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THE EFFECTS OF REALITY THERAPY PROCESS ON LOCUS OF CONTROL AND SELF-CONCEPTS AMONG MEXICAN-AMERICAN ADOLESCENTS

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One of the most difficult and complex problems facing educators today is enhancing the learning potential of the Mexican-American, the second largest ethnic minority of the United States and the largest ethnic minority in the Southwest (Carter & Segura, 1979). Too many Mexican-American students underachieve academically, drop out of school early, and enter the job market ill prepared (Nava, 1975; U.S. Commission on Civil Rights, 1978). Glasser (1969) contends that a failure identity (poor self-concept and powerlessness) develops as a result of early underachievement in the schools. This kind of school affect has serious consequences for the Mexican-Americans' use of further learning as an adaptive method of dealing with their own problems as adults as well as in part determining their life styles and responses to societal changes (Bloom, 1976; Cordona, 1970; Ramirez, 1976).

Behavioral scientists have identified two dimensions of personality which affect the ability to function effectively in the school setting: self-concept and locus of control (Bloom, 1977; Rotter, 1966; Snygg & Combs, 1949). Levels of Mexican-American self-concept and locus of control have been lower than the Anglo-American majority and other ethnic minorities because of their status in society (Anderson & Evans, 1976; Sue, 1977; Zisman, 1975).

In the literature, there exists conflicting evidence in support of the positiveness of self-concept for the Mexican-American and its relationship to academic achievement. Anderson and Johnson (1971) identified self-concept of the Mexican-American as an important predictor of academic success. Among such variables including parent's education, occupation levels, and language usage, the most significant factor predicting the level of achievement was the Mexican-American student's self-evaluation of his/her academic ability. Padilla and Ruiz (1973) affirm the findings that Mexican-American children have relatively less personal confidence in their ability to achieve academically. Felice (1973) concluded that self-concept significantly affected drop-out behavior, with low achievement and negative self-concept characteristic of students dropping out of school.

Another factor which affects school success (achievement) for minority children is the degree to which the children believe that they, rather than someone or something else, are responsible for their success or failure...
(Coleman et al., 1966). Sue (1978) compared Anglos and Mexican-Americans and found that a slightly larger percentage of Mexican-Americans perceive their environment as less controllable than Anglos. Sue (1978) argued that the externality dimension of Mexican-Americans is a function of their personal opinions of prevailing social institutions.

Few studies have examined the effects of both the Reality Therapy process and the class meeting in the school classroom. Elementary school children were subjects of all studies except two, which studied eighth and ninth graders. Conflicting evidence for support for this philosophy through the class meeting in the schools appears in the literature review (Hawes, 1970; Matthews, 1972).

Increasing levels of self-concept and perception of internalized responsibility of the Mexican-American by the Reality Therapy process and class meeting is an alternative for educators to consider for this minority’s success and, ultimately, success in society.

Purpose of the Study

The purpose of the study was to determine the effects of the Reality Therapy process and use of class meetings on Mexican-American adolescents’ perceptions of internal-external locus of control orientation and self-concepts.

METHODOLOGY

Sample

Two junior high schools were used in this study. The two schools, located two miles apart, were matched according to pertinent socioeconomic, ethnic, and academic characteristics. The students included in this study were Mexican-American males and females in a seventh grade reading class and a ninth grade fundamental English class in each of the two schools. Each of the four classrooms averaged 15-20 students with a total of approximately 80 students participating in the study.

Procedure

The classrooms were randomly assigned to the experimental and control groups according to a table of random numbers. The study used a non-randomized pretest-posttest control group design. One week prior to the initiation of the first treatment session, all participants were administered the Dimensions of Self-Concept and Nowicki-Strickland Locus of Control Scale. After eleven weeks, the same instruments were once again administered to all participants.

The two experimental group teachers were trained in an eight-hour workshop by the Vice President of the Institute for Reality Therapy. In the morning session, the concepts of Reality Therapy were explained and demonstrated. In the afternoon session, class meetings were conducted for each teacher in his/her own classroom. The teachers were also provided training in conducting the class meetings.

Treatment

Reality Therapy is based on the idea that everyone needs to have an identity and become actively involved with all that is around them (Glasser, 1965; 1969; 1981). Some individuals have a successful identity because they become involved in life in a manner that allows them to fulfill two basic needs: feeling worthwhile toward themselves and others (individual responsibility), and to love and be loved (social responsibility). In the training of the experimental group teachers, it was emphasized that providing a positive, authentic, and open academic environment to increase the chances of developing successful identities among their children is crucial. Teachers were also taught to accentuate the present time. For example, rather than reinforcing past failure, teachers should expect and help poor readers in the present. Another aspect is to deal with behavior. The purpose is to help the children become aware of what they are doing that is contributing to their failure and what can be done to significantly increase the chances for success. The teacher should encourage the students in a nonpunitive way to describe, as best as they can, the actual behavior.

The first three considerations — personal involvement, present timeliness, and accentuation of behavior — set the stage for a fourth component which is to provide meaningful learning opportunities for their students. This is accomplished by the teacher asking nonevaluative questions, not by making statements. Students should be provided with opportunities for making their own value judgments. The final concepts of Reality Therapy which were emphasized in the training of the teachers were to eliminate punishment and to not reinforce excuses.

These concepts were applied in conducting the class meetings. The class meeting is a practical and realistic classroom activity in which most teachers and students can participate easily. The regularly scheduled twice weekly class meetings discussing relevant topics were conducted for eleven consecutive weeks. Each meeting lasted for approximately 30-45 minutes. The sessions are designed to supplement the academic program by stimulating the children to think and respond. It provides an opportunity for intellectual success without the possibility of failure. The children make no mistakes by their responses or answers. Thinking, speaking, and listening in the form of discussion are emphasized rather than memory, evaluation, and grading.

Instrumentation

The Dimensions of Self-Concept, Form S (DOSC) (Michael & Smith, 1977; 1978) was used to measure five non-cognitive factors associated with self-concept in the school setting. It is a self-report instrument comprised of the following subscales: (1) Level of Aspiration, (2) Anxiety, (3) Academic Interest and Satisfaction, (4) Leadership and Initiative, and (5) Identification vs. Alienation. Level of Aspiration is a manifestation of patterns of behavior that portray the degree to which achievement levels and academic activities of students are consistent with their perceptions of
their potentialities. Anxiety reflects behavior patterns and perceptions associated with emotional instability, a lack of objectivity, a heightened exaggerated concern about tests, and the presentation of self-esteem relative to academic performance. Academic Interest and Satisfaction portrays the love of learning and pleasure gained by doing academic work while Leadership and Initiative involves demonstrating mastery of knowledge, helping others, and initiating classroom projects. Identification vs. Alienation measures the extent to which a student feels accepted as part of the academic environment which includes the regard by teachers and students.

The DOSC is a 70-item instrument requiring a forced choice among five responses. Michael and Smith (1977; 1978) reported reliability coefficients ranging from .70 to .84 for Form S of the DOSC. Omizo, Hammett, Loffredo, and Michael (1981) studied the predictive validity of the DOSC among Mexican American adolescents and reported coefficients ranging from .23 to .62 for the various subscales.

Locus of control was measured by the Nowicki-Strickland Locus of Control Scale (Nowicki & Strickland, 1973). It is a paper and pencil instrument consisting of 40 questions that are answered either yes or no. The items describe reinforcement situations across interpersonal and motivational areas such as affiliation, achievement, and dependency. Nowicki and Strickland (1973) reported reliability coefficients ranging from .68 to .81. The authors indicated that high construct validity has been established through significantly high correlations between the Nowicki-Strickland Locus of Control Scale and other measures of locus of control, such as the Rotter I-E Scale (Rotter, 1966) and the Bialer-Cromwell Scale (Bialer, 1961) although no coefficients are provided.

Analysis of Data

Multivariate analysis of variance (MANOVA) was used to analyze pre-test self-concept and locus of control measures to determine if significant differences existed between the experimental and control group participants. MANOVA was also used to analyze the posttest data on the six dependent measures. Following significant MANOVA results, post hoc univariate Fs and discriminant analysis procedures were used, respectively, to determine which dependent measures proved to be valid discriminators when analyzed independently and when controlling for the effects of all other dependent measures.

RESULTS

Fifty-six participants (Experimental n = 26, Control n = 30) completed the study. Participants who missed more than one of the class meetings or who were not available for the administration of the posttest measures were excluded from the study. Means and standard deviations for both experimental and control groups on all post dependent measures are presented in Table 1. MANOVA results indicated no significant difference between the experimental and control groups relative to the pretest scores of the dependent measures.

