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Fall 1986

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This issue marks the beginning of the sixth year of publication for the Journal of Reality Therapy. Readers will note that the cover has been redesigned to provide a more professional appearance. This reflects the continued growth of the Journal. This issue also marks the completion of terms for three members of the editorial board — Peter Appel, D. Suzanne Chapman, and Donna Evans. Each has served well for the past three years. At the same time, I am happy to welcome Robert Hoglund to the editorial board. Bob is a board member of the Institute for Reality Therapy, and a faculty member of the Institute. He has a master’s degree from Arizona State University, and is President and Founder of Reality Therapy Consultants, Inc. based in Tempe, Arizona. There are three vacancies on the editorial board as of January 1st. Of particular interest would be applicants from the Northwest, Mid-America, Sunbelt and Southwest regions to maintain geographical balance on the board. Applicants must be knowledgeable about Control theory and its applications. Please submit resumes to the editor.

There is a growing belief among criminologists that psychotherapy is an ineffective method for rehabilitating the offender. As evidence of this growing belief, consider the following statements made by several respected authorities in the field. According to Jeffery (1977, p. 136): “The application of psychotherapy to the rehabilitation of criminals and delinquents has not been successful.” Eysenck (1963, p. 235, 241) similarly asserts that psychoanalysis is non-scientific and that “psychoanalytic conclusions are based on unreliable data.” Berelson and Steiner (1964, p. 287) state, “There is no conclusive evidence that psychotherapy is more effective than general medical counseling or advice in treating neurosis or psychosis. Strictly speaking, it cannot even be considered established that psychotherapy, on the average, improves a patient’s chances of recovery beyond what they would be without any formal therapy whatsoever.”

Based upon these conclusions and others, the criminal justice system is moving away from the rehabilitative ideal toward an ideological position which advocates punishment as the “just desert” for committing crime. Jeffery (1977, p. 24) points out that the advocates for this new ideological position call for a “return to the death penalty, mandatory sentences for felonies, abolition or severe limitation of probation and parole, and other measures which emphasize the use of punishment and retribution as a crime control model.”

A major problem with this control model is that punishment does not work. In his review of experimental evidence on the effects of punishment, Jeffery (1977, pp. 274-285) finds that the effects of punishment on human beings can be devastating. Jeffery cites the following effects: operant aggressiveness, which is a form of violent behavior aimed at those who punish (the criminal justice system); complete withdrawal from reality, a state which Seligman (1975) calls “learned helplessness”; escape and avoidance responses; and the destruction of social relationships. In his concluding remarks on punishment, Jeffery asserts, “Punishment creates aggression and violence; rather than controlling violence in our society, the criminal justice system encourages and promotes violence with violence.”

It is evident that there is a need to continue searching for innovative, humane, and effective ways to alter human behavior. It is time to abandon certain forms of psychotherapy that have proven ineffective. There is an equal need to avoid treating offenders cruelly, for this too is ineffective. The State of Florida has implemented a method of changing the behavior of institutionalized juvenile offenders, Reality Therapy (Glasser, 1965). According to a Florida Department of Health and Rehabilitative Services
Many studies provide evidence that locus of control orientation, a theoretical construct developed by Julian B. Rotter, is related to both responsible and irresponsible behavior. According to Rotter (1966), people acquire generalized expectancies based on perceiving reinforcing events which are either dependent upon one’s own behavior or are beyond one’s control. Rotter (1966, p. 1) continues: “When a reinforcement is perceived by the subject as following some action of his own but not being entirely contingent upon his action, then, in our culture, it is typically perceived as the result of luck, chance, fate, as under the control of powerful others, or as unpredictable because of the great complexity of the forces surrounding him. When the event is interpreted in this way by an individual, we have labeled this a belief in external control. If the person perceives that the event is contingent upon his own behavior or his relatively permanent characteristics, we have termed this a belief in internal control.”

Individuals with an internal locus of control orientation have been found to engage in socially responsible behavior, and in Glasser’s terms, are mentally strong. Conversely, individuals with an external locus of control orientation are typically not fulfilling their needs in a socially responsible manner. Brannon (1977, p. 44), in his review of the literature, finds that “internally controlled children have been found to spend more time in and strive harder to accomplish intellectual tasks than externals, and to achieve higher grades and test scores. Such individuals also tend to display higher academic achievement, aspirations and expectations than their externally controlled counterparts. Finally, internally controlled individuals have also been found to be less easily swayed by environmental forces and to more readily accept the results of such actions, whether the results are positive or negative, than externally controlled individuals.”

Juvenile delinquents are an example of a group of individuals not meeting their needs in a responsible manner. Most research (Beck & Ollendick, 1976; Cole & Kumchy, 1981; Duke & Fenhagan, 1975; Elenewski, 1974; Groh, 1976; Keefe, 1977; Kendall, Finch, Little, Chiricos, & Ollendick, 1978; LeBlanc & Tolor, 1972; Lefcourt & Ludwig, 1965; Maquoid, 1980; Martin, 1975; Petti & Davidman, 1981; and Pomerantz, 1978) links an external locus of control with crime and delinquency. Yet, virtually all of these studies suffer from methodological difficulties that place their findings somewhat in doubt.

Early in the history of the locus of control construct, Lefcourt et al (1966, p. 191) proposed the viability of the role of psychotherapy upon modification of locus of control orientation. Recognition of this goal was based on the premises that “…an internal locus of control may be one prerequisite for competent behavior, and an external-control orientation seems common to many people who do not function in a competent, ‘healthy’ manner.” Since that statement was made, there has been a plethora of attempts to alter the locus of control of juvenile delinquents and adult offenders using a wide range of psychotherapeutic techniques.

An evaluation of these approaches indicates a mixed success pattern with some treatment modalities leading to a more internal orientation, others producing no significant change at all, and others leading to a greater external orientation. Three examples (Eitzen, 1974; Kilmann, 1974; and Postlewaite, 1975) of such efforts may prove useful.

Eitzen (1974) in a study of twenty-one juvenile delinquents who were in “Achievement Place”, a community-based home where a token economy was used to teach “… the social skills important to be successful participants in the community,” found that the juvenile delinquents developed a more internal orientation at the end of the program as compared to when they first entered.

Postlewaite (1975) studied the effects of a twice weekly ten week Human Relations Workshop which consisted of having delinquent girls at a residential treatment center interact with each other in new ways, reflect upon themselves and their experiences, and focus on problem areas and needs. The subjects were matched in terms of age, race, IQ, grade level, average grades, and length of time in placement, and were then randomly assigned to the experimental and control groups. The Rotter Internal-External Locus of Control (I-E) Scale was applied three times: one week before, one week after, and six weeks after the workshop. No significant differences in locus of control were reported, although workshop “… participants showed trends toward significant increases in their feelings of personal control at the end of treatment and at follow-up.”

