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Journal of Reality Therapy

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THE USE OF IMAGERY IN REALITY THERAPY

Gerald D. Parr
Arlin V. Peterson

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Imagery has played a major role in many approaches to therapy. For example, client visualization of real or imaged events occurs in systematic desensitization (Wolpe, 1969), emotive imagery (Lazarus and Abramovitz, 1962), covert modeling (Cautela, 1979), relaxation training (Rossman and Kahnweiler, 1977), and hypnotherapy (Crasilneck and Hall, 1975). Imagery has been applied to a variety of problems: childbirth anxiety and discomfort (Horan, 1973), drug dependency (Flannery, 1972), nonassertiveness (Kazdin, 1975; Rosenthal and Reese, 1976), career confusion or uncertainty (Crabbs, 1979), test-taking anxiety (Gunnison, 1976), and cancer and other malignancies (Simonton, Matthews-Siminton, and Creighton, 1978).

We have found the use of imagery a valuable tool in the practice of Reality Therapy. It assists the client to clarify and alter perceptual errors (Glasser, 1980) and helps make all steps of the counseling process more concrete.

Imagery in the Counseling Process

In the first step of the counseling process, making friends and getting involved, we informally assess the client’s potential for visualization. We also facilitate the client’s imagery to enhance rapport. For example:

Counselor: So you enjoy fishing.
Client: Ya, especially trout fishing in the mountains.
Counselor: As I recall, trout are easier to clean than some other fish, right?
Client: Right, because they don’t have scales. I just take my knife and cut up their belly from the rear to the gill. I strip their guts with one swipe.

It is evident that this client naturally recalls vivid details as he describes how he cleans trout. Furthermore, we believe the counselor’s unobtrusive question about cleaning trout is seen as authentic involvement by the client. It may even be possible for this client to experience a positive set with the counselor that is similar to that which would be experienced if they were to actually go fishing together. If we find that our client doesn’t spontaneously think in images, we use prompts such as, “And what do you see happening if that occurs?”, “Can you tell me what you imagine will happen if . . . ?” “How does that look to you?”, and “Tell me what you picture yourself doing . . . ” Most of our clients are able to respond with images, and we find it easy to adjust our pace and expectations to match our clients’ readiness for imagery.

In terms of the second step in reality therapy, we find imagery helps to keep the clients’ focus riveted on their present behavior. Digressions, excuses, protests, and other avoidances tend to fade when the client responds with the specificity and concreteness of visualization. For example, in the following dialogue a ninth-grade girl begins to face the real issue behind her truancy:

Counselor: You missed school yesterday.
Client: Ya, I didn’t feel well.
Counselor: What did you do with your day?
Client: Nothing, just watched TV.
Counselor: Can you picture what your day would have been like had you come to school?
Client: Ya, I would have fought with the P.E. teacher again.
Counselor: Do you see that happening today?
Client: Ya, probably.
Counselor: How, specifically do you see that happening?

In this example, the client moved from a vague description of missing school because of illness to a more tangible description of an interpersonal conflict.

The third step of reality therapy concerns having clients make value judgments regarding their behavior. We use imagery here if clients are fuzzy about their values or about how their values relate to their behavior. If the client can make this judgment with some degree of decisiveness, we move directly to the next step. An illustration of the application of imagery at this step follows:

Client: I know I shouldn’t smoke dope, but it is so relaxing.
Counselor: Can you imagine yourself relaxing without smoking pot?
Client: I don’t know. What do you mean?
Counselor: Do you remember ever feeling relaxed while being straight?
Client: Ya, I guess.
Counselor: Describe it.

Counselor: So can you tell me what is behind your saying you shouldn’t smoke dope?
Client: It’s bad for your health.
Counselor: Go on.
Client: Well, in health class we saw pictures of lungs of pot smokers.
Counselor: What do you imagine your lungs look like?
Client: Black and full of junk.

Counselor: How do you picture your life being different if you were to give up pot?
Client: I could breathe better, run better, and I guess I'd just feel better, less tired during the day.

Counselor: So when you put two pictures of your life side by side — one with pot and one without — how do they compare with what you want? And before you answer, take a minute and just relax and imagine yourself looking at two TV screens, one with you as a pot smoker, one without.

(Pause)
Client: Okay, I see. I want to quit. I just need to know how.

The next step, developing a positive plan of action, lends itself quite easily to rehearsal via visualization. Basically, this involves having the client describe and possibly role-play each step of alternate plans of action. In the following example, a college student has decided to assert himself with his roommate:

Client: I just wish I could ask Jim to turn his stereo down when I need to study.
Counselor: How do you see yourself approaching him with your request?
Client: Well, I'm not sure.
Counselor: Is there a particular time and place when you think it would be best to approach him?
Client: Ya, Sunday afternoon when we go out for an early dinner.
Counselor: Alright, now imagine you and Jim are at dinner. What do you say?
Client: Well, I'd like to tell him I just can't concentrate when his stereo is so loud.
Counselor: Can you picture in your mind's eye how you would like to say this?
Client: Ya.
Counselor: Would you like to verbalize your conversation with him as you visualize it?
Client: Okay, I'll try.

We find that ambivalence toward a plan of action often grows out of a client's reluctance to commit to one plan of action over other alternatives. An example of how we address the commitment step of counseling is the open-the-door technique. This is a guided fantasy technique where the client is asked to visualize taking an elevator ride to a tenth floor, at which time the elevator door opens and the client sees himself executing the plan of his choice. In the following, a girl is undecided about whether to accept a scholarship at a university in another city or to stay at home near her friends and family:

Counselor: Just relax and if you wish let your eyes close as I guide you on a fantasy ride on an elevator.
Client: Okay, I'm comfortable now.
Counselor: You see yourself enter an elevator and you push the button for the tenth floor. It is comfortable and you enjoy having this time to yourself so you can think freely and productively. You feel the elevator rise and it passes the first floor and you are allowing your future plans to unfold before you. (pause) As you reach the second floor you sense more certainty about your plans, and you want to give both of your plans your full consideration as you pass the next four floors. I will signal as you pass each floor ... (pause) ... third floor ... (pause) ... fourth floor ... (pause) ... fifth floor ... (pause) ... and sixth floor. Now before you reach the seventh floor, select the plan you prefer least and see yourself saying good-bye to all that it might have offered you. When you are ready to go ahead, nod your head ... Now as you pass by the eighth floor allow yourself to see your preferred plan to materialize. That's right ... now as you come to the ninth floor take all the time you need to see yourself overcoming any difficulties you might encounter with your preferred plan. Signal when you are ready for the next floor ... (pause) ... Okay, now feel the elevator coming to a rest as you reach the final floor. When the door opens picture yourself executing successfully the plan of your choice. Ready. The tenth floor is reached; the door opens ... (pause) ... Let's talk about your plans.