### Table 1

<table>
<thead>
<tr>
<th>Variables</th>
<th>Experimental (n=26)</th>
<th>Control (n=30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Aspiration</td>
<td>M = 55.12, SD = 10.11</td>
<td>M = 50.37, SD = 11.16</td>
</tr>
<tr>
<td>Anxiety</td>
<td>M = 34.54, SD = 8.03</td>
<td>M = 41.10, SD = 12.89</td>
</tr>
<tr>
<td>Academic Interest and Satisfaction</td>
<td>M = 51.50, SD = 8.28</td>
<td>M = 44.83, SD = 9.24</td>
</tr>
<tr>
<td>Leadership and Initiative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identification vs. Alienation</td>
<td>M = 45.19, SD = 11.20</td>
<td>M = 35.37, SD = 10.09</td>
</tr>
<tr>
<td>Locus of Control</td>
<td>M = 14.35, SD = 3.51</td>
<td>M = 16.40, SD = 5.51</td>
</tr>
</tbody>
</table>

MANOVA results between the experimental and control groups relative to the mean vectors of the six dependent measures ($F_{6,49} = 2.59; p < .03$) revealed a significant difference. To determine which variables accounted for the greatest amount of between group variance, univariate $F$ values and discriminant analysis procedures were conducted. Data from these analyses are presented in Table 2. Both post hoc analyses revealed Academic Interest and Leadership and Initiative measures to be valid discriminators (both $p < .01$). In addition, the Anxiety measure was a valid discriminator beyond the .05 level of significance. The other two DOSC measures and locus of control measure did not provide to be valid discriminators.

**Reality Therapy Bibliography**

by

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A 41 page annotated bibliography of reality therapy program evaluations, books, and research studies.

*Available from:*

Delta Psychological Associates, Inc.
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*Cost: $5.00 U.S. - includes handling and mailing.*
Experimental group participants also had significantly higher scores on the Leadership and Initiative scale. This dimension measured those behavior patterns and perceptions associated with starlike qualities in which a student helps others, gives direction to group activities, puts forth sound suggestions for classroom activities, and exhibits a willingness to take the initiative in starting and completing a project. Basic to these perceptions and behavior patterns is the sense of responsibility. Responsibility appeared to reflect significant increases in behavior patterns which are manifestations of the sense of responsibility.

Lower scores on the Anxiety measure of the experimental group participants indicated them to be more emotionally stable, more objective, and less preoccupied with school performance. Michael and Smith (1977; 1978) believed that underlying increased measures of Anxiety was a failure syndrome that indicated a marked discrepancy between the stabilized perception of what students believed they could achieve and the idealized perception of their expectancies concerning what their teachers maintained they could do. These results on the Anxiety dimension appeared to be consistent with Glasser's theory that successful school interaction in the form of a class meeting would build student success identities.

The experimental group participants did not differ significantly from the control group participants on the Identification vs. Alienation, Aspiration, and locus of control measures, but all scores were in the expected direction. Identification vs. Alienation measured the extent to which students felt accepted in school as worthy persons in contrast to being rejected or isolated in the school. On this pretest measure, the mean score of the experimental and control groups corresponded to a percentile rank which was the second highest of the five DOSC scales as compared to the normative sample in the DOSC Technical Manual (Michael & Smith, 1977). Since the pretest and posttest mean scores were “average,” Michael and Smith (1977) would not recommend teacher and counselor remedial strategies for these individuals. Intervention strategies are recommended for individuals in the bottom quarter or third of the percentile ranks. Also, Sue (1978) stated that Mexican-Americans had an accurate assessment of their “systematic and real external obstacles” to opportunity in social situations. He further stated that the discrepancy between what Mexican-Americans thought they could do and what opportunities were available to them may be a healthy indicator. The implication may be that a significant change resulting in increased level of dissonance from perceived increased identification with academic activities and subsequent, subtle rejection from the majority (teachers, counselors, administrators, and staff) based on attitudes transmitted from generation to generation for the past 100 years (Carter & Segura, 1979) may not be desirable. Perhaps Glasser would agree that Mexican-Americans’ “realistic” appraisal of their limitations in society enabled them to “realistically” and responsibly choose better behaviors to problem solve the real and external obstacles that impede their ability to meet their basic needs — recognition and belonging.

The Level of Aspiration dimension measured the behavior patterns related to the degree which student academic activities are consistent with their perception of potentialities in terms of past and current attainments.
The scores were also in correspondence with the norm according to the DOSC manual, and remedial strategies are not recommended by Michael and Smith (1977) for students who rank in these percentiles. These results appeared to be consistent with conclusions by Flores (1972) that Mexican-American adolescents generally showed average to high aspirations. The limited time of eleven weeks for the study may not have been long and strong enough for the treatment to affect the aspiration dimension.

The locus of control measure did not prove to be significantly different for the experimental and control group participants. These results are not consistent with Hawes' (1970) conclusions. Perhaps, a time period of sixteen weeks as used by Hawes would have been more effective in changing scores on this measure. The posttest scores on the locus of control measure for both the experimental and control groups were at the norm for adolescents in the seventh and ninth grades. Another reason for this nonsignificant difference may have been due to the instrument used in assessing locus of control. According to some Mexican-American scholars, the Mexican-American may have perceptions of little control which may vary from one specific area to another such as the intellectual domain, the physical domain, and the social domain (Bloom, 1976). The Nowicki-Strickland Locus of Control Scale may not have accurately assessed locus of control of Mexican-Americans when other domains of perception (physical and social) were not measured and considered in relation to the intellectual domain.

In summary, the treatment of applying Reality Therapy concepts and class meetings affords some promise as an intervention to assist the Mexican-American adolescent population. It appears to affect some aspects of self-concepts relative to the academic setting.

**RECOMMENDATIONS**

Based on the results of the study, the following recommendations are offered:

1. Use of a locus of control instrument which is more sensitive to the physical and social domains of the environment in relation to the intellectual domain. The Mexican-American may vary greatly among the three domains.

2. Increase in length of treatment to allow for more successful experiences which may increase the sense of responsibility and motivation to learn.

3. Modification of teacher training by extending the length of time for instruction and practical application, thereby increasing strength of treatment.

4. Integration of Reality Therapy principles into a bilingual education program to investigate the effects of cognitive reasoning skills, an area Mexican-American students need to develop in order to improve literacy skills.

References


ADLERIAN ANTECEDENTS TO REALITY THERAPY AND CONTROL THEORY

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It has been said that we stand on the shoulders of those who have gone before us. William Glasser is certainly his own man, but he has acknowledged in an interview with Donna Evans (1982) that Reality Therapy has many of its roots in the Individual Psychology of Alfred Adler. To a large extent the two systems are complementary: Adler concentrated on building a theory, leaving the method of application up to the individual therapist; Glasser developed a method of doing therapy which originally had little specific theory behind it. Reality Therapy, then, could be viewed as a method of applying Individual Psychology, even though it was not intended as such.

Over the years, Glasser's thinking has evolved somewhat, as did Adler's, and it is interesting to note that when Glasser did eventually adapt a theory to explain the effectiveness of Reality Therapy, it fell well within Adlerian concepts. This convergence of concepts occurred even though control theory is based on research in cybernetics done after Adler's death. Other major influences on Glasser's thought are Abraham Maslow and existentialism, both of which were in turn influenced by Adler. Although there are differences in the thought of Adler and Glasser, there are, amazingly, no basic conflicts, and Adler's Individual Psychology is once again seen to serve as "a synthesis in retrospect" (Ansbacher and Ansbacher, 1956, p. 18).

INDIVIDUAL PSYCHOLOGY

Individual Psychology encompasses a philosophy of life. It is founded on the idea that human beings are socially oriented and can only fulfill their basic needs by involvement in society; therefore, anything that is useful to society is "good." From this idea are derived the three life tasks facing each person: love, work, and friendship. The word "individual" comes from the Latin individuum or indivisible, a reference to Adler's belief that the human being must be viewed holistically rather than fragmented into body/mind or conscious/subconscious. Further, he or she must be viewed phenomenologically; one must "see with his eyes and listen with his ears," as Adler put it (Ansbacher and Ansbacher, 1956).