Finally, Kilmann (1974) tested the effectiveness of “direct” and “non-direct” marathon group therapy on a group of eighty-four volunteer female narcotic addicts in residence at a half-way house. The marathon lasted twenty-three hours. In the “direct” group the therapist took a highly active role and considerable responsibility for the therapeutic process. In the “non-direct” group the therapist relinquished the major responsibility for carrying out the therapeutic process to the addicts. There was also a non-treatment control group. There were no significant changes in the experimental groups, but the control group became more external.

Purpose of the Study

The main purpose of this study was to determine whether Reality Therapy is capable of bringing about perceptual changes among juveniles who have been adjudicated delinquent. Specifically, this study examines whether youths committed to a residential treatment facility developed a belief that they are responsible for their own behavior or, in other words, whether they have become internally oriented.

METHODOLOGY

Sample

The treatment group consisted of sixty consecutive admissions to the residential treatment facility. All of these juveniles had been adjudicated delinquent, usually for a felony property offense. Most of them had been previously adjudicated delinquent. They were judged to be poor candidates
for the less restrictive halfway house program, but their problems were not considered serious enough to warrant commitment to a training school or passage into the adult youthful offender program. The juveniles are male adolescents, ages twelve to sixteen years. In the following report, youths involved in this program will be referred to as treatment subjects.

The Setting
The treatment facility is a state-run residential center with a capacity for twenty-eight male residents. These residents are involved in an intensive responsibility-bound treatment program geared toward helping them lead more socially acceptable and responsible lives. The major emphasis of the program is placed on helping the treatment subjects obtain the necessary skills of coping with and working through an understanding of problem-solving techniques, achieving personal and social development, relating constructively with peers and adults, and accepting responsibility for their behavior. Two salient features of the treatment program are its alternative school program and the daily group Reality Therapy sessions.

Instrumentation
A major weakness of many empirical studies in Reality Therapy is their failure to state explicitly how and if they determined whether Reality Therapy was actually practiced in the research setting (Cook, 1972; Dakoske, 1977; Hawes, 1970; Mathews, 1972; Robert, 1971; Shearn & Randolph, 1978; and Watts, 1977). If the researcher does not attempt to determine whether Reality Therapy is actually being practiced, there is little reason to believe that any changes in the treatment group are caused by the effects of Reality Therapy.

In reaction to this research problem, this researcher developed a Reality Therapy evaluation scale. This scale was used to evaluate the four group leaders that conduct the Reality Therapy sessions at the treatment facility. In this scale, a ratio was developed which relates the number of appropriate to inappropriate statements for each Reality Therapy group leader. If a group leader had a score of eighty percent of better, he was considered to be conducting Reality Therapy.

The specific measure of locus of control utilized in this study is the Nowicki-Strickland Locus of Control Scale for Children (Nowicki & Strickland, 1973). This scale is considered one of the best measures of locus of control in children and has been shown to correlate significantly with Rotter’s adult scale and two other scales developed for children.

Procedure
Each treatment subject was administered the locus of control scale during his first and last week in the facility.

There was a minor problem with collecting group Reality Therapy data, since the treatment population was separated into four groups for purposes of doing group therapy. A subject was assigned to a group that had an opening when he first entered the treatment facility. This means that all groups were composed of subjects with varying degrees of experience with the group therapy process at the treatment facility. All the groups met at the same time in different areas of the treatment facility. As a result of the structure of the group therapy process, the groups were observed on a rotational basis. Each session was recorded because active analysis of the therapy session while it was in progress would have been distracting to the participants. A total of forty-seven sessions were observed and analyzed.

Demographic data were obtained by examining the records of the treatment center. When their records were incomplete, the necessary information was obtained directly from the treatment subjects.

Analysis of Data
An Analysis of Variance (ANOVA) was employed to analyze group Reality Therapy scores. A matched-pairs t-test was conducted for the purpose of comparing before and after locus of control scores. The above analyses were conducted by using SPSS programs (Nie, Hull, Jenkins, Steinbrenner & Bent, 1975).

RESULTS
Of the 60 treatment subjects who were initially tested, forty-five completed treatment and completed the follow-up locus of control scale. Of the fifteen subjects who did not fill out a post-treatment locus of control scale, one refused to do so and fourteen others were transferred to more secure facilities before completing treatment. An analysis of daily staff logs indicates that almost all of the transferred subjects displayed inappropriate behavior on a consistent basis. If one looks at the last inappropriate act committed, 8 of the 14 or 57.14% were runaways; one attacked another resident; one attacked a staff member; two were caught sniffing gasoline; and one was involved in breaking and entering. Clearly, the loss of this group is a threat to the generalizability of the findings of this study.

The average number of days a treatment subject was in the facility was 118.75. A subject who was transferred out of the program was in the facility 79.50 days on the average, and subjects who successfully completed treatment were at the facility for an average of 130.75 days.

ANOVA results indicate that all four group leaders were conducting Reality Therapy. There were no significant differences among group leaders in their ability to conduct Reality Therapy. The scores for the group leaders were 88.59%, 88.39%, 96.30%, and 85.39% (F3,3 = 1.66, p = .19).

The matched pairs t-test for the comparison group indicates no significant change in locus of control (Xpre-comparison = 9.31 vs Xpost-comparison = 8.80, t44 = .82, p = .21). However, the treatment group moved significantly toward an internal direction. (Xpre-treatment = 14.71 vs Xpost-treatment = 12.73, t44 = 3.27, p = .001).

Discussion
The results of this study indicate that those juvenile delinquents who participated in this study and completed treatment, perceived themselves before receiving treatment as being in a world in which they have little control over their destinies. One might assume that this assessment is, at
least in part, very realistic. These are juveniles caught in the web of the juvenile justice system. They are made painfully aware that they are entering a treatment facility in which they will be closely supervised and their time rigidly structured.

After concluding their stay in the treatment facility, treatment subjects, having received Reality Therapy, moved significantly in an internal direction. This finding is particularly significant in relation to Glasser’s current thinking. Glasser (1981, 1985) believes that one of the keys to successful treatment is to have the client reach a point at which he believes he controls his own fate and can choose to behave better. This point is illustrated in Glasser’s description of a client suffering from depression. He (1981, p. 159) states: “She complains about her depression as if it were an alien invader that has slipped into her head, and it will test my skill to get her to believe she is choosing this misery. I keep thinking if only I could teach her that this is a chosen behavior she might be more active in finding a better one. But she is passive and accepting that she is a victim, a feature of this behavior that makes it so ensnaring.” This study indicates that with Reality Therapy the residents of this treatment facility believe they have more control over their own fate.

