The Journal of Reality Therapy is directed to publication of manuscripts concerning research, theory development, or specific descriptions of the successful application of Reality Therapy principles in field settings. This journal is the official publication of the Institute for Reality Therapy.

Subscriptions: $6.00 for one year or $12.00 for two years. Foreign $7.00/ $14.00 (U.S. currency) Single copies, $3.00 per issue. Send payment order to the editor.

Advertising: Advertising rates and information available from the editor. Copy must be submitted at least two months in advance of desired publication date.

Permissions: Copyright held by the Journal of Reality Therapy. No part of any article appearing in this issue may be used or reproduced in any manner whatsoever without written permission of the editor - except in the case of brief quotations embodied in the article or review.

The Journal of Reality Therapy is published semi-annually in Fall and Spring. ISSN: 0743-0493.

Editorial Office:
Journal of Reality Therapy
203 Lake Hall
Boston-Bouve College
Northeastern University
360 Huntington Ave.
Boston, Mass. 02115
Telephone: 617-437-2485 or 3276

Cover: The cover was designed and produced by Sheri Jarosz of Brimfield, Ohio based on the design developed at the Institute for Reality Therapy in Los Angeles.

William Glasser, M.D.
President and Founder
Institute for Reality Therapy
Suite 202, 7301 Medical Center Drive
Canoga Park, California 91307
818-888-0688

Board of Directors
Institute for Reality Therapy
Canada: James Montagnes,
280 Carlton St.,
Toronto, ON M5A 2L5
Northeast: Nancy Buck,
66 Power St.,
Portsmouth R.I. 02871
Southeast: Perry Good,
510 Yorktown Dr.,
Chapel Hill, NC 27514
Midwest: Gary Leofanti, Aunt Martha's
221 Plaza, Park Forest, IL 60466
Mid-America Region: J. Robert Cockrum
2229 N. Stratford,
Owensboro, KY 42301
Sunbelt: Jeffrey Mintz,
Institute for Mental Devel.,
3400 Montrose, Suite 503,
Houston, Texas 77006
Southwest: Marcie Mann
19445 Broken Fence
Monument, CO 80132
Northwest: Martin Price
Martin DePorres Cnslg Ins.
444 Ravenna Bl. NE
Suite 403, Seattle, WA 98115
West: Richard Hawes
11633 San Vicente Blvd.
Los Angeles, CA 90049
Others: Elizabeth Mahoney, ETC.
100 E. Ocean Blvd., Suite 906,
Long Beach, Calif, 90802

Executive Director:
Ronald C. Harsham
Inst. for Reality Therapy
Suite 202, 7301 Medical Center Drive
Canoga Park, California 91307
818-888-0688

1985 International Convention
Quebec City, Quebec, Canada
June 27-30, 1985

Table of Contents
Lawrence Litwack ......................... Editor’s Comment 2
Robert E. Wubbolding .................... Using Paradox in Reality Therapy - Pt. I
Mary N. Hanna ............................ Reality Therapy: An Approach To Comprehensive Career Counseling
Willa Bruce .............................. Reality Therapy as a Management Strategy: An Idea Whose Time Has Come
Robert A. Silverberg ..................... Enhancing Life: Reality Therapy and Terminal Care
Mary B. Ballou ............................ Thoughts on Reality Therapy From A Feminist
EDITOR’S COMMENT

This fall marks the beginning of the fourth year of the Journal of Reality Therapy. It also marks several changes in the publication of the Journal. First, readers will note that there are several changes on the editorial board of the Journal based on the creation of three year terms for board members. This marks the final issue for Alex Bassin, Thomas Bratter and Perry Good whose terms expire at the end of this year. All three have been with the Journal since its inception, and have provided stellar service as reviewers.

There are three additions to the editorial board with terms that expire at the end of 1986. Peter Appel is a certified reality therapist from Charlottesville, Va. who is approved for both practicum supervision and Instructor I status. President of the Reality Association of Virginia, he is a licensed professional counselor in Virginia and National Certified Counselor. He is completing a Ph.D. in Counselor Education at the University of Virginia.

D. Suzanne Chapman is a certified reality therapist from La Crosse, Wisconsin who is an approved practicum supervisor. She has written and presented extensively on Reality Therapy. She is currently a doctoral candidate in special education at the University of South Florida. Donna Evans is Professor and Chair of the Department of Education at Skidmore College. She previously taught at the University of Maine, University of Cincinnati and Xavier University. Dr. Evans has her Ph.D. from Ohio State University. The move should prove to be particularly advantageous for the future of the Journal. All inquiries about articles, subscriptions, etc. should be sent to the editorial office of the Journal. I have moved to Boston, and have assumed the position of Professor and Chairperson of the Department of Counseling Psychology, Rehabilitation and Special Education at Northeastern University. The move should prove to be particularly advantageous for the future of the Journal. All inquiries about articles, subscriptions, etc. should be sent to the editorial address.

I am also working with Northeastern University towards the possibility of the University officially supporting the Journal by means of publication, mailing, and financial backing as a Journal published by the Department and College. I hope to be able to report the final agreement in the next issue.

Meanwhile, I would encourage readers to consider writing for the Journal. Guidelines for contributors are contained at the end of this issue. If we can sharply increase the flow of articles, we can consider expanding the size and/or frequency of publication. In addition, back copies of the Journal are available in single or bulk copies.

USING PARADOX IN REALITY THERAPY

Part I

Robert E. Wubbolding

Dr. Wubbolding is Director of the Center for Reality Therapy/Midwest and is Asst. Director of the Graduate Guidance Program at Xavier University in Cincinnati, Ohio.

Paradox: “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.” Webster

Before reading this article, there is an exercise that the reader should perform. Close your eyes and try to force them open. It is difficult if not impossible to force your eyes open. Now close them again and simply allow them to open. How easy it is!! You have just experienced a paradox. Sometimes it is easier to accomplish a task or achieve a goal in a paradoxical way than to complete it in a direct way.

Many Reality Therapists have often helped clients make plans only to have them report that “I didn’t do it” or “It didn’t help me”, etc. The conventional method of practicing Reality Therapy is to repeatedly help them make plans. Yet, a closer look at the theory and practice of the method indicates that there are many more subtle ways to accomplish behavioral change.

Based on years of observing William Glasser in role plays, as well as practicing Reality Therapy, I have found it useful to include in Step I the admonition “do the unexpected”. When the client expects an argument, don’t argue. If the client expects a discussion of inflexible behavior, stress strength-inducing behavior.

Examples of Paradox

I. Training Tapes of William Glasser

In the training tape where Glasser (1976a) and Fitz-George Peters role play, Glasser seeks to put as much distance between himself and Fitz-George. Instead of saying that he understands the problems of the ex-offender, he states the opposite. He doesn’t even drink coffee, much less take drugs. To which Fitz-George replies: “How can you help me if you don’t even drink coffee?” The ingenious reply is that Glasser’s job is not to help him take drugs (later he states that his job is to help him find a job, etc.). The apparent effort to put distance between himself and the client has a reverse effect. It increases the involvement or friendship. This use of paradox is a theme in many of the training tapes. Glasser (1976b) unexpectedly states to “Edna” that “My God, you’re sick. There’s not a part of you that’s well.” She is caught off guard and later states that she finally experiences some hope of recovery. Whereas, the physicians, to whom she had previously described her many aches and pains, had told her...
that there is nothing wrong with her, she now feels a surge of hope that someone finally admits there is something wrong with her.

In a role play in Columbus, Ohio before 500 people, Glasser (Wubbolding, ed., 1982) helped a "client" deal with his obsessing thoughts about religion. Instead of doing the expected, i.e., helping him make a plan to do something to overcome them, to keep busy, etc., Glasser suggested that he simply accept the obsessing thoughts and say to himself, "Okay, I'm going to have these thoughts for a few minutes." In other words, he is to choose the symptom rather than fight it.

