lefcourt, 1976). The implication is that if the staff are better trained and feel more confident about their abilities to provide treatment, they will feel better and so will the clients they serve.

With staff development as the goal, the Maine Youth Center (a juvenile correctional facility) and the University of Maine-Orono Teacher Corps Project joined forces to provide two years of intensive training in Reality Therapy for the entire staff of the Maine Youth Center (MYC).

Key factors in the development and implementation of the Reality Therapy training program were a desire to implement it as a treatment modality by the administration of the MYC coupled with the staff need to provide for continuity in the treatment of the youth. Other factors that were
significant included: 1) The Youth Center’s willingness to commit local resources and the cooperation of the institution’s administration. 2) The willingness of all parties to be involved in a change process provided much of the positive atmosphere that allowed the training program to enjoy initial successes. 3) The collaborative nature of the planning and development of the program greatly increased its potential for successful implementation. 5) The long-range capability of the Teacher Corps five-year funding cycle was crucial considering the need for a long-term commitment of personnel, funding, and technical support for the MYC. 6) Planning for institutionalization was started immediately with three tenured staff members plus the Superintendent of the Youth Center making a three year commitment which culminated in certification for all four persons from the Institute for Reality Therapy.

The actual implementation of the Reality Therapy training program at the Maine Youth Center began toward the end of the first year of the five-year project. At that time, an orientation to Reality Therapy session was conducted for all MYC staff, followed by a needs assessment to ascertain future training objectives.

In September, 1979, a Reality Therapy trainer was hired to implement full-scale training objectives and to systematically conduct training programs over the next two-year period. The trainer was on-site at the Center three days a week to provide training as the program was being implemented. By having continuous contact, the trainer could monitor the program, respond to situations as they arose, make adjustments and provide immediate feedback to the staff. In addition, the trainer had the responsibility for reviewing institutional procedures and policies in the context of the impact of these policies on the Reality Therapy training program.

The actual application of Reality Therapy training took place in a multi-phase approach. Each area will be discussed, including specific training programs which were implemented.

1. Orientation: As mentioned previously, all staff attended an orientation to Reality Therapy program during Year One of the project. This training program was essentially an overview to acquaint staff with the training program to follow throughout the next two years. Year Two of the project also included an orientation training program for all staff. It was a four hour program designed to specifically highlight the basic concepts of Reality Therapy:

   A. Philosophy of the Maine Youth Center: A written document developed by the Superintendent to describe the overall philosophy of the Center, including both legal mandates and the decision to use Reality Therapy as the rehabilitative treatment model.

   B. Reality Therapy Identity Chart: This chart was developed by Dr. Glasser to present the basic concepts of Reality Therapy as they relate to the formation of identity. These concepts were presented to the staff as an overview of the basic of Reality Therapy.

   C. Steps of Reality Therapy: The eight steps of Reality Therapy as a treatment approach were explained and demonstrated to the staff. This was followed by an opportunity for the staff to role play the steps with facilitator supervision.

   D. Disciplinary Steps: Glasser identified a series of school disciplinary steps which were modified for use at the MYC. These steps were explained during the orientation program and were implemented in all MYC programs.

The orientation training was conducted every three months to train newly hired staff and selected persons from other correctional facilities or community agencies. Additionally, all newly hired staff spent time individually with the Reality Therapy trainer during their first two weeks of employment to discuss the treatment model.

2. Training for Specific Groups:

   A. Cottage Treatment Staff: The Maine Youth Center employs cottage staff who are responsible for providing a reasonable living environment, as well as much of the individual and group contact with the students. They primarily attended to the physical and social needs of the youth committed to the institution.

      1. Orientation: All cottage staff received the orientation training and additional follow-up training related to specific questions they had concerning Reality Therapy and its application in their treatment programs.

      2. Monthly Seminar Meetings: Once a month the cottage staff members met in a large group for training related to specific issues. The large group was also a means to disseminate information about changes in institutional policies and procedures directly related to MYC’s movement toward a total Reality Therapy approach.

      3. Team Meetings: Once a month the Reality Therapy trainer met with each cottage team to reinforce the training conducted in the monthly seminar meetings. Team training also afforded an opportunity to address specific needs of a particular team and practice skills with more direct supervision.