Future research should examine the long-term significance of the findings of this study. It can very well be the case that long-term re-exposure of the experimental subjects to their natural environments may reverse the positive changes in locus of control orientation noted in this study. In addition, research is needed to determine whether these changes in locus of control orientation are related to changes in delinquent behavior. This study should be viewed as the beginning of a fruitful area of research linking the use of Reality Therapy to changes of locus of control orientation to subsequent changes in delinquent and other forms of irresponsible behavior.

*I would like to express my sincere appreciation for the helpful comments made by Dr. Alexander Bassin in the development of this paper.

References


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**INCREASING THE APPROPRIATE BEHAVIORS OF TWO THIRD GRADE STUDENTS WITH REALITY THERAPY: A PILOT STUDY.**

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As educators are pressed to fulfill the mandates of PL94-142, the number of youngsters referred for special services continues to rise. Yet, data presented by the *Sixth Annual Report to Congress on the Implementation of Public Law 94-142*, indicate that, “of the more than 93% (of all handicapped children) who are educated in regular schools, about two-thirds receive their education in the regular classroom with non-handicapped peers” (p.201). This regular class placement for identified milder handicapped children, along with problem behaviors of non-identified youngsters, has both special and regular educators actively searching for ways to reach youngsters who are difficult to teach and manage (Elardo & Elardo, 1976; Stainback & Stainback, 1980; Sulzer-Azaroff & Mayer, 1977; Whitman, Sciback, & Reid, 1983). One promising solution to the management of problem youngsters is the use of reality therapy.

While traditional nosological models focus on the past and search for causes, reality therapy, as developed by William Glasser (1965), emphasizes the individual’s present behavior and the satisfaction of specific needs to love and be loved and to feel worthwhile. Focusing on the three R’s, or reality, responsibility, and right-and-wrong, Glasser’s therapy “emphasizes the re-education of a person who learns how to behave in a more responsible and productive way” (Bassin, Bratter, & Rachin, 1976, p. 74). Therefore, the basic tenet of reality therapy is involvement, for both the individual and the therapist work to establish skills that improve the potential for individuals to fulfill their needs without depriving others of their needs.

Although the principles of this unconventional psychotherapy have been in existence since the 1950’s, empirically derived evidence of its successful application in educational settings has surfaced only sporadically throughout the 1970’s and early 1980’s (Atwell, 1982; Browning, 1979; Dakoske, 1977; Gang, 1975; Houston-Slowik, 1983; Jensen, 1972, 1973; Poppen, Thompson, Cates, & Gang, 1975). Attempts to incorporate reality therapy in the educational setting ranged from Jeness’ (1972, 1973) successful implementation in an entire school system to individual applications with selected male subjects from third, fourth, and fifth grade elementary programs (Dakoske, 1977; Gang, 1975; Poppen, Thompson, Cates, & Gang, 1975).

While the majority of the empirical evidence has supported the effectiveness of reality therapy in the school setting, some studies have found no significant changes in targeted behaviors through the use of these treatments.
principles (Omizo & Cubberly, 1983; Shearn & Randolph, 1978; Stowell, 1983; Welch & Dolly, 1980). For example, Shearn and Randolph's (1978) sophisticated attempt to measure the effectiveness of reality therapy against a placebo group found no significant changes in the self-concepts and on-task behaviors of targeted fourth graders. Stowell (1983) showed reality therapy had little effect on student achievement, interactions between the student and the teacher, and on task time.

Despite the isolated evidence of its ineffectiveness, reality therapy appears to be a viable tool not only for regular education settings, but for identified learning disabled or emotionally disturbed special populations as well (Borgers, 1980; Brown & Kingsley, 1975; Dolly & Page, 1981; Margolis & Muhlfelder, 1977; Shea, 1974). Changing attitudes about the social development of handicapped youngsters and the pressing issues of least restrictive environments suggest the need to pursue further research into non-intrusive types of management theories such as reality therapy.

In the present study, reality therapy techniques were implemented by a trained therapist in a regular classroom setting with targeted third grade students. The purpose of the research was to provide additional empirical evidence that reality therapy can increase the frequency of appropriate behaviors, namely, on task behaviors, interactions with peers, and interactions by the child with the classroom teacher. Due to the significance of the teachers' role within the classroom and within the perceived effectiveness of reality therapy, interaction by the teacher with the targeted youngsters was also observed.

METHOD

Subjects

Two third grade students, henceforth subject one and subject two, participated in the study. The subjects were selected on the basis of principal recommendation, teacher reports, and observation. Individually, a principal and one mainstream teacher selected six children who were having behavioral difficulties in a third grade mainstream classroom. Independent observers, unaware of the potential candidates, observed the mainstream classroom and selected five possible candidates for the study. All subjects identified by the observers were found on the principal and teacher list. Two subjects were then chosen from the aforementioned data.

Subject one was a nine-year old male who had been retained in the first grade; thus, the research year was his fifth year in school. An investigation of group achievement and intelligence test data revealed that he was below average in ability and in all achievement areas in the first grade. After retention in the first grade, his math scores increased but declined in subsequent testings as did all other areas. In pre-baseline observations, subject one exhibited a variety of off-task behaviors (e.g. daydreaming, doodling), negative interaction with peers (e.g. talking without permission, hitting other students, writing on other students' papers), and negative interaction with his classroom teacher (e.g. ignoring instructions, insolence). Over the course of the study, this student's records were being prepared for a special education eligibility decision.

Subject two was an eight-year old female. Initially above average in all achievement areas, she fell significantly below average during her second year of school. With the exception of intermittent hearing loss due to otitis media, her records were rather typical (i.e., no referral or placement in special classes). Subject two exhibited off-task behavior, negative interaction with her teacher, and particularly negative interactions with peers similar to those described for subject one.

Although not the major intent of the study, the teacher's behavior was measured as well. During pre-baseline observation, the investigators noted teacher behavior that appeared to foster inappropriate behavior in the target children. For example, the teacher would typically respond to a student's inappropriate behavior rather than praising him or her for a job well done or for on-task behavior. Thus, it was felt that the teacher would need to be included as an informal subject in the research, so that the relationship between student behavior and teacher behavior could be studied. It should be stated, however, that because teacher behavior was not the major focus, data were not collected in a formal manner (i.e., not observed and reported rigorously).

Setting

The study took place in a public elementary school serving families of a predominately lower to middle class socio-economic status. All sessions with the therapist took place either within the classroom setting or in the school cafeteria and were generally held during the lunch hour. Observations of the targeted subjects took place during the morning's instructional periods for reading and spelling.