II. Supervision and Training of Workshop Participants

In my own supervision of a Reality Therapy trainee who was unsuccessfully trying to overcome "nervous- ing" feelings about certification week, I prescribed that she spend 5 minutes per day imagining herself at the site where the training weeks are held. She is in a group of trainees and she makes a complete fool of herself. She was instructed to see the other trainees ridiculing her!! I added that she should try to feel as nervous as she can!! One week later, she stated, "The more I did this, the less I was able to feel upset."

Roleplaying seems to lend itself to the effective teaching of paradox. In a consultation session with a counselor at a drug program, I illustrated the use of paradox with a "client" who had run away several times. Upon returning after these journeys, she felt that she wanted to put the past behind her and go forward. She stated that this time she felt confidence. She had hit bottom and learned her lesson. I asked her if she had previously tried this approach of putting the past "behind" her. She hesitantly answered "Yes". I asked, "Has putting it behind you worked?" She answered, "No .... and because of that I'm a little shaky." I told her that I'd like to see her adopt the nickname "Shaky" and tell everybody in the program that she is "Shaky"; she should act shaky; exaggerate it; pretend to be even shakier than she really is. In other words, should choose "shakiness" instead of pretending it doesn't exist. After all, her choice of "self-confidence- ing" behaviors was not only shallow, it simply had not worked.

In teaching a management workshop, I congratulated a supervisee (role-play) for being on time for work two times, even though she had been late three times. This seemed rather simple and basic to me, the leader. But for at least one of the participants this was amazingly unexpected. He stated, "You blew me away when you congratulated her."

These examples illustrate that doing the unexpected or using paradox can be subtle or simple, or stated paradoxically, "subtly simple." Only a few of the many types of paradox are cited above. For the theory and practice of this method lend themselves for the extensive use of paradox. This article describes below some of the paradoxes contained in Control Theory and the steps of Reality Therapy. A later article will describe paradoxical techniques, e.g., reframing, prescriptions, paradoxical intention, uses of paradox by other authors, guidelines, and contraindications for their use.

PARADOXES OF CONTROL THEORY AND REALITY THERAPY

To perceive paradox in this method or in life in general, it is necessary to think paradoxically. In viewing Reality paradoxically it is helpful to look at it under a different light. Therefore, the ideas are not necessarily new. The perception of these ideas as paradoxical is new — a perception controlled by our behavior or thinking component. And so, there is no new addition to Reality Therapy contained below. The goal is to look at the concepts of Reality Therapy in a different, not a new light.

1. Learning Control Theory and Reality Therapy

When people learn Reality Therapy, especially the steps, for the first time, they often comment that the ideas are easy to understand. Upon putting them into practice, the discovery is quickly made that it is a difficult method to practice. The jargon-free ideas are "deceptively simple." They are easy to understand and hard to do. For though the ideas might seem easy to first glance, nevertheless, as Glasser has frequently stated, it takes approximately two years to see the world through the window of Control Theory (Glasser, 1981).

2. Fulfillment of Needs

A basic human drive is to fulfill needs. Yet these needs cannot be fulfilled directly. They can be fulfilled only through another mechanism: the "picture album" of specific wants. A further paradox is that the wants can usually be achieved only in the external world. Yet the external world is the most difficult of all the components to change. Even though human behavior is purposeful — designed to mold the external world to match inner pictures, yet, the external world is very "unmoldable" (uncontrollable).

3. Conflict in Need Fulfillment

The fulfillment of one need is both liberating and confining. Even though the needs overlap, at times they are in conflict. For instance, fulfilling the need for power or for achievement, in some instances, is tantamount to not fulfilling the need for fun. Even Reality Therapists take work home with them and thus occasionally miss an opportunity to have fun.

Similarly, selecting one picture to fulfill human need(s) implies not selecting another one. This is similar to Pascal's circle of knowledge: "The greater the circle of knowledge, the larger the perimeter of ignorance." Also, Straus (1982) states, "Every choice you make, everything you do is a kind of cage. It is a cage because by being this or choosing that you can't be doing something else. Every action you take excludes a range of alternative possibilities."

4. Picture Album and Behavioral System

The above paradox overlaps the picture album and the behavioral system. But in the behavioral system alone there are several paradoxes.

a. The element in the behavioral system which receives most
attention in the practice of Reality Therapy is the “doing” element. Yet, as we live our daily lives, we are more aware of the other two elements: feeling and thinking. An experience common to many people is that of driving a car after receiving some error-producing news, such as loss of a job, death of a relative, or a “Dear John” letter. On one hand, awareness of incidents, such as depressing, angering or rejected-ing, are very prominent. On the other hand, the actual awareness of driving the car can be very low. Sometimes the awareness is so low that accidents occur because “my mind was a million miles away” or “I wasn’t watching what I was doing.”

b. A further paradox is that in Reality Therapy we do deal with feelings . . . but not by talking about them, “getting in touch with them,” “locating them,” “ventilating them” etc., etc., etc. For “talking about . . .” and “dealing with . . .” are not identical. To talk about feelings of hunger is to deal with them very ineffectively. To talk endlessly about depressing, angering, resenting, self-pitying etc. is a failure to get to the root of the problem in the behavioral system — the “doing” component. Thus, the admonition for the Reality Therapist is “change the ‘doing’ component and you change (and deal with) the feeling component.” And so in counseling a person who is depress ii ng, the Reality Therapist does the unexpected; instead of talking about the depression, the focus is on the behavioral component receiving the least attention in the life of the depresser — the “doing” component. The depresser is asked to describe a specific day in detail, in order to focus the person’s perception on the “doing” component.

c. In some cases the paradox of stressing the “doing” component is very ineffective. Many therapists have experienced the individual, couple or family who repeatedly makes plans and fails to execute them. The process of planning to do . . . is not working. The therapist can often help the client(s) achieve the same goal by stressing the thinking component and the picture album. In other words, “If planning isn’t working, stop planning.” The goal can often be achieved paradoxically by utilizing the thinking component combined with the picture album. First, the desired event is implanted in the picture album as a want, and then the client is instructed to visualize it as present in his/her life. Maltz (1960) cites a research study that showed only a tiny difference in accuracy between those basketball players who practiced shooting free throws for twenty minutes a day and those who visualized themselves as successful free throw shooters for twenty minutes a day. Thus utilizing the “imagination” of Maltz (the picture album and the thinking component), the subjects were able to achieve their goals and attain their wants in the external world.

In my own life I utilized this method in establishing a counseling and training center. I announced to some friends that two years from a given date I would open a counseling and training center. I followed the advice of Maltz and did not concern myself with how to achieve it. To stress the “doing” component would have resulted in “discourage ing behaviors.” I posted the date on the mirror and looked at it at least in the morning and in the evening. Ten months later the building which I own opened for business. Needless to say, I utilized this form of paradox in my own counseling. In the words of Emerson, “Beware of what you want. In all likelihood you will get it.”

d. In Control Theory the purpose of all behavior is to mold the external world to match the inner pictures or wants. When clients seek counseling they do so because their behavior is ineffective in molding what would and thus they are in pain. They sometimes want the therapist to help them find a new way to control or mold the world. Ironically, it is this precise goal that is most difficult to achieve directly. Applegate summarizes this difficulty in the title of his chapter in Glasser (1965) What Are You Doing?: “If Only My Spouse Would Change.” The paradox occurs when the clients change their wants or their own behavioral systems. Paradoxically their external world often changes subsequently. When parents of an incorrigible teenager learn to stop criticizing the child, they are often pleasantly surprised to find that paradoxically the child’s behavior will often change subsequent to their own behavioral change. On the other hand, the more the parent pushes, the greater is the resistance. The analogy of forcing your eyes open illustrates the point of either trying to force a change, or allowing a change to occur. In trying to change only those elements over which the client has control, a paradox often occurs; there is change in the environment.

