The William Glasser Institute
President & Founder
William Glasser, M.D.
Executive Director
Linda Harshman
22024 Lassen Street, #118
Chatsworth, California 91311
1-818-700-8000
FAX 818-700-0555
1-800-899-0688

The William Glasser Institute-Australia
President
Lois Anderson
P.O. Box 134
Burpengary
Queensland 4505
Australia

The William Glasser Institute-Ireland
Director
Brian Lennon
6 Red Island
Skerries
Republic of Ireland
011-849-9106
FAX 011-353-1-849-2461

The Reality Therapy Association in Japan
Contact Person
Masaki Kakitani
2205-23
Oiso-Machi
Kanagawa 255
Japan
0463-33-8819
FAX 0463-61-2434

The William Glasser Institute-New Zealand
President
Sharlene Petersen
WG1-NZ
PO Box 130 059
Christchurch, New Zealand
Ph 64-3-3264056
FAX 64-3-3264057

KART: Korea Association for Reality Therapy
Chairperson
Rose-Inza Kim
707-10, Hannam 2-dong
yongsan-gu 140-212
Seoul, Korea
011-82-2-790-9361 / 9362
FAX 011-82-2-790-9363
e-mail: KCC 8608@chollin.net

Canadian Association for Reality Therapy
President
Jean Suffield
530 Des Chenes
Beloel, Quebec
J3G 2H8
Canada
514-446-5671
FAX 514-446-5908

Association for Reality Therapy-Singapore
President
Kwee-Hiong Clare Ong, Ph.D.
Robinson Road Post Office
P.O. Box 1231
Singapore 902431
e-mail: ctrt2004@yahoo.com.sg

The Institute for Reality Therapy UK
Contact Person
Institute Executive Administrator -
Adrian Gorman
PO Box 227
Billingshurst
West Sussex, RH14 0DL
United Kingdom
Tel: +44(0)1403 700023
e-mail: info@realitytherapy.org.uk
skype: Adrian.Gorman

The Israeli Reality Therapy Association
Contact Person
Refuah Institute
Prof. Joshua Ritchie, MD., Dean
95 Derech Haohoresh
Jerusalem 97278, Israel
e-mail: office@refuah.net
972 2 5715112
Fax: 972 2 5879557
web: www.refuah.net

Croatian Association for Reality Therapy
President
Dubravka Stijacic
Kuslanova 59a
10.000 Zagreb
Croatia

Reality Therapy Association-Slovenia
President
Bojana Gobbo
Morova 29
6310 Izola
Slovenia
386 666 2706
FAX 386 6674 7045
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Larry Litwack</td>
<td>Editor’s Comments</td>
<td>3</td>
</tr>
<tr>
<td>Thomas E. Bratter</td>
<td>The Myth of ADHD and the Scandal of Ritalin: Helping John Dewey Students Succeed In a Medicine-Free College Preparatory and Therapeutic High School</td>
<td>4</td>
</tr>
<tr>
<td>Diane Gossen</td>
<td>Student Behavior</td>
<td>17</td>
</tr>
<tr>
<td>Zachary Rapport</td>
<td>Using Choice Theory to Assess the Needs of Persons Who Have a Disability and Sexual/Intimacy/Romantic Issues</td>
<td>22</td>
</tr>
<tr>
<td>Ernie Perkins</td>
<td>Bipolar and the Black Door</td>
<td>26</td>
</tr>
<tr>
<td>Robert E. Wubbolding</td>
<td>Frequently Asked Questions and Brief Answers: Part I</td>
<td>29</td>
</tr>
<tr>
<td>John Brickell</td>
<td>Some Ways to Stay in Love</td>
<td>31</td>
</tr>
<tr>
<td>Thomas S. Parish</td>
<td>Some Ways to Stay in Love</td>
<td>31</td>
</tr>
</tbody>
</table>
The International Journal of Reality Therapy is directed to concepts of internal control psychology, with particular emphasis on research, theory, development, or special descriptions of the successful application of internal control systems especially as exemplified in reality therapy and choice theory.

The International Journal of Reality Therapy is published semi-annually in Fall and Spring. ISSN: 1099-7717.

Material published in the Journal reflects the views of the authors, and does not necessarily represent the official position of, or endorsement by, the William Glasser Institute. The accuracy of material published in the Journal is the responsibility of the authors.

Subscriptions: $15.00 for one year or $28.00 for two years. (U.S. currency) International rates: $23.00 for one year or $40.00 for two years. Single copies, $8.00 per issue. Send payment order to the editor. Back issues Vol. 1-8, $3.00 per issue. Vol. 9-14, $4.00 per issue. Vol. 15-19, $5.00 per issue.

Permissions: Copyright held by the International 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.

www.journalofrealitytherapy.com
On July 24, 2007, modern psychology lost one of its most influential theoreticians and practitioners. Albert Ellis died in New York at the age of 93. In a 1982 survey, clinical psychologists ranked him ahead of Freud (second, behind Carl Rogers) when asked to name the figure who had exerted the greatest influence on their field. Developed in the 1950s, Ellis called his approach rational emotive behavior therapy. Ellis believed in short-term therapy that called upon individuals to focus on what was happening in their lives at the moment and to take action to change their behavior. He believed that people had the capacity to change themselves. According to the New York Times News Service, his methods, along with those of Aaron Beck, a psychiatrist who was working independently, provided the basis for what is known as cognitive behavior therapy. Although reality therapy falls into the same general category, Wubbolding and Brickell in this issue posit a significant difference between the work of Ellis and Beck and that of Glasser.

I had the pleasure of meeting Ellis on several occasions. I invited him to speak several times at Kent State University as part of a major speaker series. Most recently, he was one of the major speakers at the 1999 national conference on Internal Control Psychology I organized at Northeastern University in Boston. The other major speakers were William Glasser, William Powers, and Alfie Kohn. In his address, entitled Rational Emotive Behavior Therapy as an Internal Control Psychology, Ellis not only described explicitly REBT, but also analyzed differences between REBT and RT/CT.

He commented during his address that

"From this reviewing of the main points of William Glasser's Choice Theory and the corresponding theories of REBT you can see that the two systems of therapiizing overlap in many respects. If Glasser's treaty of psychological disturbing is an internal rather than an external control approach, so is REBT. Definitely".

Readers who wish to read Ellis's analysis of REBT and its differences and similarities with RT/CT may find it in the Fall 1999 issue of the International Journal of Reality Therapy, Vol 19(1). Readers who wish to obtain the three videotape set of the entire conference, which includes the addresses by Powers, Glasser, Ellis, and Kohn, as well as the interactive session of the speakers and audience interaction and questions may obtain it from Whiskeyman Productions, 1-888-403-6003.

In the September 2007 issue of Counseling Today, published by the American Counseling Association, several writers commented on Ellis and his work. His widow, Debbie Joffe Ellis, wrote:

Although Ellis remained strongly aligned to REBT right to the end of his life, he demonstrated the importance of being flexible and open to new developments in the field. For example, in some of his later writings, he acknowledged that he would use so-called "irrational" techniques with some clients if his bread-and-butter REBT techniques were ineffective. He also frequently wrote about the limitations of REBT and counseling in general. He read up on many of the latest cutting-edge developments in the field in a continual effort to find new and effective ways of helping clients change.

Ann Vernon, vice president of the Albert Ellis Institute Board of Trustees, wrote:

Years ago, at an REBT conference ... Al and a select group of invited colleagues participated in a think tank to address the topic of how REBT would “live on” after Al. As I recall, Al was adamant about the future of the theory being in rational emotive education and self-help and the importance of empowering clients of all ages to use the theory.

Brooke B. Collison, ACA president, 1987-88, commented:

He was, and is, a giant in our profession - regardless of how one thinks about the theoretical, personal, and practical aspects of what he promoted. I don't see any figure on the horizon who is likely to achieve such prominence.
The Myth of ADHD and the Scandal of Ritalin: Helping John Dewey Students Succeed in Medicine-Free College Preparatory and Therapeutic High School

Thomas Edward Bratter

The author is president of The John Dewey Academy in Great Barrington, Massachusetts.

INTRODUCTION

The John Dewey Academy is a drug and psychotropic medicine-free high school for talented, troubled, troublesome, and tortured teens. More than seventy percent who arrive addicted to psychotropic medicine are detoxified. Although we developed our theories independently, Breggin's rejection of medicine has radicalized The John Dewey Academy's decision to prohibit all psychotropic medicines.

Breggin's Anti-Medicine Mission

Breggin was among the first to attack and reject the trend to medicate when he pronounced taking pills under medical supervision communicates the anti-therapeutic message that "something is wrong with your brain, and you need a potent medication to function as 'normal.'" Breggin (1991) writes, "biopsychiatrists...reject psychological approaches and instead make extraordinary claims for their efficacy" (p. 150). Breggin (1991) lambasts neuro-psychiatric/psychological researchers and the profession when he writes the psychiatrist's "training and commitment is more likely devoted to 'medical diagnosis' and 'physical treatment.'" The therapist may view the person-in-distress "with...all the empathy and understanding of a pathologist staring through a microscope at germs, and then offer...a drug" (p. 11). Breggin condemns the damage done to children and adolescents whose only crime may be excessive enthusiasm, energy, and exuberance. Breggin excoriates researchers who dehumanize children; they forget it is "age appropriate" for adolescents to be distracted and, at times, disruptive. When viewed from this perspective, prescribing Ritalin can be "cruel and unusual punishment" for those who are irritating.

There is no reputable study in a reputable journal that substantiates the cause of psychological aberrations to be chemical imbalances in the brain. Breggin (2001 & 1998) refutes the psychopharmacology cause of ADHD in a book that should be required reading for those who diagnose children and adolescents. Breggin's research is comprehensive, citing more than six hundred publications which substantiate his anti-medication and anti-Ritalin position. Understandably, Breggin received a massive, hostile reaction motivated by economic concerns from the proponents of the "better living through chemistry" club who want to silence him, especially after Breggin & Cohen (1999).

Biological psychiatry assumes mental illness is caused by a chemical imbalance in the brain. Pharmacological solutions create the comforting illusion that deviance can be controlled easily and cheaply by pills. Breggin excoriates pharmacologic researchers and the FDA for uncritically accepting self-serving and flawed studies financed by pharmaceutical corporations for economic gain. Breggin (1991) debunked assertions and justifications for medication with observations that have gained increasing validity in the past fifteen years:

In...psychiatry, claims can become truth, hopes can become achievements, and propaganda is taken as science. Nowhere is this more obvious than in psychiatric pretensions concerning the genetics, biology, and physical treatment of depression and mania...biopsychiatric research is based too often on distortions, incomplete information, and sometimes outright fraud-at the expense of reason and science.