The open-the-door technique can be and in some cases should be varied. You can use a staircase or steps up a tower, for example. You could use any metaphor, in fact, which structures the guided fantasy in such a way that the client comes to terms with options and commits to one plan of action. As a rule, we use metaphors that build on situations which the client finds familiar and pleasant. We concur with Wubbolding (1975) that forcing a plan is a pitfall of impatience, and we do not offer this technique in a spirit of imposition. Rather, we see it as a viable strategy for indecisiveness and ambivalence. We also want to stress that the counselor-client dialogue that follows the fantasy can be fruitful. If the dialogue suggests that re-cycling to an earlier step is necessary, we don't hesitate to do so.

The final steps of the reality therapy process concern translating excuses into renewed plans and allowing the therapeutic relationship to maintain a punitive-free tone. We find the use of imagery, along with other techniques, permits both, at all phases of the process. In fact, we find the blueprint of reality therapy and the technique of imagery an exciting, creative way to help people achieve their success identity.
REALITY THERAPY IN CONTINUING EDUCATION: COHESIVE CULMINATION

Virginia F. Ziegler

The basic concepts of Reality Therapy are based on fundamental psychological needs (Glasser, 1965; 1972; 1981). Learning to fulfill these inherent human needs through responsible living is central to understanding Reality Therapy (Glasser, 1965; 1972), (Ford, 1981). The concepts of Reality Therapy emerge as a strategic process for developing personal responsibility for fulfilling one's basic human needs and for the quality of one's life.

Rationale. The concepts of Reality Therapy are practical uncomplicated approaches toward attaining responsible behavior. As such, Reality Therapy is a readily understandable process for professional counselors and lay persons alike. Thus, sharing these important concepts with lay persons became a goal of the author. This account serves as a record of an initial endeavor in that regard.

Background. A proposal to conduct a course in Reality Therapy was submitted to the Director of Continuing Education at the University of New Orleans (UNO) in early spring. This appeared a natural outgrowth of the favorable response generated in the New Orleans area for Glasser’s conference scheduled for July 6, 1982. It was the author’s intention to reach persons within the community who were unfamiliar with the Reality Therapy process.

Participants: The group was small, consisting of 4 men and 2 women. The men had no prior knowledge of Reality Therapy; the women had had previous training. Twelve sessions, each 1 1/2 hours, were scheduled biweekly (Tuesday and Thursday evening).

Sessions. The sessions were segmented; initial personal activity, information giving, and concluding personal activity. To illustrate, a typical session might consist of self-introduction to group including some personal information such as, “I’m (Virginia). I like . . . . The information component might be recapping the definition of Reality Therapy, the basic needs, stages in progression from security and success identity toward failure identity. The new information might consist of the pleasure/pain aspect of the Blue Chart and the steps in Reality Therapy. The final activity might be to share with the group one positive behavior practiced since the last session that helped meet another persons’ basic needs.

Each participant kept a notebook. Charts and the chalkboard supplemented the lectures; however, no handouts were distributed because the instructor’s goal centered on providing participants the opportunity to
practice the concepts presented during the sessions. Confidentiality was established during the first session in order to create an atmosphere of trust for those participants who might choose to apply the concepts to their personal situations during class meetings. This proved invaluable in light of the personal revelations during subsequent meetings. The instructor's role was as a facilitator in assisting participants' applications of concepts to their real life experiences.

Results. There was increased evidence of mutual trust among members. For example, a man who had initially identified himself as "shy" initiated the discussion on a highly personal topic. His opening was followed by self-disclosure from a second individual who had earlier described himself as a "private person". The two women who had previously encountered Reality Therapy concepts subsequently revealed their initial dilemma, how could the course possibly promote their additional knowledge governing the concepts since the other members of the group would require basic information? The women later shared the enrichment provided by the personal activities as well as the application of the concepts themselves to their situations.

Conclusions. The last two sessions were consolidated into a 3 hour component conducted on a Saturday afternoon by group consensus. The participants were asked to prepare a brief presentation on Reality Therapy concepts that was applicable to their work. The presentations were delivered in a professional, informative manner and reflected the unique meaning gleaned from the course by each participant.

The participants were asked to write a paragraph toward the end of Fall in order to demonstrate that the Reality Therapy concepts remained operative in their lives. The participants agreed willingly; however, one requested that those be disseminated among all group members. Another suggested a subsequent reunion. Finally, a third asked if it were possible to continue meeting. Consequently, group meetings continue.

Commentary. One concluding class assignment consisted of a written account of the positive effects the Reality Therapy process produced within participants. Permission to share excerpts of their personal accounts was granted. Of course, anonymity was assured. The following are participant comments with respect to the effectiveness of the Reality Therapy process in their personal lives:

This course has taught me that I am responsible for my own life. I cannot blame others for what happens to me. This course has given me a new insight into how I relate to others and how they relate to me. This course has been very exciting and inspirational for me. It caused me to reflect more on my needs and to seek to set some specific goals to take action to meet them.

My personal growth has probably been slower and less easily recognized, but I am aware of the changes Reality Therapy has made in my life. I am more positive, less critical and more open to enjoyment than ever before in my life. I also feel I am dealing more effectively with . . . .

This class has been a super plus for me in dealing with some deep emotional difficulties. This class has given me the background necessary to understand why AA works so well. Stations of the Mind was one of the most interesting books I have ever read. The BCP approach seems to be a much quicker and more effective method to overcome many of the problems encountered in our day to day lives. Of course for me, I think I am dealing with an abundance of problems and need the most effective method available. This, I think, is it.

Bibliography
PLAN CENTERED TEST INTERPRETATION: GOING BEYOND INSIGHT

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The Reality Therapy concept of choice is central to the establishment of an individual's success or failure identity and gaining strength (Glasser, 1965, 1968, 1976). A critical element in making appropriate decisions rests upon skill in obtaining and interpreting accurate information to form workable positive plans of action.

Standardized test results can assist clients in obtaining some of this important information related to life decisions. However, this is true only when the appraisal process utilizes valid instruments that are administered properly and interpreted clearly. Research has shown that tests and testing programs are no better than the test administrator and interpreter. Tests can be valuable tools, but only to the degree that test users are aware of test limitations (Kriner, 1983).

There are three general purposes for testing: administrative, e.g., making judgments regarding curriculum or staffing in schools or agencies; instructional-diagnostic, e.g., identifying strengths and weaknesses to enhance teaching effectiveness; plan-centered, e.g., helping clients gather information about themselves useful in career choice. Reality Therapists skilled in the use of the eight steps can easily incorporate the plan-centered uses of testing into their counseling for the benefit of their clients.

The testing process, incorporating critical test selection, thorough client orientation, proper administration, and professional interpretation is a way of utilizing Step I (Be Friends). Clients who understand the purposes of testing and know that the results will be shared with them are likely to become more interested and cooperative in the effort.

Clients exhibiting negative feelings toward the testing process may demonstrate behaviors ranging from severe "anxiety-ing" to "apathy-ing". These feelings increase when competent test interpretation is absent. Professional helpers and clients must see that measurement is merely a starting point and not an ending point for change. Client awareness that the professional helper is becoming actively involved with them in designing positive action plans starting when the testing process is critical.

