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Journal of Reality Therapy
Vol. IV No. 2 Spring 1985
EDITOR'S COMMENT

At the end of the fourth year of publication, I am pleased to report that a formal agreement has been reached with Northeastern University in Boston for sponsorship and publication of the Journal. This will place the Journal on a solid professional and financial base for the future. As an approved publication of Boston-Bouve College of the University, the Journal will be in a position to increase its distribution both to individuals and to institutional libraries.

There are also three new members of the editorial board with terms that expire at the end of 1987. C. Loleta Foster is a certified reality therapist from Fayetteville, North Carolina. Dr. Foster has her Ph.D. from Kent State University in Counseling Psychology. Currently on the staff of Fayetteville State University, she is Associate Dean for Special Programs-Student Life.

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The three additions to the editorial board help to maintain the high quality review process that has been available to the Journal since its inception, and that has helped maintain the quality of Journal articles.

PARADOXICAL TECHNIQUES IN REALITY THERAPY II

Robert E. Wubbolding

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In a previous article (Wubbolding, 1984), the relationship between Control Theory and Paradoxical Techniques was explored. Examples of Paradoxical Techniques used by Glasser were described, as well as how the method of Reality Therapy is in many ways paradoxical. A paradox was defined as "a tenet contrary to received opinion; also an assertion or sentiment seemingly contradictory, or opposed to common sense, but that yet may be true in fact."

Various authors have identified an array of techniques. Raskin (1976) describing the use of paradox from another point of view, describes various treatment techniques in which paradox is utilized. Weeks and L’Abate (1982) present three general types of paradoxes with various subdivisions. Their ideas are especially useful in the practice of Reality Therapy.

The purpose of this article is to describe two general types of paradox which are central to the effective use of Reality Therapy. Special attention is also paid to contraindications and caveats for their use.

Paradoxical Techniques

For the purposes of simplicity the techniques of paradox are divided into two general types: 1) reframing, relabelling, and redefinition and 2) prescriptions.

1. Reframing, relabelling, redefinition: This technique, according to Weeks and L’Abate (1982), consists of helping clients change the ways they perceive and think about a topic. What was once seen as "bad" is now seen as "good." The problem thus becomes more desirable. In counseling a young man, who after a fight discovered that his hand was "frozen" into a fist (with no physiological basis), I suggested that he hold it up for all to see rather than hiding it under his other arm as was his habit. We both laughed and were able to see humor in what had been only a "serious" problem for him. I suggested that he try to feel proud of his temporary handicap and that if he hid it no one would know when he overcame it. I asked "Why not use it to show people you can conquer difficulties?" He was able to reframe the problem in a two-fold manner: from seriousness to humor and from a shameful event to a positive attention getting tool.

Reframing or relabelling is especially useful in Reality Therapy. For instance, to ask what people are "choosing" to do is to reframe the "doing" behavior and to help them think more in
the context of Reality Therapy rather than in a stimulus-response mentality wherein they lay responsibility on other people or on external events. In this way, many clients ascribe power over their lives to forces outside themselves through such thinking as “That person upsets me”, “I’m depressed because I’m unemployed”, “my job is stressful”, etc. There is a powerful implicit message in such questioning as “What are you choosing to do?” Weeks and L’Abate (1982) suggest congratulating a family which seeks help in counseling so that, whereas they previously felt failure, they can now reframe their thinking and thus recognize that only a family with strength and which cares about each other can admit the need for help. This same technique is used in Reality Therapy with individuals as well as with families.

Another example of reframing consists of relabelling the negative symptom, e.g., helping the depressed person see the depression as a friend. The depression becomes a personal friend who accompanies the client and can be discussed in the third person. The use of humor can easily be interjected so that the problem (friend) becomes less burdensome. The goal is for the client to think of the depression as a choice rather than “a cloud that came over me”. If this reframing occurs, this friend can more easily be dropped in favor of more helpful “friends”. (Obviously, a psychotic person should not be encouraged to think along these lines!) Reframing, relabelling, and redefining is a way to help the client think in a new way about the problem. It is most helpful for a therapist to intentionally look for new ways to think about problems presented about clients. Just as effective Reality Therapists help clients discover alternative ways to drive their “doing” behaviors, so also we can help them discover new ways to view problems. Below is a list of labels which are generally seen as negative. For the sake of practice, the reader is asked to reframe each of these using a positive label.

1. Aggressive 11. Controlling
3. Angry 13. Crying
5. Backslapping 15. Hard-skinned
7. Submissive 17. Self-sufficient
8. Looking out for #1 18. Impulsive
9. Domineering 19. Inconsistent
10. Dependent 20. Moody

2. Prescriptions
In this technique the symptom is prescribed. The client is told to choose the symptom. Victor Frankl was one of the early writers who described prescriptions. In his logotherapy, he utilized “paradoxical intention.” With certain problems such as anxiety or phobias, Frankl (1960) encouraged the client “to intend or wish, even if for a second, precisely what he fears”. He describes, for example, a young man troubled by excessive sweating. He was instructed to tell people how much he sweated and even to brag about it. Frankl reports that after phobicing for four years the client was able to quickly overcome the problem permanently. In this case, as in others, the use of humor is important. Frankl quotes Allport, “The neurotic who learns to laugh at himself may be on the way to self-management, perhaps to cure”. Weeks and L’Abate (1982) add several refinements of prescribing that are useful in Reality Therapy.

a. The symptom is scheduled. An upset person schedules the negative feelings. In counseling a young man rejected by his girlfriend, I instructed him to have an “unhappy hour” the next day at 5:00 P.M. He was to indulge his angering, depressing and self-pitying. He gave himself permission to “crank it up” and indulge it to its fullest. I called him several days later to ask whether he followed through on his plan. He stated that he was “too busy to take the time to go to ‘unhappy hour’”!!!

b. Restraining is another paradoxical technique. Milton Erickson is known for prescribing resistance. When clients choose not to change they are told of the negative consequences of change; the effects on family, friends, self, etc. The counselor might even state that change is next to impossible. In counseling a man who had been angering for many years, I said, “You’ll probably have this anger for a long time, maybe forever”. He replied almost angrily, “But I don’t want it. I want to get along better at work and at home”. To which I said, “Are you prepared to fail in your efforts to fight it?” His answer was “NO”. “Then I predict you’ll fail even more” was my response. He said, “How will I conquer it?” “By accepting it and failing in your efforts and by accepting your failures”. He said nothing further... merely thought about it!!! I further prescribed long solitary walks when he was not angry. During that time he was to choose to be as angry as possible! (It is very difficult to generate anger and to take a long brisk walk at the same time!)

c. Prescribing a relapse. The prescription above illustrates the paradoxical technique of encouraging the client to choose the symptom. Still another component was added; making the choice to relapse very difficult, i.e., to anger while walking briskly. Weeks and L’Abate (1982) emphasize that it is important that the client is told to choose the symptom, to schedule it, to embrace it as a “friend”. The therapist asks him/herself “How can I join the resistance?” Whether the paradox is a detailed prescription or a cryptic insightful remark, it should be discussed minimally without “teaching” the purpose of it. If clients subsequently describe how they defied the plan (prescription) the counselor should shun a detailed discussion of how the prescription was made with the purpose of noncompliance. (Some prescriptions are given by the counselor
expecting defiance. The client is thus in a double-bind; to follow through on the plan and to choose the symptom or to not follow through and not to choose the symptom!

