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REALITY THERAPY:
A SYSTEMS LEVEL APPROACH TO TREATMENT IN A HALFWAY HOUSE

Frederick Falther*

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One of the obstacles to maintaining effective programs within many social service agencies is the tendency of staff to resist productive changes. When changes are needed, the inclination is to make only cosmetic ones. The fundamental assumptions, on which programs are based, are rarely challenged or changed. An example of the foregoing, where both assumptions and methods were changed, occurred at a St. Louis, Missouri halfway house, the Magdala Foundation’s North Eleventh Street residence. The facility, home to approximately 70 male offenders per year, was located in a deteriorating racially mixed neighborhood. The residents averaged 24 years of age with a racial breakdown of 60/40 black to white. The staff consisted of a Director, Assistant Director, four counselors, secretary and a part-time cook.

The changes were the result of an agency management decision to use reality therapy as the primary treatment modality in each of its four residential treatment centers. The use of reality therapy as a treatment modality for community based treatment of offenders is dependent on staff and resident involvement. Involvement is not a natural occurrence between members of disjunctive groups. Problems occur when separate alienated groups of people must coexist creating a system rather than an individual level problem. That most rehabilitative treatment programs (in the field of corrections) have been unsuccessful has been documented (Martinson, 1974 and Bailey, 1966). This writer believes that many of these programs fail because they do not take into account the role of group functioning in the treatment process.

Correctionalists Clemmer (1971); Allen and Simonsen (1978); and Shichor and Allen (1976) have long recognized that the cohesiveness of the inmate group and the group's internally generated pressures for conformity have negatively effected rehabilitative programming. Attempts have been made to dilute the negative effects of the prison social order. Prison authorities have at various times tried removal and isolation of inmate leaders; the planting and creation of ‘‘snitches’’; inmate brutalization and degradation; and efforts toward mind control. These attempts have failed because as Coleman (1964) suggests, groups in order to maintain themselves are prepared to defend themselves against attack from other groups. When inmates or any group perceives that another’s behavior is threatening to their survival the results will be increased group cohesion and greater resistance to outside influences. The carnage at the New Mexico State
To properly address problems created by a strong inmate group one must first examine the role that group participation plays in need fulfillment. Groups exist because they help people fulfill basic needs, both physical and psychological. Contrary to the opinions of Cartwright and Zander (1968) who suggest that groups may exist because individuals are treated in homogeneous ways by others, the present author contends that all groups exist because individuals are driven to act in ways designed to fulfill their needs and are attracted to groups of people who satisfy their needs.

People typically belong to many groups, formal, informal, close and loosely knit, all helping to fulfill needs. All groups, regardless of structure, regulate through rewards and punishments the need fulfilling behaviors of individual members. When an individual’s behavior ceases to fulfill the needs of the group, he or she will quickly be brought back into line through the use of negative consequences or expelled from the group. Negative consequences in terms of group functioning are always some variation of the group members collectively attempting to withhold need-fulfilling behaviors. Behaviors perceived as critical to need fulfillment by the group will be more strongly controlled for. Consequently, the more important the need to the group, the less likely an individual member is to endanger its fulfillment by failing to conform.

Although changing groups and joining new ones is not uncommon, it is made difficult if, in the group one chooses to leave, a successful identity is being maintained. The pain of giving up a successful identity is often seen in people facing retirement. Compounding the desire not to give up a successful identity may be the perceived inability to establish an equally desirable identity as a member of another group. People with successful identities also face similar situations when graduating from school, receiving promotions, and changing neighborhoods. All are painful because they are identity threatening. All are made less painful if one believes that an equally desirable identity can be established in the new group. Glasser (1975) concluded that the successful identity one desires must be gained through involvement. Conversely, the belief that a successful identity can be attained is necessary for a person to seek involvement in any group.

This discussion emphasizes that the fear of losing a successful identity, whether through willful separation or as a group imposed negative consequence, will prohibit members of disjunctive groups from seeking involvement with each other. However, involvement between disjunctive group members is possible — in fact is likely if the perception exists that needs can be better fulfilled in a third group in which a successful identity is attainable. A successful residential treatment program, utilizing the principles of reality therapy, is largely dependent on the establishment of a third group where basic needs can be met for both staff and residents. The remainder of this paper will deal with establishment of the third group at the Magdala Facility and how through greater levels of involvement, staff was able to begin teaching residents to fulfill their needs responsibly.

The Residence Program

To establish a common group, workers were encouraged to accept that their attempts to control and change members of the resident group through positive and negative reinforcement were futile. Such attempts could be expected to exasperate existing problems, create new ones (such as recalcitrance) and serve as an insurmountable block to the increased levels of involvement necessary to utilize reality therapy. Instead, staff was encouraged to see their role as helping clients to examine their present behavior in terms of need fulfillment and where found inadequate, to offer assistance in planning and in some cases, the teaching of better behaviors which would minimize the chance of failure. In conjunction with the request that staff recognize the futility of attempting to control members of another group through the reward-punishment paradigm, staff members were required to give up their controlling behaviors. Controlling behaviors, in this case, are behaviors used to force members of the resident group into powerless-identityless roles. The behaviors include the creation of distinctions that connote worthlessness and lack of status, rejecting and isolating behaviors, and most importantly the use of punishment. Staff behavior changed as a result of both supervisory directives and the implementation of a treatment modality lacking staff controlled punishments for resident behavior. The treatment program, a reality therapy approach, was used to allow residents to examine and evaluate their behavior. Residents were taught to plan better behaviors when their current behaviors were not need fulfilling. Getting people to assume responsibility for their lives was the basic aim of the program.

The following is a brief account of how the program’s management of pass time or free time away from the facility was used to teach the basic concepts of reality therapy. Points earned (the program utilized a positive reinforcement token economy) by residents for responsible behaviors were used to purchase pass time. Pass time is defined as any time spent away from the facility, with or without approval from staff. Approved pass time was sold to residents for a cost considerably less than non-approved passes. Staff approval, rarely denied, was based on the following conditions being met: the pass could not be a violation of the referral agencies’ policies, the individual had sufficient points to pay for the period of time requested, and all daily responsibilities had been completed. Daily responsibilities were things any resident choosing to remain in the program had to do. They included cleaning one’s sleeping area, a daily house chore, maintaining a satisfactory level of personal hygiene, a review of the days activities with a counselor, and in rare cases, usually externally imposed, special conditions such as participation in a drug or alcohol program or the paying of restitution.

Residents were asked to choose to spend their earnings — efficiently or wastefully. Efficient spending required a series of responsible behaviors, including earning enough points, contracting to purchase a specific amount of time at a cheaper rate, and returning on time. Failure to abide by the terms of the contract did not result in restrictions, fines, criticism or any
other type of punishment. The resident simply paid for the additional time away from the facility at the higher rate. When overspending occurred, residents were asked to submit a plan to balance their accounts. The plan (residents were instructed as to how to make good plans) usually involved implementing a behavior or behaviors that would help avoid overspending in the future.