In contrast with attempts to understand a person in terms of his past, Individual Psychology is teleological, viewing people as goal-oriented and their behavior as purposive. Although the past must be taken into consideration, the emphasis is on what a person is doing in the present with an eye towards a goal in the future. Each person is unique, creative, and self-consistent, building and maintaining a view of the world (appерceptive schema) which determines his chosen behavior patterns (life style). People are actors rather than reactors, choosing their behaviors in line with their goals, masters rather than victims. Individual Psychology emphasizes use rather than possession, attaching importance not to what one has in terms of natural endowments, but what one does with what one has.

REALITY THERAPY

It is easy to see how Reality Therapy fits into this framework. From the beginning, Glasser (1965) has emphasized the necessity for involvement with at least one other person in order to meet one's basic needs, certainly a social perspective. Like Adler, Glaser has stressed the importance of a person's assuming responsibility for his or her life, and defines responsibility as "the ability to fulfill one's needs . . . in a way that does not deprive others of the ability to fulfill their needs" (1965, p. 15), once again relating the individual to the rest of society. People who are unable to meet their needs in society (Adler would call them "discouraged") end up in mental hospitals, prisons, or clinics.

Reality Therapy is also a holistic approach. Clients are taught to build psychological strengths in all areas of their lives, and Glasser (1972, 1981) has repeatedly emphasized the connection between mind and body, and that treatment of one often leads to improvement in the other. A common practice in Reality Therapy is to have the client describe a typical day, an Adlerian technique (Christensen & Schramski, 1983) which frequently serves to point up the unity and consistency of the client's personality.

Tracing the eight steps of Reality Therapy highlights its Adlerian antecedents:

What do you want? This question, recently incorporated into the original Make Friends (involvement) step, serves to remind clients that they are goal-oriented and that their behavior serves a purpose. It helps to initiate movement towards a goal.

What are you doing? Although a person's outlook on his/her past may influence present behavior, both Adler and Glasser would agree with the author of II Corinthians that "now is the accepted time." Now is the only time in which action can take place, and what a person is doing now can either create problems or solve them.

Is it working? Here clients are asked to make a value judgment about their behavior, and progress cannot be made until and unless the clients decide that their behavior is not effective. To a large extent, the recognition that one's behavior is not helping one towards one's goals constitutes insight. Adler (Ansbacher and Ansbacher, 1956) states that therapists sit with their hands in their lap as the clients recognize that they are responsible for their own cure and "own" their problem.

Plan to do better. Adler emphasized that insight alone does not produce change, and stressed the importance of action or movement towards a goal, of actually doing things differently. Both Adler and Glasser advocate building on a client's successes, which is achieved by careful planning to create a series of ever-increasing successes.

Get a commitment. Adler refers to "yes-but" people who have difficulty coming to a decision, lacking the courage to take a risk. All change involves a certain amount of risk, so a client must be committed to taking a risk in order to change.
No excuses. Glasser points out that to accept a client’s excuses for failure is to see that client as unable to change and grow, as weak, and does the client a disservice. Adler likewise sees excuses as “safeguards” a client uses to avoid behaving responsibly.

No punishment, but no interference with consequences. Adler (Ansbacher and Ansbacher, 1956, p. 397) states, “We should not say that the individual must pay for his mistake, but rather that he must inevitably experience the consequences of his error.” Adlerians emphasize the importance of natural and logical consequences in educating children. Only by experiencing consequences can persons learn to be responsible for their own behavior.

Never give up. Adler refers to “encouragement” as vitally necessary for helping clients to change. Disturbed clients have often had other helpers give up on them, adding to their discouragement.

CONTROL THEORY

The connection between Individual Psychology and control theory is even more apparent. Glasser, building on William Powers’ (1973) use of control theory, sees behavior as purposive and teleological, an attempt to make the “real” external world match one’s internal world of reference perceptions. Powers’ title, Behavior: The Control of Perception, echoes the Adlerian view that behavior is a function of subjective perception. Since one’s internal world is built out of what Adler would call “private logic” and based on “biased apperception,” people frequently experience a perceptual error when the perceptions from their internal “picture album” and those from the external world do not match. All behavior is an attempt to eliminate that perceptual error.

The Glasser-Powers description of the orders of perception, through which the brain attempts to make sense out of sensory input, corresponds to the Adlerian cognitive constructs (private logic) which filter perception (Dinkmeyer, Pew, & Dinkmeyer, 1979). To Adler, this internal world is a useful fiction, a framework designed by the individual to deal with the “real” world but which is not itself “real.” The individual orients himself in the world by organizing his picture of the world and his experiences according to the fictions of his own creation. The Glasser-Powers model of the brain as an input control system, then, goes a long way towards depicting the Adlerian concept of the creative self as the intervening variable between a stimulus and its response. “A man is not determined by his environment but by his estimate of it” (Ansbacher and Ansbacher, 1956, p. 435).

The most important question . . . is not whence? but whither? Only when we know the effective direction-giving goal of a person may we try to understand his movements . . .

All thinking, feeling, and acting is based on an [interpretation, a greater or lesser] error which we can influence by discovering it. We could not remove a [psychological] disease which is causally determined. We can, however, remove an erroneous attitude. (Ansbacher and Ansbacher, 1956, p. 91)

EDUCATION

Perhaps the most important similarity between Individual Psychology and Reality Therapy is the view of the therapist as educator (Dreikurs, 1953; Ansbacher and Ansbacher, 1956). Adler would regularly demonstrate therapy with a client before an audience much as Glasser does role plays. Both Adler and Glasser stress the importance of problem prevention and healthy growth and development through education. Adler emphasizes the need to educate parents to avoid pampering or neglecting children, which gives them exaggerated feelings of inferiority; Glasser in a similar vein speaks of helping children establish a “success identity” by meeting their needs for love and self-worth in a school environment in which they can succeed (1969, 1972). Both Adler and Glasser see the therapist as a role model from whom the client can learn better behaviors.

DISSIMILARITIES

The major dissimilarity between Individual Psychology and Reality Therapy concerns emphasis on the client’s past. Although both disciplines argue that insight alone does not produce change, and neither permits a client to escape responsibility by blaming problems on the past, Adlerians consider it vital for a client to develop insight into his or her attitudes towards past history, attitudes which have led to mistaken beliefs and life goals and the creation of the life style. Although Adlerians do not believe in elaborate diagnosis leading to categorization and labeling, they attach great importance to gathering information about the client’s unique life style and goals to help provide the client with insight. Although Glasser does not dispute the validity of this approach, he maintains that of all behaviors — thinking, feeling, and doing — the easiest to change is the doing, regardless of whether or not the change is made with accompanying insight. To Glasser, as to the behaviorists, it is not necessary to know which pithole ambushed one’s car in order to have one’s wheels realigned. Accordingly, Glasser does not make use of the Adlerian early recollections or interpretation of dreams.

Both Individual Psychology and Reality Therapy have stood the test of time. Both have been effective with a wide variety of clients. And each has something to offer the other: Individual Psychology adds depth and breadth to Reality Therapy along with some useful techniques such as paradoxical strategies (“prescribing the symptom”), and Reality Therapy stands as one of the best methods of applying many of the concepts of Individual Psychology.
EDITOR'S COMMENT

This issue concludes Volume III, the third year of publication for the Journal of Reality Therapy. The flow of articles has increased both in quality and quantity. Subscriptions continue to grow, as we not only keep almost all of our current subscribers but new ones arrive weekly. Considering the frequency of inquiries from individuals who had not previously known of the Journal, we need to increase efforts to publicize its existence.

In an effort to continue the development of the Journal, you will note that there have been several changes in the Editorial Board. Naomi Glasser and Sam Buchholtz have served the Journal well, and will now be going off the Board as we move to a rotating board term. This will provide for a new group of article reviewers each year. In addition, the remaining members of the Board have been assigned terms to end at the end of 1984 and 1985.

At this time, I would like to solicit applicants for three Editorial Board positions to run until the end of 1986. Individuals are needed with writing and/or editorial experience who are thoroughly familiar with the principles and practices of Reality Therapy. Board members usually receive from 2-4 manuscripts each six months for review, and need to have the time to return reviews within two weeks of receipt. If you are interested, please write the Editor with a copy of your resume including publication experience and Reality Therapy training. Applications must be received by May 1, 1984.