Instrumentation

Prior to implementation of the study, an observational instrument was developed. During the initial observational phase, subjects exhibited mainly off-task behavior, negative peer behavior, and negative interaction with the teacher. These, along with others, became the major categories of the instrument. Although not a formal category, the classroom structure (e.g., individual activity, group activity, unstructured activity) was added for the purpose of ascertaining frequency of behavior during certain types of classroom situations. The observational instrument was field tested over the course of a month, during which time researchers refined categories of the instrument and collected interobserver data. The median percentage of agreement was 50 and the range was 40 to 68 at the beginning of the field test period and 60 to 88 at the end of the period.

Observational Procedures

Observers collected a five-minute sample for each of the target students on a daily basis. All on and off task behavior, positive and negative interaction with peers and teacher, and teacher behavior directed to the students were coded. Cued by an audiotape, researchers observed the target students for five seconds, after which behavioral information and classroom structure were recorded during another five-second period. To the extent that it was possible, subjects were observed for 60 ten-second intervals each day.
The observational instrument contained the following major categories:

**On Task.** The target child is engaged in required work appropriate to the assigned materials, and or the child is engaged in compliance with a teacher request. For example, the child is at his/her desk reading an assigned book or is setting out pencil and paper as requested by the teacher.

**Off Task.** The target child is not engaged in the task at hand. For example, the child is walking about the room while individual work is assigned or the child is looking about the room.

**Positive Interaction by Student with Peer.** The target child is interacting with his/her peer(s) in reference to an assigned task that does not violate specific classroom rules. For example, the child is working on an assigned group task with his/her peer(s) and is discussing the task.

**Negative Interaction by Student with Peer.** The target child interacts or attempts to interact with his/her peer(s) concerning non-task related activities, or interacts with his/her peer(s) in a manner that violates specific classroom rules. For example, target student talks to peer when assigned work has been given by the teacher.

**Positive Interaction by Student with Teacher.** The target student is initiating or attempts to interact with the teacher in a positive manner. For example, the child raises his/her hand in an attempt to seek assistance from the teacher or to give a response.

**Negative Interaction by Student with Teacher.** The target child initiates or attempts to initiate interaction in a negative manner. For example, the child, without raising his/her hand, blurts out a question toward the teacher or calls the teacher an inappropriate name.

**Positive Interaction by Teacher with Student.** The teacher initiates or attempts to interact with the target child in a positive manner. For example, the teacher calls on the child to answer a question and provides positive feedback for his/her attempt to respond.

**Negative Interaction by Teacher with Student.** The teacher initiates or attempts to initiate interaction in negative manner. For example, the teacher threatens or verbally reprimands the child when he/she is attempting to gain her attention in a positive fashion or the teacher calls on the child but fails to give positive feedback for a correct response.

**Interobserver Reliability.**

Harris and Lahey (1978) recommend a percentage agreement statistic that adjusts for chance agreement. As recommended, a statistic that includes weighted occurrence and nonoccurrence agreement information was employed. In the study, agreement was scored when two observers marked identical behaviors or when they did not mark a behavior in the same interval. Reliability checks were evenly spaced over the study and, to the degree that it was possible, carried out once a week for each subject.

**Experimental Design.**

The effects of reality therapy on selected behaviors of two third grade children were examined in a multiple baseline design over subjects. The design began with observations of baseline performance (i.e., behavior in the absence of treatment) of both subjects. In one school week, the baseline behaviors of subject one showed a stable trend and intervention, as previously described, was implemented. During this time, the baseline condition was continued for subject two. After stability was noted in the baseline rate of subject two (about two weeks into the study) interventions were initiated by the therapist. Baseline and intervention phases were conducted over six complete school weeks. With the exception of one week, observational data were collected for each day of the week. Subject one and subject two each received nineteen days of “reality” intervention. Due to the closing of the school year, follow-up data were not collected.
RESULTS

Interobserver Agreement

Over the course of the study the investigators noted that some student behaviors were infrequently occurring. The infrequent behaviors were positive interaction with peer, positive interaction with teacher, and negative interaction with teacher. Hence, at the conclusion of intervention, behavioral categories were merged. Positive peer and positive teacher behaviors were merged with on-task, while negative peer behavior became an off-task behavior. Interobserver agreement scores were, therefore, computed for the following three major categories: 1) on-task behavior, 2) off-task behavior and, 3) negative interaction with peers. Mean weighted agreement statistics were .82, .77, and .76, respectively.

Analysis of Student Behavior

The percentage of behaviors for subject one appear in Figure 1 above. During the baseline phase, behaviors fluctuated substantially over all categories. On the seventh day of the investigation, intervention was applied. With the onset of treatment, on-task behavior continued to fluctuate but began to rise, albeit fluctuant, on the 19th day. On-task behavior continued to rise over the intervention phase but had a dramatic drop on the 28th day. The mean percentage of scored intervals during baseline and intervention was 24% and 20%. Very little change was noted with respect to negative interaction with peers. The trend line had a steady fluctuation over the course of the study with a mean percentage of 10% during baseline and a slight decrease to 8% during treatment.

The percentage of on-task, off-task, and negative peer behaviors for subject two are presented in Figure 2 above. As shown, intervention was commenced on the tenth day of the study. The levels of on-task behavior decreased markedly during the baseline phase. With the application of treatment, initially low levels of behavior began to increase around the 19th day. The mean percentage of on-task behavior was 27% during baseline and 30% during intervention. Off-task behavior was rising when treatment was applied on day ten. Over the course of intervention, there was a steady decrease in levels of off-task behavior. Mean baseline and intervention percentages were 22% and 17%, respectively. Negative peer behavior had a fluctuating trend line, although the level of behavior did increase slightly during the intervention phase from 7% to 11%.

Because both subjects showed a fluctuating trend across behaviors, median scores were computed and are shown on Table 1. Subject one increased on-task performance from 15 during baseline to 28 during intervention. Off-task behavior decreased from 30 to 19. Subject two had...
Table 1: Mean percent of intervals and median scores are given for both baseline median values of 25 and 23 for on-task and off-task behaviors and intervention median values of 23 and 17, respectively.

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<td>12</td>
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Table 1: Mean percent of intervals and median scores are given for both subjects during baseline and intervention.

DISCUSSION

While this pilot study focused on the development of a process for monitoring the effects of reality therapy, data demonstrate the successful use of reality techniques in facilitating a positive change in the behaviors of two third grade students. Both subjects improved their rates of on-task behavior and decreased most of their negative behaviors during intervention. However, the positive changes exhibited by the subjects were not as substantial as the improvements demonstrated by earlier studies (e.g., Dakoske, 1977; Gang, 1975; Poppen et al., 1975). There are a number of reasons that the improvement in positive behaviors was perhaps not more substantial: limited duration of the study, the approach of the end of the school year, teacher behavior and intervener/subject rapport. Further review of these issues will facilitate an understanding of their effects on the outcomes of this pilot study, as well as establish necessary recommendations for future studies involving reality therapy.