5. The Process of Reality Therapy

There are several paradoxes in the use of Reality Therapy that relate to the overall process rather than to the theory.

a. The most obvious one is that progress in strength-building is made easier and quicker if several fronts are attacked simultaneously in an unexpected way. Thus, an overweight person consumed with dieting, food, losing weight, can effectively work on several fronts simultaneously. It is important to emphasize that these several fronts are not the surface or presenting problems. For example, to develop a self-improvement reading program, keep a log, practice being assertive, approach other people, and take brisk walks is to build strength and replace negative symptoms with positive ones. Replacing weakness with strength and the solving of the all-consuming problem of weight occur simultaneously.
sessions, a client of mine, who was depress-ing and doing only the minimal amount of work on his job, decided that his depress-ing was the result of not working at his job rather than the cause of poor performance, as he originally suspected. He was also worried about his time and, in fact, was troubled by a philosophical question as to how to control TIME itself. The result was that he made very little effective use of time, felt it was slipping away from him, loafed on the job, guilt-ing and depress-ing himself with a great deal of pain.

Again, the effect was the cause not vice versa. A Reality Therapist using paradoxes looks at the client's behavior in an unconventional, inverse way, seeing the cause as the effect and vice versa.

Fundamental to Control Theory is that we want controlled perceptions: the perception of being adequate, popular, success-ful, rich, tolerant, etc. But simply wanting such a perception is not sufficient to attain it. Attaining perceptions is possible only through the behavioral system, and it is very difficult to change the perception directly. Change in the perception usually occurs through change in the behavioral system. Thus lowering one's perception from a high to a low level, e.g., changing one's perception of a salary from that of “an unacceptably low salary” to simply “a salary” without making judgments, is difficult to accomplish by a simple decision. If it is to be accomplished at all, it will probably be through change in behaviors geared to a lower level parallel to a low level of perception. Similarly, if a person treats a disliked associate in a friendly way it is often possible to perceive that person more favorably.

d. In teaching of Reality Therapy, one trainer is fond of saying, “Don’t take the problem too seriously.” To have fun with a person who has a “heavy” problem is often very helpful. Ridiculing is not appropriate, but to help the client realize that the serious problem is treatable and that there is hope, can be accomplished with some lightheartedness.

e. A less obvious example of paradox in the process of Reality Therapy is contained in the use of questions. One of the functions of the Reality Therapist is to teach the clients a better way to live. This is rarely done by lectures, but more effectively accomplished by skillful questioning. In using appropriate questions there is an implicit message: “You have power over your life. You can change. A better life is possible.” In asking someone, “Is what you’re doing helping?” there is an implicit message that a better course of action is possible. In asking, “What do you plan to do tonight to change your life?” there is an implicit message that a course of action performed immediately will help in taking charge of one’s life. In asking

In summary, both Control Theory and the practice of Reality Therapy contain many paradoxes. I have attempted, not to add dramatically to the theory or method, but to present a new way of viewing both theory and method. Part II will contain specific techniques that can be used in the practice of the 8 steps, as well as guidelines, contraindications, and ethics.

References


Glasser, W. (1976b). Reality Therapy Tapes: Role Plays, Series 3, Tape 7, California, IRT.


Editor
Lawrence Litwack
Boston, Mass.

Business Manager
Shirley Mains
Kent, Ohio
REALITY THERAPY: AN APPROACH TO COMPREHENSIVE CAREER COUNSELING

Mary N. Hanna

Ms. Hanna is a Ph.D. Candidate in Counseling Psychology at Kent State University, Kent, Ohio.

"Lieben" un "arbeiten" (love and work) was Freud's brief reply when asked what was the key to maturity (Shoben, 1956). Psychologists, sociologists, counselors, and others in related fields have investigated and worked in the area of these relationships ever since. There has been general agreement that there is a definite relationship between one's vocational and general adjustment; the degree and kind of relationship has been the subject of continued research and debate. J.O. Crites (1969, ch. 8) has detailed forty years of these investigations.

As a large amount of each person's life is spent at work, a person's choice and adjustment to work is paramount to his or her satisfaction with life. When our needs of love, worth, fun, and freedom are met in the eight plus hours spent at work each day, our life satisfaction increases greatly, and our abilities to meet these needs in the rest of life are therefore increased.

Fitzgerald and Crites (1980), Hershenson (1974), Osipow (1975), and Walsh and Osipow (1982) are among many who have pointed out that people other than young, able, white males experience detrimentally different treatment in the world of work. These experiences often negatively affect their perceptions and anticipations when interacting in the world of work. Therefore, additional time, understanding, and realistic interventions are needed with these clients in particular, if their negative perceptions of themselves and/or of their world are to be changed in order to more fully actualize their potential.

William Glasser has pointed out that we are moved to action by our perceptions of what we need and want in life (1981, p.2). Building on William Powers' (1973) use of control theory, Glasser (1981) sees all behavior as purposive, as attempts to cause the "real" world to match one's internal world of "reference perceptions." Crites (1981), in presenting Comprehensive Career Counseling, has pointed out that the "potency" of career counseling can be limited by client expectations. Both authors state that responsibility for resolving the problems is the clients', while the counselor's responsibility is to guide and support the clients and the process of the counseling intervention. Both Glasser (1975, 1981) and Crites have suggested that early involvement through interaction between the client and counselor is necessary, as is collaboration between them, in reaching the client's goals.

Glasser's Reality Therapy method of counseling and B.C.P. philosophy of psychology so closely fit Crites' previously well-researched works on career counseling, that a B.C.P.-based model for Comprehensive Career Counseling is proposed here.

IN INVOLVEMENT: STEP ONE - WHAT DO YOU WANT?

Crites' Stage 1 of gaining the clients' confidence and trust, identifying their problems, and initial information-gathering can be accomplished through the Involvement Stage discussion of "things in general" (talking about what one does is everyday American conversation). While individuals talk, the counselor can be making an assessment of their strengths, their perceptions of themselves and world, their values, and their usual and unusual ways of coping. Sometimes forming a contract to gather more information about abilities, interests, values and aptitudes is appropriate at this stage, determining both what the problem is (differential diagnosis), why the problem exists (dynamic diagnosis), and the clients' decisional style (Crites, 1981). Thus the focus of Steps 1 and 2 of career counseling with Reality Therapy would be to form a broader base for the clients' decision-making at Step 3.

Whether formal or informal, direct or indirect, appraisal is involved in understanding the needs and wants of people who come for counseling. The more reliable and valid the test, the more one can build "best guesses" about these clients, bearing in mind that in each instance one is comparing individual clients' scores to those given in test manual tables. The client is one person while the scores given are group averages only. The clients' needs and problems will dictate the testing to be done. Combining the results of well chosen tests with interview information and impressions will aid the clients in building stronger conclusions and in forming plans that will best fulfill their potential, satisfy their interests, and fit their values and personalities.

An initial consideration of any career counselor is to determine the extent to which anxiety is adversely influencing the client's ability to begin solving the current dilemma. Using a reliable measure of anxiety, such as Spielberger's The State-Trait Anxiety Inventory, and validating the results by interview findings, together help in determining quickly where the client stands. If pervasive anxiety is the problem, this condition must be cared for before the "simple" career choice process can be effectively addressed. The dynamics of the client's current problems necessarily determine the direction taken in intervention and in deciding whether the client will receive the most benefit from long-term versus short-term counseling (Crites, 1981).

Taking this much time in Reality Therapy's Step 1 for clients identifying what they do want in order to be more satisfied and satisfactory in their vocations will benefit in total time saved by avoiding trial-and-error learning in the later steps of Reality Therapy. Helping clients to gain in self-knowledge now, to better set their goals in later steps, may assure client satisfaction and success.

"Helping people to recognize what values they really believe in is part of the art of therapy . . . Once these values are clear, the task is to help
people to live by their standards’ (Glasser, 1975, p.72). Clients’ values affect their satisfaction in various occupational settings. Super’s Work Values Inventory for adults or Hall’s Occupational Outlook for teenagers can be used to gather this information quickly.