THREE BASIC QUESTIONS

Measurement of aptitude, achievement, personality and interests, and intelligence is one vehicle by which professionals can assist clients to ask and begin to answer three basic questions: WHERE AM I NOW? WHERE DO I WANT TO BE? and HOW CAN I GET THERE? (Wysong, 1966). These questions formulated by test practitioners are clearly compatible with Steps I through IV of Reality Therapy.

QUESTION I: WHERE AM I NOW?

Valid results obtained from standardized appraisal techniques can help clients more clearly gain insight about themselves. In short, measurement can assist the clients to look at "what they are doing." Test results may confirm already known client strengths and weaknesses or offer new information and thereby help clients focus upon "self". Yet, the inability or unwillingness of some persons to accurately determine their own present behavior impedes their formation of plans necessary for self-growth. Therefore, test interpretation sessions require individuals to become actively involved in determining their own present and future behaviors.

QUESTION II: WHERE DO I WANT TO BE?

The concept of measurement as a starting point that helps individuals to determine their present abilities, achievements, or interests can be viewed as a kind of present behavior. Clients can now more realistically look at future wants or goals in light of their immediate situation. Many clients may be very comfortable with the appraised "self" at present and find future wants or goals compatible with information gained through testing. Other clients, however, may see a gap between how they are and how they wish to become. In other words, they experience a perceptual error.

Likewise, testing can be used to create perceptual errors needed for formulation of future appropriate plans. With the Reality Therapist's assistance, these clients can evaluate and re-define future goals and wants, or begin to actively make plans to achieve their goals and wants. Therefore, the considerations of Where Do I Want To Be? when contrasted with Where Am I Now? form the basis of a value judgment made by the client.

QUESTION III: HOW CAN I GET THERE?

Whether the gap between measured present and desired future behavior is large or minimal, clients need help in answering the question How Do I Get There? In other words, how much do I need to change process?

The asking of these questions relates to the Reality Therapy steps of making a positive plan of action and demonstrating a commitment to that plan. Those clients who already find their present behavior compatible with their wants and goals can be helped to see that appropriate plans for change will still be necessary for success. Those clients who experience perceptual errors between how they are and how they want to be must also be assisted in accurately identifying and implementing workable plans to accomplish change and get what they want. However, the change process involves choosing (making a plan), and then committing oneself to that choice/plan. Many people will readily say they want to change, but the tasks of designing, implementing and maintaining new behaviors as part of this change process is sometimes more difficult. The positive plan of action that the professional helper and the client develop must be one that is specific and attainable. Merely identifying that change is necessary for a client to reach goals (or attain wants) is inadequate. Likewise, designing a strategy that is very general or too complex results in a vague plan soon to be
abandoned by the client (Wubbolding, 1975). Consequently, Reality Therapists can use test interpretation to assist clients to look closely at what they want and at the amount of change necessary to attain what they want.

THE TEST INTERPRETATION INTERVIEW

In helping a client ask and work toward answering the three basic questions of WHERE AM I NOW? WHERE DO I WANT TO BE? and HOW DO I GET THERE?, Reality Therapists need a structure for test interpretation interviews. Wysong (1966) has described "Phases of a Test Interpretation Interview" as one such framework. These phases can be integrated into the steps of Reality Therapy.

PHASE I

RECALLING THE TESTING EXPERIENCE. This helps clients to recall the testing activity and assists in involving them in the interpretation interview. Discussion regarding the client's recall of the testing session may also uncover information that would effect the validity of the scores for the individual. For example, during recall the client may reveal feeling ill or not understanding directions for marking the answer sheet. This obviously can distort the meaning of test results.

The Reality Therapist should review the perceptual level of the clients at the time of the test. They should ask whether the clients perceived the test at a high level of perception, making either favorable or unfavorable judgments concerning the taking, the purpose or the use of the tests and its results; or did they perceive the test a lower level of perception, and thus suspended judgments concerning it.

PHASE II

UNDERSTANDING THE PURPOSE OF TESTING. Although the testing professional has previously explained the purpose of the test during an orientation session, it is wise to again briefly review such information. A simple restatement of the purposes of the instrument aids in clarifying what clients may expect their test scores to represent. Professionals must help their clients realize that test scores are at best "good guesses" in attempting to appraise aspects of their behavior (Kriner, 1983).

PHASE III

OBJECTIVE REPORTING OF TEST SCORES. In this phase, professionals provide interpretive statements that accurately describe the client's performance on the instrument. Utilization of norm data that can be understood by the client is necessary. Likewise, a brief discussion of concepts such as the standard error of measurement helps clients to view test results as a description of how they marked the answer sheet on the test date rather than as an immutably absolute categorization of them for all time.

PHASE IV

REACTION OF THE CLIENT. By encouraging the clients' discussion of their thoughts related to test results Reality Therapists can assess and clarify the clients' evaluation of their test performance. Also, at this phase it is important to help clients compare and contrast what they previously knew about themselves with the information suggested by the test profiles. In other words, are there any surprises (differences in previous perceptions of self and present perceptions of self as indicated in test results)?

PHASE V

RELATING INFORMATION TO COUNSELING GOALS. In this phase the Reality Therapist utilizes the information gathered from the test to help clients take more effective control of their lives. The testing experience serves as a vehicle for client and counselor to define client wants, evaluate the attainability of those wants, examine what they are doing to fulfill them, evaluate what they did toward achieving their wants and finally making a plan to do better. In short, the counselor practices the steps of Reality Therapy.

SUMMARY AND CONCLUSION

Through the testing experience and the test interpretation interview the Reality Therapist has become involved with the client. The discussion of test performance with clients allows for an assessment of the "self" now (present behavior) and a value judgment upon that. A discussion of goals and wants and the change process necessary to attain those goals and wants are compatible with clients making and committing themselves to a positive plan of action necessary to undergo such change. Likewise, future interviews with the client must incorporate the additional steps of Reality Therapy including "no excuses" and "no punishment" for failure to follow through with the plan.

Bibliography


CASE EXAMPLES OF THE APPLICATION OF REALITY THERAPY TO FAMILY THERAPY
Edward E. Ford

This article is a selection from the chapter entitled Reality Therapy in Family Therapy by Edward E. Ford in the book Family Counseling and Therapy by Arthur M. Horne and Merle M. Ohlsen, published by Peacock Publishing Co., Itasca, Ill. 1982. A reprint of the entire chapter entitled A Summary Of Reality Therapy in pamphlet form is available through Ed Ford, 10209 N. 56th St., Scottsdale, Arizona 85253 at $1 per copy. A Spanish edition is also available. Mr. Ford is a faculty member of the Institute for Reality Therapy.