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AN APPLICATION FOR REALITY THERAPY IN SECRETARIAL TRAINING

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A special secretarial training program at the College of Eastern Utah is incorporating courses in secretarial science with the strength and control principles of Reality Therapy. The program incorporates control theory techniques developed by Dr. William Glasser (Glasser, 1981), the skill development practices of Dr. Gary Applegate (Applegate, 1982), and a perception model described by Dr. Stephen Covey (Covey, 1982). A traditional secretarial science curriculum prepares students with skills needed to succeed in information management careers. This secretarial curriculum is supported by Reality Therapy based training which helps participants build their skills in gaining a greater degree of inter-personal understanding and control in their life.

The process used to help students gain greater control in their life, provides trainees with a series of easily learned techniques which help them gain greater control. The trainees also participate in relationship building seminars, instruction in professional modeling, individual counseling, tutoring, remedial math and English studies, and the regular college degree oriented programs. Participation in this program does not insulate trainees from problems. Many of the problems they face are college related, i.e. registration errors, schedule changes, tests, and grades. For these students, school related difficulties are often coupled with intense personal and emotional stress. In this environment, the students, guided by the program coordinator, find many opportunities to practice choosing between alternatives and planning to efficiently meet needs.

NEED FOR THE SPECIAL TRAINING PROGRAM

Emotional and/or physical disabilities along with low levels of basic educational skills (ie, Reading, Mathematics, and English) were criteria in selecting those who would participate in State or Federally sponsored rehabilitation programs. Many of those entering training have a history of consistent failure. Prior to the implementation of this program, 70% of participants in rehabilitation programs achieved success. Even with the 70% success, most agency and college administrators felt that even more students could become completers if additional ways of providing emotional support and increasing trainee morale could be developed.

PROGRAM DEVELOPMENT

In 1981 the Southeastern Utah Division of Vocational Rehabilitation spearheaded the development of a special training program for "hardcore unemployable" people who had been attracted to Southeastern Utah by the then booming coal industry but had not been able to gain employment. The
program was a success (Kraync, 1982) and provided the foundation for the development of special secretarial training activities.

The program for secretaries was designed to provide trainees who may normally not complete a regular training program with a 34 week intensified training experience. The program was supported by a series of classes which were coined as “Life Skills”.

‘LIFE SKILL’ FEATURES

The Life Skills curriculum was initiated in August 1982. The basis for Life Skills activity is primarily the recognition of the fact that people have a basic need to succeed, and from a success identity can come the emotional strength to handle problems, deal with stress, and live more responsibly (Ford, 1975). Supporting this concept is a self-fulfilling prophecy model (Covey, 1982) which illustrates how perception determines experiences and attitudes which direct one’s behavior.

The Life Skills program emphasizes that every action a person chooses is purposeful to meet one or more of eight personal needs. The eight needs used in the program are: Fun, Belonging, Self-Worth, Security, Freedom, Knowledge, Faith, and Health.

In an orientation program which follows the format of “Taking Effective Control Seminars” (Glasser, Note 1) students are taught about how they create mental pictures and then choose actions based on those pictures. They learn how their inefficient choices may meet one or more of their needs, diminish the importance of other needs and are an attempt to change their past or control their future, and an attempt to control the actions of others. The participants also learn that more efficient choices will also meet one or more of their needs, yet will stress self control, promote living in the present, and not diminish the importance of other needs (Applegate, Note 2).

LIFE SKILL ACTIVITIES

The Life Skills experience appears successful. Trainees comment on how well their newly learned skills help them make positive changes. They further comment that they have more control in their life and a more positive outlook. The most useful realization reported by many of the trainees is of the power they gain by efficiently meeting needs, and of the positive effect that has in reducing stress. To bring this about, each need area has been developed into study units which students use as they learn to make efficient choices. Fun was the first need developed.

Early in the implementation of the Life Skills program we realized that many of the trainees had forgotten or had never learned how to build efficient fun skills. We also felt that the fun need was one which could be taught while initial friendship-making was taking place. Fun for many of the new students was had at the expense of another person, by gossiping, overeating, through the use of drugs, or by the use of alcohol. Fun for most of them was something which came into their lives at irregular, fleeting intervals. Background information on the thoughts, feelings, and actions associated with inefficient fun making was presented. The students were introduced to the ideas that it is all right to be a fun maker with adults, that laughter is truly the ultimate relief for stress, and that with training and practice one can become a promoter of fun.

Teaching efficient fun as a ‘life skill’ is accomplished through the use of a hierarchy of behaviors which progress from low risk forms of fun-making toward higher skill levels. The skill levels taught at the College of Eastern Utah are:

1. Learning and sharing trivia. Trainees are taught how to locate and use the abounding masses of luscious tidbits of information which may never make a difference in life other than to provide entertainment. Each student is required to maintain a trivia file and be able to share one new piece of trivia at a moment’s notice.

2. Making music. Music can be made by either singing or by playing a musical instrument. Trainees are taught that even the worst of singers can sound better if they sing in a shower. Each trainee is presented with a personal shower song kit. A kit consists of a Zip Lock style plastic bag, a spring loaded clothes pin with a hole drilled in one of the non-holding ends, a piece of cord to be placed through the clothes pin’s hole and hung over a shower head, and printed copies of lyrics. The students are instructed to use their song kit. During their morning shower, they are to place the lyric sheets in the plastic bag and seal the closure, clip it to the clothes pin and hang the cord over the shower head. Then during the course of their shower they are instructed to sing three different songs. Though musical instruments are not seriously considered in the program, trainees who refuse to sing in their showers are offered the use of kazooos.

3. Learning magic. Each trainee is expected to learn and demonstrate one magic trick. Magic is used throughout the Life Skills course to illustrate major instructional points and as a release during tense moments.

4. Game playing. The trainees are taught the differences between playing games for the process of play and playing games solely to win. Quiet games such as jacks, ‘UNO’, board games, and ‘Pig Pen’ are used. Active games from The New Games Book (The New Games Book, 1976) and More New Games (Kretz, 1981) are relied on for the teaching of having fun with activities which do not stress the ‘all importance’ of winning.

5. Joke telling. At this level the trainee is required to locate good joke material. (Good material is that which can be used in mixed company without causing embarrassment to any listener.) Each trainee is expected to develop a delivery technique in order to make the jokes humorous, and, finally, be able to have fun in telling the joke rather than depending upon a listener’s reaction.

6. Story Telling. Stories are told from the first day of the training program. As the trainees’ skill in fun-making increases, they are expected to use creative story telling in the Life Skills program.

7. Being child-like with children. Since all of the trainees are single parents or have daily contact with children all are expected to use the material learned during their Life Skills course with children. Demonstr-
sions on being child-like are presented and workable plans or being child-like with children are discussed.

8. Being child-like with adults. At this level the trainees are exposed to the fact that it is possible to increase efficient fun if they are able to include others. The process of teaching this skill includes having the trainees remember what they once did for fun and then include some of those activities in their present fun making (see Applegate, Note 2).

The applications of fun-making along with efficient skill building activities in the other need areas are interfaced with other training activities. During the Life Skills course, the secretarial trainees learn office relationship skills. They are trained as members of a Quality Circle. They become certified as professional models, and they learn job seeking techniques. During each stage of their training, Reality Therapy principles of efficient doing and the building of a success identity help the trainees experience increasing levels of control.

RESULTS

As the trainees begin to take greater control for meeting their needs, they claim to discover ways of improving the quality of their living. Some stated they had gained more control of situations at home; others saw within themselves improvements in their ability to handle emotional upsets and stress; and others stated they were able to create more meaningful relationships.

The actual practicing of meeting needs efficiently is considered to be the greatest single strength in the Life Skills Program. This has been evidenced in the actions of those who completed their training. The previously stated success ratio of 70% completers has been increased to 84%. This increase is credited to the linking of the Life Skills Program with the regular secretarial training activities.

APPLICATIONS

The Life Skill Program at the College of Eastern Utah, with its focus on Reality Therapy applications of gaining control, provides a format which is proving to be very successful. Indications are that the better individuals become in efficiently building their skills, the more capable they are in facing personal difficulties. This more efficient behavior helps them reduce stress, enables greater group contributions, and increases personal and group productivity.

The Life Skills Program has also increased trainee retention in college programs. It provided the foundation for the students to solve their own problems, on their own, by taking effective control of their life. This and other Reality Therapy based programs could provide techniques for consideration by institutions attempting to reduce trainee drop-out (Wilder, 1983).

Since lasting change cannot be forced upon the trainees, it is essential for the Life Skills Program instructors to use the skill building process of demonstrating genuine caring, gathering specific information, and modeling efficient behaviors to help each trainee create an improved life situation (Applegate, 1982). Efficiently meeting needs is one tool which has demonstrated productive improvement in strengthening human efficiency and effectiveness in secretarial training.

