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Editor’s Comment

This issue marks the beginning of the twelfth year of publication for the Journal. Increasingly, we are seeing diversity in terms of authorship and application of RT/CT principles. This issue is an excellent example of both. STANTON leads off the issue by exploring the use of RT in the group treatment of sexual offenders. STANWOOD, one of our international contributors, provides an important contribution to the literature of grief counseling. PEACOCK describes the use of RT/CT in working with alcoholics.

The next two articles represent a unique application of RT/CT. HART discusses the use of RT in helping individuals initiate on exercise program. UDRY carries the approach a step further by applying CT to exercise therapy for the anxious and depressed. PROTHEOE, another international contributor, explores the relationship between RT and cognitive development stages.

SIEBRANDS describes his use of CT with a college student population in a developmental education class. BROWN, a third international contributor, continues the educational application with a research-based article based on self-directed learning. PARISH and STALLINGS continue the data-based approach by examining teacher effectiveness and student ratings.

CONNER takes us into the pastoral counseling arena with a wedding meditation tied to basic needs. Finally, LAWLESS concludes the issue with a final international flavor based on reflections of the Vancouver Convention.

Readers are reminded of several things related to the Journal. First, you are asked to encourage nearby college and university libraries to subscribe to the Journal. This will help the numbers of students interested in RT/CT principles, practice, and research. Second, there continues to be a need for data-based articles examining the effectiveness of RT/CT. Finally, the quality of the Journal will continue to grow incrementally dependent on the flow of articles submitted. You are encouraged to submit material for consideration.

TREATING SEXUAL OFFENDERS: REALITY THERAPY AS A BETTER ALTERNATIVE

Dale T. Stanton

The author, in the process of RT Certification, practices in Reed City, Michigan.

In a recent church periodical representing a major denomination in the United States, I read of two ministers who were recently defrocked for sexual misconduct. This same church body has formed a working group to develop a step-by-step strategy on how to deal with incidents of clergy sexual abuse and sexual harassment in church related settings.

Such a tragic scenario illustrates the growing problem of sexual abuse that seems to be invading every segment of our society. Is the incidence of sexual abuse increasing or do we simply hear more talk about sexual abuse? There is no question that reports of victimization have risen dramatically in the last few years. Salter (1988) said the reporting of sex offenses has increased 212 percent since 1980, but many such crimes occur and go unreported. The House Select Committee On Children, Youth, and Families documented an 80 percent increase in reporting states from 1983-1985. An estimated one in four girls and one in eight boys are sexually abused before age 18 (Wooden, 1986). 1992 estimates indicate one in three girls and one in six boys are sexually abused before age 18. In the single month of May, 1992, Child-Help, a national hotline received 2000 reports of sexual abuse. Most experts think that rather than an increase in sexual abuse incidents, we are witnessing professionals being more perceptive to its occurrence and a greater willingness on the part of victims and their families to report the abuse.

Sex Offender Profile?

Who are sexual offenders? About 90 percent of those caught are men — a statistic that may be skewed by the way crime is reported, namely the fact that women do not get reported as much. However, this phenomenon is quickly changing as more and more female perpetrators are being exposed. One of the most basic observations is that there is no typical profile, and no two abusers are alike. The depiction of a stranger in a trench coat lurking in a dark alley is an inaccurate stereotype. In reality, 80 percent of all sexual abuse is committed by someone a child knows and trusts. Studies have shown that offenders come from all ethnic groups and social classes, are employed in every sort of occupation or profession, and frequently are highly respected in their communities. There is a theory that most sex offenders were victims themselves of sexual abuse, but the accuracy of such reports is difficult to document. Some offenders may claim to have been abused in order to justify their behavior or to gain sympathy from society. Offenders often begin their abusive behavior at a young age, usually as
juveniles, and even in their preteen years. Many have committed far more offenses than the ones for which they are caught.

**Solutions To The Problem**

Can sex offenders alter their ways? Is removing them from society by imprisonment the only solution? Is imprisonment a deterrent to sexual crimes? Is there an effective way to treat offenders to stop or control deviant behavior? Should treatment be offered to offenders?

The most widely accepted method of dealing with sex offenders simply has been to put them in jail, both to punish them and to protect society. But most return to the streets — sometimes in a very short time — and their imprisonment, instead of being a deterrent, may have aggravated their problem. The reoffense rate for sexual offenders may be the highest for all criminal offenses. Estimates on the recidivism rate among untreated offenders range between 35 and 80 percent (Freeman-Longo and Wall, 1986). The success rate for treating offenders tends to vary, depending on who is doing the reporting and on what basis the report is made. Gene Abel, a psychiatrist in Atlanta, Georgia, states that treatment centers for sex offenders claim an 80-85 percent success rate, and in the case of incest, success runs to 96 percent. However, these statistics are questionable, as success rates usually are based on clients’ self reports or getting caught by the law. Others may reoffend without getting caught. One thing for sure, however, is the growing recognition that imprisonment alone is ineffective in preventing deviant sexual behavior. Says Nicholas Groth, a Massachusetts psychologist who has treated more than 3000 offenders in the past two and one-half decades, “We can’t put them in jail and throw away the key, hoping that’s going to solve the problem. The best protection we can offer society is to treat these people and teach them to control themselves” (Groth, cited in Churchman, 1988).

Treating sexual offenders to control themselves with an emphasis on relapse prevention seems to be the most effective form of treatment. Most treatment programs begin with what’s called the assignment phase, which often includes one-on-one interviews, a battery of psychological tests, and a complete biographical and sexual history of the person. A primary goal is to identify the person’s specific patterns of deviant sexual arousal and behavior. The treatment phase usually includes a combination of group psychotherapy, education, behavior modification therapy, skill-building strategies, sometimes drug and alcohol treatment, and occasionally chemical therapy. Group therapy is more widely used because it is usually more effective and less costly.

**The Problem Of The Solutions**

What I find objectionable to the treatment programs with which I am familiar is that while they speak in terms of control versus cure, still they follow a medical model approach. The offender becomes a “patient” whose deviant behavior is a form of mental illness caused by some underlying pathological condition, and he is diagnosed under the DSM-III system. In place of “cure,” “the word “recovery” often is used to denote the point a patient has reached whereby he can successfully manage or control his “disease.” Some treatment programs even follow the 12-Step program in which the offender’s behavior is treated as an addiction, representative of an obsessive/compulsive personality disorder. Addiction thus is the cause of deviant behavior and the perpetrator now becomes the victim.

The paradox of this entire approach is that while the goal of treatment may be on controlling one’s impulses and behavior, the very nature of the medical model suggests to the offender that his behavior is something that happened to him from the outside, and thus, he is not totally responsible for his deeds. Believing his disease can never be cured, and that he is powerless over his sexual addiction (Step #1 of the 12-Steps), the offender may rightly question the purpose and value of his treatment program. What incentive does he have to cooperate with the treatment, if, by all indications, his efforts will prove futile?

Most treatment programs in place today also rely heavily upon Behavior Therapy in which the offender almost is viewed as a machine that needs to be fixed, or as a computer that needs reprogramming. Employing traditional stimulus-response theory, the offender is taught that his deviant behavior is cyclical in nature - a chain of events in response to certain outside cues and stimuli. Heavy emphasis is placed on conditioning the person, using such techniques as covert sensitization, aversion therapy, verbal and masturbatory satiation, and orgasmic reconditioning. These techniques often are employed in a very harsh, dehumanizing way, almost to the point of being punitive in themselves. Often called confrontational, this therapy tends to go beyond the boundaries of confronting to merciless condemnation of the offender, attacking his dignity and character, locking him into what Glasser may call a “failure identity” (Glasser, 1976). Implicit to all of this seems to be the underlying agenda of giving the offender a small taste of the pain he caused his victims. Stripped of all self-esteem and believing he is the scum of the earth and a hopeless failure, what incentive for change does this approach give to the person?

**The Reality Therapy Alternative**

In contrast to the aforesaid approaches, I believe the goal of treatment must be not only to help the offender to manage and control his behavior, but to actually change his behavior to something that better meets his needs. Thus, it is my contention that Reality Therapy/Control Theory offers a much better alternative for achieving successful, long-term results.

While it is difficult for society (much less the recipients of sexual abuse) to afford any compassion to the sexual offender, let us remember there is no behavior known to humankind of which any of us is incapable. We can relinquish our judgment of others by realising the potential for great evil as well as for great good that exists in all of us.

Without condoning, minimizing, or excusing his behavior, neither must we cast the offender as a hopeless criminal, a pervert, permanently trapped in a life of malevolent behavior toward society and himself. Rather, he is a human being, a person of value, capable of love and self worth, and thus, capable of changing his ways. Having chosen self-defeating, failure behaviors, manifested in a pattern of weakness, irresponsibility, and acting
out, this same person can choose “success identity” (Glasser, 1976), acquiring strength and self-discipline to take responsibility for himself, to change the course of his life, and thus become a beneficial and contributing member of society.

The Group Plan

I first designed the application of Reality Therapy/Control Theory to the treatment of sexual offenders in 1988 while working on my Master’s degree in Counseling and Psychology. I then utilized my plan while working as a therapist for nearly the past two years at a private agency in San Antonio, Texas, devoted exclusively to helping persons involved in deviant sexual behavior. While there were specific treatment goals prescribed by my supervisor, the other three therapists and myself were given the freedom to employ the methodology and techniques of our choice to achieve the desired goals.

Although some individual therapy was offered, the majority of the treatment was conducted in an open group setting, with changing membership and with persons at different levels of growth and progress. Weekly attendance was mandatory (as part of the participant’s probation or parole), and each person was responsible for individually covering all of the essential treatment goals within the context of the group. The group setting offers each person feedback, challenge, and support to help members make an honest self-assessment and determine specific ways to change their acting, thinking, and feeling.

The Group Procedure

As a new man entered my group, he was given a brief syllabus entitled “Introduction To Group Therapy - Personal Growth Model.” This briefly explained the purpose, format, and goals of the group and what was expected of him. The syllabus also contained a ledger that the person could use to record the completion of assignments and to monitor his own progress (I also kept a record of this).

The other part of the syllabus was titled “Steps That Lead to Change,” and spelled out the process of Reality Therapy. Following my group presentation on the basic principles of Reality Therapy/Control Theory, each client was instructed to keep the process at his disposal to follow as a guide and for making a plan to achieve behavioral changes and for solving problems. The overriding goal was to get each client to eventually develop a Reality Therapy mindset and to put control theory to work in his life (Glasser, 1984).

Summary of Reality Therapy/Control Theory Principles

Each member of the group received a page illustrating the basic concepts of Reality Therapy/Control Theory and how they apply to daily living. Included is a 12-question true or false quiz on the concepts to help both the client and myself determine if he has a sufficient grasp of the concepts in order to begin the application process to his own situation.

In addition to the hand-out, I used several visual aids. I brought in a small photo album as an aid to understanding the mental picture album we all have. A discarded thermostat was used to teach the control system concept. I went to Wal-Mart and purchased a red, plastic toy Ferrari to serve as an aid in describing Total Behavior, analogous to the car Glasser uses in his Basic Concepts Chart. Each wheel is labeled with one of the four components of human behavior, the hood is labeled “Basic Needs,” and the steering wheel is labeled “Wants.” It was not uncommon for me to push the car across the floor and pose the question, “Who’s driving your Ferrari?” to reinforce the idea that each of us is in the driver’s seat of our own lives. I also had displayed on the way, my own simplified version of the Basic Concepts chart. With the help of my visual aids, my fundamental instruction in Reality Therapy/Control Theory covered the following:

Each of us is born with five basic needs: Love and belonging, power, freedom, fun, and survival. We form an inner picture album of what we want to meet our needs. As an internal control system (symbolized by the thermostat) everything we do, think, and feel comes from inside of us and is not a robot-like response to things and people around us. Our five senses act as a camera through which we see the world as we would like it to be. Comparing what I have with the picture I want, causes my life to feel out of balance (symbolized by the tipped scale). I act upon the real world (drive my car) to get what I want and fill my needs (balance the scale).

Specific Application

Having given an overall description of the utilization of Reality Therapy/Control Theory in treating the sexual offender, I will now attempt to show the specific application of this method of counseling to this population.

Deviant behavior is a sign of weakness, not sickness (Glasser, 1975). Abandoning the medical model which condemns the person as a sick, abnormal, deficient individual (Belkin, 1984) who needs to be “cured,” Reality Therapy/Control Theory offers a phenomenological approach, which focuses on values, beliefs, goals, purposes, meaning in life, and the person’s freedom to choose and be responsible for what he makes of himself (Corey, 1986). The offender is not a machine to be reprogrammed, rather, he is a person who needs love and self-worth (Glasser, 1975). Contrary to an uncompromising judgmental approach which views the offender with scorn and distrust, he instead needs someone who cares for him and with whom he can become involved, perhaps for the first time in his life (Glasser, 1975). Unless a caring, supportive relationship is woven into treatment, the offender is reinforced in his belief that he is a bad, unworthy person.

Treating only a person’s deviant behavior is incomplete and one-dimensional. It is analogous to treating a heart attack patient without considering diet, exercise, lifestyle - everything that contributes to his overall well-being. Likewise, a wholistic approach must be used with the offender, taking into account his total behavior — his acting, thinking, and feeling — along with the spiritual dimension. The religious factor and clients’ beliefs should not be ignored in the overall scheme of treatment. Many clients I have dealt with took the initiative and introduced the
spiritual dimension and used it as a powerful resource in helping them to achieve desired changes in the course of treatment.

