The Journal of Reality Therapy is directed to publication of manuscripts concerning research, theory development, or specific descriptions of the successful application of Reality Therapy principles in field settings. This journal is the official publication of the Institute for Reality Therapy.

Subscriptions: $6.00 for one year or $12.00 for two years. Foreign $7.00/ $14.00 (U.S. currency) Single copies, $3.00 per issue. Send payment order to the editor.

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The Journal of Reality Therapy is published semi-annually in Fall and Spring. ISSN: 0743-0493.


Cover: The cover was designed and produced by Sheri Jarosz of Brimfield, Ohio based on the design developed at the Institute for Reality Therapy in Los Angeles.

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HANDLING PATIENT NON-COMPLIANCE USING REALITY THERAPY
Linda Geronilla, Ph.D, R.D., CRT

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Patient noncompliance is the most significant problem facing the medical world today. In an era when new therapies are being developed at a rapid rate, it is discouraging to think that many patients fail to receive full benefit through inadequate adherence to treatment (Haynes, 1976).

When patients do not follow the recommended therapy, providers use feelings of anger, frustration, and defeat to resolve the issue. These patients are often viewed as problematic, uncooperative, and a nuisance, and are often treated that way. The patient may then feel alienated, anxious or angry.

Overall, noncompliance interferes with therapeutic goals, and causes excessive time, money and resources to be spent on unnecessary tests and additional treatments. Noncompliance is also an obstacle in the preventive medicine area. Its most detrimental effect may be on the therapeutic relationship and the general dissatisfaction with medical care (Glanz, 1980).

The object of this article will be to review the literature on patient compliance and show that the steps of Reality Therapy can be an effective model for improving patient compliance.

STEP ONE - MAKE FRIENDS AND ASK WHAT DO YOU WANT?

The providers' orientation towards the patient, and their desire to influence the patient's compliance, have been shown to be important factors in increasing patient compliance. In a traditional medical model, the term “compliance” denotes a disposition to yield to those in charge; a subordinate relationship in which the provider says “this is good for you — do it”. The provider is in the “one-up” position of determining the patient's treatment goals and the patient is in the “one-down” position by receiving or accepting the goals of the provider. If the patients choose not to comply, they are “guilty” of not following the medical regimen prescribed “for their own good” (Stanitis & Ryan, 1982).

Models which have been shown to improve compliance stress an egalitarian symmetrical structure in which treatment goals are negotiated with a collaborative exchange. Patients who received medical care in which they were considered to be an “active participant in the treatment process” were significantly more compliant (Schulman, 1979). To do this, patients need to understand their medical problems, causes, treatment regimen, expected outcomes and consequences of noncompliance. This allows them to fully participate in planning the treatment regimen, as well as the identification of, analysis of, and solutions to the problems which might interfere with compliance.

The provider-patient relationship is an important factor in helping the client achieve self-care. One study showed that patients reacted more favorably to the personal interaction and support involved than of other facets designed to increase compliance (Talkington, 1978). Key factors which were shown to maximize compliance were good rapport and free communication between the patient and provider.

Three important aspects have been documented. Adherence is greater when sincere concern and sympathy are shown; when the patient's expectations have been fulfilled; and when the provider asks about and respects all the patient’s concerns and provides responsive information about the patient’s condition and progress (Eraker, Kirscht & Becker, 1984). Conversely, impersonality and brevity of the session are detrimental to compliance (Coe & Wesson, 1965).

Patients’ beliefs about their health and about the particular illness and its treatment have a strong influence on compliance. These beliefs can operate independently of levels of information, objective features of the condition and the regimen, etc. Therefore, an important aspect of treatment is determining what is in the patient’s “picture book”; What are the patient’s concerns, beliefs, and knowledge. This is the second part of step one in Reality Therapy which is to find out what the patient “wants”?

In order to understand the patient’s picture book, a “Health Belief Model” and a “Health Decision Model” could be used. A Health Belief Model depends upon four factors:

1. Health motivation: degree of interest in and concern about health matters in general;

2. Susceptibility: perceptions of vulnerability to the particular illness, including acceptance of the diagnosis;

3. Severity: perceptions concerning the probable seriousness of the consequences, on both the physical and social dimensions, of contracting the illness or of leaving it untreated; and

4. Benefit and costs: an evaluation of how effective the advocated health behavior might be in preventing or treating the condition, weighed against an estimate of what barriers might be involved in undertaking the recommended action (i.e. financial expense, physical and/or emotional discomfort, inconvenience, possibility of adverse side effects (Eraker, Kirscht & Becker, 1984).

In a Decision Model, patients express their preference about trade-offs between benefits and risk and/or between quantity and quality of life. The health decision model also incorporates such modifying factors as experience, knowledge, and social interaction (McNeil, Keeler, & Adelstein, 1975).

Research has demonstrated that these attitudes and perceptions can be altered when the health provider is aware of them and takes a “compliance-oriented history” as part of the routine examination process. The most
important dimensions of which to be aware are: Does the patient care about his/her health; agree with the diagnosis, perceive the condition as serious, feel the recommended therapy will work; fear side effects; feel the regimen will be too hard to follow?

Research on the decision model has been encouraging in both the prevention and treatment of specific health behaviors. For example, physicians trained in this model spent more time on patient teaching. The results showed that patients exhibited higher levels of knowledge and effective beliefs and more compliance with regimens and better blood pressure controls (Inui, Yourte & Williamson, 1976).

Providers often have difficulty in accepting the autonomy of the patients in terms of deciding whether or not to carry out aspects of their health care that the provider considers important. Because of their sophisticated education, training and values, health providers often assume that their patients will want to maximize their health. Their “picture book of wants for the patient” is that they should be willing to participate in any and all specified regimens in order to gain optimal health. The providers project their values and dictate orders which they assume that the patient will follow. These orders will include those designed for the treatment of the condition, as well as general preventative health measures. The result is often a total rearrangement of the patient’s health behaviors: eating, exercising, resting, and additive behaviors. When handed this awesome list of things to change, patients will often experience a perceptual error or frustration signal because this is not what they had “wanted.” They will either actively rebel with verbal comments (commonly called “patient resistance”), or they will nod their head agreeably and then not follow the regimen (commonly called “patient noncompliance”). The final result is that health providers frequently end up with a “perceptual error or frustration signal” because the patient is not doing what they want.

An important aspect is for the health provider to listen to and accept the patient’s “wants” and to work with those “wants” as the patient is willing. The provider must be willing to modify the “ideal” therapeutic recommendations to reflect patient preferences. Findings of one study revealed a significant difference between problems that patients identified for themselves and those identified for them by their providers (Roberts, 1982). For this reason it is important that the provider and patient work together to establish specific treatment goals to avoid communication errors. Obviously, a patient’s “want to feel better” can be different than a provider’s “want to control blood pressure,” or a patient’s “want to lose weight” can be different than a provider’s “want to follow a low calorie diet and exercise.”

Establishing a priority to the “wants” is also important. Patients’ motivations will automatically be directed toward the most pressing needs as currently perceived (Pohl, 1981). This again may not be in the same order as perceived by the provider. Patients may be more concerned about some aspect of their physical comforts or security than health behaviors. For example, they may be more concerned about their source of income for their monthly mortgage, than they are about their low cholesterol diet after a heart attack.

The patients’ emotional state will be one of the important factors to consider when helping them prioritize. Some patients may not be ready to accept their health status. A newly diagnosed patient will often experience a crisis in his/her life and will be grieving the loss of a lifestyle that was familiar and comfortable. Denial may be part of the coping style, which greatly decreases motivation to learn new health practices (Starkman & Young, 1979).

An important part of treatment at this early stage is to acknowledge and help them ventilate their fears; second, to give them sufficient information and realistic reassurance about their illness and its management; and third, to help them feel they have the support of a health provider whom they can perceive as concerned and competent (Starkman & Young, 1979).

Health providers must understand that patients vary in both their knowledge, willingness, and ability to change health behaviors.