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William Glasser, M.D. — From the Foreword
REALITY THERAPY: A MODEL FOR PHYSICIANS MANAGING ALCOHOLIC PATIENTS

Donna B. Evans

The author is chair of the Department of Education at Skidmore College, Saratoga Springs, N.Y.

Milan (1978) and others have supported the disease concept of alcoholism, that is, that there is a biological defect in persons who become alcoholic. A similarity between the disease diabetes and alcoholism has been suggested, though not documented.

It is well established that diabetes is caused by a genetic defect which causes a deficiency in insulin. The specifics of the etiology of the deranged biological aberration as it relates to alcohol are not known. Both diseases, however, appear to present themselves in a similar, unpredictable pattern in patients, related to the stage at which the disease is diagnosed.

The disease concept of alcoholism does not deny the psychological upheaval brought by alcohol on the recovering patient. It is fairly well established that mental health professionals have been notoriously unsuccessful in treating this psychological upheaval.

Alcoholics Anonymous (AA) has the most notable success rate in the rehabilitative treatment of the disease of alcoholism. AA is a worldwide organization with an estimated 900,000 membership. 91% of the people who stay sober more than five years will not drink and will remain in AA, according to 1979 figures released by the National Council on Alcoholism (NCA, 1979).

The strength of self-help groups such as AA in the rehabilitative process of alcoholics seem to be in several areas:

1. the involvement and caring for each other of the people in the fellowship of AA;
2. the encouragement of members to accept the reality of their "powerlessness over alcohol";
3. the insistence that recovering alcoholics assume responsibility for their behavior, i.e., staying sober;
4. the adherence to a plan of attending AA meetings and active participation in the support group;
5. the refusal of the AA membership to dwell on the "why's" and the "history" of one's past drinking behavior;
6. the present (rather than past) orientation of the group, i.e., "One Day At A Time".

Alcoholism, then, is not seen as a psychological or psychiatric problem, but rather as "a primary, progressive, pathological, constitutional reaction to alcohol ingestion; psycho-social symptoms are secondary, derivative, and progressive regardless of premorbid psychosocial antecedents" (Milan, 1979).

During the process of recovery, the need for an appropriate intervention tool is seen. It is in this context that Reality Therapy is suggested to aid in overcoming the psychological upheaval caused as a consequence of the disease of alcoholism. Reality Therapy is a tool which focuses on responsible behavior and asks, "What are you doing?" rather than, "Why do (or did) you drink?" Further, Reality Therapy is seen as a similar approach to that of the principles of Alcoholics Anonymous, with emphasis on maintaining a posture of responsible behavior related to abstinence from alcohol.

REALITY THERAPY AND ALCOHOLICS ANONYMOUS: SOME BASIC CONCEPTS

Responsible behavior is one of the basic concepts of Reality Therapy. The issue of responsibility in this context is equated with mental health and has implications for fulfilling one's needs, primarily one's need to give and receive love, and doing those things which provide one with a sense of worth to self and others. Thus, responsibility is a major tenet of Reality Therapy, and the teaching of responsible behavior is a major task of a person using the principles of Reality Therapy to assist others.

Learning to think responsibly, thus acquiring responsible behavior, is complicated and life-long under ideal circumstances. Persons afflicted with the organic illness of alcoholism are struggling under less than ideal conditions; the behavioral manifestations of the disease are such that irresponsible behavior is most often evident. Rehabilitative measures with recovering alcoholics must focus on restructuring such irresponsible behavior. For instance, alcoholics must assume responsibility for not inhaling the drug alcohol (and often other drugs) because their illness warrants vigilant attention to abstinence in much the same way that diabetics must assume responsibility for taking their prescribed insulin and/or controlling their diet because the illness warrants such vigilance.

Reality Therapy concentrates on behavior as a vehicle for helping persons fulfill their needs for love and worth. To be worthwhile, we must maintain a satisfactory standard of behavior. To do so, we must learn to correct ourselves when we do wrong, and to credit ourselves when we do right. If we do not evaluate our own behavior or, having evaluated it, if we do not act to improve our conduct where it is below our standards, we will not fulfill our needs to be worthwhile and will suffer as acutely as when we fail to love or be loved. Morals, standards, values, or right and wrong behavior are all intimately related to the fulfillment of our needs for self-worth and (are) . . . a necessary part of Reality Therapy (Glasser, 1965). Alcoholics patients very often have very few emotional inner resources intact due to the physical and concomitant emotional ravages of the illness. It is worthy to note that of the estimated 10 million persons in the United States suffering from the disease of alcoholism, there is no "typical alcoholic." Less than 3% of all of the people with alcoholism are found on the "Skid
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Rows" of our nation! Each year about 100,000 drinkers develop alcoholism. Most of these alcoholics are persons whose family support systems are still intact.

Alcoholism, more perhaps than any other illness, may properly be called a family disease. The set of behaviors often manifested by the family of the alcoholic clearly defines the span of pathology of alcoholism. Thus, while there is no conclusive evidence which supports the notion of an etiology of alcoholism, there is ample evidence to support the notion of a pervasive impact on the behavior of family members as the result of alcoholism and the family unit.

It is this family which often presents itself to the family practice physician for treatment. More often than not, the presenting illness will baffle the physician who has not developed a high index of suspicion that what indeed may be presenting are symptoms related to the psychosocial effects of alcoholism on the family.

The fact that alcoholism is the third major health threat in the United States, the notion of alcoholism as a family disease and the very nature of the patient population which the family practice resident serves, i.e., families, lends credence to the suggestion set forth in this paper that family practice residents be exposed to Reality Therapy as a tool for positive, efficient intervention in the recovery process of the alcoholic and the family of the alcoholic.

Reality Therapy is a therapeutic tool which is consistent with the reality of the demands of time, and with the need for effectiveness placed on the family practice physician. These issues are not addressed in the more time-consuming, less efficient traditional therapeutic approaches to the management or the alcoholic patient and family.

Reality Therapy is seen as a learning process in which the major goal is to help patients assume personal responsibility. The approach by which this is accomplished is set forth rather succinctly through eight general principles of Steps of Reality Therapy. These principles or steps are a guide for the counselor or physician which may be employed flexibly based on the patient's needs. The steps are as follows:

1. MAKE FRIENDS. Involvement is the first and most crucial step of Reality Therapy.

2. ASK: WHAT ARE YOU DOING NOW? It is necessary for patients to focus on the specifics of their present behavior, i.e., drinking, or in the case of the family, perhaps "rescuing" the drinker.

3. ASK: IS IT HELPING? It is at this point that the therapist helps the patient to make a value judgment related to the drinking behavior, to enable patients to decide whether or not they want to change.

4. MAKE A PLAN TO DO BETTER. The plan may include participation in an alcohol treatment program and/or attendance at AA meetings or Al-Anon meetings.

5. GET a COMMITMENT. The patient and the patient's family must commit themselves to a positive plan for family rehabilitation.

6. DON'T ACCEPT EXCUSES. The physician must be able to counter excuses and other manipulative behavior often practiced by alcoholics and their families in their quest for drugs and/or "reasons" for drinking alcohol.

7. DON'T PUNISH BUT DON'T INTERFERE WITH REASONABLE CONSEQUENCES. Because alcoholism is still often seen as a moral rather than a medical issue, because physicians are often uncomfortable in dealing with alcoholics, and because alcoholics and their families are often difficult to manage, physicians will often resort to punitive management such as ignoring the alcoholism.

8. DON'T GIVE UP. At least until long after the alcoholic expects you to!

The first step of Reality Therapy is similar to the encompassing principle of Alcoholics Anonymous. "Alcoholics Anonymous is a worldwide fellowship of more than one hundred thousand men and women who banded together to solve their common problems and to help fellow sufferers in recovery from that age-old, baffling malady, alcoholism" (Alcoholics Anonymous, 1977). AA is a vigorous, verbal, active self-help organization with a strong sense of involvement and caring. Reality Therapy is a vigorous, verbal, active approach to helping people. Both work!

The alcoholic patient has, more often than not, managed to alienate friends, family and even strangers, due to the secondary psycho-social symptoms related to alcohol ingestion. For a change of behavior to occur during the rehabilitation phase of alcoholism, it is necessary for the patient to be involved with at least one, and preferably more than one successful person. A major skill, then, for professionals using Reality Therapy, is the ability to get involved with patients.

