The Journal of Reality Therapy is directed to publication of manuscripts concerning research, theory development, or special descriptions of the successful application of control theory and reality therapy principles in field settings. This journal is the official publication of the Institute for Control Theory, Reality Therapy and Quality Management.

Subscriptions: $10.00 for one year or $18.00 for two years. (U.S. currency) Single copies, $5.00 per issue. Send payment order to the editor. Back issues Vol. 1-8, $3.00 per issue; Vol. 9-14, $4.00 per copy.

Permissions: Copyright held by the Journal of Reality Therapy. No part of any article appearing in this issue may be used or reproduced in any manner whatsoever without written permission of the editor - except in the case of brief quotations embodied in the article or review.

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

Mission: Our mission and our vision is first to teach the world control theory and then to teach the use of this theory in counseling, where it is called reality therapy, in education as it is practiced in Quality Schools, and in managing all people so that they do quality work where it is known as lead-management.

William Glasser
January 1993

Editorial Office:
Journal of Reality Therapy
203 Lake Hall
Northeastern University
Boston, Mass. 02115
Telephone: 617-373-2485 or 3276
FAX 617-373-8892

Institute for Control Theory, Reality Therapy and Quality Management
President & Founder
William Glasser, M.D.
Administrator
Linda Harshman
22024 Lassen Street, #118
Chatsworth, California 91311
1-818-700-8000
FAX 818-700-0555

Board of Directors
Institute for Control Theory, Reality Therapy and Quality Management
Canada: Pierre Brunet (98)
213 Louis-Bazinet
St. Charles Borromee
Quebec, Canada, J6E 7J5
514-752-5256

Northeast: Larry Litwack (96)
30 Lewis Road
Belmont, MA 02178
617-489-3238

Southeast: Karen Sewall (96)
15109 Kamputa Dr.
Centreville, VA 22020
703-986-7304

Midwest: L. Michael Reese (97)
c/o Chaddock
205 S. 24th St.
Quincy, Illinois 62301
217-222-0034

Mid-America: Elaine Kniepfel (98)
12341 Charlotte
Kansas City, MO. 64146
816-941-0118

Sunbelt: At Montgomery (97)
5040 Ithaca St.
Metairie, Louisiana 70006
504-888-7334
FAX 504-888-2082

Northeast: Steven English (97)
1106 Columbia Ave.,
Marysville, WA 98270
206-653-4884 (8-5)
FAX 206-658-0670

West: Robert Hoglund (98)
6744 So. Oak St.
Tempe, AZ 85283
602-839-7855

Mountain States: Dan Aune (98)
501 25th Ave. North
Fargo, ND 58102
701-234-0497

E.T.C.: Doug Naylor
1881 N. Gaffey St.
San Pedro, California, 90731-1270
213-435-7951

1996 International Convention
Albuquerque, New Mexico
July 10-13, 1996

1997 International Convention
Portland, Oregon
July 9-12, 1997

Journal of Reality Therapy
Vol. XV No. 1 Fall 1995

Table of Contents

Larry Litwack ................... Editor's Comment 2
William Sanchez ............ Reality Therapy, Control Theory and Latino
Olga Garriga ................. Activism: Towards Empowerment and Social Change
Lee McCardle Cunningham ... Control Theory, Reality Therapy and
Cultural Bias
Elijah Mickel ............ African Centered Control Theory: The Perceptual
System and the Quality World
Louise LaFontaine ........ Basic Needs and Sexuality: Is Something
Missing in Reality Therapy/Control Theory
Sarah Chapman . Sexual Dysfunction: A Reality Therapy Approach
Matthew Ignoffo ............ Quality Living When There is no Cure:
Using Reality Therapy and Control Theory with
HIV + and AIDS Patients
Bill C. Greenwall ......... A Comparative Analysis of Reality Therapy
and Solution — Focused Brief Therapy
William Scanlan ..... Bridges to Glasser: An Application of RT/CT
Albert J. Stumph to the Process by Which we Manage Change
Need in the Nineties
Virginia Smith Harvey .. The Development of the Basic Needs Survey
Kristen Retter
Joseph J. Stehno .......... Classroom Consulting with Reality Therapy
Tom A. Davidson ............ Praying and RT/CT
Robert E. Wubbolding .... Integrating Theory and Practice: Expanding the Theory and Use of the
Higher Level of Perception
Craig R. Scholienberger .... Creative Personalization as a Means of Increasing Client Understanding:
A Case Illustration, “The Hot Dog Theory”
Lucy Billings ............. A Fairy Tale with Special Thanks to
A Beautiful Lady on the Train and
Barnes Boffey for Sharing Have-Do-Be
Editor's Comment
Larry Litwack

At the most recent International Reality convention, I was approached by several individuals inquiring about possible articles for the Journal. They wanted to know if we would consider articles for the Journal that did not follow the clear Reality Therapy/Control Theory system, and/or did not clearly support and/or promote the theory and practice as developed and presented by William Glasser. In other words, the questions really revolved around the issue of whether the Journal of Reality Therapy was a "house organ", i.e. in existence solely to disseminate the ideas of William Glasser and the Institute in a positive, blindly supportive light.

I was somewhat surprised by the questions. However, when I reviewed the statement of purpose on the inside cover of the Journal, I could easily see how the questions might arise. The statement reads:

The Journal of Reality Therapy is directed to publication of manuscripts concerning research, theory development, or special descriptions of the successful application of control theory and reality therapy principles in field settings. This journal is the official publication of the Institute for Control Theory, Reality Therapy and Quality Management.

The above statement reflects the vision I had when I started the Journal in the Fall of 1981. I saw the Journal as a scholarly publication for practitioners of RT/CT in educational, management, and clinical settings, for undergraduate and graduate students in the behavioral and social sciences, and for faculty in colleges and universities. Our subscription list reflects that audience. At no time has the Institute or William Glasser ever suggested that content be limited in any way. Judgments have been left up to me and the members of the editorial board.

I wanted the Journal to do more than just repeat the ideas presented so clearly by William Glasser - if that was the sole purpose, the Journal would be superfluous. I wanted the Journal content to stretch our thinking, to identify creative applications of the basic principles, to foster dialogue among professionals at all levels - in other words, to critically examine what we do, how we do it, and why we do it. That is what makes ideas flourish, long after originators are gone.

A careful review of the Journal over the years would reveal that we have not always adhered to the "party line". If the Journal is to continue to grow in reputation and quality, then it must continue to provide a forum for both what is and what might be. As we start the 15th year of publication with this issue, that is what I am dedicated to.
Unfortunately, given the focus on "individual responsibility" and the premise that persons are ultimately in control of developing their quality world, RT/CT still does not reflect a conceptualization that critically examines the broader, sociopolitical contexts affecting oppressed people, particularly as determined by race, ethnicity, and class background, and the urgent need for the empowering of racial and ethnic minority clients to bring about social change. This concern was expressed by Ballou (1984) in her analysis of RT/CT and its relationship to feminist therapy:

The problem with the individual focus, which RT shares with much in contemporary psychology is the neglect of social change. If only the individual as separate from his/her context is looked at, not only are complexities and interactions reduced, but action or even awareness of needed changes in context are ignored. Focus upon the individual allows and directs non-regard for the social and institutional dangers, and thus aborts the impetus for social and institutional change. (p. 30)

That psychology in the 1990's continues this "individual focus" is well exemplified in The Bell Curve: Intelligence and Class Structure in America. (Herrenstein & Murray, 1994) and the extreme analysis of racial differences in intelligence.

Given the significant demographic changes taking place in the United States, and the fact that by the turn of the century approximately 30% of the U.S. population will be from an ethnic minority group (Office of Ethnic Minority Affairs, 1995; Sue, 1991), the ability to integrate multicultural and diversity issues within RT/CT, as a beginning step towards understanding complex contexts, remains critical to it becoming a relevant and empowering theory to assist those working with clients from diverse backgrounds. The integration of multicultural issues within RT/CT is exemplified in works related to RT/CT and special needs (Barbieri, 1994; Renna, 1990; Sansone, 1993); gay and lesbian concerns (LaFontaine, 1994); feminist issues (Ballou, 1984); and treatment issues with specific ethnic populations, for example Mexican American Adolescents (Slowik, Omizo, & Hammett, 1984), and Khmer refugees (Rosser, 1986).

Mickel (1991, 1994) has provided us with an excellent critical analysis and synthesis regarding RT/CT and an "African-Centered Perspective". The African-centered approach joins traditional cultural values which are more than 2000 years old... with control theory" (Mickel, 1994, p. 49). He has provided the field with a much needed and broader conceptualization of RT/CT as it relates to African-centered principles. Although as noted above, some conceptualization has taken place integrating RT/CT in working with Latino clients, little has been written regarding a more broad-based analysis using RT/CT, the Latino experience, and the need for social change that is directed to a quality world that concerns itself with issues of social justice and change in this country.

Latinos are one of the fastest growing ethnic minority groups in the United States. There was an estimated 53% increase in the Latino population between 1980 and 1990 (Sue, 1991). "Latinos... realized demographic growth at nearly 10 times the rate of non-Hispanic whites and more than 5 times that of African-Americans between 1980 and 1990" (Morales & Bonilla, 1993, p. 1). It is estimated that within the early part of the next century, this will be the largest ethnic minority group in the country (Perez & Salazar, 1993; Reyes & Valencia, 1993). Latinos currently make up approximately 8.9% of the total U.S. population. Of this population, which numbers approximately 22,752,000 Latinos, 64.3% are of Mexican heritage; 10.6% Puerto Rican; 4.7% Cuban; 13.4% from Central and South America (which of course signifies multiple national origins); and 7.0% being classified as "other Latinos" (Institute for Puerto Rican Policy, 1994).

This is of course a heterogeneous population that embodies complex social, economic, political, and historical differences. However, Mexican Americans, Puerto Ricans, Cubans, Central and South Americans, etc., have basic "needs" that we believe are similar and that as a Latino cultural entity, must be conceptualized differently from the mainstream United States population. The urgent need to counter the overrepresentation of Latinos"... at the economic bottom..." (Morales & Bonilla, 1993, p. 145) and the establishment of culturally relevant and empowering educational programs to counter the high Latino student dropout rate (Reyes & Valencia, 1993), are but some of the "common" individual and social needs of this population.

Given this context, and the at times almost "invisible" stance that Latinos have vis-a-vis power institutions in this country (Falcon, 1993; Sanchez, in press; Sanchez & Garriga, in press), the need for Latino activism is critical to any conceptualization that is attempting to provide relevant and empowering action plans to this diverse cultural group. It has been proposed that the need to confront issues of inequalities in economic opportunity, racism, and discrimination are critical in the development of a broader "Latino Ethnic Consciousness" (Padilla, 1985). This is a consciousness that moves to integrate individual, specific cultural concerns, with those of a wider constituency of Latino ethnics. The awareness of these needs and the ability to unite, begin a process of Latino ethnic consciousness, a consciousness that is critical to the activation and continuation of Latino activism. RT/CT does provide us with some valuable concepts that can assist us in the further conceptualization of Latino empowerment that leads to the development of a "quality world" for Latinos. This quality world must be one where issues of equality and social justice are primary, global needs for the group at large.

The purpose of this article is to examine the relationship between some key concepts within RT/CT and the Latino experience. A redefinition of issues and a preliminary synthesis will be provided as it relates to RT/CT and Latino activism. The integration of the social, political and economic contexts as well as the ability of society to control and limit the type of "pictures" it has of Latinos and the pictures Latinos have of themselves will also be analyzed. The implications for work with Latinos and the empowerment process will be presented.

TOWARDS A REDEFINITION

This analysis will attempt to redefine some of the critical elements with-
in RT/CT and its relationship to Latinos as an ethnic group. A need analysis is an excellent point of departure; however, this need analysis will attempt to broaden its scope in incorporating the Latino experience in this society. This need structure is seen as one that is socially constructed and determined by complex societal forces, which have profound influence on the ability of Latinos to create a quality world. We will discuss, in our conceptualization, the need structure with regards to elements that we feel are critically important in an understanding of Latinos and their experience in this country.

The Need to Survive as an Ethnic Group

To continue as an "ethnic" identity; to have Latino culture, language and customs affirmed; signifies in the broadest sense, one of the goals of Latino activism. The need for survival is thus "redefined" from the more narrow "biological" sense of the term [although given some of the data on poverty, for some Latinos, basic survival within a hostile economic climate is clearly an issue, see Morones & Bonilla (1993)], and conceptualized as the need for cultural survival and growth. The acknowledgment of the diversity of Latino cultures is critical to this sense of survival of a people who inhabit many parts of the world and who have complex historical, social, and political differences. The ability to have power to control the enhancement of Latino culture and thus the integration of a consistent, stable Latino ethnic identity (or picture we have inside of ourselves as part of a Latino Ethnic entity), is critical to this survival and thus an element of Latino activism.

Throughout all of this process, there are however, strong political, social, and economic forces, that present counter positions and blockages to Latino ethnic survival. The diminishing services to Latinos and other people of color (Albelda, McCrate, Melendez, & Lapidus, 1988; Jordan, 1995; Stallard, Ehrenreich, & Sklar, 1983); the limited representation of Latinos in leadership positions and social policy decision making (Falcon, 1993; Hardy-Fanta, 1993; Hero, 1992); anti-immigration laws (Hornblower, 1994); the English-Only movement (Padilla, Lindholm, Chen, Duran, Hakuta, Lambert, & Tucker, 1991); economic restructuring (Morales & Bonilla, 1993; Tienda, 1989; Torres & Bonilla, 1993), and colonialism (Fernandez, 1994a, 1994b; Lopez, 1987; Melendez & Melendez, 1993), all produce powerful, destructive forces that would set out to limit and control, and in some areas put an end to, Latino ethnicity and "consciousness". The need for Latino activism to create and enhance its "pictures" of Latino ethnicity remains crucial to the spiritual and emotional survival of Latinos in this nation and the development of a quality world for Latinos.

The Need to Belong to this Nation and Society

Latinos, as with other racial and ethnic minority groups, face the challenge of fulfilling the need to "belong" and be accepted by the mainstream in the United States. A critical aspect of this acceptance is of course self-acceptance which requires a level of ethnic consciousness and "awareness". which are components of an empowered Latino activism. Latinos, as have many other cultural groups, have played a significant role in the development of this country. Unfortunately, Latinos as a group are apt to be excluded and seen as foreigners, irrespective of their citizenship status. This has always been a nation of foreigners, and the wonderful elements of diversity need to be celebrated as part of the truly pluralistic nature of this nation. Society too, needs to be able to adjust its own "pictures", ones that provide for a pluralistic view of the people who are to be considered "Americans" and a society itself that needs to examine its "value systems" behind its pictures (Glasser, 1984). The need for Latinos to be accepted by the wider society will consistently be blocked and frustrated, if "value systems" that enhance discrimination, racism, and the view that "they" (Latinos) are the ones that need to change, not us (the mainstream), are not critically analyzed and challenged. The need for knowledge, awareness, and the development of cross cultural communication skills that embody a process of openness, flexibility, and developing critical thinking skills, are paramount for all elements of society if we are to change the values that frame our "pictures" of both ourselves and people from diverse cultural, racial and linguistic backgrounds (Ponterotto & Pedersen, 1993).

The Need for Freedom

The need for freedom is as basic an element to Latino cultural survival as is the need to belong. Here again, this need must be expanded and broadened to include the need for Latinos to enjoy economic, social, and political freedom. This freedom has been extremely problematic for Latinos, both here in the United States and elsewhere around the world,
given U.S. military and economic hegemony. Examining U.S. foreign policy towards the Caribbean, Central and South America, and other parts of the world, reveals problematic elements and assumptions, by those in power, towards Latinos throughout the world (Chomsky, 1987; Cruz, 1994; Fernandez, 1994a, 1994b; Lopez, 1987). These assumptions, based on a world view governed by concern with military and economic hegemony, cultural superiority and racism, have continually fostered exploitative and oppressive conditions for Latinos and other ethnic minority groups. These are major “contradictions”, both to the individual model of analysis and the mythology of a “level playing field” for all to be able to actualize their quality world. These are issues that this country must face if we are to provide Latinos and others with a quality world.

A major contradiction regarding issues of economic, social and political freedom is the complex political paradigm of colonialism, currently in place in Puerto Rico. This is a critical and serious issue for Latinos of Puerto Rican heritage, both here and on the island of Puerto Rico. The mythology around the social “picture” of a “good colonialism” (Fernandez, 1994b), is one that consistently needs to be challenged through Latino activism. Good colonialism is an oxymoron. Colonialism in any form is an affront, and is destructive to the development of economic, social, political and cultural freedom. The elements of colonialism not only extend to “political structures”, but to a way of thinking and behaving that are destructive to the “pictures” of Latinos as cultural and political entities (Maldonado-Denis, 1969, 1972; Memmi, 1965; Sanchez & Garriga, in press).

Freedom to express cultural beliefs, freedom to speak our native language, and freedom from being provided almost constant negative media images of Latino “pictures” (Nieves, 1995), constitute a core to the survival and ability to “belong” to this nation and society. The freedom to speak out against social injustice and to be able to critically analyze the pictures and the values behind the pictures which this society promotes, must continue to be enhanced through an aware, active, and empowered Latino activism.

The Need for Power

At the core of Latino activism is the need to enhance power for Latinos in this country/nation. Power remains one of the most crucial elements confronting Latino activism. The need for power, however, is not conceptualized as the need to control others, but as the element needed to be able as a cultural group to control our own destiny and to be able to share in the benefits and opportunities available in this country. Power is viewed as a collective resource, and one that will enhance the group and not the individual. Power encompasses many different avenues, from political, economic, to the power developed through education. The struggle to enhance these areas for Latinos will continue to remain a major goal of Latino activism. However, the need for society to examine its own inability to share power, and its concentration in the hands of only a few, describes the challenge for society as a whole to be able to examine its uses and abuses of power, both economic and military, here and around the world. Power can only be conceptualized as that which leads to issues of social justice and not the use of power to control or oppress others. Similar to that discussed by Ballou (1984), an “egalitarian relationship” (p. 31) must be the basis of a redefinition and reconceptualization of the whole concept of power. Power as a vehicle to enhance the quality world for all people, must be a “global” goal of any activism and social change movement.

Individual Responsibility and Social Action

The concept of personal responsibility in the control of one's behavior, and thus, one’s ability to develop and strive for a “quality world” presents both elements of consistency and inconsistency with that of the Latino experience. It is clear, that for an empowered Latino activism to take place, there must be a focus on action. Becoming personally committed and responsible for social change is critical to the development of a picture of oneself as having some control over the complex forces in the environment. Becoming identified with and part of “la lucha” (the struggle), enhances the development of a Latino ethnic consciousness (Padilla, 1985) and one's position as an “active agent” in the process of social change. We are all personally responsible for becoming involved in actions that will enhance the social justice quality world of our brothers and sisters.

As has been noted above, however, the strong emphasis and non-integration of complex sociopolitical contexts within RT/CT leaves this analysis prone to assessing clients as “totally free agents”, all treated equally in a society with equal access to both the psychological and physical resources of this country. The dangers of “victim blaming”, which all too quickly occurs, and the enhancement of negative “pictures” of Latinos and other ethnic minority groups, present serious drawbacks with an individualistic, “decontextualized” approach to working with Latino clients (Sanchez & Garriga, in press).

Who Defines Reality?

The ability to define one’s own reality and to set out to enhance those “pictures” of that reality, is one of the true indications of being in control and having power. Unfortunately, we also live in a society that has tremendous power through its institutions and media, in its ability to both define and enforce its particular view or pictures of what that reality should be. To get others to accept those pictures and views, and to make them think that they have always had those “pictures” is one of the ultimate forms of power, and clearly a form that can be used to oppress and “disaffirm” those who fall outside of the constructed reality that society is attempting to enforce.

For RT/CT to become an empowering theory it must confront these social dilemmas. It cannot propose that pictures are simply constructed without having an impact on those with less power in this society. The media’s ability, for example, to reinforce negative images or pictures of Latinos (Nieves, 1995) and its restrictive control over true critical analysis and debate on sociopolitical issues in general and those that continue to devastate ethnic minorities in particular (Cohen & Solomon, 1995; Croceau & Hoynes, 1994), needs to be seriously confronted and integrated into any
theory seeking to help empower clients. It is simply not enough to say that we all have "value systems" behind our pictures (Glasser, 1984). Society's power through the media and other institutions needs to be conceptualized as a potent component that does have the ability to construct negative images of Latinos that further reinforce a "victim blaming" stance. Any strategies seeking to empower Latinos must work at deconstructing the mythologies and stereotypes (Cruz, 1994) presented by major systems of power in this nation. This becomes critical to the enhancement and affirmation of Latino culture, identity, and consciousness.

The Cultural Context

Throughout all of the empowerment process, the need to recognize and be able to integrate vital Latino cultural values remains crucial to the development of relevant intervention strategies and the enhancement and affirmation of Latino ethnic identity and consciousness. Although beyond the scope of this paper, Latino cultural variables such as "respeto" (respect), "personalismo" (personalism), and "fatalismo" (fatalism), are but a few examples of critical "pictures" that need to be integrated into any treatment or counseling strategies. These variables, through cultural preservation, cultural accommodation, and cultural restructuring (Kavanagh & Kennedy, 1992; Sanchez, In press) need to be integrated in any process seeking to empower Latino clients. Within the broad-based conceptualization, Latino cultural variables also need to be seen as one of the crucial contexts in which Latinos are embedded, RT/CT needs to continue its attempts at conceptualizing how its treatment strategies can be modified, in order to make these significant cultural variables a relevant and critical feature of RT/CT and not just "add-ons".

Implications for Working with Latino Clients and the Therapy Process

Any work with Latino clients must be conceptualized along broad-based issues that attempt to enhance sociopolitical empowerment. Therapy and counseling must also be conceptualized along these lines, if we are truly interested in providing strategies that lead to empowerment, Latino activism, and creating social change. Individual client needs must be addressed through relevant contextual analysis that places the individual in a broader, historical and sociopolitical framework. Counseling is seen as a broad-based process that not only assists with individual needs, but strives towards creating an "ethnic consciousness" and a historically and sociopolitically aware action agent who will set out to participate in a more global change process, with social justice issues guiding the development of a quality world. Figure 1 presents a schematic of how the empowerment process can be viewed.

The empowerment process is embedded within a cultural context, which itself is embedded within a sociopolitical context. The cultural context has an impact on the intervention process. The process of empowerment leading to social change will in turn impact the cultural context. Anger and despair is developed by Latino clients over the limited quality world available to them. The intervention and empowerment process provides a culturally relevant, sociopolitically aware context that strives to bring about awareness of Latino identity and the development of a Latino ethnic consciousness with the sociopolitical context. The relationship between this critical context and the limited quality world is stressed.

The redefinition of anger and despair as a passion and commitment to "la lucha" or the struggle for social change is brought about through the culturally relevant, sociopolitically referenced analysis of the client's limited quality world. Involvement in socially responsive action is the beginning of Latino activism, which further enhances and affirms Latino identity and Latino ethnic consciousness. The ability for clients to "enhance" their control, and assist other Latinos to do the same, also becomes a goal of Latino activism.
Latinos face significant challenges in their struggle to develop their quality world. The reconceptualization of various critical features of RT/CT must take place, if empowering intervention strategies leading to Latino activism are to take place. The need to challenge the complex sociopolitical forces that continue to oppress Latinos and other minority groups, must be embodied in any theory that seeks to explain human behavior and provide empowering, liberating, and culturally affirming strategies. That calling for a strong Latino activism is a political statement in and of itself, will not be denied. It is the authors’ contention that all theories and therapies are political statements, and as such, need to be conceptualized within the broader sociopolitical context. Along with providing some avenues for reconceptualization within RT/CT, we hope that the issues presented in this article will also stimulate professionals themselves to become more aware of not only the complex sociopolitical forces that have significant influence over the quality world of culturally diverse clients, but their own sociopolitical “pictures” that will critically determine whether empowering and liberating strategies are practiced, or whether “status quo” concerns and issues will continue to dictate both theory and actual clinical practice.