Breggin notes, a quid pro quo exists: If researchers want to receive funding, research needs to justify dispensing medication. Psychiatric journals, subsidized by advertising from Big Pharma, know that survival depends on this money.

Breggin (1999a) continues his noble crusade by exposing the scandal of treating ADD/ADHD with methylphenidate. Breggin (1999b) documents "hundreds of studies have tried to show Ritalin is effective...few have aimed at identifying adverse reactions. Investigator bias in favor of drugs...encourage the...tendency to look for good effects rather than bad ones" (p. 19). The 1990s will be remembered when "better living through chemistry" became the rallying call for most psychiatrists. Ritalin has played a prominent part in this campaign. Breggin (1998) reports that today's generation of children will assume that they: (1) "Have something wrong in their brains...(2) Have been given pills instead of love...and (3) [Have been given] medication...rather than...[psychological] and spiritual support. [These individuals will...]blame themselves for wanting more love and attention than they have been given" (p. 95).

Breggin (1991) laments that with the availability of amphetamines, there is "a new wave of stimulant addiction and abuse among American children who obtain the drug illegally. Shockingly, many ADHD/Ritalin advocates...deny the addictiveness of stimulants and show...little concern about making these drugs available to so many children, their families, and their friends" (pp. 66-67). Having documented the existence of cognitive toxicity
produced by prolonged use of Ritalin. Breggin (1998) asserts no researcher “has attempted to confirm whether or not the brains of children can recover from the malfunction inflicted by amphetamines” (p. 49).

Smith & Kronick (1979) warned that

One of the more disturbing problems facing modern society is the role drugs should possess in the control of deviant behavior...To treat social problems as medical ones may at first glance seem [to be]...enlightened; in fact, it may prove to be a step backward...If we are to avoid raising generations of adults dependent upon treatment drugs, we must proceed cautiously and thoughtfully, carefully airing our finds (p. 939).

Twenty years later, Breggin (1998) states the hypothesis of his scholarly book, when he writes

Every time we drug a child, we are choosing our convenience...over the child’s real needs. This is another reason never to use drugs. It is unethical [and, more importantly, unlawful] to drug a child for our...convenience. It is wrong to distort the function of a child’s brain with drugs in order to “improve” the child’s behavior...

The drugging of children for behavior control should raise profound spiritual, philosophical, and ethical questions...Society ignores these critical questions at great peril...to the well-being of...children (pp. 116-117).

Contemptuously, the FDA ignored these crucial concepts which Breggin discussed almost a decade ago. Why?

Sandberg’s (1986) assertion that “no one has...produced convincing evidence for the existence of a discrete hyperkinetic syndrome, let alone support for widespread use of diagnosis. However, there is general agreement that individual components of hyperkinetic behavior—particularly overactivity, inattentiveness, and distractibility—are common” remains valid (p. 68).

Recently, Glasser (2003) confirms Sandberg and has joined the Breggin Crusade when he proposes

There is hardly a shred of experimental evidence to buttress such trendy childhood ‘disease’ entities as minimal brain dysfunction, learning disorder, or attention deficit hyperactivity disorder. No underlying local organic malfunction, physiological malfunction, or chemical basis has ever been clearly demonstrated for these syndromes and no well-controlled clinical studies have ever unequivocally supported them either. **This has not stopped the escalating prescription of such stimulants as Ritalin and Dexedrine despite a host of negative side effects, including tics, spasms, growth suppression, and chronically elevated heart rates and high blood pressure** (p. 212).

Breggin no longer can be dismissed as quixotic in his titanic struggle to educate the public; many organizations and research scientists have joined his crusade.

Valenstein (1998) argues “the claims about the relationship of brain chemistry to psychological problems and personality and behavioral traits are...most likely wrong. The claim...drugs correct a biochemical imbalance that is the root cause of most psychological problems...rests on a...shaky scientific foundation. These ideas are...an unproven hypothesis” (p. 3).

The Myth of ADHD

Walker (1998), a neurologist and psychiatrist, in the introduction, asks two provocative questions, “is hyperactivity a disease? Does Ritalin successfully treat it?” His response is “no and no.”

Rather than concluding his book, Walker (1998) begins “hyperactivity is not a disease. It’s a hoax perpetrated by doctors who have no idea what’s really wrong with these children” (p. 6). (Italics in the original)

The diagnosis of aberrant behavior rarely is objective since the assessment relies on the subjective assessment by mental health professionals who often do not interview the student, but rely on self-serving reports from teachers who justify their dull teaching performance by claiming the youth suffers from ADHD, rather than being consumed by boredom. Taylor (1986) suggests that there is consensus that “hyperactivity is disorganized and chaotic. Its cardinal feature is the combination of restlessness and inattention to a degree inappropriate to the child’s age” (p. 6). The problem is not with identifying the symptoms, but rather determining the cause(s) which can be immaturity and giftedness, not a metabolic imbalance.

Therapists retain vested interests to expand patient caseloads inasmuch as they receive reimbursement from insurance companies for treatment regarding this mythical disorder. Bratter (2002) contends that psychiatric diagnoses are not helpful for gifted, acting-out adolescents who display dangerous, destructive, and dysfunctional behavior because these labels inadvertently provide excuses for their behavior.

Complicating rendering an accurate diagnosis is the existence of nineteen “I’s” which describes not only “immature behavior” but also brilliance: Impulsive, impetuous, inquisitive, inattentive, inconsiderate, indolent, inept, ineffective, inferior, insolent, inappropriate, intemperate, insulting, irrational, ignorant, irresponsible, irritating, impertinent, intimidating, and insidious. All these symptoms describe superior intelligence, so there is legitimate confusion. Being gifted is an asset, but receiving the ADHD label is, at best, a neutral; but, more than likely, used as a pejorative.

Sadly, medication has become the primary treatment modality. Wender (1971) proposes a biochemical treatment for minimal brain dysfunction in children. During the 1970s, learning-based, cognitive, and existential therapeutic approaches were in embryonic stages, so these approaches were not effective helping children and adolescents control their impulsivity. Wender (1971) observes “some MBD children are...not hyperactive but...gave the impression...because of their constant shifting of activities and lack of goal direction...[They] are no more active than
other children on the playground but cannot curtail their activity in the classroom” (p. 13). Wender suggests hyperactivity is caused by immature and negative attitudes, though other factors such as a chaotic home environment, and the dislike of learning need to be identified. Wender (1971) posits “negativism and stubbornness ...may be looked upon as a reaction formation to an inadequate sense of self-control” (p. 145). Contrary to claims by pharmaceutical corporations which have significant financial vested interests, there is no quick medical cure for the “I” syndrome. If there were a medical solution, after ingestion of a “magic” pill, an observable behavior and attitude improvement would occur immediately. This reality infuriates the potent pharmaceutical industry which makes billions of dollars duping the public ADHD can be cured medically. No pill can create self-respect and honor or cure noxious narcissism, dishonesty, and anti-social attitudes. When viewed from this perspective, medication is ineffective because it does not cure a psychological problem. Until students are convinced that education is relevant and meaningful, they will remain disruptive and will neither concentrate or study.

Obscuring treatment, many adolescents manipulate the therapist to label them as having an “emotional disturbance” which justifies medication that is abused and/or sold. Inexplicably, medical ethics are ignored. Is it medically feasible to prescribe medication for an adolescent who has a psychoactive substance problem? During the twenty-first century, most Departments of Psychiatry emphasize biochemical cures, not teaching interns how to become sophisticated clinicians to ask realistic questions before rendering an assessment. Few are trained to recognize deceit because most treatment agents assume that what they are told is truthful and realistic.

Clinicians, furthermore, no longer take the time nor are trained how to ask four realistic questions: (1) “Does distraction occur because there is insufficient intellectual stimulation?” (2) “Are there realistic explanations for behavior and attitude patterns?” (3) “Do multiple tasks challenge or frustrate?” and (4) “Can the student concentrate for more than a half hour without being distracted in any activity?” Either the youth has ADHD or not! Clinicians rarely ask questions about the student’s competencies and interests. If psychotherapists invested the time and asked the right questions, they would recognize that there are realistic explanations explaining student discontent in the classroom. Forced to teach from a sterile and obsolete curriculum, teachers, who are boring, bored, and “burned out,” escape blame. Overwhelmed by the child’s psychological problems, parents are excused for not helping children learn self-control. Students complain that they neither respect nor trust teachers, that the curriculum is obsolete which does not help them gain a proactive concept of self or a positive identity.

When using the ADHD label, neurological psychia-

trists attribute concentration problems to a disorder which can be treated medically. In so doing, these mental health professionals relieve the student from taking control. When discussing a multi-disciplinary assessment for ADHD, Goldstein & Goldstein (1990) question whether medication is needed since they believe ADHD must be “understood from a developmental perspective. Problems with attention span, over-arousal, hyperactivity, impulsivity and difficulty with gratification have a varied impact on children of different ages...any two children randomly compared within the [ADHD] group may be experiencing very different problems” (p. 367).

Once a child receives the Attention-Deficit/Hyperactivity label, however, no one is held accountable. Rather than blaming the sterility of the curriculum, the incompetence of teachers, and/or a biochemical imbalance in students, before the trend to medicate became epidemic, Glasser (1972) explains “a child with a failure identity...who lacks a concept of himself as a loved and worthwhile individual will not work for any long-term goals” (pp. 165, 162). While the trend is to medicate disruptive students, Glasser (2000) rejects the contention that “clients are victims of mental illness caused by a neurochemical imbalance over which they have no control...The brain is not defective...[Medication] such as Prozac, may make clients feel better but cannot teach them how to connect or reconnect with people” (p. 24). [italics in the original]

The Anti-Ritalin Literature: A Brief and Biased Review

After more than a half century of abuse, Rollins et al. (2006) document “significant functional impairments methylphenidate (MPH) for pre school aged children which has not been approved by the U.S. Food and Drug Administration for use in children younger than age 6.”

This team of sixteen provides more shocking data when they write about children but which is relevant to adolescents:

Previous MPH preschool trials provide mixed results, with two studies failing to detect differences between placebo and active (Barkley, 1988; Cohen, 1981) and one reporting higher rates of adverse events compared with older children (Handen et al., 1999). Methodological differences in these studies preclude data pooling and overall assessment of MPH safety and efficacy (Greenhill, 1998). One fundamental problem is the validity of the preschool ADHD diagnosis... Furthermore, psychometric data on the validity of diagnostic instruments for preschoolers have not been published and there are no standard research diagnostic methods (p. 1275).