"In Reality Therapy, emotions and happiness are never divorced from behavior. Gaining insight into the unconscious thinking which accompanies aberrant behavior is not an objective; excuses for deviant behavior are not accepted and ones history is not made more important than ones present life" (Glasser, 1965).

Physicians practicing Reality Therapy would, therefore, ask patients, "What are you doing?" rather than, "Why are you doing it?" Alcoholics may recite numerous reasons why they ingest alcohol, but none of the reasons why will lead them to stop drinking. AA refuses to dwell on the "why's" of detrimental drinking behavior. AA members insist that before alcoholics can stop drinking and begin to change, they must admit to their powerlessness over alcohol - that their lives have become unmanageable. It doesn't matter why - the issue here is what is the behavior which one wishes to change.

When alcoholics have explored the reality of present behavior, the consequences (both psychological and psycho-social) of that behavior, and made a value judgment related to the behavior's efficacy, then they are ready to make a plan to change unsatisfactory behavior to satisfactory need fulfilling behavior.
Step eight of Alcoholics Anonymous, "Make a list of all persons we had harmed and become willing to make amends to them all", and step nine, "Make direct amends to such people wherever possible, except when to do so would injure them or others" (Alcoholics Anonymous, 1977), addresses the issue of accepting the consequences for one's past behavior in an effort to ameliorate the bonds of isolation (re-entry into involvement) and making plans to change one's behavior.

A COUNSELING PRACTICUM FOR FAMILY PRACTICE RESIDENTS

The American Medical Association urges inclusion of counseling skills in family practice resident training (Society of Teachers of Family Medicine, 1972). This mandate is consistent with the behavioral, experiential emphasis of most family practice residencies.

Many Family Practice Resident Training programs include in their goals for training a strong emphasis on the behavioral sciences. Relations through various services in hospitals rarely affords Family Practice residents the opportunity, however, for a counseling practicum.

The necessity for a counseling practicum for family practice residents was initially expressed by a family practice resident who "rotated" through an alcohol detoxification and rehabilitation unit in a large medical center on the East Coast.

As a result of experiencing these rotations, participating family practice residents established the need to: (1) develop skills in using Reality Therapy as a counseling tool to work with alcoholic patients; (2) to increase their skill in the use of effective, time-efficient methods of counseling; and (3) to increase their ability to establish positive counseling relationships with patients.

The Physicians Counseling Practicum in Reality Therapy was designed for the family practice resident who had previously participated in a rotation or equivalent experience with the Alcohol Institute. The purposes of this practicum are to enable the physician:

1. to begin to understand how to develop a facilitative counseling relationship with the alcoholic patient and family;
2. to identify and develop the characteristics and attitudes which make a counselor effective;
3. to understand the differences between long-term and short-term counseling and how to set goals for each;
4. to emphasize the relationship between counselor self-awareness and effective counseling;
5. to help family practice physicians learn to look at their behavior with patients objectively and critically through the use of audio tapes of each counseling session;
6. to help family practice physicians integrate the theoretical concepts of Reality Therapy into their counseling style;
7. to practice the steps of Reality Therapy in role-play situations and with actual clients;
8. to write anecdotal reports for each patient for each counseling session;
9. to have the physician develop a "counseling process outline" as a pre and post self-measure;
10. to encourage physicians to critique their own counseling behavior through weekly supervision meetings;" 11. to read and discuss appropriate literature.

The practicum is conceptualized as consisting of two parts. The first part involves training the family practice resident as a member of a health team.

The second part of the practicum involves individual training with a counselor educator who is also a certified Reality Therapist. A ten week training program has been designed to develop skills in family practice residents in the use of Reality Therapy as an intervention tool in working with alcoholics. Included in the ten week training period are:

A. Training in the use of five of the Carkhuff scales for measuring core conditions of counseling and evaluating one's counseling interaction, i.e., empathy (empathic understanding in interpersonal process), respect (communication of respect for the feelings, experiences and potentials of another person), genuineness (being oneself and yet employing genuine responses constructively), concreteness (specificity of expression in interpersonal process) and confrontation (being attuned to the discrepancies in a patient's behavior) (Carkhuff, 1969).

These skills underly any effective interactions between people and are essential in the practice of Reality Therapy with alcoholic patients.

B. Intensive training in the basic concepts of Reality Therapy and the steps of Reality Therapy, using video tape, role-play and supervision of counseling techniques.

These principles are applied to interacting with the alcoholic patient by the health professional as a member of the health team.

In addition, as mentioned previously, the family practice resident should meet weekly with a Reality Therapist Counselor for a one-to-one counseling practicum experience, which provides a context for integrating all of the Reality Therapy training. These meetings also address the practicum goals of writing anecdotal reports for each patient for each counseling session (goal 8), developing a counseling process outline (goal 9), developing skills of critiquing one's own counseling (goal 10), and reading and discussing appropriate literature.

The use of Reality Therapy as a therapeutic approach is seen as an efficient and useful approach to use with the alcoholic patient and family. Further, the counseling skills learned will certainly be transferrable to patient populations with non-alcoholic related concerns.

References

REALITY THERAPY WITH MEN:
AN ACTION APPROACH

Robert Allan Silverberg

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In general, men have been reluctant to become clients (Carlson, 1981; Heppner, 1981; Scher, 1979, 1981). This unwillingness appears to bear at least some relationship to the nature of the process in traditional psychotherapy. The focus on the production and exploration of feelings, the stress on both making the unconscious conscious and achieving insights in order to bring about behavioral change, the conception of the therapist as a rather remote figure, the client-therapist relationship viewed as transferential rather than possessing an existential reality in its own right, and finally, and perhaps most pertinent, an almost morbid fascination with the client’s past rather than a celebration of the present moment, all amalgamate to foster a manifest disdain for action and an attitude approaching reverence for introspection. It is not hard to understand, then, why most men would be disinclined to involve themselves in such a venture.

Rational and impersonal analysis is in fact the preferred mode of operation for making decisions and solving problems by males (Myers, 1980). Traditional forms of therapy are perceived by the man as a feminine process, requiring the expression of vulnerability, pain, and confusion, components directly in conflict to the typical man, antithetical in fact to the very definition of maleness. As Stevens (1974) has noted, “the key to successful masculinity is rationality, and all emotions, particularly tender, dependent emotions, are hindrances to this” (p. 16). Boys are, in fact, taught that to compete is all-important (Vinacke, 1959) and winning the only worthwhile goal. Such traits as dependency, passivity and vulnerability are clearly forbidden for men and are, in fact, rigidly suppressed by most males. Crites and Fitzgerald (1978) typify the perception of the “ideal man as one who stands alone”: he is independent, strong, logical, fearless, controlled and unemotional” (p. 12). Emotions, feelings, and vulnerability are thus perceived as signs of femininity by many men and, therefore, to be strictly avoided. Much too often the therapist approaches the male client with the intent to help him gain a better understanding of “deep feelings” or “insights.” The client, however, may not be particularly inclined to express such “deep feelings” or “insights,” and, in fact, may become terrified at the prospect of such expression.

Because of the rather unsatisfactory fit between traditional methods of therapy and the needs of many of his male clients, the author has found himself turning more and more to the action-oriented approach of reality therapy (Glasser, 1965, 1972) in his practice of clinical social work. He has, in fact, found this method to be highly relevant with men who have had unsuccessful experiences with more conventional methods of therapy. Because most men are cognitively oriented, the author has discovered that
the expression of feelings as a goal in itself with male clients must usually
take a back seat. Instead, his focus has turned to helping the client change
his behavior. As Glasser (1965) has observed, the attempt to change
feelings, attitudes or “thoughts” merely serves to retard therapeutic
progress, whereas changing behavior more often than not leads to a rapid
change in attitudes. Because such behavioral change is necessarily focused
on the present and on the client doing, such a method of therapy is
emminently suited to the male client intent more on acting in the present
than on the passive examination of the thoughts, feelings and events of the
past.

Since vulnerabilities, feelings, and emotions are perceived by men as
signs of femininity and to be avoided, then it follows that rather than
moving the male client toward behaviors he sees as feminine, a more
productive approach may be to begin with the concept of strengthening and
enhancing the already firmly established masculine values, e.g., logical or
rational thinking, competitiveness, aggressiveness and independence.

