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SPouse VIOLENCE: SURVIVORS
Janet A. Thatcher

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The issue of spouse violence is becoming increasingly apparent. Reports of spouse violence and of victims taking action appear in newspapers across the country. Examining the dynamics in terms of control theory may enable the helper to understand more clearly what the survivor is experiencing. In addition, the practice of reality therapy enables the survivor to determine a direction for her life - whether that be to stay with the partner or to become independent from him.

Domestic violence is defined as exerting a physical force so as to injure or to abuse. The abuse may vary from emotional abuse involving name-calling and threatening bodily harm to physical abuse involving slapping, hitting, shoving, beating, choking, bruising, and injuring. The types of violence can be categorized into four areas: (1) physical, (2) sexual, (3) destruction of property or pets, and (4) psychological. The physical violence involves using physical force to make a person do something or go somewhere against the person's will. The sexual violence includes the forcing of another to have sexual intercourse by means of physical force; forcing sexual activity such as oral sex, sodomy, etc.; forcing sex with animals; forcing a person to have sexual intercourse or sexual activity with another person; and/or forcing sexual activities with objects. By destroying property and pets, the abused individual may imagine herself in the place of the object and the impact for her may be great. The psychological violence, often times difficult for the abused victim to acknowledge as abuse, may include name-calling, intense continuous mental degradation, or threats of violence by threatening the individual's well-being or by psychologically manipulating as a form of brain-washing. Among the various types of violence, there tend to be three commonalities: (1) the violence can be used as a way of dealing with anger, stress, or frustration; (2) the violence can have serious physical and psychological consequences; and (3) all the acts are against the law.

This violence tends to occur in three phases: (1) Tension-building stage in which tension may result from constant arguing or giving each other the "silent treatment" or a combination; (2) Acute battering stage in which the abusive spouse escalates the verbal and physical attacks, often without being provoked (This violence may stop when the woman leaves, the police are called, the abuser realizes what he is doing, or someone needs to be taken to the hospital); and (3) Calm, Loving, Respite Stage in which guilt and fear replace anger between partners, in which the man is usually very apologetic, may buy her flowers or gifts, will promise her that the abuse will never happen again, and sometimes begs for forgiveness. The woman usually does forgive but she remains skeptically optimistic. It should be noted that the more times the cycle is completed, the less time it takes to complete; the longer the cycle goes uninterrupted, the worse the violence becomes; and finally, the longer the cycle goes uninterrupted, the shorter the third phase becomes. Thus, the battered woman may not be ready for intervention the first or second, or even more frequent, times that she has been abused.

Who are these women who stay in abusive relationships? According to control theory, all individuals experience the same genetic needs. The woman who repeatedly experiences battering has many of her wants dictated by her spouse. The need for survival is paramount since she may question her means of providing for herself and her children. Often times, she is totally dependent upon her spouse for food, clothing, and shelter. Due to his isolating her, she may not have any experience working outside the home. At the other extreme is the woman who is a professional career woman and who is battered. In her situation, the survival need may not be questioned, but her other needs are not being effectively fulfilled.

The patterns regarding the wants and needs are similar for survivors of battering. The need for love and belonging is pictured as the need to be needed, especially by the spouse and vice versa, to be the "perfect wife", and to have an emotional commitment to the spouse, i.e., "for better or for worse." The need for power is depicted as being taken care of by the spouse, minimizing her importance to the spouse as a means of serving his benevolence, and achieving only to the level of the spouse's tolerance. The need for fun is limited to periods of calmness and tends to be based on the spouse's definition of fun. The need for freedom comes with financial security. Her need for freedom is limited in its fulfillment due to her reliance upon her spouse, his restriction of her choices, and her fear of the consequences when she does assert her freedom. In summary, the woman's needs are minimally fulfilled and the world around her is very limited.

In viewing her behaviors, it is useful to examine these behaviors by the predominant component. Regarding her acting behaviors, the battered woman tends to be passive and placating by always trying to keep peace at home, by doing things to keep her spouse "happy", and by constantly changing because of the partner's continual change. This placating behavior may be the best that she can do in order to survive. She acts passively by allowing herself to be dominated and by allowing her spouse to make the decisions. She is often times seen as acting as a buffer between her spouse and the rest of the world. She may assume responsibility for accumulating and/or paying his debts, and for the spouse's acts and consequences legally.