Below are listed ten behaviors. For the purpose of practice only, the reader is asked to write a prescription for each behavior keeping in mind the need to “join the resistance”.

1. Temper tantruming
2. Depressing
3. Worrying
4. Oversleeping
5. Procrastinating
6. Smoking
7. Person who is unhappy with spouse’s drinking
8. Person who blushes excessively
9. Parent of adolescent who steals
10. Person exhibiting shy behaviors

Why Paradoxical Procedures Work

There have been few adequate and comprehensive discussions about why paradoxical procedures are effective. But an understanding of the principles underlying Reality Therapy provides a clear explanation of their effectiveness. One such principle is that all behavior has a purpose: to control the world to get what we want or to mold the environment to match our internal pictures. If the person exaggerates the symptoms or thinks of them in another way (reframing), the purpose of the phobicing, anxietying is changed. There is less “control” of other people and of events. The pay-off for the behavior is removed. If clients attempt to control people or situations by nervousing, sweating, etc., which obviously is not working or helping, they are told to choose, schedule, or exaggerate these non-effective behaviors. Thus, they learn that controlling the world by these behaviors is not helping. This seems, at first, illogical. It is not illogical. It is paradoxical. And one must think paradoxically to see the logic!!

Another principle of Reality Therapy is that most behaviors are chosen. When people complain of problems discussed here, they feel out of control, as though the problem has hold of them. Reframing and prescriptions help clients see the problem as a choice. If the choice can be made to feel more anxious, then the choice can be made to feel less anxious.

And so the concepts of purpose and choice, central to Reality Therapy, help explain the effectiveness of paradoxical methods.

Contraindications For Using Paradoxical Interventions

It should be emphasized that paradoxical methods should not be used indiscriminately or irresponsibly. There are few absolute rules about using paradox; yet there are conditions and caveats which any counselor should consider. Thus, Weeks and L’Abate (1982), stating that there are very few guidelines for when not to use paradox add, “The techniques are still so new and exciting that therapists have been focusing on successes and not failures.” They cite their own experience as the basis for the following contraindications:

1. One type of client who does not benefit from paradoxical intervention is the person who feels little involvement with the therapist.
2. A sociopathic client does not benefit. Weeks and L’Abate state “Tasks given . . . do not register”.
3. Paranoids are not receptive because they are overly suspicious and might become even more suspicious.
4. Most clearly, paradox should never be used in the case of destructive behavior, e.g., homicidal or suicidal behaviors.
5. When there are acute crises, e.g., grief reactions, loss of employment, etc., paradox is not appropriate.
6. Paradoxical interventions are used extensively in Family Therapy. However, West and Zarski (1983) suggest that anyone using them should be trained in systems theory and should receive supervision unless thoroughly trained. Even with training there are instances when paradox should not be used.

In summary, the Paradoxical techniques of reframing and prescribing can be used within the context of Control Theory and Reality Therapy. Clients learn to view the symptom as a friend, to see problems in a different light than they are accustomed, and to choose the very behavior they are trying to conquer. In a reverse sort of way they learn they can control their lives more effectively in that behaviors are not helpful. This seems, at first, illogical. It is not illogical. It is paradoxical. And one must think paradoxically to see the logic!!

Finally, families which project responsibility onto others are not appropriate subjects.

BIBLIOGRAPHY

ALTERNATIVES TO COCAINING

Norman H. Reuss

Mr. Reuss is a Certified Reality Therapist and Certified Alcohol Counselor at Champlain Drug & Alcohol Services, Burlington, Vermont.

Cocaine is the rising star of the drug scene. Even in Burlington, Vermont, thought of as a peaceful town bathed in the brilliant colors of autumn, cocaine is a present reality. Admissions citing cocaine as the drug of choice to Champlain Drug and Alcohol Services, Inc., have increased 300% over the last year. These statistics are common, and they are accompanied by horror stories of cocaine addiction. All of the major news and entertainment magazines have done feature articles on cocaine. Television has dramatized the struggle of broken lives. Sports heroes recovering from cocaine addiction are popular on the High School lecture circuit.

Reality Therapy has a response. Solutions to cocaine addiction framed in the context of behavior and basic needs can reveal a way out. This article will explain how a Reality Therapist can help a cocaine addicted person. The basic tool is the “alternative”. Used in an addiction therapist’s vocabulary, alternatives are “things clients can do to prevent their use of a drug”. Specific to cocaine, the question is - What does the client have to do to stop using cocaine?

Substance Centered Alternatives

Substance centered alternatives are possibly the most commonly known way to break the vicious cycles of addiction. Several years ago, the television detective Kojak broke his addiction to nicotine by popping a lollipop into his mouth. Millions of Americans have used this cure-all. Those who are more health conscious use carrot sticks, with the same effect. It gives them something to do that in some way mimics the good feelings they had previously gotten from a bad habit.

On a more sophisticated level medical doctors prescribe Methadone to patients trying to stop using Heroin. The Methadone gives a substitute Heroin high to replace the good feelings (or lack of bad feelings) that were previously the result of Heroin use. The intent is to minimize the negative consequences to the point that neither Heroin or Methadone are wanted anymore.

With cocaine use, there are two events that warrant attention. Early in a person’s history with cocaine, use will follow a pattern of chasing the high. Initial use produces the energized euphoria that is so attractive. These drug induced feelings are short lived - approximately 30 minutes with intranasal use. The person then feels compelled to use again to produce those same feelings. It won’t happen, though, since the same high will not be achieved with the same dosage. The task is to increase the dose amount to achieve the same high. An inevitable end is in sight. The “crash” is characterized by two painful feelings: depression and paranoia. The user must now switch his/her focus from chasing the high to avoiding the low.

The "crash" from cocaine feels so devastating that people will "run" coke for days on end to avoid it, stopping only when the supply is gone.

The problem for therapy is the management of abstinence produced depression and paranoia. The first course of action is caring support. Like the first step in Reality Therapy - involvement, support goes a long way. Individual therapy will work better when the client spends time with non-drug using friends. A specific plan of support can be worked out. The depression and paranoia that are of a direct chemical origin will last only a few days to a week. During this time a vacation is often a good idea. (Mothers and Weitz, 1984) When this does not work and the depression resembles clinical depression more than a low mood, a sedative-hypnotic of low dose and short duration can be used. (Smith, 1984) The support of a residential treatment facility should also be seriously considered. Support and problem-oriented counseling are always the preferred alternative.