The author has found that the development of specific plans with male
clients is an especially effective technique because it avoids much of the
excessive, ritualistic abstractions that often serve to discourage many men
from treatment. Furthermore, the typical male client, conditioned to
compete with others and desirous of “sharpening” his skills so as to better
contend in the marketplace, is usually attracted to task-oriented plans that
delineate definitive, concrete steps that promise to lead to the development
of worthwhile skills. Most men will be highly motivated to take such steps
once they are able to comprehend the rationale behind the steps. As McClelland (1978) has noted, “When everyone involved correctly under-
stands the motivational aspects of the situation in a concrete behavioral
way, then and only then are we likely to bring about change” (p. 201).

Thus, once goals are jointly constructed by the therapist and client, the
creation of a plan by which these goals may be realized will increase the
client’s motivation to change. This process is best understood in reality
therapy as the negotiation of a plan or contract: (a) the client is encouraged
to make value judgments about his behavior; (b) he is encouraged to make
plans aimed at specific, concrete goals; (c) he is asked to commit himself to
these plans; (d) he is instructed to make no excuses if he fails to keep these
plans; (e) he is instructed to spend ten minutes each day writing, then it
should the client find ten minutes too overwhelming, the task may have to
be cut down to five minutes (or less).

Tasks, like plans, may change form and content as intervention
proceeds; some are carried out successfully, some are dropped, while others
are added to fulfill the goals of the plan. If at all possible, it is also a good
idea to state the duration of therapy even if only approximate, e.g., “we
will be meeting for three months.” While the duration of treatment may
change, a time limit seems to motivate many clients to work harder, and
appears important to many men who need to have the specifics of the
contract spelled out in detail.

The client involved in such “action” therapy learns by doing, that is,
by behaving in a different, more responsible manner and thus comes to
create a different, more satisfying sense of self and relationship to the
world. This process is shared by both the therapist and the client, and
through such sharing of productive activity the therapeutic relationship is
enhanced and deepened. As a result, the client is offered the information,
techniques, and other resources that can be profitably utilized to promote
better interpersonal communication, more creative and productive
problem-solving, and the reduction of stress and anxiety.

The following cases treated by the author illustrate the application of
the principles of reality therapy to achieve the above results.

Case 1. A thirty-five year old male advertising executive was referred
because of generalized anxiety and severe, recurrent migraines, both of
which interfered with his work and persisted despite medical attention. He
proved to be an extremely competitive person, devoting much time and
energy in meticulously comparing his performance with that of the other
male co-workers in his agency. In an almost obsessive manner he would, for
example, watch his peers make telephone calls to potential clients, listening
intently for evidence of a successful sale, all the while hoping, he confided,
that the salesman would “screw up.” He complained bitterly to the
therapist that though he felt he was much more aggressive, competitive, and
intelligent than the other men, whom he described as “effete mama’s
boys,” he nevertheless was making far less money than he believed he
deserved, given his far “superior” attributes.

Developing a plan with him which conformed with and, in fact,
expanded upon the masculine virtues he valued, e.g., his competitive,
rational orientation, the client was instructed to catalog the amount of time
he spent listening to the conversations of his peers as compared to the time
actually taken competing with them by telephoning his own potential
clients. After a week of such recording, the executive reported that he spent
an average of four hours out of a typical ten-hour working day listening to
the telephone conversations of the other men. And, he added somewhat
sheepishly, he had spent at least another hour meditating about his co-
workers even when he was apparently focused on his own tasks. As a way of
both addressing and respecting those masculine virtues which he felt were
extremely important to him, it was suggested that he might become both
more aggressive and more competitive by using the twenty or so
unproductive hours each week to telephone his own clients. It was also
pointed out that he could probably cut several hours off his working day through more efficient (another "masculine" virtue) use of his time, thereby providing more leisure time for his professed outside interests, e.g., golf and fishing.

In getting this man to examine his work habits, e.g., how he wasted precious time listening to the conversations of his colleagues while ignoring his own responsibilities, he was helped both to complete a task and function in a more effective, responsible manner in the present. After three months of such changed behavior, e.g., concentrating his efforts on his own productivity, he announced that he was working only eight hours each day, making almost twice as much money as a result of his taking on several new clients, playing golf on a regular basis, and no longer suffering from the anxiety or migraines.

Case II. A twenty-four year old unemployed man entered therapy to find a woman with whom to have a relationship, and to secure a position in his field of endeavor so that he would no longer have to be dependent on his parents. He stated that though he had had several employment interviews, they were not successful because he either said the "wrong things" or would "clam up" during the interview. Living with his parents in their home, he presented a history of their having depreciated any attempts on his part to achieve independence. Despite their lack of encouragement he did manage, however, to graduate from college, but had not yet been successful in obtaining a position in his field. His parents also discouraged him from dating women. On several occasions during college he had brought a date home to meet his parents and they had refused to come out of their room to greet the woman. In one instance his father did come out but only to make an extremely disparaging remark to the woman about his son. The client had not, in fact, been involved with any women since leaving college three years ago.

A plan was developed with his client whereby he could secure a job in order to make it possible for him to move out of his extremely negative home environment. Mock interviews were carried out in the treatment sessions to modify his "nervousness" and tendency to become silent during job interviews. He was given certain suggestions to lessen some of the intense pressure he felt in regard to a need to perform during these interviews, e.g., a series of questions he might ask of the interviewer. He was also given reading material that might yield additional useful information or techniques to lessen his anxiety and provide him with useful skills. After three months, during which he worked on integrating the various suggestions, information and techniques into the rehearsals interviews, he was able to obtain a position in his field.

The next part of the plan was to help him secure an apartment of his own in order to fulfill his desire to become independent, and to make it more possible for him to involve himself in a relationship with a woman. Several sessions were used to help him overcome his resistance to moving out of his parents' home. It was pointed out that the masculine virtues he valued, e.g., independence and success with women, could best be satisfied through such a move. After two more months he was able to find an affordable apartment in the vicinity of his employment. The twin steps of first securing a job to support himself and then finding his own apartment provided this young man with an enhanced feeling of self-respect, which in turn served to motivate him to once again make an effort at involvement with women. Shortly after moving out on his own, he reported that he was dating a young woman whom he had met at his place of employment.

Reality therapy emphasizes the futility of involvement with the past, inasmuch as the past cannot be changed. Such concentration on the client's history is, in fact, likely to convince him that his options are limited by his past. The examination of the past coupled with the "teasing out" of unconscious conflicts both serve to reinforce a pathological stance on the client's part, e.g., "I am too 'sick' or 'damaged' to change my behavior." Perhaps most important, because the therapist committed to the principles of reality therapy does not attach great import to an exploration of the client's past, he is able to take the role of an active teacher in showing the client better ways to fulfill his needs in the present. As Glasser (1965) states, "The proper involvement will not be maintained unless the patient is helped to find more satisfactory patterns of behavior" (p. 54).

Glasser's (1965; 1972; 1981) emphasis on the therapist's genuine involvement, the need for autonomy, independence and self-control on the part of the client, and the concentration of the therapeutic effort on specific behaviors would appear to hold particular promise in therapy with men. The average man's very real need for a concrete form of productivity in sessions, related to an often intense urge toward achievement and toward competition with his peers, and a general aversiveness toward delving into feelings and emotions make reality therapy an attractive alternative to more conventional methods of treatment.

References
USING REALITY THERAPY IN A SOCIAL SERVICE AGENCY AS AN ASSESSMENT TOOL TO DETERMINE COUPLE ADOPTION SUITABILITY

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In order to adopt an infant or older child through most social service or adoption agencies, a person or couple must fulfill prescribed agency eligibility requirements. These vary in rigidity, but most are so restrictive that most persons who want to adopt cannot. For example, in order for a couple to adopt a white Catholic infant from many of the Catholic Social Services, the couple must document medically that one of the spouses is infertile. This is one of a number of criteria that must be met by a couple who want to be approved as an adoptive couple. (McGuire, 1981).

For many couples, gaining approval to adopt is a difficult process. This is because the approval process requires an in-depth study of the couples’ psychosocial past, present, and future. This includes, unfortunately, both the negative and positive past. Furthermore, it includes studying the couples’ residential environment. This process is universally called the “home study” and is regarded by adoption agencies as the “heart of adoption.” (McGuire, 1981).

While many methods and strategies have been and currently are employed to gain this information and to counsel couples about adoption, (Sorosky, Baran, & Pannor, 1979; Spencer, 1980; Tremitiere, 1982), Reality Therapy (RT) is effective because it is direct and confrontive, yet nurturing, practical, and easy for most people to understand. RT focuses on the life situation of the couple which permits the interviewer to secure the necessary information while concurrently being able to give advice or alternatives to help a couple meet their individual as well as their collective needs. (Ford, 1974; Applegate, 1980).