Rollins and his colleagues describe the ineptitude of the FDA which has adopted a benign neglect policy when they decry “the lack of standardized diagnostic approaches or age-related drug safety and efficacy information has not deterred physicians from prescribing MPH for preschoolers (IMS American, 1995; Kaufman et al., 1996; Rappley et al.
bly sorrowful history ignoring studies which document the adverse effects of Ritalin. The US House of Representative (1970) issued a document revealing its concerns that:

- Safety and long-term outcomes for the treatment of children with amphetamines has not been adequately researched.
- Normal children are being drugged.
- Treatment suppresses symptoms, but does not address the etiology of ADHD.
- Bradley (1937) verbalized concern that long-term use of amphetamines could produce addiction.
- Parents are coerced to medicate their children by direct pressure or through transmission of erroneous data that minimizes risk.

A quarter of a century later, after reviewing 9,000 articles and 300 reviews regarding Ritalin at a symposium conducted by the US Department of Education, Swanson (1993), whose Attention Deficit Disorder Center is funded by the US Department of Education, concludes that:

- Long term beneficial effects have not been verified by research.
- Short-term effects of stimulants should not be considered a permanent solution to chronic ADD symptoms.
- Stimulant medication may improve learning in some cases but impair learning in others.
- In practice, prescribed doses of stimulants may be too high for optimal effects on learning, and the length of action of most stimulants is viewed as too short to affect academic achievement (p. 44).

Why do these Congressional concerns raised by the US House of Representatives almost four decades ago remain unanswered? While beyond the purview of this essay, the only logical conclusion is that the drug industry obstructed vital research. Whitaker (2002) documents that drug companies have purchased positive brain research done by respected researchers to reinforce the efficacy of medication. Outrageously, the FDA continues to ignore Congressional concerns and Swanson's clinical findings. Since funding his center, it is assumed that the US government respects and trusts Swanson. Breggin (2001) documents 100 studies done by respected medical researchers and reported in trusted professional publications that support the ominous, but minimized, conclusion in the 1996 FDA warning that “Ritalin should not be used in children under six years old, since safety and efficacy...have not been established...” This concern was proposed by the International Narcotics Control Board (1999) which protested the escalating abuse of psycho stimulant drugs. “In the United States, performance enhancing drugs are... given to children to boost school performance or to help them conform to the demands of school life” (p. 1). The INCB criticized, furthermore, the “aggressive advertising by certain pharmaceutical firms.” The National Institute of Health concludes research is inconclusive about whether stimulant use increases the potential for abuse; it questions if there is a scientific basis.
for the diagnosis of ADHD. The NIH (1998) warns that psycho stimulants produce “little improvement in academic achievement or social skills”; even more alarmingly, there are “no data on the treatment of ADHD, Inattentive type” (p. 21). [Italics added for emphasis] Subsequent to the NIH findings, Breggin (1999a) has documented the adverse drug reactions of “methylphenidate (Ritalin), dextroamphetamine (Dexedrine Adderall) and methylphenetamine (Desoxyn, Gradimet)” (p.214). Breggin (1999b), in his two-part survey of psycho stimulants in the treatment of children and adolescents diagnosed with ADHD, warns about adverse reactions to stimulant medication which includes “persistent brain dysfunction and potentially irreversible CNS damage... Enough is...known about the...negative impact of stimulants to stop prescribing them for ADHD or the control of any symptoms or behaviors in children” (p. 233). [italics added for emphasis] Brown (2000) writes “stimulant treatment for children with ADD-HD has not been without controversy...However, while medication decreases inappropriate behavior, it does not improve appropriate behavior without additional intervention directed to building requisite academic and social behavior” (p. 199). Brown continues “the side effects of stimulant medication have also been of concern...Stimulant medication has been associated with the development of tics, and these medications should be used cautiously” (p. 200).

In 2003, 10,000,000 children and adolescents in the United States took Ritalin. Mathews & Abboud (2005), reporters for The Wall Street Journal, report that “The Food and Drug Administration said it plans to add information about possible [adverse] psychiatric side effects...for Concerta and Ritalin...and will investigate other ADHD medicines for similar problems (p. D1). Isn’t this policy to inform scandalously overdue? Since there is an increasing number of reports which assert Ritalin is dangerous, it needs to be asked why did the FDA take an additional year to issue a tentative conclusion which Mathews & Hensley (2006) report “in a surprise move,...a FDA advisory committee voted [8-7 with one abstention] to recommend that stimulant drugs prescribed for attention-deficit hyperactivity disorder [need a warning that these medications are known to increase] blood pressure and heart rate, which can potentially result in increased risk of heart attack, stroke, or sudden death” (p. A3). The studies which confirm the causal relationship between psycho stimulants and increased risk for cardiac problems are disregarded.

Zito et al. (2000) document that at least 1.5% of children between the ages of two and four are medicated with stimulants, anti-depressants and anti-psychotic drugs, despite the paucity of controlled scientific trials confirming safety and long-term effects with preschool children.

The treatment of ADHD is lucrative for manufacturers and psychotherapists who treat. The process of approving medication appears to have been corrupted by medical corporations which compensate scientists and invest substantial payments to universities for “overhead” and improving facilities. Why are not these “donations” viewed to be bribes? Kauffman & Julien (2000b) assert “the FDA...relies heavily on the same academic researchers who have taken money from the industry, giving the agency a conflict of interest” (p. A8). These reporters reveal Congress inadvertently contributes to the conspiracy against the consumer. Criticized for slowness to approve new medicines, the FDA acquiesced to this pressure in the 1980's. “By the end of the decade, Congress...[had transformed the FDA from an] adversarial agency into a kinder, gentler bureaucracy [which treated] pharmaceutical companies...as ‘stakeholders’ “ (p. A8). Strangely, public outrage has been muted despite Kauffman & Julien's (2000a)...warning “drug companies...make it very clear what the results better be if you [the researcher] want any more money from them” (p. A10). Kauffman & Julien (2000a) quote Angell, the editor of The New England Journal of Medicine, as saying “imagine a judge who has before him a case involving two companies suing each other—and he owns one of the companies. And he says, ‘Not to worry, I'm a judge and I learned how to evaluate things in a dispassionate way.’ He'd be laughed out of court” (p. A1). The New England Journal of Medicine which has seen its revenues increased from $386,000 in 1979 to more than $20,000,000 panders to the pharmaceutical industry. Before Drazen became the editor of this journal, he received major research grants from nine major pharmaceutical corporations which should have disqualified him from this position. Altman (2000) reports that Drazen defends “the need for doctors to work closely...with the drug industry. ...[Defending] his ties to the drug industry, Dr. Drazen said 'I have what it takes, and you are just going to have to wait and see whether you believe it. There is no way to judge it up front'” (p. A16). Perhaps not, but such assurance, at best, is premature. It seems likely that the number of scientific studies which refute the efficacy of medication will decrease, especially if any criticize the nine corporations which have compensated the new editor.

Frequently, the FDA has been forced to withdraw many medications after approval because subsequently they were proved to be deleterious and toxic. If Breggin's assertions are correct, it is scandalous Congress has failed to investigate whether a pharmaceutical conspiracy exists when the FDA has minimized the dangers of Ritalin. There can be no justification for the federal policy of pandering to corporations. Connor (2004) protests, “How can we practice in the best interests of child and adolescent patients if negative trial data are withheld from the scientific journals and only positive studies are published?” (p. 127).

Cohen (2000), president of Children and Adults with Attention Deficit/Hyperactivity Disorder, claims that “there is a high level of confidence that stimulant medications are effective [to provide short-term improvement of symptoms and produce minimal short-term side effects]."
But he contradicts himself when asserting “there is insufficient research to assess the long-term benefits or side effects of medication use” (p. 5). [italics added for emphasis] If the truth be known, Cohen has no relevant training or experience to justify his comments. Cohen ignores Swanson’s (1993) comprehensive review, which never has been refuted, that “teachers and parents should not expect...improved reading or athletic skills, positive social skills, or learning of new concepts...and they] should not expect long-term improvement in academic achievement or reduced antisocial behavior (p. 46) with Ritalin. In 1994, CHADD, which is financed by Novartis and the pharmaceutical cartel, and has no scientific staff, petitioned the Drug Enforcement Agency to reduce Ritalin from Substance II to III because it “is not a dangerous and addictive substance, and...is a beneficial and relatively benign medication which assists millions of children daily.” Breggin’s (1998) comment is worth noting, “this...conflicts with three decades of widespread Ritalin abuse and addiction” (p. 239). In 1993, the DEA concluded “methylphenidate is a central nervous system stimulant with a high potential for abuse and diversion for illegal purposes.”

All physicians take the Hippocratic Oath to “do no harm” to patients but ignore this when prescribing toxic medication never proven effective nor safe for children and adolescents. If the spate of studies are accurate, then physicians engage in a criminal conspiracy which hurts, not helps, those whom they treat.

The Rejection of Psycho Stimulant Medication at The John Dewey Academy

The John Dewey Academy rejects the unproven assumption bio-mythology of ADHD that claims persons are biochemically defective. Winsberg & Camp’s (1981) caveat remains valid two decades post hoc “neither popularity, nor the most fervent desire for a ‘better’ cure can alter...there is no scientific data to support the efficacy claims of any of these modish interventions” (p. 144). Criticizing the American tendency to over-prescribe while confirming Winsberg & Camp’s finding, Sandberg (1986) contends the scientific inadequacy of any diagnosis for the hyperkinetic impulse disorder, first described by Laufer, Denhoff, & Solomons (1957) “has not been disproved by rigorous enquiry...[nor] has it met the criterion of predictive validity in spite of a wealth of research. Regardless... it remains a very popular diagnosis that has increased markedly over the last 20 years in the United States” (p. 65). Winsberg & Camp (1981) urge caution: “Until medication is proven to be effective and safe, there should be a moratorium on prescriptions of amphetamines” (p. 144). Taylor (1986) describes adverse reactions caused by amphetamines such as “sleeplessness, headache and abdominal pain...Dysphoria has already been mentioned as a possible hazard...Increases in heart rate and blood pressure can occur...” (pp. 202, 203). Duncan, Miller & Sparks (2000) warn “our culture’s...faith in these psychiatric medications rests not on science, but on brilliant marketing by a profit-driven industry. Outcome research...funded by companies that manufacture medication—has not found these drugs to be any better than therapy, and only marginally better than placebos” (p. 27).