The eight steps of reality therapy are what we use to help people lead their lives more effectively. Whether we are seeing a couple, a child or an entire family, we learn to apply the steps creatively. We find out first what they want and then either what they are doing now that may be strength building or what they have done in the past that was helpful or enjoyable as a possible direction for making a plan in the present. With both couples and families it is essential to find out what they have in common upon which they do now agree or at least something upon which they could develop an agreement and then act on it. This is critical to rebuilding family love and unity. It isn’t the problems in the family that separate the family. All families have problems and will continue to do so. The raising of children as well as living intimately with another is enough to create friction. What is important within these relationships is to build a relational-confidence, which is a belief between two people that they can reasonably and calmly, without any prejudice, handle cooperatively and respectfully, the problems which arise from time to time. So we look for areas where people can agree, or what they have in common that could help. The job of the therapist is to help them find within their lives what they can do that will help them gain or regain a belief, a hope, in the relationship so that they can, perhaps for the first time, learn what it is to deal rationally with each other to solve problems through compromise.

Problems don’t destroy families, the inability to solve them does. Problems are merely symptoms and indicate the lack of relational-confidence. Learning how to resolve problems starts with gaining confidence in each other. The best way to start to build this confidence is to find activities members of the family can do with each other. This works for couples and also for families when the counselor helps them find activities to do as two people in a family and as a family group. This means time alone not only for the parents, but for each parent with each child. This gives each member of the family access to each other member and leads eventually to resolving difficulties in a trusting atmosphere. From building this “couple-confidence,” people can move on to learning to resolve problems together.

The criteria of the activities are important. The first is that the persons doing the activity should be aware of one another. The activity may be throwing a frisbee or playing cards, but that other consciousness must be there. When two people are together, the realization of the other person’s presence is felt more through common activity than by just talking with each other. Recall the old saying, actions speak louder than words. In a relationship which includes much bickering, the activity should have the least possible amount of stress. A highly competitive sport, for example, should be avoided. So should any activity where upset is likely to occur, such as working out the family budget, if you believe this is an area where the couple hasn’t developed sufficient relational strength to handle the problem.

The second criteria is that the activity should involve making an effort, whether physical or mental, or a combination of both. Two people riding bikes or playing cards is more productive than two people taking a ride in a car which involves very little effort.

The third criteria is that people spend time alone with each other. This is the most misunderstood criteria and yet it is extremely important. Little can be accomplished in building relational confidence on a long term basis unless this is done. Each member of the family should spend time alone with each other family member. The father, for example, should spend time alone not only with his wife, which is critical to a good marriage, but also with each child. They must do something enjoyable together. One of the pitfalls of modern families is that after children are born it is believed that all activities must be done as a family. This is a mistake. Confidence-building time the parents had been spending, prior to the arrival of the children, is reduced, and at the time when there is a decided increase in stress.

The fourth criteria for confidence-building activity is that it be done regularly, preferably every day. This, too, is often overlooked. If each member of a family can do a daily activity with each other member there is a remarkable turn-around in their individual as well as collective ability to resolve problems. This can be doing home work, washing the family car or doing a jigsaw puzzle. In all of these, two or more people are spending valuable time together. Families usually assign individual tasks around the house when it would be more constructive for members of that family to do things in pairs and use the necessary work of running a home as a vehicle to unity.

Unfortunately, most family activities in a modern Western culture are moving toward passive entertainment, or amusement. There is an illusion that this type of time spent by families is beneficial. Television robs the members of valuable confidence-building time, as do other passive spectator activities such as movies, operas and sports. These are not wrong in themselves but they provide no real confidence-building time for families. It is only when we work at creating our own fun that real strength between people begins to grow.

It is also an illusion that engaging in physical stimulation is a growth factor in building relationships. Neither eating nor drinking nor engaging in sexual activity has much to do with helping two human beings get along. The activity may “feel” good, but the chances that this will help a relationship is small unless strength building activity is ongoing. A father or mother eating in silence or near silence with a child has little benefit to the relationship. They have mutually satisfied and in the process stimulated
their bodies, but little has been done to build any sort of confidence which creates the belief “we can make it.”

Sex is believed to have much to do with helping to develop a relationship. It is usually an enjoyable part of a relationship but has little to do with creating confidence. The pleasure of sex comes from mutual stimulation which gives highly intense feelings but again does little of lasting value for the relationship unless strength building activity has been developed. Usually when I deal with a couple with sexual problems, I find that as they begin to build a solid confidence-building basis in their marriage, the sexual problems eventually resolve themselves. Sex seems to correlate with how well the couple get along in other areas of their life. It brings people close physically, but has little to do with either giving them the relational-confidence needed to resolve problems or helping them to learn how to work out difficulties when they do arise.

Although with both couples and families we try to start by finding what our clients have in common, what they can agree upon and what they can do together that will be satisfactory to both or all, sometimes we see people who are too upset to stay in the same room. Their relationships within the family are so fragile that the counselor has no alternative other than to separate them and see each person alone. This is especially true if there is highly critical interplay. When they come in initially there may be sufficient confidence or belief in the possibility of reconciliation for them to handle one session. But if they become critical, the counselor should not see them together. They know how to criticize, and allowing such behavior gives tacit approval. Unless they are able to resolve problems without making things worse, there is little value derived from having them all together. The goal of the counselor is to help the family arrive at the point where they can work together calmly and rationally to make judgments and plans and then commitments. Then the family has learned how to take responsibility for living a more effective life.

No therapy is going to help, however, unless those involved are willing to take part and do their share of work. Sometimes when asking “Is it in your mind to work at this relationship?”, I have heard a reply such as “No, I’m just here to satisfy my parents” (or spouse or child, or whoever). I might then reduce my question, somewhat and say, “Would you be willing to work at the relationship for two weeks and then make a decision?” This will sometimes get a positive reply. The more desire there is to work at a relationship, the more likelihood there is of reconciliation and family harmony.

But while working toward family harmony we are always still looking for what each person can do to build strength in his or her life separate from other members of the family.

With children who are brought in by parents, or who come in on their own, I listen to hear what strengths, if any, they have in the areas of belonging, love, worth, fun and freedom. I check out how they are doing in school. Are they close to any teachers, are they doing well in any subject, do they have friends, what activities are they in? Then I can determine where their strengths lie in relation to school. Finding out what they want helps find the best direction to go in working with children. With older children I ask if they are working. I have found nothing more important in helping a teenager to grow in terms of worth-need fulfillment than a job away from school. Unfortunately, most schooling is perceived by many children as having little value, and gives them little worth-need fulfillment which makes work a practical, necessary addition. It also develops a better perception of money.

I talk with children about their home life seeking need-fulfillment areas. With whom are they close? Is there another child with whom they can spend time or who, if they are older, will spend time with this child? Recently a widow came to see me about the youngest, aged 11, of her four children. The child was extremely disruptive, which I saw as the symptom, both at home and school. No one was spending individual time with her thus there was a lack of love-need fulfillment. The mother worked but was able to enlist the aid of her older children to spend time with the youngest who developed a better sense of belonging, love and had fun in the process. Within 2 weeks, the disruptive behavior began to disappear.