Other behavioral problems, such as substance abuse and anger management, were handled by denying pass approval (the lower purchasing price) until a plan to resolve the problem was generated. Parts of the plan — to insure some movement towards resolution — were usually added to the daily responsibility list. The effect of adding the plan to the daily responsibility list was the creation of a mutually agreed upon negative consequence — the denial of pass approval for failure to live up to the contract. The net effect of these policies regarding free time management was to shift the responsibility for initiating behavioral change from worker to client. This shift is in direct contrast to the usual behavioralist reward-punishment model in which failure sometimes rests on the counselor.

Eliminating the punishment response and other staff controlling behaviors created an atmosphere conducive to the formation of a third group. Unable to use punishment to control, staff was obliged to open new lines of communication with the residents. Increased communication led to cooperative behaviors that fulfilled the needs of both workers and residents. Some of the needs fulfilled included belonging, worthwhileness, fun, comfort and security.

As is true in all groups, rules were quickly generated to insure the continuation of need fulfilling behaviors and to limit behaviors thought to endanger need fulfillment. Residents and workers in order to insure their own need fulfillment began to conform to the normative influences of the group. People who failed to conform were isolated or excluded from the benefits gained through group involvement. Interestingly, individuals who were perceived to endanger need fulfillment through belligerent and other anti-staff/resident group behaviors were pressured (by some residents), and the facility administration was asked to remove the offender from the program.

Through the use of intra-group controlling behaviors, problems which were once the norm, such as verbal arguments and various forms of threatening hostile behaviors, were almost totally eliminated. Negativism, previously a trait of both workers and residents gave way to a “can do — let’s try” atmosphere of conciliation. Where external controls had failed, internally generated pressures to conform which were tied to need fulfillment succeeded. As Glasser (1981, p. 146) stated “... the more people being controlled share in their control (in this case through involvement in the same group) ... the more control they will accept.”

The result of this new program was greatly increased program performance. Residents successfully released* increased from 67% and 70% in 1978 and 1979 respectively to 89% in 1980. Terminations for repeated rule violations and other forms of misbehavior decreased from an average of 12% during 1978 and 1979 to 5% in 1980. Finally, the percent of residents absconding was reduced from 14.8% and 14% in 1978 and 1979 to 5% in 1980.

Fueled by a warm accepting involvement with staff, residents actually participated in the rehabilitative process, a process aimed at helping people fulfill their needs in socially accepted ways. Totally rejected was the usual rehabilitative programming — a behavioristic monster that has failed despite numerous reincarnations because it assumes, incorrectly, that people can be controlled and therefore changed through the use and threat of punishment. Residents call this process being “held in check”, for they realize such efforts are at best temporary. Instead of holding residents “in check” and being placated, staff pushed, nudged and cajoled residents into trying behaviors that might work to satisfy their long term needs.

*Successfully released — means released to the community with a job in training or in school. School and training were successful only if a stipend was being received.

REFERENCES
THE MORALITY OF REALITY THERAPY

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(This article was originally written as a letter to parents who had expressed concern about the use of reality therapy in the schools. Some conservative religious groups were claiming that RT was teaching secular behaviors and thoughts that were in opposition to Bible teachings.)

American society moves toward extremes. In the search for better methods of improving life we often accept or reject entire philosophical arguments rather than specific concepts which are objectionable. One example of this phenomena is the constant swing between conservative and liberal political thought. In the use of Reality Therapy in public schools is one illustration. This approach has come under attack recently by conservative religions on the grounds that school children are being taught “secular humanism.” The purpose of this article is to show how Reality Therapy is in harmony with basic Judeo-Christian religious beliefs.

Principle #1: Reality Therapy stresses that everyone is responsible for his or her own actions. This concept is inherent in the judgment process presented in the Bible. When Paul wrote to the Romans, he stressed this concept when he said, God “will render to every man according to his deeds.” Eternal life to those who do well and indignation and wrath to those who don’t.

But after thy hardness and impenent heart treasurest up unto thyself wrath against the day of wrath and revelation of the righteous judgment of God;

Who will render to every man according to his deeds:

To them who by patient continuance in well doing seek for glory and honour and immortality, eternal life:

Romans 2:5-8

To the Corinthians, he said, “every man shall receive his own reward according to his own labor.”

Now he that planteth and he that watereth are one: and every man shall receive his own reward according to his own labour.

I Corinthians 3:8

The soul that sinneth, it shall die, the son shall not bear the iniquity of the father, neither shall the father bear the iniquity of the son.

Ezekiel 18:20

And to the Galatians, “Be not deceived; God is not mocked: for whatsoever a man soweth, that shall he also reap.” Galatians 6:7

Reality therapy contends that people will find reasons for misbehavior, but excuses that attempt to remove responsibility are not valid. Children who don’t do their homework or study must understand that this behavior will be reflected in their grades or classroom privileges. Excuses like “I forgot,” “I lost the assignment,” “I didn’t know it was due,” “The library was closed” are not valid reasons for not doing the work. In fact, acceptance of these excuses merely teaches the errant child that breaking rules is all right if you (I) don’t get caught, or (2) have a “good” reason. Children must learn that claiming poverty, broken home life, or “executive privilege” are not reasons for breaking rules or laws. Once persons recognize this concept, they will be ready to learn more appropriate behavior.

Principle #2: In order to be responsible, a person must have rules or principles to obey and the opportunity to choose to obey. The Bible teaches that there are eternal principles and that blessings come from living according to these principles. From the Ten Commandments (Exodus 34:28), to the Sermon on the Mount (Matthew 5:3-11), we are told that keeping these principles brings happiness and breaking them brings sadness.

However, inherent in obedience to a principle is the implication that we have the choice of not obeying. If this were not so, then certainly God would have made it impossible for us to disobey. From the beginning, when He commanded Adam and Eve not to eat of the fruit of the Tree of Knowledge, they were still free to disobey.

And the Lord God took the man, and put him into the garden of Eden to dress it and to keep it.

And the Lord God commanded the man, saying, Of every tree of the garden thou mayest freely eat:

But of the tree of the knowledge of good and evil, thou shalt not eat of it: for in the day that thou eatest thereof thou shalt surely die.

Romans 2:5-8

To the Corinthians, he said, “every man shall receive his own reward according to his own labor.”

Now he that planteth and he that watereth are one: and every man shall receive his own reward according to his own labour.

I Corinthians 3:8

The soul that sinneth, it shall die, the son shall not bear the iniquity of the father, neither shall the father bear the iniquity of the son.

Ezekiel 18:20

And to the Galatians, “Be not deceived; God is not mocked: for whatsoever a man soweth, that shall he also reap.” Galatians 6:7

Joshua also emphasized this in his farewell address to the Israelites when he told them to choose whom they would serve.

Now therefore fear the Lord, and serve him in sincerity and in truth: and put away the gods which your fathers served on the other side of the flood, and in Egypt; and serve ye the Lord.