Prescribing medication creates psychological problems. Mender (1994) provides perspective when asserting that the treatment of neuro-psychiatric problems with medication “foster an atmosphere in which the doctor takes control instead of helping the patient control himself...[The] surrender of...autonomy by patients can have profoundly negative consequences” (p. 29). Dispensing medication relieves the adolescent from accepting accountability for causing pain and shame to one’s self, family, and friends. The presenting problem is a negative attitude, not a metabolic disorder or chemical imbalance. No estimations exist how many youth have been damaged by this reductionist thinking.

Psychological and Educational Profile of Dewey Students

When admitted to The John Dewey Academy, a third had been hospitalized or attended drug and alcohol treatment programs for one month, more than three-quarters had been treated by mental health specialists, and approximately half arrived addicted to potent psychotropics from which they need to be detoxified. Bratter, Kaufman, Lubbock, & Sinzheimer (2006) have listed the myriad of DSM-IV diagnoses given by inpatient programs and community-based psychotherapists to those who attend The John Dewey Academy.

Dewey youth are driven by intense emotions they can neither understand nor identify. They create crises and chaos to escape feelings of depression and loneliness. Creating constant crises with self-destructive acts, they need a structured, safe, and supportive residential environment to help them control and curtail their behavior.

When entering, the majority of Dewey students have significant educational problems. More than half have three “C’s” or lower and function at least one grade level below their chronological age. Though never visiting the Academy, Santa (2006) describes Dewey students as possessing “a myriad of diagnoses... Many are classified as dyslexic, as learning disabled, or diagnosed with attention deficit disorders...They have been subject to stimulants and anti-depressants, mood stabilizers, school IEPs, special education classes, tutors, and therapy. Despite these interventions, these students continue not to perform in school” (p. 32).

When adolescents can be helped to help themselves, they experience internal gratification and external reinforcement from others which motivates them to perform “good and decent” acts for the right reasons. One of the most neglected aspects of therapy is the power of positive and negative expectations. Therapists and teachers, who stress choice, negate the anti-therapeutic concepts of
ADHD, predestination, mental illness and/or the pre/un subconscious etiology. Fromm (1964) wrote the person can choose “to regress or to move forward...The problem of freedom versus determinism...one of conflict of inclinations and their respective intensities” (pp. 115-135). Fromm believed individuals are capable of rational thought and self-determination. The construct of self-respect becomes an interplay among the moral distinctions of what the person is, who the individual ought to be, and which specific moral acts are performed. Bratter, Bratter, Bratter (1995) asserted the primary treatment goal is to create the conditions to facilitate (re)gaining self-respect, not pursuing pleasure. Glasser (1965, & 1960) opines the concepts of choice and the capacity to change are explicit in most systems of psychotherapy. Helping the adolescent to take control can best be achieved at The John Dewey Academy because no one will excise mediocrity or failure by commiserating how “unlucky” or unjust life has been. Glasser (1998) explains how past acts influence our present identity. “But revisiting this painful past can contribute little...We are not doomed to repeat our past unless we choose to do so...We can correct...unsatisfying relationships” (pp. 334-335). Agreeing with Glasser, Breggin (1991) proposes “every individual must choose whether or not to overcome any hardship...Human beings retain a measure of free will as long as they remain conscious. Indeed, without the exercise of that flickering will, there is no hope for people; that is the helper’s role to encourage every hint of self-determination” (p. 45). The staff and faculty at The John Dewey Academy demand all students become active rather than remaining passive and dependent. Since Dewey students have become active learners, no potent psychotropic mood or mind altering medication is required. The John Dewey Academy has proven that Medicine-free is a realistic goal.

Conclusion: The Validation of a Medicine-Free Approach

The John Dewey Academy provides a positive educational and emotional experience that provides (1) an evocative approach to problem-solving maximizing constructive and creative options; (2) the opportunity to (re)gain self-respect; (3) a resilience to endure inevitable painful fears, failure, and rejection; (4) help to formulate realistic intermediate to long-term educational, personal, and professional goals and the strength to achieve them; (5) an optimistic outlook about one’s self and one’s capacity to succeed at tasks considered important; (6) a desire to change rather than remain complacent; (7) an ability to take control of one’s life by making conscious, responsible choices; (8) the courage to shatter restricting boundaries of innocence and ignorance which characterize immature thinking; and (9) a desire to seek truth.

Prior to attending The John Dewey Academy, most students had mediocre grades and inconsistent academic records. Many functioned more than one grade level below their chronological age, so they needed intensive, individualized instruction to remedy educational deficits. If The John Dewey Academy excluded those who had poor academic performances and inferior standardized test scores, this record would be more impressive. The two Dewey admissions criteria are (1) having a positive attitude about being honest and working diligently and (2) agreeing to become a contributing member to the community in this voluntary educational-treatment program. Objectively, The John Dewey Academy is not elite. Seventy-five percent of those who have a mandatory interview are admitted. Elite prep schools, in contrast, demand tangible proof that the applicant not only has superior academic potential but also has excelled educationally. Enrollment is limited to those who are in the top five percent. Like all elite prep schools, The John Dewey Academy wants to be judged by the reputations of the colleges which admit its graduates and, more important, by their performances at those institutions of higher learning. In its twenty-three year history, all John Dewey (100%) graduates attend competitive and prestigious colleges. Seventy percent attend the most selective one hundred institutions of higher learning. More than a third have made the Dean’s List at Bard, Bates, Carleton, Columbia (College & University), & Connecticut College; Cornell, George Washington, & Georgetown Universities: Haverford, Hobart, Holy Cross, Mount Holyoke, & Muhlenberg Colleges; NYU (College of Arts and Sciences & Tisch School for the Performing Arts), Oberlin College, Ohio Wesleyan University, RPI, Rochester University, Spelman & Skidmore Colleges, Syracuse University (Visual and Performing Arts & Newhouse School of Communications), Trinity College, Tufts University, Union College, the Universities of Chicago, Hartford, & Massachusetts; Vassar, Wellesley, & Williams Colleges.

Two members of the JDA class of 2002 attend Harvard and NYU Law Schools. Two members of the class of 2003 attend Albany and Pace Law Schools. Another 2003 graduate has enrolled in the clinical psychology Ph.D. program at Yeshiva University.

In the 2000s, less than ten percent of Dewey graduates have discontinued higher education and become recidivists. Equally significant, less than ten percent of this school’s alumni resume psychotherapy or take psychotropic medication. None has taken any psycho stimulant to assuage academic problems.

Bratter, Bratter, Coiner, & Steiner (2006) contend “critics ...cannot explain how and why adolescents, who were extreme casualties, improve” in a...treatment milieu with escalating expectations for “intellectual excellence and moral integrity [that] can be achieved without compromising one for the other” (p. 14). It needs to be stressed there is no other special purpose school or residential treatment program that rivals the performances of graduates, which confirms that The John Dewey Academy disproves the need for medication.

Gifted and unconvincing adolescents need to be held accountable for behavior, not given excuses, no matter...
how logical and legitimate, for mediocre performances. Unless bright students are expected to learn, to become responsible and productive, they will settle for mediocrity.

REFERENCES


International Journal of Reality Therapy • Fall 2007 • Vol.XXVII, number 1 • 11


Cohen, M. (2000a) “AD/HD, CDC, AAP, OHI and XYZ: Some answers ...even more questions,” Attention: The Magazine for Families and Adults with Attention-Deficit/Hyperactivity Disorder. 6:3: 5-6.


I extend appreciation to William Glasser, my mentor for forty years, and Peter Breggin, whose research has validated my anti-psychotropic medicine and Ritalin beliefs.

The author may be contacted at The John Dewey Academy, 389 Main Street, Great Barrington, MA. Or through info@jda.org
Research Review

Larry Litwack

The author is editor of the International Journal of Reality Therapy. He is emeritus professor of counseling psychology at Northeastern University in Boston.

One of the major criticisms over the years of reality therapy and choice theory has been the dearth of hard research data relating to the efficacy of reality therapy as a therapeutic approach in the mental health field and as an educational philosophy/approach in education. This has become more important in today's climate that requires hard research data to support funding requests from state and federal funding agencies.

Although the William Glasser Institute itself has encouraged research studies, it has not produced data other than anecdotal reports. However, a significant body of knowledge has evolved from a number of research studies done by others over the past 37 years. This is particularly evident through doctoral dissertations done since 1970.

There have been several reports of these studies which have appeared in this Journal over the years. Readers are referred to the work of Banmen (1982), Franklin (1987, 1993), Murphy (1997), Barry (1996), and Baca (1997).

Using the resources of Proquest, which has replaced what was formerly known as Dissertation Abstracts, the following is a listing of dissertations done over the years which have not been previously reported in the Journal.


Abbass, B.A. (1998) Reality therapy in the classroom. Saint Mary's University (Canada)


REFERENCES


The author may be reached at llitwack@aol.com
ABSTRACT

A reprint of an article originally published in Fall 2002, this provides an overview of a different perspective on self-discipline that has been utilized by a number of educators world-wide.

Do you think you have a difficult job? Is it because you are trying to control what you cannot - students? It is not a road to happiness if you are trying to make them do things you want. It is a road to exhaustion, discouragement, anxiety and danger. The familiar warning signs are conflict, health problems and the expressed desire for a job change or early retirement. If you recognize these markers, ask yourself:

• Do I want to be responsible for my students' behavior or do I want them to be responsible for their own behavior?
• Do I think it's my job to make them learn or do I think I am responsible to provide them with a safe information rich environment so they can learn for themselves?

Welcome to Restitution Self-Discipline, if you want students to be responsible for their own behavior and learning. It is about restoring and strengthening young adolescents by obtaining a balance between providing them with enough structure and educating them to understand and manage their own behavior in ways that help rather than hurt others.

For a long time, when our society talked about discipline we meant consequences, both positive (rewards) and negative (removal of privileges). However, consequences are external discipline or sanctions. They are something we do to others or have done to us. Consequences are about learning to please others or to stay out of their way, and they are both positive and negative “pay backs”.

Restitution as we use the word is not a payback. It is about self-discipline. The original meaning of the word discipline derives from the Greek word disciplina that means learning. Self-discipline is learning about oneself, learning to be a moral person and learning to repair mistakes to heal hurt for oneself and for others. A real restitution embodies: 1) creativity and it strengthens the person who offers to make it, and it helps the group, and 2) identifying the needs of both the victim and the offender and the solution is one that helps both parties. Mistakes are shifted into learning conditions.