What follows will focus on the application of key Control Theory terms and objectives.

**Basic Needs.** The sexual offender shares with all humans the same basic needs. His problem is that his needs were not being met, and out of weakness, chose to meet his needs in a destructive, irresponsible way, namely by misusing another person and breaking the law.

**Picture Album.** He has pasted in his album pictures of himself satisfying his sexual urges with ways other than what is socially acceptable (Glasser, 1984).

**Motivation.** Although unlawful, destructive, and self-defeating, his behavior is his best attempt to reduce the difference between what he wants (the picture in his album) and what he has (the way he sees the world) (Glasser, 1984). Thus his behavior has purpose and validity for him at the time.

**Control System.** Rather than being a conditioned response to outside stimuli, the offender’s behavior is internally motivated; it is need satisfying — he thereby fulfills a want he had pictured as unmet (Glasser, 1984).

**Total Behaviors.** The difference between what he wants and what he has generates a “signal” in his brain to behave. A sexual offense is a combination of poor choices and erroneous thoughts, negative feelings, destructive actions, and involving the body. Some of those behaviors include but are not limited to:

A. **Thinking** - Preoccupation with sex, fantasies, impaired thinking: denial, blaming, rationalization, minimization, failure identity, planning the act.

B. **Feeling** - Loneliness, boredom, low self-worth, arousal, orgasmic pleasure, regret, fear of getting caught, guilt, shame, self-hate, despair.

C. **Acting** - Watching for sexual stimulation, impulsiveness (acting without regard for consequences) committing a sexual act, breaking the law, perhaps negative addictions.

D. **Physiology** - Metabolic responses associated with the sexual act - rush of adrenaline, increased heartbeat and respiration, release of pleasure producing chemicals; physiological responses associated with anxiety and fear of getting caught.

**Behavioral Reorganization Process.** Dissatisfied with usually socially accepted sexual activities, the person creates new behaviors to gain or regain control in the midst of frustration, even though the new behavior is deviant and damaging (the behavioral reorganization system does not know right from wrong, good from bad - it only creates (Glasser, 1984).

**Treatment Goals**

*The goals of treatment must be to help the offender:*

1) Change the picture of deviant sexual activity satisfying his basic needs to something less destructive and sufficiently fulfilling. (Although it is nearly impossible to remove a sexually-satisfying picture (Glasser, 1984) we try to help the person find at least some reasonably satisfying, alternative pictures.)

2) Develop strength and skills to meet his needs in a responsible way.

**Achieving Goals**

To achieve the above goals, treatment will focus on five R’s: Reality, Responsibility, Relationships, Right Behavior, and Relearning.

1) **Reality.** The offender, in his unsuccessful attempt to fulfill his needs broke the law, thus denying the rules of society and the reality of the world around him. Through his group involvement, the offender must face the reality of his destructive behavior, recognize that reality exists, and that he must fulfill his needs within its framework (Glasser, 1975).

2) **Responsibility.** The group process will help the offender to focus on his present behavior and whether or not it is fulfilling his needs in a responsible way. If he is failing in meeting his needs responsibly, he is in danger of acting out and getting into trouble again. The group will help him develop the strength and ability to fulfill his needs and to do so in a way that does not deprive others of the ability to fulfill their needs (Glasser, 1975). A responsible person does that which gives him a feeling of self-worth and a feeling that he is worthwhile to others.

3) **Relationships.** A fundamental weakness of the offender is his inability to establish a loving and caring relationship with others. Rather than seeing them as persons, he views others as objects whom he can selfishly use and manipulate to satisfy his sexual desires. The group will help him see both himself and others as persons of value and worth, and to develop socialization skills to interact with them on that level. Although he may never totally eradicate the deviant pictures from his album, he can gain enough strength through the love and worth of the group to make not offending a realistic choice.

4) **Right Behavior.** The group will focus on evaluating behavior and maintaining a satisfactory standard of behavior, correcting self when wrong and crediting self when right (Glasser, 1975). The offender must always focus on present behavior and what he is doing now. Flying in the face of conventional therapy, Reality Therapy contends that dwelling on the offender’s history and past crimes is not productive. He must learn better and more responsible ways to behave now and in the future. The only history that is relevant is that the offender has acted irresponsibly or he would not be in the group. Recalling and rehashing past deviant behavior in graphic detail and language is degrading and dehumanizing, and only perpetuates the offender’s sense of failure and low-self worth, which locks him into a sense of being powerless to change himself. Thus, we also do not try to gain insight into some underlying cause for the offender’s behavior. We do not ask ‘Why??’ but ‘What?’ What are you doing, not why are you doing it? (Glasser 1975). Knowing all the reasons in the world for why the offender acted abusively will not prevent him from reoffending until he fulfills his
GRIEF AND THE PROCESS OF RECOVERY

Dorothy L. Stanwood

The author is a grief counselor who works at the Living Through Loss Counselling Society in Vancouver, British Columbia. This article is based on a presentation at the IRT Conference in 1992.

The experience of major loss is a universal part of our lives and the response to loss is always grief (either consciously or unconsciously acknowledged). I am speaking of the instinctive response of pain which Dr. Glasser describes when the picture in our "picture album" is removed from the real world. This is the one time (besides the response of pleasure) when Dr. Glasser acknowledges that we re-act rather than act.

When I speak of major loss, I'm not only talking of loss through death but through separation and divorce, the loss of a good friend, the move from a city, house, country or school or loss of our job, or chronic disability. Some of these are transitional losses. We may move to Vancouver, and since - after all - we think this is one of the most beautiful cities in the world, we can't understand why we feel low. We ignore the fact that we are grieving for all the love and friendship we had back on the prairies, or, even worse, a place where we could speak our own language and all the cultural differences that implied. In a quite different way, a long-term depression can also be due to severe childhood losses which we don't even remember, as they are so well hidden.

Some therapists believe that this time of reaction to pain is quite short; that within about six weeks we are definitely acting, dealing with the pain in the ways we know how. I agree with this in that we start to act, at least to eat and sleep, creating new behaviors, no matter how bizarre, in an attempt to regain some sense of control in our lives, but in no way can I say that we are ready to put our grief behind us, "and get on with our lives." I want to emphasize this point, because, as Reality Therapists, we may be too eager to think in terms of "getting on," thus re-enforcing our culture's attitudes and papering over the cracks.

The Work Of Grief

Before I begin to discuss the way in which we recover from our grief, I first want to describe all the ways it can affect us. We look on our journey through grief as a diagram like the above:
We start off with the event, and then there may be a period of shock and numbness, of unreality, especially after a sudden death, and of busyness and activity. Then we may move down, perhaps not until four to six months later, to the deep pit of our grief and we begin to go round a circle of mixed emotions, thoughts and actions, which is our 'grief work' before being ready to regain our energy and to experience a renewed strength and perhaps an altered identity, though it may be stronger than before, more compassionate and mature. Of course, we may try to move more easily from one side to the other, gliding over the top of our grief. There are times when that's all we can do, or, for a childhood loss, it is the only way we can survive at the time. But the grief is always part of us, perhaps to be dealt with later, or perhaps incorporated into our personalities in some other way.

This painful time of grief does not, of course, preclude its ups and downs. It looks a bit more like this, because even at the worst of times we are attempting to meet our needs and having some successes.

Notice that I said we are doing our 'grief work.' Even in grieving, we can use an active behavioral word, and that, in itself, gives us hope. It is better than seeing ourselves as a helpless victim.

The Characteristics Of Grief

What are the characteristics of grief? Our clients often turn to us because they wonder if they're going crazy, and there's no support from the community around them, or experience in their lives to help. Generally their thoughts or feelings are entirely normal, and even the apparently bizarre is usually normal in a grief situation.

First, our bodies are affected. We may sleep for long periods, or very little, eat a lot or hardly at all, have headaches, chest pains where the tears are in a tight knot, stomach aches, constipation and the aggravation of every other ache or illness a person may be experiencing. In particular, we should know that during the first year after a major loss our immune system is often lowered and we are more prone to be open to infection.

We are certainly affected mentally, often being in a state of confusion or numbness, being unable to concentrate, even to enjoy reading a book, and being very forgetful, losing our car keys and so on. One can see how hard this makes it for someone who is working. It can take a lot of energy and leave us exhausted, although the structure that work gives us can be valuable.

Our feelings change in every possible way. We may be deeply sad, yearning for a loved one, searching, thinking we see him or her on the street, and feeling extremely lonely. We are lonely in two different ways, missing the person or place we love, and feeling lonely in our grief. Often there is no one to talk to, or the people close to us are grieving in quite different ways, sometimes looking to us to continue meeting their needs for love and belonging so that we feel drained and irritable trying to be loving when so much energy is turned inward. We also notice that everyone in the community, in the malls and stores, seems to be happy and in groups, and this is really painful around Christmas time and other major holidays. We not only feel lonely, we can feel rejected - quite unreasonably so at times; and more than this, we can feel abandoned. That is a feeling that goes very deep but is very real, and, as with other feelings, it can help to recognize it. Clarifying our specific feelings gives us more sense of control than being inundated with vague and overwhelming feelings.

We struggle with unwelcome feelings such as anger, perhaps at the person who died. When someone has left us in a separation or divorce, our deep hurt can blaze out in anger - though at least there's a lot of energy there! We are also angry at the system - the hospital or the law courts - and a murder or divorce case can prolong the agony for years. Besides blaming others, we blame ourselves, feeling guilty, and ashamed. We obsess over the things we could have said or done differently and that's particularly hard when someone dies suddenly. There was no time to say goodbye. And the shame and guilt can go terribly deep when someone we love has committed suicide. One other important feeling is that of being out of control. We all need to have some measure of control in our lives to live from day to day. When we realize that we can't stop the one we love from dying, or leaving us, we really feel helpless and out of control. It affects our whole life. It's not surprising that with our confusion and forgetfulness and lack of control we can lose our self-esteem and self-confidence. In fact, our whole faith or world-view can be shaken. The world no longer seems a secure or safe place. We can feel anxious and even have panic attacks. We're not sure we can protect the other people in our lives; and what about our own mortality? The ground is really shaking from under us.

With all these thoughts and feelings, what we are actually doing is crying, sitting, or going in and out restlessly, not taking care of ourselves, getting cross easily, avoiding people while complaining of being lonely, talking about our loss, and so on.

Our behavior is affected in the four different ways we Reality Therapists recognize: feeling (sad), doing (crying), being unwell, and thinking about our loss or otherwise being forgetful.

This thinking leads back to feeling sad and thus we go round in a downward cycle. Change comes when, while acknowledging the feeling as much as we need to, we then go on to recovery through changes in our doing and thinking, and this includes changes in our picture albums as our biologically driven needs pressure us into finding new pictures which can eventually be met in the world we live in.

The Extent Of Our Loss

Before I describe the steps we can take to recover from our grief, I first want to point out the number of losses each and every loss entails. This can
explain why we are sometimes so overwhelmed and unable to pick up the pieces as quickly as other people think we should. Even the person experiencing the loss is usually unaware of how many losses he or she is grieving.

Let's take an example: suppose someone moves to Vancouver from Winnipeg (and Vancouver is very much a city people move to from other places). The Primary Loss is the move from Winnipeg.

Primary loss: Move from Winnipeg

Secondary losses: However, let's take a look at the secondary losses. We may possibly have left

- our family
- friends
- home
- roots
- school or work
- social life
- sports
- community
- church or synagogue
- the weather
- the cultural climate and history

and this list is only a start.

Symbolic losses: Now let us look at the symbolic losses which no one else sees and which even we don't recognize:

- our sense of identity as a Winnipegger
- security in the knowledge of our neighborhood
- the people who shared our memories
- our self-confidence which comes from a familiar setting
- our sense of safety in the world

We have also repressed severe childhood losses, including severe abuse, as it was the only way to survive; but unless we remember and grieve the loss, we may be stuck in behaviors which prevent us from living a satisfying life in the present. A recent loss is a common time when early losses and their pain come to the fore. Interestingly, most of the members of my Loss Through Death groups have lost a parent or member of their family of origin, and very often there has been serious loss in their early life. The person I just mentioned whose father jumped off the bridge came into the group because of the recent death of her step-father, but the big sobs of pain were those of a little girl, still grieving for her real father.

2. A Safe And Compassionate Person To Grieve With:

Second, we need to remember the most important rule of Reality Therapy, that we offer a safe and supporting environment if we are going to help someone who is grieving. Again, though obvious, we need to remember that for some people the school is not a safe place, the hospital is not a safe place. We may not want to share our deepest pain with someone there, or appear vulnerable when we want to look strong. People will open their hearts when they know they can trust us, that their story is confidential, and that we really want to listen - and I say listen. How much easier it is to say something, no matter how foolish, than to listen and feel helpless. That is not very comfortable for us, but it is offering to meet one basic need, the one for love and belonging, and if we can be in their picture album as a person to turn to we have made the most important first step.

We believe that grieving is not something human beings were expected to do alone, although one can certainly sit at home being depressed. As well as individual counselling for people who come to us, we have groups for those going through a loss through death, those suffering from separation and divorce issues, and for children. These offer people a chance to share experiences, to support each other and to break through the loneliness of grief.