Obviously, the closing of the school year posed a major problem for the study. Because the process of involvement and commitment are highly individual, the shortened period of intervention made successful application of reality therapy techniques with each client a difficult task. The limited duration of treatment and subsequent lack of follow-up procedures made it impossible to answer questions relevant to the "staying power" of the intervention (Dakoske, 1977). Can short term intervention with reality therapy facilitate a lasting change in behavior? Are there additional effects of treatment across settings? Were the effects generalized to other behaviors not specifically identified for treatment? These issues remain to be addressed by future studies focusing on the durability of reality techniques over time.

Although the limited duration of treatment may have affected its impact on the behaviors of targeted subjects, several additional variables that may have also hindered treatment effects warrant identification: substitute teachers, subsequent variability in classroom structure, and withdrawal of contact with the intervener near the end of the school year. Additonally, subject two was often sullen and noncommunicative with the intervener, making it difficult to establish a foundation for involvement, evaluation, and commitment to change. These factors must be considered when reviewing the data from the final days of the project.

Throughout the study an attempt was made, albeit informally, to monitor interactions between the target student and the classroom teacher. Because the teacher plays such an important role in the development of the child's self image, clearly her positive involvement with the youngster is a necessary ingredient to the success of reality therapy. Indeed, the foundation of successful reality therapy is the basic relationship between the client and the intervener, and the teacher serves an important role in nurturing that relationship within the classroom setting. Therefore, the teacher must have knowledge about reality therapy techniques and of her role within the actual process of therapy. When a positive working relationship between the intervener, the subjects and the teacher is lacking, reality therapy techniques are not as powerful. Although the data were gathered on an informal basis, it is evident that the lack of teacher involvement and knowledge of reality techniques may have affected the intervention. Future studies must address teacher characteristics as an important variable within reality therapy for, "positive changes in teacher behavior will probably foster large gains in appropriate student behavior" (Poppen, Thompson, Cates, & Gang, 1975, p.137).

Addressing these issues may provide important fuel to the argument for the inclusion of reality therapy in the schools. As Glasser (1969) believed, "if a child, no matter what his background, can succeed in school, he has an excellent chance for success in life" (p.6). Reality techniques encourage the youngster to become a responsible participant in the schooling process and to make a commitment toward change and subsequently toward growth.

While the major results of this pilot study are inconclusive, they do show some of the problems inherent in attempting to assess the effects of reality therapy techniques. Moreover, a positive result of this pilot study is the creation of valid instrumentation. Although the study focused on youngsters in the elementary school, initial validation of the observation instrument was conducted with students from both the elementary and the middle school. Thus, it is felt that the instrument has utility for youngsters of different ages.

Admittedly, the success of reality therapy is interrelated to a number of variables. Data from the study do yield several identifiable conditions that should be addressed before initiating research of this type:

1) teacher cooperation and positive involvement with the students must be in place,
2) the teacher must be knowledgeable in the basic tenets of reality therapy,
3) a flexible time frame for intervention must be included,
4) feedback given to target subjects and to the teacher must be specific,
5) classroom rules and identifiable structure should be in place, and
6) follow-up procedures must be planned and implemented.

Reality therapy is a personal, humanized form of intervention that has potential within the school setting. Future studies that address some of the issues raised by this pilot study will likely yield additional evidence to the effectiveness of this nonintrusive therapy.
References

REALITY THERAPY WITH THE KHMER REFUGEE RESETTLED IN THE UNITED STATES

Rhonda L. Rosser

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Background
After the fall of Saigon in 1975, over 750,000 Southeast Asian refugees resettled in the United States. They represent the diverse cultures of Vietnam, Cambodia (Kampuchea) and Laos. Some 105,000 Khmer (Cambodian) refugees have resettled in this country alone. In Greensboro, North Carolina, over 300 individual Khmer representing 43 families reside. These Khmer people were initially resettled beginning in January of 1981 under a federal project through the Office of Refugee Resettlement called “FASP” or, Favorable Alternative Site Program. They have come to this country and to Greensboro after having survived one of the worst holocausts in recent modern history.

In April of 1975, the Khmer Rouge Communists took over Cambodia under the leadership of Pol Pot. This regime attempted to return Cambodia to the “year zero” and to begin with a total agrarian society. Intellectuals and Khmer with any semblance of education were sought out and killed. The population under the Pol Pot regime (1975-1979) was diminished by one third; it is estimated over two million Khmer died at the hands of the Khmer Rouge.

The survivors of this tragic regime have lived through the horrors of forced labor camps, experienced the loss of family and friends through separation and death, lost their country, their occupational status, and then waited in a refugee camp before being resettled in this country. Once they arrive in the United States, they are faced with a host of problems. It is necessary to learn a new language, seek employment, learn a new culture, and cope with the frustrations of finding housing, paying rent, learning to buy groceries and other everyday tasks that require a new repertoire of skills. Compounded with this, many refugees often face hostile stares of Americans that do not welcome them into the country.

The Khmer refugees often suffer many emotional problems after arriving in this country. After experiencing tremendous losses and persecution, as well as having witnessed tortures to family and friends, coupled with the enormity of leaving one’s country, learning a new culture seems like an impossible task. However, the Khmer people are a real testimony to the resilience of the human spirit. The fact that they have so few problems after what they have experienced is incredible.
Therapy may show why this is a preferred mode of treatment with the Khmer refugee, and to the refugee experience. Outlining the basic tenets of Reality Therapy may show why this is a preferred mode of treatment with the Khmer refugee, given experiences they have suffered, and the enormity of the tasks that lie ahead of them. To more fully understand the use of Reality Therapy with the Khmer refugee, one section of this paper will tie together the basic concepts and process of reality therapy to a particular case and explain how reality therapy was useful as a counseling intervention with a young Khmer woman experiencing great difficulties.

**Reality Therapy and the Khmer Refugee**

Counseling with clients from other cultures is a challenging undertaking. Southeast Asian refugee clients in particular are certainly a challenge given the losses they have suffered. Many of the Cambodian refugees in the United States are having problems adjusting to American culture while at the same time trying to resolve feelings of extreme loss. Robinson (1980) indicates that after the resettlement process is taken care of, Indochinese refugees have time to reflect on their ordeal, and desolation strikes when the full weight of the sorrow and loss strikes home.