The Least Coercive Road

Teaching the ideas of Restitution Self-Discipline in schools is based on what we call the Least Coercive Road, a process to help create conditions for students to be honest with themselves and to evaluate the impact of their actions on others. It is based on teaching William Glasser's theory that one's actions are directly linked to having a basic need met. We all have the same basic needs of belonging, personal power, freedom and creativity/fun. The Least Coercive Road's four parts and eight tools give educators common language to help students move toward self-discipline.

THE LEAST COERCIVE ROAD OVERVIEW

I. Opening up the Territory (Freedom)
   1. Does it really matter?
   2. Yes, if...

II. Social Contract (Belonging)
  3. Person I want to be
  4. Class beliefs

III. Limits (Personal Power)
  5. My Job Your Job
  6. Bottom Lines

IV. Restitution (Creativity & Fun)
  7. Self-Restitution
  8. Restitution Triangle

Restitution Self-discipline Definition

1. To create conditions.
2. To fix the mistake, and
3. To return to the group strengthened.
PART I. OPEN UP THE TERRITORY

This part is named “Open Up The Territory” and it is based on the basic need for freedom. It has to do with giving choices which gains you, the teacher, “freedom from” responsibility, while at the same time providing students “freedom to” do the task in their own way. There are two restitution practices or tools a teacher can use to “Open Up the Territory”.

**Tool 1. Does It Really Matter?**

What teacher hasn’t thought, “Does it really matter?” Some people call this “choosing your battles”. Another way to phrase it would be, “Is this a hill you want to die on.” Restitution advocates asking themselves one of these questions before going toe to toe with a student on a discipline issue. For example, Does it really matter if his feet are up or if her shirt has a slogan on it? Many incidents can be bypassed if the answer to this question is “No, it doesn’t really matter.” However, it does matter when it is tied to safety or to a core belief. Then you can’t say, “It’s okay.”

To determine what really matters to you, as an educator, ask yourself the following questions:

1. What are my family beliefs?
2. What do I believe about learning?
3. What does it say about me if I do it?
4. What will help me be loving, powerful, free and playful with my class?
5. Who am I becoming in the life of this student?
6. What do I want for them long after they’ve left my class?

As one teacher said,

“I took time to decide what really mattered during work time. For example, sharpening pencils during work time drives me crazy, because it is so noisy. To account for this, students can sharpen pencils in the morning or during snack time. Otherwise, they need to borrow a pencil from me. I simply have a “sharp pencils” container on my desk for students.

Also, I don’t believe students have to be silent when working unless they are taking a test. The important part for me is that the work is getting done. As long as the class is on task, they can talk with a neighbor or some music may be played.

Taking the time to look at what was important helped because I knew where I stood on the behavior before it occurred and I expressed my expectations to students at the beginning of the year.”

**Tool 2. Yes, If**

The second tool in “Open Up The Territory” is “Yes, If”. Say, “Yes” as often as possible. If you can’t say “Yes”, say “Yes, if...”. The “if” is always followed by some version of what the teacher or the school needs.

Example:

(Student) “Can I get out of homework tonight, we have an out of town game?” (Teacher) “Yes, if you can show me you know the work.”

“Yes, if you can do double tomorrow.”

“Yes, if you can work faster and smarter in class and get it done.”

“Yes, when you can come up with a way to learn without having homework. Create a solution.”

PART II. THE SOCIAL CONTRACT

Establishing the Social Contract with the school and personalized by the various teams is rooted in our need for belonging. It is our nature to want to be with people. To do so, we need to make social agreements by first thinking about the kind of person one wants to be and establishing class beliefs. Specialists, counselors, assistants and administrators should be involved in developing the social contract of at least one team in the school so they feel part of the process.

**Tool 3. Person I Want To Be**

Students are asked to reflect on the kind of person they want to be. First, they draw or write about the kind of friend, student, or team member they want to be. Secondly, they think about the kind of family member (e.g. sister, daughter, grandchild, niece) they want to be. From this information, students create self-portraits based on the kind of person they would like to be. Students are building themselves up from inside out.

**Tool 4. Class Beliefs**

Students are encouraged to share their self-portraits and talk about their family beliefs with their parents the night before the team beliefs building exercise is done. This is very important to do because the parents are our partners. It also helps to set the stage for discussion on how the team’s classes be set up so all people, including the teacher, get what they need. A common picture of the ideal learning environment and the beliefs behind this picture is created so everyone can stand shoulder to shoulder looking at it, each individual managing oneself towards the common. This is how one school and team did it to identify the kind of learning environment that is most desirable:

As a school, we brainstormed what we want our middle school to look like, feel like, and sound like. The students, parents, and the school staff completed this activity. The information was compiled down into three short lists and posted throughout our building. My team posted the list as a large Y-chart on the back wall in all classrooms used by the team.
PART III. LIMITS

The third part of the Least Coercive Road arises out of the Social Contract. It is called “Limits” and is rooted in the power need. Each of us wants to feel competent and we also want to know there is some predictability or control in our life.

Tool 5. Roles: My Job/Your Job

“My Job/Your Job” is where the teacher and students collectively define each other’s jobs. One middle school teacher comments:

At the beginning of the year my team worked with our students during flex and reading time to create a list of teacher jobs (my jobs) and student jobs (your jobs). Grouping specific ideas into more general statements condensed the list. The new list was used for a student activity and as a visual reminder when students approached us for such things as extra time, forgotten supplies, or lost assignments. Parents see these lists during our Open House, and we discuss with them what this means for their student. This has worked very successfully for us.”

It is also important to list what my job and your job is not. This exposes the gray areas and identifies potential conflict that could occur because individuals are not clear about what is expected of them. For example, a teacher may write, “my job is not to take or give abuse” or “my job is not to make you learn”.

Tool 6. Rules: Bottom Lines

The second tool in this section is bottom lines. Some people think of punishment when they hear the word bottom line, but this is not our meaning. The purpose of a bottom line is to preserve the Social Contract. All staff must be involved in creating the “Bottom Lines” which includes having a common picture of what constitutes a bottom line and what consistent follow through entails.

Individuals cannot be permitted to override what the school/team decides. However, individual questions are welcomed and the voiced dissent can help the school/team define boundaries and purpose. The bottom line is used when an individual is deemed to interfere with a belief the group holds dear. If an individual doesn’t want to look at himself, reflect on values, or make amends, school personnel have to fall back to the monitor position of external discipline which involves consequences. For example, consequences are needed to protect people from being injured. Usually, this would include some form of removal such as the individual going to a see a counselor or an administrator, or he must leave the classroom, playground, gym, lunchroom or the school depending on the threat of injury to others.

“Bottom lines” are used sparingly and only when the team has been unable to create conditions for individuals to think and manage themselves in a responsible, non-hurting way. A bottom line is a last resort. It is also important to realize this is monitoring. This alone will not help us to get to Restitution - we need beliefs and self-evaluation discussions.

Part IV. RESTITUTION

This fourth module is rooted in the basic need of creativity/fun. People who learn Restitution continue to do it because it is a pleasurable experience inventing win-win solutions with students who have violated an aspect of the Social Contract (e.g. school belief, didn’t do their job).

A restitution evolves us all as human beings. There is the potential for learning and healing for both parties. The following is an example of a restorative restitution that evolved from my work with school staff as a multi-racial middle school in Winnipeg. An Ukrainian student said to an English as a Second Language student from Pakistan, “You f...go back to your own country.”

This was first of all a bottom line situation so the student was suspended for a day. The staff asked me if they should suggest the student study Pakistan as a restitution? I said they could do that and he might agree but would he be doing it to avoid your wrath, would he be doing it to please his parents or would he be doing it to become a less racist person? Only the third motivation would be strengthening for him. They had their qualms. I asked, “What ethnic background is this boy?” They said, “Ukrainian.” I said my guess was that there was someone in his family, a grandparent, uncle or aunt who didn’t speak English when they came to Winnipeg. I suggested they have him interview his relative about how it would be, and also recognize when one’s actions, thoughts, words and feelings are not aligned with who one wants to be. The third process is picking up a piece of the problem to work on. By doing this, you hold a piece of the solution. The third process is verbalizing what you will do next time. This completes the self-restitution.

Most of the time, when a teacher models self restitution students will self-evaluate and suggest how they can change by responding, “It wasn’t just you, I should have...done my part.” This models making mistakes and fixing them is normal. If a student jumps up and says, “Yeah, you sure did mess up!” the teacher can reflect by
The Restitution Triangle

![Diagram of the Restitution Triangle]

**SELF-RESTITUTION**

1. I don't like how I am talking to you.
   1. I had information you do not have.
   2. I was tired and trying to go too fast.
   3. I was not clear on what I wanted.
   4. My picture was different from yours.

2. My part of the problem is...
   1. I had information you do not have.
   2. I was tired and trying to go too fast.
   3. I was not clear on what I wanted.
   4. My picture was different from yours.

3. Next time I will... 

One teacher began to use the statements of self-restitution which had unexpected consequences.

While I intuitively understood that I was part of the problem, I was at first leery to admit it to a student. It seemed that I would be losing power to do so, and I was reluctant to give any of that up. However, I have learned I get more of my power need met by allowing them to exercise more freedom because I am being more of the kind of person I want to be.

**Tool 8. The Restitution Triangle**

The second tool, the Restitution Triangle, instructs us to first stabilize the youth, then seek the underlying cause for the behavior (the need), to validate the need and to say, “I agree, it’s important to meet your need.” Then we add, “The way you met it hurt someone else.” At this point, it is productive to ask if the student could have done worse to help her understand herself. A student who is aggressive is usually sticking up for herself and to be worse would be to not care about the value violated by another’s taunt. For students who are passive, skip school, walk out of a conference or come to school stoned, the worse thing they are avoiding is being in pain. We can agree with them that it’s not good to be in pain. We can say, “It’s okay to make a mistake. It’s how we learn.” Then we say to the youth, “Think about the kind of person you want to be in this difficult situation.” We also ask her to reflect on our group beliefs to evaluate her position on them and to figure out how to remedy the situation in a win-win way.

**CONCLUSION**

It is very important for students to have role models so we encourage teachers to demonstrate restitution practices with their students. As one teacher concluded:

“The philosophy of restitution is wonderful: the students take responsibility for their actions and make it right on their own. It teaches the children to do what they’re supposed to be doing, whether someone is watching over them or not. Because restitution doesn’t rely on rewards and punishments, children learn to do the right thing for themselves, not for someone else. This is a skill that once learned, they’ll carry with them throughout their lives, and I’m happy to be part of the process. My entire middle school uses restitution, and I believe the more students are exposed to the principles of it, the more it will positively affect their behavior.”