References


CONTROL THEORY, REALITY THERAPY AND CULTURAL BIAS

Lee McCardle Cunningham

The author is a counselor and leadership consultant in private practice in Tempe, Arizona. She is Reality Therapy Certified and is a Basic Practicum Supervisor with the Institute.

ABSTRACT

As counselors become more aware of multicultural issues, it has become obvious that counseling modalities originating in Western culture may contain inherent cultural bias and are not always appropriate for culturally dissimilar clients. The paper examines the principles of control theory and the practice of reality therapy in regard to the ten most frequently encountered examples of cultural bias in counseling.

As the counseling profession has grown more aware of cross-cultural issues in counseling, frequent mention is made of the fact that most modern counseling theories have arisen from Western culture and are therefore not always applicable to multicultural counseling (Usher, 1989).

Control theory is a biological theory of behavior, and thus its principles are universal to all humankind (Glasser, 1984). Reality therapy is explained by control theory; however, the development of reality therapy predated the application of control theory to human behavior. Reality therapy was born in Western thought and experience, and therefore, questions may arise about its universal suitability in multicultural counseling applications. In addition, the trend in the counseling field is toward an "eclectic" or multimodal approach in dealing with the culturally dissimilar (Usher, 1989).

Cultural bias is a product of the perceptual system, and no one can claim to be totally free of it. Thus, there are two potential sources of cultural bias that are of concern to the counselor; bias on the part of the counselor, and bias that may be inherent in the modality itself. Either source of bias can undermine the best intentions of counselor and client and lead to frustration, premature termination, and ineffectiveness.

Pedersen (1987) identified ten assumptions reflecting cultural bias, considered the most frequently encountered examples of cultural bias in multicultural counseling. The purpose of this paper is to examine reality therapy and its practice in regard to these ten assumptions.

Assumptions Regarding Normal Behavior

The first source of cultural bias mentioned by Pedersen (1987) is the supposition that "normal" behavior does not vary from culture to culture, that there is a universal standard of "normality". This, however, is not the case. Mickel (1991) points out that "Culture defines the way of life which is considered natural by those who practice it. It determines the way we perceive reality. It gives meaning to the things we do. Our perceptions
determine behavior. Thus, culture determines, to a great extent, our behavior.” People recognize themselves to be a part of various larger systems, like families, communities, social classes, ethnic groups, nations, and others. This group identification is an identity, which becomes a controlled perception once it is defined. Therefore, it can be said that there is a connection between a person’s perception of himself or herself as an individual and a person’s perception of himself or herself as part of a larger system. The self-concept of each larger group or system is a controlled perception for the individuals that make up the group (Robertson, 1990). Thus, “normal” behavior for a cultural group may well vary according to what is in the collective quality world and perceived world of this group. While the common needs of the human race make people one with each other (Wubbolding, 1990), diverse pictures and perceptions may create variations in the behaviors of individuals of various cultural systems.

The primary implication of this source of cultural bias is the danger of diagnostic error in dealing with a culturally different individual (Usher, 1989). In reality therapy, however, the use of diagnostic classification in determining treatment has been viewed as “inaccurate . . . a major road block to psychiatric treatment” (Glasser, 1965). Awareness of this particular source of bias underscores the importance of self-evaluation in the counseling process. The counselor who uses reality therapy in skillfully, nonjudgmentally guiding a client toward self-evaluation will no doubt be less subject to the cultural bias of “universal normalcy”.

Emphasis on Individualism

The United States is a young culture, born in revolution, rooted in the ideal of rugged individualism. Pedersen (1987) states that “Many counselors in the United States presume that counseling is primarily directed towards the development of individuals rather than units of individuals or groups such as the family, organizations, or society.” Responsibility toward oneself is emphasized in Western society, while responsibility toward family and community is emphasized in many other parts of the world. Indeed, individualism is viewed in some cultures as an impediment toward growth (Sue & Sue, 1990). A counselor in China, for example, may guide his or her client’s goals according to what is perceived to be better for the collective Chinese society. The preferences of the individual are viewed as secondary (Zhang, 1994). Mickel (1991, p. 70) refers to an Afrocentric perspective in stating, “People share responsibility not only for themselves but for others. We must all work for the good of humanity. The move toward self-actualization is essentially seen in our relations to others . . . ”

As has already been discussed, humans do function as individual control systems within the context of other, larger systems. How the individual relates within these larger systems is to some extent a function of culture. All humans have the same needs, and every person has wants. It would be a mistake, however, for the counselor to assume that a client with a collective orientation will be willing to address these wants directly, or be willing to carry out a plan that may get the client more of what he or she individually may want at the expense of family or community expectations. When exploring the client’s wants, the larger systems of family and community should be taken into consideration. The client may be encouraged to consider the views of others in the self-evaluation process, and the plan may even involve changing the client’s total behavior in order to meet the collective expectations. This may be difficult for an individualistic counselor, but appropriate for the client.

Fragmentation by Academic Disciplines

The third assumption according to Pedersen (1987) is that cultural bias in counseling has arisen because the counseling profession has neglected other fields that are involved in the problems and issues common to humans, such as anthropology, sociology, and medicine.

This viewpoint is well justified; Pedersen is not the first person to notice this gap. Norbert Weiner, author of Cybernetics and early researcher in control theory, applied principles based in engineering to neurophysiology and medicine. He was also asked by anthropologists Gregory Bateson and Margaret Mead to apply these principles to anthropology and sociology (Wubbolding, 1994). It was Glasser, however (1984) who was ultimately responsible for translating the concepts of control theory into usable form for social scientists, integrating it into the practice of reality therapy. Thus, reality therapy does have a background in academic integration, albeit an unusual one.

The control theory concept of “total behavior” (Glasser, 1984) emphasizes the idea that one’s physiology cannot be separated from the rest of the psyche. This obviously has implications for the field of medicine. Likewise, it stands to reason that people, as individual control systems, cannot be separated from the larger systems they operate in, and still be fully understood. Wubbolding (1994) raises a very interesting question in this regard; “Could there be a collective, societal control system or a series of them?” If this is indeed the case, other academic disciplines could do well by examining control theory, as well as vice versa.

Dependence on Abstract Words

Western culture is a low-context culture, more dependent on abstract words to convey messages and less reliant on physical context and nonverbal (Pedersen, 1987). Thus, Western counselors tend to depend on abstractions in their practice, assuming that these abstractions are understood by the client in the way that the counselor intended. While low-context abstractions may save some time in imparting ideas, they may also impart misconceptions, particularly to ones who may have a different frame of reference (Pedersen, 1987). Reality therapy as is frequently taught and practiced contains a number of abstractions that could be misconstrued or even deemed offensive in some cultures.

Reality Therapy, reflecting Western society, promotes a nonjudgmental, friendly relationship based on, among other things, personal involvement and positive regard (Wubbolding, 1988). These principles are not unique to reality therapy; they are generally taken for granted as components of most current Western counseling theory (Corey & Corey, 1991).
One example of a potential misunderstanding involves a counselor from China, Wei jun Zhang (1994), who commented on the use of reality therapy as well as other Western Modalities in dealing with a fifteen-year-old male client who had been involved in vandalism. Zhang believed that the nonjudgmental approach used in a role-play would give the client the message that vandalism is all right. This, of course, is not at all what the reality therapist would have in mind. This misunderstanding is consistent with the idea that a counselor should take an active, directive stance in counseling Asian-Americans (Sue & Sue, 1990). The assumption of “positive regard” may, to the Western counselor, be based in a humanistic belief that humankind has an unconditional self-world; this may be in opposition to some cultural views, such as the Black American cultural view of mankind as having a sinful nature (Usher, 1989).

Practitioners of reality therapy generally rely on the use of many direct questions throughout every phase of the procedures; indeed, “The emphasis on questioning sets Reality Therapy apart from most other methods . . .” (Wubbolding, 1988). The use of many direct questions, however, may be offensive to the client from a high-context culture. With Asians, for example, questioning should be approached in a subtle, indirect way (Wubbolding, 1990).

High context cultures, such as Asian American, Hispanic, Native American, and Black American, also tend to rely heavily on group identification and understanding in communication (Sue & Sue, 1990). Thus, the importance of understanding the larger system is again underscored.

Overemphasis on Independence

Fifth, Pedersen (1987) mentions the Western assumption that independence is a desirable characteristic while dependencies are to be discouraged. This assumption is closely related to the second, emphasis on individualism. Interpersonal relationships conducted in a way that would be commonly accepted and encouraged in other cultures are likely to be viewed as excessive dependency by a Western counselor.

Many cultures, such as Hispanic or Asian, view the family, rather than the individual, as the psychosocial unit of operation. There are even differences in the way different cultures view family structure. In some cultures, such as Hispanic, Black American or Native American, the extended family and even family friends play far more of a major role in each other’s lives than extended family members do in Anglo society (Sue & Sue, 1990). In addition, similar dependencies are noted in employer-employee, student-teacher, or other roles (Pedersen, 1987).

Glasser (1984) defines one of the four basic psychological needs as freedom, the ability to make choices for oneself. The concept of a universal freedom need does not necessarily run counter to a collective orientation or “groupness”, nor are “freedom” and “independence” synonymous. In collective societies, the common good may be seen as an overarching goal that many frequently choose to uphold over personal interests (Zhang, 1994). Having a purpose that transcends one’s own life is viewed as worth self-sacrifice. Thus, one can choose to limit his or her independence. Seligman (1990, p. 228) mentioned this choice as a “paradoxical” choice that individualistic people may increasingly choose to make; . . . “as a tactic of self-improvement . . . choose to scale down its own importance, in the knowledge that depression and meaninglessness follow from self-preoccupation. Perhaps we could retain our belief in the importance of the individual but diminish our preoccupation with our own comfort and discomfort”.

When counseling with someone from a culture that emphasizes interdependence rather than independence, the reality therapist may spend more time exploring family, community, and societal expectations as well as the desires of the client. It may be more constructive for such a client to learn how to fill his or her needs more effectively within a necessary dependency rather than learning greater independence.

Neglect of Client’s Support Systems

According to Pedersen (1987), it is common for counselors to minimize the role of family and peers in supporting a client, and instead, emphasize the formal counseling relationship. He maintained that counselors should recognize the potential effectiveness of the natural support system and help the client utilize it, since in some cultures it is more acceptable to discuss personal issues with a family member than a professional counselor (Usher, 1989).

The basic approach of individual reality therapy does generally focus on the client and the therapist, and so this source of cultural bias may be present. Individual reality therapy is, however, not the only application of control theory and reality therapy. Control theory and reality therapy have been applied to education (Glasser, 1990), business management (Glasser, 1993; Cunningham, 1993), marriage and family counseling (Ford, 1987; Wubbolding, 1988), group counseling (Wubbolding, 1991) and religion (Moore, 1987). In these contexts, natural support systems are widely emphasized.

Mickel (1990, p. 32) wrote, “In the final analysis, the responsibility of the therapeutic process is to prepare the system to accept the reality of many possibilities.” Integration of the process of reality therapy with family/community support systems could be one beneficial possibility. In many cases, it would be easy to glean information about a client’s natural support system simply by remembering to ask the client about it. Then, the client could be asked to self-evaluate his or her own effectiveness in utilizing the natural support system, and if practical, it could become part of a plan.

Dependence on Linear Thinking

A seventh assumption is that “everyone depends on linear thinking — wherein each cause has an effect and each effect is tied to a cause — to understand the world around them” (Pedersen, 1987, p. 21). A left-brain, linear approach emphasizes the logical, rational, cognitive, and verbal. Linear thinking in counseling is most obvious in the use of tests to describe constructs in degrees (Usher, 1989).

Much of the world is not socialized to think in this way. Circular or nonlinear thinking, which is characteristic of African or Native American
cultures, does not follow a single stream of thought and does not necessarily categorize an event according to its relationship to other surrounding events (Usher, 1989). Many cultures have a right brain orientation, and stress an intuitive, harmonious, holistic approach (Sue & Sue, 1990). In reality therapy, linear thinking may be evident most often by a cognitive-behavioral approach that culminates in “do-plans”. Hallock-Bannigan (1994, p. 33) says in this regard, “The actual solution is not as important as is the essential inclusion of Quality in the solution choice”, and encourages counselors to be willing to take some risks, leaving the traditional techniques behind and “welcome the unknown.” While at times the work of the reality therapist may appear behavioral, it is important to remember that it is not based on a linear, stimulus-response model, but the continuous control theory feedback loop. Perhaps some clients may be better served by making use of alternate, right-brain methods of communication, such as drawing, music, collage making, storytelling, and movement; or, planning a session in which a client brings items of significance to show the counselor, such as photographs (Westwood & Ishiyama, 1990), in order to examine what is “Quality” for them. Glasser (1989, p. 13) recognized that “...what we teach is flexible and that there are no hard and fast rules. What we ask is that our counselors have a clear control theory reason for doing what they do”. At times, a symbolic distancing from the issues may allow for a more relaxed attitude toward the process (Cunningham, 1993).

Focus on Changing Individual, Not System

Pedersen (1987) stated that counselors frequently assume that their role is to change individuals to fit the system, without questioning whether the system should be changed to fit the individuals, and thus end up as agents of the status quo.

Of course, those who understand control theory know that any change is change of a system; the question is, which system is the focus of the change, and why?

While the counseling approach of reality therapy is generally individualistic, part of the mission of the Institute for Control Theory, Reality Therapy and Quality Management is to “teach the world control theory”. This mission certainly indicates a desire to bring about systemic change on a large scale. Nonetheless, personal responsibility remains a primary tenet of reality therapy. Whether one views culturally different clients as “helpless victims” or “irresponsible individuals”, a success identity can be developed through responsibility within the context of the client’s culture (Chung, 1994).

Neglect of History

Pedersen (1987) maintained that counselors tend to focus on present events that have led up to a crisis, viewing past events as less relevant to the problem at hand. He linked this present focus to a lack of awareness of historical context on the part of the counselor. One corroborating example of how history can be relevant is counseling of Native Americans, since they have more of an orientation toward the past (Sue & Sue, 1990) and may perceive themselves as being intimately connected to their forebears (Usher, 1989).

It appears that Pedersen is dealing with two different points: the personal history of the client and the general history of the client’s cultural group. There is no doubt that reality therapy is focused on need-satisfaction in the present, based on the idea that the only behavior one can change is one’s own. This does not imply that a client’s cultural history and context are not relevant. One wonders, however, how much time the client should have to spend educating the counselor in this regard, and how unbiased it would be to view the majority client as having responsibility and free will while viewing the minority client as limited by history.

Cultural Encapsulation

The tenth point mentioned by Pedersen (1987) is the danger that counselors may assume they already know all of their assumptions. To be thus blinded to one’s own biases lessens the chances of being able to work effectively with culturally dissimilar people.

Pedersen (1987) maintained that counselors need to be willing and able to challenge their assumptions and coordinate them with the beliefs of others. Since no two perceived worlds are the same, all counseling can be considered cross-cultural to some extent. At the same time, it can be said that because culture shapes so much of one’s experience, everyone is, in a sense, culturally encapsulated (Wubbolding, 1990).

The counselor, like the client, is a control system constantly in the process of behaving and comparing wants with experience. Self-evaluation, on the part of both the counselor and the client, is the key to overcoming the pitfalls of cultural encapsulation. The counselor must be able to self-evaluate his or her effectiveness in communicating with the culturally dissimilar, and be able to make changes where it is necessary and appropriate. When the counselor refrains from evaluating the client, but rather teaches the client to self-evaluate, the impact of counselor bias is greatly diminished.

Conclusion

There are areas in which the reality therapist should be especially cognizant of the impact of cultural differences. Direct questioning may not be appropriate for every client. The client may have a collective, interdependent orientation rather than an individualistic, independent outlook. The counselor may have to be more thorough in working with more than one system in dealing with some clients. The counselor may want to become more familiar with the client’s cultural history. The counselor may have to become creative in utilizing alternative methods of communication, always with the control theory framework in mind. The counselor will want to be careful not to impose his or her cultural values on the client in the name of reality therapy because of indifference or ignorance.

Reality therapy does have much to recommend it in working with people of different cultures. Since the client determines the goals of counseling and has the responsibility for evaluation, there is less risk of the client...
being judged according to the counselor’s standards and values. An emphasis on ongoing personal self-evaluation can assist the counselor in developing greater awareness of his or her own biases.

Especially, the theoretical framework of control theory is an advantage to the use of reality therapy in multicultural counseling. While the product (behavior) differs from person to person and culture to culture, the process (feedback) is the same. The understanding of basic needs that bond the human race can allow the reality therapist to transcend “techniques” and cultural norms in finding the most effective approach, while still having a clear idea of the purpose and direction of the counseling.

References

AFRICAN CENTERED CONTROL THEORY: THE PERCEPTUAL SYSTEM AND THE QUALITY WORLD
Elijah Mickel
The author is assistant professor of social work at the University of North Carolina, Greensboro.

ABSTRACT
From a control theory perspective, our quality world is formed as a result of the interpretations of the perceptual system. Pictures selected for inclusion in our quality world are screened by our sensory as well as our values and knowledge filters. This article is primarily concerned with one possible, communal interpretation of information contained in the real world. This, in essence, is the foundation upon which the African centered perspective is built. The article provides a cursory view of the perceptual system from an African centered perspective. It discusses the two major perceptual components—knowledge and values from the African centered perspective. The article defines the quality world from the collective communal perception rather than individual perceptions.

AFRICAN CENTERED PERCEPTUAL SYSTEM FOR CHANGE

The first step in understanding the African centered perceptual system is to understand the pictures which comprise one’s quality world. It is through self evaluation that the therapist is able to discern cultural similarities and/or differences. The therapist must speak to what one is able to perceive for oneself. Next, attempt to understand what others bring to the therapeutic relationship. Knowledge of self is imperative. Understanding your own perceptions is required if you plan to assist others with their feelings, thinking, actions and physiology within their real (perceived) world.

The next step is for the therapist to assess the components of the quality world. The components are comprised of the values and knowledge which cross the filters (axiology and epistemology). During the assessment process, we must discern the components of these systems. The ways of knowing (epistemology), in concert with judgment (axiology), define the coding process.

Finally, therapists must learn to encode as well as decode the quality world of those with whom they work. It is impossible to decode without understanding culture. It is impossible to encode without understanding the totality of the environment. Both are necessary for effective communication which in the final analysis is based upon interpretation. One example of interpretation is the very connotation of African-centered, Black or Afro-American which continues to be controversial. According to Baldwin (1986), “Thus, although much of this controversy remains, it is clear that whichever terms one chooses to employ in this regard (Black Psychology or African Psychology), one must ultimately be referring to “African phenomena.”” We must investigate the culture (community frame of reference) of those we choose to assist in the move to responsible choices. Before we move to step one, we must define perception.
PERCEPTION

In his seminal works, William Glasser (1981, 1984) describes the perceptual system as the input. According to Glasser (1981) “Therefore, except for one exception which will be explained later, when we discuss feelings in detail, all that we experience can be divided into two parts — what we sense or what goes into our brain, which for the rest of this book we will call our perceptions or input, and what our brain generates as it attempts to control some part of the world, which we will call our behavior or output (p. 29).”

J. Piaget (1960) defines perception as “the knowledge we have of objects or of their movements by direct and immediate contact...” He goes on to relate perception to need. According to Piaget (1960, p. 91), “When a response is associated with a perception there is more in this connection than a passive association (i.e. becoming stamped in as a result of repetition alone); meanings also enter into it, since association occurs only in the presence of a need and its satisfaction (p. 53).”

Our wants, in the real world, are viewed through our perceptual system which is comprised of our sensory system, knowledge and values. Our sensory system is comprised of our hearing, seeing, feeling, touching, tasting and sense of smell. Glasser (1984) describes this system in terms of pictures. He relates, “I like to think that all our senses combine into an extraordinary camera that can take visual pictures, auditory pictures, gustatory pictures, tactile pictures and so forth. In simple terms, this sensory camera can take a picture of anything we can perceive through any of our senses. I like to use the word pictures rather than the technically correct term, perceptions, because pictures are easier to understand. Since more than 80 percent of the perceptions we store in our albums are visual, pictures is also a reasonably accurate term (p. 21).” The perceptual system responds to our behavior. Behavior is the control of perceptions (Powers, 1973).

Coding is the general term for the selective filtering mechanism of a system by which it rejects, accepts or translates incoming information. Under the auspice of cultural variance, systems selectively filter their interpretation of the world. This selective filtering, coding, is essential to a sense of quality. Quality systems are balanced systems.

The steady state and dynamic homeostasis concerns itself with the ratio of energy exchanges and the method whereby relations between parts remain complementary. What is placed in the quality world must be doable if it is to be perceived as rational. According to hooks (1989), “If the identified audience, those spoken to, is determined solely by ruling groups who control production and distribution, then it is easy for the marginal voice striving for a hearing to allow what is said to be over determined by the needs of that majority group who appears to be listening, to be tuned in. It becomes easy to speak about what that group wants to hear, to describe and define experience in a language compatible with existing images and ways of knowing, constructed within social frameworks that reinforce domination (p. 15).”
experience: (1) the belief works in some way to make us feel good, and (2) a lot of other people believe the same way we do and this makes us more certain that what we believe is correct (p. 4)." This is the essential foundation of communal knowledge.

Our knowledge system is comprised of many ways of knowing. Included in the triangulation are: (1) Tenacity - It is true because it is true and it has always been known to be true; 2. Authority - Established belief (books, people); 3. A priori - It is through free communication and discourse that we can reach the truth because of our natural inclination which tends toward truth. The positions accepted are self-evident; 4. Common Sense - Those judgments which are grounded in our experiences, wisdom, and prejudices. It explains everything even when those explanations are in conflict with each other; 5. Tradition - Those beliefs based on custom, habit and repetition. It includes that knowledge passed from our foreparents with an understanding that this knowledge is worthy of being given great weight, and 6. Intuition - we know because we know - our cultural or collective interpretation of the world. Knowledge is also comprised of the scientific way of knowing.

Science is generally defined as a process leading to explanation, understanding, reduction and control. Those who ascribe to the scientific way of knowing posit that there are real things (in the real world), whose characteristics are independent of our feelings about them. There is a self correction process. The truth is accepted only after testing. The aim of science is theory, which is used to explain natural phenomena. A theory is a set of interrelated constructs (concepts), definitions and propositions that present a systematic view of phenomena by specifying relations among variables, with the purpose of explaining and predicting the phenomena. The scientific method: 1. Defines a question; 2. Develops a hypothesis (conjectural statement, tentative proposition which discusses the relation between two or more variables); 3. Tests the hypothesis and 4. Draws a conclusion.

Although, for the purpose of understanding, the knowledge filter is presented as distinct from the value filter, they are interconnected and interdependent. One does not exist without the other, and what impacts upon one has a concomitant impact upon the other. Knowing is as requisite to perception as it is to valuing. Therefore, in order to understand knowledge, we must clearly articulate our values.

VALUES

Talking with one another is loving one another

Thatcher (1987), relates, "In control theory psychology, the valuing filter is a component of how the Real World is perceived. Thus, these wants determine how individuals evaluate what is perceived in the Real World and how the total behaviors are viewed (p. 23)." Our wants are an expression of our basic needs.