Patients can be classified in several ways:

1. Do not know whether their behavior is ineffective or beneficial (ignorant).
2. Know their behavior is ineffective but do not know a preferable behavior or how to get the assistance needed (needs information on what to do).
3. Know their behavior is ineffective and know what they should do, but do not know how to do it (needs instructions on how).
4. Know their behavior is ineffective, what to do, how to do it, says they want to change, but fails when tries. (excuser).
5. Know their behavior is ineffective, what to do, and how to do it, but say they do not want to change (resister).
6. Know their behavior is ineffective, what to do, how to do it, and can maintain the desired behaviors (effective controller).

Another important aspect is for providers to find out what the patient expects or “wants” from them as providers. Some clients may come for a very specific treatment that they have read or been told about. Others may want to ask specific questions about a treatment procedure. Still others may just want to affirm that what they are currently doing is “right”. And still others may want moral support during their endeavors or need someone who will “check-up” on them to keep them motivated. Getting patients to examine what they want and where their priorities fall, helps them to see that they must take responsibility for their behaviors.

To help patients gain skills that they need to improve their health, Reality Therapy emphasizes teaching the eight steps. In order to do this, a form has been developed utilizing the eight steps (Form A). It is imperative that patients and health providers use this form together. For example a weight control patient might write:
FORM A
MOTIVATION USING REALITY THERAPY

By Linda Geronilla, Ph.D., R.D.

1. What do I want? List your goals in precise terms.
2. What am I doing now to meet my goals? (or not doing)
3. Is what I am doing helping me?
4. What are my plans to do better? Make the plan simple, specific, realistic, and a "do" plan (not "don't")
5. Am I committed to follow my plan daily? (yes or no)
6. What excuses do I usually make?
7. What are the consequences of not doing my plan?

When you are debating what to do ask yourself: "What do I really want?" Restate your goal, "Is this going to help me reach my goal?"

I want to be an ideal weight for my height.
I want to wear shorts, slacks and bathing suits and feel comfortable.
I want my stripes on my jogging pants to be straight.
I want to have more energy.

STEP 2 - WHAT ARE YOU DOING NOW?

This step asks the patients to describe their health behaviors specifically. While listening to the health behaviors it is imperative that the health provider not be judgmental or critical of the behaviors. Patients often tell health providers what they think they want to hear because of fear, forgetfulness, and embarrassment. They often directly conceal behaviors because when they told the truth in the past, they were criticized. They view health providers as moralistic and unsympathetic, and telling the truth does not seem useful material on which to build a relationship. Health providers must be extremely careful in the way that they ask questions, in order to avoid the stereotypical image. Asking open-ended questions which assume some deviation from "idealistic health behaviors" can be an aid in obtaining accurate and complete information. A question phrased as "When did you have alcohol yesterday?" will probably get more information than "Do you consume alcohol?" or "When was the first time you ate during the day and what did you have? is better than "Tell me what you ate for breakfast."

STEP 3 - IS WHAT YOU ARE DOING HELPING YOU?

This step is the most crucial in obtaining cooperation. As long as patients believe what they are doing is not harming themselves, they will probably continue to do it. This step asks patients to critically examine and evaluate their health behaviors. It is critical that the health provider not make this value judgment for the patient. Patients must judge their behavior as not helpful.

Some patients who fall under the first classification of ignorance, truly do not know that their behavior is detrimental. It is the health providers, and not the patients, who experience "frustration signals" during the intake process. What they want their patients to do is often different than what is being done. A dietitian might be controlling for low calorie, high nutrient foods while the patient may be controlling for foods which taste good. The health providers must try to find a way to transfer their perceptual error to the patient through the educational process. An example of the proper way to transfer the error to the patient is the following:

TRANSFERRING A PERCEPTUAL ERROR TO A PATIENT BY ADDING INFORMATION

Mark comes in to his doctor for his annual work physical. He mentions that he has lost 20 pounds and would like to lose another 20 to attain his ideal weight (wants). His doctor asks Mark how he has lost the first 20 pounds. Mark comments that he eats 300 calories for breakfast, another 300 calories for lunch and 400 for dinner (controlling for). His doctor asks Mark what he eats for each meal. At lunch Mark eats a candy bar and a can of soda out of a vending machine because he works out at the gym for the rest of his lunch break. Mark's physician has a perceptual error because he wants Mark to eat something nutritional instead of junk for his 300 calories. Mark has no error because he is getting what he wants by controlling for the 300 calories at lunch. Mark's physician has to go back to
agreed that he would like to do this. He asked Mark what he thought might be better for him. He said a sandwich. His physician showed him an example of his can of soda and candy bar as compared to a sandwich in terms of nutrients. Mark made the statement that the sandwich was better for him (step 3).

Mark then commented that he got the candy bar because it was convenient and that he did not have time to go to the cafeteria for lunch. They discussed the idea of "how" he could get the sandwich without going out. They came up with the idea that he could pack it at breakfast and bring it to work in his coat pocket (step 4). He then made a commitment that he would do this (step 5).

Besides having insufficient information, many patients have erroneous information upon which they base their decisions to comply. The provider should make an effort to understand the patient’s beliefs and their origins. These can originate from cultural standards, previous experience with an illness, misinterpretation of factual information and acceptance of erroneous information from non medical sources (Eraker, Kirscht, & Becker, 1984). The correction of this erroneous information must be handled carefully. The health provider must determine the seriousness of the consequences of the health belief and determine when the relationship is strong enough to handle the confrontation. For example, many patients believe that they need vitamins. If the patient is taking a mega dose of a fat soluble vitamin, like A, which can have serious effects, the health provider should try to intervene as quickly as possible. The erroneous information needs to be confronted in a manner causing the patient to view the provider as a concerned reliable source of information. The provider could say “I’m concerned about the vitamins that you are taking. I wonder if you would be willing to talk about them and consider reading some related literature?”

**STEP 4 - MAKE A PLAN TO DO BETTER**

An erroneous belief of many providers is that information alone will improve compliance. Increased knowledge has been associated with increased compliance in some studies. Knowledge is necessary but not sufficient to ensure compliance with medical regimens. Even patients with good knowledge have been found to have poor management control of their medical problems (Williams, Anderson, Watkins & Coyle, 1967).

Studies that used a combined behavioral and informational approach consistently achieved better results. It is important to realize the provision of information alone without assistance in changing or adapting behavior is not likely to achieve the desired results of better compliance (Shope, 1981).

Often the first inclination of health providers is to provide as much information as possible. Many health providers only have one session with their patients, and often this is at a very inconvenient time, such as diet instructions when the patient is leaving the hospital. These complex instructions often overwhelm patients and they experience “information overload.”

To avoid this overload, the provider should focus on supplying a limited amount of information at any one time. Such information could be divided into three classifications:

1. Content that is *essential* for the protection of life and the prevention of acute complications (i.e. avoid diabetic shock);
2. Content that is *important* for the maintenance of health, prevention of long-term complications and the provision for optimal functioning of all systems (i.e. diabetic exchange system); and
3. Content that is *desirable* because it provides the person with a conceptual understanding of the disease and with the ability to maintain the regimen and the lifestyle with optimal flexibility (i.e. conversion of any recipe into the diabetic exchange) (Resler, 1982).

Accuracy in adapting the teaching to the needs and capabilities of the patient depends on careful and thorough goal-setting and negotiation in a collaborative activity.

Once a patient appears successful in understanding and utilizing the first level of information which is designed to prevent acute complications, the provider can begin to introduce the second level which is directed toward health maintenance, and then proceed to the third level.

Many health agencies and hospitals have some type of program outline of sequential topics or scheduled teaching times to show they have met their responsibility for teaching various aspects of the medical regimen. Excessive reliance on such programs have actually worked against rather than for effective goal-setting. Competent health counseling requires prioritizing to meet the patient’s immediate needs adequately. Long term goals can be dealt with when appropriate (Resler, 1982).

Improved levels of compliance have also been associated with decreases in the regimen’s complexity, duration, requirements for changes in lifestyle, inconvenience, and cost (Eraker, Kirscht, Becker, 1984). To accomplish this, several general rules can be followed:

First, keep plans simple. This includes prioritizing the regimen and breaking down the treatment plan into less complex stages that can be implemented sequentially. It is helpful to implement a graduated regimen in which treatment procedures are added in an increasing order of difficulty as the patient demonstrates proficiency in each prior component.