Creativity is needed from the counselor in searching to find ways to help a family grow. And while you are doing this, you are also helping individual members in the relationship develop responsibility not only for themselves and what they are doing, but also for other members of the family. A young teenager came to me in a school setting crying and stating her whole family “was in a mess and she didn’t know what to do.” She made a plan to spend time with a younger brother by helping him with his homework. The parents’ late evening and early morning arguments were preventing the little brother from getting a good night’s sleep so she decided to take him into her room where he slept better. She helped a younger sister in the same way. The mother ultimately noticed what she was doing, and realized how much she had been neglecting the children. She began to work with her daughter cooperatively spending more time with each child doing strength building activities. Ultimately, the whole family, with the exception of an older brother away at school, began to work things out and became closer.

Sometimes nothing can be done to reconcile a family. Then the only alternative is to help people grow individually. Typical in this area, for example, is the child whose parents are unwilling to work with him or her or the other way — a child unwilling to work things out with the parents. Then it is best to work with the person or persons willing to do so and help them deal with the world and make peace with the parents as best as possible. I was seeing the mother of a 15-year-old girl who had left home and moved in with her boyfriend’s parents. She continued going to school, did well, had a job and was using the boyfriend more as a means to an end than as a lover. The mother needed therapy to help her deal with the child’s leaving. Fortunately, there was a supportive husband and other children at home with whom she could fulfill her needs. In fact, the other children were “glad to get rid of their crazy sister.”

Reality therapy asks that people take responsibility for their lives in terms of what they want. This is not such a difficult task when helping a family member deal with a situation over which they have control. The problem arises when each member has to deal with another and someone
other than your client refuses to do anything which would make it possible to build relational-confidence and make negotiation possible. Then the counselor has to help make a plan with the willing member to make peace with the unwilling member or members of the family. There is an excellent example of this in Douglas Walker’s case in What Are You Doing? (Glasser, N., 1980, chap. 9). His client, Wren, is a young adult who wants to complete her college education. For financial reasons she has moved back into her parents home and she tells Walker that her parents “assigned her all kinds of errands, hassled her about when she came home and gave unsolicited opinions, mostly negative, about her friends . . . they rarely spoke except to argue.” Walker and Wren knew she would not be able to continue living with her parents and thereby graduate “unless some changes in relating occurred.” Having determined (the value judgment) that she wanted to stay in her parents home, Wren needed a plan and Walker asks her, “I know there seem to be a lot of hassles with your parents but are there ever any conversations which don’t have an element of contention?” She says there aren’t, so she just stays in her room. “What would you think about the possibility of your initiating a conversation on some nonvolatile subject? Ask your folks about what it is they are doing in terms of their work, something like that?” He tells her to pick the time carefully, make the conversation short and then “take a few moments to ask them something about their day or share something about your day that is completely benign . . . She tries this and she made it work. Sometimes you can’t get rid of the bad, but you can usually add a little good. We didn’t get rid of all the arguments, but we did reduce the percentage of conversation time that was taken up arguing. That made home a better place to be.”

Probably the single biggest obstacle to rebuilding strong relationships is criticism. It is overwhelming how much criticism goes on in families and how much this affects the harmony of their lives. Constant criticism is often what makes it almost impossible for people to reconcile. It reflects a belief on the part of the one criticizing that the other person hasn’t the capacity to figure things out. So if the person being criticized hasn’t an idea of what to do, or a behavior which might help overcome his or her present inability to act wisely, criticism can only result in increased frustration and decreased self-confidence. This leads to even less rational behavior when a person overrides his or her judgment system and ultimately, in many cases lashes out, making things worse.

Families who really do want to reconcile or are looking desperately for a way to deal with another family member rationally think they can use criticism as a vehicle to this end. It doesn’t work, and they know it. Many times I have said to a person, “How does criticizing him/her help?” and often I get the reply, “I know it doesn’t, but I don’t know what else to do” or “I can’t help myself.” Fighting, bickering, yelling and screaming, even physical harm all go on constantly, and all in the name of trying to deal better with human conflicts.

There are several ways to deal with this. Let’s say there is a crisis situation like this: a teenager is leading an independent life within the family home, coming and going at will, refusing to do anything within the home in the way of work. I have found in this situation, almost universally, a lot of criticism. I ask the parents to stop all criticism and say nothing, for example, when the child comes in at 4:00 in the morning. “But what good will that do?”, I hear. My reply is “Is what you are doing now helping you get along with the child or doing anything at all to make things better?” “No, but what else can we do?” And again, I say, “Say nothing when the child comes in late.”

There is a strong urge to preach and tell another member of the family what he or she is doing wrong, and thereby straighten up the other person. But this has never worked yet and never will. People begin to change by how they are treated, not by what is said to them. You must get them to examine in a calm rational atmosphere with someone they accept as warm and caring what they are doing and what they want. Eliminating criticism can make this possible. This internal process of self-evaluation has a better possibility to develop if members of a family say nothing. Even young children will learn better how to handle their future problems if allowed to develop self-evaluation without criticism.

But children do need to learn to obey rules which is the essence of discipline. I find myself teaching parents many skills they need to know, such as how to talk with the children when there is a problem, how to handle them when a crisis occurs. We do role plays. I take the part of the parent and they are the child. This gives the parents something they can do, a skill they can learn and then apply. Parents often need instruction, I find, more than anything else. Most are willing and capable of working with their children but simply do not know how.

When there is frequent fighting or bickering I teach people to separate when handling a crisis. Walk away and do something else rather than confront. This helps both parties to calm down so that they can act rationally. No one can resolve a conflict with another when either one of the parties is upset. When children are upset I recommend sending them to their rooms until they are ready to come out and work things out. This teaches children to separate from others when upset and that they have control over when they are ready to reconcile. When children are primary-grade age or younger, I suggest parents put them in a chair. The child can see the parent but does not have access to the parent or others in the family until he or she can “smile and work out a plan to get along.”

These are practical, down-to-earth ways of handling problems and really help. But it is important for a client to realize it is his or her problem, it is what the client wants, what he or she is doing and the client’s plan, not the counselor’s. Often when clients return for another session, they say “what you told me to do doesn’t work.” There must at some time be a shift of responsibility from counselor to client. Repeating the value judgment can help do this especially in the earlier sessions. I am reminded of the cartoon, Frank and Ernest by Bob Thaves in which two men are standing at a bar drinking and one is saying to the other “My psychiatrist has switched to Reality Therapy and now he’s blaming me for everything I do.”

Also, in the beginning of therapy I advise the family members to talk about problems only in the counseling session. Do not discuss them at home. Those involved haven’t as yet developed sufficient confidence to
handle stressful conversation. People who have heart attacks don’t go jogging the next day. After the body has developed enough “strength” to handle the rigors of training, they begin a course of exercise. People are similar in relationships. Conflicts between humans are the single most difficult obstacle to happiness. To attempt to resolve conflicts through conversation too early in therapy can cause a loss of hope in getting things back to normal, a sense of failure that “nothing will work” and, probably worst of all, a tendency to give up on any type of reconciliation.

People often like to think that because they have had long talks at home about their problems that the problems will disappear. They will come into the office and tell me they have “worked things out.” But this is not true. The problems are still there and will be until they have changed the pattern of their behavior in such a way that they are able to handle the conflicts in their lives more effectively.