Much of the research has indicated that only a small percentage of the Indochinese refugees utilize mental health services. One reason for this is that the notion of “mental illness” in Asian culture is one that often invokes fears of ridicule for the refugee. It is important in cross cultural counseling for the counselors to get out of their offices and meet minority clients on the client’s ground and within the client’s cultural setting. This is especially true for the Khmer refugee, who feels as though “private problems” should not be discussed, and would never seek out help for himself/herself concerning a private problem.

Additionally, talking about “feelings” is not a Southeast Asian behavior, and as Tung (1985) relates:

> Depression, regrets, guilt, shame, or similar preoccupying sentiments may weigh heavily on a Southeast Asian’s mind and life, yet these are still perceived as essentially private concerns, and to talk about them would be about as discrete and commendable as parading in the nude in public.

Reality Therapy is most definitely a “doing” therapy. The emphasis is not on how a person feels, but rather, on what action the person is taking in his or her life to improve the quality of life. For the Khmer refugee who culturally has tremendous difficulty expressing feelings, concentrating on what she/he is doing is much more comfortable than more traditional therapies that concentrate on the feeling aspects of a person’s life.

The Reality Therapist working with the Khmer refugee is concerned with helping the client in his/her adjustment to life in a new culture. Kinzie, Trans, Breckenridge, and Bloom (1980) indicate that some forms of psychiatric treatment that question about feelings and sensitive relationships may seem threatening to the Indochinese refugee patient. As Reality Therapy is concerned with what the client is doing about a particular problem, this would enable it to be again more effective than other therapeutic approaches.

**Reality Therapy, the Present, and the Khmer Refugee**

As the focus of Reality Therapy is on the present and not on the past, this also enables it to be more effectively used with the Khmer refugee population.

Much research has proven that discussing past events with the Khmer refugees leaves them feeling worse, not better. Kinzie, Fredrickson, Ben, Fleck, and Karls, (1984, p. 649) reported that:

> ... patients spoke of unpleasant memories only with great effort. Even then the result was not a catharsis; grief or working through did not resolve their trauma. In fact, the interview itself appeared to stimulate further intrusive thoughts.

Boehmlein, Kinzie, Rath, & Fleck (1985, p. 959) in their one year follow-up study of post-traumatic stress disorders among survivors of Cambodian concentration camps found that detailed inquiry often intensified symptoms, and their therapy tended to support avoidance of past events and to encourage coping with current problems. They also emphasized here that:

> This approach is consistent with the traditional Cambodian coping style and with their expectations of the treatment they would receive from American physicians.

With little exception, most of the research available on the Khmer refugee and mental health needs points to therapeutic interventions that focus on the present and immediate future, rather than the past. Reality Therapy believes that the past cannot be changed, only the present, (Glasser, 1965). Therefore, Reality Therapy would serve the Southeast Asian refugee well in that delving into the past seems to not prove fruitful for them.

**Reality Therapy, and the Khmer View of Western Medicine/Aid**

The Khmer refugee tends not only to express emotional disturbances somatically, but often feels cheated upon going to the doctor and then receiving no medication (Muecke, 1983). Tung (1985) and Kinzie (1981) also indicated that the use of medicine actively suggested to the Indochinese refugee patient that something was being done, and that no medical consultation was complete without a prescription or an administration of medication.

The use of Reality Therapy does not condone the use of drugs for psychiatric purposes except in some particular cases. However, in going to a reality therapist, one does in a sense leave with a prescription of sorts. That is the “plan” that the counselor and counselee have devised to begin taking action in helping the client come closer to fulfilling his/her needs to live a more satisfying life.

Using this “plan” with the Khmer refugee and writing down, doing over, and getting a commitment, is more in line with the Khmer expectations...
of receiving “help” than nebulously talking about feelings, and leaving with no direct action to be taken. The written “plan” is in effect like a prescription because it is immediate and it is something tangible that the Khmer refugee leaves with.

**Reality Therapy, the Person of the Therapist, and the Khmer Refugee**

In Reality Therapy, the foundation for making friends with the client involves the therapist becoming emotionally involved with the client (Glasser, 1965). The Khmer refugee, given his experiences, and living in a totally alien culture, is most definitely in need of a therapist that is able to be a friend. He needs to feel that he has a strong ally in his new country, and that there is at least one person he can truly count on.

The Reality Therapist should be well versed in the culture of the Khmer for the counseling relationship to have meaning. Williams and Westermeyer (1983) related an incident involving a Southeast Asian refugee woman that attempted suicide because her daughter had been disrespectful in allowing a Hmong boy to carry her books home from school. This example underscores the extreme importance of the therapist having a thorough knowledge of the culture with whom she/he is working, to be effective.

Reality Therapy emphasizes that the therapist must have great strength in leading a responsible life himself/herself, and also strength to stand up to clients that may act irresponsibly and to continue to point out reality to them no matter how hard they struggle against it. (Glasser, 1965)

This is of particular importance for the Reality Therapist working with the Khmer refugee. It takes great strength. Because the refugee has had such an unbelievably difficult life, the tendency often is to want to excuse behavior. This does not help the refugee. The beauty of using Reality Therapy with the Khmer is in the dignity of the person inherent in the philosophy. In counseling with the Khmer refugee, by refusing to accept excuses, by becoming emotionally involved with the client, and by carefully working on a plan to improve the quality of a refugee’s life, the reality therapist is saying, “I believe in you. Your past is in the past. Let’s start anew here in American and work to make the rest of your life here as enjoyable and as happy as we can.”

**“What are you doing now?” and the Khmer Refugee**

After the Reality Therapist has made friends with the refugee and ascertained the concerns of the refugee, the relationship progresses to the “What are you doing?” stage. Here the therapist tries to find out what the client is doing and whether it is helpful for the client in working on fulfilling needs. If the therapist is working with a refugee that speaks little English, or through a translator, it may be necessary to juggle words around to get to a correct understanding. For example, in asking refugees “What do you want?” it would be more useful to ask “What in life will make you a happier person?”. Instead of saying “What are you doing now?” it would be better to ask “Tell me some things you have tried to make your headache (or whatever) better.”

It is at this point that the skilled Reality Therapist with a solid understanding of the culture of the Khmer can determine if the Khmer client has tried traditional healing methods that may “cure” the client in a traditional Khmer ceremony. Many Khmer, particularly the rural Khmer, but by no means exclusively rural, believe a great many diseases, particularly mental illness, are the manifestation of supernatural powers. The cross cultural Reality Therapy working with the Khmer refugee should first ascertain if the problem has been dealt with through a Buddhist monk (if one is available) or through certain prescribed Khmer rituals. In their work with unaccompanied Khmer refugee minors, Duncan and Kang (1984) found that simple Khmer ceremonies such as Ban Skol, and Pratchon Ban were helpful in alleviating disturbing dreams and visits by hostile spirits upsetting to these children.