Patients who have trouble understanding and remembering what is expected of them will have a higher rate of noncompliance. “Studies have shown that after five minutes, patients forgot about half the doctor’s instructions, and remember best the material in the first one-third of the presentation. They recall the diagnosis better than they do the prescribed therapy.” Such findings suggest that the provider speak briefly and selectively, emphasizing information necessary for compliance clearly and early in the communication, and then repeat that information, both orally and through simple written instructions to which the patient may later refer. This information should be specific, individualized and carefully organized (Becker & Maiman, 1980).
Second, make it realistic in terms of cost and available resources. Make it something that the patient can be successful in accomplishing.

Third, make it something the patient can do independently of others, so that he/she does not have to rely on anyone else.

Fourth, make a plan specific for each patient. Talk about what the patient can do, where he/she can do it, how often, when, etc. Tailor the regimen to the patient’s regular daily routine in order to minimize both inconvenience and forgetfulness (Sackett, Gibson, Taylor, Roberts and Rolinson, 1978).

Fifth, try to get him/her to do it as soon as possible.

Sixth, try to make it something which is repetitive several times in a week to begin the establishment of good habits.

To teach flexible behaviors, the health provider can discuss difficulties patients may experience with their plans and develop alternate plans. This especially works well with “excusers” who often fall “victim” to circumstances. For example, the provider can ask “What if it rains and you can not go for your walk? What else can you do for your exercise?” or “What if they do not have diet soda when you go out to eat?”

STEP 5 - OBTAIN A COMMITMENT

Data now support the provider-client contract as a tool for increasing the likelihood of compliance to prescribed therapy. Some of the advantages are “(1) written outline of behavioral expectations is created; (2) the patient becomes involved in the decision making process concerning the regimen, and thus has an opportunity to discuss potential problems and solutions; and (3) formal commitment to the program is elicited;” (Becker and Maiman, 1980, 126).

A health contract (Form B) was developed to be used with patients which incorporates the health behaviors with the basic needs. The patient fills out this form and is responsible for filling in the appropriate spaces daily.

STEP 6 - DON’T ACCEPT EXCUSES

Reasons that patients give for noncompliance are: lack of information or understanding, disagreement with the recommendation, side effects, forgetting, financial considerations, or too busy (Talkington, 1978). When patients were asked to estimate their rate of adherence there was often an overestimation to adherence. (Dunbar, 1980).

As Reality Therapists, we believe it is a waste of time to listen to excuses for it reinforces the failure identity. The benefit of Reality Therapy comes from a recommitment to an existing plan or from developing a new plan, not from seeking fault or reasons for failure.

When patients are chronic “excusers”, the health provider can ask them to list their excuses (Form A) and ask patients to make a value judgment if they feel the excuses are helping them get what they want. Providers need to point out irresponsible behavior. A steadfast attitude of the provider that excuses are not sufficient reason for failure to carry out plans to behave more responsibly is a communication of faith in the patient’s ability to behave responsibly.

If patients continually make excuses, it may be time to reestablish goals by returning to step one by asking “What do you want?” and renegotiating a totally different plan based upon the “new” want.

FORM B

I WILL BE RESPONSIBLE FOR MYSELF BY ENGAGING IN THE FOLLOWING PLANS IN ORDER TO OBTAIN MY GOALS.

<table>
<thead>
<tr>
<th>Month</th>
<th>Dates</th>
<th>My Eval.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Intake Records</td>
<td>Calories (day/week)</td>
<td></td>
</tr>
<tr>
<td>Exercise:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relax:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Love/Belonging:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worth/Recognition:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fun:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freedom:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature: 

STEP 7 - DON’T CRITICIZE OR PUNISH, BUT DON’T INTERFERE WITH REASONABLE CONSEQUENCES

Reality Therapy specifies the elimination of punishment and criticism when a patient fails to carry out a plan because this tends to destroy the therapeutic relationship and reaffirms a failure identity by increasing the error signal. Rather, the provider should find out if the patients are knowledgeable of their health consequences. Patients can list the consequences on Form B. If patients are ignorant of the consequences, the health providers have an obligation to educate them. There is nothing wrong with a graphic description of health consequences as long as such information is accurate and is accompanied by specific behavioral recommendations that the patient can easily and quickly undertake to reduce the threat (Becker & Maiman, 1980).

Some patients may need to suffer the consequences of their incomplete plans in order to clarify their needs. For example, patients with diabetes
may have to experience hypoglycemic reactions before they may be willing to follow the appropriate instructions for insulin and diet.

**STEP 8 - NEVER GIVE UP - HAVE CONTINUOUS FOLLOW-UP**

It appears reasonable that in order to change long-standing and complex health behaviors, intense and sustained time and effort must be maintained between the provider and patient. Support, encouragement and reinforcement have all been shown to increase patient compliance. Continuity of care has been shown to improve patient compliance (Becker, Drachman, & Kirscht, 1974). Provisions must be made for the patient to maintain contact with the provider until all aspects of the regimen are going smoothly.

Patients who have a large number of behaviors to change may require constant reassurance that the regimens will become manageable. This step insures that providers will not make unreasonable expectations on the patients and that help will be available for as long a time as necessary.

If a patient continually fails to complete his/her plan, it may be an indication the provider should help the patient reevaluate his/her goals or make new plans.

**CONCLUSION**

Compliance should be viewed in a comprehensive context, as a dynamic and complex process involving both the provider and the client. Studies have identified factors which have sought to improve compliance. Providers must be alert to the places where they can intervene in order to improve compliance. Reality Therapy appears to be a model which could effectively be used to increase patient compliance.

**REFERENCES**


LEGAL, ETHICAL, PROFESSIONAL ISSUES IN REALITY THERAPY

The Reality Therapist and ‘Professional Organizationing’

Robert E. Wubbolding

The author is Director of the Center for Reality Therapy/Midwest. On the faculty of Xavier University in Cincinnati, he is completing a three year term on the editorial board of the JRT. This represents the first of a continuing column. Ideas and issues to be covered should be sent to the author.

Participants training for certification in Reality Therapy and other counseling methods, frequently ask questions which cannot be immediately answered even if they possess a thorough knowledge of counseling principles: “When do I break confidentiality?” “What is my first responsibility; to my client or to my employer?” “How do I talk over my cases with a consultant?” “What do I do when a person seriously threatens suicide?” “What are my legal responsibilities?” “What are the trends in legislation affecting counselors?”

To be able to answer these questions with certainty and responsibility is crucial for therapists, especially those in private practice. This is the first column which I will regularly write for JRT revolving around the issues of professionalism. This article concerns 2 professional organizations: Aacd (American Association for Counseling and Development) and CGCA (Canadian Guidance and Counselling Association). Subsequent articles will cover such topics as ethics, legal responsibilities, licensure, working with other professionals, other organizations for psychology and social work, etc.

The focus of most professional organizations includes communication, education, and lobbying. Professional organizations attempt to provide their membership with information on recent trends in the profession. For instance, Guidepost recently contained information about the licensure of counselors, the National Board for Certified Counselors, the main speeches at the annual convention, recent publications, etc. The organizations also publish and promote materials designed for use with the public. Thus Cognica (1984) recently featured a film developed by the National Film Board of Canada entitled I Want to Be an Engineer.

Educational efforts include conferences, both national and regional, as well as publications of books, films, video cassettes, position papers, etc. Among the publications is Guidance and Counselling Services in Canada, a position paper of CGCA which explains the “Needs” of students, female clients, exceptional and handicapped clients, prison inmates, unemployed persons, immigrants, etc. An important source published by A.A.C.D. is the Ethical Standards Casebook which describes in a case by case format how various ethical issues can be handled.

Most importantly the communication and educational efforts are epitomized by the publication of the professional journals especially Canadian Counsellor (CGCA) and The Journal for Counseling and Development (Aacd). Space does not permit a thorough discussion of these journals or of the specific journals published by the 14 divisions of Aacd.

Lobbying and testifying before governmental committees is a function of the officers and staff of professional organizations. Thus, Past President Edwin L. Herr testified before the House Subcommittee on Post-Secondary Education in support of the Higher Education Act Amendments of 1984 (Guidepost, 1984).