And if it seem evil unto you to serve the Lord, choose you this day whom ye will serve; whether the gods which your fathers served that were on the other side of the flood, or the gods of the Amorites, in whose land ye dwell: but as for me and my house, we will serve the Lord.

Joshua 24:14-15

It becomes apparent then that in order to be responsible, we must understand that there are laws to be obeyed and we must elect to obey or disobey, in other words, make a value judgment just as the Israelites were asked to do.
Principle #3: *All actions are followed by consequences.*

Marvel not at this: for the hour is coming, in the which all that are in the graves shall hear his voice,
And shall come forth; they that have done good, unto the resurrection of life; and that they have done evil, unto the resurrection of damnation.  
John 5:28-29

Every man shall be put to death for his own sin.  
Deuteronomy 24:16

Living with these consequences is a most powerful influence in learning appropriate behavior. Too often, in social and legal systems, consequences of behavior are discharged because of some often irrelevant reason such as age, ignorance, intent, etc. When people mature in an environment devoid of rational consequences, they mature into amoral, if not immoral, individuals who interpret their behavior to be rational and "right" because such is their desire.

Principle #4: *People are capable of changing their behavior.* Reality Therapy asks people to examine their personal behavior and the consequence of such behavior. They then make value judgments as to the appropriateness of their behavior in achieving their goals in a rational society. Once they decide their behavior is inappropriate, Reality Therapy helps them work out ways of behaving better in the future. This is the same process referred to in the Bible as repentance. Repentance is the process of giving up a negative behavior and beginning a positive behavior. Sometimes God would send a spokesman to warn people of the probable consequences of their behavior if it continued.

If the wicked restore the pledge, give again that he had robbed, walk in the statues of life without committing iniquity, he shall surely live, as he shall not die.  
Ezekiel 33:15

Thus repentance is a process of change. The principles of Reality Therapy likewise embody a process for change.

Repent and turn yourselves from all your transgressions so iniquity shall not be your ruin.  
Ezekiel 18:30

Repentance, as taught in the Bible, seems to embody three phases:

(1) recognition of inappropriate behavior;

And the publican, standing afar off, would not lift up so much as his eyes unto heaven, but smote upon his breast, saying, God be merciful to me a sinner.  
Luke 18:13

(2) feelings of genuine sorrow;

Therefore also now, saith the Lord, turn ye even to me with all your heart, and with fasting, and with weeping and with mourning:  
Joel 2:12

(3) begin behaving appropriately.

Bring forth therefore fruits meet for repentance:  
Matthew 3:8

But shewed first unto them of Damascus, and at Jerusalem, and throughout all the coasts of Judea, and then to the Gentiles, that they should repent and turn to God, and do works meet for repentance.  
Acts 26:20

These are the same three basic principles of Reality Therapy:  *(1)* identify behavior, *(2)* make a value judgment, and *(3)* plan to do better.

Principle #5: *Involvement is important in changing people.* Reality Therapy stresses the value of the counselor, parent or teacher developing a warm, positive relationship with the misbehaving individual, not an acceptance of inappropriate behavior, but a firm belief in the intrinsic value of the individual. This is what the Bible teaches when we are instructed to love one another and forgive one another.

This is my commandment, That ye love one another, as I have loved you.  
John 15:12

And be ye kind one to another, tenderhearted, forgiving one another, even as God for Christ’s sake hath forgiven you.  
Ephesians 5:32

We can love the individual without condoning the misbehavior.

**Conclusion**

The Bible doesn’t teach that people should be forced to obey any given law. To the contrary, appropriate laws are established, each with a related consequence for obedience and another consequence for disobedience. People are to be taught the law and the reasons for obedience, but they still are free to obey or disobey, according to their own judgment or values. Nevertheless, they must accept the consequences of their choice.

There will be no attention paid to excuses. It is imperative, therefore, that people be taught how to analyze their behavior in terms of the consequences to themselves and society, and to make value judgments about future actions based on this analysis.

Reality Therapy is a process of caring and teaching people to become strong enough to effectively deal with the value conflicts with which we are constantly faced. Reality Therapy teaches responsibility toward rules and laws, and encourages people to think critically about life and behavior, in order to become contributive and productive members of society.

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**REFERENCES**

CRISIS INTERVENTION: A REALITY-BASED APPROACH

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The Emergency Ward has been the traditional "front line" for confronting cases of crises and the acute problems associated with metropolitan living. The ability to confront these situations with rapid and efficient assessment and effective rapport is a cumulative skill of the social workers in this setting, and reflects techniques geared to the specific problems affecting the population being served. These techniques must encompass the mutual concern for alleviating distressing emotions that often characterize a crisis while promoting the potential for personality growth and strengthening self-worth.

The target population addressed in this paper represents individuals who have been displaced from their homes; these people might best be called economic refugees. They are mostly males who range in age from 18 to 70 and are either on fixed low incomes from Social Security or Welfare assistance, transient unskilled labor wages or have no income at all. Many are forced to seek shelter in run-down rooming houses or public shelters, while others simply wander the streets, seeking refuge in vacant buildings or public parks. The lack of adequate nutrition and hygiene eventually brings many to the hospital.

Certain techniques have proven effective in application to crisis intervention. The techniques described here are an eclectic approach based on the humanistic tenets of such theorists as Alfred Adler, Albert Ellis and, specifically, William Glasser, each with their respective concepts of Individual, Rational-Emotive and Reality therapies. (1) Similar techniques have proven effective in treating socially and culturally alienated people in the past (2)(3) and seem especially well suited for remedial intervention with the growing number of homeless, impoverished and lonely people in today's metropolitan areas whose lifestyles are largely economically defined.

Approaches based on developmental models are difficult to apply in crisis intervention without adequate patient cooperation and regularly scheduled follow-up appointments. Highly structured behavioral approaches are likewise difficult to implement when the environmental forces affecting the patient's behavior cannot be fully appreciated. Traditional client-therapist roles have the danger of nurturing dependency at a time when the opportunity for independent thinking and decision making is optimum. (4)

Emotional crises appear against the backdrop of an individual's lifestyle. Differentiating between "normal" behavior and behavior elicited by the crisis can be difficult when assessing a population whose defense/coping mechanisms and survival skills have long been tested. Personal reactions to crises vary, as Parkes has illustrated, and might best be described as an indication of how well an individual can, "... restructure the way of looking at the world and his plans for living in it." (5) Perhaps the most constructive way of viewing a crisis is that of Pasewark and Albers, who describe a crisis as a "learning dilemma". (6)

The ability to learn from a crisis rests on the ability of an individual to form an effective coping strategy. Often this must be accomplished with little or no effective coping experience on which to draw. Attempts at strategic planning are often thwarted by strong and irrational emotions which are believed to be a reaction of the individual to a challenge of his unique concept of reality and self-identity. (7) Panic and fear can occur as the attempts to integrate new ways of thinking are met by habitual patterns of thinking and behaving that are equated with identity and self-esteem. This state of transient confusion, what Weiss calls the "Transitional State". (8), can manifest itself in the complete absence of problem solving, "I don't know what to do..." or the fixation on a resolution without appropriate concern for the consequences (i.e. homicidal and suicidal ideation). The goal of crisis intervention must reduce the level of emotional preoccupation while facilitating constructive thinking. By treating adversity as an opportunity for growth, real progress in developing a productive and satisfying lifestyle is possible.