The author may be reached at restitution@sasktel.net
Restoring Our Teens DVD Series
This is a published fast moving professional training program for educators. It is a complete, DVD-based staff development program in four modules (eight 20 minute lessons) with supporting text and practice exercises. It is accompanied by a manual and Diane Gossen’s new book It’s All About We. This four disc series focuses on working with adolescents to help them move from consequences to self-discipline and reparations. Youth are interviewed by educators, youth workers and police liaison who work together to help them get stronger by fixing their problems. There have been dramatic reductions in discipline disruptions, from 30-80%. Schools share practical ideas.

Item 200 - $150.00

Heal the Hurt DVD
This DVD shows Diane Gossen working with a group who are learning the Restitution Triangle. This presentation includes a strategy for stabilizing the identity of disaffected youth and offers many stories showing us the depth of restorative interactions.

Item DVD 13 – $30.00.

Steps to Success DVD
Joel Shimoji, a high school math teacher talks about how he uses LEAD management with his students. He says to them “seventy-five percent of this class is math; twenty-five percent is learning to manage yourself in the new economy.”

Item 771 - $30.00

For more information on resources or workshops with Diane Gossen, please visit www.realrestitution.com
Phone 1-800-450-4352 Fax 306-955-8834
Using Choice Theory to Assess the Needs of Persons Who Have a Disability and Sexual/Intimacy/Romantic Issues

Zachary Rapport
Assistant Professor of Psychology, Lincoln University

ABSTRACT
Choice Theory is used all over the world. Consequently, practitioners are likely to come across clients who have a disability and sexual/intimacy/romantic issues. In this article, the author describes the five basic needs, the test to assess each need, and the role that unhappiness or happiness plays in the assessment process. Based on the Needs Strength Profile created by Carleen Glasser, the author provides an assessment form specifically applicable to persons who have a disability and sexual/intimacy/romantic issues. Also, he provides instructions, an example, and explains the advantages of the assessment form.

Introduction
I have identified a gap in the literature. While much of the primary literature on Choice Theory—the writings of Dr. William Glasser, Dr. Robert Wubbolding, and Carleen Glasser—does address assessing the needs of the general population, nothing in the literature applies the need assessment process specifically to persons who have a disability and sexual/intimacy/romantic issues. This is important because Choice theory is widely used around the world as a method of counseling. Because of its wide use many practitioners are highly likely to come across persons who have a disability and sexual/intimacy/romantic issues. Consequently, those who use Choice theory in their practices may benefit from an awareness of the ways they can adapt the current assessment process to the clients who have a disability and sexual/intimacy/romantic issues. Specifically, this paper is meant to fill the gap (or, at least, start the process of filling the gap) of doing a needs assessment with the above mentioned population.

Structure of paper
In this paper, I will answer the following questions: What is Choice Theory? How does a practitioner assess a client’s needs? How can one adapt the current needs assessment process to serve clients who have disabilities and sexual/intimacy/romantic issues.

Limitations
I will not cover every possible way in which a Choice Theory practitioner can assess a client’s needs. Rather, this paper focuses on the general assessment process promoted in the primary writings on Choice Theory.

What is Choice Theory?
In 1965, Psychiatrist, Dr. William Glasser, created a new method of psychotherapy—Reality Therapy. He also created control theory. About ten years ago, Glasser changed the name of his theory (from Control Theory to Choice Theory) to more accurately reflect the central concept of his theory: that a person’s choices are the most important factor in that person’s mental health. Without diverting too much from our topic, here is a visual representation of Glasser’s entire theory. I will focus on the part of his theory on the reader’s right side “Basic Needs” and show how an assessment of those needs can assist a disabled person who has sexual/intimacy/romantic issues.

Unhappiness—the biggest indicator
All people behave as they do they have basic, internal needs—not because they respond to external signals. To the extent one meet those needs, one feels happy. To the extent one fails to meet those needs, one feels unhappy. Therefore, happiness or unhappiness are the keys to identifying the extent to which someone is meeting his or her needs. This is true regardless of a person’s disability status, but it is something to keep in mind during the assessment or self-assessment process.

5 Basic Needs
All people have five basic needs: (a) survival, (b) belonging/love, (c) power, (d) freedom and, (e) fun.

Survival means: the urge to engage in sex, to eat, to sleep, and to have economic security. The test to determine the strength of your need for survival is to ask yourself this question: Compared to other people I know, to what extent will I take risks? The more you will take risks, the lower your need for survival.
Belonging/love. Love means: commitment. It is seen through your willingness to share your Quality World (see "Quality World" section). The test to determine the strength of your need for love and belonging is to ask yourself this question: Compared to my family and friends, to what extent will I give love as opposed to take love? The more you will give love, the higher your need for it.

Power means: to feel important, recognized, respected, accomplished being heard. An individual's need for power often spawns him or her to use external control. The test to determine the strength of your need for power is to ask yourself this question: Do I always want to have my own way, to have the last word, to own people, and to be seen as right in most of the things I do and say? The more you answer yes, the greater your need for power.

Freedom means: to live your life as you choose. The test to determine the strength of your need for freedom is to ask yourself this question: Does following rules, conforming, staying in one place, and staying in one group bother me? The more it bothers you, the greater your need for freedom.

Fun means: to laugh and learn. The test to assess the strength of your need for fun is to ask yourself this question: To what extent do I laugh with others and desire to learn? The more you laugh and desire to learn, the greater your need for fun.

Creating Your Need Strength Profile

To be able to compare your profile, we will arrange the five needs in the following order: survival, love & belonging, power, freedom, and fun. Then, one at a time, rate each of the five needs on a scale from 1 to 5, 1 being very low, 2 low, 3 average, 4 high and 5 very high (see chart below).

Creating Your Need Strength Profile

<table>
<thead>
<tr>
<th>Survival</th>
<th>Love &amp; Belonging</th>
<th>Power</th>
<th>Freedom</th>
<th>Fun</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Compare your profile above with your partner's need strength profile. Discuss.

Needs Assessment

Usually the assessment process is done, somewhat informally, during a counseling session. The counselor will ask questions to find-out about a person's basic needs. Carleen Glasser (William Glasser's wife) created the following form. In a teaching situation, this form may come in handy for disabled students and/or as a self-assessment form done privately. Based on Carleen's form, I have created a form specifically designed to assess the needs of a person with a disability and sexual/intimacy/romantic issues. Following, then, is the revised needs assessment form. To complete the form, insert the definition of each need. Insert the test for each.
### Needs Assessment Form

<table>
<thead>
<tr>
<th>Need &amp; definition</th>
<th>The test</th>
<th>Rating 1-5</th>
<th>How does your disability affect your needs?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1 = weak</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = mild</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = average</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = strong</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = very strong</td>
<td></td>
</tr>
</tbody>
</table>

#### Survival
- What is the test to determine the strength of your need for survival?
- How does your disability affect your need for survival?

#### Love/Belonging
- What is the test to determine the strength of your need for love/belonging?
- How does your disability affect your need for love and belonging?

#### Freedom
- What is the test to determine the strength of your need for freedom?
- How does your disability affect your need for freedom?

#### Power
- What is the test to determine the strength of your need for power?
  - (Positive aspect and negative/external control aspect)
- How does your disability affect your need for power?

#### Fun
- What is the test to determine the strength of your need for fun?
- How does your disability affect your need for fun?

---

need. Based on the definition and test, rate the person’s need using the rating scale provided. Answer the question about the perceived effect the disability has on meeting a particular need.

For example, let’s take a male confined to a wheelchair. He may write that people tend to include him more in various social activities because people are sensitive to excluding a person in a wheelchair and because he is well liked as a person. So his moderate need for belonging is well met. On the other hand, he may report that he gets fewer dates than when he was not confined to a wheelchair. So his need for a deep intimate connection (love) is not well met.

In the emotional area, the overall effect of unmet needs is unhappiness. This adapted version of the assessment will reveal this man’s perceptions. Once he (or someone else) assesses his needs, we can use that information to design plans to address the unmet or insufficiently met needs. That means, helping him create a plan to get his needs met. Regarding the man above, his counselor might get him to brainstorm ideas for getting his needs met and then offer to train him in communications skills to negotiate intimacy. The bottom line in Choice theory is improving one’s relationships. That is the main goal here.

“To satisfy every need, we must have good relationships with other people. This means that satisfying the need for love and belonging is the key to satisfying the other four needs.” (Glasser, 2000c, pp.22-23)

### DISCUSSION

An additional benefit of using Choice Theory to assess the needs of persons with disabilities and intimacy issues is the normalizing effect it may have on everyone. The needs assessment is easily adapted to address anyone’s needs—all without medicalizing, pathologizing, or de-humanizing the person who has a disability. The assessment, itself, emphasizes that all people have these same needs (to different degrees). The person with a disability is a member of the rest of humanity. On the one hand, the person with a disability is affirmed as a member of the group while also taking into account the person’s unique perceptions of his or her needs. Sounds like a win-win situation to me.
REFERENCES


The author may be reached at: professorrapport@yahoo.com.
I believe that psychology is a science of theories. Minds, emotions, and behaviors are so diverse and their actions are so varied that a great number of different approaches, ideas, and theories have been developed in dealing with their disorders. Therefore, I feel that I too have a right to present my theory. I will do so in an account of a personal experience and then apply my experience and theory for the reader's consideration.

I preached my first sermon as an eleven year old child in a small, rural, fundamental Southern Baptist church in Arkansas. I was licensed as a Southern Baptist minister at the age of twelve, possibly the youngest licensed minister in the Southern Baptist Convention at the time. Starting preaching as an eleven year old child, had both advantages and disadvantages. The advantages have brought me to where I am at this stage of my life. I am the most happy of men, content with who I am, where I am, what I am, and with whose I am.

The disadvantages almost took me in an entirely different direction.

As a small child trying to preach the gospel in the best way that I knew, people in an effort to encourage me would often say such things as “God has a purpose in calling you so young. I believe you will be the next Billy Graham.” Or, “God has great plans for your life, you can count on that.”

These dear people never realized that they were placing a tremendously big and hungry monkey on my back. That monkey was never going to be satisfied until I was the pastor of the biggest church in the country, or the chief executive office of one of the denomination’s greatest agencies or boards. After all, since God had such great plans for my life as was evident in my being called into the ministry at such an early age, anything less would be a testimony of my failure.