As above, space does not permit a thorough discussion of the scope of these organizations. It is sufficient to emphasize that knowledge of counseling theory must be implemented by knowledge of professional organizations, among which are:

American Association for Counseling and Development
599 Stevenson Avenue
Alexandria, VA 22304

Canadian Guidance & Counselling Association
P.O. Box 13059
KANATA, ON.
K2K 1X3
CANADA

BIBLIOGRAPHY

Alexandria, Va., American Association for Counseling and Development.


What do you mean? You’re counseling for pay?

Wearing your heart on your sleeve is just a way of controlling for love.

Humor may be the essential ingredient in real learning.

Paul Duval 88 Duff St., Watertown, MA 02172
REALITY THERAPY IN THE ELEMENTARY/JUNIOR HIGH SCHOOL

Elizabeth Jan Johnson

The author is a certified reality therapist who works as a guidance counselor in Canterbury, Connecticut.

Little has been recorded about reality therapy in the elementary and junior high schools. Counseling in general at this level is far less popular than at the high school and college levels. The intent of this article is to show the need for reality therapy in the elementary and junior high school setting. I will do this by discussing the school where I am presently employed and working with a portion of the six hundred students.

I meet daily with approximately twenty students, varying in ages from five to fourteen, with problems ranging from failing math to emotional blindness. Most have a solidly ingrained failure identity. I also frequently meet with several staff members and the administration to help resolve school-related problems.

The faculty became aware of the approach used through a workshop I presented last year. It involved an explanation of the basic steps of reality therapy, an overview of control theory, and role-playing in which teachers portrayed difficult students. The ten steps of discipline were also reviewed. Hand-outs were distributed and bookmarks were made with the therapy's steps on one side and the discipline stages on the other. Many teachers placed them in their plan books for convenient reference. Staff meetings have originated from this workshop.

Another result of the workshop led to teachers leading their own open-ended classroom meetings, taking care of their average discipline problems without outside intervention (e.g. sending students to the principal's office), and having fewer disruptions in their teaching day. The principal and superintendent are very supportive of the use of reality therapy, and this benefits the students, who now view the principal's office as warm and friendly versus punitive and painful.

A third positive result of the presentation is that individual teachers and I frequently meet to devise various plans concerning their students' behavior. It has been determined that problem-ownership and clarifying problems is much less time-consuming when the ten steps of discipline are utilized. This system is the primary method of dealing with disruption. It provides a consistent way to handle most, if not all, student problems and is fairly easy to practice. The staff feels more in control when they incorporate one of the steps which is a time-out space for students displaying inappropriate behavior; the responsibility of creating a punishment is no longer necessary. The students also feel in control by being able to frequently move themselves to a time-out space before teacher intervention occurs, recognizing their need for time alone in order to gain perspective.

An additional result of the in-service is that the teachers bi-weekly record comments as to the academic, social, and behavioral progress of each student participating in the counseling process. Providing a total and updated picture of each student is extremely beneficial.

The administration has also become involved in using reality therapy. The principal and I talk with suspended students or those who are often truant to devise plans ensuring the students' success. Strategies for particularly difficult meetings are frequently planned prior to the meeting to obtain desired pictures based on the therapy's techniques.

There are numerous ways reality therapy is incorporated in the school system. Students, parents, and teaching techniques are all involved in the process. It has been discovered that being involved in a fun, successful activity versus earning a sticker or other tangible items provides a heightened feeling of worth and accomplishment. Junior high students involved in the counseling process satisfy their need fulfilling pictures through assisting kindergarten and first-grade classes by reading students a story, explaining a math concept to a small group, etc. This privilege is earned through various means including displaying appropriate conduct for a certain amount of time and completing homework assignments for a specified amount of days.

Many parents are also experiencing involvement through a nine-week program called "Systematic Training for Effective Parenting." I combine the program with reality therapy techniques for the purpose of sharpening parenting skills. Parents learn that they have choices and options in dealing with their children. They also gain a better understanding of how the school is striving to teach students to become more responsible and independent thinkers.

The students are also indirectly taught the process of reality therapy through their classes. For example, I teach career education and family education in the junior high school using a group format. Chairs are put in a circle and every class begins with an involvement activity (e.g. name one special thing you did for someone this week; if you could be any animal, what would you like to be and why). During the classes there is a great deal of role-playing (e.g. how to interview for a job) and the students are given as much power as possible. Power is defined in Webster's dictionary as the "ability to do or act." The opportunity to display power in a positive way helps provide a sense of worth, and is essential to students' success in any school system. The opportunity is provided through allowing students to help devise the class curriculum, by having input into their report card grades, and by choosing the mode of communication they want to present assigned topics (e.g. written report, oral report, or pictorial). Students need to feel power/control and need to be given choices and options, whether it be choosing a particular science project, or deciding when "school spirit day" will take place. This school's junior high students also have significant input into the establishment of the school rules and consequences.

An additional way some students are involved in meeting their needs is through Planning and Placement Team (P.P.T.) meetings. The students' participation in these meetings is strongly recommended to ensure their
academic needs are being met. When students are referred for a special service (e.g. counseling, organizational skills, speech, adaptive physical education resource room, or remedial reading), they will often attend their meeting. Their own needs and how they think they might best be satisfied are discussed. The students are frequently given the opportunity to verbalize, and steps are taken to ensure a non-threatening atmosphere. The students view the new service more positively than if they had no control over the P.P.T.’s decision.

This technique of student involvement (the first and most important step) is also employed in dealing with unacceptable classroom behavior. I frequently meet with a student and teacher to discuss an existing problem. We devise a plan and meet later to note the student’s progress and make any necessary revisions. The student’s involvement in the process is often enough to curb the undesirable behavior.

Personal involvement occurs not only between students and teachers, but between students and local nursing home residents as well. I, the counselor, have established a “Grandparent Program” in which elderly residents come to the school and spend time with the younger students. Many accept the residents as their own “grandparents” who, in return, receive and meet their need for love and belonging.

Parents reinforce their children’s relationship and involvement with the counseling process. For example, Michelle, a sixth grade student, commented, “My parents are really proud and appreciate all the work that (the counselor) has done with me. They know (she) has helped solve some hard problems that maybe I couldn’t solve myself.”

The knowledge of reality therapy and its techniques are continued past graduation. It is not uncommon for someone who has participated in counseling to visit a year or more after graduation to relay how successfully he/she is dealing with his/her present situation through the process learned in the junior high years.

In conclusion, the concepts of reality therapy can and need to be successfully implemented in the elementary and junior high schools. Teachers and administration need the knowledge to deal with the discipline problems existing at this level. Plans need to be devised with the student’s involvement for the purpose of obtaining educational goals. Students are then able to learn how to meet their needs through choosing responsible behaviors. School can be viewed as a desirable place because of the power students are given in their class choices and with the establishment of school rules. Students’ involvement in any situation concerning their well-being is the key to success.

A fourth grade student who came to my office recently said, “I need a plan real bad.” That is the biggest indicator to me that reality therapy is definitely needed and used.

Control Theory has a potential function in every teaching situation: it eases the tensions that often exist between teachers and students. Students sometimes feel threatened because teachers constantly exercise or flaunt control. Much of the tension that exists in the classroom is created when students and/or teachers experience a loss of control. Teachers necessarily don’t want to lose control of their classrooms and students don’t want to feel that someone else has such extensive control of their lives. Control Theory seems to provide the solution to this conflict. By releasing some control and recognizing that students should have the responsibility for a number of choices, including their behavior and its consequences, teachers will, in fact, have more “controlled” classrooms. It’s really a question of logistics — students, accepting ownership of their actions and understanding the concept of the choice they make, feel more in control of their lives and invest a minimum of energy (if any) resisting the teacher who, in turn, is no longer intent on placing energy into controlling a classroom which is more in control of itself.

Control Theory maintains that we each choose our behaviors to satisfy our needs, and that we also choose the consequences which result from our behavior choices. Two vital factors exist here for the educator: (1) Teachers must get a “handle” on student interests and needs and address them specifically. If a teacher can give a kid an opportunity to satisfy a picture in the kid’s head of what he/she really wants, the kid will likely choose appropriate behavior. (2) In Control Theory, there is no punishment (penalties exacted and controlled by the teacher, denying student control and creating frustration); instead, there are known consequences chosen by students when choosing unacceptable behavior.