Her thinking behaviors include the process of equating dominance with masculinity. She maintains the myth that males are superior and thus always right. Her locus of control is external and she allows others to control her destiny. The battered woman also thinks that she has no basic rights, that she does not count, and that her beatings are justifiable.

Guiling and shaming are among her feeling behaviors. Her guiling is focused on her assuming responsibility for the entire relationship which she views as not being happy. She also is ashamed that she has not discovered what will make the spouse happy and thus ending the abuse, and that she is
creating both the abuse and the situations that lead to the abuse. She also experiences a sense of helplessness and has little confidence within herself, especially regarding relationships. She has blind faith, either the unshakable faith that life will improve or that nothing can be done. The feeling of isolation occurs because her spouse is cutting her off from friends. As a result and as a part of the process, she feels that no one understands her. The fearing feeling is very predominant in that she fears further beatings and abuse (magnified by the unpredictable nature of the assaults), the loss of her spouse, and the safety of her children. She fears the future which may include divorce, changing, the unknown, and possible retribution from the spouse who battered.

Her physiologic behaviors tend to be used as her means of surviving. She often uses physiologic behaviors such as aching and paining in order to keep a potentially abuse situation calm. The abused woman tends to age prematurely due to the stress which she experiences. Her physiologic behaviors may include ulcering, high blood pressuring, gynaecological difficulties, aching and paining.

How does the battered woman view being beaten? Her initial perception is negative and painful. As the beatings continue and/or become more severe, the perception changes to neutral or matter-of-fact. With continual batterings, time passing, and a gradual and growing intolerance to not fulfilling her needs, she may begin to perceive the abuse as undeserved and painful. Much of the process of changing her views comes through her prioritizing her wants and listening to the input from caring individuals in the real world.

It should be noted that the survivor of abuse possesses many positive attributes of which she tends not to be aware. She tends to be resourceful, persevering, brave, intelligent, and creative in her efforts to survive and to escape abuse. These attributes may help her rebuild her life.

Knowing who these women are is not sufficient for the helper/counselor. Assisting the abused woman by using the technique of reality therapy may be helpful. The establishment of an appropriate counseling environment is crucial in order to secure the trust of the battered woman. She has not allowed herself to trust anyone, especially outside the family, and so listening and believing may be very difficult for her. The counselor will need to communicate hopefulness but not in an unrealistic manner. The concept that there is a way to work it out and to acquire some peace needs to be communicated. Communicating helpfulness by knowing community resources, helping her to develop an escape plan, etc., will aid her in her recovering and decision-making. An essential aspect of the counseling environment is to listen openly without editorial comment. Not criticizing her for past, present, and future decisions is vital to the relationship because she has been doing the best she can at the time and she has usually received criticism from her spouse. The counselor will need to be nonjudgmental about the situation, about the abused woman, and about the spouse. It is important to inform the survivor of her rights, the possible dangers (legal, physical, emotional) of further abuse, and about her options. The counselor needs to remain as a need-fulfilling person to the abused woman.

Often, the abused woman is focused on her past and so the counselor may wish to allow her to talk of these past events. These past events may be evoking present feelings and thinking behaviors for the battered woman. On the other hand, some survivors will not think or feel about these past painful events. It is then the counselor’s role to gradually help them to reconstruct the past and to develop possible patterns in their or the spouses’ behaviors.

Another aspect of the environment includes the counselor’s sharing the parameters of the agency, i.e., telling the woman what the agency/counselor will and will not do, seeking from the woman her expectations of the agency/counselor, and seeking the woman’s commitment to counseling. (Maintaining the anonymity of the agency’s location is essential for developing a secure and safe environment for the woman.)

The maintaining of the counseling environment is ongoing but the abused woman needs more than a healthy counseling environment. The “procedures that lead to change” will aid the woman in determining a direction for her life. The following is a summary of what the counselor might do since each individual will present unique situation and dynamics. Where the counselor begins is determined by the woman’s situation at the time of counseling. The abused woman may have significant difficulty with identifying her wants; she is far more aware of what she does not want, i.e. beatings, fearfulness, insecurity. The reasons for this lack of verbalizing a direction include the following: (1) her lacking trust in others, (2) not having confidence in herself, (3) not viewing herself as capable or worthy to get what she wants, (4) her lacking exposure to possibilities, and (5) sensing that she does not have the right to what she wants.