3. Grieving The Grief:

Now apart from talking and listening, what do we do? After all, this is where Reality Therapy really differs from Rogerian listening techniques. Well, what we do is we grieve the grief. That may sound as though we are not moving along, but it is a “work” that can’t be skipped on the road of recovery; and remember that we said that grieving is “work.” To grieve is to talk about the person we lost, to cry, to laugh at the good times, to rage with anger, to talk to the person, to write in journals, to write letters, to look at photos and arrange them in albums, to share pictures and stories with other people, and sometimes to value special objects, clothes and mementos. We may find it hard to forgive ourselves and can use Gestalt methods to get a sense of a lost person’s forgiveness, or write a dialogue with the person.

I think that in terms of Reality Therapy, we are so devastated by the loss of the person, place or object in the real world that along with our
instinctive reactions of “fight” or “flight,” we want to create a place in our interior world where they can’t be removed. As their picture gradually becomes replaced in the picture album by the new pictures our needs have created, people start feeling a little worried and frightened but there is always a place in our memories, or in the case of someone very much loved, in our hearts, and this is what our words and actions are trying to do.

4. Caring For ourselves:

While people are working through these stages of grief, we can help them to take some basic steps which provide structure and a sense of control.

The first is that while we are grieving we need to take care of our bodies because they are affected as part of our overall behavior, and yet we may be ignoring them as unimportant. Our immune system may be lowered and yet we forget to eat. If, as helpers, we can encourage people to shop and cook, to eat fruit and drink water, to try to avoid alcohol, caffeine and sugar as much as possible, then we are starting them on the road to recovery. Along with this, if we can encourage people at least to walk for exercise, they may sleep better, and lack of sleep is often another problem. Above all they are doing something definite and creating structure and purpose. Naturally, as Reality Therapists, we want to be specific. “What will you be having for supper tonight?” That alone leads to a lot of considerations; the difficulty of shopping and cooking for one person, of eating alone, of even bothering to set the table. It can take a lot of planning and commitment for that meal to take place. The same is true of the difficulty in sleeping. Apart from one’s inner thoughts, there can be the strangeness of sleeping alone, the fear of being in the house alone, and we need to use lots of specific strategies to alleviate some of the insecurity and fear.

With all these specific plans we are beginning to do something very important that I shall return to later. We are putting at least one person in the picture album, and that is oneself. The beginning of caring for oneself is the beginning of loving and accepting oneself.

5. Meeting Our Needs Through Nurturing:

We need to remind ourselves once again that grieving is caused by the massive loss of someone or something very important in our picture album, and along with a loss of love and belonging, we have lost our sense of achievement, sometimes our means of survival, and any memory of fun we ever had. No wonder we feel out of control and are scrambling “to get the car back on the road.” And yet even during this time, these same needs are struggling to be met. Let’s begin to meet some of our needs by nurturing ourselves. This includes more than staying alive. We need to know that during this vulnerable time we can give ourselves permission to take care of ourselves. What is soothing and comforting for us? We can take hot baths, or listen to music; we can read light books or see funny movies. We can splurge on massage therapy, a facial, or new clothes or earrings. We are lucky if we have a pet, that source of unconditional love, but even a stuffed toy will help. We may even enjoy some of these things but feel guilty, especially at laughing and having fun. This is where a teaching of Reality Therapy helps people understand that they are moving towards healing as they begin to meet their needs, including the need for fun.

6. Restoring Self-Esteem:

One of the most important turning points in the beginning of our upward journey from grief is the restoring of our self-esteem. When we consider that we have felt out of control, and have sometimes lost our sense of identity, our role, our sense of purpose, and our adequacy at work, we are grieving for the loss of ourselves as we used to be, and the return of ourselves in the picture album as a person to be loved and as an achiever is very important. Of course, it comes as we gradually have success in meeting our wants, but we can encourage people not only to act but to change their thoughts about themselves by consciously naming their good qualities, to affirm themselves, and if necessary by practicing affirmations in a structured way. I sometimes ask people to tell their good qualities to the group (quite a challenge for some) and write them up on the board. Then they can write them on a card to take home and put up on the fridge or the bathroom mirror. It is important for friends and counselors to assure people that even going through this grief takes a great deal of strength, and certainly reaching out to a strange counselor or being willing to share in a group takes a lot of courage. They are, indeed, strong survivors.

7. Changing Negative Thoughts Into Positive:

This leads me into the general theme of changing negative into positive thinking. I am more and more convinced that Dr. Glasser’s insistence on change being affected by change in our thinking is absolutely crucial. One of the first areas of change is in the picture album itself, and we will gradually add pictures as our instictual needs drive us to create them. Ideally, we shall already have a picture of ourself, the person who helps us and perhaps a Higher Power in the album. We need to encourage people through exercises and teaching to recognize and reach for these new “wants” which can often be ignored as too small to count. “How can it help to go to a movie or have a meal out with a friend?” is our first thought. But it is always important to have even a little of what we want if we cannot have it all. In a scale of 1 to 10, people are very discouraged if there are not even any 8s or 9s, but the 1s and 2s also count and do add up. In particular, they can place us on a spiral going up, which gives us hope, and hope is one of the most basic motivators of recovery.

We can also become aware, and some group games can help here, of the generally negative tone we may bring to everything in life. It is easy to say “I never look good,” “I can never find anything to wear,” or “No one ever asks me out.” We can work hard at saying the positive opposite, “I like this hairstyle,” “I just found a new blouse at the consignment shop” or whatever, and especially “I can phone so and so on Saturday.” This last leads to a commitment to action in a very hard area. It is so hard to phone and be rejected when we’re feeling vulnerable, and one is so resentful that friends and family aren’t phoning us, but if action can lead to success, we’re on our way.
8. Using The Arts:

In our enthusiasm for counseling or teaching, let's not forget that from time immemorial human beings have used the arts for healing from grief. We write and appreciate poetry, listen to music, and paint pictures. In more formal therapeutic terms, we can use music and art therapy, acting, role playing, using puppets, dolls and stuffed toys, both for adults and especially for children. We have been very excited to have an art therapy student working with us at Living Through Loss, and hope she will continue to see clients at our office.

9. The Place Of Ritual:

Our recovery from grief, going back to the very first human beings, has always used art in the service of ritual. It is in ritual that we can come together to share emotion, to restore hope, to place ourselves in a community, and where order and beauty replace overwhelming and chaotic feelings. Dr. Wolfelt, a leading American Thanatologist, has said that the ignoring of ritual in our society is one of the most serious concerns he is dealing with at present (Conference on Grieving, Seattle, 1991). And ritual does not just include the funeral service. We can use it in a hundred ways, especially for birthdays and anniversaries; lighting a candle, buying flowers, writing a card, baking a cake, letting off balloons and so on. Religious services are important too because death, in particular, touches the core of the mystery of our spiritual quest as nothing else does. For the same reason, prayer and meditation can be valuable.

10. New Pictures And New Strength:

Finally, with new pictures and enough successes we feel our energy and identity restored and even strengthened. And here is the good news. We don't have to leave the old pictures entirely behind in our renewed life but sometimes, in a transformed way, we can bring them with us. Think of a person who has left her country. She can start an ethnic society to encourage the culture, the music and dancing, the language and clothes of her other country, or open a restaurant with food we can all enjoy. She can also do volunteer work to help new immigrants coming in. We can think of an angry mother whose child was killed by a drunk driver. She can join Mothers Against Drunk Drivers and fight to bring in new legislation. Then we may think, too, of philosophy and religion, and those who write poetry or paint or compose music. It is not an exaggeration to say that all the most profound works of art and literature in the world have come about through the experience of tragedy, balancing hope and optimism and transformed in the human mind, for everyone to appreciate. Our grief and healing can become our blessing, and the blessing of the world around us.

Selected Bibliography


USING RT/CT TO ENHANCE ALCOHOL USE/ABUSE AWARENESS

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INTRODUCTION

The program integrates Reality Therapy and Control Theory with literature related to addictions and alcohol abuse. In Positive Addiction, Glasser (1976) talks about the pain of failure we feel because our weakness limits our ability to meet our needs. He also states that addiction is so powerful because it consistently relieves pain while providing intense pleasure. In the short run this may work. But over time, this behavior is inefficient, ineffective and often leads to giving up and settling for less.

Nakken (1988) observed that addicts often have the illusion that an object or event can nurture them. The addiction, alcohol, often substitutes for the real need of love and belonging.

In Addictive Thinking, Twerski (1990) discusses the complicated and contradictory thinking patterns of addicts. Their distorted concept of time sees only the moment and not the future. The addict's behavior is programmed to avoid pain and to seek pleasure in the moment without regard to any future consequence. This has been described by Glasser (1984) as reorganization resulting in new organized behaviors.

Fingarette (1988) refers to heavy drinking as a central activity in the lives and identities of people that many have referred to as alcoholics. This central activity resembles the Internal World or Picture Album of the Chart, (Glasser, 1986).

The program also utilizes the AA (1990) concept of raising the bottom so that the potential alcoholic may be spared many years in the fatal progression of addiction. Raising the bottom involves education and clearly looking at goals and behaviors and how they are linked. This is done in a supportive environment so that clients feel safe enough to openly and honestly discuss their behaviors involving alcohol use and to explore issues critical to the change process.

WHAT DOES DRINKING DO FOR YOU?

One of the questions often asked of alcohol abusers is, “Why do you drink?” To ask in RT terms you might say, “What does drinking do for you?” When actual answers to this question are categorized they fit nicely into the four psychological needs.

Love and Belonging - “I get together with friends and have a few drinks.”
Power and Recognition - “I get real funny and make people laugh when I’ve had a few.” “He can really hold his booze.”

Fun - “Hey, having fun is what ‘partying’ is all about.”

Freedom - “You have to let loose once in a while.”

From my observations alcohol is often perceived on both a personal and social level as a catalyst for need satisfaction. People drink because they believe it makes them feel better.

Using specific questions can further illustrate how alcohol is perceived as a means to satisfy needs. Do people (you) usually drink alone? A ‘NO’ answer would address the need for love and belonging, where a ‘YES’ answer may indicate a problem. Do you or your friends get braver or funnier after a few drinks? Have you ever done anything after a few drinks that you would not have done prior to drinking? These two questions address the need for power and recognition and may indicate whether the client is actively seeking mood swings. Even with a hangover the next day do you ever talk about all the fun you had the night before? Have you ever said or heard someone say, “I’ll drink whenever I want” or “I can stop anytime I want!” Empathic choice statements like these are usually indicative of a problem with alcohol.

Discussions about alcohol use are often very emotional. Encouraging this feeling component usually elicits more from the client and allows the counselor to learn about specific alcohol related activities and attitudes. Acknowledging and working with these emotionally charged issues in a non-threatening environment usually develops rapport both individually and within the group.

It is also important to look at what each client wants to accomplish with his or her life. The following exercises are a crucial part of this process and require time, effort and thought from the client.

GOALS (What do you want?)*
List two goals you had two years ago.
Have you reached these goals?
If not, where are you in your plans?
List two goals you have for yourself two years from now.
What are you doing now to insure success in reaching these goals?

COSTS (What are you doing?)*
A. How many times a week do you drink? ________
B. How many drinks do you have each time? ________
C. A x B = drinks/wk x 52 = ________ drinks/yr
D. Cost/drink ________ x drinks/yr ________ = ________ cost/yr
E. Hours spend drinking/wk ________ x 52 = ________ hrs/yr drinking
* (These are separate sheets given as homework)

The Goal sheet is covered first. Start with a general discussion of the exercise by asking questions like the following. Was this exercise difficult to complete? Tell me about it. What did it feel like to write down your goals? Have you ever done this before? An open discussion along these lines generally relaxes the clients so they feel more comfortable discussing their specific goals.

Important issues to look for or ask about are illustrated by the following questions. Does the client have goals? Is there excitement and commitment for these goals? How specific are the goals? Is there a plan to follow? Is the client following the plan? How is progress being evaluated? How will the client know when the goal is achieved?

If there is some vagueness about goals the following quote from “Alice’s Adventures in Wonderland” (Carroll, 1981) often puts things in perspective and encourages discussion. The quote is from the point in the story where Alice meets the Cheshire Cat.

“Cheshire-Puss ---- Would you tell me, please, which way I ought to go from here?”

“That depends a good deal on where you want to get to.” said the Cat.

“I don’t much care where ---” said Alice.

“Then it doesn’t matter which way you go,” said the Cat.

The quote makes obvious what is often obscured to us by the complexities of our lives. And it does so in a non-threatening manner. In a supportive encouraging atmosphere most people are willing and eager to talk about what they want. This is also an opportunity for teaching/learning about goal setting, making plans and commitment to action.

Once the goals have been thoroughly discussed it is time to look at the specific alcohol related behaviors as outlined in the ‘COSTS (What are you doing?) exercise. The first step in doing this is to compare pictures. It is important to know what the client really means when he or she is talking about drinking. Experience has revealed that “one drink” was really almost a fifth of vodka and “one sip” was really chugging a 16 ounce beer. Looking at other pictures has revealed that some people don’t consider drinks at dinner or a couple of beers in front of the TV as drinking. Others don’t call it drinking if it is only beer. Still others don’t consider it drinking unless they go out and have several. Looking closely at these pictures can be very revealing.

Before discussing the actual answers to questions A through E on the COSTS sheet, ask if there were any surprises. This helps the client relax, encourages participation and gives the counselor a clearer picture of the client’s behavior.

When the actual answers are discussed look for any areas of potential conflict. Are the number of drinks high and the costs low? Are clients bragging about mooching drinks? How has this behavior affected the client’s relationships? Does the time spent include recuperation and work days lost? Were lost wages included in the costs or even considered by the
client? Were there days when the client went without even one drink?