The authors, as emergency ward social workers, have recognized the benefits of approaches like that of William Glasser's Reality Therapy (9) in crisis intervention. This approach quickly directs attention to the crisis event and the patient's reaction to this event. The patient is asked to make a value judgment regarding the effectiveness of his current coping strategy (or lack of strategy) and to assess other options that could be more effective. Attention is focused on the present and concrete plans for coping are discussed with a strategy agreed upon by the patient. Little attention is focused on past failures or weaknesses and regrets. Workers look for strengths, no matter how seemingly insignificant, and positive attitudes that can be reinforced and utilized to cope with the crisis at hand.

Getting a value judgment from the patient regarding his present behavior is most important to effect any constructive change. Having the patient decide whether his current behavior is helping him achieve his goals is usually the first step in establishing objectivity which will be necessary to think about other, perhaps more effective, options. Responsibility for decision making is clearly in the hands of the patient and he is encouraged to take this point of view rather than feeling victimized. We do not believe in changing a lifestyle simply because it does not conform to the predominant way of life, nor do we wish to encourage dependency. The therapeutic goal in crisis work should be directed toward the establishment
of a level of "adaptive functioning" (10) where the patient can help himself through the identification and modification of irrational thinking and behavior, within the context of the presenting problem. This holds true whether the crisis results from an actual trauma or from a chronic behavior problem.

By focusing on the cognitive process underlying the emotional crisis, social workers try to modify this process in a way that conforms with reality and utilizes the individual's strengths. This is accomplished through a careful exploration of the various options and their possible consequences. The social workers may suggest possible options or resources to help the patient. These alternatives and options may represent actual changes in behavior patterns, modifications of ways of looking at the world and one's self, or they may be actual resolutions to concrete problems. One or more of these options is selected and a course of action is discussed and promoted.

The interviews are relaxed and informal. The social workers dress casually and use down-to-earth language. Therapeutic dialogue is guided to focus on the present behavior and cognition. Past histories are used only in as much as they relate to the continuity of events affecting the patient now. Worries and anxieties about the future are strongly linked to the present decision making, reflecting the axiom; the future will take care of itself if the present is well lived.

Co-therapy, the presence of two social workers during the interview, is utilized, when appropriate, to reduce the possibility of dependence and to enable the individual to benefit from two unique personalities, both accepting his uniqueness. The individual is able to observe as well as participate in a discussion of his options and their consequences. One worker usually remains as the primary therapist and directs the dialogue.

An example of this technique is the case of a 67 year old man who had been living and sharing a small apartment with an elderly woman. Mr. H had an argument with this woman and had been asked to leave. He lived on a fixed low income and feared that he would be unable to live alone. He appeared in the emergency ward complaining of chest pain. Medical attention revealed no physiological reason for this pain. When confronted with this fact, the patient became angry at the medical staff, insisting that he was ill. Attempts to calm him were unsuccessful and he was soon threatening to leave the hospital and kill himself. Mr. H was met in the emergency ward by the primary worker and brought to the office. He was receptive to offers of coffee and a cigarette and was introduced to the co-worker. Within a few minutes he was visibly calmer and had established a good rapport with both workers. The primary worker listened to the patient's experience, recalling himself how painful it was to have had an argument with a close friend. Mr. H was able to see similarities and asked for details about the worker's recovery. The worker answered honestly and directly.

Mr. H then mentioned that he had been in the merchant marine and this topic was seized upon as a way of exploring the patient's strengths in making and breaking close relationships. The patient was quite proud of his earlier years and gave several vignettes about close friends that he had left in various global ports. Both workers commented as to put the present separation in perspective and lauded the patient for his adaptability. Strengths that would be necessary for coping with the present crisis were incorporated into the dialogue and the patient was soon able to focus on his need for temporary food and shelter.

Various possibilities were discussed and the workers gave the patient a list of services available to feed and shelter people who were temporarily homeless. Mr. H elected to stay at one of the shelters until he had saved enough money to secure a small room. He agreed to stop by again to report on his progress and, on each subsequent visit, discussed specific problems he encountered with finding and securing a room. Mr. H demonstrated increasingly independent thinking and used the visits to re-confirm his adaptive abilities and sense of self-worth. Eventually he did locate a small room and has learned to function rather well.

The role of the social worker in crisis work is to become a catalyst, promoting creative thinking by the patient and attempting to illustrate the rational consequences of each alternative that the patient considers. Ultimately, the role of the social worker is to become superfluous. Actual choices and cognitive alterations are the responsibility of the patient; even if these choices do not seem to be the most desirable to the worker, they should be discussed and, in the final analysis, respected. No overt attempt to show bias or to appear judgmental is made.

Helping the patient discern what he needs from what he wants, toward a process of self-actualization, is not only beneficial but rewarding as well. Introspection can often reveal that basic needs and strengths are already possessed; desires and wants, although certainly valid, are often not essential to one's happiness. It can be safely said that happiness depends on decisions made rather than on conditions.

In many cases, the present crisis may reflect a deficit in resolving a previous crisis (11). The approach, however, remains the same. Crisis intervention is best viewed as adjustment in the present rather than being oriented to psychopathology and the past.

An example of what might be termed a "deficit" from an unresolved crisis was seen in a 42 year old man, divorced and living literally "on-the-street". Mr. Z had once been a teacher with hopes of attaining a degree from a local graduate school. When his wife left him, some five years in the past, he found life difficult to cope with, and eased his stress with alcohol. The patient was referred to the social worker in the emergency ward where he had been brought because of intoxication. He had extremely poor hygiene and was wearing soiled clothing. Mr. Z requested to be placed in a detoxification facility.

Records indicated that Mr. Z had been seen by many psychiatrists and had been diagnosed as manic-depressive with episodes of violent behavior when inebriated. Initial dialogue showed that the patient was highly skilled
in manipulative behavior — an admitted “survival skill” for life “on the skids”. With patience, a good therapeutic rapport was developed with the social worker. The patient was pleased to reveal himself as a “normal” person and highlighted his conversation with emphasis on his above-average intellect, nine years of a happy marriage and a middle-class background. When a value judgment was called for by the social worker, Mr. Z quickly presented his diagnosis of manic-depression as an excuse for the lack of personal responsibility.

Focusing on the patient’s present condition, Mr. Z soon voiced disgust for his present lifestyle and the wish to return to his previous level of functioning. After a discussion of options, including alternate lifestyles that could be pursued, the patient decided upon a plan that would address his immediate needs for alcohol detoxification, housing, food, employment and relationships. The patient and social worker agreed to meet weekly for eight weeks with the patient formulating his own plan for the next subsequent session. The worker acknowledged at least one mode of action in which the patient could reasonably be expected to succeed and reinforced the completion of this action on the following session.