She will need to be educated about her rights as a person before she is willing to identify her wants. Some of these rights include the following:

1. You have the right not to be abused.
2. You have the right to be angry over past beatings.
3. You have the right to choose to change the situation.
4. You have the right to freedom from fear of abuse.
5. You have the right to request and expect assistance from police and social agencies.
6. You have the right to share your feelings and not be isolated from others.
7. You have the right to be treated like an adult.
8. You have the right to leave the battering environment.
9. You have the right to privacy.
10. You have the right to express your own thoughts and feelings.
11. You have the right to develop your own individual talents and abilities.
12. You have the right to legally prosecute the partner who is abusing you.
13. You have the right not to be perfect."
(Ball and Wyman, 1977, p. 551.)

The one that needs to be communicated clearly is "You have the right not to be abused." Once she accepts these rights, then the counselor may help her begin to determine her wants. Clarification of her wants may be accomplished by having her examine the opposite of her not-wants, having her prioritize, having her reframe her not-wants, having her do various roles, i.e. wife, mother, woman, daughter, etc. structuring her process in defining "a family", the role of "wife and female", the role of "husband and male", other significant relationships and especially who she is as a person. This process of identifying her wants may be very difficult and foreign for the abused woman and the counselor's role is to be patient and persistent.

The counselor's role also involves helping the abused woman identify and modify her total behaviors. Initially, the abused woman will express her feeling behaviors, if she expresses anything. Her anger will be present, but probably difficult for her to express. The guilt and self-blame may be expressed more easily as she can direct these feelings toward herself. As the counseling environment becomes safer, the survivor will be able to express her feeling component openly and clearly. The counselor may aid the survivor in distinguishing the various feelings and aid her to cope with those feelings which she senses as a lack of control.

The abused woman may be able to express some of her thinking behaviors but may remain reserved in doing this. Her spouse has criticizing her thoughts and opinions so she has learned to maintain her ideas to herself and/or to discount her ideas as unimportant or noncredible. The counselor may assist the woman in verbalizing her ideas, giving the ideas credence, and discussing her self-confidence.

The acting component of the survivor's total behaviors may be the most difficult for her to recognize. By identifying her spouse's acting behaviors and her own behaviors, she becomes aware of her responsibility. By labeling his abusive acts and seeing patterns over time, she may realize what is actually happening, and denying remedial action may become more and more difficult for her. The counselor needs to approach the acting component very carefully and slowly because the abused woman's denial tends to be very established and the protection of her spouse is paramount. The counselor will need to assist her in identifying without blaming, identifying patterns, identifying those behaviors where she has direct control and identifying her passive, aggressive, and assertive behaviors.

As with the other components, the abused woman will need to identify her physiologic behaviors and to acknowledge the physical abuse. It may be in this area that she has some direct control, by learning to take care of her physiologic wants, i.e. eating balanced meals, learning to exercise, etc.

Throughout the counseling, the abused woman is viewed nonjudgmentally by the counselor. At appropriate points, the counselor needs to request that the abused woman evaluate her wants, total behaviors, perceptions of herself and her spouse, the consequences of his action and her lack of action, and her plans. She will undoubtedly have significant difficulty with this process because she has not had the practice or responsibility of making decisions of this magnitude. The counselor may help her by asking questions which clarify her worst fears, examine the pros and cons of the situation, and remind her of her and her children's physical and emotional well-being. The abused woman may resist this responsibility but the counselor needs to remain minimally judgmental - giving only the indication that the abuse will continue if no other intervention is done. This aspect of the counseling may be difficult for the counselor because he or she may be angered by the disrespect given the woman and by the woman's passivity, under such circumstances.

Once value judgments about changing or modifying her situation have been secured, the woman may be ready for making some plans. The plans may seem minimal and insignificant to the counselor but to the abused woman, these plans may appear drastic and frightening. Her views are that any behavioral change in the home will create a crisis with the spouse, and she may show resistance. The counselor needs to remind her of her value judgments and her commitment to make life different for herself. The initial plans need to be focused on building strength for her survival, i.e. developing an escape route, developing a source of income, securing a different living arrangement. The criteria of the plan need to be checked so that they remain realistic, success-oriented, and within her control. The plan-making needs to progress slowly so the survivor should be reassured of the long-term process and progress. If the survivor decides to return to her partner, against the counselor's recommendations, it is essential to remember that the abused woman is experiencing her own timetable and is making her own decisions which is exactly what the counselor is encouraging her to do.