These questions plant ideas, encourage discussion and help both the client and the counselor to more clearly define and understand the actual behaviors and costs associated with them.

THE MOMENT OF TRUTH

Towards the end of the discussion, ask the clients how many hours a week they spend at work during an average week. If the clients are students, ask how many hours a week they spend in class. Compare that to the number of hours spent drinking.

Ask the clients if their behavior is getting them what they want now or taking them in the direction they want to go. Regardless of the answer, the opportunity to use Reality Therapy and Control Theory is unlimited. If the answer is “YES” it would be appropriate to review the process to make sure the clients are really getting what they want. If the answer is “NO” it would be important to work with the clients to help themselves to get what they want. Either way is a potentially win-win situation.

From my experience there are a couple of ways to use this process with alcohol abusers. There is the level of basic excuses that centers around not having enough time and money to get or do what they really want. These exercises can clearly point out how much time and money are spent on inefficient activities. From here it is possible to move in many directions.

Do the clients see any importance in changing either their goals or their behaviors? What changes would they make? How could they use their time and money more efficiently to help them reach their goals? Working at this level may be enough with clients who have clear goals and enough strength, but have just lost focus. There is however, another group of clients that have neither clear goals nor the strength to reach them.

Our strength, or sense of competence and self-worth, comes from our successes. Our successes initially come within the context of our families, and result from our knowledge and skills being valued by our family members. This initial success can be fostered by our school systems. Often though, our families and schools have failed to nurture this strength and sense of self-worth.

Clients who lack this strength have developed a myriad of behaviors in order to cope. Some of these behaviors are giving up, delinquency, mental illness, psychosomatic illness, depressing and addictions of all kinds. These behaviors were adopted by the clients to survive. Within these behaviors are knowledge, skills and energy that have not been recognized, valued and guided into more socially appropriate need fulfilling behaviors.

Reality Therapy and Control Theory, in the hands of a skillful practitioner, are powerful tools to help clients develop strength, a sense of self-worth and behaviors that lead to successfully meeting their needs.

References


INTERNATIONAL RESOURCE LIBRARY

The Board of Directors has approved the establishment of an International Resource Library to be housed at Northeastern University, the home of the Journal for Reality Therapy. This library will contain the following:

1) Annotated bibliography of all published articles.
2) Abstracts of doctoral dissertations regarding reality therapy and control theory.
3) Identification of books, media, and other resources available elsewhere with names, addresses, and sources of such material.

The October 1992 resource library is available upon request at a production/mailing cost of $7.00. In addition, individuals are encouraged to send information, materials, etc. to the Library for listing. The mailing address for the Library will be:

Reality Therapy Resource Library
203 Lake Hall
Northeastern University
Boston, MA 02115
Telephone: 617-437-2485
USING REALITY THERAPY FOR EXERCISE INITIATION

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Habitual physical activity has been found to have a favorable influence on health conditions, including coronary heart disease (Haskell, 1984), hypertension (Siscovick, LaPorte, Newman, 1985), osteoporosis (Krolner & Taft, 1983), diabetes (Siscovick, et al., 1985), acute respiratory disease (Hanson, 1984), low back pain (Deyo, 1983), and mental illness (Morgan, 1982). In light of the known benefits of regular exercise, 40% of Americans do not exercise during leisure time, another 40% are active at levels probably too low and infrequent for fitness and health gains, while just 20% exercise regularly and intensely enough to meet the current guidelines for fitness (Stephens, Jacobs, & White, 1985) or to reduce the risk for several chronic diseases and premature death (Paffenbarger, Hyde, Wing & Hsieh, 1986). Interestingly, about one-half of those who begin or renew a personal exercise program will fail to maintain it at the level initially intended, and a like proportion have failed in previous attempts (Dishman, 1988). Due to the high probability of exercise “dropout”, the study of exercise adherence has become quite popular in recent years (Dishman, 1988).

Adherence refers to “continued involvement”, thus, this definition assumes that an individual has begun a program, but has had difficulty maintaining active participation in his/her program. What about those individuals who have never commenced upon an exercise program, yet believe exercise is something they “should” do — is their problem one of initiation? It would appear that these individuals need guidance specific to “initiation” or “getting started”. Obviously, the benefits of exercise cannot accrue for the inactive, therefore, not only are we concerned with getting these people started, but we need to help them to develop a program that is both realistic and effective that ensures that they will get what they want. It is possible that traditional attempts at “getting started” have contributed to adherence problems later on in one’s program if an exerciser’s specific needs are not recognized early on as he/she commences upon his/her exercise program. Therefore, while current adherence issues focus on continuance, it is proposed that specific strategies need to be developed for initiation. Perhaps, in the long run, this specificity to “exercise initiation” will result in fewer adherence problems.

Based on my own experience counseling “would-be” exercisers, I have found that Reality Therapy is an effective method for helping individuals to initiate a realistic exercise program. In this paper I will outline how I have applied Glasser’s approach toward counseling individuals interested in initiating a personal exercise program. Specifically, I will address how exercise involvement may contribute to meeting the basic needs, the unique nature of the exerciser’s picture album, and the application of the steps of Reality Therapy to exercise initiation counseling.

Basic Needs Met Through Exercise?

Glasser (1984) believes that people are driven by five basic needs, that together make up the forces that drive all individuals. The basic needs include; survival, belonging, power, fun and freedom. Glasser states that one must satisfy these five needs continually and that one quickly becomes aware of any need that is not satisfied. He notes that, once aware of a need that is lacking, one has no choice but to satisfy that need. Exercise involvement can contribute to meeting most of the basic needs.

The first need, the need to survive is considered an immediate need — in order to belong, to have power, to experience freedom, and to have fun, we must survive! Admittedly, food, sleep, and shelter are the primary requirements for survival, yet exercise participation may positively influence one’s overall health status which may lead to prolonged survival.

The need to belong may also be enhanced via exercise participation. For example, some of the clients I see tell me that they have limited social opportunities to meet other people, or they believe that there are few activities they can share in with their spouse and family. Active participation in an exercise program may open up many new opportunities for meeting others (e.g., community gyms, fitness clubs, walking trails). Also, as will be addressed later, one of the main motives for exercise involvement is weight reduction/maintenance. Often times, however, once the weight is lost, the client loses interest in his/her exercise program, only for those extra pounds to reappear in the future. If the activity can be shared with loved ones (e.g., walking with a spouse), the client may be motivated to continue due to the social nature of the activity — enjoying the shared time with his/her spouse, friends and/or children, while at the same time benefitting from the weight loss/maintenance.

Exercise involvement can also contribute to the need for power. We may begin to set health goals for ourselves, such as, weight loss per month, miles walked per week, lowering of cholesterol, and so on. Therefore, we can achieve power from intrinsic sources as we sense increases in our own self-esteem, confidence and commitment.

The need for freedom may be one of the more obvious needs that can be met via exercise participation. A daily exercise schedule can allow an individual to “get away from it all” for a while. For example, I often ask my clients how much time they have to themselves from the minute they get up in the morning to the time they go to bed. A large majority of them laugh upon being asked this question, saying that they have little time to themselves. It is not surprising, then, how interested they are in finding some time for themselves. Approaching exercise as a way to “kill two birds with one stone”, that is, allowing oneself a little freedom (i.e., time to oneself)
while, at the same time, benefitting physically is quite palatable to a majority of "would-be" exercisers.

Finally, the need for fun can be achieved through exercise participation, however, it is often difficult to convince a "would-be" exerciser that exercise can be fun. Unfortunately, many individuals have a negative attitude toward exercise. This attitude can be the result of unpleasant physical activity experiences as a youngster (e.g., being picked last in gym class), unrealistic goals (e.g., wanting to lose 20 pounds in two weeks), or simply believing exercise is a physically uncomfortable means (e.g., sweating, breathing hard, muscle aches) for getting what they want. Using the process of Reality Therapy outlined below, the exercise counselor can help the "would-be" exerciser to have fun right off the bat by designing pleasant exercise experiences that include realistic goals and do not lead to uncomfortable physical sensations.

Most would-be exercisers initiate an exercise program to fulfill an extrinsic goal such as weight loss. Obviously, commencing and committing to an exercise program can help an individual meet this goal. The key to continued exercise, however, is making the activity intrinsically satisfying. If the exercise counselor can help the exerciser see how his/her program can provide the intrinsic rewards of belonging, power, freedom and fun, "get started" need not require extrinsic motivators such as weight loss — fortunately, these will come in time.

The Exerciser's Unique Picture Album

The basic needs are often not met directly, but rather are met through the inner world of wants — the picture album (Glasser, 1984). In applying Glasser's picture album analogy to the "would-be" exerciser, I have chosen to expand on the nine characteristics of the inner picture album as offered by Wubbolding (1985):

1. **All pictures are need fulfilling**: The pictures an individual chooses to insert into his/her album are based upon satisfying a need in some way. Therefore, an individual may insert a picture of him/herself 30 pounds lighter with increased muscle tone.

2. **Pictures are related to each sense**: Our wants are related to sensory "wants". Thus, we may visualize ourself as "more attractive" 30 pounds lighter or we may sense the muscle tone that would result from exercise participation.

3. **Pictures are removable**: Pictures can be removed from and/or changed in our album. For example, many exercisers focus on weight loss rather than fat loss. With the help of an educated exercise counselor, the exerciser can change his/her picture from "losing 30 pounds" to "losing 10% fat", thereby focusing on an optimal body composition (lean and fat percentages), rather than simply on weight loss.

4. **Some pictures are realistic and some are unrealistic**: Everyone has at least some unrealistic wants; this is not abnormal. However, the key to exercise counseling is to determine whether or not the client's pictures can be fulfilled through a realistic exercise program (see "Application of the Process of Reality Therapy to Exercise Initiation" below). Perhaps the exerciser wants to look like a 5'10" model, yet is only 5'4" — obviously this picture can not be fulfilled via exercise (perhaps by surgery, but not by exercise!).

5. **Pictures are specific and unique**: The basic needs are general motivators, while our pictures are quite specific. Therefore, although two exercisers can see exercise involvement as fun, one person may not think it is fun if it is performed at 5:30 am, while the other person may not think it is fun if it is performed during the lunch hour.

6. **Pictures can be blurred**: Wubbolding (1985) states that a "clarity-continuum of pictures can be identified from 'crystal clear' to 'very blurred'" (p. 29). Applied to the "would-be" exerciser, he/she may be interested in beginning an exercise program, yet may not be sure what mode of exercise he/she would be most interested in (e.g., walking, cycling, aerobic dance, weight training).

7. **Pictures exist in priority**: Some wants are more important than others. For example, an exerciser may be most interested in toning his/her lower body, rather than the upper body, or may prefer cardiovascular exercise over muscular exercise.

8. **Pictures can be in conflict with one another**: New pictures can conflict with old pictures, as people are motivated to mold the external world to match their ever changing inner world (Wubbolding, 1985). Your client may desire a "fat burning" exercise prescription, yet may not be willing to partake in the most efficient prescription for this goal — aerobic exercise of long duration and moderate intensity.

9. **Pictures can be in conflict with the pictures of other people**: It is possible that the picture your client has in his/her picture album is realistic, yet may be in conflict with the pictures of another person. For example, as mentioned previously, some people desire to begin an exercise program in an effort to lose weight. Unfortunately, their efforts can sometimes be sabotaged by another who does not want them to lose weight (e.g., spouse).

According to Glasser (1984), our picture album is "the world we would like to live in, where somehow or other all of our desires, even conflicting ones, are satisfied" (p. 30). As an exercise counselor helping individuals to initiate exercise programs, I have found it helpful to discover my client's unique "exercise picture album" in order to better understand my client's wants. Once I determine the exerciser's wants, I am better equipped to design a program that is fulfilling and one that the exerciser may be more motivated to continue.

Applying the Process of Reality Therapy to Exercise Initiation

Glasser's Reality Therapy offers a systematic method of assisting the client as he/she pursues his/her wants. Applied to exercise counseling, this approach places the responsibility for exercise initiation on the exerciser, as he/she is encouraged to take control of his/her behavior. Glasser's
approach can assist the “would-be” exerciser to develop a realistic exercise plan that is satisfying, in and of itself, therefore, a plan that is more likely to lead to motivated initiation and future adherence.

**Make Friends and Ask What Do You Want?**

In the initial stages of exercise counseling it is important to gain the trust of clients. A large part of “making friends” with clients is accepting them as they are. This is especially important in exercise counseling as many of the clients may be overweight and may be looking for guidance in developing an exercise program as a method of weight loss. Logically, many exercise counselors are interested in this form of counseling due to their own participation and belief in the benefits of exercise. Unfortunately, although well-meaning, the enthusiasm many exercise professionals display can be intimidating to people who perceive themselves as uncoordinated, “out-of-shape”, “not worthy of exercise”, or who have not “internalized” the exercise process. When making friends, make it clear that you are interested in helping the clients meet their needs, not your own. To lighten the atmosphere, I will often say something like, “I’m not here to turn you into ‘Marathon Man’ or ‘Aerobic Annie’. I’m here to help you develop a plan that will work for you — incorporating your likes, your schedule, etc…”.

This approach is effective for those clients who may be threatened by their perceptions of what you have “up your sleeve”. Obviously, for those individuals who are looking for a more advanced program, you may “make friends” by sharing common exercise goals and interests.