Reality Therapy is a tool that effectively can help the adoption worker quickly assess whether or not a couple should be recommended for approval to adopt, and assist couples to decide “for themselves” whether or not they, indeed, wish to adopt. The following is an experiential account of how I use RT with adoptive couples during my first meeting with them, called the “adoption inquiry”, and throughout the “home study process.”

The first step in the adoption process is the inquiry. When a couple comes to our office to inquire about adopting, I first make friends with them. In doing so, I share something about myself before asking them to answer questions about themselves. Usually I tell them what I do for fun, where I live, a story about my toddler daughter, or something else that reflects something about why I am interested in living a happy positive life and am concerned about helping others do the same. This takes about five minutes. Next, I ask them about their interests, where they live, and other identifying information such as place of employment etc. that is required for their case file. Once I have talked with them for about ten or fifteen minutes, I ask them about why they want to adopt. I ask them how adopting will meet their needs as individuals and as a couple e.g., “What will you gain psychologically or socially by adopting?” I deliberately do not ask them “what they want” but simply explore with them the situation or condition that led them to consider adoption. Sometime during the adoption inquiry meeting I ask them these questions: “What led you to consider adoption?”, “Do you have any friends who have adopted?”, “Do you have any friends who are adopted?”, “Are you adopted?”, “What will you do if after you apply with Catholic Social Service and go through a home study, you are denied approval to adopt?” As the couple answers these questions, I continue to share with them some of my life experiences and related experiences working with adopted children and people I know who have adopted. I intentionally avoid asking them what they want at this time because I have discovered that most people will be reluctant to be honest until they trust me.

Adoption for many people, particularly where one or both spouses are infertile, is a big step in their lives and they do not take it lightly. Many of the infertile couples interviewed are hesitant to discuss their infertility during an inquiry meeting. Talking about something like infertility for them is confidential and they want to know something about me before they will discuss their intimate lives. I, therefore, delay any discussion until we know more about each other. I have discovered that asking adoption couples what they want concerning adoption tends to make them feel defensive and places a barrier between us. I do, however, during a first meeting ask them “what they have been doing” in the recent past, usually no more than a month past concerning adoption. I ask them about what other agencies they have approached, whether or not they have explored adopting a foreign child, and if they have talked to any immediate family members about adopting. These are only a few of the information giving questions I ask them concerning their interest and desire to adopt.

At this point in the adoption process, I concentrate on the behavioral step of RT and de-emphasize the existential component of exploring the couples’ wants. Focusing on what couples are doing concerning their motivation to adopt is non-threatening and helps them open up about their “real” concerns about adopting. Steps 1, 2, and 3 of RT are particularly helpful in this regard because it helps to examine concretely what they are doing in their life presently to realistically prepare themselves for adoption, and to look at what they are doing specifically that shows they would make good adoptive parents.

In the inquiry process, I begin to explore with the couple the kinds of things they are presently doing that shows the quality of their marriage and whether or not they could adequately parent a child. I ask them “Do you presently spend any time with children on a regular basis?” Do you have relatives who have children with whom you interact?”, “Do you visit day
care centers and spend a little time interacting with the children?", "Have you taken any child care classes?", "Have you ever changed a diaper?", "If you have an infant in your home, who would take care of it most of the time?", "Do you and your spouse regularly participate in activities together?", "Do you criticize each other?", "Do you hug each other daily?". I also provide the opportunity for the couple to discuss other areas: "Tell me what you do for fun together" and "Tell me what you do together where you get along the best, the worst."

I further explore their relationship by asking a series of other questions like, "What does your spouse like to do best?", "Who does most of the house work?", "Do you eat lunch together daily?". Assessing the strength of their relationship is critical from an adoptive point-of-view because if the couples' marriage is presently unstable because they frequently criticize each other and share few interests, adding a child to their lives may create additional problems. The addition of a child may demand the wife spend even less time with her husband, for example, and strain the marriage. For this reason, and others, the psycho-social strength of the adoptive couples' relationship must be examined. The strength of the marriage, how the spouses go about resolving conflicts as well as helping the other fulfill his/her basic needs must be assessed realistically. This assessment will determine whether or not the couple will be approved to adopt.

During the initial inquiry, I provide the couple with Catholic Social Service eligibility requirements for adopting, and ask them questions about how they perceive these requirements applying to them. I wait until I have talked with them for about an hour, however, because this is similar to asking them "What do you want?". It is difficult for many couples to talk about whether or not they meet the infertility requirement to adopt through Catholic Social Service. Experience has proven it would be a mistake to ask them how this rule applies to them until some trust level has been established. Once I sense the trust level has been established, I directly ask them whether or not they think they meet the infertility requirements by discussing their "infertility story." This aspect of the adoption process is important because if the couple has difficulty with "their infertility" or as some adoption researchers suggest, "personal loss", and cannot resolve it, Catholic Social Service and many other adoption agencies will reject their applications. The agency adoption committee, who makes the final decision on approval or rejection based on the home study report, believes that people who cannot resolve the "infertility issue" probably will inadequately care for a child. (Kraft, Palombo, Mitchell, Dean, Meyers, & Schmidt, 1980; Sorosky, Baran & Pannor, 1979). Whether or not this will occur in all cases is debatable, but this is the policy of the agency.

If the couple remain reluctant to discuss their infertility, I ask them if avoiding the painful issue will help them to resolve it. I inquire if they know of another way to deal with their perceptions of infertility, and if so I would be willing to consider their suggestions because it would help me do my job in adoptions much better. If they decide not to talk about infertility, I gently tell them that they need to consider what would help them refocus on their initial motivation to adopt. This presents them with a perceptual error that must be resolved, or they cannot adopt through Catholic Social Service or any other agency that has similar eligibility criteria. In short, I confront the couple with their perception of wanting to adopt, and with their perception of remaining quiet about their infertility, which is preventing them from adopting or "getting them what they want."

Although I have discovered that primarily steps 1, 2, and 3 are helpful, step 4, (helping the couple to make a plan) can be used. I ask the couple what they think would help them to be eligible to adopt a child, and if they have any ideas about how they would go about getting what they want. This is an appropriate question when the couple says they could check with another agency which has more lenient eligibility criteria. I usually ask them if they would like to look at some materials describing the eligibility requirements of other agencies. They usually agree and we can examine the criteria together. This does not avoid the perceptual error, however, because later I ask, "Now that you have looked at other agency requirements regarding infertility, do you think the way you are thinking about infertility presently will help you adopt a child?" If we do not achieve some resolution, I can ask them if they would like to consider finding ways to satisfy their desire to adopt a child. When they affirm their commitment, I will make another appointment. If they decline, I suggest they contact other agencies, and that, if they desire, I will be able to help them in any way I can.

Never in any situation do I force them to come to grips with their infertility or any other perceived inadequacy concerning adopting. I do what I can to make friends, explore with them what they are doing now about adoption, help them make some plans to seek further assistance or to consult another agency that may help them better, or offer my services in helping them adopt through Catholic Social Service by meeting the agency's eligibility requirements.

A considerable number of couples who come to our office for adoption information have a history of "conception failures", failures dealing with other adoption agencies, and failures dealing with the medical profession. They frequently complain and blame others for their misfortune. Reality Therapy is useful in working with these couples as well, because it focuses on the life situation of the person as well as the "realities of the external world." In the adoption inquiry and the home study process, this translates into focusing on the couples' adoption life situation, and helping them evaluate their motives and behaviors about adopting so they can clearly see they are responsible for whatever happens in the adoption process. This is useful for the adoption worker because it short circuits the adoptive couples when they begin to blame the adoption worker for previous failures. Using step 2 and step 3 are helpful in this regard because they short circuit the perceptions and actions of hostile adoptive couples. It is common, for example, for an adoptive couple to attempt to use the adoption worker as a scapegoat for their misfortune, and for them to throw hostile remarks at the adoption worker if he/she does not immediately solve their problems by instantly approving them and giving them a baby. When this happens, I simply ask the couple "What are you doing now . . . ?" questions and
follow it up with “Is what you are doing now getting you what you want?” questions.

Thus RT is particularly useful in preventing “burn-out” amongst adoption workers, and is an invaluable tool in helping both the couple deal with their infertility or meeting other adoption agency eligibility criteria, and adoption workers maintain their own psychological health. Both of these are necessary in adoption work, and Reality Therapy is an excellent assessment and counseling tool to do it.

References


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