The values discussed herein are grounded in the basic principles of human personality based upon traditional African beliefs. These are the philosophical principles which are included in the African centered quality management (Mickel, 1994): (1) The Divine Image of Humans; (2) The Perfectibility of Humans; (3) The Teachability of Humans; (4) Free Will of Humans, and (5) The Essentiality of Moral Social Practice. This model also includes the seven principles of the Nguo Saba which are used to guide and interpret daily community living. These principles are: (1) Umoja; (2) Kujichagulia; (3) Ujima; (4) Ujamaa; (5) Nia; (6) Kuumba, and (7) Imani. We must move from the philosophical to the practical. In this move the human personality must guide the practice. In addition to the aforementioned components of the African values system there are practice values. As a social worker who practices reality therapy, I adhere to a code of ethics as well as a professional values system that I have used to guide my training of hundreds of students. These values are exemplified in the work of Biesteck (1957). They include: (1) acceptance; (2) confidentiality; (3) controlled emotional involvement; (4) individualization; (5) self determination, and (6) nonjudgmental attitude. Finally, the matrix includes the basic needs which continue to exist because they have value.

The African centered valued matrix explicates the correlation between confidentiality, divine image and spirituality. Teachability, fun, creativity and controlled emotional involvement are related values. Power, perfectibility, collective works, cooperative economics, purpose and purposeful expression of feelings are also tied together. Self determination, individualization, freedom and freewill are interrelated. Love, unity, acceptance, a nonjudgmental attitude and essentiality of moral social practice share characteristics (Figure One).

— Figure One —

AFRICAN CENTERED VALUES MATRIX

<table>
<thead>
<tr>
<th>DIVINE IMAGE OF HUMAN BEINGS</th>
<th>SPIRITUAL</th>
<th>IMANI</th>
<th>CONFIDENTIALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEACHABILITY OF HUMANS</td>
<td>FUN</td>
<td>KUUMBA</td>
<td>CONTROLLED EMOTIONAL INVOLVEMENT</td>
</tr>
<tr>
<td>PERFECTIBILITY OF HUMANS</td>
<td>POWER</td>
<td>UJIMA/NIUJAMA</td>
<td>PURPOSEFUL EXPRESSION OF FEELINGS</td>
</tr>
<tr>
<td>FREE WILL</td>
<td>FREEDOM</td>
<td>KUJICHAGULIA</td>
<td>CLIENT SELF-DETERMINATION</td>
</tr>
<tr>
<td>ESSENTIALITY OF MORAL SOCIAL PRACTICE</td>
<td>LOVE</td>
<td>UMOMA</td>
<td>ACCEPTANCE</td>
</tr>
</tbody>
</table>

ELIJAH MICKEL, DSW (C) 1994
Systems always require more energy than they expend in order to continue their existence. The energy which leads to an understanding of the communal interpretation of reality is found in the knowledge and value attributed to the concept of an African centered spirituality. According to Heider (1985), “Group work must include spiritual awareness if it is to touch the existential anxiety of our times. Without awe, the awful remains unspoken, a diffuse malaise remains (p. 143).” Spiritual needs manifest themselves within the context of communal and cultural expression. Three perceptual dimensions exist in the definition. The first is the individual dimension, the second is the community which is comprised of individuals, and the third is the cultural which is comprised of communities. Thus, each dimension encompasses the other.

The divine image is also expressed through Iman (faith). It is through faith in our humanity that we can move to a balanced harmonious natural order within the universe. Faith has been defined as the “evidence of things not seen.” It is an opportunity for perception to be transformed into reality. Faith is the foundation upon which the creative process is transformed to action. Worry has as its foundation doubt. It is a barrier or filter to faith. Belief is a permeable boundary that filters but does not exclude acting. According to Dennis (1989), “As a result of my study and experience, I now consider faith to be the overarching human need, and include it as such as a routine part of my clinical practice (p. 55).”

Glasser (1989) writes, “If you examine my definition you will notice that all of the needs are, in essence, satisfied by belief. As far as we are concerned, the world is the way it is because this is what we believe (p. 3).” When we have faith based on spirituality, it can be expressed through our action of confidentiality. It was related by Biesteck (1957). “Confidentiality is the preservation of secret information concerning the client which is disclosed in the professional relationship (p. 121).”

This divine image posits that one has both a physical and spiritual self. The energy source used by communities to sustain themselves has been codified by some as religion, but I would submit spirituality as a better term. Spirituality which transcends all cultures and all political groupings (races) is the energy giving force which sustains when all else fails. The great theologian Howard Thurman (1965) approaches clarity (although he perceives a connection between spirituality and religion) when he states:

“...but it must be remembered that what is true in any religion is to be found in that religion because it is true, it is not true because it is found in that religion. The ethical insight which makes for the most healthy and creative human relations is not the unique possession of any religion, however inspired it may be. It does not belong exclusively to any people or to any age. It has an ancient history, and it has been at work informing the quality of life and human relations longer than the records and the memories of man. Just as scattered through the earliest accounts of man's journey on this planet are flashes and shafts of light illuminating the meaning of man and his fellows, so in our times we find the widest variety of experiments pointing in the same directions and making manifest the same goals. Men

are made for one another. In this grand discovery there is a disclosure of another dimension: this experience of one another is not enough. There is a meaning in life greater than, but informing, all the immediate meanings — and the name given to this meaning is religion, because it embodies, however faintly, a sense of the ultimate and the divine.” (p. 112).

The teachability of humans posits that people are teachable and capable of moral cultivation which leads to his or her high self. This principle recognizes the value of information as a key process in choosing behavior (which, after all, is based upon perception). People use their creativity to fashion a way of coping within society. According to Biesteck (1957), “The controlled emotional involvement is the caseworker’s sensitivity to the client’s feelings, an understanding of their meaning, and a purposeful, appropriate response to the client’s feelings (p. 51).”

The perfectibility of humans posits that there is a continuum of development. The principle is that people develop progressively and are perpetually becoming. According to Biesteck (1957), “Purposeful expression of feelings is the recognition of the client’s need to express his feelings freely, especially his negative feelings (p. 35).”

There is no more empowering concept than purpose (Nia). There seems to be with each of us, an intense search for purpose. It is through our understanding of Ujima (collective works and responsibility) that we work to build and contribute more to our group than our predecessors. Ujamaa (Cooperative Economics) is based upon communal sharing while working to meet the needs of the world community.

Free will means that people are free to act as they will. Systems have options when they make action and people must learn to accept responsibility for the choices they make. This free will is grounded in collective moral conscience. Collective behavior is organized around the control of communal perceptions. According to Biesteck (1957), “Individualization is based upon the right of human beings to be individuals and to be treated not just as a human being but as this human being with this person’s differences (p. 25).” Individualization is anathema to the African centered perspective unless the individual is willing to choose to subsume his or her needs to those required for the communal good.

The community members that have self determination (kujichagulia) know their history and the history of its membership. In times of trouble and distress, members with similar perceptions fall back upon their collective strength-fulfilling behaviors and look to them for answers to present problems. People do what they do to meet their need for self determination. Biesteck (1957) relates, “The principle of client self-determination is the practical recognition of the right and need of clients to freedom in making their own choices and decisions in the casework process (p. 103).”

Umoja (Unity) is the essence of the African-centered approach to interdependence. There are no divisions in its structure, except ones that are artificially created. To be interdependent is to be a part of the whole. There are no outer limits to relationships nor are there limits on members’ involve-
ment. That involvement is simply collective unity. According to Biesteck (1957), “Acceptance is the principle of action wherein the caseworker perceives and deals with the client as he really is... maintaining all the while a sense of the client’s innate dignity and personal worth (p. 72).” Begin where clients are, not where you would like them to be.

Biesteck (1957), further relates, “The nonjudgmental attitude is a quality of the casework relationship; it is based on a conviction that the casework function excludes assigning guilt or innocence, or degree of client responsibility for causation of the problem or needs, but does include making evaluative judgments about the attitudes, standards, or actions of the client...(p. 90).”

The essentiality of moral social practice relates that good is that which lasts and uplifts people. It charges people with making the world a better place in which to live. Moral social practice is essential to the well being of all humanity. In order to teach in a more effective manner, reality therapists can use the perceptual system.

**CONCLUSION**

African centered control theory is based upon the knowledge and values which determine a specific interpretation of the world. Its major premise is interdependence. It is a world view that in many respects approximates a communal approach to perception. That is, those individuals who form the collective have a similar perceptual interpretation of the world. Baldwin (1985), writes, “In any case, we are all born into communities, whether we like it or not or know it or not and whether or not we get along with the community... In the twentieth century, and in the modern State, the idea — the sense — of community has been submerged for a very long time. (p. 123)” This perspective is about the reemergence of the sense of communal interdependence.

Communal interdependence is recognized through the construct of systems. The elements of the system work together (Hoglund, 1994). A system is a group of processes, components or elements that work together forming a whole. According to Heider (1985), “Since all creation is a whole, separateness is an illusion. Like it or not, we are team players. Power comes through cooperation, independence through service, and a greater self through selflessness (p. 77).” A system is interdependent. Each component impacts upon and responds to the other elements. A change in one part brings about concomitant changes in the other parts. The function of the reality therapist, from a communal perspective, is to assist the individual, through the group, organization or community to move from dependence to interdependence.

The quality world (Glasser 1989, 1990) recodes our basic needs into what we want and what we want determines our actions. Within the relational system, the want fulfilling behaviors are often in conflict. This conflict is based upon the temporary disequilibrium between the real and quality worlds. From the systems perspective, conflict provides intrinsic motivation as the system will seek balance. If the system cannot meet its needs responsibly, it continues to behave until the need is satisfied even to the point of irresponsible, irrational behaviors. It has no choice but to seek balance. This balance may result in effective irresponsible behaviors or effective responsible behavior. Effective behavior is that which results in a balanced system. The system must seek balance between the real and quality worlds. Each role, task, and function of the system requires a continual balance between what it has and what it wants.

**Bibliography**


BASIC NEEDS AND SEXUALITY: IS SOMETHING MISSING IN REALITY THERAPY/CONTROL THEORY

Louise LaFontaine

The author is associate professor of Special Education at Northeastern University. She is also a member of the Education Subcommittee of the Massachusetts Governor's Commission on Gay and Lesbian Youth.

ABSTRACT

The article discusses the lack of information and awareness of issues related to homosexuality from a reality therapy/control theory approach. A challenge for professionals to remedy this omission and work within a more diversified framework is presented.

The literature of reality therapy/control theory describes five basic needs:

1. to survive and reproduce
2. to belong and love
3. to gain power
4. to be free
5. to have fun

The first of these needs is described by Glasser (1986) as follows: "Simple survival instructions like hunger, thirst, and sexual frustration are relatively clear-cut, and we quickly learn what particular discomfort is attached to all the aspects of this need." (p.24)

The question is where is this need discussed either in the above context or in relation to the other four basic needs. Reality therapy/control theory is a therapeutic orientation which views these needs as a fundamental basis for its theoretical/philosophical foundation.

The concern of the author is the lack of discussion of human sexuality in general and homosexuality in particular. An earlier article (LaFontaine, 1994) discussed these issues in relation to the quality school approach to education. There appeared to be little, if any, references in the Journal of Reality Therapy to a discussion of issues related to homosexuality. It seemed important to follow up with a closer look at the literature of reality therapy/control theory to ascertain quite clearly that not only has this area been neglected in regard to implementation of the quality school, but also throughout the entire area of sexuality. In addition, there is even less information in the specific area of homosexuality.

There are several organizations which work specifically with issues related to homosexuality either from the viewpoint of gays and lesbians, or of families and friends of gays and lesbians. These organizations are volunteer groups that have been organized throughout the country and the world to help to fill a need for a population which has been, and still is, subjected to widespread discrimination. Homophobia, which is essentially a fear of homosexuality, is prevalent in all parts of society, but the effect is nowhere so devastating as in our schools. The author has discussed this issue in relation to the "Quality School" model in an earlier article (LaFontaine, 1994). To appreciate the ramifications of the dearth of material in this area in reality therapy/control theory, it is important to look at the lack of recognition of the needs of this population in general, and then to examine what can be done by those who are trained in the reality therapy/control theory model to address these needs.

The author has had extensive experience with one particular group that has chapters nationwide and in many foreign countries. The group is PFLAG (Parents, Families, and Friends, of Lesbians and Gays). The author has been primarily as chapter coordinator for a group in southeastern Massachusetts since 1989.

To fully comprehend the extent of the need for individuals trained as
educators, counselors, administrators, and other school personnel, it is necessary to take a step back and look at the context of the work described above. Massachusetts, on a national level, is probably the most friendly and accepting state for gays and lesbians to live in due to many factors. First, there is a statewide gay civil rights law that was passed in 1987; this is true of only nine other states. Second, there is a students' rights law that was passed in December, 1994 and that is the first in the nation. Third, there is a Governor's Commission on Gay and Lesbian Youth which has the full support of the current administration and the Department of Education. Fourth, the certification standards for training of all school personnel have been amended to include the phrase "sexual orientation" along with race, religion, gender, ethnicity, and disability in terms of issues which school personnel must be trained to be sensitive to in their work with all students.

In spite of the above laws and other supportive measures, the people who come to the PFLAG meeting tell the same stories over and over again. Horror stories of discrimination, isolation, harassment, violence, school dropouts, high suicide rates, and turmoil in all aspects of the lives of families and their children. And the recurring theme is one of needs. Students talk about the needs to be loved, to feel worthwhile, to have friends, to not be isolated, to not be afraid, to be able to talk, and to feel safe. Families and friends acknowledge the same needs, but also talk about the lack of support, the ignorance and at times hostility of their clergy, and the recurring theme is one of needs.

If the situation is so difficult in a state that is more supportive and actually has legislation in place to back up this support, the question is exactly what are gays and lesbians and their families and friends facing in other areas where there is little or no formal support available. The reason for looking at the picture of Massachusetts specifically is to highlight the urgency of these issues in other areas.

Reality therapy talks about the basic needs of all people and how they have pictures in their minds of how they want these needs to be met. Each individual has different pictures depending on his/her personal experience, but it is believed that people are always trying to meet these psychological and survival needs. In the counseling and teaching environment, it is critical to address these needs for clients and/or students. It is also critical for those working with reality therapy to address these needs for themselves to be effective in their work.

There are several unanswered questions related to the failure of reality therapy/control theory to provide open discussions, to conduct research concerning needs for this population, and to have professionals incorporating this area into their counseling and educative process. The fact that discussion is lacking is clear. The need for such discussion is also clear in light of the evidence presented very briefly about the needs of gays and lesbians, particularly gay and lesbian youth. This need has been documented in many studies and reports, and in innumerable first hand accounts. Is this a need which has not been perceived? Is it a need where there is a lack of trained personnel who are capable of responding to the need? Are there issues relating to homophobia underlying the lack of information and subsequent development of supportive techniques for working with gays and lesbians?

These questions are all worthy of more intensive investigation. It is certainly not the intent of the author to make unfounded criticisms of an approach which is viewed as a potentially valuable tool for productive work with a gay and lesbian population in general and gay and lesbian youth in particular. Rather, the intention is to point out as forcefully as possible that the basic tenets of reality therapy are well suited to deal with the needs discussed above. The very fact that the focus is on need is the reason that such a discipline could be so potent in providing techniques for working with homosexuality, an area where need is primary, and the neglect is obvious.

Several specific steps could be taken to implement these techniques.
1. The subject of homosexuality could be discussed in the literature.
2. Workshop and conference presentations in this area could be encouraged and supported.
3. Training for certification in reality therapy could include specific discussions of issues related to homosexuality, from the perspective of both education and therapy.
4. Counselors and educators who use reality therapy/control theory could be provided with information and resources concerning the issues and problems facing gays and lesbians, with an emphasis on the specific issues and problems that occur.
5. Research into the nature of the problems faced in school settings could be encouraged with a view to incorporating this information into the processes involved in establishing the "Quality School" model.

In a more general sense, and basic to the philosophy of reality therapy, it is important to look at the issues of choice and responsibility in relation to one's behavior in the total context of diversity and how this affects the counseling and teaching methodology proposed. There are many critical aspects of an individual's life which are not chosen. Some of the major aspects are of great importance in relation to how individuals behave and what their sense of responsibility may be. Gender, race, ethnicity, disability, and sexual orientation are not choices. Nor is there any choice involved by individuals at present in regard to the societal framework into which a person is born and functions. There is some disagreement among professionals about the aspect of choice in relation to homosexuality. Glasser (1985) discusses this briefly in relation to the sexual pictures individuals have in their heads and states that "they are not innate" (p.25). The author, based on her work in this area, does not agree with this perception.

There are many layers of historical/societal attitudes, customs, laws, and behavior which are pre-existent and which an individual must deal with at any given time. When something as important as one's sexual identity is an issue, which has been part of an ethos of discrimination, hatred, harassment, and violence for a long period of time, it is essential that professionals who are proposing particular techniques and procedures to help
people to lead need fulfilling lives at least recognize the role of sexual orientation in the life of an individual. This author is focusing on only one of the categories listed that is not subject to choice, primarily because this is an area where little recognition has been given to date by reality therapy/control theory.

The challenge is for the professionals in this area to look at the framework in which people must make their choices and to investigate the effect of that framework on individuals. For too long a period there has been an insularity among reality therapists who have tended to talk to each other using a common language and common concepts where there is general agreement. If reality therapy/control theory is to remain vital and to develop and grow, and to provide valuable services to all individuals who might benefit from the theories and techniques proposed, then reality therapy/control theory must take an inclusive approach which is reflective of the diversity of society today. That approach also needs to welcome and encourage controversy, differences of opinions, and a general exploration as to how the strength and purposes and basic philosophy can continue to provide a relevant voice in the therapeutic and educational world of today.

SEXUAL DYSFUNCTION: A REALITY THERAPY APPROACH
Sarah Chapman

The author is currently completing an Honours degree in Psychology at Charles Sturt University-Mitchell in Bathurst, Australia.

ABSTRACT

While many clinicians have used Reality Therapy within a marriage and family counselling context, to date there are no publications which address the suitability of Reality Therapy for the treatment of sexual dysfunction. This paper illustrates the applicability of Reality Therapy to the treatment of this problem.

A number of researchers have discussed (or demonstrated) the applicability of Reality Therapy to marriage guidance and counselling. For example, Smadi (1991) found that married clients who learned to provide their partners with opportunities to satisfy their needs, with opportunities to express their feelings and thoughts, and to compromise with their partners on their incompatible wants, were able to develop an emotionally satisfying relationship with their spouse. Wubbolding (1988) also argues that the principles underlying Reality Therapy are clearly applicable to marital relationships insofar as all such relationships consist of two human beings who have common needs and wants. When a marriage endures, there is congruence between each member’s wants, how they live (behave), and the way they view the world. Thus, when plans and strategies for meeting the couple’s needs are discussed, clarified, and worked toward, they provide a powerful binding force that compensates for the differences between them.

Given that Reality Therapy provides an effective theoretical framework for marriage counselling, it seems reasonable to suggest that it may also be successfully applied to the treatment of sexual dysfunction.

SEXUAL DYSFUNCTION: AN OPERATIONAL DEFINITION

Hawton (in Hawton, Salkovskis, Kirk & Clark, 1993: 371) defines sexual dysfunction as “persistent impairment of the normal patterns of sexual interest or response”. Despite its simplicity, this definition is problematic in that while we can distinguish between sexual deviations (such as frotteurism) or variations (such as homosexuality), it is virtually impossible to define the range of “normal patterns” of sexuality.

An alternative (and more appropriate) definition of sexual dysfunction is provided by the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition, 1994), where sexual dysfunction is characterized by both disturbance in sexual desire and in the physiological changes that accompany sexual arousal. According to the DSM-IV, an additional and notable feature of sexual dysfunction is that it causes the afflicted individual considerable distress and that he or she often experiences considerable difficulty in maintaining or establishing interpersonal relations.
The present paper limits its conceptualization of sexual difficulties to sexual dysfunctions. Despite this, it should be noted that Reality Therapy may also be used to treat couples who report being dissatisfied with their sexual relationship, as many of the factors which may contribute to dissatisfaction with one's sexual relationship (such as general relationship difficulties or boredom with unvaried sexual activity) are often shared by those exhibiting dysfunctional sexual behaviour.

While the treatment approach to be discussed here may be applied to couples in which one or both partners experience sexual dysfunction due to a medical ailment (for example, erectile dysfunction resulting from diabetes mellitus), for individuals whose sexual dysfunction is attributable to substance abuse (for example, excessive alcohol consumption or use of barbiturates), the individual's chemical dependence should form the basis of therapeutic intervention (addressing this problem may also eradicate the individual's sexual dysfunction, however, the individual's sexual dysfunction is not of primary concern). In cases where substance-induced sexual dysfunction is implicated, it is important for the clinician to establish whether the individual's drug use constitutes "true" substance abuse, or is more appropriately considered recreational drug use, as only the latter may be addressed within the bounds of sex therapy (recreational drug use may exacerbate an individual's dysfunctional sexual behavior or may be a reaction to a sexually dysfunctional or emotionally unsatisfying relationship).

AETIOLOGY

A useful conceptualisation for understanding the aetiology of sexual dysfunction is provided by Hawton (in Hawton, Salkovskis, Kirk & Clark, 1993), who clusters the factors which research has shown to be associated with sexual dysfunction into three primary groups: Predisposing factors (defined as those which render an individual more vulnerable to the development of sexual dysfunction, such as child sexual abuse), precipitants (which lead to the appearance of a sexual problem, such as childbirth), and maintaining factors (the individual's psychological responses and attitudes to the sexual problem, and stressors which may maintain or exacerbate the dysfunctional sexual behavior).

Hawton argues that the combination of predisposing, precipitant and maintaining factors results in an individual manifesting some form of dysfunctional sexual behavior. For example, a woman who had learned very little sexual etiquette before her marriage (predisposing factor) discovers that her husband has had ongoing sexual relations with another woman for over six months (precipitating factor). As a result, she experiences considerable anxiety whenever her husband makes sexual advances toward her and actively avoids physical intimacy. (maintaining factor).

TAKING EFFECTIVE CONTROL OF THE PROBLEM

The treatment of sexual dysfunction within heterosexual relationships, once an auxiliary component of marital therapy, has recently been recognized as an independent form of treatment simply referred to as "sex therapy" (Heiman, LoPiccolo & LoPiccolo, in Gurman & Kniskern, 1981). Arguably the most popular treatment for sexual dysfunction is that developed by Masters and Johnson, whose highly controversial 1960s research investigating the nature of the human sexual response culminated in the publication of their landmark work Human Sexual Inadequacy.

Prior to Masters and Johnson's publication, psychoanalytic theory and practice dominated the therapeutic approach to sexual problems. Within the psychodynamic framework, sexual dysfunction is considered a manifestation of an underlying (or unconscious) conflict (Atwood & Dershowitz, 1992) and therapeutic intervention aims to alleviate sexual dysfunction by resolving its infrastructure (the underlying conflict). Following the publication of Human Sexual Inadequacy, the psychoanalytic approach was scrutinized by sexologists and psychologists alike. It failed to withstand empirical investigation (Heiman, LoPiccolo & LoPiccolo, in Gurman & Kniskern, 1981), and the duration of therapy required for successful treatment was considered prohibitive.

There are currently a number of different approaches to the treatment of sexual dysfunction (most of which incorporate aspects of the Masters and Johnson program). Sarason and Sarason (1989), for example, conceptualize sexual dysfunction within a psychosocial framework. As such, treatment focuses on recognition of past learning and of environmental stressors which may have a negative impact on the individual's sexual functioning (such factors are often related to lifestyle and include overindulgence in food and drink as well as overcommitment to work).

Cognitive-behavioral approaches to the treatment of sexual dysfunction are characterized by the active role of the therapist: He or she actively and directly educates the client about sexual physiology and sexual techniques, "restructures maladaptive behavior patterns and cognitions regarding sexuality, and uses anxiety-reduction and skill-training techniques to improve the patient's functioning" (Heiman, LoPiccolo & LoPiccolo, in Gurman & Kniskern, 1981: 594). It is the opinion of this author that the application of Reality Therapy to the treatment of sexual dysfunction is a modification of the cognitive-behavioral approach and represents a new frontier in the treatment of this problem.