In a few cases, a persisting paranoid psychosis will develop. Butyrophenones (Haldol®) and phenothiazines (Thorazine®) are recommended chemical alternatives to guard against the client’s re-use of cocaine to avoid these painful thoughts. (Cohen, 1983) This course of treatment is to be considered very carefully, and would be most safely recommended in a residential detoxification setting.

‘TRUST ME’ Centered Alternative

As Glasser has explained, the Reality Therapist’s job is to get clients to place the therapist’s picture in their picture album. This is done through involvement and trust. Dr. Glasser illustrated this years ago in one of his video role plays. Ann Lutter played an alcoholic client, denying the magnitude of her alcohol problem and arguing with Glasser over the recommended treatment plan. Dr. Glasser used his trump card, “You either get a job, or I’ll drop you from therapy”. This is one ‘trust me’ alternative. The therapist, trading upon his/her involvement, asks for something to be done and trusts that the result will be helpful. In the world of addiction treatment, Alcoholics Anonymous relies upon the ‘trust me’ alternative almost exclusively. It trades upon a recovery track record and accepting reputation to tell alcoholics, “Trust me, when you do this (meetings, twelve steps, Big Book, sponsor) you will get better”. Although few alcoholics initially believe these things will help, they do believe in AA though and are willing to give it a try.

For the cocaine addicted person, the trust me alternatives are not as clearly defined. Some metropolitan areas do have Cocaine Anonymous, Narcotics Anonymous, or ongoing cocaine recovery support groups that offer a prescribed treatment plan that must be accepted upon the credibility of the program. Mostly though, the Reality Therapist must work from the experience of what works. Glasser’s book Positive Addiction, (1976), presents such examples. I gave the book to my first cocaine client, Jim (not his real name) and asked him to read it. As he read about what other people had done to get for themselves the good feelings of positive addiction, he began to think of alternatives to his use of cocaine. Using Glasser’s six criteria of a positive addiction (Glasser, 1976), I helped Jim focus on one idea he could put into action immediately. Jim chose basketball dribbling.
He immediately began to dribble a basketball for one hour every day. Occasionally, Jim interrupts the flow of motion to take a shot, mostly though he just dribbles and enjoys the good feelings that come from the constant movement of his body and the basketball. Jim has remained cocaine free for two years and continues his daily exercise.

I use this same approach with most of my clients. Initially, some clients resist the idea of repetitive exercise or daily meditation. I freely share my own positive experience of running to replace cigarette smoking, and the positive experiences of my clients in replacing their destructive habits with positive additions. I then bargain for an experimental plan for one week. I literally ask my clients to trust me and try something I know will work. Once they try positive addiction, they discover for themselves that it really does work.

Needs Centered Alternative

Reality Therapists know why people use cocaine - to satisfy one or more of the basic needs. Understanding this, I will no longer use the words cocaine addiction. Dr. Glasser suggested the use of verbs to describe behavior when he first described BCP (Control Psychology). In his most recent book Take Effective Control of Your Life, (1984), he almost insists upon it. In place of cocaine addiction, I use the verb - cocaining. If you say the word 'cocaining,' you can immediately understand the direction of the needs centered alternative. The task is to help the client figure out what basic need cocaining is satisfying. A clue to cocaine's popularity is it almost universally meets the basic need for self worth.

All of the basic concepts of Reality Therapy apply to the needs centered alternative. Reality therapists should keep the focus on cocaining though; there will be a temptation to run afield and discuss other behaviors and other basic needs. A client's "distracting" will move you both away from a painful area. Using the eight steps of Reality Therapy and the principles of control therapy as a springboard, I have developed five steps out of failure that I use with clients to work on their own Needs Centered Alternatives.

1. **STOP** what you are doing and ask yourself, "What need am I trying to meet with this miserable, painful, addicting behavior (cocaining)?"
   
   **Notice:**
   
   • Your behavior is purposeful. You are trying to meet your basic need for belonging (love), self-worth, fun, choices, and survival.
   
   • It is your behavior that has gotten you where you are.
   
   • You do have a choice.

2. **MAKE A VALUE JUDGMENT**, try asking yourself, "Is this cocaining going to get me what I really need?"
   
   **Notice:**
   
   • You are experiencing misery and pain, the "accumulated unhappiness" that is the negative consequence of irresponsible behavior.
   
   • Value judgments work best when they are either YES or NO. When a person uses if/but's, value judgments are weakened and so is the person.

3. **MAKE A PLAN TO DO BETTER**, sit back and relax, ask yourself, "What could I do to get what I need from the world that would be so much better than this?"
   
   **Good plans are:**
   
   • simple That means not complicated.
   
   • immediate That means start today.
   
   • usually the product of individual thought. When that does not work, though, ask a successful person what he/she would do in your situation, and try it!

4. **DO IT**, plans do not work without action.
   
   **Remember:**
   
   • Do not wait until you feel like putting your plan into action.
   
   • Put the plan into action and see how much better you feel.
   
   • Give your plan a reasonable amount of time to work; changing bad habits takes time.

5. **NEVER GIVE UP**, the give up person has taken the first step into failure. Reassess your situation: To change and grow, people need two things:
   
   1) **INFORMATION**, the stuff plans are made from. Information comes from books, pamphlets, advice, conversation, folklore, and experience.
   
   2) **STRENGTH**, the stuff life is made from. Strength comes from success and "communal" support (when people care and share).

**Conclusions**

These three alternatives are presented in a logical order of progression. Initially, the client will be in a painful period of chemical withdrawal. To help the client avoid a continued problem with cocaine use, a substance-centered alternative may be necessary. As the client begins to trust your ability to help, and you show you're committed to involvement in his/her life, the substance centered alternative will give way to the "trust-me" centered alternative. What the client begins doing based upon trust may eventually become a good habit and last a life time. Many alcoholics have chosen AA as a way of life, though they went to the first meetings because it was someone else's idea. For recovery to be as successful as possible, the individual's basic needs must be considered. The needs-centered alternative empowers the client to fully participate in the therapeutic process. The client discovers his/her needs, and does something effective to meet those needs. Cocaine and cocaining can then be removed from the person's picture album of need satisfying behavior.

**REFERENCES**


TREATMENT TEAM INTEGRATION OF REALITY THERAPY

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When a Reality Therapist is one of the team members where there are a number of non-Reality Therapists, the task of integrating and accommodating alternative approaches while interjecting the concepts of Reality Therapy for the benefit of the overall treatment team can be formidable. The present article offers several suggestions and considerations when attempting to accomplish this task.

In application, the steps of Reality Therapy have been shown to be effective in assisting clients to achieve higher levels of functioning or otherwise resolve conflicts which they face in their lives. The basic eight steps that Glasser offers as a means to positive therapeutic outcomes highlight person volition and responsibility as concepts important in producing these changes. Individual practitioners who utilize Glasser’s Reality Therapy usually do well in treating their clients, since the approach to therapy Glasser recommends is straightforward and methodical. Clinical problems faced by the therapist can usually be overcome by redirecting clinical behavior using the eight steps to achieve therapeutic gains. There is high value and economy working with a client utilizing the steps of Reality Therapy as a guide to the clinical process. Difficulties in applying Reality Therapy may arise for the practitioner who is a member of a treatment team where other team members are not adherents to the concepts of Reality Therapy. The reasons for this range from adherence to traditional lines of thinking to basic misunderstandings in relation to the process of helping others.