Typical “homework” assignments included making an inventory of strengths, attending an Alcoholics Anonymous meeting, following up on various job leads and becoming re-acquainted with an old friend. On each session the patient became more able to propose options and to ponder their consequences without prompting from the social worker. It was clear that he had “learned” to develop an effective coping strategy. The patient has since maintained his sobriety and is living in a rooming house. He continues to look for the work of his choice but, at the same time, has realized that he must accept lesser jobs to survive.

Follow-up for crisis intervention usually involves the need of the patient to reconfirm new behavior patterns and self-worth. A small number of patients visit the office regularly and, as needed, offer to help with the problem solving of other patients in need. Offers of companionship and advocacy have been very helpful and mutually beneficial in nurturing positive self-worth. Such interactions between patients and former patients can have more therapeutic effectiveness than that of client-therapist interactions alone and further suggests the value of “equality” in the therapeutic alliance (12).

A good therapeutic environment should be one that is comfortable to both the patient and the social worker. Creating an atmosphere conducive to alleviating emotional stress and promoting creative thinking is difficult in the midst of a large metropolitan hospital’s emergency ward. Decorating the office with posters and personal mementos of the workers has done much to cushion the sterile and hurried atmosphere of the hospital. A variety of seating arrangements allows the patient to sit beside, in front of, or at some distance to the social worker. The workers try to sit beside the patient and share coffee or cigarettes that are made available. A poster in the office reflects the overall philosophy: If you give a man a fish, you feed him for a day. Teach him to fish and you feed him for life.

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A COMPARING AND CONTRASTING OF REALITY THERAPY AND RATIONAL EMOTIVE THERAPY

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Rational Emotive Therapy, developed by Albert Ellis, and Reality Therapy, developed by William Glasser, are two forms of present-oriented, re-educative therapy useful in counseling. These two therapies can be compared and contrasted on a philosophical basis and on methodologies.

Rational Emotive Therapy and Reality Therapy are humanistic, cognitive, and behaviorally oriented therapies. However, Ellis views man as not needing other men for love (Ellis, 1973), whereas Glasser postulates the need to love and be loved as a basic psychological need (Glasser, 1965). The need for self worth described by Glasser (1965, 1975) is not accepted by Ellis, who states valuing of oneself in relation to simply being or existing is the key (Ellis, 1979), that all the individual need do is keep within the empirical realm and avoid self evaluation.

Ellis’s A-B-C theory of human behavior and personality change is interesting and supported by various research studies. A. is Activating Events which occur and C is the emotional and/or behavioral Consequence of reacting to A. Many theorists then say A caused C. However, Ellis does not accept this. Rather he states C followed from B, the Belief the individual holds about A (Ellis & Greiger, 1977; Ellis & Whiteley, 1979; Ellis, 1973). The Belief system may be rational or irrational. It is the irrational aspects which are dealt with in psychotherapy or counseling. Irrationality is defined as “any thought, emotion, or behavior that leads to self defeating or self destructive consequences that significantly interfere with survival and happiness of the organism” (Ellis & Greiger, 1977, p. 15).

One way to categorize irrational belief is under three main “MUST” headings: 1. I MUST be competent, adequate, and achieving, and I MUST win approval for my performances or else I rate as a rotten person;” 2. “You MUST act kindly and considerately and justly toward me, or else you amount to a louse;” 3. “The conditions under which I live MUST remain good and easy, so that I get practically everything I want without too much effort and discomfort, or else the world turns damnable, and life hardly seems worth living” (Ellis & Whiteley, 1979, p. 3-4; Ellis & Greiger, 1977, p. 61). According to Hummel (1980) irrational beliefs inhibit career development. One thousand adolescents and young adults wrote self sketches concerning career development. From these sketches, twelve irrational beliefs were delineated. These irrational beliefs included: the past is all important and must keep determining feelings and plans for a career; it is awful and defeating if the individual cannot follow through the original career plans; and the need to be completely competent and successful in all activities or the individual will never be accepted in any career.

Glasser has also developed a theory of human behavior, termed behavior, the control of perception psychology (BCP psychology) (Glasser, 1981). Purposes drive the whole behavioral system and these purposes are necessary to meet basic needs; i.e. love, worth, fun, and freedom. Individuals must control to some degree for these needs. If individuals do not see what they want, it becomes a perceptual error, creating an error signal. The signal will stimulate redirection or reorganization systems so that a behavior occurs to attempt to close the error. Where there is no error, it is controlled perception. The new information system is a subsystem of the redirection system and allows the individual to act on new information and behave in a different manner to control the perception.

The new information system may be similar to the cognitive techniques Ellis uses in his therapy to assist clients to change their thinking process and then behavior. Cognitive techniques include use of a self-help report form, imagery, and bibliotherapy (Ellis & Whiteley, 1979). Bibliotherapy and teaching parents principles of Reality Therapy are frequent techniques used by a reality therapist.

Both therapists speak to behavior as composed of doing, thinking, and feeling. Ellis seems to expend more energy on the thinking and feeling component. Glasser focuses on the doing component of behavior because he thinks a feeling cannot be changed per se, but the action portion is changeable.

Behavior of clients in counseling with Rational Emotive Therapy now moves from the A-B-C into D and E. D is the Disputing of irrational beliefs, and E is the Effect of this Disputing in behavior. Disputing may take several forms — debating, discriminating, and defining (Ellis & Greiger, 1977). Debating is questioning and challenging the irrational belief in such a way as to dispute the belief. Discriminating is the distinguishing between wants and needs, and ascertaining the good and bad points in the behavior. Defining is the technique of decreasing overgeneralization in terminology and developing precise terms (Ellis & Greiger, 1977, p. 33). The E, the Effect, can have cognitive, emotive, and behavioral aspects to it and is the end product of the Disputing step. The Discriminating aspect of Disputing and the Effect are similar to Glasser’s third step in Reality Therapy, the value judgment clients make relative to their behavior — is it helping or is it against the rules.

Ellis uses many experiential-emotive techniques, particularly in Disputing irrational beliefs. One such technique is to begin with a client’s feelings and directly probing until the individual admits to a feeling of inadequacy and worthlessness (Ellis, 1973). This would not be a technique a reality therapist would use. The emotive technique of revealing one’s own authentic feelings and responses, modeling the main principles of the theory, could be used by therapists of either persuasion. Ellis’s (1973) technique of mimicking a client’s manner and behavior would not be a useful technique in the Reality Therapy model.

Rational Emotive Therapy behavioristic techniques such as role playing and reinforcement are also used by reality therapists. The
homework assignment is a technique stressed by Rational Emotive Therapy therapists (Ellis, 1973; Ellis & Whiteley, 1979; Ellis & Greiger, 1977; Morris & Kanitz, 1975; Cox, 1979). Part of the homework assignment is to examine the A-B-C-D-E's, but the portion that deals with stating new goals and specific actions the individual would like to take would parallel step four and five in Reality Therapy — make a plan to do better and get a commitment. Rational Emotive Therapy also emphasizes self management and contracting procedures (Ellis, 1973; Ellis & Greiger, 1977).