APPLICATION TO THE TREATMENT OF SEXUAL DYSFUNCTION

The application of Reality Therapy to the treatment of sexual dysfunction can be divided into assessment, intervention, and action phases. During the assessment phase, the Reality Therapist should aim to identify the nature and extent of the individual's (or couple's) dysfunctional sexual behavior, and to clarify the aetiology of the problem.

While the traditional assessment procedures for the treatment of sexual dysfunction include direct observations (or videotaping) of sexual behavior, sex history interviews, and paper and pencil inventories, these measures have little to recommend them: Observing sexual interaction between a couple may exacerbate their dysfunctional sexual behavior (for example, a man suffering from premature ejaculation may feel intense pressure "to perform", thereby rendering him impotent and reinforcing his failure identity); sex history interviews may provide the couple with a rationalization for their dysfunctional behavior (and divert the therapist's attention.
away from the negative patterns of interaction which are reinforcing the couple’s behavior); while paper and pencil inventories are extremely susceptible to social desirability, defensiveness, and simple falsification by the respondent.

Table 1 outlines an appropriate assessment interview for a Reality Therapist to conduct when a client couple seek to correct their sexually dysfunctional behavior.

**Table 1. Components of a Reality Therapy Assessment Interview for the Treatment of Sexually Dysfunctional Behavior**

During the assessment interview the Reality Therapist should:

1. **Clarify the sexual problem:**
   - determine its precise nature and development;
   - the time of onset;
   - and identify the desired changes in the sexual relationship.

2. **Obtain general sexual information**
   - determine the couple’s specific attitudes to sexuality;
   - the perceived source of the problem (including the couple’s theories to explain its occurrence);
   - the extent of the problem (whether the problem is generalized or specific to certain situations and whether it is recently acquired or enduring);
   - whether the couple believe they lack information about sexual technique and response (therapists should make their own assessment of the couple’s level of sexual knowledge as oftentimes they will misrepresent their level of knowledge);
   - treatments to date (reasons why the treatment failed; reactions to previous treatment.)

3. **Obtain general relationship information**
   - information relating to the development of the relationship and the couple’s sexual adjustment;
   - address issues such as children and contraception, infidelity, and level of attraction between the partners;
   - assess each individual’s perception of the relationship:
     - (a) is the level of emotional and physical intimacy discrepant with either of the partner’s desired level?
     - (b) is there adequate opportunity for self-disclosure (sharing of thoughts, beliefs, attitudes, and feelings)?
     - (c) are they committed to the relationship? (are their needs - both sexual and non-sexual - being met?)
     - (e) is conflict often resolved (are partners able to negotiate, compromise, and discuss problems within the relationship?)

4. **Identify any lifestyle factors which may be contributing to the problem**
   - school or occupational demands, leisure time activities, religious beliefs, use of alcohol or other drugs.

5. **Assess the medical status of each partner**
   - identify any medication which may be affecting the individual’s sexual functioning;
   - possible health problems (which may be related to lifestyle - if so, is the couple willing to make lifestyle changes?)

6. **Assess the couple’s psychiatric history, and each partner’s appearance and mood.** It may also be necessary to arrange for a physical examination of one or both partners.

During the **intervention** phase of treatment, the Reality Therapist should aim to highlight the contextual nature of the couple’s problem and to challenge their reality (see Table 2). As noted by Atwood and Dershowitz (1992: 198) “sexual problems do not exist in a vacuum... (and) are often related to problems in the couple’s emotional relationship, such as poor communication, hostility and competitiveness, power and intimacy issues, or sex role problems.” During the intervention phase of treatment, the therapist should also help the couple develop a plan for successful intervention, elicit commitment to the plan, and aim to identify any “power struggles” which may be occurring.

For those couples whose sexual dysfunction may be partly attributed to naivete, Reality Therapists should include a treatment component designed to enhance the couple’s sexual skills. Researchers have found that couples shown videotapes of genital caressing and exploration, masturbation, shared orgasm, intercourse, and oral genital play, often report that this provides them with a positive model of functional sexual behavior and is instrumental in allowing them to build a more satisfying sexual relationship (see Mobarak, Tamerin & Tamerin, 1986). Additional methods which may be used to improve the couple’s sexual skills include behavioral rehearsal.

**Table 2. Successfully Challenging Client Reality**

The following examples illustrate ways in which the Reality Therapist can challenge the client couple’s perceptions regarding the nature and extent of their problem. **Is your behavior helping or hurting you?**

If a woman reports avoiding intercourse with her partner because she resents his dedication and commitment to his career, the therapist would attempt to make the client realize that her decision to avoid intimacy is depriving her of sexual pleasure, and is unlikely to change her partner’s behavior.

**Is what you’re doing helping you get what you want?**

The therapist may use this question to lead the couple to the conclusion that withholding sexuality is an indirect way of responding to relationship stress which is unlikely to result in either partner meeting their needs: Withholding sexuality as a way of punishing one’s partner does not allow either partner the opportunity to fulfill their need to give and receive love.

**Is what you want realistic or attainable?**

This question may be used to make the couple aware that they are making unrealistic demands on their partner (or themselves) with respect to their sexual relationship. For example, a woman may expect her partner to be a perfect lover each and every time they engage in sexual activity, while a man may demand that his partner be ever-ready for intercourse.

**Does it help you to look at it that way?**

A woman whose husband suffers from an erectile dysfunction develops an aversion to sexual activity as her husband’s frequent inability to maintain an erection leads to the development and reinforcement of the belief that he no longer finds her sexually attractive. Her concomitant feelings of depression and guilt lessen her desire for sexual activity. Upon finding that her husband still finds her sexually attractive, the therapist would help her to realize that she alone is not responsible for the problem and would then examine the couple’s emotional relationship.
The action phase of Reality Therapy treatment proposed here represents a modification of a four-tiered approach to marriage and family counselling proposed by Wubbolding (1988). Readers should note that this is a general model for effective therapeutic intervention, and that each couple (or individual) seeking treatment from a Reality Therapist is required to establish a specific plan which is suited to their particular problem.

The first stage of the model focuses on compromise and the avoidance of destructive arguments between the couple. During this stage, the therapist encourages the couple to discover which of their needs (both as individuals and as a couple) are not being met. This requires them to listen to one another and to respect their partner's views (with the ultimate aim of compromising on any incompatible needs and wants). The therapist's primary goal at this stage of the intervention is to discourage the couple from behaving in a hostile fashion toward one another. This is an attempt to create an aura in their relationship which will be erotic (it is thought that this will promote positive sexual feelings between the partners and ultimately increase the likelihood of functional sexual behavior). A second aim of the Reality Therapist is to have both individuals feel a sense of power and self-worth once their negotiation is completed and they have communicated their needs to their partner.

The second stage involved in the author's model for the Reality Therapy treatment of sexual dysfunction is to enhance both the physical and emotional intimacy experienced by the couple. This is achieved by facilitating self-disclosure (creating a climate within the relationship in which both individuals can share their thoughts, beliefs, attitudes, and feelings), teaching the couple how to establish and/or maintain commitment to their relationship (encouraging the couple to provide each other with the opportunity to meet their needs), teaching the couple to communicate (and fulfill) their sexual needs, and equipping each partner with appropriate and effective skills for conflict resolution (emphasizing the need for negotiation, compromise, and open, honest discussion of problems within the relationship). Evidently, the way in which these therapeutic goals are reached will depend on the nature (and extent) of the couple's sexual dysfunction, and upon the individualized action plan formulated by the couple.

The third treatment component requires the couple to engage in a mutually enjoyable, non-sexual activity. This is designed to enhance the couple's emotional relationship, and it must therefore include awareness of one another (that is, the couple should choose an activity which requires them to interact with one another). Despite the emphasis on interaction, there should be no discussion of emotionally charged topics (including but not limited to, the couple's sexual dysfunction) or any criticism of self or partner. Finally, this activity should be performed often, but for short periods of time (this prevents the couple from postponing or cancelling their scheduled activity due to work-related or other commitments).

The following case studies illustrate the way in which the above guidelines may be applied to the treatment of dysfunctional sexual behaviour. (Case illustrations are from Schover, 1986: 110.)

*Mrs V* had enjoyed sex and had been easily orgasmic during her late teens. She married early and found that her husband was addicted to heroin. She, subsequently, also started to use alcohol and street drugs. The husband was eventually jailed for selling drugs, and *Mrs V* drifted into casual sexual relationships with several abusive men. One night, on her way home from a party, she was raped. She later joined AA, which made it possible for her to stabilize her life.

On his release from jail, her husband also joined AA, and the couple once again resumed their marriage. *Mrs V*, however, now panicked at the thought of sex. She hated even the thought of being seen in the nude or engaging in sexual touching. She saw her past sexual desire as an impetus for "sick" and degrading behavior, and was determined not to experience such feelings again.

In the case of Mr and *Mrs V*, the Reality Therapist would de-emphasize the couple's past and focus on correcting Mrs V's sexual aversion by confronting her reason for avoiding sexual intimacy. This would be achieved by emphasizing that Mrs V's association between sexual desire and substance abuse is one which she has created, and that it is possible for her to develop a gratifying sexual relationship with her husband without revisiting negative behavior patterns. The therapist would also emphasize that for both Mr and Mrs V to fulfill their primary needs and to achieve a balanced lifestyle, their problem needs to be resolved: Mrs V's aversion to intercourse is depriving both her and her husband of fulfilling their need to belong (to give and receive love), and their need for power (to develop and maintain positive self-esteem).

*Mrs C* and her husband had married partly because of their gratifying sex life. They had one child. *Mr C* had suffered a cerebrovascular accident and subsequent aphasia some time ago, but had almost totally recovered and now worked as a plumber. Following a second stroke, he again became aphasic. He recovered his speech, but remained on disability because of a right-sided weakness. *Mrs C* worked part-time and did most of the housework. *Mr C* took care of their child, but spent a lot of time visiting with friends. The couple came for therapy because Mrs C was no longer interested in sex and had difficulty becoming aroused. By contrast, she was able to quickly get aroused and reach orgasm through self-stimulation.

It soon became clear that Mrs C resented her husband's lack of participation in family decisions and responsibilities. She saw him as passive and childlike. Her love for him had become more maternal and less sexual. The more he nagged her to have sex, or tried to make her feel guilty, the angrier she felt. Sex became for her just another way she "serviced" her husband.
An appropriate action plan for Mr and Mrs C might comprise the following: Mr C may be asked to consult with his wife and then specify the amount of time per week he will spend socializing with his friends and which household duties he will perform (such as making the mortgage payments, or preparing the family meal every second evening). Specifying household duties makes the plan process-centered rather than goal-centered (an example of a goal-centered plan would be for Mr C "to try to become more involved in family decision-making and responsibilities"). While not addressing the couple's sexual dysfunction directly, it is assumed that Mr C's increased contribution to household and family maintenance would make Mrs C feel less like she is her husband's servant.

A direct strategy for increasing Mrs. C's enjoyment of sex would be to have her specify her sexual wants (such as types of sexual activity she most enjoys), and then have the couple formulate a specific plan for fulfilling them. (Mr C would also be encouraged to communicate his expectations about the couple's sexual relationship.)

In summary, therapeutic intervention from a Reality Therapy framework aims to help the clients communicate their needs, and to establish a sense of involvement in the relationship and the treatment of the problem behavior. While intervention focuses primarily on the context in which the dysfunctional behavior is occurring, techniques designed to facilitate functional sexual behavior may also be employed.

CONCLUSIONS

The present paper has addressed the suitability of Reality Therapy for the treatment of sexual dysfunction. Reality Therapy emphasizes the therapist's personal involvement with the client, the clients' responsibility for their own behavior (and therefore their own happiness), and the need to formulate and enact positive plans for changing negative behavior patterns. When used to correct dysfunctional sexual behavior, the focus of therapeutic intervention lies in recognition of the fact that the couple's emotional relationship is damaged by the feelings of guilt, inadequacy, and frustration that accompany dysfunctional sexual behavior. As a result, the Reality Therapist attempts to facilitate sexual and nonsexual communication between partners.

References


"QUALITY LIVING WHEN THERE IS NO CURE:
Using Reality Therapy and Control Theory with
HIV + and AIDS Patients"

Matthew Ignoffo

The author is Associate Professor at the U.S. Military Academy Prep School in Ft. Monmouth, New Jersey.

ABSTRACT

To help HIV + and AIDS patients regain a sense of self-control in the face of what seems like an uncontrollable situation, sidestep the disease itself and deal with empowering the patient's self-image and improving the patient's attitude toward the disease and death. In the plan step of the Reality Therapy process, the client is helped to identify the "Inner Critic," the internal voice of morbid self-sabotage. Then the client can discover ways to release the more creative and need-fulfilling part of the identity, the internal voice of life called the Inner Genius. The introspection which results can help make attitudinal healing possible. The goal is to create quality living when there is no physical cure.

To help HIV + and AIDS clients, I use the basic premise of Reality Therapy and Control Theory: since the past is over and gone, we are free to do something now to bring relief for our problems; thus, instead of feeling like helpless stimulus-response victims, we can face reality and take responsibility at this very moment to create new outcomes for ourselves. The foundation rests on what I call the "Personal Commitment" which is written in the form of a contract that each of my clients are asked to read and, if they choose, sign:

1. I have the resources within me to deal with all of my problems.
2. All of my behavior has a positive goal, even though that goal may have become lost in my misdirected negative behavior.
3. Negative behavior comes from the fact that I have allowed only one aspect of my whole personality to rule my life; by rebalancing my total personality, I regain control of my behavior.
4. I can do something now to change my behavior regardless of what I have done in the past.
5. Since helplessness comes from the loss of choices, I can now retake control of my life by creating more and better choices.
6. I create more and better choices by changing my view of myself from that of a helpless victim to that of a resourceful, empowered person.
7. By retaking control of my life, I create quality and become a realistic, responsible, self-reliant person no matter what problems I face.

After discussing this contract with the client, I focus on two ideas from the Control Theory chart:

1. We experience people and events in our own unique way (the filtering system).
2. Our behavior is based on our choices of thinking and doing which, in turn, produce results in our emotions and bodies (the four wheels which make up total behavior in Glasser's car).

Once these principles have been established, I use the strategies discussed below as the planning part of the Reality Therapy process. I will illustrate the procedure using a case study based on a number of real clients. All identifying information has been altered.

CASE STUDY

"Almost everybody I know is dead," Joel said.

People in their 80s and 90s speak this way, describing their increasing isolation as they watch friends and family die. But Joel, a healthy looking musician recently diagnosed with AIDS, was in his mid 20s.

"I'm dying," he continued.

"So am I," I said. "Nobody is immortal."

"Nice try, Doc. But I know WHEN I'm going to die."

"AIDS is not a death warrant. People live with AIDS," I countered, trying to keep my first discussion with Joel constructive.

"I know you're trying to help, Doc," he said, consoling me as our roles seemed to reverse. "But let's not fool ourselves. I'm going to die - SOON! No positive thought will change that. And don't try to help me understand God's will. I wanted to be an accomplished pianist, but I know that won't happen now. That's God's will!"

His voice became sharp with sarcasm. He was bitter and angry, yet at the same time, frightened and desolate. He had recently rejected a visit from a hospice priest saying, "My parish priest rejected me because I'm gay and I have AIDS. God doesn't want me. Why should I want him?"

One of the few people who had rapport with Joel was the buddy assigned to him by the local hospice. It was the buddy who suggested that Joel see me. Joel's lack of eagerness to meet with me or anyone else meant that I would have to use Control Theory management in addition to Reality Therapy counseling in dealing with his case. I am describing his case because, as a resistant client, he clearly illustrates the way Reality Therapy can be used in difficult counseling situations.

For Joel, as for many people with AIDS, the psychological elements of the disease had never been addressed at all except in the most negative form - condemnation. His parish priest had echoed the common rebuke that AIDS was the "gay plague" sent by an angry God to destroy all homosexuals. Naturally this view did nothing but deepen Joel's sense of self-hatred. As far as he was concerned, the only thing left in life was the unnerving wait as death approached.

I felt intimidatd when I first started working with HIV + and AIDS clients because the disease seemed overwhelming both to me and to them. The survival need of these clients is obviously threatened as it is in any case of terminal disease. Moreover, AIDS threatens the need for power because
the clients commonly feel that they have lost all sense of self-control. The need for belonging is weakened because these clients feel a decreasing sense of being part of the living human race. Furthermore, the need for fun is virtually eliminated because there is little to look forward to except death. Finally the need for freedom is lost because the clients feel lonely, orphaned, and utterly abandoned.

In the face of what seems like an uncontrollable situation, I find that my most effective results come when I sidestep the issue of the disease itself and help each client overcome the feelings of being an abandoned victim of the disease: the point is to take the client’s focus off the two back wheels (negative emotions and bodily distress) and help him/her refocus on the directional front wheels (new thinking and new actions). Once the self-defeating viewpoint is replaced with new choices, the client can open up to the possibility of attitudinal healing even when physical cure is impossible.

1. **THE INNER CRITIC**

I began by telling Joel about the Inner Critic, that negative voice we all hear inside our heads especially when things in our lives aren’t going well. This self-sabotaging voice defines and perpetuates the perspective of being a victim which can produce a sense of total worthlessness in an AIDS patient. To prevent misunderstanding, I emphasize that the Inner Critic is not a split personality nor is it possession by an alien entity; the Critic is simply a personality pattern which is one facet of our total behavior.

When asked whether he was aware of his Inner Critic, Joel laughed bitterly and said, “Sure, I hear it all the time. It’s telling me right now that I’m a fool to think that you can help me. It keeps reminding me that I’m going to die.”

Most of us know that the Inner Critic exists. What we don’t know is what it really is and how to get control over it. I requested that Joel start keeping a journal. I wanted Joel to begin the journal by drawing a picture of the personified Inner Critic as if it were a real person in the physical world. Clients have viewed their Critics as vampires, gremlins, witches, old schoolmarms, and even the devil himself.

As with many clients, Joel was reluctant to do this initial exercise because he thought it seemed irrelevant. Consequently, he at first refused to begin the journal. I told him, “You don’t have to, but if you allow yourself to do the exercise, we might be able to do some interesting work together.” Leaving the choice totally up to him, we agreed that he would call me if he decided to start journaling. This step was the beginning of re-establishing Joel’s sense of control over himself. I made a point of assuring him that he was the sole manager of his own life and that he did not have to do anything which he thought did not fulfill his needs.

Two weeks later, Joel informed me through his hospice buddy that he had begun the journal. His Critic looked like the traditional figure of death, the Grim Reaper. At our next meeting, I asked Joel to continue his journal by getting into a dialogue with the Critic, asking three interview questions:

1. “What are you doing TO me?”
2. “What are you doing FOR me?”
3. “What is your name?”

The Critic agreed to answer only the first interview question. The response began with these words: “I’m here to let you know that you don’t deserve to live. God doesn’t care about you. God hates fags.”

After Joel had reread and reread this response several times in the privacy of his bedroom, he was overcome with sadness. He noted in his journal, “I exploded with tears and couldn’t stop. I beat my fists into the bed and screamed into the blankets. I recognized these words. When I was 16, I told my parents I was gay, and these are the words they used when they told me I either had to promise I was lying or else get out of the house. I told them I was lying, but I wasn’t. I tried to talk to my parish priest, but he just told me I was sinning if I was gay. I hated all of them. I hated myself. A year later, I finally left home. I never went back. I couldn’t talk to any of them anymore.”

The Critic, using the voices of Joel’s parents, was actually Thanatos, the ancient Greek personification of death. This is the voice which tells us that since we cannot fulfill our needs, there is little point to living. Under the influence of the Critic’s profound negativism, Joel entered a pervasive depression, a severe loneliness in which he felt so far removed from life that death seemed to be the only escape.

During one of his depressive periods, Joel called me on the phone, caustically stating that he thought the journaling was a waste of time and that he did not think there was any point in continuing to work with me. Offering no resistance and avoiding anything that Joel might perceive as pressure, I responded, “That’s OK. You don’t have to do the journaling, but can I come and see you from time to time?”

“Sure, Doc,” he said sardonically. “I got nothin’ but time.”

I waited nearly a week before visiting him again. He looked haggard and pale but managed a smile. “I see you haven’t given up, Doc.”

“One of my groundrules is ‘Never give up.’ Maybe we can start over again.”

I had to keep reminding myself that a quick, easy fix is impossible. The client is going to become discouraged and so am I, but discouragement is really an essential part of the process. Acknowledging this fact helps defuse pessimism.

2. **FOCUS ON THE PRESENT**

Joel’s Inner Critic was speaking to him from the past and was not allowing him to live in the present or to go on into the future. In fact, according to the Critic, he deserved no future other than death and eternal damnation. Joel went through several periods in which he felt so far removed from life that death seemed to be the only escape.

Data from a valued patient:
the present. Therefore, during one of our better meetings, I asked Joel, "Since you understand what the Critic is and what it is doing to you, what can you do now?" Together we worked on a plan of action he could take. He decided to reconcile himself, if possible, with his parents whom he had not seen in nearly ten years.

Almost grudgingly, he called home. He learned for the first time that his father had passed away several years before. His mother was as uneasy about talking to Joel as he was with her; however, they did manage to begin regular visits which eventually led to their acceptance of each other despite the fact that neither approved of the others' view in the matter of Joel's homosexuality. Fortunately, when he finally revealed that he had AIDS, his mother was grateful to have him back in her life; she told him that she regretted missing so many years with him.

Concerning his father's death, Joel said, "The old boy doesn't have to deal with me, but I still have to deal with him." After alternately reviling his father and wishing that he could talk to him, Joel decided to reconcile his depression and anger through a series of "letters to the dead," as he called them, which he addressed to his father. It was during these journaling exercises that the Grim Reaper finally revealed its true identity: his father, Sal.

3. THE INNER GENIUS

The Inner Genius is the need-fulfiller, the power of creative life within us all; it is the energy behind what Dr. Glasser calls "Positive Addictions." I think of the Genius as the transformed Inner Critic. Despite all of its negative mental chatter, the Inner Critic actually serves a positive purpose: usually to shield us from dealing with unpleasant aspects of life, to help us escape responsibility, failure, or pain. When this purpose is identified and acknowledged, the Critic's "boogie man" act is no longer necessary. Instead of being the enemy, the Critic becomes a strong ally, the life-affirming, need-fulfilling Inner Genius.

At this point in counseling, Joel performed what he called a "mock baptism," changing the Critic's name from the Grim Reaper to Sal. As Joel continued writing about and dialoguing with Sal, I asked him to notice any changes in the Critic. Joel, told me, "Now that I know his real name, he's less scary. He isn't so angry either. I see him as just a tired old man. He's my father."

We had discovered that the Critic's name was Sal, and we knew what its negative purpose was: to tell Joel that he was worthless and that God hated him. I asked Joel to try the one unanswered interview question again: "What are you doing FOR me?"

Through more discussions and journaling, Joel realized that both the horrifying Grim Reaper and tired old Sal had both disappeared; in their place was what Joel called, "a beautiful young man, like an angel." Joel said he sensed that this angel was actually the image of his own soul. The angel's name was Jo-Jo, a nickname his parents had given him when he was a boy, long before the family's disintegration. Carrying a golden timepiece, Jo-Jo finally revealed his need-fulfilling purpose, what he was doing FOR Joel: "I'm here to remind you to make the most of the life you have. Be fully alive before it is time to die."

4. MYTHIC DRAMA

In his journal, Joel had drawn pictures of the Grim Reaper ("scary death waiting to take me"), Sal ("the tired old man who's hidden under the Reaper's long, black cloak"), and Jo-Jo ("the glowing angelic boy inside my soul"). I asked Joel to create an archetypal myth or allegorical drama with these three figures as the principal characters. The point of writing such a story is to allow the various parts of the personality to act out their roles, a very helpful step toward personal reintegration. In the analogy of Glasser's car, this step helps align the four wheels so that they all aim in the same direction.