Gaining the clients’ confidence and trust, identifying their problems, and gathering the initial information are the substance of Crites’ Stage I of Comprehensive Career Counseling. The next piece of information to be gathered by this model is gained from an assessment of the clients’ intellectual abilities. To determine at the same time whether their visual-performance or their verbal IQ is higher, a test of choice would be the age-appropriate form of a Wechsler Intelligence Test. Whether the clients’ performance or their verbal IQ is higher, a test of choice would be the age-appropriate form of a Wechsler Intelligence Test. Whether the clients’ problems involve unrealism (when abilities are less than required for their work) or unfulfillment (when abilities are greater than required for their work) can be addressed at this time in Step/Stage 1.

Aptitudes can be assessed by some of the many available tests such as the GAT-B at any U.S. Employment Service office, or, for younger clients in the eighth through twelfth grades, the Differential Aptitude Test can be taken independently. Aptitude tests will further select the specific employment skills of the client. Others are available at local employment search and support governmental agencies.

An appropriate measure of interests can be chosen next based upon the mental status assessment results. One of the Strong-Campbell Interest Inventory tests is appropriate for those clients of average-or-higher ability, while the Career Assessment Inventory is appropriate for those with average-low-average ability. Then, results showing which occupations are enjoyed by “satisfied and successful” workers whose interest patterns are most like those of the client are fitted with the former data, to determine whether there is congruence between these abilities, attitudes, values, and interests.

One of the more valid personality inventories will ascertain whether there is congruence between personality and all of the above. With congruence, career goal setting and behavior analysis can go forward.

It is essential that validation of the tests and collaboration in the process occur between the clients and the counselor through discussions of these findings. This then may be related to present behaviors and anticipated outcomes of behavior changes.

AWARENESS: STEP 2 - WHAT ARE YOU DOING?

Strengthening clients’ recognition that their present behavior is not helping is a powerful motivation toward positive change (Glasser, 1975, p.71). In order to change behaviors, BCP points out that people need to recognize that what they are feeling about situations is not only a feeling; any ongoing feeling is also a choice of behaviors (Glasser, 1981, p.270). Often, in career counseling, the issues become more than a job change or present job dissatisfaction, because the person’s same perceptions and feeling habits operate in all areas of his life, causing conflicts (Shoben, 1957). In Step 2, open-ended, non-directive questions and feedback will give the therapist information with which to understand the client’s usual coping style (doing, feeling and thinking behaviors). Clients will come to see how their choices have been involved in the uncomfortable circumstances that have brought them to counseling (Glasser, 1981, p.272).

ANALYSIS: STEP 3 - IS IT WORKING?

At Stage 3 of Reality Therapy, and at this point (Stage II) in Crites’ model of Comprehensive Career Counseling, the counselor’s technique changes. Here clients must evaluate their behavior, which will increase their perception of a difference between what they want and need and what they currently have (Glasser, 1981, p.271). The counselor takes an active role in helping the client to see that alternative actions are possible, as the client becomes uncomfortable with the results of past choices. Alternatives are formed, and plans and contracts are made. At this stage, the counseling techniques of explicit questions and statements, interposition, juxtaposition, yoking and paradox are the techniques of choice.

MAKE A PLAN TO DO BETTER - STEP FOUR

“The job of the therapist is to . . . quickly work toward a better behavior” (Glasser, 1981, p.172). At this critical point in Reality Therapy, the clients commit to new perceptions of changes in their wants and needs and plan ways to behave to cause these to be realized in their “real” world.

The clients plan actions and commit to their being carried out. Thus, by attending to and intervening in the external behaviors of the client, the internal causes of the career and life maladjustments can be most efficiently and finally addressed (Glasser, 1981). “Our behavioral system is a learning system and therapy is a teaching situation . . . . Our new-information system exists to learn new behaviors and therapy should be a source of new information . . . . Is (the client) doomed to suffer a huge perceptual error for the rest of his life? The answer is it’s up to him” (Glasser, 1981, p.273).

Clients have been making decisions until the present based upon their past experiences and their learned decision-making style. If these clients use a fact-gathering, alternatives-forming, and planned-selection-of-action style of decision-making, intervention will not be needed. If not, clients will benefit in all areas of life if this part of their adjustment is stressed in “career counseling.” Information for diagnosis of their decisional style can be gathered informally through interview and formally through testing. Crites’ Career Maturity Inventory has five Attitude factors and five Competence factors; Super’s Career Development Inventory has two attitude factors and one competence factor. Comparing competence and attitude in career decision making ability factors may aid in determining the best direction for counseling (Crites, 1981).
Crites' Stage III of problem resolution and Glasser's Steps 6-8 of accepting no excuses, giving no punishment, and never giving up allow the clients to recycle through steps 3-8 again and again until the problems are resolved. This often is essential to the fulfilling of the initial contract.

Once self-assessment has been completed, discussed, and plans for new behaviors have been made and carried out, the clients will form new perceptions of their world and their interaction in their world. Part of the process will be for the clients to seek and present information about new occupations now of interest to them as part of the follow-through. In both counseling models, the counselor will be the listener in this stage of the counseling, as clients take more and more active responsibility for their own progress. The counselor can guide the clients to sources of information. In the cases of those clients who lack skills, more interventions may be given by the counselor as discussed and referred to above, or sources of guidance or training may be suggested by the counselor. The counseling does not end at this point, however. Follow-through and carrying out of the plans is vital to real behavior and attitude change, and to the client experiencing the value of the counseling that has been received up to this point. When clients have received this satisfaction, they will then be ready for the termination stage of counseling.

Although the client has initiated counseling with career problems, and although solution of these career problems has been the continuing focus of the counseling model outlined, the outcome of this model will be more far-reaching than the focus. From ascertaining and possibly initially addressing the anxiety traits of the client, major approaches to life may be altered. By centering the counseling at the present developmental level of the client, and attending the needs at that level, greater maturity in career developmental level, and, concomitantly, overall developmental level, may result. By adjusting the clients' occupation to one that is a “best fit” to the clients' interests, values, abilities, and aptitudes, the overall personality adjustment of the clients may be positively affected. By ascertaining the clients' decisional style and training the clients in good decision-making skills, the future decisions of the clients may be positively affected. By use of the Reality Therapy model, one which incorporates planfulness, commitment, and follow-through, clients can learn effective means of impacting their environment.

Thus “career counseling” is a vehicle for life-adjustment counseling for clients. It becomes a means for becoming aware of and satisfying much of the broader wants and needs. Learning a more effective means of coping with frustrations; becoming aware of skills, values, interests, and abilities; creating and choosing from among informed alternatives; setting, planning to meet, and carrying out these goals, and then evaluating outcomes in a job-related context can in itself become a learned and generalized process. When this process is learned, clients can fulfill the desired outcome from their having received “career” counseling - they will have learned how to live a more fulfilled total life.

**References**


REALITY THERAPY AS A MANAGEMENT STRATEGY: AN IDEA WHOSE TIME HAS COME

Willa Bruce

Ph.D. Candidate, Virginia Polytechnic Institute and State University

During the past decade there has been an increasing recognition in the fields of management and administration of the importance of providing help for employees whose behavior creates a problem in the work place. Many organizations consider the provision of help a part of their responsibility. Others do it because personal problems can adversely affect job performance, and, thereby overall organizational effectiveness (Cairo, 1983). It is currently estimated that, at any one time, from 10 to 20 per cent of the work force can be categorized as problem employees (Hall and Fletcher, 1984 and Schneider, 1979). The costs to employers in lost time, reduced productivity, and spill-over effects on other workers is now estimated to be about 195 billion dollars a year (EAP, 1983). Yet, despite the obvious need for a manager to be able to deal with a problem employee, there is little in the management literature on strategies or tactics that work. Rather, "most managers handle . . . (problem employees) in a way that guarantees that they will grow worse." (Karrass and Glasser, 1980)

Reality Therapy can provide the manager a means of dealing with a problem employee and a means by which problems can be prevented. With therapy defined as a "specific treatment," Reality Therapy can be conceived of as a specific treatment which enables a person to deal with reality, i.e., with that "quality appertaining to phenomena that we recognize as having a being independent of our own volition (we cannot 'wish them away')" (Berger and Luckman, 1966).