I became the interim pastor of my first church two months after my sixteenth birthday. This was a position that lasted a whole summer. Then the church wisely recognized what I refused to believe. I lived in Northeast Arkansas and went to high school there. The church was in Northeast Mississippi, about one hundred and fifty miles from home through a route that took me through Memphis. I drove to Mississippi each Saturday and returned home on Sunday after church. I did that for the whole summer, occasionally traveling by Greyhound bus. However when school started the church looked elsewhere for an official pastor realizing that a kid barely sixteen had no business trying to maintain such a schedule.

I was heartbroken that they didn’t recognize my tremendous future and failed to want to be a part of it.

The next summer I became the pastor of my first church in the same county where I lived. I continued pastoral work for the rest of my high school days, throughout my college years, and seminary years, giving far more attention to my churches than I did to my education. College and seminary were to me only barriers to my great success as a full-time pastor of a city church someplace.

That city church came in 1965 in Columbus, Ohio when I became the pastor of the Woodland Heights Baptist Church in that city. Woodland Heights was one of the strongest and largest Southern Baptist churches in Columbus at the time, which made it one of the strongest and largest in the state. I was twenty-six and I was on my way to fulfilling the many prophesies that had been pronounced upon me as a child.

When I accepted the invitation of the church to become their pastor, I was the typical hayseed kid from the country who knew absolutely nothing of the city. There were “For Sale” signs all over the community. House after house was on the market and I had no idea why. I asked one of the men on the committee, a real estate salesman, what the signs meant and he assured me that it was just a typical thing that happened every summer. It cost nothing, he said, to put your house on the market and many would do so asking a high price. If their house sold, they would move on to a bigger and nicer house, if it didn’t, and most didn’t expect it would, they were content to continue living where they were. I bought his explanation without realizing the truth.

The truth presented a much blacker picture. It was the era of forced busing, a crazy idea of the Supreme Court that decided busing children across the city would bring equality to the school systems. The era became known as the “White Flight Era.” Families were willing to give away their equality in their homes if someone would just take over the payments so they could move to the suburbs and
escape from having to bus their children far from their communities. And, Woodland Heights was right in the most active of the white flight areas.

I was there for two and a half years, and the community changed from being a lower middle class white community to becoming a middle and upper middle class black community. The upper middle class came from a new housing development of nice homes that were purchased almost exclusively by blacks. I worked night and day, averaging fifteen visits in homes everyday, trying to reach the people of my community. I walked the streets, knocked on doors, made friends with families, but as hard as I worked, the church did not grow. It was not that we weren't reaching new people, we were. I baptized almost one hundred and fifty people while I was there, yet as new people came into the church, other people were moving out of the community and the church. Furthermore, we never cracked the color barrier. We welcomed the blacks and I never selected the homes I visited, but there was a large black church that had just relocated from an older part of the city to our community. Their new building was beautiful, well equipped, and big. Their pastor was one of the best preachers in the state, and if I had a choice, I would have gone there myself. Of course, it became the church of choice for the new black arrivals.

My dream of building a great church was not going to be fulfilled at Woodland Heights, though I felt that church was going to “make me or break me.” I believed my future was going to be built upon my success there, and success was not forthcoming.

There was a greater problem than this however.

My congregation was composed of wonderful and good mountain people from the mountains of Kentucky and West Virginia. Wanda and I were the only college graduates in the almost two hundred average attendees that composed our typical Sunday morning worship service. Although it might not have been the typical manner for mountain people to handle their disagreements, it seemed my congregation had developed their own way of handling theirs.

They fought.

I was called to homes where I found blood flowing because a husband and wife had gotten into a fight. And, our fellowship was continuously being disrupted by members having verbal confrontations.

My emotions became riders on the roller coaster of situations. I could be on the mountain top one hour because of a perceived victory at church and then be in the pits the next hour because of a phone call. The hostilities were never directed towards me personally, I was too needed as the problem solver for that. My congregation was young families for the most part. They were far away from their family support systems, and I had become the father figure. As such, I was expected to be the wise problem solver and every argument was brought to me, and each squabble only accelerated my wild ride on my personal roller coaster. I developed bleeding ulcers, and had been rushed to the hospital on two different occasions. But, the emotional trauma came to a head on a beautiful Sunday morning.

Because of the size of my church, the reputation I was building in evangelism, and my preaching style, I was being invited to preach revivals all over the state. I accepted these invitations with the understanding that I would not leave my church on Sundays. If the church would accept my coming on Monday night and preaching during the week, I would come. Many accepted my proposition and I accepted more revivals than I should have.

I had been gone for a week and got to my church that Sunday morning feeling that I was on top of the world. Woodland Heights was at its highest level, the revival had gone great, and I was home with my people. I got to my office well before anyone else and was making the last minutes’ preparations on my sermon when Paul knocked on my office door. Paul was my rock. I could always count on Paul.

“Bro. Ernie,” he said, “we have a problem.”

Then he shared an account that involved two of the most popular ladies in my congregation. These two ladies were neighbors but they had gotten into a fight that had almost come to blows over some now forgotten event. The church had taken sides and I had a major problem on my hands.

I stepped to the pulpit that morning and saw each lady on her side of the auditorium surrounded by her friends and family. I could see the daggers and arrows of hostility flying cross the church from one side to the other.

I stood there, trying to start my sermon, but unable to do so. I was seeing people whom I loved acting like children. And, I was seeing my dream coming apart right before my eyes. No one could build a great church with immature members such as these.

And, I broke.

The description of the next few minutes is that of an event that is as real as any thing I have ever experienced. It is not embellished. It is exactly as I experienced it those many years ago.

I fell to the floor behind my pulpit, weeping uncontrollably, all strength gone from my body. This, however, was not the problem. This was and is the normal way in which I handle great grief. I hold my emotions with no tears until they finally break as a dam and I react as I described it above. My wife, Wanda, had seen me react to my father's death in the same manner, so she realized that the best thing to do was to let me recover on my own. Thus, when...
two men jumped up from each side of the auditorium to rush to my aid, she stood and shouted, “Leave him alone. Don’t anyone touch him.”

The men stopped and slowly made their way back to their seats.

I heard none of that because I was in my own private world ... a world of darkness.

Before me stood a double-wide doorway with open doors beyond which was more darkness. And, I was being drawn toward the doorway and the darkness beyond with the understanding that all I had to do was to go through the door and I would never have to face the situation before me again. That doorway was my route to freedom. Enter it, I knew, and all of my problems would be over.

I felt myself being drawn stronger and stronger toward the door. But just as I got to it, I realize I couldn’t go through it. I made myself stop, forcing myself against the current that was pulling me. I felt I was fighting a current as strong as any current I had ever fought in those times I tried swimming against a river’s current. But, fight I did, and slowly, ever so slowly it seemed to me, I pulled myself away from the door and made myself stand to my feet.

I preached some type of sermon that morning and came back to do the same thing that night, but God only knows what I preached and the effectiveness in which I preached.

I spent that Sunday afternoon in my bed weeping with Wanda’s trying to comfort me the best she could not fully realizing what my problem was. The next day after my assuring her that I would be okay, she went to her work as a first grade teacher. After she left I realized I needed to talk to someone. I called a pastor acquaintance, Delano. Delano had once been the pastor of Woodland Heights. I asked if I could come over and see him. He invited me to come to his office. I spent that day weeping trying to share with him my pain. Probably, he never understood, but he listened, and I guess that was what I needed more than anything. I was totally out of control of myself. It was a wonder that he or Wanda had not called for medical assistance, or that they had not taken me to a hospital.

Would my situation have led to, or I would have been diagnosed, as bipolar? I have no idea. But, I was heading for a breakdown that I believe would have taken me to that diagnosis if I had continued in my downward spiral.

Now, let me share my theory.

I believe that each bipolar person has his or her cross roads where he or she makes a decision. The decision will determine whether they spend their lives as bipolar patients or whether they will spend their lives not as bipolar patients.

I believe that very few, if any, realize that they are making a choice. But, there is a moment when consciously or unconsciously the person will yield to or refuse to yield to the pull to enter the “black door.” There are many factors which make it harder for some to back away than it is for others. These factors include genetic and family history, the degree of the personal hurt, lost, or trauma they are facing, the strength of their support system of family and friends, and personal relationships.

If they can back away from the moment of collapse, they can live their lives as emotionally normal persons. If they cannot, or will not, back away from the moment of collapse, they enter the world of the bipolar and probably will be a citizen of that world for the rest of their lives. Medications are a great help for persons in that world, and I personally believe that most will never be able to get off of their medications.

My beautiful daughter-in-law was bipolar for more than twenty years. Her entering her black door is not an indictment of, or a judgment against, her lack of strength. If I had the same situation in my life as she had in hers, I too might not have been able to back away from the black door. None of us have the right to judgment anyone else at this point. Personality and emotional situations are different and each of us has our own support systems and personal strengths. However, if the person can find the right counselor at the right time to help them find the strength to back away, a life long situation might be avoided. Unfortunately in the current medical world, the answer is too quickly to go to medications and not to counseling. Thus, I believe we will see an increasing epidemic of bipolar diagnoses in our country.

As I continue to read and study I am slowing coming to understand many of the problems and situation that my bipolar daughter-in-law faced. When Anna’s medicines were working well, she was working well. However twice in the twelve years of her marriage to my son, her medicines had been re-regulated, changed, and on both of the occasions, she had to be hospitalized. The first time was traumatic for all of us. She was delusional, seeing and hearing people outside the house throwing rocks against the house. It was a hard experience for my son, indeed it was for all of us. However, the next time it happened about seven years later, Timothy, my son, saw the symptoms earlier and we were able to get her to the doctor sooner. As hard as the experiences had been on us, however, I realize that the experience had been much harder on Anna.

We had come to recognized many of the characteristics of the bipolar person. Anna’s life and contribution to my son and to the rest of the family were made by one who had her own problems but who overcame those problems. She was a successful wife, career woman, church member, and a loving family member. We lost a jewel when we lost Anna to cancer in December, 2006. She was truly one in a million.
Frequently Asked Questions and Brief Answers: Part I

Robert E. Wubbolding
John Brickell

The first author is Director of Training for the William Glasser Institute. The second author is Director of the Centre for Reality Therapy, United Kingdom

This article presents brief answers for questions often asked of teachers and practitioners of choice theory and reality therapy. These questions and answers provide compact responses that can be extended and elaborated on. The answers presume some knowledge of choice theory and reality therapy and should be understood against a background of information gleaned from reading, training or discussion (Glasser, 1998; Wubbolding, 2000).