At first, Joel wrote a story which was a variation on the THE WIZARD OF OZ. The frightening Grim Reaper, like the Wizard, was simply a Halloween mask behind which his father was hiding. Jo-Jo was the Good Witch who knew the secret of how to get home. But Joel felt that this story was too superficial. In one of his fits of angry depression, he tore the pages out of his journal and told me, once again, that he wanted to forget the whole process. But a few days later, he began to write again.

Joel's second drama was set in a swamp called AIDS which smelled of mildew and decay; it was a terrible place where there was only perpetual darkness. He saw himself as a vulnerable little boy lost in this swamp. The Grim Reaper was always trying to drag him down into the muck which, Joel said, represented the death of his body and his soul. Sal was weakly trying to pull the little boy back from death, but he couldn't. Sal could do nothing but whisper, "I'm sorry I can't help you." Finally Jo-Jo came into the scene, tore the bony fingers of the Reaper away from the boy, and then slashed the whole swamp open as if it were nothing but a canvas stage backdrop. The story ended with warm healing light pouring onto the boy.

After finishing the story, Joel hesitantly told me that at last he felt something positive was happening. He then explained why he had been so hostile toward people's attempts to help him, even refusing to take medications for his depression. "I don't like to accept help anymore," he said. "It hurts too much when you believe in somebody or something and then find that there's nothing there."

He continued his thoughts on this topic in his journal:

"I believed that love was the same thing as being hurt. My family loved little Jo-Jo, but they hurt teenage Joel — treated Joel like dirt. When I ran away, I fell in love with a man who said he'd care for me. He abused me and treated me like dirt too — I let him do it because that's how I saw myself. And then he gave me AIDS and died. My lover couldn't accept me just as I was, and my father didn't accept who I was either. I ran away from my father, and he never even tried to find me. God was the same way. He didn't accept me, and when I ran from him, 1
thought that he let me go. But for the first time in my life, I believe that love is not the same thing as hurt or abuse. Now I can believe that I am not dirt. I ran away from God, but he came looking for me.”

At no time during our work did I attempt to change Joe’s feelings of resistance or reluctance. No matter how frustrated or impatient I felt with the lengthy process we were going through, I reminded myself that Joe’s frustration and impatience were much greater. He had been at war with himself and God for a long time. AIDS and homosexuality were the battleground. It wasn’t easy for him to rebalance the scales of his life. I always accepted whatever emotion he was feeling as perfectly normal. In this way, I never made myself or our work a target for his anger or fear.

5. SYNTHESIS AND SELF-TALK

Now that he had admitted that some progress was being made, I wanted to move along more swiftly because his health was rapidly failing. His hair was falling out, and his face was gaunt. Yet he still displayed his characteristic feistiness which I believe was his survival need exerting itself.

It was time to clarify the major difference between the Inner Critic’s voice of death and the Inner Genius’s voice of life. The Critic’s negative, life-robbing self-talk is very powerful and must be countered by life-affirming, need-fulfilling self-talk. There are four qualities which transform the Critic’s negative mental chatter into the Genius’s positive beliefs:

1. POSITIVE: the new self-talk must focus on what the person wants, not what s/he does not want. The Critic always directs us toward what we fear, ultimately toward death; the Genius moves us toward what will create more abundant life.

2. PRESENT: the new self-talk must focus on the present, not on the past or the future. The Critic naggs about the failures of the past and the dangers of the future; the Genius discovers the power of the present, disconnected from the past and moving toward a more life-fulfilling future.

3. PERSONAL: the new self-talk must focus on the individual person, not on other people or life in general. The Critic makes up self-sabotaging commandments about how difficult life is and how forsaken all human beings are; the Genius speaks directly to the person’s own soul about moment-to-moment enlightenment.

4. POWERFUL: the new self-talk must focus on the exuberant, creative energy that keeps us growing. The Critic’s negativism is stated in extremely powerful beliefs; the Genius’s counter-beliefs must be stated with equal power.

6. MAKING THE DIFFERENCE

Having explained the difference between the Critic and Genius, I asked Joel to journal on the key Reality Therapy question: “What can I do differently now?”

In his journal, he drew a picture of himself playing the piano with God seated next to him on the bench. God’s hand was resting on Joel’s shoulder as the opening notes of Beethoven’s “Ode to Joy” spiraled in the air around them. Under the picture, Joel wrote what he called his mantra which incorporated the four qualities of the Inner Genius’s positive self-talk: “I am safe and secure with God in my heart.”

He explained that formerly he had focused on how sorry he had felt for himself and how much he hated his parents, life, and God. Such a viewpoint only served to keep him alienated. He committed to doing something different: every time he noticed self-destructive thinking and behavior, he would stop himself, picture God’s hand on his shoulder, and recite the mantra. Thus Joel’s new thinking and doing (the front wheels) would aim his emotions and body (the back wheels) in a new direction.

A person like Joel feels traumatized by terminal disease. He experiences a sense of being cut off from life. The strategies which I have described help release the deeper artistic, childlike parts of the personality so that the four psychological needs can once again be attended to. Alienated from one’s needs, estranged from one’s self, and cut off from life in general, the person imprisons him/herself like a child in a dark dungeon. Therapeutic use of introspection allows this disowned internal child — the Inner Genius — to re-express itself. The new total behavior which the client can create brings about the healthy perspective of seeing one’s self as a living, worthwhile being.

Joel had felt so terrified by AIDS that, as he later told me, he was seriously thinking of suicide when he first came to me. After the depths of his emotions were examined, the powerful fear created by the disease was dissipated. To use an analogy, if a bottle of soda is shaken, air pressure builds up, gaining strength simply because of the inability of the air to escape. With sufficient pressure, the bottle can break. However, if the air is allowed to escape, its destructive power is eliminated. Similarly, using the methods described in this article, the counselee can short-circuit the past pain so that s/he is able to experience the present and go on into the future.

When the Inner Critic transforms into the Inner Genius during the plan step of Reality Therapy counseling, I believe that the client does three things: shift the focus of attention away from the disease; become aware of introspective thoughts and feelings that are usually overlooked, disowned, or denied; and ultimately, open up to the ancient challenge, “Know Thyself.” The enlightened introspection which results is a way of perceptual or attitudinal healing. The client regains control of all four wheels of his car.

One of Joel’s last journal entries before his death reads as follows: “My gayness tore my family apart. My AIDS brought us back together. If I wasn’t gay, I probably wouldn’t have AIDS. But if I wasn’t gay and I didn’t get AIDS, we would have lived out some empty suburban life, never knowing who we were or what we meant to each other. Now I am closer to my mother and I can feel that my father is always near me ready to welcome me when the time comes. I used to fear and hate AIDS — and God for
giving me AIDS. Now I know that AIDS is part of living. I think AIDS is just another one of God's disguises. God has been here with me all along. I just didn't know it until I could accept AIDS, and by accepting AIDS, I accepted the one who has AIDS—me. This is the first time in my life that I ever really accepted me. This is how God broke through the darkness—by using AIDS.’’

CONCLUSION

To clarify the process illustrated in this case study, I should point out that having my clients deal with the spiritual aspect of their disease is not my intention; my efforts are directed mainly toward helping terminal clients create more quality in the time they have left. However, Joe did put God into the process, and I simply followed the client’s lead; despite his original, intense anger with God, Joel’s belonging need was fulfilled in spiritual reconciliation. I have found that clients who choose to discover internal spiritual strength tend to make more profound progress than those who do not.

Not all AIDS patients experience the depth of insight that Joel did. However, if they progress past the denial, anger, and depression stages of the dying process, they are usually grateful to open themselves to help which carries them beyond the seemingly cruel impossibility of a physical cure. Underneath their bitterness and fear, they still cling to the physiological need to survive. They desire to know that life is really not meaningless and that there is some purpose to their suffering.

The Inner Critic and Inner Genius are metaphorical means of accessing what is in the client’s quality world. Traumatized clients commonly do not have many words to express their pain or their quality world simply because much of this information was originally created at an early pre-verbal point in life. Using the metaphors illustrated in this case study, the clients have non-intellectualized, non-verbal ways of accessing information that is crucial to the therapeutic process of need-fulfillment. Ultimately, my methods are aimed at helping my clients connect personal needs with personal resources. By making this connection, the clients discover the internal power to control their lives and thereby to create quality no matter what problems lie in their way.

AIDS clients, just like any other clients, need to feel that they have regained control over their lives. In addition, they need to feel that they still belong to the world of the living. Furthermore, they need to look forward to being able to manage the rest of their lives as well as to face their deaths with a sense of both responsibility and serenity. They also need to be free from the fear that comes from seeing themselves as lonely, abandoned orphans. Ultimately they need to understand that AIDS and death are not the uncontrollable terrors which they seem to be.

Working with patients traumatized by AIDS or any other terminal disease, Reality Therapists will confront the Inner Critic and the Inner Genius, the voices of both death and life. It is important for the counselor as well as the client to be aware of the “still small voice” which is behind all the other conflicting sounds. Sanctimonious judgments aside, even AIDS can be seen as an opportunity for empowerment.

RECOMMENDED READING

A COMPARATIVE ANALYSIS OF REALITY THERAPY AND SOLUTION-FOCUSED BRIEF THERAPY

Bill C. Greenwalt

The author is in private practice as a counselor in Radcliff, Kentucky.

ABSTRACT

The similarities of the techniques used in reality therapy and solution-focused therapy are discussed by using the process of reality therapy as a guide. Minor differences appear to occur where solution-focused therapy has not been fully developed. An integration of the two therapies potentially could result in a way for reality therapy and control theory to incorporate a family systems approach in working with couples and families.

Reality therapy, developed by William Glasser (1965), and solution-focused brief therapy, developed by Michelle Weiner-Davis (1992), have similar developmental histories. Glasser became disillusioned with the lack of progress of his patients during his internship as a psychoanalytic psychiatrist. Patients seemed to remain caught in dysfunctional behavior even after years of treatment. Forsaking the traditional psychoanalytic approach, he began developing techniques that resulted in dramatic changes from patients in relatively brief periods of time. Reality therapy was unique in that it was more a way of doing therapy than a complete theory in the beginning. The theory came much later when Glasser developed control theory as a means of explaining behavior and personality (Glasser, 1981, 1984a).

Weiner-Davis (1992) also became disillusioned with psychoanalytic influences prevalent in much of family therapy. Couples spent too much time talking about problems and their causes. Her clients did not appear to improve after gaining insight into the past. As she searched for a more effective way of assisting couples and families to overcome problems, she was greatly influenced by Milton Erickson’s focus on solutions and successes of individuals. From this, she began developing a method of doing therapy called “solution-focused brief therapy” (O’Hanlon and Weiner-Davis, 1989; Weiner-Davis, 1992). The therapy is more a way of doing therapy using a family systems base than an independent theory. Consequently, it is similar to the beginning stage of reality therapy with its emphasis on how to do therapy.

The two therapies have much more in common than their similar beginnings in technique rather than history. This paper discusses the similarities of the two approaches to therapy and concludes with a brief discussion of the potential integration of the two methods. The process of reality therapy provides the framework for making the comparisons.

POSITIVE ORIENTATION

Corey (1991) says reality therapy is “both anti-deterministic and positive” (p. 448). This statement is true about both therapies. Glasser emphasizes the importance of building on the successes of the clients and of instilling hope of getting what is wanted (Glasser, 1984b). Walter and Peller (1992) list the positive focus on the first assumption of solution-focused therapy: “Focusing on the positive, on the solution, and on the future facilitates change in the desired direction” (p. 10).

Reality therapy “discounts the therapeutic value of exploration of the client’s past, dreams, the unconscious, early childhood experiences and transference” (Corey, 1991, p. 457). The therapist is interested in the past only as it relates to the present (Glasser, 1965). “The therapist looks for effective present behaviors and also asks about times in the past when clients functioned effectively” (Glasser, 1984, p. 342). Clients learn more from their successes than they do from their failures. Behaviors resulting in failure often cause the problem to seem larger than what it really is, because the client is unable to get what is wanted. As people continue to try unsuccessfully to control the world around them in an attempt to get what is wanted, a failure identity may develop. However, everyone has used effective behaviors in the past that can be utilized successfully again (Glasser, 1965, 1984b).

Similarly, O’Hanlon and Weiner-Davis say that the solution-focused therapist does not have to know a lot about the problem to work on the solution. “Rather than detailed information about the complaint, what appears to be significant for solution-oriented therapists is what clients are already doing that is working” (p. 39). Clients can learn much from the exceptions to the problems. Sometimes the client improves dramatically by just realizing that exceptions do exist and often to a greater degree than the stated problem. For example, few people are depressed all of the time. The client may focus only on the depressing times and forget about what occurs during the rest of the day when depressing behaviors are not a problem. Therefore, part of the problem is a matter of perspective. The positive focus allows the client the opportunity to see the bigger picture, and the problem is no longer as large as it appeared.

Both reality therapy and solution-focused therapy have a positive orientation. Problems are discussed briefly to understand what the client is wanting. However, the focus is soon shifted to look for more positive behaviors to help the client develop a positive solution.

CLIENT-THERAPIST RELATIONSHIP

The foundation of reality therapy is to make friends or to become involved with the client (Glasser, 1965, 1984b). While the relationship is not healing by itself, it is an essential part of therapy. Clients often come to therapy lonely and depressed, because their lives are not going the way they would like. They want to form a relationship with another individual to satisfy the need for love and belonging. The therapist establishes that relationship through a genuine caring and accepting attitude. The therapist accepts clients as they are without demanding or forcing any changes. In this way clients can evaluate their own behaviors to decide for themselves what type of changes if any they want to make.

The reality therapist spends as much time as necessary to become...
involved with the client. This may be accomplished by talking about clients' interests, hobbies, recreational activities, or anything else they wish to discuss. The therapist identifies and expresses mutual interests or activities where possible. For example, if a client expresses an interest in going to the movies, the therapist may ask the client to recommend a good movie. Or the therapist may discuss movies that they both have seen. This establishes a rapport that enables the confrontation necessary during therapy.

The importance of the relationship between the therapist and client is less clear in solution-focused therapy. Walter and Peller (1992) assume a relationship exists from the very beginning. “We do not assume that we have to do something or something different to create rapport or establish a relationship” (p. 42). However, they discuss ways to enhance the relationship. The therapist matches and paces the client by using the same terminology, energy, and tone to maintain rapport with the client.

O’Hanlon and Weiner-Davis (1989) place more emphasis upon establishing a relationship. They state: “When we meet clients we usually spend the first few minutes chatting about anything but what might be considered the reason they are sitting in our office” (p. 81). This is done to join the client and “to show nonjudgmental interest in them” (p. 82). While they do not elaborate on the necessity of the joining process, they do acknowledge some importance.

Reality therapy places greater importance on the client-therapist relationship. While O’Hanlon and Weiner-Davis place some emphasis on joining the client, they do not give a rationale for doing so. Reality therapy sees involvement with the client as essential for the therapeutic process.

WHAT DO YOU WANT

The next phase in reality therapy is to ask clients what they want. This tells the therapist what brought them into therapy. Here it is important to listen attentively to the client. At this point clients often express wants that are beyond their control. For example, these wants may involve other people. “I want John to come back home and not divorce me.” While this is a sincere want, it is not within the ability of the client or the therapist to get John to do anything. We can only affect our own behaviors and not the behaviors of other people. We can behave in a way that facilitates the other person’s changing, but that change is not guaranteed (Glasser, 1965, 1984b).

The therapist continues by asking, “In wanting that, what do you really want?” Here the client is asked to examine what it is that John gives to the individual. The client may respond, “I really want to be loved and feel secure.” This is something that the client has control over and can accomplish. When the therapist finds out what is really wanted, goals are established for therapy. This gives the client and therapist a clear understanding of what is being accomplished in therapy (Glasser, 1965, 1984b).

Walter and Peller (1992) say that the solution-focused therapist often asks clients what their goal is for coming into therapy (p. 64). They also say the response is often a complaint or wish instead of a clearly stated goal usable for therapy. This is very similar to what happens in reality therapy. The therapist continues until the “clients change their expressions of unhappiness into statements of goals” (p. 66).

O’Hanlon and Weiner-Davis (1988) say, “... clients, not therapists, identify the goals to be accomplished in treatment” (p. 44). Clients know best what they want to have happen. This recognizes the unique individuality of all cases and allows a direct focus of therapy. Clients begin to take responsibility for their lives from the very beginning, instead of allowing others to tell them what they need to do.

While one may argue theoretical differences at this point, whether the therapist calls it a “want” or a “goal” really does not make much pragmatic difference in the management of the case. Either way the client is telling the therapist the direction for therapy and establishes criteria for determining when therapy is successful. Both therapies teach clients to take responsibility for their own lives.

WHAT ARE YOU DOING?

The importance of this question for reality therapy is seen in the fact that Naomi Glasser (1980) used it as her title for a book of case studies. Wubbolding (1988) discusses each word separately as he explains the question in his book. The question gets clients thinking about what they are choosing to do to get what they want. Both the positive and negative are solicited. Clients are usually doing some things that at least have some measure of success and some things that are possibly counterproductive. Clients often do not realize choices are being made that affect the problem. For example, the depressed client does not realize the connection between choosing to stay at home and remaining depressed. By choosing depressing activities, the client chooses to depress.

The connection is exemplified further by discussing the times when the client feels less depressed. The therapist emphasizes the difference in the chosen behaviors to get the individual to choose activities that lead to greater happiness. The client learns to accept personal responsibility for what is done and what is thought resulting in undesirable feelings (Glasser, 1965, 1984a).

The solution-focused therapist begins to look for exceptions to the problem. A person is never totally sad or depressed. Times exist when things go better. The therapist helps the client to discover these times and discusses them in great detail with the client. These exceptions “offer a tremendous amount of information about what is needed to solve the problem” (O’Hanlon and Weiner-Davis, 1989, p. 82). The client may need to do more of the exception without doing anything else. At the very least, the client will have an idea of the type of changes necessary to improve the situation.

The primary focus of the discussion is on positive things in solution-focused therapy, while reality therapy wants the client to recognize the personal choice made and will discuss both positive and negative behaviors. Both therapies emphasize and build on the successes, but reality therapy wants the individual to recognize that it is a personal choice that makes a difference. Solution-focused therapists probably would not have much difficulty with this concept.
The reality therapist next gets the client to evaluate the behaviors, “It is the clients who decide if what they are doing is getting them what they want” (Corey, 1991, p. 375). Since the goal of therapy is to help the clients get what they want, it is only natural that they decide if what they are doing is working or not. Usually their behaviors are not getting them what they want, or they would not come to therapy. However, at times clients simply need to do more of what they have done. They have either stopped too soon or have not done what works long enough. In making a judgment on the behavior, clients also learn that the behavior is under their control (Glasser, 1965, 1984b).

When therapists ask clients if their behaviors helped them get what they want, they often reply, “Of course not.” They will then look at the therapist like they are questioning his/her sanity. They would not have come to therapy if their behaviors got them what they wanted. However, the question really gets them to recognize the fact that they do have choices. They chose to do what they did. As they realize they made the choice to do what they did, they also recognize they can make changes (Wubbolding, 1988).

The solution-focused therapists do not stop when they find exceptions to the problem. Questions are asked about the difference between when the problem is occurring and when the problem is not happening. What do the clients do differently, and how are they able to do things differently at those particular times? In other words, the clients evaluate their behavior at the time the exceptions occur. The focus is always on the exceptions to maintain the positive focus (O’Hanlon and Weiner-Davis, 1989).

Both therapies emphasize the importance of clients’ evaluating their own behavior to get them to see that they have control over what they do. The therapists use different questioning techniques, but seem to accomplish the same thing.

### MAKE A PLAN

Both therapies stress the importance of the development of a plan for changing behavior. Weiner-Davis (1992) made this comment about solution-focused therapy: “People know what to do differently when they leave the session; they go home with a plan” (p. 17). After the client evaluates present behavior in reality therapy and decides it is not accomplishing the desired effect, the therapist assists the client in developing a plan that may get what is wanted. The client is responsible for developing the plan, while the therapist’s task is to assist (Glasser, 1965, 1984b). Walter and Peller (1992) say: “The client is the expert” (p. 28). Clients know how to solve their problems better than the therapist.

Wubbolding (1988) dedicates a whole chapter explaining what makes a good plan. The first characteristic of a good plan is that it is need-fulfilling. The four basic psychological needs are: 1) love and belonging; 2) power and the sense of self-worth; 3) fun; and 4) freedom. Everyone must fulfill these basic needs some before they can feel self-fulfilled (Glasser, 1965, 1984b).

The plan fulfills basic needs related to what is wanted. For example, clients who want to overcome depressing behaviors may develop a plan that relates to one of the basic needs. They may make a plan to do some activity with a close friend satisfying the need for love and belonging, or they may decide to do something for fun (Wubbolding, 1988).

A good plan is simple, realistic, and attainable. The more elaborate the plan, the more likely that the plan will fail. Since one of the primary aims of therapy is to build success into the life of the client, the plan should remain as simple as possible to gain immediate success. Weiner-Davis (1992) says: “frequently the best solutions are the simplest and the ones most easily overlooked” (p. 19). A few very small changes can result in dramatic improvement in the life of the client (Glasser, 1965, 1984b; Wubbolding, 1988). One assumption of solution-focused therapy is “small changing leads to larger changing” (Walter and Peller, 1992, p. 18). They explain: “... a client who has experienced some success at achieving something manageable is, therefore, in a more resourceful state to find solutions to other, more difficult problems” (p. 19).

The client must be able to remember the details of the plan and do the plan within a short period of time. A plan to find a job within the next week may not be realistic or attainable. However, a plan can be made to fill out and submit to an employer three job applications each day for the next four days. Getting the job is beyond the control of the client and should not be a part of the plan (Glasser, 1965, 1984b; Wubbolding, 1988).

Everything within the plan involves behaviors of the clients, since people control only their own behaviors. A plan dependent on the action of others often results in alibis and excuses. Situations often appear hopeless because clients are waiting for the other person to change first or do not see how their behavior is affecting what is happening (Glasser, 1981, 1984b; Wubbolding, 1988). Using family systems theory, Weiner-Davis (1992) says: “Relationships are such that if one person makes significant changes, the relationship must change” (P. 20). While the plan may affect other people, the primary focus of the plan is the action of the client.

The plan is something done and not something stopped. The focus in both reality therapy and solution-focused therapy is on doing something to create positive change. Since behavior is described in the positive, it is described as action that requires a doing component to the behavior (Wubbolding, 1988). O’Hanlon and Weiner-Davis (1989) say: “The goals should ideally be observable things-things people do or say” (p. 102).

A good plan is specific and done in the immediate future. A vague plan tends not to get done. The therapist finds out as many details as possible about how the plan will be fulfilled by asking questions like: “When will you begin the plan?” “How will you begin?” “What will you do first?” Other questions are asked to get as many specifics as possible. Sometimes people just need to get organized, and this gives them that opportunity. Plans started immediately are always more effective. A plan to do something starting next week allows the client time to do much negative thinking about what could go wrong. Then the plan is not done because of the extreme pessimism (Wubbolding, 1988). Walter and Peller (1992) say:
"We want to define the goal in a process way as something they can be on track with, immediately" (p. 55). The emphasis is to get the client to work on issues in the here and now. The plan is made in process form so the client can clearly see the action necessary to produce the change (Walter and Peller, 1992; Wubbolding, 1988).