      4. Case Study: Cottage teams were encouraged to present individual cases during team meeting training. Through this approach, the training they received could be applied to developing treatment plans for their students. It also provided staff with feedback on treatment plans they had developed with students.

      5. Consultation: All staff members were periodically scheduled for observation of their activities with students by the Reality Therapy trainer.

   B. Teachers: The Maine Youth Center has its own educational facilities and staff on the grounds. Because the educational component is a significant program within the structure of MYC, special attention was given to training the educational staff.
1. Steps of Reality Therapy and Application: The educational staff received weekly training on each specific step of Reality Therapy, including structured "homework" in applying each step with their students. This training also tied in the steps of Reality Therapy with the basic concepts of identity developed by Glasser (1972).

2. Concepts: The teachers all received training in the basic concepts of Reality Therapy, with special emphasis on their relevance to classroom settings, curriculum development, and educational objectives.

3. Small Group Discussions: The teachers were divided into three small training groups to discuss specific cases, and receive feedback on their application of Reality Therapy with their students. These discussions included brainstorming, critiquing, and role playing, as well as question and answer periods.

4. Schools Without Failure Concepts: As a component of the overall Reality Therapy program at MYC, the educational program graduated toward the application of a "Schools Without Failure" concept. A training program geared toward this began in May, 1980, to include the concepts and implementation of this approach. Concurrent with this training, several committees were formed to study curriculum development, and grading systems, which formed the groundwork for the systematic changes necessary within the educational program.

5. Classroom Implementation: As the teachers began to apply Reality Therapy within their classrooms, they had the opportunity to solicit observation and feedback from the Reality Therapy trainer.

C. Business and Support Services Staff: Although the business and support services staff did not have continuous, daily contact with the youth, on many occasions they either dealt with the youth directly or indirectly. In any event, the Reality Therapy program affected them in various ways. Even those who had little opportunity to use Reality Therapy in their work were involved in training so they would understand the treatment approach and how Reality Therapy fit into the total MYC picture.

1. Orientation: All business and support service personnel attended the general Reality Therapy orientation training on the basic concepts and steps of Reality Therapy.

2. Quarterly Training Seminars: These sessions included a summary of the training presented to the treatment staff, emphasizing the basic issues and concepts.

D. Community and Aftercare: One of the core components of the five-year project included building support systems for the students upon their return to the community. The Youth Center had an aftercare program which was designed to monitor the students’ progress for several months after they were released. The nature of the aftercare program included involvement with parents, schools, and a variety of community agencies throughout the state. A goal of the project was to provide training and information to community persons involved with MYC students in an effort to reinforce and provide continuity to the rehabilitation process.

1. Quarterly Training Seminars: The aftercare personnel met quarterly at MYC for training and information. During that time they received training similar to that provided for the on-site staff.

2. Release Contracts: When students were released from the Center, they signed a contract related to goals they had worked on during their committal. The aftercare personnel were being systematically included in providing input to the treatment staff to help the student successfully reintegrate into the community.

3. Community Training: During Year Three of the project, Reality Therapy training programs were provided for parents and others community persons involved with MYC students. These training sessions were held in the communities around the state to help eliminate transportation costs for the community persons.

All staff were involved in the 360 hours of Reality Therapy training provided during the two years the trainer was on-site. As a result of the training, the Maine Youth Center staff were far more knowledgeable about treatment and specific strategies they could use to work with the students more effectively. A staff which is well trained is more competent in providing treatment and more confident in their abilities and skills when working with their clients, which benefits everyone involved.

The model described in this article was coupled with an extensive assessment and evaluation component. Future articles will focus on some of the strengths, pitfalls, and present a statistical analysis of the effectiveness of this model.

BIBLIOGRAPHY


REALITY THERAPY RESEARCH REVIEW

John Banmen*

*Dr. Banmen is Associate Professor at the University of British Columbia, Vancouver, Canada, and is a certified reality therapist.

Since the publication of Reality Therapy: New directions in psychiatry popular with professionals and non-professionals alike. During the intervening years, there have been many reports of the successful application of reality therapy with a variety of populations and in many different settings on the effectiveness of reality therapy. This lack of research has become an area of increasing concern for Glasser and many other reality therapists.