It is helpful for educators to use some basic dialogue which will become familiar to students and which can be clarified verbally and through ensuing actions. The following dialogue is one which occurred between a teacher and one of the teenage students with whom warm involvement had been established. Recently, he has been getting into fights at school and has been arrested for the assault of a school security guard.

T- Tell me what you picture when you think of what you really want.
S- The picture in my mind is being “fresh” — rapping and breaking and nobody messing with me.
T- What you’re doing — getting into so many fights — helping you get what you want — that rep as a fresh dude?
S- Nah, but there’s nothing I can do about it. I gotta fight to survive.
T- You mean you have decided to choose to fight.
in affluent middle-class suburbs and urban populations consistently and often certain that it wouldn't have gone as well without CT and RT. 

Even when a situation doesn't work out as anticipated, I'm dependably. Control Theory and Reality Therapy have assisted me in teaching and teachers alike. My own teaching experiences document these claims. 

Education includes a vital ingredient in education, the role of which can't be overstated: humor. Laughing together has magical effects on teacher/student relationships. In order to enhance appreciation of this story, consider the following:

1. Many of my students are delinquent in bringing in homework assignments and some will even choose not to take a test. Students (Special Education high school urban population) and teacher together discussed possible consequences and it was agreed that in choosing to do nothing, they would choose to receive nothing or a “O” or F, its equivalent in the school’s grading system. 

2. Offensive cursing was a problem we worked hard to negotiate; one of our compromises was to accept the letter “F” in lieu of F—. This may be offensive to some readers and educators, but it seemed fine to us for starters.

I encouraged two of my students one morning, “Please choose to take the test. You will get credit for trying, but, as you know, the chosen consequence for doing nothing will be a zero or F.” They chose to do nothing. I rose to get my grade book. In answer to one student’s query, “Where is Mrs. P. going?” another spontaneously replied, “I bet she’s getting her grade book. She’s choosing to “F” it up!” How we all laughed together! For me, the reasons for my laughter and pleasure were multifold but it seemed fine to us for starters.

Students are also aware of the techniques of Reality Therapy of which Control Therapy is an integral part. Each concept lends itself to the implementation of the other. As students realize that they have choices to make, teachers may have already established involvement, but there is always room for improving quality involvement. Then, all of the steps of Reality Therapy come into play as teachers question students about what they really want, making certain that value judgments belong to the students. Plan making, follow-ups, reasonable consequences, accepting no excuses, and never giving up all have their necessary places. As students and teachers become increasingly creative in behavior choices and with a decrease emphasis on punishment, more energies and time will be diverted to valuable academic and artistic endeavors. Taking effective control of their lives will invariably enable education to be more need-fulfilling for students and teachers alike. My own teaching experiences document these claims. Control Theory and Reality Therapy have assisted me in teaching elementary and secondary Special Education and heterogeneous classrooms in affluent middle-class suburbs and urban populations consistenly and dependably. Even when a situation doesn’t work out as anticipated, I’m often certain that it wouldn’t have gone as well without CT and RT.

On several occasions, students on the verge of a physical confrontation displayed such a marked hesitation in their actions that I observed them practically thinking aloud, struggling to choose the appropriate behavior. Though it took only moments, it seemed that they’d run through their heads something like this: “Nah, I don’t really want to choose a fight and the consequences” (all kinds of pies flashing) — then, the decided, positive step away from the fight and a choice to move in a better direction. More than once, my smiling support and my comment, “Great choice!” we met with an understanding grin, powerful eye contact, and a look of pride on the face of a kid knowing what it feels like to take control of his life.

Certain phrases and concepts are repeated on a daily basis by the teacher in relating to individual students as well as to the entire class. After previous and frequent exposure to the terminology of Control Theory, when he was in crisis, both the teacher and the student had tools, which both understood, available for common use. True, the student had not related to himself the idea that he was choosing to fight. However, he knew exactly where the teacher was coming from. Although he seemed exasperated at first, he had to concede that, according to classroom experience with Control Theory and its familiar concepts and dialogue, he was choosing the wrong behavior as well as the unpleasant consequences that resulted from this behavior, and that he was giving excuses, which are taboo. What he was doing (getting into fights) definitely wasn’t helping him to get what he wants (his freedom, control of his own life). His leading question “What else can I do?” was a telltale clue lighting the teacher’s way to guide him on the success pathway by inquiring, “What are some ways you could choose to do something that would help you get what you want?”

Plan making, follow-ups, reasonable consequences, accepting no excuses, and never giving up all have their necessary places. As students and teachers become increasingly creative in behavior choices and with a decrease emphasis on punishment, more energies and time will be diverted to valuable academic and artistic endeavors. Taking effective control of their lives will invariably enable education to be more need-fulfilling for students and teachers alike. My own teaching experiences document these claims. Control Theory and Reality Therapy have assisted me in teaching elementary and secondary Special Education and heterogeneous classrooms in affluent middle-class suburbs and urban populations consistenly and dependably. Even when a situation doesn’t work out as anticipated, I’m often certain that it wouldn’t have gone as well without CT and RT.
THE USE OF REALITY THERAPY WITH BATTERED WOMEN IN DOMESTIC VIOLENCE SHELTERS
Vicky Whipple

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Wife abuse has existed throughout history, although it has only been in the last decade that it has been given recognition as a major problem in American society. Some studies estimate that as many as one out of every two marriages in this country experience at least one episode of violence. Derschner (1984) and others cite 2.3% as the percentage of the married population that engages in severe wifebeating.

In this article, the terms “battered wife/woman” or “abused wife/woman” are interchangeable. They refer to any relationship in which a woman is abused by a male partner, whether or not they are married. The level of abuse may range from slapping, shoving, and throwing objects, to brutal beatings, choking, and life-threatening situations.

Understanding the characteristics and needs of the battered woman is central to any effective counseling approach. Davidson (1978) paints this picture:

The victims may exemplify society's old image of ideal womanhood — submissive, religious, nonassertive, accepting of whatever the husband's life brings. They may be anxious about housekeeping and develop devotion to the home and family to the exclusion of outside friends and interests. The husband comes first for these women who perceive themselves as having little control over many areas of their own lives . . . They become numb, resigned, incapable of independent thinking . . . The wifebeater's wife seldom has access to money, even if sometimes she herself has a job . . . The husband controls the purse strings and demands an accounting of any unfamiliar expense.

Accordiing to Reality Therapy (Thatcher and Wubbolding, 1982), people have four basic needs: belonging, recognition, fun, and freedom/control. It is their behavior, which is either responsible or irresponsible, that results in the fulfillment or lack of fulfillment of these needs.

The battered woman lacks all four of these basic needs. Her need to be loved is not satisfied; she is beaten by the same person who claims to love her. The tender moments of sorrow and forgiveness that often follow a battering incident keep her involved in the relationship because they are the only glimpses of “love” that she has. Walker (1979) states that:

Even women who have long ago left a battering relationship will recollect with fondness the sincerity and love they felt during this period. The traditional notion that two people who love each other surmount overwhelming odds against them prevails. (pp. 67-68).

The battered woman feels anything but competent; she is repeatedly told by her abuser that she is worthless, that she is to blame for the abuse, and that she can’t do anything right or without him. Over a period of time she becomes “brainwashed”, a prisoner in her own home. As noted previously (Davidson, 1978), she feels a keen lack of control over her own life.

“Fun” is a rare experience for the battered woman. Just as workers in the area of child abuse often speak of the “frozen watchfulness” of an infant or child who is abused (Derschner, 1984), so the abused wife never knows what to expect and must constantly be on her guard. Though there are times when violence erupts from verbal arguments between the partners, there are other times when violence occurs with absolutely no provocation on the part of the wife. Her tendency to feel guilty if she does something for herself instead of being singly devoted to her family also contributes to her lack of “fun”.