This discussion emphasized the similarities between reality therapy and solution-focused therapy in the establishment of a plan for clients. Both therapies use some of the very same questioning techniques and strive to accomplish the same thing for the same purposes. However, the two therapies are not identical. The primary difference is how the plan is developed and presented to the client. Reality therapy stresses this as a definite action of the client. The client is responsible for formulating the plan as the therapist guides the client through skillful questioning. On the other hand, solution-focused therapists gather information and then take a break within the session to formulate a task for the client. Admittedly much of the task is established by what the client tells the therapist, but the plan is established by the therapist independently or with the corroboration of observers of the counseling session. A clear distinction to the fine points of the technique is obvious at this point. While reality therapy continues to emphasize the importance of the client’s maintaining responsibility and control over behavior, the solution-focused therapist assumes a position of power over the client by dictating a plan. Although the process leading up to this point may be very similar, this is a very important difference. While the reason for solution-focused therapists maintaining a position of power over the client can be traced to its roots in the hypnotic techniques of Erickson, it appears inconsistent with the desire to get clients to accept responsibility for their own lives.

GET A COMMITMENT

Reality therapists try to get a commitment to complete the plan. The firmer the commitment, the stronger the likelihood of the plan being done. The involvement with the client is important at this point. The more involved the therapist is with the client, the more the client will want to follow through on any commitment. This is one reason reality therapy places so much emphasis on the involvement step (Glasser, 1965, 1984b; Wubbolding, 1988).

A commitment to the plan is not as necessary for solution-focused therapy. Walter and Peller (1992) say: ‘‘We do not necessarily expect the client to do the task and we never ask directly if the task was done’’ (p. 137). At one time, clients were asked about the task when they returned. However, this was stopped because clients were defensive when they had not done the task. This may be a direct result of the lack of involvement between the therapist and the client and the assertion of power by the therapist over the client in the development of the plan.

NO EXCUSES

Reality therapists do not listen to excuses. The reason clients did not follow through on a particular plan is not as important as finding out when they can do the plan. This enables the client to focus on behaviors that will produce change. Clients are often accustomed to giving excuses for not doing things that result in positive behaviors. By taking the focus off the excuse, the client can put more energy into choosing effective behaviors (Glasser, 1965, 1984b).

Reality therapy does not explore the past because it is often used as an excuse for choosing ineffective behaviors today. For example, a client may say: ‘‘I cannot help being an alcoholic, because my father and mother were both alcoholics.’’ The client tries to remove personal responsibility in order to continue to choose to drink. The reality therapist recognizes the difficulty of the past, but emphasizes the present choice. Anyone can choose to do different behaviors. ‘‘When we look back into the past, we look for successes, for effectiveness, for behaviors that worked’’ (Glasser, 1984b, p. 337). People have enough difficulty coping with the present without worrying about the past.

The solution-focused therapist also focuses on the present without going into much detail about the past. Enough information is gathered from the clients to understand the problem and to work on solutions. However, the client is not asked about past difficulties in an attempt to understand the etiology of the presenting problem better. This is done in order to maintain a positive focus in therapy. The fact that therapists stopped asking about the assigned tasks indicates that they did not want to dwell on excuses. The theory is not developed to the point of understanding why excuses are unacceptable (O’Hanlon and Weiner-Davis, 1989; Walter and Peller, 1992).

NO PUNISHMENT

Neither reality therapy nor solution-focused therapy inflict punishment on clients who fail to do a plan or task. The therapist is at the services of the client. Since clients set the goals for therapy, they choose to make the changes that they want to make. If they choose to remain the same, that is also their choice. Reality therapists will point out that not changing is a legitimate choice. No one forces any client to make a particular change (Glasser, 1965, 1984b; O’Hanlon and Weiner Davis, 1989).

NEVER GIVE UP

People need to know that the therapist will not give up on them even if they do not improve as rapidly as the therapist wants them to improve. Sometimes it takes a long time to learn more effective behaviors and to choose to use those behaviors. The reality therapist will allow the client to take as long as necessary to become more successful (Glasser, 1965, 1984b). Solution-focused therapy claims improvement comes dramatically fast. It is a brief therapy and does not discuss the possibility of being a long term therapy. Termination is done after the goal for therapy is met. That is one of the reasons setting specific goals is important. ‘‘Therapy concludes when clients are confident they are on a solution track. This does not mean that the problem is totally resolved or that there is nothing more to do’’ (Walter and Peller, p. 255). Once clients believe they can control the situation, therapy is no longer needed. While this implies that the solution-focused therapist will not give up on the client, it is not explicitly stated anywhere.
INTEGRATION

Reality therapy and solution-focused therapy have many other similarities. Since most of the assumptions of the solution-focused approach can be found in the works of Glasser, this causes one to wonder if the two therapies could be integrated to establish a dynamic theory that combines a family systems approach with control theory.

Reality therapy developed first as technique, with Glasser adding theory later in the form of control theory (Glasser, 1981). The theory explains why the approach works as it does. Franklin (1993) lists eighty-two doctoral dissertations written on reality therapy and control theory from 1970 to 1990. These studies offer further support to the theory used to explain the techniques. Since solution-focused therapy uses so many of the basic assumptions of reality therapy, it seems logical that the theory would also fit. The techniques used are often so similar that a therapist could be using either therapy. Both the reality therapist and the solution-focused therapist work on some of the same goals: 1) build on the strengths of the client; 2) emphasize personal responsibility; and 3) emphasize personal choice. All of this indicates extremely similar therapies.

Solution-focused therapy does have a significant difference that could strengthen reality therapy. Solution-focused therapy is very systems oriented. The fact that it originated in the field of marriage and family therapy attests to that. This can be very beneficial to reality therapy since it originated with individual therapy. Glasser (1984a) believes that reality therapy can be used in marriage and family therapy, but he has left the expansion of the theory to those who know family systems. Very little has been written discussing the application of control theory to a family system approach. Solution-focused therapy may offer an opportunity to bridge that gap. By using control theory to understand why the various techniques work as they do, the solution-focused therapist can assist the reality therapists in knowing how to work with couples and families more effectively.

Both therapies have much they can contribute to the other. Reality therapy offers control theory and solution-focused therapy provides an understanding of family systems, enabling reality therapy to move beyond an individual approach. The integration of the two therapies results in a stronger and potentially more effective therapeutic approach in working with families.

SUMMARY

This paper examined some of the similarities between reality therapy and solution-focused therapy. The process of reality therapy was used to guide the discussion to demonstrate the many similarities of the two approaches. The differences noted were small and probably more the result of the lack of development of the solution-focused therapy than a significant difference. The most significant difference was the type of client/therapist relationship necessary to do therapy and the manner in which a plan is developed. Even this difference may not be as large as it appears since O’Hanlon and Weiner-Davis (1989) indicate the need to establish some type of relationship. The process of reality therapy and the assumptions of solution-focused therapy indicate similar goals for therapy.

An integration of the two therapies enhances both therapies. Reality therapy contributes a developed theory for explaining why the techniques used work as they do. Solution-focused therapy gives a family systems approach, enabling reality therapy to be used more effectively in marriage and family therapy.

Reference

BRIDGES TO GLASSER
An application of Reality Therapy/Control Theory to the process by which we manage change

William Scanlan
Albert J. Stumph

The first author is Director of the Bureau of Management and Program Evaluation of the Division of Quality Assurance of the New York State Office of Mental Retardation and Developmental Disabilities.

The second author is a training director with The Center For Development Of Human Services, Buffalo State College. He specializes in the field of foster care and adoption.

ABSTRACT
This article describes the application of Reality Therapy/Control Theory concepts to the way we manage changes in our lives. It uses the construct developed by William Bridges in which he delineates 3 passages with which we manage change. Applying RT/CT to this construct allows those in the helping professions to comprehend the best use by clients of opportunities presented by change.

Change is situational: the new site, the new boss, the new team, the new policy. Transition is the psychological process people go through to come to terms with the new situation. Change is external; transition is internal.

William Bridges, Managing Transitions (1991)

Change is one of the constants of life, as sure as death and taxes. It is happening all around us and to us all the time. Indeed it is in the environment in which we live. It is the passage of time, the movements we make, the rhythm of our growth and decline.

We experience change constantly. We don’t really control it, even when we choose it. We may choose to retire or perhaps buy a new car or we may choose not to do these things. However, our aging process will continue and our old car will wear out with time. It is worth recognizing that even though we don’t control change, we can choose effective behaviors to manage our transitions, the psychological responses to our experience of change. Why not use change and the transition process to meet our basic need for fun?

Changes, whether we initiate them or they occur, may cause us to grieve because change involves loss. The work of Kübler-Ross (1970) on grief and dying has become the standard construct for describing the grief process, the stages through which we must pass to complete the process of losing and gaining. Popular application of the model has extended it beyond its original purpose, to delineate the psychological process of dying, to explain the process we engage in when dealing with any loss or change.

The Kübler-Ross model has been found to be very effective as a construct for understanding the grief process. However, to rely solely on this model to describe how we move through transition in change would create a situation in which life itself becomes a grief process. Although some would say this is indeed true, a preferable construct is one which offers a positive and optimistic view of life. The Kübler-Ross construct applies well when describing how we deal with loss, but falters when we want to describe the process of embracing gains.

William Glasser (Take Effective Control of Your Life, 1984) proposes that our behaviors are our chosen attempts to get what we want to meet our needs. All behaviors at any time should be seen as our best effort to get what we want, whether or not they are effective. When we recognize that we have chosen ineffective behaviors to get what we want, we move quickly to find more effective behaviors to correct the mistake. However, that haste can short-circuit the grief process. We choose to move quickly in spite of the fact that we know the grief process repeats itself. A grief process which is short-circuited seems to recycle more often and more intensely. This can make our transition, the psychological process of managing change, more difficult because grief is a sign that we have to let go and prepare to move on.

A design is needed to understand transition which will describe the transition process in positive terms. This design will allow experimentation with behaviors and acknowledge that these behaviors are our best efforts to get what we want. Such a construct would embrace the connections between gains and losses — the movement of need-satisfying pictures forward and to the rear, respectively, of our quality world. It would help us to feel good, even excited, about the process.

William Bridges, in his 1980 book Transitions (p. 88), provides such a construct. He speaks of three passages through which we must travel during transition. Transition is the internal work done to move through the psychological stages which are brought on by change. This process and work of moving applies whether we have initiated the change or if the change simply happens.

Passage 1 Endings: That which is being left behind, given up.

Passage 2 Neutral zone: The gap in continuity, the psychological space, between the ending and the beginning.

Passage 3 Beginning: The nurturing of the spirit needed to carry out the new.

As with the Kübler-Ross stages of grief, the openings to these passages go both ways. Just because we have traversed a passage once does not mean that we will not return to it. Put another way, even if the need-fulfilling picture is moved to the back of or out of our quality world, it does not guarantee that we will leave it there. We may reenter each of these passages more than once during a transition, each time choosing those behaviors which we deemed our best efforts for traversing it.

Let us take a closer look at each passage in Bridges’ construct.

Bridges calls his first passage Endings (Transitions, p. 90), “that which is being left behind, given up.” That something ends in change is easily comprehended. The process of ending may not be so clear. What is certain is that we must move that which is ending away from our quality world. (Take Effective Control of Your Life, pp 171 - 181) This means letting go of
some things with which we were comfortable, namely need-fulfilling pictures in our quality world and formerly effective behaviors. The behaviors we choose to facilitate this process will be our best efforts at the time. Some of these behaviors will be more effective than others. But we must recognize the continued experimentation with behaviors is the only effective way to pass through endings.

Bridges calls his second passage Neutral Zone (Transitions, p. 112), "the gap in continuity, the psychological space, between the ending and the beginning." Just what is meant by a "gap in continuity?" It is best described as a passage of disorientation, a time when our psychological process of transition is not quiet, but rather is in reorganization. We are experimenting with many behaviors to bring us to a state of equilibrium because we have not fully moved the old need-fulfilling picture(s) to the rear of our quality world, nor have we fully embraced the new need-fulfilling picture(s). The zone may be neutral in that it is a gap between the ending and the beginning, but our behavioral system is actively reorganizing to take control of the transition. It is in this passage that we are most creative.

Bridges calls his third passage Beginning (Transitions, p. 134), "the nurturing of the spirit needed to carry out the new." As we move the new need-fulfilling picture(s) into our quality world, we behave in ways which feed our spirit and which should lead us to embrace the new picture(s). Even though we focus on a new picture(s), the passage we must traverse is one which leads to finding peace of spirit and joy in the new. This mystical sounding language means only that having the new picture in our minds as need-fulfilling is not enough. We must act to orient ourselves to the new task, place, person, or whatever the new picture is. We will then begin to feel satisfaction as we act to meet needs. These orientation behaviors are effective if they help us embrace the new.

By combining Bridges' concepts with reality therapy counseling techniques and a control theory understanding of human psychology, we can create a useful construct which can be used by people in transition. Let us examine how a reality therapist could help a person in transition make effective use of Bridges' ideas. Consider the following example.

Dick and Jane, now in their mid-forties, have raised their 3 children to the point at which the youngest is in middle school and the eldest is in college. Dick has a successful career and has been the main breadwinner for the family for over 20 years. Jane has always worked part time for both her own satisfaction and to supplement the family income. Jane, with Dick and the children's support, returns to college to obtain her masters degree. Everyone agrees that the children are sufficiently independent to their own retirement.

Although Jane is successful in school, she just does not feel right. Often she is just too tired to enjoy her studies or her family. She finds herself becoming impatient with Dick and the children. She nagsthem and makes unreasonable demands upon them. The family seems to be losing its way.

ENDINGS:
A reality therapist will begin by asking Jane to describe what she is doing. As she describes her activities, they may learn in the process that Jane continues to carry out many of the tasks for the family which she did before returning to school. For example, she still attempts to prepare the fine meals both at breakfast and dinner that she did when she had more time. By identifying this and other similar examples, Jane discovers that she has not brought closure, gone through an ending, to her picture of a quality mother. She has not moved the old picture of herself to the back of her quality world. She is behaving to achieve a quality world, but she must give up this old picture if she is to fully embrace her new identity as mother, wife, student and professional.

THE NEUTRAL ZONE:
As Jane better understands control theory, she will examine herself in the neutral zone. Her sense of disorientation, "just not feeling right," indicates her situation in this passage. She will look at certain of her behaviors, perhaps nagging or even the total behavior of feeling bad, as attempts to gain sympathy or to cope with the loss of a meaningful identity, that of "super mom."

It is important that people recognize their neutral zone processes. It is often experienced as a vague and unsettled period because the old is not fully put aside and the new has not been fully engaged. In Reality Therapy/Control Theory terms, it shows up as behaviors coming from the reorganizational capacity, the creative component of the mind. The pictures of the old are not fully moved out, and the new picture is not clear or far enough forward that it is experienced as need-fulfilling.

Our culture prioritizes rapid change, and the practice of Reality Therapy supports the theory that people should be helped to find behaviors which can get them what they want. That is to say that culturally and theoretically we tend to minimize the neutral zone process. In our attempts to move to get what we want we sometimes reject or neglect the opportunities of the present.

The neutral zone is a passage of great creativity. People should be encouraged to take advantage of it by taking that dream vacation, exploring that new idea, and/or testing that recipe. Taking advantage of such reorganizing behaviors will help with endings (moving the old picture away), as well as beginnings (nourishing the new picture as it is brought forward). People may even discover a more need-fulfilling picture than that which they had originally intended to embrace.

Jane may want to explore various opportunities with her family which may create an entirely new family identity and even more satisfying roles for each member. For example, she may discover new and more creative ways to share her school experience with her husband and children, which may lead to more fun in their lives.
BEGINNINGS:

This is that final period of transition which should be entered into with enthusiasm for new possibilities. Ways of doing, thinking and feeling have a new orientation. They seek new, need-satisfying pictures in our quality worlds. Total behaviors provide the basis for nurturing and strengthening the person embarking on this new era. As initial halting first steps are taken, they will enliven new thinking and produce feelings that add to a sense of control for the future. It is a sense of loss of control which marked the beginning of the process of transition. The sense of regaining control is the mark of embracing the new beginning. It happens in small steps, but grows more and more comfortable as one experiences need fulfillment and an appropriate sense of control.

Jane may discover the satisfaction of belonging and power in the beginnings passage because she is able to engage in more informed conversation based on her new learning. She may enjoy the fun of new friends and the freedom that comes from exploring different ideas. She may learn that the new identity she has chosen for herself meets her needs, and those of her family, at least as well as and perhaps better than that which she has left behind. And is this not what she and Dick hoped would come about when they embarked on this change?

It is the belief of the authors that joining Bridges’ construct on the stages of transition to Glasser’s reality therapy and control theory psychology produces a model which can be used to guide people through transition. This revised model is described via the following questions.

- In which passage is the person engaged?
- What behaviors are used to move pictures out of or into the quality world?
- How can the person in transition be helped to make it a positive experience?
- Is what the person is doing directed at the past, present, or future?
- Is the person taking advantage of the opportunities for fun in this transition process?
- Is the person taking the time needed for nurturance and growth?

Bridges’ construct for understanding transition, combined with the use of Reality Therapy/Control Theory to manage change, provides a way for us both to make sense of how we feel about change and to take effective control of the transition process. This combination can help us make good choices to manage stress. Finally, if the neutral zone processes are embraced and used well, many of us would experience our own creativity more fully. This could have significant impact on our own lives and the lives of those with whom we come into contact.

References

A NEW PARADIGM: EVOLUTION OF THE SURVIVAL NEED IN THE NINETIES
William A. Howatt

The author is an Advanced Practicum Instructor with the Institute, Vice-President of the Canadian Association of Reality Therapy, Teacher of Human Services Counselling at Annapolis Campus of Nova Scotia Community College, and Counsellor in private practice.

ABSTRACT

The purpose of this text is to create discussion about the survival need. The author explores some of the different cause factors that have been influential in formulating a new paradigm for survival. The physical survival need is traditionally thought to operate only at an unconscious level. This text discusses how people in society in 1995 are no longer taking this need for granted. Many people in our evolving society are in fact spending much more conscious time trying to meet the daily challenges of survival.

“The human mind is as driven to understand as the body is driven to survive.”

— Hugh Gilmore

Have you ever heard anyone make a statement such as, “I did it because I had no other choice!”, leaving the inference that it was a life or death situation? These individuals probably believe they were being “controlled by society”. Reality therapy would interpret their beliefs (control society) as being a stimulus response society.

Control theory and reality therapy over the years have taught me a great deal about the whys of human behavior. Control theory teaches there are four psychological needs in the new-brain (cerebral cortex) which all exist at a conscious level:

1. Love — belonging, connection, friendship, affection, acceptance, companionship
2. Power — self-worth, self-esteem, self-efficacy, talent, control of one’s self
3. Freedom — liberty, freedom, autonomy, independence
4. Fun — enjoyment, pleasure, amusement, happiness, delight

Along with the four psychological needs there is one other basic need - the survival need which is located in a cluster in the top region of the old-brain. The survival need operates at an unconscious level. Glasser (1984) suggests the old-brain communicates with the new-brain through a barrage of signals which the new brain processes as various drives such as hunger, thirst, sex or whatever the old-brain needs to communicate. Control theory describes all human behavior as our best attempt (with the information presently available in our behavior system) to satisfy the demand of one or more needs.
Wubbolding (1986) states the first principle of Reality Therapy is "Human beings are motivated to fulfill needs and wants. Wants are unique to each" (page 3). Reality therapy has taught me that while establishing the counselling environment, it is important to be aware of and assess how the client is or is not satisfying his/her four basic psychological needs. It is also more efficient for the counsellor to assess these four needs than the thousands of wants, when trying to prepare clients to learn what they really want at that point in their life.

I recall, when I was counselling adolescents in a correctional facility several years ago, having countless discussions with these young men about their perception of a controlling world. The majority of these adolescents believed their present choices of behavior were forced on them. They felt society left them with no alternatives but to continue what they were doing to survive on the streets. It was obvious to me these young people were frustrated and concerned about how to cope in today's society.

During these counselling experiences, I first had the notion these young people were, at a conscious level, working to satisfy more than the four basic psychological needs. It appeared to me that many of these adolescents were placing an increasing importance on the need for survival in their assimilation into an increasingly complex society. I recall frightening behaviors in an attempt to satisfy their survival need such as sleeping under stairs or in boiler rooms, carrying a knife or gun for protection - unfortunately, many of these creative attempts led to their incarceration. The adolescents were becoming aware of the fact that if they did not learn more effective ways of meeting their survival need, they would most likely end up returning to jail. They wanted to get themselves out of situation A (a difference between what an individual wants and has, which leaves the individual with no choice except to behave.) of Glasser's control theory chart. The adolescents that chose to balance this unmet need consistently worked hard to find a solution for their unmet survival need.

Common questions asked by these young men included; 'Where will I live and will it be safe? Where will the food come from? Where will I get a job? These are all questions that many of us once took for granted. These concerns led to a personal paradigm change in my counselling approach. I began to address the survival need whenever I was doing a need assessment. Until they felt their concerns for survival were adequately addressed, thereby providing a reduction in their anxiety and a new sense of hope, it was very difficult to assist clients to move forward to address concerns such as drug/alcohol concerns, abuse issues or anger management.

As a reality therapist, I became cognizant that many of these young men were becoming dependent on me for new information when developing their counselling plan. I found myself becoming increasingly insightful on all of the potential resources in the community that would assist them in obtaining basic survival needs (e.g., shelter food and clothing). These clients felt a sense of urgency with regard to survival. Unlike the other psychological needs where you may be able to get by for a month not having the need met, (e.g., People usually can live without fun for a month but would have difficulty getting by that long without food), the survival need takes precedence.

I started to formulate, with this new insight, the perception that the physical survival need was experiencing an evolution. It appeared to be partially developing in a new category — a pseudo conscious psychological need. In this new paradigm, I perceived that people are consciously spending more time focusing on safety, food and shelter in today's society. However, this new paradigm was not at all consistent with my original interpretations of Glasser's teachings of the survival need which he describes as:

Under most conditions it is capable of keeping all my bodily processes, or internal environment, at a homeostatic or stable level, that is, working smoothly, evenly, and well within the upper and lower limits of what the body is capable of doing. It works when I am asleep, unconscious, or sick, always trying to keep me healthy and sexually ready as possible. (1981, Page 12)

Glasser (1984) also teaches that people who live in affluent countries such as North America for the most part do not have to be concerned with survival.

In my new paradigm (See figure #1) I have divided the survival need in two directions. This figure is not intended to cover all of the different facets of survival; the purpose is to illustrate a visual picture of this new paradigm.

**Survival Need Paradigm**

![Survival Need Paradigm](image)

W. A. Howatt M.Ed., R.T.C. (c) 1995

Part one of the chart, the traditional accepted direction, represents the role of survival in the old-brain. Glasser (1994) teaches that evolution of all our four psychological needs, currently found in our new-brain, most likely came from the old-brain. The survival need is responsible for monitoring blood pressure, fighting germs, excretion of chemicals — all of which are done at an unconscious level. When time is a factor, urgent requests from the old-brain survival need will usually override all other present psychological needs. The example Glasser (1984) provides in control theory is "any time we get short of air, everything else is unimportant" (page 6). However, the survival need is no more important than any other need and Glasser confirms this." As important as the need for survival is, it is by no means the dominant force in our lives" (1984, page 8).

Part two of the chart represents the split of the traditional survival need. This section suggests individuals are at a conscious level in today's society striving for the more basic elements of our existance, that were once
taken for granted such as food, personal safety, shelter, clothing, money, etc., for the primary purpose of survival. When an individual is able to satisfy the survival need at an acceptable level, he/she is in a position to receive secondary benefits for one or more psychological needs. For example, obtaining an income will put food on the table, then give a person a sense of self-worth. Increased anxiety and concern for survival are causing many individuals to spend more conscious time on the survival need, which leaves less time to satisfy the other four psychological needs. The following analogy will help explain this point. It was given to me by my father-in-law Jerry Avis, who worked as a Guidance Counsellor in the Nova Scotia Community College system for twenty-five years. He explains, "Each of us on a daily basis starts the day out with 1000 brain units. That is all we have for that day — once we use them up they are gone. An example could be that if we spend 800 brain units worrying about survival, this leaves only 200 brain units to meet our other 4 needs." This means that individuals are left spending more conscious time on the need for survival, therefore they have less time for the other needs.