Perhaps the most plausible explanation for disagreements between Reality Therapists and other clinicians of various treatment methodologies is that all therapists, regardless of their theoretical orientation or methodologies, believe that their particular style of involvement with clients is helpful. The perception of being helpful to others provides the clinician with a sense of self-esteem and competency. When the method of obtaining this desirable outcome is challenged or disputed, the clinician’s behavior is likely to become increasingly protective and territorial in relation to his/her own beliefs about therapy. In this way, the clinician’s ability to preserve a sense of self-esteem and competency within the clinical role is maintained.

Regardless of the reasons, individual members of a treatment team may choose to approach the same clients with widely varying treatment orientations and methods. As a result, extreme variations can result in a disjointed and confusing experience for the client. In all probability, this would be perceived by all team members as undesirable. Thus, it is of no surprise that individual members of a treatment team often agree to establish a more unified approach to client care to produce positive outcomes for clients.

RELABELLING

Perhaps the most effective method of integrating Reality Therapy in a mixed treatment setting is to identify those concepts key to Reality Therapy and attempt to accommodate other approaches by renaming them. This can be especially effective when other members of the treatment team and the Reality Therapist come to an open consensus with regard to these concepts, and agree that the renaming has not resulted in a loss of validity for either of the concepts in question. Granted, there are concepts unique to Reality Therapy that cannot be renamed without losing the thrust of their value in application. However, a significant number of concepts can successfully be relabelled.

For example, although there are significant differences between behaviorism and control theory, (behaviorists believe in external control, control theorists in internal control) there are also enough similarities in the approaches that would allow therapists from each of these schools to work together with some degree of efficiency. Step one of Reality Therapy, “making friends” can easily be translated into “establishing the therapist as an unconditional positive reinforcer.” If both therapists can agree some type of significant involvement needs to take place before a productive working relationship can be developed with a client, they should experience little difficulty in beginning to work with that client. In another instance the behavioral concept of “negative learning history” can be effectively relabelled to “negative self-image” to approximate the Reality Therapy concept of failure identity.

The same relabelling techniques could be used when reconciling differences between therapists using a traditional model of thinking and Reality Therapists. Defense mechanisms such as repression, displacement, and rationalization are viewed as the outputs of the behavior system in control theory terms. Relabelling these to “defensive behavioral outputs” may serve to provide a common ground between both approaches while at the same time retaining a significant degree of validity for both. The point here is not so much what new term is applied in these situations, but rather that an attempt be made to seek mutual agreement upon terminology to convey the meaning of related concepts of varying clinical approaches. Once this is accomplished, few possibilities exist for serious differences to develop which would impede uniform approach to client care.

EMPHASIZE SIMILARITIES

In terms of developing and retaining workable team relationships so that clients receive maximum care afforded by a uniform staff approach, emphasizing similarities between treatment approaches is likely to be more effective than emphasizing differences. Although a number of concepts
contained in Reality Therapy are in direct contrast to traditional, and some non-traditional treatment approaches, a number are also very similar. Emphasizing the similarities between Reality Therapy and other approaches allows persons relatively unfamiliar with Reality Therapy to address directly those concepts unique to Reality Therapy that are potentially more valuable in treating clients than an approach they may be currently applying. Highlighting similarities between Reality Therapy and other intervention strategies allows for greater focus upon those concepts of Reality Therapy, which although they may be more controversial, may also well be the central feature and contribution of Reality Therapy.

For example, most non-Reality Therapists would probably have little trouble accepting the notion that human beings behave and that this behavior has a purpose. While this concept may not be held by all approaches, it makes enough sense that most approaches adhere to this idea. However, convincing non-Reality Therapists of the Reality Therapy concept that personal volition and responsibility are involved in selection of these behaviors may not be as easy. As the concepts of personal volition and responsibility are central to understanding and application of Reality Therapy, these can be focused upon directly in relation to a specific client’s presenting problems and expectations for change. In this way, if there are disagreements between Reality Therapists and non-Reality Therapists, the disagreements are issues which are central, and related directly to client care.

The emphasizing of similarities between approaches also allows non-Reality Therapists to perceive the Reality Therapist as an ally in the effort to assist a client. This is accomplished as the non-Reality Therapist’s own perception for self-esteem is retained by allowing someone else to note the similarity in thinking and technique in assessing and treating a client. This may also serve to develop a sense of belonging and affinity in relation to the treatment team possibly contributing to greater overall flexibility. Emphasizing similarities between approaches may lead to greater staff uniformity of approach in relation to the treatment of clients.

**BE VERY FAMILIAR WITH REALITY THERAPY**

One’s own familiarity with, and comfort in using Reality Therapy on a treatment team where not all team members are adherents to the concepts of Reality Therapy can sometimes be difficult. It can also be counterproductive for clients receiving treatment from the team. Efforts to develop team uniformity are valued as desirable. They can be achieved through the processes of relabelling, emphasizing similarity, and thorough knowledge of and application of the steps of Reality Therapy. In this way, the key concepts of Reality Therapy are retained for the overall enhancement of quality clinical care.

Further, it may also be advisable for the Reality Therapist to teach other staff the basic concepts of Reality Therapy in formal and informal settings. This would accomplish the task of presenting in a non-threatening way key Reality Therapy concepts to begin the integration process. To enhance the accommodation-integration process, it would also be advisable for the Reality Therapist to learn treatment approaches offered from the non-Reality Therapists of the treatment team. Open discussion regarding the similarities and differences among approaches can often lead to mutual agreements. Agreements of this type often lead to a blending process whereby clinical care becomes more consolidated and more beneficial to clients receiving treatment from the team.

In summary, the use of Reality Therapy on a treatment team where not all team members are adherents to the concepts of Reality Therapy can sometimes be difficult. It can also be counterproductive for clients receiving treatment from the team. Efforts to develop team uniformity are valued as desirable. They can be achieved through the processes of relabelling, emphasizing similarity, and thorough knowledge of and application of the steps of Reality Therapy. In this way, the key concepts of Reality Therapy are retained for the overall enhancement of quality clinical care.
Counselor supervision is a process with many purposes, responsibilities and goals. It is a complex task, far more than the simple teaching of certain skills. Boyd (1978) describes three purposes for counselor supervision: 1) facilitation of the counselor's personal and professional development, 2) promotion of counselor competencies, and 3) promotion of accountable counseling and guidance services and programs. Boyd says that the supervisor adopts four distinct roles to achieve these purposes: supervisor as teacher, as counselor, as evaluator, and as consultant. Boyd says that the role of consultant is the supervisor's primary role, from which the other roles can be selected. This article will address how Reality Therapy supervision makes use of these four roles to complete the responsibilities of the counselor supervisor.