Freedom is not even in the vocabulary of battered women. Their lives are controlled by their husbands. They are often kept isolated at home without a car and given no money - or only enough for food and necessities, and sometimes not even that. Abusive husbands have been known to check the mileage on the car to make sure the wife only goes where she says she is going; if she is one minute late she is accused of having an affair. The battered woman comes to feel helpless — like a caged animal waiting only for the next attack.

The eight steps of Reality Therapy are intended to assist clients to learn better ways to fulfill their needs. The use of Reality Therapy with battered women, therefore, will mean helping them to see that their current behavior is not meeting their needs, and then helping them to choose more effective behaviors. The following is a description of how Reality Therapy can be integrated into the therapy program of a domestic violence shelter.

**Step 1 - Making Friends.**

A woman who comes to a domestic violence shelter, either for emergency housing or counseling, is in a state of crisis. Shelter workers need to make every effort to help the battered client feel accepted and cared for. Showing her around the shelter and offering her a cup of coffee could be opening gestures of friendship. A facility that is clean, comfortable, and allows for privacy is also conducive to establishing a caring atmosphere.

In the counseling session itself, the battered woman can be asked to “tell her story” and given time to repeat the details of battering incidents. A supply of tissues and a comforting touch of the hand are a necessity at this stage of therapy. The client can be reassured that she is believed, that her feelings of anger and despair are normal, and that she doesn’t deserve the treatment she has received. This helps establish a sense of being cared for and understood, an important component of Reality Therapy. “Reality Therapy is a method of working with people through caring, from which comes the initial strength a person needs to change.” (Ford and Zorn, 1985)
In Control Theory terms, the client’s total perceptual error is reduced because the therapist helps meet the belonging need. (Glasser, 1984).

After she has had time to relate her story, it is appropriate to give her information about domestic violence so that she can see that her experiences are not unique but rather fit a pattern that many others have experienced. This also strengthens the bond of mutuality between client and therapist. She is assured that she has been “heard.”

It is not unusual for an abused wife, once she has described the abusive treatment she has received, to begin to feel guilty — either for having “exposed” her husband or for being so “stupid” that she has stayed in the relationship. At this point, the therapist can begin to help her rethink her interpretation of her situation and point out her strengths (Vey and Yukl, 1982). For example, rather than feeling she has betrayed her husband, she can view her asking for help as evidence that she loves him and wants to help him and their marriage. If she has stayed in the relationship a long time despite repeated incidents of violence, she can interpret that as the strength of loyalty, and that ability to make a strong commitment can now be used to help end the violence. The therapist can point out to her that it took a lot of courage to ask for help; that courage can now help her make other choices to better her life.

After establishing some mutuality in the counseling relationship and beginning to look at the client’s strengths, the therapist is ready to help the client to come to grips with the question: What do you want? She may be too confused at first to know what she wants. If she is in residence, a good night’s sleep and something to eat may be very practical ways of facilitating her thinking ability. Talking with other abused women and attending a support group may also help her come to a decision.

Shelters exist and provide services to battered women to help end the domestic violence cycle. When a woman is ready to identify that as her personal goal (she wants to do whatever is necessary to end the violence), therapy can proceed to the next step. If the woman does not identify ending the violence as her priority, but instead chooses to maintain the relationship at all costs, she may decide to terminate her relationship with shelter staff.

**Step 2 - What are you doing?**

During this stage, the therapist can ask the client what she has done in the past to end the abuse in her life. Each behavior or attempt to end the violence can then be discussed.

In may be difficult for the abused wife to understand that she indeed has made some type of response because her victimization has resulted in her feeling helpless. The therapist can help her identify her particular responses to episodes of violence, whether that involves crying, running out of the house, hiding in the bathroom, etc.

As the battered woman discusses her previous attempts to end the violence, the counselor can teach her that there is a cycle to violence (Walker, 1979; Derschner, 1984), that her past responses have not ended it, and that she must now try something different or the cycle will continue.

The counselor can also help the client realize how isolated she has become by asking her what friends she has and/or to whom she turns for help. Often the battered woman has no one she feels close to. Teaching her that isolation contributes to battering is important.

There may be a tendency at this stage for the wife to continue to vent her anger at her partner and complain about how she has been treated. The therapist must keep bringing her back to discussing her own behavior, acknowledging that her husband’s behavior has definitely been inappropriate, but that she has control over her own behavior. The therapist may need to spend time helping her understand the difference between what she is responsible for and what she is not responsible for, and that only by changing her own behavior, ie, her response to his violence, will she be able to end the violence.

**Step 3 - Evaluation**

Each attempt made by the woman to end abuse in her life can be evaluated: Did any of her actions accomplish the goal of ending the violence? Since she is seeking help from a domestic violence shelter, the answer most probably will be that nothing she has done has stopped it. It is important to evaluate why it didn’t work and then to try something different.

Examples of behaviors that might be considered follow:

- If the police were called, did she press charges? If she didn’t, maybe this time she should. If she did, did she later drop the charges? Maybe this time she should follow through and take him to court.
- If she stayed and did “nothing”, did that stop him from hitting her again? If not, what action can she consider now? (According to Control Theory, she could not do “nothing.” Did she depress? Did she hide in her room? Did she cry?)
- If she stayed and tried to talk to him about the abuse, did talking and listening to his apologies stop it from happening again? If not, what else is she willing to consider doing?
- If she left, went to a friend’s overnight, and then returned, did the abuse stop permanently or only temporarily? Would staying away longer be more effective?
- If she obtained an Order of Protection, did she use it? If she used it for awhile and then didn’t, did that stop the violence? Can she agree to enforce her Order of Protection this time and not give in to him again?

The purpose in evaluating all these attempts to end violence is to enable her to see that, although she is not responsible for the abuse directed at her, she has helped perpetuate the violence, and that she can now change her behavioral response so that the violence will come to an end. She is not a helpless victim but indeed has control over her life.

**Stage 4 - Plan**

Before a specific plan can be agreed upon, the battered woman has to make a decision about how she wants to respond to the most recent episode of violence: Does she want to file for divorce? Does she want to get an Order of Protection? Does she want to live apart from him temporarily? Does she want to return home?

The counselor and client together can then write up a plan that is realistic and immediate, based on her over-all goal. For example, if she
wants to return home, are there “conditions” that she wants to write down and discuss with him? If he violates those conditions, what will she do?

An example of a simple, specific, and time limited plan would include the following:

Over-all Goal: to live apart from husband for six months and pursue counseling.

Sample Plan:
1. Obtain an Order of Protection
   Appointment made for 1:00 p.m. Thursday
2. After Order of Protection is issued and husband moves out of the house, move back home. Enforce the Order of Protection if necessary (i.e. call the police if he harasses in any way).
3. Attend weekly support group at shelter for personal encouragement.
4. Request that husband participate in marital counseling. If he agrees, make an appointment; if he does not, inform him that there is no hope of reconciliation until he is willing to attend and changes are made.

Stage 5 - Commitment
The client helped draw up the plan which should be written down for future reference by shelter staff and to clarify the plan in the woman’s mind. A commitment to follow through can be indicated by a signature on the written plan. Since the plan is clearly spelled out, the client knows exactly what she must do. While she is making a commitment with the therapist, she is really making a commitment to herself, to take control of her life rather than letting her husband’s abusive behavior control her.

Stage 6 - No Excuses
When the client reports back to the counselor, her progress is checked. If she has completed the plan, new goals can be set for the next day or the next week. If she has not followed through, the counselor can discuss the situation with her to determine if the goals were agreeable but the plan was not workable, or if the goals themselves need to be changed. For example, a client may have felt that she was “expected” to file for divorce, but then couldn’t bring herself to talk to a lawyer. In this case, the goal would need to be rewritten to validate the client’s feelings and desires to maintain her relationship. In other situations, the goal may stay the same but the plan would be changed.

Since the battered woman is used to being controlled by someone else and has come to feel helpless about herself and her circumstances, it is important that she have the experience of making choices. It is equally important that excuses not be accepted for failure to follow an agreed-upon plan. Reevaluating a plan can, if necessary, reinforce her sense of control over her own life. In Control Theory terms, not accepting excuses validates the fact that she can control her own behavior, even though she cannot control her husband’s.