Now, it is true that, phenomenologically, everything that happens is a reality. However, from the perspective of Reality Therapy, action can be called realistic, or unrealistic, only when its remote (sic) as well as immediate consequences are taken into consideration, compared, and weighed. If the . . . pain, suffering which ultimately occur as a result of a given action exceed the immediate satisfaction produced, that action may be termed unrealistic; whereas, if the satisfaction which ultimately occurs as a result of an action is greater than the immediate effort or sacrifice associated with it, such an action can be called realistic. (Mowrer, 1975)

Thus, the Reality Therapist encourages examination of actions in light of that reality which cannot be "wished away," and facilitates realistic choices which can lead to greater self actualization, and, thus, to motivation and job satisfaction.

While it may take a creative leap for some to envision the manager as a Reality Therapist, Glasser insists that anyone who works with people can be trained to use Reality Therapy in their work (Evans, 1976). He points out that Reality Therapy provides a positive approach to dealing with under-motivated, problem employees.

Reality Therapy is also a problem preventive. Glasser observes that most administrators make the assumption that an employee knows what to do, whether on the job, or in dealing with his personal problems. However, he cautions, "the employee often doesn't have any idea of what to do, at all." The manager, as Reality Therapist, is in a position to teach the employee what to do. Thus, Reality Therapy appears to be a badly needed management intervention which can lead us out of the current "crisis of usefulness" in the organization sciences, a crisis engendered because "academicians do not address the practical needs of managers" (Strasser and Bateman, 1984).

The steps of Reality Therapy, as they are used in management, have been articulated by Karrass and Glasser (1980) in their book, Both Win Management, in which they coin the term "Reality Performance Management," (RPM), as the use of Reality Therapy in management. The steps of RPM are listed below:

1. Establish a good working relationship with employees, especially the ones who are doing poorly. This step will be difficult because the manager's natural tendency is to reject problem employees. But the manager's acceptance will help the employee feel a sense of belonging, and, with that, gain the strength to focus on the problem and what can be done about it.
2. Get the facts on the table. Avoid talking about past mistakes and do not accept excuses. Rather, look at the specific performance problem. Emphasize the facts of the employee's behavior which indicate there is a problem.
3. Have the employees evaluate their performance, and suggest ways performance can improve. Get agreement that something must be done.
4. Negotiate a "Get Well" action plan. Make certain the plan is specific as to what is to be done, when, how, and how much. Set up review points to check progress.
5. Get a responsible commitment to the plan from the employee. Use a handshake to confirm the commitment. If the plan doesn't work, re-negotiate. Don't ask why it didn't work, just focus on what didn't work, and change that.
6. Don't accept excuses. Focus on performance. Emphasize getting performance accomplished. Respond to excuses by saying, "Don't tell me why it didn't happen. Tell me when it is going to happen."
7. Let natural consequences take over. Don't punish and don't put down. Within an organization, the natural consequences of poor performance include: no raise, no promotion, reduction in responsibility, no bonus, temporary loss of fringe benefits (such
6. Never criticize or berate.

5. Convey your respect by keeping appointments and being on time.

4. Never ask a question if you are not prepared to listen to the

2. Take your time when talking with an employee. Learn to say,

1. Give recognition and praise when things are done correctly.

7. Give the employee your undivided, uninterrupted attention.

8. Make work fun whenever possible by easy banter and pleasant


Again, Reality Therapy provides a means by which Barnard’s theory can be implemented in daily management activities.

Reality Therapy is particularly amenable to use by managers because it is relatively quick and easy to learn and is action oriented. Managers have neither the time, nor inclination, to analyze or diagnose; yet, they daily must deal with persons who may have some personal problem which can impede organizational effectiveness. As Reality Therapy rejects the notion of conventional psychotherapy, it offers today’s manager a means of more effectively carrying out the “functions of the executive.”

In the book, Both-Win Management, these ideas are articulated in detail. Chapters 1 and 2 define the RPM approach to management. Chapters 3 through 8 explain the steps of RPM in detail. In chapters 9 and 10 instruction is given for dealing with specific problems which are recurrent in organizations. Part Two of Both-Win Management, which includes chapters 11 through 15, incorporates the tactics of negotiation within the strategy of RPM to provide a prescription for management success.

Although Both-Win Management is a breakthrough in management thought, clearly it does not provide all the answers. One of its inadequacies is that there appears to be an implicit assumption that the manager and employee operate in a vacuum which is little impacted by organizational constraints and environmental impingements. While a chart of “Typical Organizational Constraints” is presented, the extent to which these constraints can impede a manager’s use of RPM is not identified. Yet a manager’s boss or an organizational policy can severely impede the manager’s ability to refuse to accept excuses and to allow natural consequences to take over. One way to overcome this inadequacy is to view the manager as the person in the middle who must consciously use Reality Therapy with the boss as well as the subordinate, and Both-Win Management would be more helpful if it provided directions for its implementation with bosses as well as with subordinates.

The strategy of RPM also violates the traditional management tenet that a boss cannot be friends with an employee. Certainly neither therapist and client, nor manager and subordinate, are organizational equals. This is not to say that as individuals they are innately different, nor is it to imply that we need one theory for “them” and another for “us.” Yet a manager who has made friends by being open and honest, and engaged in “easy banter” with employees may find that when a problem occurs and that same manager is required to discuss inappropriate behavior with an employee, the employee with a “failure identity” can use personal information gained from the relationship to attempt to destroy the manager’s credibility. Both-Win Management would be more helpful if more than one paragraph had been devoted to the “failing employee.” A
discussion of overt and covert actions this employee may use to escape the pain would have alerted the manager to such a potential.

With these caveats it can be concluded that Reality Therapy in the form of Reality Performance Management is a guide which can provide a means by which the manager can establish a more productive relationship in which problems are less likely to occur and by which problem employees can be effectively managed. As such, it is an idea whose time has come.

Bibliography

ENHANCING LIFE: REALITY THERAPY AND TERMINAL CARE
Robert A. Silverberg
Dr. Silverberg is Associate Professor and Director of the Division of Social Work at Kent State University, Kent, Ohio.

Despite a rapidly growing technology that constantly adds to our computerized ingenuity, death remains a nagging enigma beyond our understanding or even our comprehension. The western world's magnificent obsession with control has not changed the inevitability of death, which remains a certainty rather than an option. But the course of dying can be under the control of patients, their families, and the clinical caretakers. Thus, though death is and will continue to be an ineluctable fact, the act of dying is an event which can lead to differing alternatives, i.e., even given the admittedly guarded, precarious nature of terminal illness with its imposed limitations on patients' activities, at least some choice will remain to the patients in how they wish to spend the remaining days of their lives.

Clinical thanatology is certainly not a new discipline within the behavioral sciences and health care professions. Many significant studies deal with clinical prescriptions, the psychosocial dynamics and processes involving those individuals coping with the crisis of terminal disease, and the significance of the various emotional responses by patients and their families, including shock, denial, rage, depression, fear, and confusion (Epstein, 1975; Feifel, 1977; Garfield, 1978; Glasser and Strauss, 1965; Goldberg, 1973; Kastenbaum and Aisenberg, 1976; Kubler-Ross, 1969; Tousley, 1982; Weisman, 1972, 1979). The current literature has, however, emphasized the different stages and phase-specific models in approaching dying patients and their families, and such emphasis necessitates interpretation of the clinical process in specifically developmental terms. Along with stressing the developmental aspects of dying, the field of clinical thanatology usually manifests support of a rather widely accepted model of non-directive intervention attributable to client-centered, existential, or analytic modes of intervention. Kubler-Ross (1969), along with many others has given the care of such patients a distinctly spiritual, almost religious or sacred flavor. Pattison (1978) is representative of this "relaxed," or "hands-off" approach:

Third, helping is not so much doing as being. In our anxiety to accomplish something, to do something about dying, to feel we are valuable, or whatever, I find a zealousness to do things. But this may be for our own benefit, not that of the dying. To comfort is to share. To share is the willingness to be without having to do (p. 162).