Once you have made friends, your clients may be more comfortable being honest with you regarding their wants. At this point, simply ask, “what do you want in an exercise program?”. It is important that you do not make value judgments at this stage. For example, clients may say that they want to lose 50 pounds in three weeks. Although you may know that this is highly improbable via a healthy approach, suspend judgment. It is likely that your clients will come to the same realization as your counseling sessions progress.

**What Are You Doing Now?**

If weight loss is the goal and exercise is the preferred means, ask what they are currently doing to get started on an exercise program. If they have not started at all, share with them that they may not realize it, but the simple fact that they have sought exercise counseling is evidence that they have done something. This comment serves a dual purpose, first, it is a compliment (“keeping a friend”) and, second, it gives clients tangible proof that they have indeed done something. This is also a way to uncover previously tried weight loss strategies that have led to the decision to choose exercise “this time”. Keeping a mental log of what they have done in the past may be beneficial to your counseling session as evidence of previous unsuccessful attempts (e.g., weight via loss yo-yo dieting) may lend support for the current plan.

**Is What You Are Doing Helping You?**

To continue, ask if what they are doing is helping them. If they are looking to get started on an exercise program, once again, the mere fact that they have sought help is evidence that they have done something. Even at this early stage, ask them if they think the counseling is helping (or whether they think it will help) — this will help to obtain further cooperation.

Aside from their acknowledgment that they have come to see you, they may admit that they haven’t done anything else. Obviously, if they are not doing anything, what they are doing (i.e., nothing) is hurting them, however, it is crucial to have the clients acknowledge this fact as this allows them to become responsible for their behavior.

**Make A Plan To Do Better**

This may involve the majority of the time of the exercise counseling session. Although it is stressed that the clients acknowledge their behavior and take an active role in their exercise plan development, your services have been sought due to your exercise expertise. At this point, a fine line develops between guidance and client “ownership” of their plan. As noted earlier, you may help would-be exercisers to determine what exercise program may be most comfortable based on information they shared with you (likes, schedule, past weight loss attempts, etc). As you develop an exercise plan, it is crucial that you allow clients to “personally design” their program, while you act to guide their plan development with leading questions such as, “You shared with me that you do not enjoy getting up early, what time of day would be best for you to exercise?”, and, “Given that you have decided that after work is the best time for you to exercise, what days of the week are going to be the best days for you to exercise?”, as well as, “You mentioned that you do not have any exercise equipment in your home, what activities might you be able to do that do not require equipment?”, and so on. Asking leading questions allows you to guide the exercisers, but puts the responsibility of plan development on them. According to Geronilla (1985), the plan must be simple, realistic, specific, repetitive, flexible, and immediate.

**Obtain A Commitment**

Once the plan is developed, the counselor must obtain a commitment from clients. More than likely, if clients have played an active role in their plan development, and their plan is simple, realistic, specific and flexible, obtaining commitment may come easily. The challenge for the counselor, at this point, is to stress the repetition of behavior and the immediacy of commencing the plan. This is particularly true for exercise-based counseling, as physical goals — such as increased endurance or decreased weight — can only be achieved through consistent behavior (repetition). Also, as with any other goal, the longer people wait to initiate, the less likely they may be to initiate!

I have found it beneficial to develop an exercise contract based on the plan that is formed. Once gain, the contract offers an additional means by which to obtain a commitment. In Geronilla’s (1985) article on patient non-
compliance, she states that “data now support the provider-client contract as a tool for increasing the likelihood of compliance to prescribed therapy” (p. 10). She lists the advantages of developing a contract as:

- a written outline of behavioral expectations is created;
- the client becomes involved in the decision making process concerning the regimen and thus has an opportunity to discuss potential problems and solutions;
- a formal commitment to the program is elicited (p. 10).

Therefore, in addition to agreeing on obtaining commitment to “the plan”, the “contract” may also include commitment to an agreed upon initiation date and weekly frequency of the planned exercise behavior.

Don’t Accept Excuses

As an exercise counselor, you are likely to hear a variety of excuses for noncompliance: bad weather, lack of time, too tired, other commitments, and so on. Although some reasons for noncompliance are valid and should be attended to (e.g., injury, illness, undue fatigue), the majority of excuses simply cannot be tolerated when utilizing a Reality Therapy approach. As Geronilla (1985) echoes, “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” (p. 10). Interestingly, the counselor can use excuses as “ammunition” to ask whether an excuse is “getting them what they want?”. Obviously, if excuses continue, you may need to back up and have the clients determine what it is that they really want.

Don’t Criticize Or Punish

If clients are not adhering to their plan, the exercise counselor must be careful not to criticize their behavior, after all, the focus is on what the clients want — not what the counselor wants. Once again, the process of Reality Therapy allows the counselor to “back up” and ask the clients to evaluate the efficacy of their behaviors and, if needed, to re-evaluate what it is that they want. It is possible that continued noncompliance is a signal that “the exercise plan” may need to be re-designed. Even the most realistic exercise plans may need to be modified. Also, some clients may need to experience continued states of frustration, failure and/or disgust to “truly” become motivated. For example, clients who do not initiate their plan may find themselves continuing to gain weight or experiencing chronic shortness of breath. In time, this continued weight gain or lack of endurance may lead them to become more serious about their wants.

Never Give Up — Have Continuous Follow-Up

To conclude, believe in your clients and give them continuous support as they work towards initiating their exercise plan. As mentioned earlier, many clients may have had negative exercise experiences in the past, possibly due to their perception that others did not believe in them or support their efforts. By expressing to clients that you have faith in them and that you truly believe they can do it, your clients may find you to be a “refreshing” exercise professional and you may become an integral part of their motivation to initiate their exercise plan. Also, continuous tracking of their exercise behavior via phone calls, follow-up sessions, or written communication will serve as reminders about their commitment to their exercise plan.

Given the variety of physiological and psychological rewards of exercise participation (Dishman, 1988), a large number of people can benefit from initiating a personal exercise program. As this paper has described, the nature of the initiation process may be a crucial component of future exercise adherence. Reality Therapy can be easily applied to exercise counseling, offering an effective method of helping “would-be” exercisers get what they want — committing to a realistic exercise program!
The purpose of this article is twofold. The first part of this discussion will suggest that exercise therapy has the ability to address the four aspects of total behavior as reality therapy; thus, exercise therapy can serve as a powerful adjunct to reality therapy in the treatment of anxiety and depression. In short, evidence that suggests that exercise therapy addresses the four aspects of total behavior as reality therapy will be presented. The second part of the discussion will work from the assumption that exercise therapy and reality therapy can work well together and will provide specific suggestions for implementing exercise therapy from a control theory perspective.

EXERCISE THERAPY FROM A CONTROL THEORY PERSPECTIVE

While adages such as "a healthy body-healthy mind" imply the benefits of regular exercise, it has only been recently that convincing evidence has accumulated supporting the strong relationship between exercise and reductions in anxiety and depression (Sime, 1984). While there continues to be a multitude of unanswered questions in this area, some consistent findings have emerged. In the following section, the four aspects of total behavior will be discussed in relation to what is known about improvements in mental health as a result of exercise.

**Physiology:** When using control theory, a strong emphasis is not given to trying to change individuals' physiology because of the difficulty one typically encounters in trying to change this aspect of behavior (thus, it is analogous to one of the back wheels of the car). While the difficulty of influencing a depressed client's physiology may be quite real in many conventional counseling environments, it is suggested that exercise therapy may aid the counselor and client in producing direct effects on physiology and thereby induce improvements in mental health. For example, one substance whose production is thought to be stimulated by exercise is known as beta-endorphins. Beta-endorphins are naturally occurring substances produced by the brain, the pituitary gland, and other tissues (Morgan, 1985) and these endorphins produce a morphine-like state that people describe as "euphoria". It has been suggested that aerobic exercise of moderate to high intensity stimulates the production of these endogenous opiates producing what is referred to as "runner high" or its more general term "exercise high" (Benyo, 1990). So powerful are the effects of beta-endorphins in producing positive mood states that they are thought to play a part in the development of exercise addiction in those individuals who develop a "must-have" craving for its effects.

A second substance that is thought to improve moods as a result of exercise is norepinephrine. Similar to beta-endorphins, norepinephrine is a substance produced by the body's hormonal system. Studies have shown that depressed individuals tend to have low levels of norepinephrine, but it appears that exercise may be able to restore norepinephrine to those levels that nondepressed individuals experience (Brown & Van Huss, 1973; Ransford, 1982).

In summary, because of the physiological changes associated with exercise, getting depressed/anxious clients to exercise may be a way to provide them with an appropriate adjunct to reality therapy.

**Feeling:** The improved mood states/feelings, following exercise, which frequently last up to five hours, suggest that exercise is one way to help clients who are attempting to choose to stop depressing. Numerous studies (Goldwater & Collins, 1985; Weinberg, Jackson, & Kolodny, 1988) have shown that exercise is associated with reductions in negative feelings and increases in positive mood states, creating what is often called an "iceberg effect" among regular exercisers. This iceberg effect is represented by high scores on scales such as vigor and energy and low scores on measures such as tension and anxiety. It is also important to note that aerobic exercise may be more beneficial than other types of stress reduction techniques such as massage (Weinberg et al., 1988) which focus on the externally provided or outside-in and that the longer that the exercise program continues, the greater the changes in positive mood states tend to be (Petruzel, Landers,
The fact that positive changes in mood may take awhile to become apparent reinforces Glasser’s urging to “Never Give Up!” on a client while the client is developing new original behaviors.

Thinking: According to control theory the thinking aspect is represented as one of the front wheels of the car because it thought to be an aspect of total behavior over which individuals can exert a great deal of control. It is thought that individuals benefit from exercise not only because of the activity per se but that because the activity allows them “time-out” from stressful situations (Bahrke & Morgan, 1978). In other words, exercise provides a needed distraction period that allows the cycle of negative thoughts and behaviors to be broken. Viewed from a control theory perspective, exercise therapy can be seen as a way that does not so much change what people are thinking as much as it is encouraging them to start doing.

Doing: Reality therapy interventions stress getting clients to change what they are doing as it is thought that this helps maintain a “here-and-now” orientation, therefore focusing on changing what is under clients’ control. Exercise therapy may play a role in reinforcing the focus on the doing component of behavior because it allows individuals to take control of their muscle movement, exertion level, etc. - all of which provide a powerful source of personal control (Solomon & Bumpus, 1978; Sonstroem, 1984). Hinkle (1988) suggests that the feelings of mastery acquired through exercise may generalize to other aspects of the clients’ life. In addition, because exercise is associated with reductions in body fat composition and increases in muscle mass, “fit” individuals may perceive themselves as more attractive in our society and thereby experience increased confidence in social interactions.

To summarize, the discussion so far has suggested that exercise therapy closely reflects the tenets of control theory. Because exercise therapy and reality therapy appear to work on the same four aspects of total behavior, it seems that they are well suited for use together. The remainder of this article will focus on providing specific guidelines for clients and therapists who are working together to initiate an exercise program aimed at reducing anxiety and depression. These guidelines integrate a control theory perspective with what is known about the effective use of exercise therapy.

EXERCISE THERAPY GUIDELINES FROM A CONTROL THEORY PERSPECTIVE

Exercisers should:

- see a physician for a complete physical (including a stress test) before undertaking an exercise program.
- establish a goal of exercising a minimum of 3-5 times/week at an intensity of 70-85% of maximum aerobic capacity. While exercise at moderate to high intensity (as the above) seems to be necessary, in order to bring about the desired mood changes (Berger, 1984), exercise therapy should be enjoyable to individuals as enjoyment is associated with continued participation (Berger, 1987; Berger & Owen, 1988).
- establish a goal other than just that of relief from their depression/anxiety (i.e., learn to enjoy the exercise experience itself).
- develop an awareness of physical and psychological strain in order to be able to distinguish between the discomforts of exercise from the pain associated with overuse injuries.
- exercise with others if possible. Exercise partners who are of similar ability and supportive are the most desirable.
- keep a record of activity in order to maintain self-motivation, provide feedback, and verify progress.
- develop a contract with themselves that provides rewards for success - there are sure to be many!

Counselors and Exercise Therapists should:

- recognize exercise therapy is not an elixir. More specifically while those with mild depression may respond well to exercise therapy, more severe endogenous depression and those occurring in conjunction with psychotic episodes may not show improvements.
- be aware that self-acceptance is a vital part of self-concept and that well designed exercise programs will promote self-acceptance. Self-acceptance can be enhanced through non-judgmental feedback at the end of fitness evaluations, individualized fitness programs that correspond to clients current ability, and acceptance of clients regardless of fitness levels.
- be aware that 98% of the clients beginning treatment at a mental health clinic indicated that they would be willing to undertake an exercise program if it was recommended by the mental health counselor (Leer, 1980). However, therapists should realize that at the outset of an exercise program novice exercisers often do not perceive the experience as pleasurable. As a result, mood elevations may not occur immediately. Counselors may need to encourage exercisers to focus on short-term and/or intrinsic rewards at the beginning and encourage a gradual shift to the development of intrinsic rewards.
- be sure at the outset that the dosage of exercise is correct and follows a preplanned graduated approach, and involve the client in the design of the exercise program. As with any other plan adherence is improved if the client values the activity and contributes to its development.
- acknowledge that exercise can be a double edged sword and that:
  1) the possibility exists that patients may become negatively addicted to exercise; individuals with compulsive personalities may be especially prone to this condition.
  2) excessive exercise has been linked to anxiety and depression (Dischman, 1988), so moderate exercise levels that do not disrupt job, family responsibilities, etc. should be encouraged.