From the preceding discussion, it can be seen that there are similarities in techniques, but not in the basic philosophy between Rational Emotive Therapy and Reality Therapy. However, there is at least one rational-reality based approach to counseling described in the literature. Cox (1979) describes this approach to treating the criminal child abuser. A part of the program consisted of teaching each client the five basic criteria for rational thinking and the three reality therapy tenets through handouts and individual counseling sessions. Clients were asked to think about their behavior, and verbal reinforcement for using these teachings was given. The basic criteria for rational thinking or acting taught were: 1. it is based on objective facts, 2. it is life-preserving; 3. it helps a person achieve his self-defined goals; 4. and 5. it enables a person to function with a minimum of significant internal conflict or conflict with the environment (Goodman & Maultsby, 1974). The reality therapy tenets used were: 1. two basic psychological needs are to love and be loved, and to feel worthwhile to self and others; any person with a serious emotional problem is missing involvement with someone and thus cannot meet the two basic psychological needs; and responsibility is the ability to fulfill one's needs in a way that does not prevent others from fulfilling their needs (Glasser, 1965; 1975).

In conclusion, this writer suggests that a rational-reality based approach could be useful in career counseling. A major similarity in the two approaches is the emphasis on responsibility — the client as responsible for his behavior. This is important in career counseling, particularly to dispute the belief that a career choice must be consistent with the wishes of others or the individual will be disapproved of as a person (Hummel, 1980). Glasser’s failure identity (1965, 1975) description of lonely, self critical and irrational individuals and success identity of involved, self accepting, and rational individuals appear to be supported by Ellis. Building toward or supporting a success identity in reference to career development would be useful as Ellis states one goal of Rational Emotive Therapy is to assist individuals to work productively and creatively at some paying activity (Morris & Kanitz, 1975).

A major difference in the Rational Emotive Therapy and Reality Therapy principles is in the involvement area. Glasser discusses involvement, making friends, as crucial to developing a relationship — to help meet the need for belonging (Glasser, 1965; 1975). Ellis (1973) philosophically would not see this as an essential need, makes depth-centered interpretations from the first session, and is didactic and explicatory. Involvement is not highlighted in Ellis’s writing nor in his presentations. Although his writings emphasize unconditional positive regard as an important element in therapy, Ellis’s case examples do not focus on this. He sounds rather dogmatic, directive, and confrontive. The “pure” Rational Emotive Therapy therapist would not be supportive of the first and most important step of Reality Therapy — make friends.

REFERENCES


NOTE: In addition to the guidelines for contributors on p. 32, the Journal of Reality Therapy is also interested in printing a case study of RT in action in each issue. Potential contributors are asked to follow the format used in What Are You Doing edited by Naomi Glasser. Send cases to the editor following manuscript guidelines.
DETERMINANTS OF ATTITUDE TOWARD REALITY THERAPY

Robert J. Drummond*

*This research was sponsored by the University of Maine Teacher Corps Project. The author is Professor of Education, University of North Florida, Jacksonville.

Reality therapy methods have been utilized in a wide variety of contexts from the classroom to correctional settings. Reality therapy (Glasser, 1965) is an approach to helping individuals develop sufficient confidence to handle the stresses and problems of life. It is a system that teaches individuals how to look at what they want, how to look at what they are doing, how to evaluate their behavior, and how to make plans for achieving their goals.

The approach has been used periodically in correctional settings. Glasser worked with youthful female offenders in Ventura, California. There have been numerous studies on the effects of reality therapy on youthful offenders (Williams, 1976; German, 1975; Shea, 1973) and steps in program implementation (Molstad, 1981). There has been little empirical research on factors that might assist institutions in the implementation of training for the staff in reality therapy.

The purpose of this study was to identify the key variables that relate to the implementation of reality therapy by the staff in a juvenile correctional facility. More specifically, the study addressed factors which predicted the attitude workers had toward reality therapy. The relative contribution of demographic, personality, and on-the-job behaviors to predicting the attitude of correctional workers toward reality therapy were studied.

METHOD

Subjects were sixty-six workers in a juvenile correctional facility in Maine. Forty-four were males and twelve females. The median age was 43 and the mean 41.6. The average number of years employed was 7.82. In the sample, 22 were cottage personnel, 5 in teaching positions, 8 in administrative positions, 11 in treatment, and the remainder in other types of positions.

CONTEXT

The administrative staff at the Maine Youth Center decided to implement reality therapy as primary method of treatment. The inservice training in reality therapy was funded as part of a Teacher Corps project on Youth Advocacy, University of Maine at Orono. The training program used was a Double T Model. The trainer trained a core of staff who then in turn trained additional staff members (Mehnert & Barnard, 1979).

The Maine Youth Center is located in South Portland and is the only juvenile correctional facility in the state. It houses about 200 youthful offenders and employs approximately 240 staff who are classified as cottage, grounds, educational, treatment, and administrative personnel. The youth are both male and female ranging from 12 to 18 years of age. The average stay is approximately five months.

INSTRUMENTS

The staff completed the Nowicki-Strickland Adult Reaction Scale (1973), Reality Therapy Activities Questionnaire (Drummond, 1980A), The Reality Therapy Attitude Scale (Drummond, 1980B), and a demographic data sheet.

The Nowicki-Strickland Adult Reaction Scale contains 40 yes/no statements dealing with locus of control, the degree of internal or external orientation of the respondents. The scale is scored in the direction of externality. It measures the construct defined by Rotter (1966).

The Reality Therapy Activities Questionnaire included eight dimensions of reality therapy such as not accepting excuses, being persistent, getting youth to set plans, etc., which are rated by staff as to their frequency of use and the degree of success in using them.

The Reality Therapy Attitude Scale contains 18 Likert type of items relating to the theory, philosophy, and perceived value of reality therapy. A five-point scale ranging from Strongly Agree to Strongly Disagree was used.

The staff also completed a demographic data sheet in which the respondents checked their type of position, age, length of employment at the center, and number of years of education.

PROCEDURE

The staff was asked to complete the questionnaire anonymously. The data were coded and multiple stepwise regression was utilized with attitude toward reality therapy the dependent variable and locus of control, demographic variables, and the frequency and success in using dimensions of reality therapy, independent variables, (Nie et al, 1978).

RESULTS

A multiple correlation of .70 was computed and accounted for 49.6 percent of the variance. The summary is presented in Table 1. The first variable entered was highest level of school completed. This variable correlated .37 with attitude toward reality therapy and contributed 13.4 percent of the variance. The second variable was the frequency of not accepting the excuses of the youth for their behavior. This variable correlated .23 with attitude toward reality therapy and added 10.7 additional variance. The third variable was Locus of Control which had 5.2 percent unique variance. The success at being persistent was the fourth variable and yielded 3.2 percent of the variance. The fifth variable was number of years employed at the youth center and explained 1.7 percent of
the variance and correlated -.20 with attitude toward reality therapy. Sex and age, although contributing slightly to the explained variance, had zero order correlations with reality therapy.