Step 7 - Don’t punish
One of the most disheartening factors for therapists working with battered women is the high percentage of these women who return to batterers without having done something to effectively end the cycle of violence going on in the relationship. It is important that shelter staff allow a woman to make that choice, however, and learn for herself that his promises are meaningless if he is unwilling to get outside help. Since criticism is destructive and denies others the freedom to take responsibility for their own lives (Ford, 1983), it must be avoided, especially when the woman has to make a return trip to the shelter.

It is equally important, however, for the shelter to have guidelines about readmission of clients so that the battered woman knows what she will face if she returns to the batterer but then needs refuge again. Help is available to enable her to end abuse — but she must also face the consequences of her choices.

Step 8 — Don’t give up
Over a period of time, a woman who once felt weak, helpless and powerless can grow to become a strong, assertive person. Each therapeutic contact with a battered woman lends itself to that growth process. Knowing that someone cares and that there is help available may be the very thing that enables her to finally break away from a relationship that is destroying her. In Control Theory terms, if a battered woman finds acceptance from and feels cared for by her therapist, a large part of her total error can be reduced, enabling her to think more clearly about how to change her behavior.

In summary, Reality Therapy can very easily be introduced into the therapeutic work of domestic violence shelters and can be effective in empowering a battered woman to take more effective control of her life.

BIBLIOGRAPHY
CHARACTERISTICS OF THE INNER PICTURE ALBUM

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It is a fundamental principle in Reality Therapy that human beings are internally motivated by basic human needs. Glasser (1965) identified love and self-worth as basic motivations of human behavior. These internal drives lead to behavior which results in a success identity or a failure identity (Glasser, 1972). More recently the basic motivators of human behavior have been described as: Belonging, Power (Recognition, etc.), Fun, and Freedom (Glasser, 1981, 1984).

As Glasser frequently states, human beings do not fulfill their needs directly, but rather they are met through the inner world of wants (the picture album), the behavioral system which maneuvers the world, and the perceptual system (sensory camera) which filters the images of the world.

In the practical application of Reality Therapy, it is essential to explore the client’s picture album since it is the more proximate source of all motivation and affects human behavior. Similarly, in teaching Control Theory, it is useful to teach the characteristics of the album as a refinement of the component of step I “What do you want?” It is then easier for the practitioner of Reality Therapy to incorporate Control Theory into the Steps of Reality Therapy.

Described below are nine characteristics of the inner picture album or world of wants. Some of these have been described by Glasser (1984). Others result from the observations of other practitioners of Reality Therapy.

1. All pictures are need-fulfilling.
   Some people have the picture of sky-diving as an activity that provides fun. For others, sky-diving is the last activity which is seen as need fulfilling. But whatever pictures a person chooses to insert into the album, he/she does this because the picture (want, desire) satisfies a need in some way.

2. Pictures are related to each sense.
   We have wants related to touch, taste, smell, sight, and hearing. For instance, in the play Amadeus (1978), the jealous and vicious Salieri has a high need for power. At first, he sees his own mediocre musical compositions as superior to those of Mozart. When he listens to his own music he hears a beautiful melody because it is need fulfilling. His desire is that others, especially the king, possess similar picture albums so that his own power, status, influence and fame would be enhanced.

   Likewise, in the picture album are wants related to tastes that are sweet, smells that are fragrant, and tactile “wants” related to surfaces that are warm and soft, etc.

3. Pictures are removable.
   Since a picture is synonymous with a “want”, it is not the same as a memory which, though removable, is more difficult to extinguish than wants. It is not an uncommon experience, for instance, to have had a relationship and to have removed the person from the album while retaining the memory. The person is thus remembered but is not regarded as desired or need fulfilling. In other words, the picture, not the memory, has been removed from the album. Consequently, it is clear that pictures are changeable. In fact, one of the goals of counseling with some clients is to help them change their wants. This is, of course, in many cases, not an easy task to accomplish. They can be asked, however, if they wish to remove the picture, “put it in the back of the album” as Glasser frequently says, or even remove it completely and “bury it in the backyard”.

4. Some pictures are realistic and some are unrealistic.
   Frequently adolescent clients have a burning desire to “get my parents off my back.” A parent sometimes wishes the child would act the way he did before he became a teenager.” A spouse often seeks to remake the partner according to his/her own pictures. These “unrealistic” or unattainable wants are not abnormal or unhealthy, and so experienced counselors do not reject, out of hand, the unrealistic pictures of the client. Rather they recognize that everyone has at least some unrealistic wants. With odds 5 million to 1, even Reality Therapists buy lottery tickets.

   Consequently, the client is helped through the skillful use of the third step of Reality Therapy to evaluate whether all of, part of, or none of the pictures can be fulfilled.

5. Pictures are specific and unique.
   We want to wear specific clothes, eat a specific food, relate to specific people, achieve in a specific way on the job, enjoy life in ways that are unique to each of us. Needs are common motivators and are common to all human beings. But picture albums differ. Witness, for example, the wide variety of clothes worn by people in an airport, or shopping center. Rarely does anyone wear the exact same outfit as someone else. Obviously, no two people in the world have the exact same album. And yet there is commonality among picture albums. Society is able to function because of common wants.

6. Pictures can be blurred.
   Because pictures are specific, it should not be concluded that they are always clear and precise. Some people have not defined all of their pictures. This is evident from the results of interest inventories given to junior high school students. Frequently, their interests are vague and imprecise. They often define their pictures about careers and other interests as they move into and/or through secondary school.

   Another example illustrates this point. A shopper goes to the shopping center. The desire is for shoes, not for an automobile, a boat, or a raincoat. The precise picture of this or that pair of shoes is not yet defined. It becomes clear only after trying on a few pairs of shoes, i.e. after “behaving” in relation to the shoes and “perceiving” them. Thus a clarity-
continuum of pictures can be identified: from “crystal clear” to “very blurred.”

7. Pictures exist in priority.

Some wants are more important than others. At meal time, a person wants food. But to eat peas rather than carrots might be a low priority. It is helpful to consciously determine whether a want is a “burning desire” or a “weak whim.” Part of the first step of Reality Therapy is to help the client sort out the pictures in the album and to put them in categories of “burning desire”, “strong desire”, “moderately desired”, or “weak whim”.

8. Pictures can be in conflict with one another.

To want a fish dinner excludes a meat dinner unless, of course, a compromise can be worked out. Yet many people agonize over even such a simple decision to the point of asking the waitress to decide for them. Similarly, new pictures can conflict with old ones. Because of this phenomenon, people are motivated to mold the external world to match their ever changing inner world. Thus they change jobs, buy new clothes, form new relations, etc.

9. Pictures can be in conflict with the pictures of other people.

Having one’s own conflicting pictures is relatively minor compared with the implications of the conflict between the pictures of one person and the pictures of another person, group, race, culture, and nation. The divergence and conflict among billions of picture albums makes life interesting, exciting, thrilling, as well as painful, threatening, and dangerous. Horse races exist because one person wants “Fleet Feet” to win and another bets on “Fast Lass”. Many want to merely watch others skydive and find it exciting to watch sky-divers fulfill their intense desire for the real thing. Groups, cultures, and nations are formed because of commonality in wants. They even impose their wants on other groups, cultures, and nations. To remove conflict from among picture albums would be to remove most of the pages from the history books.

The importance of the picture album in practicing Reality Therapy and teaching Control Theory can hardly be overemphasized. In addition to the general needs, the picture album and the frustrations, (the gaps between what we have and what we want at a given moment) are the sources of all human motivation. Because of wants, we generate the billions of behaviors that occur each day on the planet Earth. It is the problems and decisions originating in human picture albums that are the raison d’etre of counselors and the counseling profession. It is thus evident that if therapists are to help their clients live more effectively, they must help them sort out and define in precise ways this exciting inner world which, linked to the need system, is the source of all human motivation.

BIBLIOGRAPHY


HELPING CLIENTS ASSESS AND EVALUATE THEIR NEEDS

Linda Geronilla, Ph.D.

Dr. Geronilla is a certified reality therapist who is the director of Reality Counseling for Nutrition in Charleston, West. Va.

The assessment of client needs is the first step in the formation of therapeutic goals. This assessment is used to:

1) Help clients identify and evaluate their needs in order to make better decisions to fulfill their needs, and
2) Help clients communicate their needs to others in order to live and work together more effectively.