Conclusion

This article has attempted to establish links between control and exercise therapy. It has been suggested that these approaches may be integrated and provide therapeutic effects especially for those experiencing anxiety and depression.
REALITY THERAPY AND THE CONCEPT OF COGNITIVE DEVELOPMENTAL STAGES

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Introduction

It is not a new thing to say that the way we practice Reality Therapy is the way people learn best. Clearly, we practice Reality Therapy the way we do because it works to help people picture new or at least different ways of behaving and begin to try new doing behaviors and incorporate those behaviors into their own repertoire. At the same time we, the counselors, are doing the same. That is the nature of human exchange that leads to growth. The result is both of us change or grow through this interchange as needs are being filled and especially if we are risking new behaviors. I have been thinking about this process and what it means to me in terms of some of the literature I have read over the last few years.

I have found myself reflecting on the way I practice Reality Therapy. I notice myself building a relationship with the client (as Glasser says creating a supportive counselling environment), and I find myself gently sensing what is happening to that relationship and holding on to it at all costs. At the same time I find myself trying to identify with the client’s experience, to locate some pictures that he/she currently has in his/her quality world and working with those pictures. Often the pictures are not what I would call quality at all. Often the nearest I can come to the client’s quality picture is quite different, and by gentle questioning I find myself locating a picture in my head that the client can want and believe is attainable for him/her. I remember seeing Glasser do just that in a role play with a man who was a drug addict and whom he finally helped to choose to go to a party with a male nurse. The point I am making is that I find Reality Therapy often to be a juggling act searching for quality pictures that the client can believe for himself/herself while constantly building trust to help the client’s believing. I seem to be purposefully opening up new “quality” pictures for the client to consider. I always ask myself, “Have I built enough trust for him/her to risk believing this picture enough to try it”. What interests me is where this pattern appears in the literature. From all the things that could be said about how this pattern relates to developmental stages, I have chosen a few.

John Powell

I remember reading a book by John Powell (1976) in which he describes something he calls “vision therapy”. The central point of his idea seems to be that we humans grow not through accumulating more information like stacking bricks, but by changing vision such as developing...
a new way of looking at the same bricks so that they can be resorted into a new stack. The information is the same, but the way we arrange it in our head is different, and the rearranging is a painstaking and risky business. I believe that we are doing something like this in Reality Therapy. We are helping people look at the same information in a new way, to build a new picture that they will act upon if we can maintain enough of the counseling environment for them to risk the test to see if that picture can work for them.

I have noticed also how tired and stressed my clients often are as a result of trying to choose their behaviors from the old pictures that used to work but no longer seem to give consistent positive feedback. All this rang true for me when I recently read a passage from Powell's (1976) book "Fully Human Fully Alive". This passage helped me understand the process of denying reality. He said:-

However, staying in the old ruts isn’t easy either. To persist in the old, diminished vision requires that one must constantly deny all contrary experience and information. One must stubbornly reassert his or her faulty vision in the face of mounting contradictory evidence. This can be strenuous and exhausting. It results over a period of time in considerable inner tension and stress. And the stronger the contrary evidence, the more energy the poor person must expend in the mechanism of denial (p. 85).

Not only is the process of restacking the bricks an energy consuming one, but so is the process of denial of reality. The difference that makes the change desirable for the client is the relationship with the counselor. Presumably this is true whether the picture to be chosen is something relatively simple like choosing to be accompanied to a party by a male nurse, or even if it is a complex matrix of pictures like "the way the world works for me". This "the way the world works" picture is what Thomas Kuhn (1970) describes as a paradigm. What I am saying is that whether it is dumping a former picture as simple as "the way I go to parties", or whether it is dumping a former paradigm like "the way the world causes me to behave"; in either case it is only trusting relationships that will lead me to knock down the pile of bricks that have been laboriously stacked over the years, and more trust that will lead me to restack them. This is why even small changes often are so slow, and why paradigm shifts, like the one that Wigle (1989) describes from S-R theory to Control Theory, are so painfully slow to begin and slow to continue as we restack the bricks.

Piaget

Those of us who do Reality Therapy are probably not very conscious of stages of human development as we support our clients to try to picture themselves behaving differently, but we certainly are conscious that growth is a rather "lumpy", discontinuous process. The simple behaviors our clients choose to try today are the small lumps in the developmental process, and the bigger lumps are the stages that have been identified by Piaget (Ginsburg & Opper, 1969) and perhaps Maslow (1968). If Reality Therapy is the best way for us as humans to be guided through the small lumps, then it must be the way over the large lumps as well.

Piaget (Ginsburg & Opper, 1969), seems to have been more interested in the processes underlying thinking than the actual content of the thinking. He focussed particularly on stages of development of thinking through childhood and adolescence. He used tests, the content of which we associate with math and science to identify stages of thinking, and found each stage to be qualitatively different from the former in that it involved a change to the underlying ‘structure’. Stage transition, he found, depends on a mix of development and experience. To quote Ginsburg and Opper (1969): -

... cognitive advance occurs as a function of appropriate neurological development, a proper social environment, experience with things, and internal cognitive reorganization (p. 206).

The point is that for Piaget, after a lifetime of experience of observing intellectual development, learning is a lumpy process. It involves inherited developmental stages and experience with the social environment and things, to produce a cognitive reorganization, a reorganization of the pictures. So Piaget agrees with Powell (1976) about the discontinuous nature of development, and that stage transition means internal reorganization. We can glean more however. If the stages are as certain as they seem from the literature, we can say that our common human genetics is the likely source of these stages. What I am saying is that apparently Piaget’s stages are part of the genetic plan. How else can the stages be so generally applicable across the species?

Now we can conclude that if, as Glasser says, the needs are genetic; then it appears that the stages of development that we pass through as we fill our needs are genetic also. In other words, the kinds of behaviors needed to fill the needs to lead a happy life are genetically determined; so are the kinds of behaviors needed to reach the sequential stages of development and so are the stages themselves. It appears that whatever our experience, it is the amount of need-fulfilling experience that counts and that the pictures (bricks) need to be reorganized periodically for stability. When we know about needs, we also know which kinds of behaviors are best for development to reach and transcend the sometimes difficult stages. Further, just as something in our body triggers a signal that we have what we want and that our needs are momentarily fulfilled, so something in our body triggers the reorganization of experiences that is a stage transition. We believe that it is the genes that send the signal to stop making red blood cells or bone cells, so it is probably the genes that signal the appropriate time for stage transition also.

That leads me to ask two questions.

1. Are there more stages of the sort recognized by Piaget and Kohlberg of which we are unaware and

2. If stage transition is achieved through accumulating need-fulfilling behavior, can we think of the small lumps as stages in filling the needs, a bit like laying a single brick in the wall? That is the picture I seem to
be choosing, namely that need-fulfilling behavior lays down courses of developmental bricks, and the genetic plan decides when the structure is becoming unstable and must be reorganized. We are reluctant to restack our carefully laid bricks but finally it becomes inevitable as we see the reality that our cognitive structure is now unstable. It may be that when we can believe that individuals with whom we are involved have already restacked their bricks, we can believe that it is possible for us to do it too. Again, that is the way of Reality Therapy.

Sprinthall and Thies-Sprinthall

These two authors dropped the word 'learning' in favor of "cognitive development". This is interesting, especially since their main interest is in the development of adults whom many believe to be past developing. They have accumulated an impressive list of evidence to support cognitive development which they see as occurring in the following way and their work summarizes much of what I have been trying to say.

1. All humans process experience through cognitive structures called stages - Piaget's concept of schemata.
2. Such cognitive structures are organized in a hierarchical sequence of stages from the less complex to the more complex.
3. Growth occurs first within a particular stage and then only to the next stage in the sequence. This latter change is a qualitative shift - a major quantum leap to a significantly more complex system of processing experience.
4. Growth is neither automatic nor unilateral but occurs only with appropriate interaction between the human and the environment.
5. Behavior can be determined and predicted by an individual's particular stage of development. Predictions, however, are not exact." (Sprinthall and Thies-Sprinthall, 1983, p. 16)

Implications

The important point, however, is how the concept of stages helps enhance our understanding of Control Theory/Reality Therapy. As a Reality Therapist, I am interested to know about stages because they help me understand how the counselor and the client can often ascribe such different meaning to the same information. If a lifetime were represented as a graph of need-fulfilling behaviors over time, and if we imagine counselor and client on either side of a reconstructive stage transition then the difference in perceptions is clearer (See diagram 1). The client perceives information based on the way he has arranged his bricks so far. The counselor has rearranged his bricks and perceives the same information differently. The counselor encourages the client to imagine the possibility of a different arrangement of bricks and to start trying behaviors to test it. Eventually however, the client begins to see that he/she must do enough behaviors to reconstruct his/her wall completely, and this is a risky business.
The tendency at developmental stages is to stop behaving as much as possible because it hurts to rebuild and this is why modelling and trust are so important. But the concept of developmental stages helps the counselor reaffirm the importance of constant need-fulfilling behaviors because these are the way to stage transition. To know about developmental stages helps to understand why we are often unprepared to take risks, why some clients struggle to make even the smallest change, and why some who are between stages progress quickly. It helps us understand why some of us as counselors work so hard to help clients restart old behaviors and search for new ones, but it gives us hope. This model confirms what Glasser implies, that stage transition is inevitable if we keep trying need-fulfilling behaviors, because stage transition is written in the genes.

Maslow

Maslow's (1968) book “Toward a Psychology of Being” is on my mind because it talks about what appears to me to be one more stage. Perhaps this is related to the paradigm shift from SR theory to the Control Theory model, but it looks to me more like a second stage within the Control Theory model. (This, however, is not an issue I would like to argue at this time.) Maslow wrote of the “contrasting dynamics of B-love (love for the being of another person, unneeding love, unselfish love) and D-love (deficiency love, love need, selfish love)” (Maslow, 1968, p. 42). He pictured the former as a fully functioning person, mostly giving love with certainty and independence because he/she has all needs fulfilled. He pictured the latter as a person constantly trying to fill his/her needs and substantially dependent on interaction with other people to do so. Based on his clinical work, he saw the change from D-love to B-love in many people that was “much less an acquisition of habits or associations one by one, and much more a total change of the total person, ie a new person . . .”. (p. 39)

There is much in Maslow's (1985) book that suggests psychological development of the type suggested by Powell (1976) and the others. He pictures this change from “needy” to “all needs fulfilled” as being a change in the total person, and leads to a person becoming more stable, more selfless, and more autonomous. One addition is that he sees this change as being triggered by single life experiences such as tragedies, deaths, traumata, conversions, and sudden insights which forced change in the life-outlook of the person and consequently in everything that he did. (p. 39)

This makes sense if we think of a single traumatic experience as a way of bringing us to confront the unreality of our former arrangement of the bricks. Perhaps this was something we had been unwilling to do until we believed that the pain of maintaining the former paradigm was even greater than the pain of the kind of “surrender” needed for rearrangement.

In one of my clients, I notice that the willingness to begin the change to Control Theory arose as a result of the panic filled discovery that punishing his students no longer worked. The most I can say is that, for some people, the paradigm shift from “the world controls me” to “I am responsible for me” is just such a traumatic transformation. I am unwilling to say it is the same transformation of which Maslow (1968) wrote. But there is a similarity in that we see the same kind of developmental pattern resulting in a climax of unreality and an unwillingness to “restack the bricks” until some life experience “demands” it. Also we see the same kind of character changing climax that results in a change in all the behaviors, and most remarkably all this in a complex, highly integrated, holistic being.

Consequences

As a teacher I find some of the consequences of stage development significant because they emphasize the difference between education as recall and education as development. I would like to refer to two specific quotes from Sprinthall and Thies-Sprinthall (1983). The first refers to a teacher’s ability to build the classroom “counseling environment”, something that I find tends in my experience of many Australian schools to be very boss managed rather than responsive and humane. After an extensive literature survey they concluded:-

The overall results were highly similar, namely, that persons judged at higher stages of development function more complexly, possess a wider repertoire of behavioral skills, perceive problems more broadly, and can respond more accurately and empathically to the needs of others.”

It would seem then that stage development is at least as significant a factor in choosing teachers as is knowledge alone, especially if we are to relate to our students/clients as Glasser suggests.

The second quote has to do with the way our training institutions evaluate prospective teachers, especially where the evaluator and the evaluatee are at different stages of development. I am assuming that knowledge is adequate in both cases.

In specific regard to teacher/student supervision, Theis-Sprinthall found a significant relationship between the quality of the supervisor evaluation and cognitive-developmental level . . ., the higher stage supervisors were more accurate in judging the quality of performance in student teaching than their lower-stage colleagues. In fact, it was quite troubling to find that lower-stage supervisors tended to rate higher-stage student teachers most inaccurately” (Sprinthall and Thies-Sprinthall, 1983, p. 21).

Surely stage development is important when lower-stage teachers can wrongly evaluate the skills of higher-stage students. Further, if stage development is as the literature suggests, then the stages alone are a kind of measure of personal quality and by implication suggest the aim of education and the aim of living. The literature seems to be saying that we build and rebuild the complex network of pictures that is probably Glasser’s “All We Know World” that I have represented as a wall of bricks. The literature seems to be saying also that, as we build and rebuild, there is a change (improvement) in the way we relate to other people - a change in our quality.
Conclusion

I believe that "quality" means personal "quality development", and that in examining development it is worth noting the direction in which the stages are heading; namely to a person who is more complex and holistic, more perceptive and responsive, and more empathic to the needs of others. Quality then, is at the end of that continuum.