People talk more reasonably after they have spent time doing activities alone together. If the talk flows from the activity, such as what might happen while washing the dishes or the car, playing cards or fixing something around the house, then the conversation, because it flows naturally and pertains to what is being done, will be helpful. Ultimately, it will build the belief they can talk reasonably without eventually yelling at one another.

REALITY THERAPY FOR SELF HELP

Patricia Haines

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Unlike many theoretical approaches which are used in therapy to correct pathology, Reality Therapy (R.T.) provides the means for personal and professional growth, when used as a continual program of self development.

Dedication to consistent practice is essential to success. Often growth takes a back seat to problem solving since problem resolution is viewed as an immediate concern. Mental Health practitioners have struggled with this concept in prevention versus treatment. Most practitioners recognize that prevention of disturbance is more desirable than correction, but time and energy seem to dictate a priority for correction. Therefore, attention to strengthening the power and skill to live successfully has been neglected.

Individuals can solve problems and grow simultaneously. In R.T. terms, persons determine what they want. Their wants may involve solving or they may involve fulfilling the need for love and belonging, increasing worth and recognition and including more fun in lifestyle. If problem solving and growth are integrated into the total life experience, the basic need for freedom is consistently met.

Putting intentions into writing along with a method of accountability for self provides a greater likelihood of success. Written plans bring intentions to action. Success becomes a reality only through action.

The following plan for improvement is being used by persons who wish to overcome a specific problem or by individuals who simply desire to improve the quality of their living. According to the R.T. concept, the best plans are made by those who are willing to change that which they are doing now in order to get what they want. This writer utilizes the R.T. Plan for Improvement routinely.

The form shown here can be used by individuals to create and monitor their plans to do better.


Ed Ford has taken the ideas of Behavior: The Control Of Perception psychology and Reality Therapy, along with the concepts from his book, Permanent Love, and has produced a unique book on loving. He deals with such topics as learning what to do with what we want once we have it so that we can fulfill our needs; of changing a seemingly locked-in negative perception of those we want to love; of recognizing the illusions of love and sex which we carry into our relationships and married life; of how we abuse the need for control when our other needs aren’t being met; of how we can create love in our own world and discover the joy of knowing another’s world.
INSTRUCTIONS FOR USING THE PLAN FOR IMPROVEMENT*

Date: (Date of Entry)

What Do You Want? In simple terms list what you really want. What goal do you wish to achieve or what problem do you wish to solve?

What Are You Doing Now? List specific actions you have taken to reach your goal or resolve the problem. Thinking about it or realizing something must be done does not constitute action. Recognizing that a problem exists is not half the battle. It is perhaps one-fourth. After recognition comes the true test of dedication to change.

Is It Helping or Hurting? Write ways in which your actions are helping to relieve the problem or ways in which your choice of actions is not working.

What Is My Plan To Do Better? Make a plan with specific actions which will help you achieve your goal or alleviate the problem. Write only those actions which you are willing to do.

Am I Committed to Follow My Plan? Are you committed to faithfully and consistently follow the actions stated in your plan. Think about it before you mark "yes" in this column. Your answer here reflects how badly you want to achieve your goals or solve the problem.

Date: Date of each subsequent day.

Did I Follow My Plan Today? Answer Yes or No. An answer of "Some times" really means no. Therefore, list it as "No". A "No" answer reflects a lack of commitment to following your plan and to achieving your goal.

What Excuses Did I Give for Not Following My Plan? What excuses did you give yourself for not following through with your plan of action? Write them down, then recognize that they are excuses, not reasons.

What Were The Consequences? What happened as a result of not following your plan? Perhaps the most significant result is no change for the better or matters became worse.

Review What I Want. If you did not follow through with your plan, you should look at your goal. Again decide if that is what you really want.

What Is My Next Plan? If you decide you really want your original goal, make another plan of action to achieve it. Go through the same process until the goal is reached. Goals should be flexible. Therefore, if necessary, change your want and amend the goal.

Never Give Up! Never give up on yourself. You can fulfill your needs for love and belonging, worth and recognition, fun and freedom to choose by using this plan for self-improvement.

*Based on Dr. William Glasser's Eight Steps of Reality Therapy.
Eighty to one hundred mental health participants anxiously gather in Los Angeles for a week to refine their skills and demonstrate their competency as Reality Therapists. This is certification week, the final segment in the process of obtaining Reality Therapy certification.

To reach this point, a candidate attends an initial one week Reality Therapy workshop. The basic reality therapy concepts and competencies are introduced by a certified RT trainer and practiced through role playing sessions. Upon the satisfactory completion of this workshop, the trainee is required to complete a practicum experience. After an interval of at least six months, a candidate can be accepted in a second intensive RT workshop. During this workshop, there is a review of fundamental principles and concepts, trainer demonstrations of specific competencies, and practice of role playing interactions. If the second intensive week is successfully completed, a year of field work application of Reality Therapy is required before an RT trainer can nominate an individual for certification week.

By the time the RT candidates have arrived at certification week, they have been screened, have read and practiced, and are highly motivated to hone their skills and share their knowledge with colleagues and trainers. Upon arriving for the first session of certification week, participants are placed in small groups of 8-10 candidates with an experienced Certified Reality Therapist. As master teachers of RT, these trainers are eager to inculcate as many techniques and skills as possible in the 4½ day period.

Initially, it appears that the most efficient way for the trainer to impact his/her small group is to either directly role play the therapist or the client and to give immediate feedback to the group, critiquing the participant’s performance. This approach is most efficient when members of the small group know little or nothing about Reality Therapy. The greater the awareness of Reality Therapy by the group members, the less effective and satisfying is a directive approach by the trainer. The certification candidate needs to be continuously involved in the certification process, not just when it is his or her two role plays or when passively listening to the trainer’s processing of the role play.

It is true that most people selected for certification week would find almost any new RT information, concepts, or techniques relevant in their internal world. However, relevance is only one needed ingredient in fostering learning. Along with relevance, there should be involvement (in this case with the small group), and stimulation of the thought process in order to maximize learning. (Glasser, 1969) A high level of relevance of a particular subject area can temporarily sustain a group’s interest, but interest will wane for many without involvement and stimulation of the thought process.

A potential source of energy to stimulate thought processes has been discovered to be in the interrelation of group members themselves. The word synergism has been coined to define the phenomena where the interrelationships of people produce results and relationships not obtained by any person taken separately. (Fox, 1982). The unleashing of synergistic energy is the most efficient strategy that RT trainer can utilize during certification week. As each student describes his/her own perception on an issue, shares a technique that works for him or her, demonstrates empathy for a fellow student, shows genuineness in front of peers, group cohesiveness emerges; a sense of belonging grows. This sense of belonging decreases the anxiety of group members. In B.C.P. terms, a sense of belonging reduces the total error signal allowing the redirection system to elicit new efficient behaviors.