Because the Khmer believe in Theravada Buddhism, it is important to understand how this affects all aspects of daily existence and the interrelationship of mind and body. Helman (1984) notes that in societies where ill health and other forms of misfortune are blamed on social causes (witchcraft, sorcery, or evil eye), or on supernatural causes (gods, spirits, or ancestral ghosts), sacred folk healers are particularly helpful. He defines their approach as a holistic one, dealing with all aspects of the patient’s life including his relationship with other people, with the natural environment and with supernatural forces, as well as any physical or emotional symptoms. This certainly pertains to the Khmer refugees and their outlook on life and its relationship to their own health, both mental and physical.

The culturally trained Reality Therapist in attempting to find out what the Khmer refugee has tried at this point uses the what are you doing, what have you tried, and is it helping type of questions to reveal if a culture bound ceremonial procedure would be in order at this point.

**Reality Therapy - The Khmer Refugee and “Relearning”**

Glasser (1965) says that when the client admits his behavior has been irresponsible, the relearning phase of therapy begins. For the Khmer refugee client, there may actually be no irresponsible behavior (although there certainly may be). Often for the refugee, the Reality Therapist is not teaching him better ways of behavior: he is simply helping him find ways to adjust more easily in his new culture in America.

The Khmer refugee coming to the reality therapist unable to fulfill his/her needs, may simply not possess the proper knowledge of how to go about fulfilling those needs. The Reality Therapist, then, is a real teacher to the Khmer refugee, a role the Khmer person is very comfortable in dealing with in a doctor/patient, counselor/client relationship.

**An Individual Refugee/Client Case**

The client was a 15-year-old Cambodian female brought to the attention of the refugee staff by a volunteer to the refugee problem, and through a concerned social worker on the refugee staff. The client had lived in the United States for almost two years. She had a one-month-old baby girl. She
Speaking with the translator at a refugee office as to the mental health needs of the Khmer, he replied:

"When someone asks about my past, it makes me sick. I want to cry. I don't want to remember the past. I want to think of the good thing now, and for the future. I am happy to be in the U.S.A. You ask refugee about Pol Pot, very very sad. Don't ask him. Teach him to make the good life here in the United States."

Sokhom, Oum
Translator
Khmer Refugee
Former High School French Teacher
Author

The use of Reality Therapy has been proven to be a highly successful counseling technique for use with the Khmer refugees resettled in Greensboro, North Carolina. It allows the refugee to begin a new life here in the United States with dignity and with the hope for a happy and fulfilling future. It enables the Khmer refugees to begin with the present, put aside the past, and start rebuilding their lives in their new country unencumbered and free to become any one of their dreams.

References

Robert E. Wubbolding

In Reality Therapy it is necessary to establish a friendly atmosphere and to help clients determine their wants (Glasser, 1986). Also, at the basis of change in counseling is the necessity of telling the client what the therapist wants or expects, e.g., to take the counseling seriously, to be on time for appointments, etc. Thus, the picture albums of both client and therapist should be laid open in the beginning of counseling. Such self-disclosure both sets the tone and leads to change (Wubbolding, 1985).

This self-disclosure especially on the part of the therapist is, in the beginning, merely a discussion of the issue emphasized in the current counseling and psychological literature: Informed Consent. Hare-Mustin, Marecek, Kaplan, and Liss-Levinson (1979) state that the informed consent of the client covers three areas:

1. The procedures, goals, and possible side-effects of therapy.
2. The qualifications, policies, and practices of the therapist.
3. The available sources of help other than therapy.

Berger (1982) adds that unlicensed therapists have a special ethical obligation to inform their clients that insurance companies have no responsibility to pay for the therapy. He furthermore says, "The patient has a right to a therapist who is committed solely and completely to promoting his or her best interests and personal welfare. Associated with this is the client's right to be provided with the necessary information to enable him or her to make an informed choice regarding therapy.

The responsibilities of the therapist in connection with this right include the following.

a. To provide the client at the outset with information concerning goals, procedures, and the therapist's theoretical orientation in regard to the therapeutic process;
b. To call attention at the outset to any potential value conflicts between therapist and client;
c. To avoid conflict of interest;
d. To avoid gratifying his or her own needs at the patient's expense;
e. Not to engage in any form of sexual activity with the patient" (p. 82).

More emphatically, various ethical codes require that professional persons inform clients about the nature of the service they will receive. Thus, the American Psychological Association (1981) says, "Psychologists fully inform consumers as to the purpose and nature of an evaluative, treatment, educational, or training procedure".

Likewise, the National Association of Social Workers (1979) asserts, "The social worker should provide clients with accurate information regarding the extent and nature of the service available to them." Finally, the American Association for Counseling and Development has stated, "The member must inform the client of the purposes, goals, techniques, rules of procedure and limitations that may affect the relationship at or before the time that the counseling relationship is entered".

PROFESSIONAL DISCLOSURE

A statement of professional disclosure is most useful in fulfilling this important ethical responsibility. For many years, authors have advocated such a statement (Gross, 1977; Witmer, 1978). Gill (1982) adds that "such a statement would be made available to potential clients prior to an initial interview either by handing the statement to the person or displaying it in a conspicuous place."

The importance of professional disclosure as a means of facilitating informed consent is sometimes reflected in legislation. There are 18 states that license counselors. One such law, the Ohio Counselor and Social Worker Law, requires that if a licensed person receives remuneration, "the client (must be) furnished a copy of a professional disclosure statement unless such a statement is displayed in a conspicuous location at the place where the services are performed and a copy of the statement is provided to the client upon request". The law, based on current counseling literature in this matter, states precisely what must be contained in the statement:

a. The name, title, business address, and business telephone number of the professional counselor, counselor assistant, social work assistant, social worker, or independent social worker performing the services;
b. His formal professional education including the institutions he attended, the dates he attended them, and the degrees he received from them;
c. His areas of competence in the field in which he is licensed or certified and the services he provides;
d. In the case of a person licensed under this chapter and rules adopted under it who is engaged in a private individual practice, partnership, or group practice, the person's fee schedule, listed by type of service or hourly rate;
e. At the bottom of the first page of the disclosure statement, the words "This information is required by the Counselor and Social Worker Board, which regulates all licensed and registered counselors and social workers"; and
PROFESSIONAL DISCLOSURE AND REALITY THERAPY

Below is contained one version of a statement of professional disclosure geared to the practice of Reality Therapy. It contains all of the above mentioned elements and conforms with Ohio’s law governing psychologists as well as that governing counselors and social workers.