A counselor supervisor has a number of responsibilities. The supervisor has a responsibility to train the counselor both personally and professionally, to safeguard the welfare of the supervisee's clients, and to promote high quality standards for the profession. The supervisor has a duty to teach appropriate professional ethics, and maintain a proper ethical stance regarding the supervisee (Cormier and Bernard, 1982) including not imposing the supervisor's theoretical bias, avoiding dual relationships with the supervisee (either sexual or counseling relationships — because of the "diminished consent" of the supervisee), and making sure the supervisee knows the supervisory and evaluation procedures, and the criteria for evaluation. Cormier and Bernard also point out a number of ethical areas that the ethical supervisor must keep in mind concerning the client, including informed consent, confidentiality, and vicarious liability.

Within just this brief summary of the supervisor's roles and responsibilities, it becomes clear that the task of counselor supervision entails a myriad of difficult considerations. While Bernard (1979) and others have written about the development process of counselor learning, very little has been written about specific guidelines for the use of the four supervisory roles. The supervisor using Reality Therapy needs to have an understanding of the process of supervision, the developmental stages of counselor growth, the use of the four supervisory roles, and the use of Reality Therapy to direct the course of supervision.

The assumptions of Reality Therapy have been used effectively in the group supervision of counselors (Schaughency, 1977). It is currently being used by supervisors certified by the Institute for Reality Therapy in the teaching of Reality Therapy who use the process of Reality Therapy to teach it. Reality Therapy can be used to foster counselor learning in individual supervision sessions, using each of the four roles. After a discussion of Reality Therapy principles applied to counselor supervision, the process of Reality Therapy Supervision will be discussed.

The Principles of Reality Therapy Applied to Counselor Supervision

The following principles are essential parts of the process of Reality Therapy Supervision.

1. Counselors are internally motivated.

While the work of counseling is to facilitate the client's understanding of self and his/her difficulties, and facilitate some action in solution of those difficulties, counselors approach this work with their own internal motivations and pictures of what can/should/will happen in counseling.

2. Counselors are motivated by their needs.

Counselors have at least the following needs which may result in appropriate or inappropriate behavior on the counselor's part: a.) the need to belong; the need to be needed, b.) the need to see themselves as effective to some degree and improving, e.) the need to enjoy the work of counseling, and d.) the need to try new things and to be able to feel a sense of control in their learning.

3. Counselors will choose various behaviors in counseling, in supervision and with their colleagues to attempt to get their needs met.

Counselors' choices of behaviors depend in part on what has worked in past experience, what they can see potentially working, and on what new behaviors they can create.

4. The supervisor's job is to teach counselors how to use flexible behaviors to help clients meet their needs.

The supervisor also teaches counselors how to meet their own needs appropriately in counseling sessions, in supervision, and to some extent, in life. The supervisor shows flexible, creative, responsible behaviors in doing the work of supervision, in order to teach the counselor by modeling as well as by consulting or instructing.

The Process of Reality Therapy Supervision

Reality Therapy Supervision is an approach that can be used in teaching the principles of Reality Therapy or other kinds of counseling techniques. Reality Therapy Supervision follows the steps of Reality Therapy to address the learning needs of the counselor, and makes use of the four supervisory roles.
Step #1 INVIOLMENT

In the first step of Reality Therapy Supervision, a relationship is established between supervisor and supervisee. Such a relationship focuses upon the goals and expectations that the supervisee foresees for the counseling and the supervisory relationships. The supervisor shares the supervisory expectations, and contracts with the supervisee for the method and standards of evaluation. The supervisor begins with the consultant role, relinquishing control of the learning to the supervisee. The initial question, “What do you want?” or “What do you want to accomplish in your counseling?” establishes the supervisor as consultant to the supervisee. This question is asked at the beginning of the supervisory relationship and regarding an individual counseling session. Other supervisory roles are adopted when they are necessary for the supervisee’s learning. There may be times when the supervisee does not know what he/she wants or what is realistic and possible to want. At some of these times it may be necessary for the supervisor to adopt the teacher, counselor, or evaluator roles. The Reality Therapy supervisor may need to teach the supervisee what to expect in a counseling session, counsel about a personal issue affecting the counseling, or help the supervisee evaluate the appropriateness of his/her goals for the counseling.

Step #2 DEALING WITH PRESENT BEHAVIOR

Once the supervisor has some understanding of the goals that the supervisee had for a particular counseling session, the supervisor directs the person to report the specific behaviors that the counselor used to reach these goals. Initially this process may be somewhat threatening because of the implied evaluative format, but the supervisor and supervisee have already become involved, and have discussed the standards of evaluation.

The focus on behavior in Reality Therapy Supervision is principally on (doing) behaviors, but also includes some focus on the supervisee’s thinking and feeling (behaviors). Such consideration is necessary for the supervisory responsibility of facilitating the supervisee’s personal and professional development. For example, a supervisee’s prejudicial or emotional reaction to certain clients may suggest further exploration of the internal world of the supervisee. While the primary emphasis would be on the nature of what the counselor does differently because of the reaction, and the consequences that are both evident and possible in the client’s responses, the supervisor may choose to ask supervisees to examine the thinking and/or feeling component of their behavior.

While the second step is to focus on present behavior, the Reality Therapy supervisor may recycle back to the first step at any time if it will help in the supervision process. Thus the supervisor may ask the counselor who got irritated at a client, and has said so, to restate the goals of counseling, or what was desired. At this step it is also essential to connect the consequences of the behavior with the behavior itself. The Reality Therapy supervisor may choose to adopt the teaching role to point out the effects on a client of the counselor’s irritation.

Step #3 VALUE JUDGMENT

Patterson (1983) and others have stressed the fact that the evaluation role is an essential part of supervision. This is true in Reality Therapy Supervision, yet in Reality Therapy Supervision, the responsibility of making the value judgment is shared. The Reality Therapy Supervisor works from the beginning of the supervisory relationship to facilitate the supervisee’s ability to make evaluations of his/her own performances.

The supervisor takes special care to teach the counselor how to evaluate performance in preparation for self-supervision. This is done by asking counselors to make value judgments concerning the efficacy of their counseling interventions. At times, the Reality Therapy Supervisor may need to help the counselor make a proper evaluation of effectiveness. This is done when the counselor requests it or admits not being able to do it alone, by making the evaluation of the behavior and discussing the process and criteria used in making it. It is also done when the counselor seems repeatedly unaware of the effects of certain behaviors, or when the protection of the client is paramount over the issue of allowing the supervisee to make the value judgment.