By the trainer encouraging and eliciting certification trainee participation, he/she establishes a spirit of cooperation where specific alternate suggestions can be offered without fear of rejection. This openness allows the trainer to better understand the internal world of the group members, determining the teaching focus of the next session. By proceeding in this open manner, the trainer is able to decrease anxiety, better diagnose the individual’s needs and minimize the tendency of students relying on the teacher for the one correct answer.

Dr. Glasser used the term “Certainty Principle” to describe the tendency of our schools to develop and reinforce a mind set in students of thinking there is one, and only one, answer to each question. Group involvement increases different levels of awareness, increases alternative solutions to problems which puts to rest the absurd idea of the Certainty Principle. Just the knowledge that there is not one right answer increases our ability to listen to others, which then increases our sensitivity to what others are trying to say. As we listen and openly respond to others, synergistic learning can take place.

As the synergistic process unfolds, the increased group awareness and sensitivity can be uplifting and inspiring to the trainer. The inevitable and unpredictable blockage of this group phenomena maintains the interest level of even the most experienced trainer. The over-dominating, the withdrawn, the tired, the bored, the scapegoated member enables the trainer to directly utilize the RT clinical approach in a meaningful situation to demonstrate its effectiveness in focusing and resolving the difficulty. Through modeling a real situation, the members cognitively and affectively experience the power of the approach and appreciate the skill of the trainer, drawing everyone into a more cohesive group.

The successes of the group enhance the positive feedback of the trainer
and the trainee. When the members feel positive about the performance of the trainer modeling RT, there is a high probability that they will assimilate and exhibit more characteristics of the trainer which may enhance their effectiveness as a counselor.

By encouraging trainees’ intra-group involvement in seeking information, giving information, sharing of counseling experiences, giving opinions, evaluating, expressing feelings and processing role playing, the RT trainer facilitates the intra-relationships of group members. This coordinated interaction produces results and relationships unable to be elicited if he/she had taken a directive stance.

RT trainers need to refrain from a directive approach and recall Dr. Glasser’s message of almost 20 years ago for relevant involvement and thinking as essential ingredients in the learning process. Through the RT trainer’s encouragement and orchestration of group involvement, the inevitable synergistic impact on the trainees will eventually enable them to better become RT Counselors; the major objective of certification week.

LIVING WITH MENTAL PATIENTS

Al Garner

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In the social work jobs I’ve had, I’ve always found the people being helped to be much different from the popular conceptions. Delinquents, the aged, the poor, and others never turned out to be what the books or the media had described.

The same was true of mental patients. I started and ran a home for men in their 20’s and 30’s, living with them for two years. It took a lot of time, discussion, and soul-searching to appreciate the subtleties of their behavior, which break down into the following characteristics:

I. Positive
   A. Non-criminal  B. Like everyone else  C. Pleasant

II. Neutral (as part of their condition)
   A. Buried emotions  B. Identity problems  C. Overly sensitive
   D. Spoiled  E. Immature  F. Other
      1. Dependent on parents
      2. Unassertive
      3. Low self-esteem

III. Irresponsible
   A. Childish as opposed to immature
      1. Selfish as opposed to self-centered
      2. Clinging to parents as opposed to past dependence on parents
      3. Refusal to take pride as opposed to low self-esteem
   B. Lazy
      1. Oversleep  2. Unhygienic  3. No follow-through
   C. Resentful

I. POSITIVE CHARACTERISTICS

The residents had little interest in criminal activities. Except for minor incidents, they were not violent; their use of soft drugs and alcohol was minor, and while they abused property, they didn’t steal it. Aside from their mental quirks, residents were normal. Although they seemed not to be aware of things, they were. When a couple of times it looked like there was going to be a fight, they emerged from the woodwork to watch. After the tension had passed, they drifted away as if nothing had happened. Many were nice, gentle people who could be warm and ingratiating. Some were very likeable and could have gone far on personality alone.

II. NEUTRAL CHARACTERISTICS

Most had one or more emotions buried deep within which was eating away. Theirs was a world of repressed anger, sadness, fear, anxiety, or other feeling. Many didn’t know where they fit with their families or with society. Some had a confused sexual identity, and many had withdrawn into

Bibliography


their private worlds. Changes in staff were far more of an adjustment for them than would have been expected. Changes tended to “throw” them. One article advised there be two weeks time between any major changes such as moving or a change of job. Some didn’t know how to hang laundry, mow lawns, mop floors, or wash dishes. In one home, residents broke two brand-new washing machines.

Many people in the field often made the aside, “They act like kids.” One psychologist sounded like he was describing them when he spoke of cultists, saying they are “seeking an escape from freedom. They are people in search of a return to the comfort of childhood . . . an escape from adult responsibility. . . . a search for security in an individual who relieves them of making decisions . . . All of us want to be children again, but are not willing to give up that much freedom.”

Residents were far too close to their parents. Their parents had spoiled them, done all their thinking for them, and fought all their battles. Hence the honeymoon the first two weeks each resident moved in. He appreciated the interest and concern, until he found he had to reciprocate with hygiene, chores, meetings, and self-improvement.

Many residents were easily dominated and manipulated. They didn’t stick up for themselves and could be talked into signing anything. It seemed they had never played competitive sports or been in the service. They had no “fight”, and tolerated far too many discourtesies from each other. They didn’t think they could generate something good; they looked for it to come to them. They thought too highly of the staff and took up their time rather than each other’s. Notes or reports on them were very threatening. (One way to counter this is to have them write notes and reports on the homes and the staff.

III. IRRESPONSIBLE CHARACTERISTICS

To suggest that “anyone needing help” is irresponsible is to appear “judgmental,” which is the cardinal sin in social work. Therapists don’t find clients irresponsible. Here is how it worked:

A resident would move into the house. After taking two weeks to get used to it, he didn’t want to get out of bed in the morning. Maybe he had a problem with this; maybe there was something “mental” about getting up; therapists told me. Later he didn’t wash and bathe himself. Maybe there was a “mental” factor here, too. Then he didn’t want to do chores — “an authority problem.” He couldn’t get to appointments on time — “stress level.” He wouldn’t participate in day treatment — “withdrawal.” He wouldn’t take his pills — “rebellion.” He was bored because he “hadn’t been provided a stimulating environment.” He fidgeted constantly — “agitated” (or 20 cups of coffee?). He didn’t cooperate because we hadn’t “understood, been compassionate, or been a friend.” (It got so we couldn’t look at him sideways without setting off another neurosis.) He, his social worker, and his relatives had an excuse for everything.

Any non-professional who lives with residents for a long time can never accept this. Non-professionals know what they see — irresponsibility, which is another major clue to the mystery of mental illness. Many residents shunned responsibility in any and all forms. The reason they didn’t want anything was because wanting something involved responsibility.

One didn’t handle the electric lawn mower right, making it smoke and damaging the motor. He wouldn’t say he was sorry he did it, or even sorry it happened. We discussed it over and over — no result, not sorry. Another time a resident used very poor judgment in bending the handle of a hammer too weak for a job clear back to the claw part of it. I talked it over with another resident who insisted it was the hammer’s fault, not the resident’s. Nothing could convince him the first resident was responsible.