Whatever the trigger that begins the process, I am convinced that development is a lumpy process, and that there are many small lumps and some very large ones. I am convinced also that development is through need-fulfilling behavior, that the climax leading to stage transition is genetically determined, and that actual stage transition depends on the Reality Therapy method of relationships and commitment to need-fulfilling behavior. I am less interested in identifying the naming stages than I am in remembering with my clients and students how much patience and commitment goes into real growth and stage transition, and how painful it can be. I am convinced also that memory of information is probably grossly overemphasized as a measure of development. At least I conclude that recall can be. I am convinced also that memory of information is probably grossly overemphasized as a measure of development. At least I conclude that recall is a necessary but not sufficient condition for stage transition, and that this truth is often lost in the training of teachers and managing classrooms.

References

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INTEGRATING DEVELOPMENTAL EDUCATION WITH CONTROL THEORY: ONE COLLEGE INSTRUCTOR’S EXPERIENCE

Larry Siebrands

The first semester of last year I was asked to teach a college course in Developmental Education, "Achieving College Success." It's a course that introduces students to study skills — test taking, time management, note taking, critical thinking skills, organization, speed reading, memory and recall — which prepare them for the academic rigors of the college curriculum. It's a class that I wish I would have had when I started college.

My initial teaching approach to the class was quite traditional. I taught study skills as content to be learned very much like content in other classroom settings. As the second semester began, however, I desired to make some changes in my teaching approach, because I saw limitations to my "traditional" approach. Teaching study skills as a content course helped the student acquire new skills; however, it seemed only to appeal to a student's desire for better grades. As important as that might be, what seemed to be lacking was a sense of involving the whole student, that is, a deeper motivation for learning. What was needed was an approach that sought to motivate the student from within rather than from without, motivation coming from a greater depth rather than for grades alone.

I had taken a course at Kansas State University and had become familiar with Dr. Glasser's control theory. Being impressed with its applicability to the college classroom, I sought to integrate it into my plan for teaching during the second semester. My primary task was to determine which of Glasser's control theory ideas to implement. I spent a little time “daydreaming” about the challenge (Glasser sees daydreaming as a useful time for reorganization and creativity), and settled in on four possible ways to incorporate control theory into my classroom.

First, I decided on implementing the process of jointly collaborating with the students on setting course objectives. Glasser says, "Lead managers do not depend on rules. They try to solve problems by managing the operation in a way that makes it apparent to the workers that if they work hard, they will feel good, which means that they will satisfy their needs" (Quality School, p. 123). My previous boss management approach would have meant setting the course that would be covered, and so on. This time, however, I prepared my syllabus with the dates on which the class met on the left hand side of the page and the topics for discussion on the right side of the page. At the first class session, I invited
desirable topic last. Though not achieving total consensus, the syllabus became
a topic of study first on the list of topics to read and discuss, and the least
students pursued the topics. Discussion had a new edge to it, and activities
a product of group effort.

During the semester, I noticed the heightened enthusiasm with which the
students pursued the topics. Discussion had a new edge to it, and activities
relating to the topics were undertaken with a more interested flavor. At the end
of the semester, I constructed a 25-item questionnaire in which I asked students
to rank select activities on a scale of 1 to 5 based upon their satisfaction with the
topic as an important aspect of the class. Questions which related to their col-
collaborative efforts with the syllabus were ranked high. As Alan Tough (1968) in
WHY ADULTS LEARN states, “Learners who have opportunity to partici-
pate in the goal setting of an activity will approach the task with greater enthu-
siasm and with a higher degree of learning” (p. 45). This effort at introducing
an aspect of control theory was successful!

A second implementation of control theory related to Glasser’s idea of the
importance of daydreaming in order to see ourselves in quality pictures that are
appealing to us, fulfilling one of our needs. Glasser says, “new behaviors are
constantly being made available to us through a remarkable creative process
called reorganization . . . The one time when we almost always become aware
of reorganization is when we dream.”

To expand their daydreaming, I asked each student to participate in a self-
directed learning experience using the Sigi-plus computerized occupational
program which integrates experience, values, educational background, and
other variables and channels them into specific, broad occupational areas.
Someone interested in health sciences, for example, suddenly has a broad
spectrum of 20 or 30 occupational choices within this broad field.

Following the expansion of their vocational dreams, students were asked
to discuss how their vocational dreams had been affected by this experience and
how their course of study at the college contributed to making this dream come
to life. From that discussion, it was an easy jump into the area of producing
quality work to fit with the quality dream. Likewise, it was a fruitful discussion
to be able to talk about how we can reduce the difference between what we
want (our vocational goals) and what we have (our academic endeavors to
make those goals come true).

My end-of-class questionnaire rated this event as quite positive as a factor
which helped them see a reason for their academic quest.

The third major incorporation of control theory into my classroom came
from Glasser’s comment that our behavior contributes a great deal to whether
we can meaningfully pursue and reach our goals in life. Glasser talks about
how perhaps the most powerful behavior in our lives is anger; it acts negatively
or positively on us. Therefore, it is important to know ourselves, what feeling
forces act on us to influence us positively or negatively.

Having had training at administering and interpreting the Taylor Johnson
Temperament Analysis, I invited each of my students to take this test at the
beginning of our class session. The TJTA measures categories such as anxiety,
self-control, anger, impulsiveness, etc. After taking the test, each student was
helped to see this “temperament picture” of himself. The student was asked to
journal how these select areas of temperament helped or hindered him or her in
the movement towards the quality vocational picture. Glasser points out that
“Because we always have control over the doing component of our behavior, if
we markedly change that component, we cannot avoid changing the thinking,
feeling, and physiological components as well.” Therefore, students were asked
to embark on suggested directions to take more intentional control of their
temperament in order to maximize inner resources which were being used to
pursue their academic and vocational goals.

At the end of the semester, students were once again invited to take the
TJTA. Realizing that this test is designed to measure long term change rather
than short term changes, the results of this second test were to be viewed con-
servatively. Nevertheless, the students taking the test for the second time
recorded results which were in a healthier range than the first time. Whether the
students’ efforts made to take more control of their temperament influenced
the results of the second TJTA test remains speculative; however, my personal
observations witnessed a change in temperament, indicating evidence of
greater control. Sharing my observations with them, I encouraged them to
channel this control into their academic and vocational pursuits.

My fourth attempt to bring control theory into the class room was in the
area of assessment. In Glasser’s book, QUALITY SCHOOL, the ideal picture
touches upon mastery learning, i.e. seeking to educate students to be proficient
within a subject area, utilizing a testing approach which is part of the education
process rather than only a measurement tool, that is, testing as punishment or
reward. “Nothing that we encounter leads to a greater and quicker loss of
control than to be criticized . . . The general rule when you want to correct
someone is to do it by saying, ‘Let’s take a look and see what is and is not
working for me, for you, and for both of us.’”

Against that theoretical backdrop, students in my class were invited to
participate in the making of the final test. Main themes were selected which
seemed to be most important in relationship to the educational objectives of the
class established at the beginning of the semester. From these themes, a test
bank was constructed, using the test questions produced by the students and
reviewed by the class. A select number of these questions were used to create
the final test.

In order to provide opportunity for mastery learning, students were told
that if they scored below the goal which they set for themselves, they would be
allowed to pursue a self-directed learning project related to the area which gave
them the most difficulty. Completing this project would allow them to adjust
their final test grade upward to the accepted level. As Glasser has said, “No
student should . . . be satisfied with less than a ‘B’ grade when opportunities
are available to move up to a higher level of performance.” To give students a
measure of control of the testing process and the final grade is to give them
power to succeed!
The end-of-course questionnaire asked students to evaluate this concept of testing and grading that they had experienced. Students surprised me by appreciating this approach to assessment; however, many expressed a sense of uneasiness at such a nontraditional approach to learning. They had been so used to the traditional punishment/reward approach to testing that they had a hard time experiencing such a method! Their high grades were positive reinforcement for them that control theory can give them a positive experience at controlling their success in learning.

In conclusion, my enthusiasm for the place of Control Theory in Developmental Education causes me to seek to implement it into future classes in the semesters to come. In addition, I have conducted several summer teacher training workshops, encouraging teachers to consider using aspects of Control Theory in all educational settings. It has the potential of affecting nearly all areas of education in a positive way!

References

CONTROL THEORY PSYCHOLOGY AND SELF-DIRECTED LEARNING IN ADULT EDUCATION
Sheldon Brown

Although the principles of self-directed learning and control theory psychology were developed by different individuals working independently, the basic andragogical tenets of self-directed learning in humanistic adult education are consistent with the principles of control theory psychology. Glasser (1984) asserts that humans are internally motivated to meet basic physiological and psychological needs in an attempt to take effective control of their lives. Similarly, Darkenwald and Merriam (1982) state “it is the challenge of . . . identifying needs and helping adults to lead more fulfilling lives to which andragogy responds” (p. 86). Knowles (1975), a strong advocate of self-directedness, maintains that the need to take responsibility for their lives is a natural, psychological characteristic of adults. Likewise, a goal of control theory psychology is to help people accept responsibility for their behavior so that they may make more effective, need-fulfilling choices. From a control theory perspective, Ford (1989) believes “we are a self-directing species, with our own internal control systems that are responsible for the things that come from within” (p. 173).

Wlodkowski (1985) defines effective facilitation of adult learning as a process that meets the fundamental needs of adult learners. He explains “when adults do not want to learn what we have to offer, it is quite probable that they either experience needs that interfere with the learning process or that our instruction negates, satiates or threatens their current need state” (p. 107). Similarly, Glasser (1980) states “people don’t learn what they don’t want to learn, but teaching becomes effective as soon as people who hurt discover that they can learn a better way” (p. 52).

A tenet common to control theory psychology and self-directed learning is that learners are responsible for their learning behavior and that learners are internally motivated to engage in learning behavior because it is in some way need-fulfilling. Parish (1988a) has utilized control theory strategies with college students to foster the development of personal responsibility and an internal locus of control. Using the same strategies, Parish (1988b) found that college students developed more positive interpersonal skills and higher self-concepts.

The present study was conducted in order to determine whether introducing the concepts of control theory psychology to community college students would increase their readiness for self-directed learning. In other words, if students understand what their needs are and how they can be met effectively, will they perceive themselves as being ready to take more responsibility for their own learning? This study attempts to answer this question.
Method

A total of 9 community college students (8 females and 1 male) voluntarily participated in all three phases of the study. The students, training for employment in the human services, were enrolled in a fourth-semester course entitled Interviewing Skills. The course examines the underlying theories of effective interviewing, identifies the fundamental skills with which interviews are conducted, and introduces control theory psychology as one theory of why people behave the way they do.

Phase 1. Prior to the start of the unit on control theory psychology, the students completed the Self-Directed Learning Readiness Scale (SDLRS), developed by Guglielmino and Guglielmino (1977) to measure the individual’s readiness for self-directed learning. The SDLRS is a self-report questionnaire with Likert-type items. The instrument has been found to be highly reliable.

Phase 2. After the SDLRS was completed, the basic concepts of control theory psychology were introduced over a period of four 2-hour class meetings. The learning material was derived from a number of sources, including a diagram of the control theory model as illustrated by Gilbert and Hunninghake (1988), and descriptions of the basic needs and behavioral system detailed by Good (1987). A variety of cooperative learning strategies, including jigsaws and focused discussions, were utilized to cover the learning material. According to Sullo (1990), “the well-structured cooperative learning group experience will allow all group participants to satisfy their basic needs. Under these conditions, participants are more likely to actively pursue more information about ... control theory” (p. 69). No attempt was made to teach control theory strategies as tools of intervention in helping relationships as this was deemed to be outside the parameters of the course.

Phase 3. At the end of the final class meeting, the students once again completed the Self-Directed Learning Readiness Scale.

Results

A t-test was performed in order to compare the pre- and post-control theory unit scores of readiness for self-directed learning. Using the Self-Directed Learning Readiness Scale, the self-directed learning readiness scores (t = 1.35, df = 13, p > .20) were found to be significantly higher (i.e., increased readiness) on the post-control theory ratings (X = 238) as compared to the pre-control theory ratings (X = 218.6). According to Guglielmino and Guglielmino (1977), a mean score of 238 would place in the 80th percentile.

Discussion

These findings indicate that a basic understanding of control theory psychology, obtained through the use of cooperative learning strategies, increases students’ perceptions that they are ready to accept more responsibility for their own learning. This outcome is consistent with the goals of proponents of self-directed learning and control theory psychology. The use of cooperative learning strategies to facilitate these changes has tremendous potential and warrants further study and discussion in the field of adult education.

These findings, along with those of the previously-cited studies, indicate that the integration of control theory psychology into adult learning programs impacts significantly on learners’ self-concept, sense of responsibility, development of interpersonal skills and an internal locus of control, and readiness for self-directed learning. Cumulatively, these results have implications for curriculum development, specifically for programs aimed at facilitating the transition from high school to post-secondary education. The principles of control theory psychology may be of particular relevance to instructors who are involved with high-risk students. Indeed, these principles are applicable across the broad spectrum of educational experiences.

Based on the research conducted to date, the integration of control theory psychology concepts with adult learning principles can be structured so that the goals of humanistic adult education can be achieved and the basic needs of the adult learner can be met effectively. As a result, the quality of the learning experience is enhanced, and the likelihood of success in adult education is increased.