The third step of Reality Therapy Supervision is very important when the supervisor adopts the counselor role. Because the supervisory relationship has different aims from the counseling relationship, the Reality Therapy Supervisor works to avoid a primary focus on the counselor’s personal issues. At the same time, it may become necessary for the supervisor to adopt the counseling role in dealing with a counselor’s personal issues that affect the counseling. For example, counselors who expect themselves to be perfect, need a supervisor to help examine their wants and evaluate how attainable they are. This means that the Reality Therapy Supervisor adopts the counseling role to focus on personal issues of the counselor, while maintaining the overall role of a supervisory consultant. Cormier and Bernard (1982) clearly explain the ethically correct decision in this situation; if the counselor needs counseling, the supervisor may refer him/her to an outside professional, or assume a counseling relationship while dropping the supervisory relationship. While the Reality Therapy Supervisor makes plans and commitments with the supervisee, and the supervisee may need to spend time in the supervision on personal issues affecting the counseling, the supervisor expects a certain level of strength and responsibility in the supervisee that may not be present in clients.
Step #4 PLAN

In this step, there are two separate plans that are made and implemented: the counselor's and the supervisor's. The supervisory process is concerned with helping the supervisee come up with an action plan for planning, counseling, evaluation, or dealing with a personal issue with regard to the sessions. The Reality Therapy Supervisor asks the counselor to make a simple, measurable, specific plan to do something in the counseling sessions. Because the focus can be on the counselor's internal world (expectations, planning, or conceptualization), the supervisor can adopt the role of counselor in facilitating the supervisee's plan. The supervisor can also adopt the roles of evaluator, teacher, or consultant depending upon the focus needed by the supervisee in planning.

The second part of this step is the supervisory plans that are made. Because the supervisor is primarily a consultant, the selection of supervisory strategies are made with the counselor. The supervisor may use any or all of the following strategies: role playing, modeling techniques, brainstorming, confrontation, exemplification, joint case conceptualization, instruction, live observation, live supervision, or the critique of counseling tapes. The choice of a supervisory plan depends upon the supervisor and supervisee. However, the supervisor maintains a primary responsibility to select the appropriate supervisory role and activity for facilitating the supervisee's development.

Investigations of the "parallel process" in supervision (Claverre, 1982; Doehrman, 1976; as well as Ekstein and Wallerstein, 1958), have some interesting implications for supervisors. This research has indicated that the problems the supervisee presents to the supervisor often find a parallel in the supervisee's approach to the client (and vice versa). This implies that the supervisory choice of strategies needs to be reflective of the learning intended for the supervisee. For example, the supervisor who targets the counselor's need to learn self-evaluation, might focus on showing the counselor how the supervisor evaluates his/her supervision. Another example is the supervisory focus on what the supervisee wants to happen in counseling in order to help teach the supervisee how to help the client focus on his/her wants in life.

Step #5 COMMITMENT

The Reality Therapy Supervisor is in a different position from the Reality Therapist, whose clients may lack a significant amount of motivation to change their behavior. The supervisee is presumed to have a higher level of interest and enthusiasm than many clients. Yet, it is also important for the Reality Therapy Supervisor to teach the supervisee how to make a responsible commitment. This can best be done through making and keeping commitments with the supervisee, and through asking supervisees to make and keep commitments concerning their counseling, the plans made in supervision, their timeliness in attending supervision sessions, and other administrative responsibilities. The Reality Therapy Supervisor helps the supervisee learn how to make plans that are designed for success, by asking a series of "what if" questions to eliminate possible future "roadblocks" and excuses. It can also be done through asking the supervisee to evaluate the commitment made to a plan. As the supervisee internalizes the evaluation of his/her own effectiveness, the commitments that are made will be stronger and more responsible.

Steps #6, 7, & 8 FOLLOW-UP STEPS

It is essential that the Reality Therapy Supervisor follow up on plans made in supervision, without accepting excuses, without punishing the supervisee, and without giving up on the supervisee. The supervisor who punishes a supervisee, even subtly, may find the supervisee subtly punishing a client. While the supervisor does not punish, it is important to evaluate a supervisee's progress, and give specific feedback related to it in accordance with the agreement made about the standards and procedures of evaluation. The supervisor who neglects the appropriate use of the evaluation role, may find that the supervisee's over-concern or lack of concern about performance can prevent progress. It may especially be important to be sensitive to the inexperienced supervisee who may be punishing him/herself for hypercritically evaluated performance. In such a case, the supervisor may need to adopt the counselor role, to help the supervisee focus on ineffective self-evaluative behaviors and learn realistic standards for performance.

Summary

The four supervisory roles of counselor, consultant, teacher, and evaluator help the supervisee grow personally and professionally. Reality Therapy Supervision utilizes each of the roles to work with counselors using Reality Therapy or any other approach. The flexibility of Reality Therapy Supervision allows it to focus on the supervisee's learning of techniques, ethics, self-evaluation, conceptualization, and personal integration of all of these to become a more effective counselor. The following are key points to remember in applying Reality Therapy Supervision:

1. Use the role to teach the role; use the step to teach the step.
   The counselor who is not helping the client become more specific with what the client wants, may need the Reality Therapy supervisor to ask him/her to become more specific about what he/she wants to accomplish in the counseling. The supervisor who lectures to a supervisee may find that supervisee becoming "long-winded" with clients. Be aware of the parallel process.

2. Work to improve the counselor's self-evaluation skills.
   The counselor needs to internalize the process of evaluation in an effective, realistic way for whatever kind of counseling techniques being used.

3. The goals of counselor supervision are the integration of skills, planning, and personal development.
The counselor should complete the process of supervision with realistic and appropriate expectations about the kinds of things to expect in counseling, and realistic, appropriate action strategies for counseling (whether they are Reality Therapy, behavioral, client-centered, or others).

4. Use the Reality Therapy process as part of supervisory planning.

The Reality Therapy Supervisor asks the same questions of self: What do I want to accomplish in this supervision session? What am I doing to get what I want? Is it working? What else can I do? When will I do it? (etc.)

5. Counselor growth is a developmental process.

The supervisee beginning supervision for the first time will probably be at a different stage in terms of self-knowledge, counseling skills, and conceptual ability, than the experienced counselor who is a supervisee.

6. Use Control Theory terms in supervision to help the counselor learn how to avoid linear thinking.

This means using such terminology as: pictures in the head, wants, really wants, and choosing to do. It is important to help the counselor learn more effective ways of conceptualizing client difficulties and alternatives to meeting their needs.

Bibliography


counseling but that the husband makes only a token effort,”; and (d) being personable, i.e., by self-disclosing, by using humor, and by addressing the supervisees on a first name basis.

Another consideration relevant to trust and rapport is that small group supervision demands that the supervisees become comfortable with each other. A fierce competitiveness among trainees can develop if the supervisor doesn’t take steps to encourage their cohesiveness. These are some of the procedures we employ to foster a mutual support system based on cooperativeness:

(1) Get acquainted activities. We use direct questions such as “Where have you worked?” as well as creative questions such as “Thinking of yourself as a machine, what comes to mind?” We also have the trainees work on tasks in pairs, e.g., identify five counselor responses to a client who makes excuses for failing to carry out homework.