Therapists and counselors should check respective state laws for variations in requirements. Nevertheless, the reader is invited to adapt the statement for personal use. It also contains a description of Reality Therapy written in non-technical terms for clients.

SAMPLE STATEMENT OF PROFESSIONAL DISCLOSURE:

Areas Of Competence Of Therapists

1. Reality Therapy applied to the following areas and persons: child and adolescent, personal and social, marriage and family, pastoral, employee assistance, mental health, consultation and supervision, diagnosis and treatment of mental and emotional disorders.

2. Description of Reality Therapy is attached. This theory will also be discussed with you personally.

Fee Schedule

1. At the present time the fee for counseling/therapy is per 50 minute session.

2. There is no charge for telephone calls if these are kept to a minimum.

Client Rights

The following are client rights.

1. To ask any questions regarding the procedures used during counseling/therapy.

2. To expect confidentiality. Within limits, information revealed by you will be kept confidential. It will not be revealed to other persons or agencies without your written permission.

3. To request in writing any part of your records to be released to any person or agency which you designate. We will tell you whether, in our opinion, making the record public will be harmful to you.

Limitations Of Rights

The main limitation is in the area of confidentiality. In certain situations confidentiality does not apply: an order by a court; in the case of child abuse; for your own welfare or that of others in serious or life threatening situations; in the case of death, the surviving spouse or executor of the estate can give consent.

The Process Of Counseling/Therapy

1. Possible benefits derived from counseling/therapy include:
   a. Better social relationships.
   b. Better personal adjustment.
   c. Better family life.
   d. Better ability to cope with the problems and stresses of life.

2. It is important to note that we make no guarantees that you will receive these benefits. We believe that a better life is possible for most people. At the same time, our professional ethics do not permit us to make any such guarantees.

3. Counseling/Therapy might involve some feelings of discomfort. These can occur when a person changes his/her life. We view this discomfort as a stepping stone to more effective and satisfying living.

Commitment To Counseling

1. We promise:
   A. To provide you with the best help of which we are capable.
   B. To be straightforward and honest with you.
   C. To respect your dignity and integrity as a unique person.

2. We ask you:
   A. To enter counseling for 50 minute sessions and agree to pay the fee.
   B. To provide 24 hour notice if you are unable to keep the appointment. A charge will be made for the time reserved. (This charge is not reimbursed by insurance carriers.)
   C. To have a designated final session at which we will discuss progress and next steps. This session should be designated prior to the final appointment.

We believe that your commitment is important and helpful to you in order to achieve the goals of your counseling/therapy. Please recognize that there is no moral, legal, or financial obligation to complete the maximum number of sessions listed above. You will be charged only as we have described above.

I fully understand the above agreement and I freely agree to the above conditions.

Client(s) Signature(s)

Psychologist’s Signature
The above statements conform with the Ohio Psychology law which regulates the practice of Psychology. Also, this information is required by the Counselor and Social Worker Board which regulates the practice of professional Counseling and Social Work.

Ohio State Board of Psychology  State of Ohio Counselor & Social
65 South Front Street, Room 507 Worker Board
Columbus, Ohio 43266  65 South Front Street, Room 210
Columbus, Ohio 43266
Phone: (614) 466-8808 Phone: (614) 466-0912

DESCRIPTION OF REALITY THERAPY

Reality Therapy is a method of helping people take better control of their lives. It helps people to identify and to clarify what they want and what they need and then to evaluate whether they can realistically attain what they want. It helps them to examine their own behaviors and to evaluate them with clear criteria. This is followed by positive planning designed to help control their own lives as well as fulfill their realistic wants and their needs. The result is added strength, more self-confidence, better human relations, and a personal plan for a more effective life. It, thus, provides people with a self-help tool to use daily to cope with adversity, to grow personally, and to get more effective control of their lives.

Reality Therapy is based on several principles, such as:

1. People are responsible for their own behavior - not society, not heredity, not past history;
2. People can change and live more effective lives;
3. People behave for a purpose - to mold their environment as a sculptor molds clay, to match their own inner pictures of what they want.

The intended results described are achievable through continuous effort and hard work.

The purpose of this article has been to provide the reader with a working knowledge of the importance of one current issue in counseling and therapy: Informed Consent and Professional Disclosure. Authors, professional codes of ethics, and even legislation state that a written statement of counselor competencies, etc., should be provided to clients. A sample statement and working definition of Reality Therapy as a specialty is provided.

References

Guidelines for Contributors

a) Manuscripts should be submitted in triplicate to the Editor, Lawrence Litwack, Journal of Reality Therapy, at the editorial office address. In the case of a manuscript written by more than one author, the covering letter should indicate the name and address of the author with whom the editor should correspond — that is, the corresponding author.

b) Manuscripts must be typewritten double-spaced on 8 1/2 x 11 white paper. The name, highest earned degree and professional notation (e.g., R.N.), title or rank, organization, and address of each author should appear on the manuscript's last page. In manuscripts written by more than one author, the corresponding author should indicate the order in which coauthors' names should appear in The Journal if the manuscript is accepted. Rejected manuscripts will not be returned unless a stamped, self-addressed envelope is enclosed.

c) In accordance with the Copyright Revision Act of 1976, we are required to have the following statement in writing before we may proceed with a review:

"In consideration of The Journal of Reality Therapy taking action in reviewing and editing my submission, the author(s) undersigned hereby transfer, assign or otherwise convey all copyright ownership to The Journal of Reality Therapy in the event such work is published by The Journal."

d) Authors should strive for brevity, readability, and grammatical accuracy. The title of a manuscript should be succinct and lend itself to indexing.

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

f) CHARTS, GRAPHS, TABLES: Camera-ready art must be furnished for charts, graphs, and tables by the author OR The Journal's printer can prepare the art and bill the author. Authors electing to furnish camera-ready art must adhere to Journal format for tables and figures and should either specify 8 point English Times typeface or use IBM typewriter ball "Modern, 72" for the copy. Illustrations that repeat information given in the text and which do not enhance the manuscript should be omitted. Each table, chart, or graph should be numbered and cited in the text where it is to appear.

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

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

1. Has the subject been covered adequately in The Journal so that publishing this manuscript would be redundant?
2. Is the manuscript on a problem or topic of sufficient importance in demonstrating Reality Therapy to warrant its publication?
3. Is the content of the manuscript scientifically accurate and philosophically sound?
4. Does the manuscript contain any false or misleading statements?
5. Does the manuscript have readability, i.e., is it clearly written, succinct, and easily understood?
6. Will the manuscript require a great deal of revising to make it acceptable?

i) All accepted manuscripts are subject to copy editing.

j) Following the appearance of an article in The Journal, the author(s) will receive two complimentary copies of that issue.