In summary, the survivor of abuse experiences many difficult situations where logical thinking fails to explain the dynamics. Her survival need must be fulfilled and oftentimes at the trade-off of her other needs. Her behaviors appear confusing and contradictory to others but these behaviors are her best way of getting her needs met. The counselor's role is to continually ask the questions based in reality therapy, to ask them as effectively as possible, and to allow the survivor to determine the direction.

Bibliography

EDITOR'S COMMENT

This issue completes the seventh year of publication for the Journal of Reality Therapy. The quality and number of submissions continue to improve. At the present time, approximately fifty per cent of the articles submitted receive favorable reviews. Accepted articles are usually printed within six months or less of acceptance. We hope to continue working to improve the Journal. Ideas from readers are welcome.

I am pleased to announce the appointment of three new members of the editorial board for three-year terms ending in 1990. These appointments mean that the editorial board now has representatives from each of the nine regions in the United States and Canada. Joining the board from the Southeast region is Perry Good. Perry is a field faculty member of the Institute and is a former chairperson of the IRT board. Perry brings specific expertise in teaching and consultation. From the Northeast region comes David Moran. David has just completed a term on the IRT board. A field faculty member of the Institute, David brings specific background in school settings. The third addition is Rhon Carleton from Utah. Rhon is a colonel in the U.S. Air Force and is Installation Staff Chaplain at Hill Air Force Base. A faculty member of the Institute, Rhon has served in the Air Force since 1962, and brings a background in pastoral counseling as well as substance abuse and marriage/family counseling. We are pleased to welcome them to the board.

CONTROL THEORY CONCEPTS CONTRIBUTE TO EFFECTIVE REALITY THERAPY WITH SUICIDAL CLIENTS

Suzy Hallock

Many excellent resources are helpful to the therapist and client in counseling sessions characterized by client exploration of suicide. Wubbolding’s article in the Fall, 1987 issue of the Journal of Reality Therapy documents possible counselor behaviors in assessing lethality (direct questions, past attempts, asking for a plan, checking out the means, and making unilateral contracts) and interventions (informing with discretion and consultation). Wubbolding advocates the use of effective reality therapy to "help the client gain better control through plans which enhance involvement with others, increase a sense of accomplishment, make life more enjoyable, and provide a feeling of independence. Such plans should be short-range, specific, and attainable". (p.15)

It is useful to expand the concept of effective reality therapy to incorporate session discussion of the reorganization system. I see suicidal clients most often as people who have exhausted available, organized behaviors; yet, they remain frustrated in an attempt to meet a basic need. Thwarted by a poverty of pictures as to how to meet the need, or exhausted after having attempted either a narrow repertory or a wide array of behaviors, the client’s reorganization system keeps working on the dilemma. I explain it to clients in lay terms: “There is a part of your brain which is always working for you. It tries to help solve your dilemma. It is the place where your dreams, or even nightmares, are born. This place in your brain is like a simmering pot, bubbling all the time. It’s like popcorn popping all over the place. Every kernel that pops is another idea, a suggestion of a new way you can behave, a new choice of something you can do. Sometimes the smarter you are, the more it bubbles, so that can be a little confusing.” I sometimes tell clients that the creative system in the brain works a little like a car starting on a cold morning, a metaphor easily understood in Vermont. At first it may grind a little, then spurt and then turn over and keep purring away with lots of energy. Glasser (1984) says that “New ideas do not usually appear in their final form. An idea may start as a tiny thought, a different feeling, or some combination of both.”

I also tell clients that the creative, reorganization system is an amoral system, and it isn’t until the ideas it generates pass through the values filter that we give the ideas “thumbs up” or “thumbs down.” My work with suicidal clients usually involves a discussion of their held values around the notion of suicide. Clients have quoted scriptures, professed beliefs in reincarnation, considered existentialism, presented familial history of suicide, and repeated superstitions about suicide, all of which I listen to carefully and take seriously. As a reality therapist, I ask questions so that I get a
better glimpse into the client's internal world. Inevitably what follows is an enlightening session in which the client's view on life purpose is examined. I sometimes ask what the client thinks about Kant's notion that the person who commits suicide is one who deserts his post. Does my client believe in a unique life purpose? And if so, what purposes might he or she have?