One way to determine what the focus of future research should be is to examine the research which has been done to date, limited though it may be. This article is intended to summarize the research to date and offer some suggestions in direction for future research.

One area where the effect of reality therapy has been studied is within the prison system. Bennight (1975) measured the effect of reality therapy in a prison program which was designed to deliver employment services to offenders. The use of reality therapy as well as aptitude tests and Holland’s Self-Directed Search resulted in a placement rate higher than that which is usually achieved. Results show that in a 2-year period, 2,795 clients were taken into the program. Of this number 2,170 were released from institutions and available to work. Job placements were made for 941.

Williams (1976) studied the impact of a fifteen week long program in reality therapy conducted with forty-three inmates. The program stressed the active role the client must take to change his style of living. Over 80% much enjoyed it. Participants liked reality therapy because it gave them the opportunity to find out more about themselves and become more responsible, and it helped them to take a more realistic and responsible outlook on life in general, and prison in particular. No inmates in the Results suggest that reality therapy seems to work because it provides the offenders become better adjusted and develop more interests. The offenders were also able to express themselves better.

The use of reality therapy with disturbed youth and black students and youth has also been studied by a few researchers. Brown and Kingley (1973) studied the effect of individual contracting and guided group interaction on the self-concept of disordered youth. The ideal self-perceptions was measured by the Lambert/Bower self-test scale. The authors suggest that this program promoted a more realistic and mature self-orientation of the 13-18 year old youths. German (1975) found that group reality therapy had a significant and positive effect on both the residents and staff in an institution for adolescents. The study also concluded that reality therapy can be used by trained and supervised paraprofessionals to change others’ self-appraisal of their behavior and their actual behavior in a positive direction.

Hawes (1971) studied the effects of a “School Without Failure Program” on black students. The major objective of the program is to encourage individual responsibility in children, and thereby effect their classroom behavior and enhance their self-concept. The third and sixth grade pupils showed significant increases in: 1.) behavior toward tasks assumed to be appropriate to the school setting; 2.) behavior in which processing and seeking information were salient and apparent; 3.) behavior which is primarily motivated by the satisfaction derived from interacting with other people through a given activity or task; 4.) the number of teacher and child interactions and; 5.) the number of child initiated interactions. In effect, the program improved significantly student’s self-responsibility, their self-concept and their classroom behavior.

The most extensive research so far has been done in the school system. Some of these studies have produced mixed results. Browning (1979) measured the effect of reality therapy classroom management techniques on teacher attitudes, student attitudes, student achievement and student classroom behavior. The results show significant changes in the way teachers regard student discipline, positive changes in attitude of students toward school environment, and an increase in the students’ grade point average. However, the students’ attitude towards themselves and the rate of student misbehavior did not change. Dakoske (1977) studied the long and short term effects of reality therapy on the self-concept and discipline of fifth grade students. Differences were found on both variables immediately following treatment, but after one year there were no significant differences in self-concept between the experimental and control groups. Matthews (1973) measured the effects of reality therapy on self-concept, social adjustment, reading achievement and discipline of fourth and fifth graders. There were no significant differences between the experimental and control groups on self-concept, social adjustment or reading achievement scores. However, the experimental group did decrease in the number of discipline problems, and the data also indicated that the experimental group decreased in problem behaviors more than the control group.

These studies suggest some inconsistent results in educational settings in areas such as self-concept, adjustment and achievement. However, all but one of these studies indicate that reality therapy does reduce discipline problems and inappropriate behaviors. Other studies (Banmen, 1982) which only measured the effect of reality therapy on discipline problems in the classroom also support this conclusion.

Gang (1975) found that a Reality Therapy Intervention Program was effective in increasing desirable behaviors and decreasing undesirable behaviors in all six students in the study. In addition, the teachers felt that the establishment of an ongoing genuine relationship between the student and the teacher was an essential condition for the successful outcomes achieved. Poppen et al. (1976) describe research which supports
the application of reality therapy to disciplining problems, using counselor-trained teachers. Data confirm that counselor-trained teachers can successfully use reality therapy to reduce the frequency of undesirable pupil behavior and increase the frequency of desirable behavior. Thompson and Cates (1976) found that a ten-step program to teach discipline to students, based on reality therapy and the principles of Thomas and Poppen, resulted in improved behaviors for all the students who completed the study.