Clients see the world in many different ways, based upon their own learning, values, attitudes, thinking, inferences and interpretations. Therefore, therapists need a variety of practical and accessible methods to augment and expand their assessment strategies. In order to help clients make the assessment process more effective and efficient, I have developed several assessment handouts.

Evaluation of My Psychological Needs Using RT (Form A)

This handout can be used as both a method to help clients in the initial assessment and as a subjective way of evaluating the effects of therapy at termination. I ask clients to evaluate their needs in the form of a grading scale based on frustration signals. This form can also be used when lecturing with a large audience.

Evaluating My Roles Using RT (Form B)

I ask clients to circle their major roles and then to specify for whom or what they do. I then ask them to evaluate their needs by placing a check mark in the appropriate column. Physical and spiritual needs were added to the psychological needs to make a more wholistic approach. I also ask clients to estimate the hours they spend in a week in the various roles and to choose the most important roles. This form has been used with clients who have trouble managing time or who have a tendency to be overly altruistic and neglect personal needs.

Sometimes clients have trouble evaluating what they want most. In order to accomplish this, an additional step can be added. Have the clients take their eight major roles and place them on another piece of paper which has been divided into eight parts. Now, divide the parts and place them in front of the client. Tell them that they have a dilemma or conflict in their life and they can not have all eight of their roles. They must choose among them and remove one of their roles. Have them continue removing one role at a time until only one is left. This can make value judgments crystal clear.

30

31
### FORM A

**EVALUATION OF MY PSYCHOLOGICAL NEEDS USING REALITY THERAPY**

<table>
<thead>
<tr>
<th>LOWE</th>
<th>Do I have relationships which meet my needs for affection, attention, sharing, cooperation, giving, taking, etc.?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spouse  A B C D E</td>
</tr>
<tr>
<td></td>
<td>Children  A B C D E</td>
</tr>
<tr>
<td></td>
<td>Father  A B C D E</td>
</tr>
<tr>
<td></td>
<td>Sister  A B C D E</td>
</tr>
<tr>
<td></td>
<td>Brother  A B C D E</td>
</tr>
<tr>
<td></td>
<td>Friends  A B C D E</td>
</tr>
</tbody>
</table>

**BELONGING**

List organizations, clubs, or groups in which I feel affection, inclusion, and some belonging

| Work  A B C D E |

**RECOGNITION**

Do I receive enough recognition or appreciation from others?

| Boss  A B C D E |
| Co-worker  A B C D E |
| Spouse  A B C D E |
| Children  A B C D E |
| Parents  A B C D E |
| Friends  A B C D E |

**WORTH**

Do I feel good about my own self-esteem or worth?

| A B C D E |
| Do I appreciate my good qualities and stroke myself for a job well done?

List several qualities I like about myself or things that I do well at:

**FUN**

Do I have enough fun?

| Activity  A B C D E |
| Frequency  A B C D E |
| Self/Others  A B C D E |

**FREEDOM**

Do I control my own life (or let others)?

| A B C D E |
| Am I able to do what I want without feeling controlled?

| A B C D E |
| Am I free to express myself without being criticized?

| A B C D E |
| Do I spend my time the way I want?

| A B C D E |
| Do I spend my money the way I want? |

Linda Geronilla, Ph.D. 1985

### FORM B

**EVALUATING MY ROLES USING REALITY THERAPY**

<table>
<thead>
<tr>
<th>ROLE</th>
<th>Specify the Role. Check the needs which get fulfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daughter/Son</td>
<td></td>
</tr>
<tr>
<td>Sister/Brother</td>
<td></td>
</tr>
<tr>
<td>Cousin</td>
<td></td>
</tr>
<tr>
<td>Wife/Husband</td>
<td></td>
</tr>
<tr>
<td>Lover</td>
<td></td>
</tr>
<tr>
<td>Law</td>
<td></td>
</tr>
<tr>
<td>Mother/Father</td>
<td></td>
</tr>
<tr>
<td>Aunt/Uncle</td>
<td></td>
</tr>
<tr>
<td>Grandparent</td>
<td></td>
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<tr>
<td>Godparent</td>
<td></td>
</tr>
<tr>
<td>Friend</td>
<td></td>
</tr>
<tr>
<td>Neighbor</td>
<td></td>
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<tr>
<td>Member/Leader</td>
<td></td>
</tr>
<tr>
<td>Club, Group, Organizations</td>
<td></td>
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<tr>
<td>Church Member, Worker, Leader</td>
<td></td>
</tr>
<tr>
<td>Volunteer</td>
<td></td>
</tr>
<tr>
<td>Boss/Worker</td>
<td></td>
</tr>
<tr>
<td>Student/Learner</td>
<td></td>
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<tr>
<td>Homemaker</td>
<td></td>
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<tr>
<td>Housekeeper/Cook</td>
<td></td>
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<tr>
<td>Gardener/Mower</td>
<td></td>
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<tr>
<td>Driver/Chauffeur</td>
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<td>Shopper</td>
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<tr>
<td>Sporter</td>
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<tr>
<td>Hobbier</td>
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<tr>
<td>TV Watcher</td>
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<tr>
<td>Exerciser</td>
<td></td>
</tr>
<tr>
<td>Relaxer</td>
<td></td>
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<tr>
<td>Dieter/Eater</td>
<td></td>
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</tbody>
</table>

### What Do I Want in My Picture Album (Form C)

I use this form with more creative, imaginative or idealistic clients to evaluate and prioritize their needs. This form can be used in two ways: 1) to evaluate their current picture album, or 2) to ask them what they want their picture album to look like. Clients can either do it on the same sheet using a different colored pen or on a separate piece of paper.

### Planning Life Changes Using Reality Therapy (Form D)

This form can be used with clients who are in transition. This has worked well with clients who have developed a physical illness or disability (heart attack, stroke, amputee), clients facing a stress (moving or a loss of income), or clients entering a new developmental stage (parenthood, retirement, death).
FORM C

NAME ___________________________ DATE __________

WHAT DO I WANT IN MY PICTURE ALBUM

Reality Therapy believes that there are four things which are essential for a person to feel good or have a successful identity. They are love and belonging, worth and recognition (self-esteem), fun, and freedom.

Place the roles, persons, clubs, groups, organizations, activities, places or things which help you fulfill these needs in the appropriate square. Place those closer to the center block which are the most important in fulfilling that need.

<table>
<thead>
<tr>
<th>LOVE / BELONGING</th>
<th>WORTH / RECOGNITION (ESTEEM)</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>FUN</th>
<th>FREEDOM</th>
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</table>

In order to understand the needs of RT, clients are first asked to start with their prior needs fulfillment, and then asked to generate new ways of meeting their needs. This procedure stresses the idea of building upon strengths and developing new flexible behaviors.

FORM D

NAME ___________________________ AGE ___________ SEX _______ DATE ___________ STAGE/CRISES _______

PLANNING LIFE CHANGES USING REALITY THERAPY (FOR NEW DEVELOPMENTAL STAGES OR CRISIS)

Life is like a beach colony. One damn thing after another.

<table>
<thead>
<tr>
<th>PSYCHOLOGICAL NEEDS</th>
<th>HOW MY NEEDS WERE MET</th>
<th>HOW MY NEEDS CAN BE MET</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOVE</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td>BELONGING</td>
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<td>WORTH</td>
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<tr>
<td>RECOGNITION</td>
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<td>FUN</td>
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<td>FREEDOM</td>
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</tbody>
</table>

This form can be used both with the client and the client's family. The family can be asked to project what the client would say. This has been very helpful for family members who are overprotective and infringe on the client's freedom needs. The golden rule for freedom is "Do only what they can not do for themselves — and no more."

After both client and family have filled out the form, they get together and discuss it. It is an excellent vehicle to aid in the communication of frustration signals.

Summary

Reality Therapists can expand their vision to assimilate new views and alternative ways in assessing their clients' needs. This will help them enlarge their picture album of strategies of ways to help their clients. The ultimate result of these assessment forms is to make Reality Therapy more effective and efficient by teaching clients how to understand and evaluate their needs.
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