I began an informal study from this new paradigm on how the general populace in 1995 is viewing the importance of survival. The purpose of this study was to prove or disprove my new paradigm. I was curious if other individuals, apart from my clients, were focusing more on survival in today's society.

First I obtained a clear and accepted definition for survival. Webster's Ninth New Collegiate Dictionary defines survival as: 1) One that survives. 2. The continuation of life. Roget's International Thesaurus also provided me with a list of generic words that were interchangeable with the same meaning. The list included; get along, prolong existence, keep alive, extend, eke out an existence, being alive, retain, manage, endure, persevere . . .

For the purposes of this study, I chose to use the news media as the source of information to confirm my perceptions. I proceeded by watching the evening TV news and reading the daily paper for a period of two weeks. I realize the news media is slanted toward identifying stories that are predominantly survival need related and this study has no scientific validity to prove it's findings. Nor does this study have enough validity to disprove it's findings. I am hopeful this informal study will inspire the reader to create a source of information to confirm my perceptions. I proceeded by watching the TV news and reading the daily paper for a period of two weeks. With the above noted changes in society (increase in family break ups, increase in violence and a decrease in government spending), I am working with a clientele for whom conscious thought of survival is at the forefront.

From the data collected, there were three categories I chose to include in my paradigm. The first indicator from this study supporting my observations was that family break ups are hitting epidemic proportions. Gibson (1986) confirmed this observation, "with at least one out of every three marriages ending in divorce, more and more children are growing up in non-traditional families with a single parent or step-parent" (page 5). The majority of formal research in familial breakups indicates that a large number of children will have to be raised by single parent families. The majority of these are classified as low income. From my brief study I have concluded that the families of these breakups are under great pressures to survive, for example: obtain food, shelter, clothing, money... in today's society.

The second indicator was that in North America violent crimes are another prime example of how people fear for survival. Do you think individuals today are thinking more about their personal safety? Have you thought about your personal safety in the last twenty four hours? If you have, then I can assure you, you are not alone. Peter Kizilios (1995) states, "The problem of violent crime in America has reached epidemic proportions. In 1994, the incarceration rate in the United States rose to an all-time high — 519 out of every 100,000 citizens, or 1.3 million inmates, were behind bars" (page 6).

The final consideration from my study refers to the decrease in government spending. These cuts place another stress on members of society, e.g., cuts in federal social programs. Subsequently, society as a whole appears to be evolving into an increasingly complicated and challenging place to live. If current trends in society continue, the present concern for survival will only become greater. Meanwhile, governments inform us that society is in a period of transition and we all must learn to adapt. I define adapt as "Modern day survival of the fittest".

Once I had proven to myself that society's view on survival was changing, I then looked at what society was doing to cope with the change. Communities across North America are responding to the importance of survival in the nineties, as evident in attempts to keep up with the staggering demands for local food banks, home security systems and personal security precautions . . .

Conclusion: In my private practice I am seeing many of the similarities to adolescents I worked with in an institution. With the above noted changes in society (increase in family break ups, increase in violence and a decrease in government spending), I am working with a clientele for whom conscious thought of survival is at the forefront.

As the year 2000 looms ahead, I recommend that counsellors be aware of the potential uncertainty in many clients with regards to their basic survival. If we are aware of the concerns for survival in today's world, we, as practitioners of reality therapy, will be more effective in helping clients experience a phenomenological satisfaction of their quality world pictures. We all know, when the client is able to satisfy these pictures, he/she will enjoy the peaceful and happy existence we all search for on a daily basis. It is now clearer than ever to me why Dr. Glasser teaches 5, not 4 basic needs.

Reference
THE DEVELOPMENT OF THE BASIC NEEDS SURVEY

Virginia Smith Harvey
Kristen Retter

The Development of the Basic Needs Survey

The Basic Needs Survey (Retter, 1991) was developed to facilitate the assessment of the relative strength of Glasser's four basic psychological needs while assessing children and planning their programs. The Basic Needs Survey demonstrated short term reliability with elementary children in grades 3 through 6 in a test re-test format and was found to be at an appropriate reading level for use at the elementary and junior high levels. The Basic Needs Survey is useful in the development of therapeutic strategies and effective behavior modification systems.

THE DEVELOPMENT OF THE BASIC NEEDS SURVEY

William Glasser (1984) attributes actions, thoughts, and feelings to attempts to meet basic needs rather than as a result of external factors. He delineates the basic psychological needs as power, belonging, freedom, and fun (Glasser, 1989). While the basic needs are part of the human condition, the ways in which individuals meet these needs are learned and specific to each person. If a particular need is not satisfied, or if there is a conflict between needs, the unmet need will drive behavior. Determination of which needs are unmet, or are in conflict, is integral in the application of control theory in therapy and in the development of quality school programs (Glasser, 1990).

The strength of need drive is correlated with the time committed to fulfill that need, but perceived needs are not necessarily strongly correlated with success in meeting these needs (Peterson & Woodward, 1992). At times perceived needs are as strong, but not met in an efficient manner (Parish, 1992). In this situation, successful interventions identify additional methods to meet the unmet need, possibly by linking activities, persons, or objects that meet a different need to the unmet need. Such linking renders the needs complementary rather than competitive (Peterson & Woodward, 1992).

The positive effects of teaching reality therapy principles to children, and of having the children examine their needs, have been discussed by several authors (Dempster & Raff, 1989; Hart-Hester, Heuchert, & Whittier, 1989; Johnson, 1989; MacDonald, 1989; McPadden, 1991; Parish & Wicks, 1990; Poppen, Thompson, Cates, & Gang, 1985; Renna, 1991; Sullo, 1989; Williamson, 1992). Lafontaine (1990) specifically suggests that control theory and consideration of psychological needs are useful in the development of programs for special education students.

Retter (1991) developed the Basic Needs Survey to facilitate the assessment of the relative strength of Glasser's four basic psychological needs while assessing and planning programs for children. This article describes (a) the development of that instrument, (b) a study regarding its reliability, (c) an assessment of its readability, and (d) suggestions for application.

THE BASIC NEEDS SURVEY

This study took place in a mid-sized New England city 40 miles from Boston. The 1990 census revealed a total population of almost 80,000: 92% white, 3% Hispanic, 2% Asian-American, 2% African-American, < 1% Native-American, and 1% other. In 1990, the median family income was $42,666, as compared with a state median family income of $42,656 and a national median family income of $34,416 (CACI, 1991). The school district has a student population of 12,000 students, kindergarten through twelfth grade, with approximately 1,250 students identified as educationally disabled.

One elementary and one junior high school with socioeconomically diverse populations were chosen for participation. Within these schools, heterogeneously grouped third, fourth, fifth, seventh, and ninth grade classes of children and adolescents (N = 148) were taught the concept of the four basic psychological needs. They were then asked to share how they met their needs in each area. From the responses generated in these focus groups, 80 items that occurred repeatedly from third through the ninth grade levels were selected for inclusion in the Basic Needs Survey. These were organized into a 20-item survey, each item containing one choice for each of the four psychological needs. A sample item follows:

I would like to:

(a) go out to dinner with Mom and Dad. (love)
(b) get all the attention at a party. (power)
(c) watch a funny movie. (fun)
(d) do whatever I want to do. (freedom)

The validity of the survey was substantially augmented by the choices having been generated by children in a group setting, rather than by adults attempting to guess what children find rewarding.

When taking the Basic Needs Survey, the respondent ranks the choices in each item according to perceived desirability. The total responses for each basic need are tallied and compared with each of the other basic needs for that individual. Possible scores for each basic need range from 80 (if a need were chosen fourth for all 20 items) to 20 (if a need were chosen first for all 20 items).

The reliability of the Basic Needs Survey was determined through a test-retest (two week interval) procedure with 260 students grades three through six. Of the students who completed both administrations, 115 were girls and 145 were boys. The mean age was 10.0 (standard deviation 1.3) with a range of 8 through 13 years. Correlations were strong, ranging from .66 to .79. The average score for love and belonging was the highest, followed by the needs for fun, freedom, and power and control. However, it should be noted that all of the scores are similar, in that each need was chosen between 23% and 26% of the time. Results are shown in Table 1.
of overriding importance, the results are useful in the development of therapeutic strategies and in the implementation of effective behavior modification techniques. For example, often adults assume that a child who misbehaves in class does so in order to seize control. The results of the Basic Needs Survey reveal that the misbehaving child may do so to satisfy any one of the basic psychological needs. If the Basic Needs Survey reveals that the child has an extremely strong need for fun, interventions that find more appropriate methods to have fun would be most successful.

In addition, therapeutic time can be spent empowering the child or adolescent to explore and increase methods to meet unmet needs. When the Basic Needs Survey reveals conflicting needs, successful interventions link activities, persons, or objects that meet a different need to the unmet need, as suggested by Peterson and Woodward (1992). Further, the survey could be used to determine the compatibility between the driving needs of adults and the needs of the children with whom they work.

The primary limitation of this study, and of the Basic Needs Survey, is that it was developed in a northern New England city and has yet to be used in other settings. Although the children who participated in the focus groups were of varied socioeconomic status, for the most part the choices were generated by children whose quality world was not poverty stricken. This clearly affected the responses. In addition, although efforts were made to choose items that were attractive to a wide age range, the instrument has limited potential for use with older teenagers.

Implications and Applications
The Basic Needs Survey (Retter, 1991) was developed to facilitate consideration of basic needs while assessing and planning programs for children. The survey compares the relative strength of each of the four basic psychological needs as defined by Glasser (1984). The Basic Needs Survey demonstrated short term reliability with elementary children in grades 3 through 6 in a test/re-test format and was found to be at an appropriate reading level for use at the elementary and junior high levels.

The Basic Needs Survey has several application implications. Since its development five years ago, it has been used as a tool by psychologists within a public school setting to augment initial interviews. As such, it has been found to be an effective and efficient means to rapidly assess the needs drive of referred children and adolescents prior to (and often in place of) lengthy psychological assessments.

In particular, it has been extremely helpful in assessing the needs drive of those who have been referred for disruptive behavior. One of the most important results of using the Basic Needs Survey is that it redefines disruptive behaviors for adults in the child’s environment. That is, behaviors are no longer seen as driven by maliciousness (with the intent to harm or embarrass others) or as a result of a deficiency in the child. Instead, the behaviors are seen as a strength: a strong drive to meet legitimate, positive, and universal needs. The referring problem is thus redefined as the child having chosen a socially undesirable method of meeting these needs, and the solution is redefined as finding alternative methods to meet these unmet needs.

Because the Basic Needs Survey indicates whether particular needs are of overriding importance, the results are useful in the development of therapeutic strategies and in the implementation of effective behavior modification systems. The results of the Basic Needs Survey reveal that the misbehaving child may do so to satisfy any one of the basic psychological needs. If the Basic Needs Survey reveals that the child has an extremely strong need for fun, interventions that find more appropriate methods to have fun would be most successful.

In addition, therapeutic time can be spent empowering the child or adolescent to explore and increase methods to meet unmet needs. When the Basic Needs Survey reveals conflicting needs, successful interventions link activities, persons, or objects that meet a different need to the unmet need, as suggested by Peterson and Woodward (1992). Further, the survey could be used to determine the compatibility between the driving needs of adults and the needs of the children with whom they work.

The primary limitation of this study, and of the Basic Needs Survey, is that it was developed in a northern New England city and has yet to be used in other settings. Although the children who participated in the focus groups were of varied socioeconomic status, for the most part the choices were generated by children whose quality world was not poverty stricken. This clearly affected the responses. In addition, although efforts were made to choose items that were attractive to a wide age range, the instrument has limited potential for use with older teenagers.

Implications for further research include studies with clinical populations, diverse populations, and longitudinal studies. The comparison of responses by referred children with the responses by non-referred children is of interest, and the authors are currently collecting data to investigate this dimension. Additional possibilities include investigating the responses to the Basic Needs Survey in other geographic locations and with more diverse populations. Finally, a study investigating the long term reliability and predictive validity of the Basic Needs Survey would explore the stability of strength of needs drives.

The Basic Needs Survey was developed to facilitate the assessment of the relative strength of Glasser’s four basic psychological needs while assessing children and planning their programs. It could be useful to psychologists, social workers, and counselors in correctional settings, group homes, and clinics in addition to those working in schools in the development of therapeutic strategies and effective behavior modification systems.

References


Retter, K. W. (1991, July), Basic needs survey. Presentation at the Institute for Reality Therapy Certification Week, Providence, RI.


---

**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 1995 resource library is available upon request at a production/mailing cost of $11.00 (U.S. and Canada) and $14.00 (International). In addition, individuals are encouraged to send information, materials, etc. to the Library for listing. The mailing address for the Library is:

**Reality Therapy Resource Library**
203 Lake Hall
Northeastern University
Boston, MA 02115
Telephone: 617-373-2485
FAX 617-373-8892

---

**CLASSROOM CONSULTING WITH REALITY THERAPY**

Joseph J. Stehno

The author (R.T.C.) is a high school counselor in Pembroke, NH and an adjunct professor with Franklin Pierce College.

**ABSTRACT**

In this article, three consultation models are presented and discussed. The author suggests that a process model, such as Reality Therapy, can be used effectively to help teachers in school settings solve common problems on their own. A case study demonstrates how a teacher, with counselor/consultant assistance, was able to identify her Quality World, evaluate her options, and initiate a plan that addressed her needs and the needs of her students.

**Scenario 1:** You’re walking down the hall and a teacher says “I just don’t know what to do with Johnny. He’s always getting into trouble.” Since you’re on your way to a meeting with some parents, you quickly arrange a mutually agreeable time to get together later that day.

**Scenario 2:** You’re sitting in your office, a teacher walks in and says “My students just don’t want to learn. They seem bored with everything I try.” She looks like she’s depressing. You’ve just started to “attack” a pile of reports.

As a busy counselor, these interruptions may seem like intrusions, at best, or as yet another request you’re expected to do something about. Looked at from a Control Theory perspective, however, these types of situations are opportunities to serve as a consultant with peers by using the principles and steps of Reality Therapy.

**Three Kinds of Consulting**

As counselors/consultants, we have three ways of responding to requests for assistance. First, the “Purchase” or “Expert” model (Block, 1981; Schein, 1969). In this model, information or services are purchased externally because an individual (or organization) just does not have the time or resources to implement a plan of their own. In the scenarios described above, the implication is that you, the counselor, will “fix” the teachers’ problems by making a commitment to “see” Johnny or by performing some magical group counseling session with the unmotivated class. These methods may work well temporarily but have dubious effects in the long-run. In addition, the counselor who operates with this model allows teachers to take an inactive, “backseat” role in the process. In other words, the teacher is saying “I’ve found this problem I can’t solve. You fix it” and the counselor agrees.

The second way we can intervene as counselor/consultants is with the “Doctor-Patient” or “Pair-of-Hands” model (Block, 1981; Schein, 1969). This familiar model goes like this: something’s wrong and the consultant (doctor) diagnoses the problem and prescribes treatment. In the first scenario, the busy counselor, relying on the “Doctor-Patient” model,
might suspect ADD/ADHD and refers Johnny, via parents, to a physician. Maybe more restrictions or some disciplinary action would do the trick, so Johnny is sent to the assistant principal. In Scenario 2, the counselor might recommend a workshop or a graduate course on innovative teaching techniques. Whatever the suggestion, as a consultant, the teachers are relying on an external source to provide information, direction, and/or a solution. The counselor, not surprisingly, is able to maintain power and control while reinforcing the teachers' dependency.

Certainly there are times when the “Purchase/Expert” and “Doctor-Patient/Pair-of-Hands” models are necessary and effective, such as in crisis situations or when time and circumstances limit deeper, more intense discussions. Inherent in the two models just described, however, is the underlying reliance on Stimulus Response (S-R) theory. Teachers who look outside themselves for expertise may find it easier to get someone else to do their job or suggest a solution than to work through the problem on their own. We do, indeed, live in a culture that promotes dependence. When, as counselors/consultants, we regularly rely on either of these S-R models as our “modus operandi,” we are conditioning those we work with to continue to view our roles in S-R ways. We unconsciously perpetuate dependence and deprive our peers of self-reliance and greater control in discovering their own solutions.

The “Process Consultation” or “Collaborative” model (Block, 1981; Schein, 1969) is the third option. This model can be defined as “a set of activities on the part of the consultant which helps the client to perceive, understand, and act upon process events which occur in the client's environment” (Schein, 1969, p. 9). In other words, the consultant and client (teacher, in this case) collaborate as equal partners, engaged in a joint venture. “It is a key assumption underlying P-C (Process Consultation) that the client must learn to see the problem for himself, to share in the diagnosis, and to be actively involved in generating a remedy” (Schein, 1969, p. 7). As in the practice of Reality Therapy, the counselor/consultant works with the client (teacher) to “teach the client that he or she has needs that must be satisfied and that there are always better ways to satisfy them than what he or she is choosing to do now” (Glasser, 1989, p. 5).

A Comparison of Process Consultation and Reality Therapy Models

The Process Consultation/Collaborative (P-C/C) and Reality Therapy (RT) models are surprisingly similar in both process and the content of each stage of the process, as the following chart illustrates:

<table>
<thead>
<tr>
<th>Process Consultation/Collaborative (Block, 1981; Schein, 1969)</th>
<th>Reality Therapy (Wubbolding, 1988)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Stage-Initial Contact</td>
<td>Involvement</td>
</tr>
<tr>
<td>-form relationship</td>
<td>-be friends</td>
</tr>
<tr>
<td>-establish two-way communication</td>
<td>-use attending skills</td>
</tr>
<tr>
<td>-be authentic</td>
<td>-Always be . . . courteous,</td>
</tr>
<tr>
<td>-build trust</td>
<td>determined, enthusiastic</td>
</tr>
<tr>
<td></td>
<td>firm, &amp; genuine</td>
</tr>
<tr>
<td></td>
<td>-suspend judgment</td>
</tr>
<tr>
<td></td>
<td>-negotiate wants</td>
</tr>
<tr>
<td></td>
<td>-cope with mixed motivation</td>
</tr>
<tr>
<td></td>
<td>-surface concerns</td>
</tr>
<tr>
<td></td>
<td>-ask direct questions</td>
</tr>
<tr>
<td></td>
<td>-give verbal support</td>
</tr>
<tr>
<td></td>
<td>-probe for underlying concerns</td>
</tr>
<tr>
<td></td>
<td>-be clear about problem</td>
</tr>
</tbody>
</table>

2nd Stage-Define Relationship & contract
-How is problem being managed?
-obtain clear & simple picture of what is happening
-redefine problem, if necessary
-ask questions
-observe directly

3rd Stage-Data Gathering & Diagnosis
-What do you Want?
-get specific
-total behaviors
-explore quality world
-"How do you look at it?"

4th Stage-Intervention (Sherwood, 1983)
-what have you done?
-Iocus on present

5th Stage-Reduce Involvement & Termination
-gradually reduce involvement
-reinvolvement always possible
-periodic reassessment
-make joint decision
-return to Stages 2, 3 or 4

In both the P-C/C and RT models, the initial task is to develop a relationship and establish involvement. The counselor/consultant, as an "expert in . . . how to establish a helping relationship" (Schein, 1969, p. 9), models appropriate and effective involvement skills. Establishing "wants"
is the major task of the second stage of both models. While the P-C/C model emphasizes problem identification, the RT model seeks to discover and define the client’s Quality World. What matters at this stage is that the client and the consultant agree and make an outcome-based contract. In the third stage, the counselor/consultant explores doing behaviors so the client can evaluate and ascertain effective and ineffective actions. The P-C/C consultant may seek to examine the past while the RT counselor focuses on Total Behaviors. Exploration results in both parties clearly understanding what the client really wants and the client is motivated to proceed to the next stage, Intervention or Making a Plan. The fifth and final stage of the process involves assessment of the plan, termination, or revisiting an earlier stage. Both the P-C/C and RT models guide people through the process of finding their own solutions, solutions that they evaluate and deem effective, as opposed to a prescribed plan from an expert.

Application - The Case of Mrs. H.

Setting: self-contained high school classroom.

Presenting problem: students swearing, using inappropriate language in class, and acting disrespectful towards the teacher and each other.

Contact: Mrs. H. met the counselor in the hall. We agreed to meet after school that day.

The Meeting

1st Stage: Involvement

Since we had worked together for several weeks, we spent a few minutes chatting informally, creating a relaxed atmosphere. I asked her to tell me about the situation, asking specific questions for clarification until I fully understood her perspective.

2nd Stage: What do you Want?

Mrs. H. stated she wanted her students to respect her and each other... to talk quietly... to ask for things politely... to feel relaxed and comfortable with her... to have fun but be serious about their schoolwork... and... to get along with each other.

3rd Stage: What are you Doing?

Mrs. H. stated she has talked to her students about respect, cooperation, and kindness. In fact, she talks to them frequently about these principles. She posted classroom “rules” (her rules) on a posterboard and hung it in a conspicuous place. Mrs. H. sends students to the discipline office for “time-outs” when they swear, are rude, or use inappropriate language. For several students, she has called home numerous times and has talked to their parents. Mrs. H. feels she has tried everything. Her students are continuing to swear and be rude to her and each other. She wants to have a couple of them suspended.

Is what you are doing Helping?

Mrs. H. acknowledges that nothing has seemed to work. After strong (yelling) reprimands, the students settle down for awhile. Calls home resulted in the students coming in the next day angering at her and refusing to do their schoolwork. It seems the more she talks to them (lectures them), the more they swear and act disrespectful. Sending them to the discipline office helps somewhat, but this is only a temporary solution: “It gets them out of my hair so I can get some teaching done.” She suspects that because most of her students have limited vocabularies and reading abilities, her posted classroom rules have little impact.

What Mrs. H. really Wants

During this evaluation of her “doing” behaviors, Mrs. H. stated she really wants (her Quality World) to be liked and accepted by her students and she wants her students to get along with each other (need for belonging). When asked if her “doing” behaviors were helping her meet this need, she stated that it would be difficult for the students to respect her if all she did was tell them what to do, yell at them, and send them out of the room.

4th Stage: Make a Plan

It was quite easy, at this point, for Mrs. H. “saw” that she had not been spending much time getting to know her students personally. She was trying to command respect. Thus, we brainstormed ways she could become more involved and spend quality time each day with individuals or small groups of students. She rearranged her teaching methods to build in a few minutes each period with each student. In addition, she negotiated several “fun” social activities outside the classroom with her students, such as going on walks after lunch and volleyball. She brought in games and played with her class during the two daily “breaks.” She arranged “free-time” for her students to work on the computers or talk quietly at the end of each period. She took down the classroom rules and, in a group session we co-facilitated, the students came up with their own rules, wrote them on another piece of posterboard, and hung the board in the back of the room so they could see it, as a reminder, when they entered the room. By creating a more involved, cooperative environment, Mrs. H. and her students were thus able to meet their Basic Needs in positive ways.

5th Stage: Follow-up

The atmosphere is much calmer, more peaceful, and friendlier. Since Mrs. H. became more involved, her students generally talk respectfully and swearing is rarely heard. Only two students have been sent to the discipline office in the last month and these were for incidents that happened outside the classroom, before school. Mrs. H. feels much better about her students and her ability to teach. She is even enjoying coming to school and spending social time with her class. So are her students.
Conclusion

When Mrs. H. was “Boss-Manager” and looked to the discipline office, yelled, made threats of suspension, and called home (all external, S-R solutions), she was hoping someone or something else would solve her problems. When she realized that her needs and the needs of her students were not being met, she was able to reorganize her thinking and create effective solutions.

Professional peers occasionally need assistance identifying their Quality World, evaluating options, and finding workable solutions. The counselor/consultant who employs a process model, such as Process Consultation/Collaboration or Reality Therapy, provides support, encouragement and direction. Viewed as an “ally,” the counselor/consultant guides others to choose needfulfilling behaviors which help them gain more effective control of their lives.