Two other studies were unable to find any positive effects from the use of reality therapy in the classroom. Shearn and Randolph (1978) found no significant differences for self-concept and on-task behavior with 150 fourth graders. Welch and Dolly (1980) examined the influence of in-service training, using reality therapy and “class-meeting” techniques on the behavior of teachers and students. They measured the effects of this training on teacher affective behaviors, student on-task behaviors, discipline, referrals and student absences, and found no significant differences in teacher and student behavior.

Studies have also been done with other populations. Browne and Ritter (1972) used reality therapy with geriatric psychiatric patients and found improvements in life skills and personal behavior. Zapf (1974) studied the effect of reality therapy on the personal growth of a group of retarded adult women living in the community. Personal growth was measured by the observations of goal achievements and multiple baseline techniques. The program achieved only moderate success.

Schaughency (1977) found reality therapy to be useful in improving the effectiveness of group supervision. This workshop resulted in improved communication, increased level of trust among workshop members, higher levels of involvement in decision-making, increased participation, heightened optimism about group potential, improved problem-solving, more sharing of leadership functions and better acceptance of and commitment to group goals. The reality therapy model was thus successfully employed as a process for group supervision.

Nelson (1974) wrote about a case study involving a 20 year old female diagnosed as a paranoid schizophrenic. After 8 months of living in a seclusion room of a locked ward in a state hospital, a reality therapy treatment plan was initiated. After 3 months, the patient graduated to a semi-private room and with only a quarter of her original dose of phenothiazines. In 6 months she was discharged.

Martig (1979) measured the effects of group reality therapy on college students. Both the experimental and control groups consisted of twenty-two students each. The experimental subjects attended two sessions of group reality therapy per week for five weeks. Both male and female subjects were significantly affected on variables of withdrawal, dominance, locus of control and self-discipline. All subjects also experienced decreased anxiety and nervousness.

Finally, one of the most important areas of research involve studies which compare the effectiveness of reality therapy to that of other therapeutic models and techniques. Crowley (1974) found client centered group therapy to be more effective with adolescent males than reality group therapy as measured by independent raters. However, analysis of variance showed no significant differences with any one criterion of behavior and personality measurements used. Butcher and Heaps (1974) found micro-teaching for seven minutes to be a more consistent predictor of student teaching effectiveness than reality therapy role-playing. Shearon (1976) measured the effects of psychodrama, bibliotherapy and reality therapy on the professed and inferred self-concepts of fourth graders. He found that none of these three approaches produced significant gains in self-concept as compared to the control groups.

**SUMMARY**

When reviewing these results, the first and most obvious conclusion researchers can draw is that much more research is needed. Many practitioners, on the other hand, might be pleasantly surprised with the amount of research activity having been done so far.

All of the research studies mentioned in this review were completed before the concepts of the book *Stations of the Mind* (1981) were made available. Studies measuring behavior changes show more positive results than those attempting internal self-perception and self-concept changes. This trend might now change with B.C.P. Psychology.

One possible explanation of some of the inconsistencies in some of the results might be the effectiveness with which the practitioner of reality therapy uses reality therapy. More attempts to provide an assessment of the practitioners’ skills is needed.

Only one study measured the long-term effects of reality therapy. This area will need considerably more attention when building evidence for long term changes as a result of reality therapy. Much more research is also needed in the area of comparing the effectiveness of reality therapy with other therapeutic models. Reality therapy might establish a clear advantage in terms of short term treatment and long term effect. Reality therapy is being used with many populations and specific problems which have not been included in any formal research. Finally, the effectiveness of reality therapy training needs to be studied and evaluated.

It is through program evaluation and formal research that reality therapy will establish itself as a viable alternative to many of the present practices now in vogue and establish itself more firmly in the academic community of colleges and universities. It is hoped that this review of selected research studies will help motivate others to carry on and publish more research, or simply just use the research findings and assist and encourage others in various research activities.