Although it may be rather common to find professionals "doing things" in order to avoid feeling useless, or perhaps even more pertinent, to avoid feeling their own mortality or vulnerabilities, helping as being is often not enough. Thus, the accepted model in terminal care too often ignores the
need for active helping, educating, or instructing within a therapeutic relationship and the value of time-limited, structured, and directed "doing" (Glasser, 1965, 1981) as an inherent part of such care.

Given the emphasis on behavioral and cognitive therapies during the past fifteen years, it is notable that the clinical thanatology literature, except for some brief reports (Averill, 1968; Preston, 1973; Ramsay; 1979; Ramsay and Happee, 1977; and Whitman and Lukes, 1975), and an edited volume (Sobel, 1981) is so sparse. Reality therapy, as a humanistic, cognitive, and behaviorally oriented form of therapy — particularly with its focus on the doing component of behavior (Ford, 1982; Glasser, 1965, 1981; Sewall, 1982) — would appear to offer a potentially profitable alternative to more non-directive approaches to treatment. Simply being with the dying patient may be more appropriately and profitably carried out by those who have been most intimate with the patient, e.g., family members and close friends (Sobel, 1981), than by the clinician.

The general aim of reality therapy in terminal care is to help the patient and/or family members determine and manage their own adaptive responses. Rather than imposing a specific strategy of coping, reality therapy strives to educate patients, helping them to regain a sense of control along with a capacity to maintain a feeling of self-worth and dignity in the face of impending death. Unlike more traditional therapies, therapeutic success is not dependent on or measured in months or years of intense and ongoing focusing on so-called unconscious processes, particularly inasmuch as such focusing fails to guarantee an increased therapeutic success rate (Garfield and Bergen, 1978) and in any event is inappropriate with patients who have so little time left to live. Teaching effective, specific coping skills (Vey and Yukl, 1982) rather than stressing unconscious phenomena would certainly appear to be the more humane and effective strategy with terminal patients. Such patients are often terribly frightened about a process and event they know little about, and to introduce another factor lying beyond the patients' control or understanding is to heighten their feelings of helplessness, irrationality, and lack of self-direction (Glasser, 1965).

Rather than helping the terminal patient die "correctly," i.e., to pass through the clinician's prescribed and preconceived notions or goals about the proper stages required to achieve a "good death," the reality therapist seeks to help such patients live comfortably, realistically, and practically with their terminal condition. The patient is provided with alternative ways to cope with living while dying, an approach that teaches the solving of problems (Ford, 1982) toward the ends of comfort, flexible morale, control, and an appropriate death (Weisman, 1972). Unlike much current clinical practice, patients are not maneuvered to die in the way that the health care practitioner would choose for them; rather, the patients are given, to the limits of their capability, the opportunity to choose for themselves from a myriad of possible responses. The reality therapist does not assume that practical or concrete concerns in the "here and now" — worries over physical attractiveness and hygiene, work and financial matters, and medical information, as well as pain, anxiety, depression, and so on — are superficial matters that the individual utilizes to defend against or conceal "deeper" thoughts or feelings related to the acceptance or denial of death.

On the contrary, helping the patient resolve such fundamental issues by active, direct techniques will do more to elicit the goal of acceptance than the long, often futile discussions of a non-directive approach. The dying person intensely feels the loss of control of his life, feels instead controlled by his disease and the other individuals in his environment (Barton, 1977). Specific problems related to the care of the terminally ill patient arise within the hospital situation because of the often rather rigid expectations of the health care establishment in regard to how the patient and his/her family should behave.

The traditional hospital situation which emphasizes docility, compliance, and dependency, often seems to assume that patients are not competent to make decisions governing their own lives (Epstein, 1975) and thus expect them to comply passively with the decisions and judgments of health-care professionals. Persons are thus rendered "dead" before they actually die in that their participation in life, except for feelings of grief, loss, and pain, is ended. Any dreams, desires, hopes, or achievements are no longer considered in interactions. No longer considered persons, they receive little acknowledgement of their very real need to know what is going to happen to them, as decisions about their care — including the basic decision of whether or not to tell them that they are dying — are made without consulting them.

Strategies for increasing the patients's responsibility and self-control (Banmen, 1983; Glasser, 1965, 1981) have major implications for the therapist. The reality therapist strives to reinstate a sense of personal control by helping patients become aware of those facets of their lives that still can be modified or maintained despite the reality of their fatal illness. Increased awareness as to how the patient can control and select specific alternatives and behaviors is likely to be more helpful in alleviating and preventing future distress than confronting the pain of death itself. Helping such an individual become aware of the possibilities for control and the options for choices (Perlmuter and Monty, 1977), however limited such options are, may serve to prevent destructive malaise, learned helplessness (Seligman, 1975), and isolation. As Banmen (1983) notes, reality therapy is concerned with "teaching people about control systems, to evaluate their perceptions of reality, to appraise and change the reference perceptions in their internal world (p. 13)." A change in the way the patient perceives reality and the consequent development of self-control strategies can provide for an appropriate life before death and a dignified dying:

Dignified dying is not an exotic concept; it simply means that one continues to regard a dying patient as a responsible person, capable of clear perceptions, honest relationships, and purposeful behavior, consistent with the inroads of physical decline and disability (Weisman, 1980, p. 756).

A case study illustrates the importance of discovering and emphasizing those aspects of life that patients can control in the midst of a dying that they can not control. A fifty-four-year-old woman suffering from leukemia was seen by the social worker because of her belligerent, demanding, and unresponsive behavior. She became visibly agitated as she painfully related...
how she had always prided herself on her self-sufficiency and resourcefulness. She was humiliated to be so dependent both on her husband and four grown children, who she felt were still “little babies” needing her care, and on the hospital staff, who she felt considered her an “object” to “do things to.” In discussions she became aware of her intense shame, humiliation, and guilt over a helpless, dependent state that so contrasted with the active, productive life she had led as a wife, mother and homemaker before the onset of her illness.

The social worker asked this woman what she might do for herself within the physical and emotional restrictions imposed by her illness. “How come nobody else here had the sense to ask me that?” she responded, and then expressed the wish to be let in on what the staff was “cooking up” in regard to her treatment.

Much of what had provided this once-active woman with a feeling of selfworth and firm sense of identity — her role as a wife, mother of four children and homemaker — was rapidly slipping away forever under the onslaught of her fatal illness. It she could have a say in her treatment, she might yet come to feel that she possessed at least some minimal control of her life and the hospital situation. Loss of that control had resulted in her active and passive resistance, a desperate attempt to sustain her last vestiges of identity.

It was suggested that this woman attend a conference with the staff and speak to them as a colleague rather than a patient about how best to care for her needs. Following this conference, several of her suggestions were adopted by the staff, while others were negotiated. In a joint session with family members, the social worker encouraged the patient to explore other options that might more effectively meet her need to be more independent and in control of her life and her environment. Focusing on the woman’s strengths, he remarked that both she and her husband had mentioned her talents as a cook adept at creating ethnic specialties “from nothing,” and perhaps something could be set up right in her room so that she could continue to make use of this creative talent. She visibly brightened at this suggestion, and began to discuss enthusiastically the possibility of preparing some of her favorite foods. She subsequently and very successfully prepared several exotic meals for herself and her husband. Three days before this woman died she prepared an international buffet for the multiethnic staff.

Rather simple control techniques, e.g., practicing imagery (Parr and Peterson, 1983) or rehearsal (mentally or with the therapist) of assertive behavior with an overbearing staff member or family member are particularly promising treatment aspects of terminal care. Another goal of the reality therapist is to promote the patients’ realistic appraisal of their situation and heightened awareness of their possible choices (Bannen, 1983; Glasser, 1965, 1981). Highly stressful events such as dying often cause patients to fix the responsibility for events on erroneous or unbalanced assumptions attenuating the patients’ ability to control themselves and their environment (Janis and Rodin, 1979). One patient, for example, after reading some material on cancer and its possible relationship to suppressed emotions, attributed the onset of his disease to having never expressed his feelings; another held the environment, specifically pollution, responsible for his illness, with a resultant displacement of intense hostility onto the hospital staff and his family. Such fixing of responsibility is an attempt by the patient to cope with and restate some minimal control during a period of intensified and often unendurable fears, sinking spirits, and increasing isolation. By teaching patients how better to fulfill their needs (Glasser, 1965), reality therapy allows them to make more responsible decisions and increase their ability to acquire the necessary information on which to base choices. The patients become better able to control themselves, their environment (Sobel and Worden, 1981; Weisman and Sobel, 1979) and the way they live their final days.