References

TEACHER EFFECTIVENESS RATINGS AND 
STUDENTS' HOMEWORK RATINGS: SUPPORT 
FOR THE "QUALITY SCHOOL" MODEL? 
Thomas S. Parish and Mark Stallings

The first author, RTC, is a frequent Journal contributor. He is a professor at Kansas State University, Manhattan, Kansas. The second author, a teacher at Gilmer High School in Ellijay, Georgia, is a doctoral candidate at Kansas State.

In a recent article by Parish (1991), the Teacher Effectiveness Questionnaire (TEQ) was introduced to assess instructional effectiveness. The ten (10) questions that compose this questionnaire were derived from William Glasser's book entitled The Quality School. As proposed by Parish (1991), each time students answer "yes" to a question on this scale it is believed that teachers will more likely be admitted into their students' "Quality Worlds" or their "All-I-Want Worlds." Of course, saying that this is so doesn't make it so, therefore the present study sought to examine (1) the relationship between students' overall scores on the TEQ with each of the items on the questionnaire that it is thought to reflect, plus (2) the relationship between students' overall scores on the TEQ with teachers' ratings on how well their students did their homework.

Method

A total of 1142 students, and their 12 teachers, voluntarily participated in the present study. In all, there were 85 seventh graders, as well as 1057 ninth-twelfth graders — all attending schools in Ellijay, Georgia. These students completed the ten items on the TEQ assigning a value of 1 to 5 to each (ranging from strongly agree to strongly disagree), while their teachers rated their students on a scale from 1-10 regarding how well they did their homework.

Results and Discussion

As shown in Table 1, the TEQ total score was found to be significantly correlated with each item on the scale, with the range of correlations varying from .42 to .78. These highly significant correlations (p < .001) suggest that this questionnaire is internally consistent and may, indeed, be assessing consistently the various aspects of students' "Quality Worlds," and as such, should provide teachers and/or administrators a glimpse of what's important to them, and whether or not their teachers are being successful in their attempts to gain admission into these worlds.

Curiously, though teachers' ratings of students' homework endeavors did correlate significantly with the TEQ total score, and nearly all the items on it, these correlations were very modest, ranging from .05 to .12. What's suggested by these findings is that teacher effectiveness might not be the only key factor involved in fostering within students a desire to do homework. One other possibility is that the need-fulfilling nature of the task, as well as the need-fulfilling nature of the teacher and his/her teaching techniques, both need to be considered. Thus, as depicted in Table 2, when teachers fulfill needs and the task is need-fulfilling too (see box 1), students will most likely admit both the teacher and the subject matter into their "Quality Worlds" or their "All-I-Want Worlds." In contrast, when neither the teacher nor the task are perceived to be need-fulfilling (see box 4), both would more likely be excluded from their students' "Quality Worlds" or their "All-I-Want Worlds," and instead be placed in their students' "All-I-Don't-Want Worlds". When, however, the teacher is need-fulfilling but the subject matter is not, or visa versa (see boxes 2 & 3), then homework may fall in neither the students' "All-I-Want Worlds" or "All-I-Don't-Want Worlds," but somewhere in between. Consequently, getting homework done, even for the caring, nurturant teacher isn't a sure thing, and that may be why the correlation between the students' TEQ scores and the teachers' ratings of their students' homework assignments was so low. Of course, additional research is needed to ascertain anything conclusively, but the data presented in the present study do provide needed insight regarding our never-ending search to better understand our students and what motivates them.

Table 1

Summary Table of Correlations Between TEQ Scores and (A) the Individual Items Composing It, as well as (B) the Teachers' Homework Ratings

<table>
<thead>
<tr>
<th>TEQ Item</th>
<th>A TEQ Scores</th>
<th>B Teacher Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is your teacher . . .</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Deeply interested in the subject matter?</td>
<td>.57***</td>
<td>.12**</td>
</tr>
<tr>
<td>2. Deeply interested in his/her students?</td>
<td>.78***</td>
<td>.07*</td>
</tr>
<tr>
<td>3. Likely to present class discussions rather than straight lectures?</td>
<td>.63***</td>
<td>.05</td>
</tr>
<tr>
<td>4. Able to teach on students' level?</td>
<td>.76***</td>
<td>.10**</td>
</tr>
<tr>
<td>5. Able to comfortably interact with students?</td>
<td>.78***</td>
<td>.11**</td>
</tr>
<tr>
<td>6. Unlikely to threaten and/or punish?</td>
<td>.42***</td>
<td>.08*</td>
</tr>
<tr>
<td>7. Able to inject humor, variety, and/or drama into his/her classes?</td>
<td>.73***</td>
<td>.08**</td>
</tr>
<tr>
<td>8. Likely to treat students with kindness and courtesy?</td>
<td>.75***</td>
<td>.10**</td>
</tr>
<tr>
<td>9. Likely to ask students to do things that feel good?</td>
<td>.71***</td>
<td>.10**</td>
</tr>
<tr>
<td>10. Likely to see input from the class regarding possible courses of action?</td>
<td>.72***</td>
<td>.07*</td>
</tr>
<tr>
<td>11. Overall TEQ Score</td>
<td>.78***</td>
<td>.12**</td>
</tr>
</tbody>
</table>

* p < .05
** p < .01
*** p < .001
### Table 2

**Possible Interaction Model Between Teacher and Task Need Satisfaction**

<table>
<thead>
<tr>
<th>Level of Need Fulfillment of the Teacher</th>
<th>HI</th>
<th>LO</th>
</tr>
</thead>
<tbody>
<tr>
<td>HI</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>LO</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

### References


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### TEACHING LOVE AS A TOTAL BEHAVIOR:

**A WEDDING MEDITATION**

Richard W. Conner

The author is pastor of the Hopewell United Methodist Church in Downingtown, Pennsylvania.

Many married persons do not know how to create marriage into a need satisfying experience. Many persons divorce, three out of five, then remarry, trying again and again. A Lou Harris study on marriage and family life in America indicates upwards to 60 percent of persons who divorce remarry within four years (Harris 1987). While others will choose to suffer through the misery they create—

"Failures, suffering in many ways for long periods, seldom learn from their pain to behave more responsibly. Millions of unhappy married couples, for example, respond to each other with irritation and anger because they do not know how to do otherwise. Starving for love, they give each other only pain. Frustrated in their lot in relationship and pushed by painful feelings, they either act quickly and thoughtlessly or do nothing except wallow in their own suffering." (Glasser, 1975)

As the pastor of a large church in the suburbs of Philadelphia, I officiate at many weddings. As a part of my responsibility, how can I teach persons behaviors that will help them stay married and hopefully create a need satisfying Quality Marriage? What I do in both counseling and the marriage ceremony itself is to communicate love as a total behavior and how to work on the parts of total behavior over which we do have control.

One of the greatest contributions of Dr. Glasser to understanding how persons live life and are satisfied is the concept of total behavior and the four components of each behavior: doing, thinking, feeling, and physiology (Glasser 1984). So many couples come to marriage with a narrow intent of experiencing love as only physical and romantic. Therefore, "I will love you forever," usually means as long as I "feel" the way I do. Instead, from the very beginning of marriage, couples need to be taught to also focus in each behavior on the components of "thinking and doing."

Almost all wedding ceremonies are now being video taped to be played back after the honeymoon is over, hopefully at a time when the following meditation can be helpful. The purpose of this article is to share one of my marriage meditations that teach the importance of the thinking and doing components of each behavior of love.

The following marriage meditation was shared by the author at the marriage of Carolyn E. Fitzgerald and Daniel G. Daneker on June 20, 1992 at the Port Elizabeth United Methodist Church, Port Elizabeth, New Jersey and is used with permission.
A MARRIAGE MEDITATION “... we also ought to love one another.”
(I John 4:11)

What a happy day this is, Carolyn and Dan. There are a lot of memories swirling around in my mind. I was with you when the two of you first met, and it was such a good thing for me to watch as the two of you discovered each other and grew in your relationship. Certainly, I, along with your family and friends, pray that happiness and love will be celebrated by the two of you many, many years into the future.

What is love? I have just read one verse of scripture from 1 John. In 1 John there are 105 verses, and in 26 of them, the word “love” is found. This love though is not just any kind of love. Most of the time in 1 John, the word love is “agape” love, which is like God’s love, love that has no beginning or end. Agape love is the love that Henri J. Nouwen in Reaching Out talks about when he says that real love is never just “an automatic reaction”, nor is real love just a “feeling”. But what he calls love is a relationship which must grow and deepen. (Nouwen, 1975).

To show this I would like you to picture in your mind a chair, and not just any chair, but what I am calling today, the “love” chair. And like all good chairs, the love chair is supported by four legs, and each time you sit on the chair, indeed, all four legs are important. The chair will not be supported if one of the legs are missing. Yet each leg is different.

The Physical Leg.

The first leg is that of the physical part of when you love. Both of you are “beautiful” people. And when we meet someone for the first time, 90% of the judgment we make has a lot to do with physical attraction. There are a lot of cosmetics and gadgets sold to make us beautiful, and it is an exciting thing to meet that handsome man or beautiful woman and enjoy the physical part of love. And I want to say today, that I enjoy attractiveness and physical love. Physical love is important. The chair will not support love without it. But please, of all the four legs on the chair, I believe that the physical leg is not the most important.

The Romantic Leg

The second leg on the love chair is that of romantic love or the feeling part of when you love. Romantic love is a wonderful love. It is a love when someone becomes just so very special, and at the time, we don’t even know why? Sometimes, suddenly, there is a very special person in our dreams and in our prayers. There is a very special person we think about all of the time. It’s as if all of what we want in life has now been focused on this one person with an intensity of all that we believe happiness is.

I want you to know that I believe in the romantic part of love. I believe in birds singing, daisies blooming, and running barefoot through the meadow; nevertheless, the romantic part of love will wear thin when someone loses the cap to the toothpaste, or when you find hair on the bar of soap, or when the car seat is extended up to the dash and you can’t get it back! Once upon a time there was a lady who complained to her pastor, “When I first dated him, I used to sink into his arms. Now I’m up to my arms in his sink.” Although the chair will not support love without it, there has to be more than just this romantic leg to the chair, and there is.

The Thinking Leg

The third leg on the love chair is the “thinking” part of when you love. This is expressed today by the two of you in the vows you are sharing. It is true that so often we can decide to become what we are thinking. Are your thoughts that of making your marriage last “for better or worse; for richer or poorer; in sickness and in health”? Are your thoughts “until death do us part”? What will you choose to think at the times in your marriage when the two of you are angry and disappointed? What will you choose to think when both of you are happy and satisfied? What are the two of you thinking when it comes to your future together? There is an old Chinese proverb that reads, “Married couples who love each other, tell each other thousands of things without talking.”

The Doing Leg

And yet as important as the thinking part of love is, the most important leg on the love chair is the “doing” part of love. The doing part of love goes beyond just the physical part, or the romantic part, or for that matter the thinking part. If we love someone what will we do? How much are you willing to do and do and do each day to keep your love alive? Doing, like playing games together, making things like arts or crafts, dancing, taking a walk, doing grocery shopping, or whatever the two you are going to do together, do on a regular basis. Doing quality activities on a regular basis builds intimacy that will last a lifetime. (Ford, 1987)

Two years ago, I was the guest preacher at a church in a neighboring community. When I arrived I was welcomed by a husband and wife who asked me to guess how old they were. Now, don’t you hate that? They looked old, and I didn’t know what to say. They were both 96 years old, and they had been married for over 65 years! They said it with smiles and such enthusiasm.

Let me ask you, now into their 90’s, how important is the physical part of their love for each other? I am afraid that there would be those cruel enough to say “little”. Our society does not always value the beauty of aging. Are there romantic parts of their love for each other? I don’t know, but I do suspect that they are bonded together all of the time, after all these years with intensity. Do they think love? Yes, I am certain that after 65 years their thoughts are merged together. What are the doing parts of their love?

Well, after welcoming me to their church, he took her by the arm and in a most loving way, led his wife of over 65 years to her seat in the choir where they both continue to sing! And 65 years from now may someone say the same thing about Carolyn and Dan.

References
RT/CT: How It All Came To Be
Joseph E. Lawless

The author, a former school principal, is an advanced practicum supervisor and Quality School Consultant in Aurora, Ontario, Canada.

A young doctor named Glasser, with zeal
Said "Psychiatry's got no appeal!
I think they're all wet,
So a new course I'll set,
That will be more effective, I feel.

Now, what's to be done won't take long,
We've just got to love and belong.
With freedom to choose,
And with power — can't lose!
'twill be really quite fun to press on.

There's no doubt we all will survive,
Why, since starting I feel more alive!
If we all get the picture,
Without judgment or stricture
I'm sure that the theory will thrive.

Our work will, I'm sure, travel far
If we think and we do as we are.
And our feelings? — we'll see —
And physiology? —
They'll be, totally, part of our car.

Now — Make friends! (That's something all crave.)
Don't forget how the clients behave.
Then we'll add our creation
Of evaluation
And plan, so their future they'll save.''

So he started to see if 'twould work
(Reality was this man's quirk)
He worked 'til quite gaunt,
Asking "What do you want?"
(Other questions were merely a perk).

When Vancouver he had to forsake,
He simply resorted to tape.
He promoted his love
While the 'planes soared above,
And for us did the conference make.

To Naomi, who supported this quest,
To you, Doctor Glasser, with zest,
We'd just like to say
"Thanks!" — 'cause you've led the way.
In practice, your theory's the best!
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