These were two classic cases of the thinking of many residents: things happened to them, not because of them. They did not want control of their present or future. One put it perfectly: “Being this way allows me to do the things I want to.” Whatever he wanted to do was all right because he was “ill.”

Here lay the challenge of the work: finding out what residents couldn’t do and what they wouldn’t do — separating the irresponsible characteristics from the neutral characteristics.

For example, their conversation often came back to themselves, “I did this. . . . My way was . . . The way it happened to me . . . I thought . . . I said . . . but in my case . . .”, etc. When some wanted something, they had to have it right then. They would persist until yelled at. Once we were cooking some pudding in a pot. One needed the pot. In front of the rest of us, he dumped the pudding down the drain and used the pot.

Some coughed or sneezed on the dishes or into the refrigerator. “Please,” “thank you,” and “excuse me” were foreign words. Some went in and out of their room at all hours, turning on the lights and letting the door slam, while their roommate tried to sleep. Some persisted in using revolting table manners and would do nothing to change. On Halloween they sat in the front room with the house lit up, not answering the door when kids knocked. In these ways they “walked on” each other and everything the house stood for. They persisted in such behavior, yet wondered why they didn’t have friends.

While they talked of becoming independent, they usually went home at the slightest excuse. After months in my home of having to do chores and get up early, they would move back home to sleep day and night and have everything done for them.

Although they had little esteem to begin with, there was no excuse for such outrageous manners, hygiene, and non-cooperation. A person with pride wouldn’t have fallen into such behavior; but pride or shame for one’s actions meant responsibility for them.

The most striking trait was laziness, yet it is one most glossed over. The average person does more in a day than a resident does in a month. My house managers and I heard many fine theories as to why this existed, but as time went on, we accepted none of them. We knew what we saw: residents sat indoors during perfect weather; they turned down rides to the beach; they never made anything in the kitchen that took effort. When it came to
chores, two of us spent all our time supervising six residents during the half hour of chores a day. It was the worst part of the day.

Laziness took many forms:

1. **Oversleep.** Medication was responsible for only a fraction of the 10 to 16 hours a day many residents spent in bed. The rest was escapism. When the phone was for them or something else came up, they were right out of bed. They weren't asleep, but lying in a stupor.

2. **Unhygienic.** Some residents didn't shower properly or daily, didn't own or use a deodorant, and didn't change underwear or socks. Some slept in their clothes. Fresh air had to be let in continually, which ran up the utilities. Allowing smoking inside was the kiss of death.

3. **No Follow-Through.** Residents often moved in with plans to jog, surf, start a vegetable garden, find work, schooling, or whatever. Most got as far as the front door.

4. **Games.** - I'm 80% disabled (obviously not). - I can drive a car (but not make a bed). - You're treating me like a kid (although I'm acting like one). - I'm sorry (but not enough to make up for what I did). - The hospital, my folks, or my pills caused all my troubles (hardly). - Day treatment is horrible (while at day treatment he was telling them how horrible the home was). - My doctor doesn't want me to work (false). - My doctor doesn't want to hear from you (false). - No one has had it as rough as 'I have (hardly). - I am paying to stay here (the government was paying). - Too many meetings (too much reality). - I'm moving out (because all my games are up).

5. **Bored.** The boredom was beyond comprehension. None ever read a book, few watched TV, almost none had hobbies, few looked for work, and almost none exercised.

Some residents lived in emotional vacuums. They lived at the edge of life, not really alive. Physically they were there, but not emotionally. (When I hear a "chronic" patient has been "sick" for five to ten years, I feel I can prove (1) he has not really wanted to get well, (2) he hasn't been in a system which has confronted him enough to make him want to get well, and (3) he has been allowed to waste 90% of his time watching TV, sleeping, sitting around, etc.)

Many lived for the moment. Self-control, self-discipline, and foresight rarely existed. They spoiled themselves with coffee, cigarettes, food, sweets, spending money, sleep, TV, self-analysis, pleasure, entertainment, and favors. Being so lazy was boring, miserable, and nerve-racking, but it was easy. Nothing could have been easier. As one recovered mental patient would tell residents, "It's easy to be crazy; stop playing the sick game," (a statement profound in its simplicity.)

Those from their mid-20's on up were very resentful about being dependent, about my interest in their process when it came to effort on their part, and about life itself. (Some of this feeling for the mental health department system was justified, but the rest was not.)

**CONCLUSION**

Too often professional training, which is from the top down, misses the mark. More of the bottom up approach of those non-related people who spend 8 hours/day or who live with residents is needed. It is only then the three major clues appear — being spoiled, immature, and irresponsible. There is a crying need to show that irresponsibility for many small things and for facing life is far and away the most dominant. Professionals are trained to "understand" it, which too often has the effect of excusing it.

What should help is the rating form below. Each level — professionals, non-professionals, relatives, and residents — would rate residents. (The last three are immense, untapped reservoirs.) The ratings would bring a more realistic and quantitative look, and would be ideally suited for tying in with a behavior modification system.

Reality Therapy points out how treating mental illness as a "medical" problem by labeling conditions and treating them accordingly doesn't work (exactly my experience). It recommends psychiatrists determine if there is an organic cause of a resident's problem. If not, his condition has come about from trying to fulfill his needs in an irresponsible manner and he could only get well by acquiring increasing levels of responsible behavior. The approach was to disregard the concept of the resident's being "mentally ill," and to confront him with reality and teach him better behavior (tailor-made for dealing with the characteristics I had observed). It required residents to work (which most programs ignore or don't value highly enough); and it advocated a more confrontive and binding type of group therapy. (My efforts at confrontive meetings brought whining from residents and continual admonitions from County workers.)
RATING RESIDENTS

Rate: 1-2 poor 3-4 adequate 5-6 very good

Positive

Mental
- Memory (short term)
- Memory (long term)
- Attention span
- Good judgment
- Common sense
- Alert
- Aware
- Can manage money
- In touch with feelings

Maturity
- Assertive
- Realistic
- Responsible
- Confident
- Moderate
- Active
- Positive
- Open-minded
- Pride
- Empathy
- Humor
- Foresight
- Contributes

Motivation
- Work habits
- Self-discipline
- Honesty
- Hygiene
- Dress
- Grooming
- General manners
- Table manners

Miscellaneous
- Knows chores

Total A

Negative

Mental
- Deluded
- Hostile
- Compulsive
- Confused
- Withdrawn
- Preoccupied
- Tense
- Hyper
- Frustrated
- Adverse to physical contact
- Sexual problems
- Gets lost

Immaturity
- Childish
- Spoiled
- Selfish
- Stubborn
- Craves attention
- Wants magical relationships
- Clings to folks
- Expresses feelings inappropriately

Motivation
- Lazy
- Bored
- Spoils self
- Plays head games
- Postpones

Miscellaneous
- Defensive
- Resentful
- Uses others

Total B


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