(2) Highlight similarities among the supervisees. Cohesiveness builds when the similarities among the supervisees are made salient. The supervisor might promote a common bond by pairing on similarities of concern, experience (or inexperience), conceptualization, or counseling technique. For example, a supervisor might say, “Bill, I suspect many of us feel a bit apprehensive when a client is silent in the first interview. As a matter of fact, Mary Jane expressed a similar concern earlier today.”

(3) Place trainees in a helping role with each other. Just as altruism is a curative factor in group counseling, a tone of cooperativeness in group supervision is facilitated when students look to each other rather than only the supervisor for advice, feedback, and confirmation. We often find ourselves, for example, saying, “That’s a good question, Michael, and I’m remembering that Bill wrestled with that same issue. Bill, what do you recommend to Michael regarding this?”

With rapport and trust established, the supervisor structures the practicum experience around reading, case presentations, modeling, rehearsal, live demonstration, and skill assessment.

A THEORETICAL MODEL

The Worthington and Roehlke study (1979) also revealed that trainees value structure and want to be provided with literature on counseling. For us, the Reality Therapy model of counseling is readily understood and provides a reliable framework by which trainees can organize their interventions. Within each stage of the counseling process, we encourage the eclectic use of counseling techniques. Some of the techniques we encourage at each step of the counseling process appear in Table 1.

<table>
<thead>
<tr>
<th>Steps</th>
<th>Possible Techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Involvement</td>
<td>1. Relationship skills such as following and focusing, active listening, paraphrasing, pacing, and self-disclosure.</td>
</tr>
<tr>
<td>2. Focus on the present situation</td>
<td>2. Open-ended questions, guided imagery, role playing and role reversal, confrontations, audio or video-taped feedback, immediacy, and possible use of creative media such as puppets and art work.</td>
</tr>
<tr>
<td>6. Accept no excuses</td>
<td>6. Recycle to techniques used in Steps 1-3.</td>
</tr>
<tr>
<td>7. Formulate consequences</td>
<td>7. Amend contract and use rehearsal and guided imagery to address covert verbalization of natural consequences.</td>
</tr>
</tbody>
</table>

We allow and encourage supervisees to be creatively eclectic in the use of counseling techniques while also stressing the importance of relating how techniques contribute to the counseling process.

CASE PRESENTATIONS

Supervisees are asked to provide case material about their clients. The elements of a typical case history includes: demographic data (age, marital status, occupation, and residence), description of the current situation and the presenting problem, intrapersonal features, interpersonal style, relevant environmental factors, and the counselor’s conceptualization of the problem and the goals of counseling. After the supervisee presents this material, we ask: “What behavior change needs to occur for your client to move from a failure identity to a success identity?” and “What do you know about your client and his situation that you can utilize to promote that change?” If the supervisee seems engulfed with information, we stress the first question. Conversely, if the supervisee seems stuck about where to go with the client, we emphasize the second question.

MODELING

There is a substantial body of literature to support that modeling or vicarious learning is an effective ingredient in the learning of complex skills. Studies by Robinson, Froehle, and Kurpius (1979) and Hector, Davis,
Denton, Hays, and Hector (1979) indicate that modeling is an effective technique in practicum supervision. The model can be the supervisor or a peer because the research supports the value of both mastery and coping models.

The procedure we use in modeling skills follows this sequence: (a) the trainee presents the case history of the client; (b) the trainee identifies the area where help is needed; (c) a peer volunteers to role play being the client based on the trainee’s descriptions; (d) the supervisor or a peer volunteers to act as counselor; (e) the volunteer counselor and client role play the situation so the target skills are viewed by the trainee; (f) the role played demonstration is discussed and processed; and (g) the trainee is asked to discuss how these skills might be received by the real client. With the modeling completed, supervision naturally leads to rehearsal of the new skills.

REHEARSAL

Again, having a peer serve as the client, the trainee role plays the skill which was demonstrated and discussed earlier. If the trainee becomes stuck at any point in the role play, the supervisor offers prompts and coaching. Once the role played vignette is completed, the supervisor and peers give the trainee feedback. We have found the most productive feedback is specific and descriptive rather than general and evaluative. When necessary, the trainee will rehearse the skill again, incorporating the ideas developed during this debriefing session. Finally, trainees verbally describe how they might apply the newly acquired skills during the next meeting with their clients.

LIVE DEMONSTRATIONS

We use the same paradigm when trainees demonstrate their work with their actual clients: preview the client’s case history and current situation, live demonstration, process commentary (feedback and discussion), and plan what interventions will be used next. There are also ethical considerations pertinent to live demonstrations. First, the client is asked if the session could be observed, by whom, and for what purpose. Second, informed consent in writing is acquired from the client. Last, the confidentiality of the client’s communication is protected by informing all the trainees about the ethics of privileged communication.

SKILL ASSESSMENT

Throughout the practicum experience supervisees are asked to conduct an ongoing assessment of their skills. Input about these skills are provided by the supervisor and peers, and, at times, by actual clients. Toward the end of the practicum, the supervisor and supervisee compare their ratings on these skills. Table 2 presents a counseling skills checklist we use in our training that can also be used with other counseling supervision models.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Counseling Skills Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratings</td>
<td>Very Effective</td>
</tr>
<tr>
<td>1. Nonverbal Focusing and Following (eye contact, animation, leaning forward).</td>
<td>5</td>
</tr>
<tr>
<td>2. Encouragement (head nods, minimal encouragements such as “mm-mm”, warmth, positive regard).</td>
<td>5</td>
</tr>
<tr>
<td>3. Genuineness (congruent, friendly, personal, self-disclosing and humor as appropriate).</td>
<td>5</td>
</tr>
<tr>
<td>4. Accurate Understanding (paraphrases, clarification, summarization).</td>
<td>5</td>
</tr>
<tr>
<td>5. Concreteness (behavioral focus in the present).</td>
<td>5</td>
</tr>
<tr>
<td>6. Potency (use of confrontation immediacy, and a variety of techniques).</td>
<td>5</td>
</tr>
<tr>
<td>7. Goal Direction and Purpose (staying on topic, giving homework, having clients evaluate their behavior accepting no excuses, providing adequate structure).</td>
<td>5</td>
</tr>
<tr>
<td>8. Pacing and Timing (Interventions match client readiness).</td>
<td>5</td>
</tr>
<tr>
<td>9. Locus of Responsibility (Client is increasingly proactive; counselor avoids rescuer role).</td>
<td>5</td>
</tr>
<tr>
<td>10. Professional Poise (counselor conveys confidence, appropriate assertiveness).</td>
<td>5</td>
</tr>
</tbody>
</table>
To conclude, we recommend a model of supervision that is based on establishing trust and rapport, providing a theoretical framework of Reality Therapy, and encouraging a variety of counseling techniques. Case presentations often lead to the modeling and rehearsal of specific skills during small group supervision. Live demonstrations and actual contact with clients allow supervisees to conduct an on-going assessment of their skills.