Lastly, but perhaps most importantly, the goals and principles of reality therapy are predicated upon “achieving the proper involvement, a completely honest, human relationship in which the patient for perhaps the first time in his life, realizes that someone cares enough about him not only to accept him but to help him fulfill his needs in the real world” (Glasser, 1965, p. 25). Glasser also states that in this emotional involvement with patients the therapists must at least to some extent be so affected by the patients and their problems that they will “suffer with him” (p. 28). Not to be so affected by the patient’s suffering precludes, according to Glasser, successful therapy. A growing literature in cognitive and behavioral therapy supports Glasser’s emphasis on the importance of the therapist’s involvement in an intense relationship with the client (Klein et al., 1969; Patterson, 1968; Pollak, 1981; Ryan and Gizynski, 1971; Sloane, 1969; and Sloane et al., 1975). Hospital staff and family members, on the other hand, may easily retreat from such involvement (Weisman, 1972, 1974). Several clinical studies demonstrate that such changes in relationships with others may create psychosocial stress of such magnitude that the patient is quite liable to suffer a rather swift decline and even death (Weisman, 1974). A significant relationship need not necessarily involve a family member (Weisman, 1974); the therapist and/or other professionals may be able to sustain this critical emotional connection with the dying person through the terminal phase.

The dying process, of course, provokes intense emotions and anxiety to everybody involved with the patient, including the therapist (Schneiderman, 1978). Obviously, the greater the involvement by the therapist and the more intense the relationship with the patient, the greater is the possibility for distressing and immobilizing feelings of anger, depression, guilt, and helplessness on the part of the therapist (Pollak, 1981). When dealing with the painful realities of death, the clinician may resort to the same defenses of detachment, isolation, and intellectualization as the patient’s family members (Weisman, 1977). Such reactions on the part of the therapist or hospital staff, while understandable, only provoke or heighten intense feelings of alienation and abandonment in the patient. By experiencing
solidarity with another person through identification with his/her suffering and struggles (Glasser, 1965), therapists thereby become more fully aware of their own frailty, vulnerability, and transience — and also, however, of their courage and compassion.

**SUMMARY**

Reality therapy, with its emphasis on the importance of personal responsibility, goal-setting, choice, self-control, and active interaction with one’s environment, offers a practical philosophy and methodology for the therapist working with the terminally ill patient and his/her family. The clinician fostering the actualization of appropriate or dignified dying seeks to help patients become more aware of all possible options, engage in active problem-solving, initiate and renegotiate contracts or plans, and participate as much as possible in decisions related to their care. The patients thus focus on improving the quality of their admittedly limited life, which in turn helps to improve the quality of their death.

**References**


THOUGHTS ON REALITY THERAPY
FROM A FEMINIST
Mary B. Ballou

Dr. Ballou is Assistant Professor of Counseling Psychology, Rehabilitation, and Special Education at Northeastern University in Boston, Mass.

The goal of this article is to identify some of the aspects of Reality Therapy (R.T.) which are inconsistent with a Feminist's orientation to therapy. The intent is not to contrast the two nor to systematically assess R.T. through a Feminist orientation to therapy. Rather a few points of contradiction will be explored in hopes that as R.T. continues to develop, it will do so with more consciousness of women and ideology.

At first glance, it would seem Reality Therapy is not inconsistent with Feminist Therapy (F.T.) In fact, it would seem that if a therapist were aware of women's issues and sexism, R.T. would be a treatment modality in concert with F.T. A closer look, however, reveals serious contradictions between the two.

F.T. has been developing over the last decade through the application of feminism to therapy. The development of F.T. has been diverse and multi-faceted involving a number of individuals. Ballou & Gabalac have reviewed this development in detail. While diversity is present in F.T., there are several consensual principles. These principles are used in this article as a basis for analysis of R.T.

Fundamental reliance on women's experience is one of the prime principles in F.T. This does not mean all women's experiences are the same. Indeed a recognition of the variety of women's experiences is essential. This variety of experience will be discussed later with the concept of pluralism.

Women's experience is the basis of practice and theory building. It serves, at the same time, as both a basic foundation of knowledge and as its validation. It is the construct and becomes the criterion. F.T. stems from and relates to women's experience. F.T. does not contain apriori assumptions, either theoretical or social, which filter the words of or form the understanding about clients. The emphasis on women's experience is important. It varies among women, and is distinctly different from men's experience.

To be a woman, white or black, married or single, heterosexual or lesbian, rich or poor is substantially different from being a man; different obviously in physiology but also in social, interpersonal, and organizational response. Economics, values, life options, physical safety and attitudinal sets are all significantly and definably different among males and females, as has been well documented in the psychology of women literature. These very differences must be brought to therapy in conscious and articulated ways, as must differences in class and race.

Experience is the second word in the phrase women's experience. Its' importance is also primary. Experience, that which actually occurs, is felt, and/or perceived, as the base. A grounding in experience is very different than that which is logically fitting, interpreted by others, externally imposed, or in concert with approved ideas as is the case in many other theories. In F.T. experience is the key: not the ordering of information through formulae, whether the formulae be the rules of logic or hypothesized biological processes. Truth, relative though it may be, is accorded to one's own experience, not another's beliefs, assumptions, theory, or interpretations. The concept surely has important philosophical implications, and must direct theory building. It also has direct implications for events in therapy.

In therapy, it means, for example, that a client's experience, and insight into that experience, is quintessential. The experience is not interpreted into concepts such as mentally healthy goals, success or failure identities.

R.T. stands in contradiction to F.T. regarding both women and their experience. Though R.T. holds itself out as genderless, it does not acknowledge differences in men and women, or attend to differential treatment of them.

The guidelines of R.T. focus upon the individual. In doing so, differences in gender, class, race, and ethnicity are undercut, except as the client may bring them into the session. While the strategy for change in R.T., identifying clients' needs and planning more effective ways to meet them, is advantageous, the absence of overt attention to gender, class, race, and ethnicity is a serious lack from a feminist view. External sociocultural forces are important variables in individuals' experience of themselves in the world, in behavior change efforts, and in psychotherapeutic process and outcome (Lorion, 1978). R.T. also stems from a set of assumptions about specific human needs, individual's control of the world, genetic forces, a biological control system and chosen behaviors, as illustrated in Glasser's recent statement "therefore, there is no 'stress' in the outside world, there are only situations we call stressful because we cannot control them satisfactorily with the behaviors we choose. But this 'stress' is almost unique to any one of us; in ordinary living there are few, if any, real stressful situations that no one can control" (Glasser, 1984 p. 322). While R.T.'s procedures may be, the theoretical assumptions are not grounded in experience. Logical deduction from assumption, not induction from experience, is the theoretical stance.

On second inspection, this contradiction appears irreconcilable. R.T. has no regard within its theory and practice guidelines for women's experience, class, race, or ethnicity. It ignores sex-roles and sex ascriptions. The world view implicit in R.T. is far too unidimensional. It simplifies the complexity of women's experience, and influencing factors in human problems to genderless, biologic, individualistic need fulfillment. Once simplified, it then employs a pragmatic approach which in view of acknowledged sexism can be harmful to women. Indeed, assumptions of individual control of the external and choice are a second major source of contradiction between R.T. and F.T. F.T. holds the belief that sexism as well as racism, classism, ethnocentrism are responsible for many of the
problems of women and other oppressed groups. Individuals internalize, come to believe, to perceive, and behave in accord with the dominant social beliefs (Schaef 1982). Regarding women, these beliefs are sexist and harmful. F.T. holds them to be causative and reinforcing to pathology (Carter and Rawlings, 1977). This leads to an overt commitment in F.T. to social change (Ballou, 1984).