**DISCUSSION**

Education level of the staff appears to be a factor in the acceptance of reality therapy. Staff with more years of formal education tend to be more positive toward reality therapy than those with less. The second predictor which was significant at the final step was the frequency with which the staff reported they did not accept the excuses of the youth. Putting the principles in practice, one would hypothesize, would have an impact on attitude especially if the staff member achieved success in the practice. Not accepting excuses is probably one step that is easier to execute and remember.

The age and sex of the staff did not appear to have any relationship with attitude toward reality therapy. Years employed at the center was negatively correlated with attitude. There was a slight tendency for those employed a shorter time at the Center to have more positive attitudes than those employed for a longer time.

Locus of control did not have a significant correlation with attitude. The loading was negative indicating that the direction was toward internal orientation. It would appear that in setting up training programs, the educational level of the staff needs to be taken into consideration. Possibly different strategies and materials need to be developed for staff with high school education or below.

The program needs to include how to make immediate and direct applications of reality therapy. Staff need to achieve success in translating the principles to the roles they perform on their job. The trainer needs to identify the current practices being used which are related to those being taught. This is especially true for employees who have been on the staff for a longer period of time. The trainer needs to consider strategies to overcome the resistance of long-term employees to new programs.

Although the results of this study need to be cautiously interpreted, additional research needs to be conducted to identify correlates of positive attitude and successful implementation of the treatment program. Additional variables such as work values and job satisfaction should be studied. The study should be replicated with a larger sample of staff at different stages of the training program. This study is just one part of an overall evaluation program looking at the impact of training in reality therapy on the performance of the staff as well as the behavior of the youth. The results of these studies can give information to those implementing the programs to how well training is being accepted and to how well the program is working as well as in identifying areas that will help in improving the program.

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ASSERTIVENESS: A CHOICE

Janet A. Thatcher & Robert E. Wubbolding*

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"What do I do when...?" "What can I say when...?" "How do I know that what I am doing/saying is appropriate?" "When I say what I think, then..."

All of these questions and statements involve some aspect of being assertive, aggressive, or passive. They also involve the element of choice which may or may not be viewed as possible. To a counselor or therapist, the client presents a situation in which questions and issues are asked or at least thought about, and, therefore, need to be evaluated by the client, with the assistance of the helping person. With the emphasis in the past few years on assertion training, much has been written that indicates that the expression of one's feelings and rights is always appropriate and that if done correctly "life will be fine." The choice of being assertive, aggressive, or passive, and the consequences of this choice may have a significant impact on every aspect of the person's life, e.g., relationships, careers, etc. Therefore, a more intensified and in-depth examination of assertiveness and its consequences - positive and negative - as well as its relationship to Reality Therapy is useful.

Since Reality Therapy is a treatment modality in which clients are aided in identifying and building strength, making choices and decisions, assuming responsibility, and controlling their life, it is an appropriate method for aiding clients in the choice to be assertive.

ASSERTION TRAINING

The purpose of assertion training is to help people choose whether or not to change unsatisfactory behaviors so as to exert their rights and express their inner worlds. Some methods have emphasized doing, some feeling, some thinking. According to Osborn and Harris, assertive training helps people to overcome anxiety and to enhance interpersonal relationships. It inculcates skills which facilitate direct and honest communication. Moreover, conversation and the unambiguous expression of opinions is improved, resulting in "a greater degree of self-confidence and control over one's life" (Osborn and Harris, 1975, p. 49). Colter and Guerra (1976) add that assertion training is also "a philosophy of life aimed at acquiring greater self-respect and dignity" and helps meet interpersonal needs without excessive guilt and without violating the rights of others.

A theme related to the philosophy of Reality Therapy is emphasized by Booraem and Flowers (Whiteley and Flowers, 1978, p. 46) who state that assertion is a right not an obligation, a choice among many choices, and one alternative which a person may choose or not choose to exercise. In addition, Smith describes some specific rights: to take responsibility for one's own emotions, judgments, etc.; to offer no reasons or excuses for one's behavior; to change one's mind; to make mistakes; to say "I don't know", "I don't understand", and "I don't care", etc. (Smith, 1975, p. 28-72).

In summary, assertion training aims at enhancing the overall mental health of people by presenting the opportunity to choose to fulfill their needs through more appropriate thinking, doing, and feeling behaviors.

REALITY THERAPY AND BEHAVIOR: CONTROL OF PERCEPTION PSYCHOLOGY

Reality Therapy and Behavior: Control of Perception Psychology (BCP) teaches people to observe and to evaluate how they are driving their behavioral system (directing their doing, thinking, and feeling) and to plan a more realistic, responsible and healthy way to live. This results in helping them fulfill their needs in a flexible and successful manner rather than in a rigid and failing manner.

The focus in Reality Therapy is on the "doing" component of the behavioral system. To develop a more flexible or successful behavioral system, a person must act or "do" along the four pathways of Reality Therapy:

1. Belonging: giving and receiving love and involvement with others.
2. Self worth or Recognition: gaining acknowledgment from others and enhancing competencies.
3. Fun: partaking in activities a person is not obligated to do.
4. Freedom or Control: being able to live without excessive external restraints and being free to make decisions with a reasonable amount of impulse control.

In summary, the use of Reality Therapy and assertion training are complementary in many ways. Both stress human rights and legitimate needs, building psychological strength through positive actions, involvement with others in a direct and clear relationship, and finally the singular importance of choice related to the fulfillment of desires.

CONTENT OF ASSERTION TRAINING UTILIZING REALITY THERAPY AND BCP PSYCHOLOGY

The following is an attempt to integrate the steps of Reality Therapy with the concepts of traditional assertion training in both process and content. The time framework for such training is flexible and adaptable. The role of the trainer throughout the program is to structure and facilitate, to model, and to intervene when necessary, but not to dominate or reduce the responsibility of the participants.

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The goals of such a training session would include the following:

1. To increase the knowledge of the participants about assertion skills.
2. To develop participant skills of assertion.
3. To teach the steps of Reality Therapy as a basis for the choice of using assertive skills.
4. To evaluate the knowledge gained and skills practiced through role-plays observed by the trainer and participants.

Making Friends Stage: The purpose of this segment will aid the participants in getting to know each other and the trainer, a warm-up exercise in which the participants actively learn information about at least one other person in the group. This technique is not confined to the opening of the training, but is used often and with variation. Since the basis of Reality Therapy is involvement with others, the warm-up exercise would serve as a basis from which to build.

Also, included in this phase is the determination of what the participants want. To an extent, the assumption may be made that they desire assertion skills due to their presence at the training, but expansion and specificity is needed. This aspect may then be accomplished by having the participants list, as individuals and as a group, the areas in which they experience difficulty, and also having them list those areas in which they at present feel confident in acting assertively.