REFERENCES


THE PRACTICUM EXPERIENCE: GOALS AND REQUIREMENTS

Michael Pieracci & Carol Ellis

Both authors are certified reality therapists. Pieracci is employed at Catholic Family & Child Services in Richland, WA. Ellis is employed by the Benton-Franklin Juvenile Detention Center in Kennewick, WA.

Preface:

This document has been adopted by the Northwest Region in an attempt to assure a high level of competence in those professionals that the Region recommends for Certification Week.

I. Role Plays:

Four role plays for each practicum are required. There should be a role play for both an aggressive and an unmotivated client in both the student’s work situation and a private practice setting.

II. Blue Chart Presentation:

Practicum I students should be able to discuss the upper Blue Chart in detail. Practicum II students should be able to present Control Theory as depicted in the lower Blue Chart. Presentations should be detailed and approximately 45-60 minutes in length.

III. Certification Week Presentation:

Nothing is required of Practicum I students in the area of certification week presentation.

IV. Case Studies:

Four written case studies are required of both Practicum I & II students.

V. Book Reports:

Three assigned book reports are required of both Practicum I & II students. They should be written, but may be verbally presented if the practicum supervisor approves.

VI. Essay on Philosophy of Therapy:

Practicum I students will be required to write an extensive essay on their personal philosophy of therapy. This essay will be an essential component of the entire Practicum experience. Students should anticipate revisions and additions at various times in their practicum experience. At the completion of Practicum I, it will be given to the Practicum II supervisor for continued development.

It is proposed that two major shifts occur in the structuring of Practicum experiences:

1. Practicum I should be focused on the “Basic Concepts of Reality Therapy” as depicted in the Blue Chart. Practicum II should focus on Control Theory. To extend Glasser’s optical metaphor of “pictures” in one’s mind, the “lens” that the supervisor uses to view the student’s performance in Practicum I should be the Basic Concepts, while in Practicum II, the “lens” should be Control Theory.

2. Practicum I and Practicum II supervisors (since it is now the Regional policy that they be different people whenever possible) should work in conjunction with each other. The structure of Practicums should encourage collaboration, cooperation, and mutual appraisals of students’ abilities. For this reason all materials and evaluations that a Practicum I supervisor has on file for a given student should be passed along to the Practicum II supervisor.

CRITERIA FOR SUCCESSFUL ROLE PLAYS

Practicum I Students:

Practicum I students are expected to perform a minimum of four role plays. The student should do a successful role play with both an aggressive client and an unmotivated client in both the student’s work situation and a private practice setting. This will allow students to demonstrate how the steps of RT will operate within the limitation of their individual work setting and within the freedom from limits that is accorded the private setting. Thus students will be enabled to apply their skills in both a truly creative way and also in a situation-specific arena.
A successful role play will be one in which the student shows skill in developing rapport, a plan, and commitment to the plan (Steps 1,2,3,4,5) within an atmosphere of committed, non-judgmental, non-critical, development of self-responsibility (Steps 6,7,8). Each role play should contain several therapy interventions aimed at each of the first 5 steps. A single response, for example, aimed at forcing the client to make an evaluation of behavior may be sufficient with a real client, but for the purpose of educating and training the student to attack the problem of the client's lack of self-evaluation, several different intervention options should be developed. This may mean that the student will interrupt the role-play and attempt another approach to the client's self-evaluation. For Practicum I students, this should be encouraged. The purpose in these role-plays is the development of options in dealing with a client. As such, Practicum I role-plays are to be pictured as work-sessions!

Practicum II:

Practicum II students should be able to envision themselves as possessing an ever-growing array of responses and options. Flexibility will also permeate their work and, of course, their own personality needs to be present for the client. The goal of role-plays in Practicum II is the attainment of cohesive wholes: i.e., given a situation, can the student bring the client through each of the first five steps of RT in such a way that there is a flow in the process.

As in Practicum I, there should be a minimum of four role plays distributed in the same manner as in Practicum I. However, since there is a time-limit restriction during Certification Week, during Practicum II, students should be expected to take the client through the first five RT steps in a 10 minute period.

CRITERIA FOR SUCCESSFUL BOOK REPORTS

All students are expected to read and report on three books for each Practicum. For Practicum I students, the required readings are Reality Therapy, The Identity Society, and Schools Without Failure. Practicum II students are expected to read and report on What Are You Doing and Take Effective Control of Your Life. The reports may be in written or via verbal presentation.

Since each of Glasser's books deal with a distinct subject matter, the Supervisor should be careful to ensure that the student fully understands the important points in each of these books as they relate to the student's career interest or expertise. Therefore, it will call upon the supervisor's repertoire of RT knowledge, as described by the content in each of Glasser's books, to determine the specific requirements of a given student's report. Reports may be an overview approach to the material in the books, a synthesis of Glasser's material with another theorist, or an in depth discussion of one or two major elements of the book. Beginning students might be encouraged to take the overview approach. Advanced career individuals might be encouraged to perform an in depth analysis. Flexibility and relevance should be the guidelines for the Supervisor's determination of what constitutes a student's successful completion of a book report. The supervisor needs to feel assured that the student has a grasp of the material in such a way that students have been enabled, or empowered, by the knowledge to make themselves a better person and better therapist.

CRITERIA FOR SUCCESSFUL CASE STUDY

Practicum I Students:

Practicum I students will be required to complete four case studies. These cases should be previous or current clients. A "session" may not necessarily be a sit-down, face-to-face, in an office type of session. One of RT's strengths is its applicability to informal or non-traditional situations for therapy. RT can truly be viewed as a form of "street therapy" as well as an effective "office therapy." A case study involving such situations should be anticipated by the supervisor and encouraged from students who work in situations that call for such "street" sessions.

The goal of Case Studies in Practicum I is the attainment of skill in applying the Basic Concepts of RT, as depicted in the Blue Chart, to specific clients. Case studies should include the following elements:

1. A short description of the client's background.
2. The client's presenting problem.
3. What the student did with the client that was RT.
4. A description of how the therapy and client developed over a period of time.
   a. how using particular RT principles led to either a specific behavioral change or an attitudinal change characterized by growth in self-responsibility or the success identity.
   b. how the client's needs were not being met.
   c. how RT effected more satisfactory need fulfillment.

All the case studies will be given to the Practicum II supervisor for follow up in Control Theory application.

Practicum II Students:

Four case studies will also be required for Practicum II. With supervisor's permission, the same four clients discussed in the Practicum I case studies may be used.

The goal of case studies in Practicum II is to assure the student's ability to recognize Control Theory principles in the work with clients. Therefore, the focus and style of the case study will be different than what the student experienced in Practicum I.

CRITERIA FOR SUCCESSFUL COMPLETION OF ESSAY ON PHILOSOPHY OF THERAPY

Practicum I Students:

The purpose of this requirement is to clarify what it is that the student does when engaged in therapeutic activity. The goal of the Certification progress is to assure the public that the CRT is knowledgeable in the basic concept of RT. For this reason it is important that students realize what it is that they "know" about RT. It is not enough to say, "I like RT and do RT