In other words, the society, its attitudes, economics, and politics play a large part in the “failure-identity”, to use R.T.’s term, of women. F.T. sees social, historical, and economic forces as important forces in women’s problems. It does not absolve the individual from the need to understand, change, and later challenge. At the same time, F.T. does not hold the individual totally responsible. F.T. aims at the intersection of victim (socially caused) and agent. F.T. holds that individual change must be coupled with social change and done so in context. R.T. does not have a historical or social context, but rather places the focus on the individual’s present behavior. By focusing solely upon the individual, and thus ignoring historical and social forces, R.T. does nothing to change or challenge these forces. The individual focus inherent in R.T. has two major problems. The first spoken to above results in holding the individual solely responsible for present behavior. This can be clearly seen in Glasser’s words, “Reality Therapy completely denies this theory and says that nothing we do, feel, or think is a reaction to external events.” (p323).

Many critics have in recent years begun to make clear the shortcomings and danger of the individual focus. Sarason (1981) in Psychology Misdirected wrote eloquently of the limits and problems with psychology’s essential study of the individual organism unrelated to history, structure, and unverbalized world views of the social order. He states, “individualism, competitiveness, the worship of technology, participation in the marketplace, adherence to ‘more is better and bigger is gorgeous’ — are scientists aware how they regard themselves and others. The theories they use to explain themselves and others, have sources in the social order and its institutions, and that reforming these institutions will require more than individual resolve?” (p181). It is a narrow world-view which focuses upon the individual and holds that individual responsible for his/her present behavior without regard for social forces. A more adequate world-view allows for the complexity of external forces interacting with the individual organism.

The second major problem with the individual focus which R.T. shares with much in contemporary psychology is the neglect of social change. If only the individual as separate from his/her context is looked at, not only are complexities and interactions reduced, but action or even awareness of needed changes in context are ignored. The harmful aspects of the social order and the institutions, attitudes, assumptions and world views which support and shape it are legion. Sexism, racism, capitalism, materialism, rugged individualism with its corollary of competition all have well documented negative effects on mental health. Focus upon the individual allows and directs non-regard of the social and institutional dangers, and thus aborts the impetus for social and institutional change. R.T.’s focus upon the individual with key concepts of individual responsibility and individual change is in stark contrast to the F.T. view of complex interactions between individuals and social forces, and commitment to change those harmful aspects of social forces. R.T. ignores while F.T. demands social change (Ballou and Gabalac, 1984).

F.T. and R.T. are however in concert regarding two fundamental concepts. The first is the therapeutic relationship, and the second is accepting the client’s value system. F.T. seems to have articulated these concepts, and has a more developed analysis of them. Both F.T. and R.T. hold the relationship and the client’s values as critically important. Glasser posits involvement, with its genuineness, and acceptance as necessarily characteristic of the relationship between therapist and client, and sees the relationship as potentially fulfilling love and belonging needs for the client. Working within the client’s values, not the therapist’s, is another element in R.T. Both are cardinal aspects within R.T.’s writing and training practices, they are also common in all counseling approaches except perhaps psychoanalysis. F.T. has a more sophisticated and theoretically integrated analysis of these two aspects than R.T. The relationship in F.T. is held to be, of necessity, egalitarian (Carter and Rawlings 1977). Working with the client’s value system is seen in F.T. as a fundamental acceptance of pluralism (Schaef 1981).

Ballou and Gabalac (1984) have discussed both egalitarian relationships and pluralism as critically important fundamental concepts of F.T. They present the functional principles in the egalitarian relationship as the power to label and the right to bargain and insist that these must be available to the client and actively present in the attitude and action in the counseling session thus insuring an egalitarian relationship and disallowing unequal power, either implicit or explicit, to the therapist in the relationship. Pluralism is discussed as a position which accords equal validity to different world-views, including not only values but beliefs, attitudes, class, race, ethnicity, life-style preferences, and ideological positions. In addition, F.T. raises value systems and world views in pre-therapeutic discussion, for the purpose of assessing, then insuring awareness and acceptance of, any differences between the therapist and client. If there is a conflict between them, then the therapist helps the client to find another therapist where the conflict does not exist. These positions on pluralism and the egalitarian relationship stem from sophisticated analysis, and are well integrated with the feminist orientation to therapy. They are seen by F.T. to be quintessential elements because of the enhanced sensitivity to power, including implicit power and both interpersonal and social forces, which have oppressed people without status throughout the history of mankind. F.T. and R.T. both treat the client’s values and the therapeutic relationship with importance and respect. F.T. however has a more complex analysis, including social and philosophical integration in addition to the personal.

Although this article is not intended to be a comprehensive critique of R.T., it has provided a few points of discussion through a feminist’s view. It is clear at the end of this discussion that F.T. has some differences from R.T. These differences reside in R.T.’s focus on the individual, and lack of attention to the historical/social contexts which influence and shape both individuals and the theories and strategies developed to explain and assist
them. For feminist therapists, R.T., may be a useful strategy for concrete individual change, but it is not adequate as a more general theory or orientation to therapy. For R.T. perhaps some of the points raised through this Feminist critique will assist in R.T’s continued development and broadening.

References


Guidelines for Contributors

a) Manuscripts should be submitted in triplicate to the Editor, Lawrence Litwack, Journal of Reality Therapy, at the editorial office address. In the case of a manuscript written by more than one author, the covering letter should indicate the name and address of the author with whom the editor should correspond — that is, the corresponding author.
b) Manuscripts must be typewritten double-spaced on 8½ x 11 white paper. The name, highest earned degree and professional notation (e.g., R.N.), title or rank, organization, and address of each author should appear on the manuscript’s last page. In manuscripts written by more than one author, the corresponding author should indicate the order in which coauthors’ names should appear in The Journal if the manuscript is accepted. Rejected manuscripts will not be returned unless a stamped, self-addressed envelope is enclosed.
c) In accordance with the Copyright Revision Act of 1976, we are required to have the following statement in writing before we may proceed with a review:

"In consideration of The Journal of Reality Therapy taking action in reviewing and editing my submission, the author(s) undersigned hereby transfer, assign or otherwise convey all copyright ownership to The Journal of Reality Therapy in the event such work is published by The Journal."
d) Authors should strive for brevity, readability, and grammatical accuracy. The title of a manuscript should be succinct and lend itself to indexing.
e) Manuscripts should be prepared in accordance with the Publication Manual of the American Psychological Association, Third Edition.
f) CHARTS, GRAPHS, TABLES: Camera-ready art must be furnished for charts, graphs, and tables by the author OR The Journal’s printer can prepare the art and bill the author. Authors electing to furnish camera-ready art must adhere to Journal format for tables and figures and should either specify 8 point English Times typeface or use IBM typewriter ball “Modern, 72” for the copy. Illustrations that repeat information given in the text and which do not enhance the manuscript should be omitted. Each table, chart, or graph should be numbered and cited in the text where it is to appear.
g) Manuscripts are received with the understanding they are not under simultaneous consideration by any other publication. The Journal will not be responsible in the event a manuscript is lost, and once published, manuscripts may not be published elsewhere without written permission from the corresponding author of the article and the editor of The Journal.
h) When a manuscript is received by the editor, it is referred to two members of the review board. Reviewers are asked to consider these questions:
   1. Has the subject been covered adequately in The Journal so that publishing this manuscript would be redundant?
   2. Is the manuscript on a problem or topic of sufficient importance in demonstrating Reality Therapy to warrant its publication?
   3. Is the content of the manuscript scientifically accurate and philosophically sound?
   4. Does the manuscript contain any false or misleading statements?
   5. Does the manuscript have readability, i.e., is it clearly written, succinct, and easily understood?
   6. Will the manuscript require a great deal of revising to make it acceptable?
i) All accepted manuscripts are subject to copy editing.
j) Following the appearance of an article in The Journal, the author(s) will receive two complimentary copies of that issue.