(1) “What is the difference between choice theory and reality therapy?” Choice theory is an explanation of human behavior. According to Webster’s New World College Dictionary (1999), the definition of the word theory includes: “a formulation of apparent relationships or underlying principles of certain observed phenomena ... that branch of an art or science consisting of a knowledge of its principles and methods rather than in its practice” (p. 1485). Choice theory answers questions about why people do what they do, i.e., what motivates human behavior. According to the principles of choice theory, people generate behaviors for the purpose of satisfying human needs, fulfilling wants and closing the gap between what people want and what they perceive they are getting from the external world (Glasser, 1980, 1998). A second purpose of human behavior is to communicate with the world, to send a message to people (Wubbolding & Brickell, 2005). This message is often quite different from the one received by other people. For example, a rebellious adolescent wants to “be left alone” and attempts to communicate this desire to his/her environment. However, the message often received by those around him/her is translated as “I need to control or set this individual straight. Consequently, I need to get on his/her back more than I have in the past.”

Reality therapy is the delivery system. If choice theory is the train track, reality therapy is the train. If choice theory is the highway, reality therapy is the vehicle delivering the product. In schools it is known as lead management. It operationalizes, applies and conveys choice theory principles to clients, students, parents, educators, employees or any other consumer of services. Choice theory focuses on knowledge of how the mind works. Reality therapy focuses on skills for dealing with human minds, i.e., behaviors or choices generated by human beings.

(2) “What is the WDEP system?” WDEP is a tool for teaching and learning reality therapy skills. If reality therapy is worth studying, it is worth remembering. These four letters provide a method for remembering basic reality therapy questions and concepts originally formulated by William Glasser (1972). When utilized and practiced, learners perceive a depth not seen in the initial exposure to this system. They gain a skillful, creative and artful method for effective intervention on their jobs and in their personal lives. Using tools for summarizing counseling methods is standard. Albert Ellis summarized rational emotive behavioral therapy with the ABCs (Ellis, 2000). Arnold Lazarus expresses multi-modal therapy with BASIC-ill (Sharf, 2008).

(3) “What is the suitcase of behavior?” Besides the analogy of the car representing total behavior (Glasser, 2005), it is useful to think of human behavior as a suitcase. The lowest level or the bottom layer of behavior packed in the suitcase consists of physiology, over which we have the least direct control. Emotions are layered just above physiology, in the hierarchy of control, but human beings have little direct control over feelings. Cognition occupies the third level just below actions. While we possess some ability to change our thinking by directly choosing other thoughts, the most effective way to move the suitcase of total behavior is to lift it by the handle attached to the action level. In 12 step programs, there is an axiom: “You can act your way to a new way of thinking easier than you can think your way to a new way of acting.”

(4) “Does reality therapy deal with feelings and emotions?” Yes. Skilled practitioners of reality therapy acknowledge feelings and listen to descriptions of hurts, fears, disappointments, depression, anger, rage and upsetness as well as hearing clients’ joys, hopes, ideals, satisfactions, tolerances, feelings of altruism, generosity and a host of other positive emotions. Connecting with clients on their level, i.e., as they express the most obvious part of their behavior helps to establish and maintain the counseling/therapy/teaching alliance. The Swedish proverb applies here: “A joy shared is twice a joy. A sorrow shared is half a sorrow.”

On a deeper level, reality therapy addresses feelings through the action level of total behavior. Lifting the suitcase by the action handle results in a change in all four levels of behavior. Feelings change when people decide to take energetic action and follow through on plans.
(5) “Where do you place reality therapy among the theories of counseling and psychotherapy?” While reality therapy contains elements of existential therapy, it fits more appropriately in the cognitive behavioral category. Helping clients or students evaluate their behavior is primarily a cognitive activity. At the same time, self-evaluation precedes the all-important focus on actions.

(6) “How does reality therapy differ from cognitive therapies?” The theories of Beck (1976) and Ellis (Ellis & Harper, 1997) are based on the principle that dysfunctional behavior is due to irrational thinking or self-talk. Reality therapy posits that all behavior springs from needs and wants. Beck and Ellis seem to deny the existence of human needs while practitioners of reality therapy place needs at the core of human existence as the engines of human choice.

(7) “What is the meaning of the phrase ‘current reality’ as used by some instructors?” Current reality refers to human beings’ perception of their current life situation or their current story. Others may disagree about the way things are, but in order to help a client or student it is crucial to understand how they view themselves in the world. Useful questions include: “How do you see your current relationships?” “How do you think other people see them?” “How do you think other people look at you?” “How would you like them to see you?” Asking questions about current reality can also include inquiries and clarifications about their wants, actions, feelings, self-talk as well as self-evaluation.

In summary, trainees present a myriad of questions that require brief but clear and accurate answers. In a future article, the authors will present additional frequently asked questions and answers. The reader is invited to send questions to the first author of this article.

REFERENCES

The first author may be reached at: wubsrt@fuse.net.
Some Ways to Stay in Love

Thomas S. Parish

The author was formerly on the faculty at Upper Iowa University, Kansas State University, and Oklahoma State University. He currently lives in Topeka, Kansas.

ABSTRACT

This brief paper elaborates on some helpful “tips” that should be beneficial to nearly everyone. Left on a coffee table, or on one’s night stand, it might be “accidentally” shared with someone who might need it the most. Nevertheless, whoever does read these “tips,” and puts them into action, should be pleased with the results, as will others who share their life space with that individual. In Reality Therapy terms, this article attempts to convey some highly “efficient” behaviors that can enhance one’s love for another, and should also help eliminate the use of “inefficient” habits that fail to aid, but only hinder, our love for each other.

Some Ways to Stay In Love

In an article written by Roberta Caploe, entitled “Fifteen Ways to Stay in Love,” Ms. Caploe recounts an interview she had with Dr. Phil and Robin McGraw, regarding the things that they had done in order to remain “lovebirds” for thirty years and counting.

The following “tips” were offered by the couple in this article in an effort to help others achieve similar successes in their relationships with one another. Accompanying their “tips” is some commentary offered by the author of the current article:

1. “Have an attitude that your children join your marriage” (Caploe, 2007, p.117).
In explaining this notion Dr. Phil points out that couples must bond to one another first, last, and in-between, for this was how it was before the children came along, and must also be so after they are gone. Notably, however, it really isn’t that simple. You see, while children grow up and move out, today more and more of them are experiencing problems like a “failure to launch,” and/or a desire to move back in with their parents if things become too rocky for them as adults outside their childhood home. In addition, those children often have their own children, so the family really does not return to just two, but usually grows and grows exponentially. What Dr. Phil probably meant, though, is that the best thing a couple could actually do for their children, as well as for themselves, is to love one another continually, for in doing so, they (i.e., the children) will become better prepared to act likewise while they are at home, and then beyond their childhood home as well.

2. “Honor the four most important minutes of the day” (Caploe, 2007, p.117).
Spend a little “quality time” together each day, either at the beginning or end of it. In so doing, couples will more likely convey to one another just how valued they are to each other.

This basically means that we accept our spouse and our children for who they are, but that doesn’t mean that we can’t help them to improve in ways that are “acceptable” to all concerned. We need to choose to be patient, and not be too pushy. We need to be like a sage fisherman. Otherwise, our greatest dreams could easily become our worst nightmares.

But even better than that is to learn to communicate better with one another, and never say things in a moment of thoughtlessness that could linger in your significant other’s mind forever. When all else fails, just fall back to point #2, and be sure to show love for each other for at least the “four most important minutes of the day” and share some quality time together before retiring for the night.

Remember that in some countries one need only say “I divorce you” three times, and it is so. Each time the “D” word is spoken, the bond between couples is potentially damaged, and maybe irreparably so.

6. “Show support, as friends do” (Caploe, 2007, p.118).
As couples do so, each partner will quickly learn that s/he will be helping his/her significant other to like himself/herself. Friends are people who help you to like yourself. It’s really that simple, but very few couples work toward achieving this end, i.e., being a “true friend,” as well as a lover too.
This is totally in keeping with the “Platinum Rule”
which is that “We should do unto others as they
want done unto them.” William Glasser has often
reported that the way in which one seeks to have his
or her needs fulfilled are “unique, and that the level
of our basic needs might vary greatly between indi-
viduals. One’s job, then, is to figure out how much
“love and belonging,” “worth and recognition,”
“fun,” “freedom,” and “need for survival” is needed
by one’s significant other so that s/he can “do unto
one’s companion as one’s companion wants done
unto him or her.”

8. “When you’re home together, be together”
For many, this is truly very difficult to do, but if it
isn’t done ...the couples’ love for one another will
likely be lost in the shuffle.

In other words, don’t just rely on words to convey
your love for one another. After all, if a picture
could be worth a thousand words, how many words
could a tender, loving touch be worth? Why don’t
you try it and see?

10. “Don’t let other people meddle” (Caploe, 2007,
p.118).
If you put others first, your significant other might
readily think that you consider him/her last, and
when that happens your loving relationship with
him/her might damaged or perhaps destroyed.

11. “Flirt” (Caploe, 2007, p.118),
...but not with others. Such actions should really
be reserved for your significant other. Sure, go
ahead, and tell him/her how great s/he looks, and
be sure to convey that no one else could possibly
affect you similarly.

This suggests that you can more likely get what you
want if you help your significant other to get what
s/he wants first. Helping him/her to be sated may,
in turn, cause you to be more appreciated.

13. “Continue to do little things that you know are
important to him/her” (Caploe, 2007, p.118).
Said somewhat differently, don’t do “little things”
that torment and tease, but only do those things
that you are sure will please.

In so doing, both you and your companion may
find your love for one another renewed, especially
when you do things you both like to do.

15. “Know that one person cannot have all the power”
(Unless one of you concedes it to the other).... But
woe unto the couple who both want great power,
for when that happens, things tend to go sour.

These are only a few tips (with commentary) regarding
how to improve one’s love for another. Of course, more
ideas can be readily added as one sees fit. The primary goal
is to be respectful of one another’s needs, and not leave the
other hurting and wondering what s/he should do next. For
when that happens, s/he may soon become one’s ex.

REFERENCE
Caploe, R. (June, 2007). Fifteen ways to stay in love.

The author may be contacted at
parishthomas@yahoo.com
Guidelines for Contributors

a) Manuscripts should be submitted to the Editor, Larry 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 submitted on disc, either on rich text or word. 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 co-author's 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 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, Fifth 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 the 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.