References

PRAYING AND CT/RT
Tom A. Davidson

The author is a retired minister in Annandale, Virginia.

ABSTRACT

Praying is a behavior that is chosen by those who believe that it can help them to satisfy their needs. Their ability to pray comes from their All-They-Know-World; their choosing to pray comes from their Quality World, because of the importance they attach to praying.

All praying is a form of communication. As communication, whatever its purpose, praying involves 1) that which is communicated, 2) the one doing the communicating, and 3) the one to whom the communication is directed.

When God is the one to whom the communication is directed, praying often takes the form of petition. Other forms of praying can include thanksgiving, confession, commitment and renewal. Such praying is done by those who believe that it can help them satisfy their need for survival, belonging, power, freedom, and fun.

Praying is a behavior that is chosen by those who believe that it can help them to satisfy their needs. Their ability to pray comes from their All-They-Know-World; their choosing to pray comes from their Quality World, because of the importance they attach to praying.

According to Brian,

“We had completed our mission and were returning to base. We were over the ocean, and it was night. Something went wrong. My engine malfunctioned, and I had to eject. I landed in the water, alone and afraid. All night long I prayed. In the afternoon of the next day, I was sighted and rescued.”

Motivated by his need for survival, Brian prayed to be rescued.

Sarah relates,

“For the longest time, I could do nothing but depress and feel sorry for myself. In spite of all I did to make our marriage work, I still felt unloved and unappreciated. I did not want to separate, and I most surely did not want a divorce. The only thing left that I knew to do was to pray. So I prayed. I filled my days and nights with praying. Finally, our marriage took a turn for the better, and has continued to improve ever since.”

Sarah prayed for a happier marriage, in which her need for belonging, being loved and appreciated would be satisfied.

Patti’s need was different:

“I knew they wanted me to mess up”, she said. “They were looking for something to use against me so they could fire me. So far as I knew, I had done nothing to deserve this kind of treatment. I felt powerless. Then, for some reason, I began to pray like I had never prayed before. It was not long at all before
The relationship is strained, there are prayers of renewal. Whenever the relationship is strained, there are prayers of renewal. When there is an estrangement in the relationship, prayers of confession prepare the way for forgiveness and reconciliation between the one doing the communicating and the one to whom the praying is directed.

THOSE DOING THE COMMUNICATING

All five of those who prayed their prayers of petition were professing followers of Christ. All five of them offered essentially the same kind of prayer to God, but not all their praying was the same. Their All-They-Knew-Worlds doubtlessly were similar to each other; but it was not humanly possible for their All-They-Knew-Worlds to be exactly the same.

Their individual learning, aptitudes, interests, experiences and life-circumstances varied one from the other. The combination of these variables in each one of them resulted in the creation of their own knowledge and understanding, their own perception, of praying. For this reason, it was their All-They-Knew-World that determined the nature and content of their respective praying.

Their praying was determined also by the value that praying had for them. Whatever value they chose to give to praying, as they perceived praying to be, they placed in their Quality World. Thus, whether they prayed or not was greatly influenced by how important a place praying had in their Quality World.

Because the picture of his Quality World was that praying could help him survive, Brian prayed to be rescued. Likewise, Sarah chose to assign an importance to praying when she chose to believe that praying could improve her marriage.

Patti finally remembered another way she had not yet tried to solve her problem at work . . . she had not prayed. Whether reading the article about prayer enhanced her understanding of prayer, or perhaps gave her a greater appreciation for praying, she decided to pray for help.

None of them knew for sure that their praying would help them get what they wanted. They all valued what they knew and believed about praying strongly enough to do the praying that they did. What they communicated in their praying was specific and, as best they knew, responsible. At the time of their praying, however, the attainability of their wants was unknown to them.

All of them went through a period of self-evaluation. They wondered whether God could and would help them. They asked themselves whether they were important enough to God for God to help them, and what they should do in order to get God’s help.

As he prayed for survival, Brian reflected upon the small place of importance he had been giving to God and to praying in his Quality World. He freely admitted that mixed with his prayers of petition that night were also prayers of confession, of renewal and re-commitment.

During the course of his praying for fun and enjoyment, Dan began to remember the many good things in his life. He remembered the time he
successfully came through a serious illness, the impressive promotions and raises he had been given, the love of his wife and family, and his friends. As a result of his self-evaluation, he also communicated to God his prayers of thanksgiving.

When Patti realized that what she was doing at work was not helping her, she had already begun to self-evaluate. When she re-examined her All-She-Knew-World, she remembered having been told that praying was a viable way to help her get what she wanted. Retrieving this valued information, she placed it in her Quality World. She prayed prayers of recommitment and petition, and redirected her efforts toward getting what she wanted.

Earlier, Louis had little knowledge about praying, and little regard for the knowledge he had. Fortunately, new information came to him that "prayer changes things". With this new information, he gave praying a new importance in his Quality World. He began to pray for God's help, and redirected his efforts toward gaining his freedom.

Though their All-They-Knew-Worlds were different from each other, and their Quality Worlds were not the same, yet all five regarded themselves as children of God. With the knowledge they had gained about praying, and the importance they chose to give to praying, they believed they were loved by God.

THE ONE TO WHOM PRAYING IS DIRECTED

All of them were confident that it was not their praying that affected the changing, but God (to whom their communication was directed) who did the affecting. Their openness to God provided the channel which they used to communicate with God, and which God used to communicate with them.

Later on, they all believed that they had experienced what the apostle Paul wrote to the Christians at Rome: "We know that in everything God works for good with those who love him . . . ." (Romans 8:28) Expressed in Control Theory language, if God has a Quality World, one of the most treasured pictures in God's album must surely be "those who love him".

Jesus said to his followers, "Ask, and it will be given you; seek, and you will find; knock, and it will be opened to you . . . What man of you, if his son asks him for a loaf, will give him a stone? Or, if he asks for a fish, will give him a serpent? If you then, who are evil, know how to give good gifts to your children, how much more will your Father who is in heaven give good things to those who ask him?" (Matthew 7:7-11)

Out of God's All-God-Knows-World, I believe God knows what "good things" are best for "those who love him". What these "good things" prove to be, and how they are given, cannot be predicted or controlled.

Gratefully thanking God, humbly confessing to God, earnestly petitioning God, and continually renewing their commitment to God, these five people and many more like them attest to the importance of praying.

They affirm that praying really does help them to satisfy their need for survival, belonging, power, freedom and fun.

INTEGRATING THEORY AND PRACTICE:
EXPANDING THE THEORY AND USE OF THE HIGHER LEVEL OF PERCEPTION

Robert E. Wubbolding

The author is Director of Training for the Institute and Professor of Counseling at Xavier University, Cincinnati, Ohio.

ABSTRACT

In the classic training tape Very Angry Married Couple (1988) William Glasser asks each spouse a simple but profound question, "Whose behavior can you control?" In an effort to integrate theory and practice I have asked many trainees where this question fits in the control loop (Glasser, 1986). It is rare that anyone puts it where it belongs - at the upper level of perception or the valuing filter. It is the contention of this article that the higher level of perception serves a wider purpose than to label perceptions as positive [yellow], or negative [red], or neutral [green] (Glasser, 1986). The higher level of perception also serves as a labelling device for what is seen as controllable or uncontrollable.

FILTERS: CONVENTIONAL FUNCTION

The conventional teaching about the two filters in the perceptual system is that the low level filter serves to label the incoming perceptions or to recognize them. Thus, a person walks into a room, sees a chair and acknowledges it as such. Because it is not yet seen as comfortable or uncomfortable, aesthetic or ugly, it is merely seen or labeled as "chair". Thus, the name is given to the lower level filter "total knowledge." (Glasser, 1986). It is at this point that we know or recognize the world around us. The perception then passes through the upper level filter and could receive a neutral value.

On the other hand, if a person sits in the chair for a full day and finds the chair comfortable, the perception passes through the upper level filter and receives a value. Suppose the same person then tours the state penitentiary and sees a strange chair with electrical cables attached to the arm rests and to a kind of hat worn while sitting in it. The perception of this chair is probably minus or negative and given a bright red in the person's perceived world. (Glasser, 1985; Wubbolding, 1995).

FILTERS: ADDITIONAL FUNCTION

Essential to control theory is the principle that the purpose of all behavior is to control, i.e., to fulfill wants and needs. If people seek control, it follows that they have perceptions of whether or not, in fact, they have control. It also follows that some things in the outer world are more controllable and some less controllable. Controlling some things and behaviors is more intensely desired while controlling others is seen as insignificant.

It is apparent that besides labeling perceptions as need-satisfying [positive or yellow], not need-satisfying [negative or red] or neutral [green], the upper level filter serves an added purpose.
CLAUDIA SOWA (1992) has provided a useful conceptualization that can be adapted to control theory and reality therapy [Figure 1].

She divides perceptions on the vertical axis as “important” and “unimportant” and on the horizontal axis as “controllable” and “uncontrollable.” She uses the matrix in the context of stress management and says that the stressors are first identified and classified in one of the four quadrants, and then “reviewed.” The stressors are either acted on [quadrants 1], or let go [quadrant 3]. Clients are then encouraged to change perceptions from quadrants 2 and 4 through counseling.

The implications for therapy and for classroom use is clear (Glasser and Wubbolding, 1995). Perceptions are explored not as part of the self-evaluation but as part of the W of the WDEP system (Wubbolding, 1986). Along with exploring wants, level of commitment, and locus of control, the values clients put on experiences are also explored. The controllability and uncontrollability can be explored as part of the discussion of perception. Clients are then asked what part of the matrix they want to work on and how hard they want to work on it [level of commitment]. The conventional use of the WDEP (Wants, Doing, Evaluation, & Planning) system is employed, including what have they tried that has helped and not helped followed by simple, attainable, measurable, immediate and consistent [SAMIC] planning.

CLASSROOM APPLICATIONS

The dual axis figure is an excellent tool for teaching control theory and for helping students at any educational level take better control. Below is a selection of perceptions described by graduate students in a counseling lab course [Figure 2] followed by selected comments made in answer to two questions.

**Figure 2**

Graduate Counseling Lab Students’ Perceptions

**QUESTIONS:**

The following are questions which students were asked followed by their responses.

1. **What items do I want to move from one category to another?**
   - Diet
   - Exercise
   - Reaction to death of friend
   - Can’t control son but could treat him differently
   - Put what others think of me in the unimportant category
   - Make decision to unpack after moving recently

2. **If I were to work on any of these, what would I do differently?**
   - Examine my life goals and perhaps spend more time with my family
   - Plan less, meditate more
   - Exercise regularly
• Arrange to have more time for myself
• Seek help in dealing with periodic feelings of despondancy and excessive worrying
• Start to clean
• Find someone to give and receive love

SUMMARY

It is clear that the use of this tool can be used in individual counseling and in small or large groups. Useful for gaining insight to controllable and uncontrollable perceptions and their relative importance or unimportance, it thus serves as an extension of the valuing filter. Not only does this filter label input as positive, negative or neutral, it also places in categories our present experiences as well as experiences which we expect to have in the future. This process can be a very effective prelude to more effective choices.

References


CREATIVE PERSONALIZATION AS A MEANS OF INCREASING CLIENT UNDERSTANDING: A CASE ILLUSTRATION.
“The Hot Dog Theory”
Craig R. Schollenberger

The author, RTC, is a supervisor for a crisis intervention unit at Berks County MH/MR, Service Access and Management in Reading, Pennsylvania.

ABSTRACT

Many behavioral theories are presented in a manner that is difficult for the lay person or client to relate to. Control Theory (CT) and Reality Therapy (RT) avoid the technical vocabulary of many therapeutic approaches and is relatively jargon free. Even in CT and RT, however, clients may benefit from the use of metaphor, analogy and story telling to creatively personalize the basics of a behavioral theory. Meeting one’s basic needs of survival, love & belonging, power, freedom and fun are presented using an analogy centered around buying a hot dog for lunch. Creative personalization of theory may enable clients to more easily apply concepts in improving their everyday life. Underlying principles for this case illustration are based on William Glasser’s Control Theory and Reality Therapy.

Creative personalization of theory is one means to improve clients’ understanding of what the therapist, teacher or manager is trying to say. Its use requires an understanding of; 1) the theory or principle being presented; 2) the ability to use metaphor, simile and analogy; and 3) the client’s Quality World.

The Merriam-Webster Dictionary (1993) notes the following:

anal-o-gy: correspondence between the members of pairs or sets of linguistic forms that serves as a basis for the creation of another form.
met-a-phor: a figure of speech in which a word or phrase literally denoting one kind of object or idea is used in place of another to suggest a likeness or analogy between them (as in drowning in money).
sim-i-le: a figure of speech comparing two unlike things that is often introduced by like or as (as in cheeks like roses).

As previously mentioned, creative personalization requires the understanding of the client’s Quality World. For example, the story or phrase found helpful for a client who has interest in theater and classical music would be different from the one told to a client whose sole interest is football.

Although Control Theory and Reality Therapy are relatively jargon-free, I have found the reintroduction of CT/RT using analogy and story telling to be helpful to some clients. Clients’ greater sense of understanding was measured by self report.
Due to the anecdotal nature of my findings, no attempt can be made to generalize these observations. However, you are encouraged to try creative personalization for two reasons: 1) it is something else to try when what you are doing is not working; and 2) it provides an opportunity to introduce humor and fun into the session where appropriate. A case illustration may be helpful at this point.

The "Hot Dog Theory of Behavior" first stumbled out of my mouth while in conversation with a woman who had recently been discharged from her third psychiatric hospitalization in a row. It seemed the real reason this woman was in my office was because she was lonely, had no friends and had no life.

I was trying to think of an analogy for ideas presented in Control Theory (Glasser, 1984) and Reality Therapy (Glasser, 1975) that would stick with this woman, something simple, related to everyday life. The CT Chart (Institute of Reality Therapy, 1990) was full of metaphors: the "Total Behavior Car," the "Library of Organized Behaviors" and the scales in the "Comparing Place." These were all easy to understand, but did not string together with a common theme that made it easy to remember.

In desperation, I said, "Did you ever hear of the Hot Dog Theory of Behavior?" She looked at me like I had three heads.

"The what!?" she responded. If nothing else, I certainly had her attention. This woman had participated in partial hospitalization programs, been at a state hospital for eight months and had several stays in private psychiatric hospitals, but she'd never heard anything like this.

Now I was really fishing for what to say next, and came out with, "Well, it's 11:30 and I'm starting to get an uncomfortable feeling in the pit of my stomach. When you leave, I'll probably take some time out to identify this as hunger. As I think about this sense of hunger, I get a picture in my head of a hot dog with chili sauce and onions."

"Now, I know there's a guy with a pushcart in front of the Court House that sells hot dogs for 75¢. I reach in my pocket and find two dollars. This is great, I can get two. What if he's not there? Well, there's another guy with a pushcart by the Post Office that sells dogs for a buck. If the guy isn't at the Court House, I'll walk down to the Post Office and get two from the other guy."

"After I've figured all this out, I get up from my desk, walk out of the building and walk down to the guy standing in front of the Court House that sells hot dogs for 75¢. I reach in my pocket and find two dollars. This is great, I can get two. What if he's not there? Well, there's another guy with a pushcart by the Post Office that sells dogs for a buck. If the guy isn't at the Court House, I'll walk down to the Post Office and get two from the other guy."

"So, I pay the guy a dollar-fifty and immediately start peeling the paper back to quickly begin eating the first hot dog. About half-way through my second hot dog, my eating pace begins to slow down because I am just beginning to get a message that my need for food is being fulfilled. I now, slowly, savor the last few bites and throw the wrappers in the trash."

Now, by this time, this woman is looking at me like I'm the one who should have been hospitalized. So, I said, "What have we learned here? I got an uncomfortable feeling that kept getting worse and worse. I identified the feeling as hunger. Next, I got a picture in my head of how I wanted to satisfy that need and made a plan to make that happen. After that, I made 'Plan B' in case something got in the way of 'Plan A'."

"After my planning was complete, I executed my plan: walking out of the building, standing in line, ordering, paying my money, unwrapping the hot dogs and eating them. Then and only then, after I finished all this stuff, did I get a signal that I had effectively filled my need for food."

"So?" she said.

I replied, "All your basic needs are fulfilled the same way. Whether it's survival, love and belonging, power, freedom or fun, they all get filled the same way. You identify the need, get a picture in your head of how you want to fill it, make a plan, sometimes a couple, and then carry out your plan. Get it?"

"I think so," she replied.

"So what would you do if you identified a bad feeling as loneliness, a desire to fill your basic need for love and belonging?"

"Well, I guess I could think about who I would want to spend some time with, like my sister."

"What would you do then?" I asked.

"I could call her on the phone and ask if it was OK for me to come over," she responded.

"When would you begin to feel good?"

"When I was there and we were talking in her kitchen, or maybe playing with her new baby."

"I think you're catching on," I said, "but let's go back to the Hot Dog Theory for a minute. Would you eat a piece of a hot dog laying in the street?"

"Oh, God no!" she emphatically responded.

"I'll ask you the same question in a different way. If you hadn't eaten in three days and had no money and no other way of getting food and you saw a piece of hot dog laying in the street, what then?"

"I'd probably go for it," she said.

"Exactly, this is what happens when our needs are not met for any length of time."

"That's gross."

"I know, but eating that piece of hot dog off the street would be your best attempt, at the time, to fill your needs."

This is the closest I've ever come to single session therapy. It seemed that the light had gone on for this woman. There seemed to be a difference in how she looked at things.
The client had a history of drug and alcohol abuse. In an effort to stop using, she basically had stopped behaving. She was not involved with substance abuse, but she was not getting her needs met either. I referred this client to a drug and alcohol support group to learn new, substance-free ways to get her needs met with others encountering similar difficulties. After her initial interview with the group’s leader, an evaluation was sent to me that the client, "had no mental health issues.

I saw her about a year later on the street. She was smiling. A long time stuttering problem had lessened. She reported having developed an interest in karate and participating in tournaments. She also had begun to lose weight, something she had been attempting for years.

For me, the most useful analogy derived from using the Hot Dog Theory is that the feeling part of behavior does not begin to improve until after there are changes in the thinking and doing. In many cases, when talking with individuals who are depressing, I offer a suggestion that they go for a walk each day to help lift the depressing. The usual reply is, “I’m too depressed to walk.” Using the Hot Dog Theory gives them a concrete example of how feeling good only comes after a successful plan is implemented.

Hunger is an easily understood illustration of the painful signal that occurs when you are not in effective control of your life. The satisfying feeling after a meal is a clear example of how to know when you have made a successful plan to gain more effective control.

The Hot Dog Theory is one illustration of creatively personalizing the CT/RT process. Due to its link to the basic need for survival, I have found the Hot Dog Theory helpful and easily understood by several clients. However, it is only one way of creatively personalizing CT/RT theory. Search your own creativity to find new, meaningful ways to explain CT and RT to those in your care.

References

A FAIRY TALE WITH SPECIAL THANKS TO A BEAUTIFUL LADY ON THE TRAIN AND BARNES BOFFEY FOR SHARING HAVE-DO-BE

Lucy Billings

The author, an advanced practicum supervisor, lives in Memphis, Tennessee.

Once upon a time, not so long ago, there lived a Beautiful Lady with her husband and son in a kingdom called Have. The Beautiful Lady was very happy because she had moved to Have from a nearby kingdom called Have-Not where people were very poor and very hungry. The Beautiful Lady knew that Have was a much better place to live than Have-Not. She was very happy and learned to speak the language of Have very well.

“I have a beautiful home and great wealth. I have a big car and a view of the ocean. I have my health and the love of my family. What more could anyone want?”

But having was not enough and soon the Beautiful Lady became weary of Have, left her husband, took her son and went to live in a nearby kingdom called Do. Now the Beautiful Lady was very happy because Do was a much better place to live than Have-Not. She was very happy and learned to speak the language of Have very well.

“I have a beautiful home and great wealth. I have a big car and a view of the ocean. I have my health and the love of my family. What more could anyone want?”

But having was not enough and soon the Beautiful Lady became weary of Have, left her husband, took her son and went to live in a nearby kingdom called Do. Now the Beautiful Lady was very happy because Do was a much better place to live than Have-Not. She was very happy and learned to speak the language of Have very well.

“I have a beautiful home and great wealth. I have a big car and a view of the ocean. I have my health and the love of my family. What more could anyone want?”

The Beautiful Lady learned the language very well and very quickly. She was very happy to live in Do. It was a much better place than Have-Not where people were poor and hungry and it was a much better place than Have where all the people were so materialistic.

But doing was not enough and soon the Beautiful Lady realized that her son was not happy. He would not do anything with her. He wanted to live in Have and became so unhappy that he began to speak the Don’t Have language.

“I don’t have my dad and I don’t have a surf board and I don’t have any fun anymore.’’

The Beautiful Lady was very upset. She wanted her son to speak Do and she tried everything. She signed him up to do swimming lessons and to do swimming and to do scouts. She made an appointment with a Do therapist who suggested a special Do school.

With her son in a special Do school, the Beautiful Lady soon became
weary of doing - even the Handsome Prince seemed boring and dull. One day she heard of another kingdom called Be which was a much better place to live than Do, which was a much better place to live than Have, which was a much better place to live than Have-Not. So she boarded a train to search for the kingdom of Be.

On the train, the Beautiful Lady sat next to a Wise Old Woman who asked, “Where are you going, Beautiful Lady?”

The Beautiful Lady told the Wise Old Woman about her past and her search for the Kingdom of Be.

“Well, now you are the lucky one,” said the Wise Old Woman, “because I am on my way to Be right now.”

“I can’t wait to find a kingdom that transcends the exigencies of Have-Not, the materialism of Have and the conation of Do!” exclaimed the Beautiful Lady in fluent Be language.

“My dear, my dear. One kingdom is not a much better place than the other. For me to be wise, I must live and speak in all the kingdoms.”

“Surely, in the kingdom of Be I will be expanding my horizons, maximizing my potential and be self actualized,” continued the Beautiful Lady, perfecting her command of the Be language with every breath.

“True,” said the Wise Old Woman, and I also want to be able to communicate with people of Do and Have and Have-Not who don’t understand the language of Be. It is not wise for me to be a Be elitist. Let me teach you a universal language that is understood in all kingdoms.”

The Wise Old Woman reached into her big black bag and took out a magic slate that looked like this.

<table>
<thead>
<tr>
<th>WANT</th>
<th>HAVE</th>
<th>DO</th>
<th>BE</th>
</tr>
</thead>
<tbody>
<tr>
<td>travel</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Wise Old Woman asked the Beautiful Lady to make a list of everything she wanted under the word want and watched the country side roll by as the beautiful lady worked on her list. When the task was finished the Wise Old Woman asked, “What did you learn?”

“I learned that it was easy to list the things I wanted that I don’t have, but harder to remember the things that I want that I have already and want to keep,” answered the Beautiful Lady.

The Wise Old Woman then instructed the Beautiful Lady to decide if each want was a have, do or be and check the appropriate column. The Beautiful Lady worked quickly through the task and then the Wise Old Woman asked, “What did you learn?”

“Most of my checks are under do because that is the language I have been using and my son’s would have been under have. No wonder we were having such a hard time communicating. We were not talking the same language.”

The Wise Old Woman continued “The last step is the key to universal understanding. Start with any check and ask two IF YOU WERE questions. Here, here we will try your first one together.
Guidelines for Contributors

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

b) Manuscripts must be typewritten double-spaced on 8 1/2-11 white paper. The name and address of each author should appear on the manuscript's last page. In manuscripts written by more than one author, the corresponding author should indicate the order in which coauthors' names should appear in The Journal if the manuscript is accepted.

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

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

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

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

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

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

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

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

i) All accepted manuscripts are subject to copy editing.

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