It is important during all aspects of the training to use humor. The participants will be involved and relaxed if they feel comfortable. The use of humor usually serves this purpose appropriately. This aspect of the training will also aid the trainer in assessing the strengths and weaknesses of the individuals and the group as a whole. The dynamics of the group need to be continually monitored by the trainer.

What Are You Doing Stage: In this stage, the participants individually assess their behavior through the use of various techniques. The first activity is to delineate their strengths through the use of the “Strength Shield” as described by Simon (1972, p. 278), and the “Strength Bombardment” exercise as described by Alberti and Emmons (1974, p. 79).

As a further assessment, each participant completes one or more of the various paper-and-pencil measures of assertiveness. Some of these include the following: Assertiveness Inventory by Lieberman, King, DeRisi, and McCann (1975, p. 146-147) and Assertiveness Inventory by Gambirill and Richey (Whiteley and Flowers, 1978, p. 88), parts of the Assertive Data Collection Package by Colter and Guerra (1976, p. 213-222), Assertive Behavior Assessment for Women by Osborn and Harris (p. 193-196), and Assertive Quotient by Phelps and Austin (1975, p. 5-7). Feedback and explanations must be given to each participant, and questions answered.

As a part of the explanation for the individuals and group, information regarding the various categories of behaviors from which a person chooses will be presented. Jakubowski-Spector (1973, p. 76-79) uses the categories of assertive behavior, non assertive behavior, and aggressive behavior as a basis of distinction. Similarly, Lange, Rimm, and Loxley’s definition parallels the use of Reality Therapy in assertiveness training:

“Assertiveness is the expression of one’s feelings, beliefs, opinions, and needs in a direct, honest, and appropriate manner. Such assertive behavior will reflect a high regard for one’s own personal rights and the rights of others.” (Whiteley and Flowers, 1978, p. 101).

The participants will apply these categories and definitions to their individual situations throughout the training.

Another aspect of the second stage is the assessment and description of participants’ non-verbal assertiveness. Eye contact, body space, handshake, touching, body posture, facial expressions, and voice characteristics are observed through role plays or ordinary daily life situations. Feedback on the degree of assertiveness is given, and group discussion in a non-critical way is facilitated by the trainer.

Is It Working Stage: In this stage, the participants define which present assertive behaviors they wish to increase. They determine which assertive behaviors are effective, i.e. which ones are working. They are reminded that being assertive may be “a dangerous technique if you use it with people who are controlling for what they believe is important. If you need, work with, or live with people, you may win a lot of small battles, but assertiveness tends to increase little skirmishes into big wars” (Glasser, 1981, p. 229). Through group discussion, they evaluate the validity of results of the paper and pencil assessments conducted in the What Are You Doing Stage, and determine strong elements of their behavioral system which need further bolstering. From these assessments they also identify aggressive or passive aspects of their behavioral systems, and formulate possible alternative assertive options from which they could choose. A similar procedure is followed with the non-verbal activities described in the What Are You Doing State. Group discussions are characterized by questions such as “Does that particular behavior work for you?” “Are you satisfied with the way you meet people?” “shake hands with others?” “talk to others?” “act in a group?”

Plan of Action Stage: The Plan of Action stage involves two sub-stages: teaching alternative behaviors and making a plan of action. In the first sub-stage, the trainer discusses and demonstrates the various assertive behaviors. By far the most extensive aspect of the training, the trainer will need to divide the skills into manageable segments. Jakubowski-Spector (Whiteley and Flowers, 1978, p. 167-168) has divided the skills into five types. Some slight alterations to adapt them to Reality Therapy and BCP Psychology are as follows:

1. Simple Assertion: a brief statement of what the person thinks, feels or wants. Example: “It’s my opinion that Plan A is a good one.” Or, “I want a raise in pay.”
2. Empathic Assertion: a statement of the recognition of the other person’s opinions or actions but then assertion of one’s self. Example: “I appreciate your advice, but I’ll do it my way.”
In addition to the explanation and demonstration by the trainer, the participants will need to practice these skills to a satisfactory level. In the process of practicing the skills, it is important that the role play situations be as real as possible in order to examine the consequences and reactions of all parties.

The other sub-stage involves the plan of action. In this phase, each person develops a plan of action which will be specific, simple, positively-directed, dependent upon-the-self-to-do, repetitive, immediate, and attainable. The individual will need to specifically state the skills to be done and with whom. It is important for the trainer to oversee the plan making so that the plans meet the criteria of good plans. Each participant should role play the plan so that it can be executed effectively after the training has been completed. Each of these plans is written, with the participant having a copy as well as the trainer.

**Commitment Stage:** The commitment stage is associated closely with the value judgment and plan of action stages. In this stage, a commitment to follow through on the plan is secured as a reassurance of the value judgment. Each participant may wish to sign a plan of action as well as the trainer.

Experience has shown that at this phase, some of the participants demonstrate some hesitancy and fear of carrying out the plans. The trainer and other participants can aid the individual in re-examining and/or role playing the plan of action. If the fear and/or hesitancy persists, then a new plan of action with less threatening or more attainable steps needs to be devised. It needs to be continually reinforced by the trainer and the participants themselves that they must choose to assert themselves.

**No Excuses Stage:** In this stage which penetrates the other stages, the trainer should not solicit or accept any excuses. Rather he/she should tactfully, patiently, and relentlessly ask the participants to determine what they want, to make value judgments, and to evaluate whether their plans are realistic, appropriate, attainable and need-fulfilling. Once again, being assertive is pointed out as having a choice with advantages, disadvantages, and consequences.

**BIBLIOGRAPHY**

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The Educator Training Center, a division of the Institute for Reality
Therapy, is a national organization deliberately created to teach the theory
and practices of Reality Therapy to educators. Established in 1968, the
Center has trained more than 93,000 staff from organizations in every state,
and enjoys a reputation for excellence and practicality.

Doug Naylor directs the Center’s activities with his Resident Staff of
Elizabeth Mahoney, Leslie Ann Butcher, Tom McGuiness and Dennis
McLaughlin. Each Resident Staff member is an IRT Faculty Associate.
Assisted by a national cadre of Certified Reality Therapists in Education,
and a network of universities, the Center conducts one-week Intensive
Seminars (Reality Therapy in classroom management and counseling for
school personnel).

In addition to the one-week Intensive Seminars designed for educators
that teach the counseling and classroom application of Reality Therapy, the
Center offers schools and districts in-service opportunities in varying
degrees. Initial programs (2-4 hours) introduce “Glasser’s Ideas” and
provide basic information about Reality Therapy. Intermediate programs
(6-10 hours) focus Reality Therapy on a specific area in education:
discipline, motivation, stress and instruction. Advanced programs, like
Staff Leadership Training and the Student Leadership Training programs
incorporate the training of trainers approach to provide a “ripple” effect in
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development.

Through the Center, Reality Therapy is expanding to other areas with
increasing success. Liz Mahoney has developed a hospital management
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