In addition to the unilateral contract well explained by Wubbolding (1987), I assign homework reading from an appropriate resource. Most used are Life After Life by Moody, Death: The Final Stage of Growth, and Chapter 2, "The Beginning of Life" from On Children and Death, both by Kubler-Ross. This approach, called "bibliotherapy," proves useful in the discovery of held values and/or makes a contribution to the formation of a new value. Such a contribution — to a new way of thinking — enhances therapeutic process which enriches the unique life pattern of each person.

Still another technique which helps the counselor understand the client's internal world is to ask questions about characters in film, fiction, or in public life which reveal the client's values. Some clients have talked with me about Sissy Spacek's portrayal of a suicidal woman in "'Night Mother"; a 1986 film about a young woman who carefully plans and executes her suicide. Still others have mentioned Virginia Woolf's walk into the sea with rocks in her pockets. One wondered if Sylvia Plath thought that Ted would come by and find her with her head in the oven. And, more recently, someone mentioned still another Sissy Spacek role. This one, Crimes of the Heart, presents a young woman whose attempts to suicide don't work. Any reference such as these can yield pertinent information for therapy.

Corey, Corey and Callanan (1984) indicate that the "contemplation of suicide can be a way of refusing to live in the old ways, and the therapist's task is to give protection and support as the client searches for new reasons to live." I often use this notion and explain to clients that their brain is really sending them an alarm signal to do something. But we usually have more than one choice of what to do. I even sometimes say that we can "do" suicide later, but is there anything else we can try first?

So many clients over the years have told me they felt compelled to "suicide" because the thought had occurred to them, and therefore, they must be crazy. I explain that in the reorganization system, thoughts are presented whether moral or not, whether feasible or not, whether satisfying or not, whether congruent or alien to held values or not, but only the thought comes from the system. The thought is not the same as a behavior one must choose. Clients are visibly relieved to hear that there is a part of the brain whose only purpose is to create. Survival does not act as a governor on the creative engine; if it did, its purpose would be short circuited. None of the ideas can be subjected to censorship in their beginnings; if they were, the system would not be truly creative. Thinking can sometimes provide a rehearsal to doing, but with suicide, thinking behaviors can provide the source of rich therapeutic work resulting in other behavioral choices for the client. I suggest to people that the system is probably telling us that the old ways aren't working anymore, and that the system is perking away trying to come up with some new ways. What might those ways be? What new behaviors can my client try to meet needs? Is suicide really the only road on the map? Where does my client really wish to go? In this approach, I am ever mindful of providing a supportive counseling environment. Although I take the information about suicide very seriously, it is also important that I give the client the sense that together we can better manage whatever situation is now out of control.

Further, it is helpful to clients to understand that many people who are faced with conflicts which appear insoluble consider suicide. I say it is fairly normal to think about suicide. I tell clients that most people have told me they consider suicide when they are sad and frustrated, but that the people who talk to me about these kinds of things also tell me later when their lives are more in control that they are glad they were able to find a better behavior.

A very intellectually gifted and attractive high school senior told me that she considered suiciding over her advanced placement calculus class. She wanted to gain admission to an Ivy League college, and despite excellent mathematics aptitude (as measured on a Scholastic Aptitude Test), she was not achieving well in the calculus class. She had the picture of the Ivy League college in her head as potentially satisfying, but the class was not satisfying. Although I usually encourage students to achieve as much and as best as they can in mathematics classes, for this student, course achievement was resulting in more and more frustration. After we tried some behaviors, such as meeting the teacher after school and peer tutoring, this student decided to audit the class. In this way, she could remain in the class, hear the lectures, do the homework and take the tests, all without the pressure to perform. Initially, she believed that the pictures of performance in calculus class and admission to the college of her choice could only coexist in her album. But, as an early admission before Christmas that year indicated, her personhood was much more than achievement in one class. When I saw her a year later, I asked about her satisfactions in the new and challenging setting. She told me that she was doing well in the new setting and that her reorganization system was working well for her.

Still another client presented saying that she was depressing and ready to suicide. Her husband of 14 years had just left her for another woman. Since this was her second marriage, she could not bear the thought of starting over again at 46. She had no interest in sexual activity whatsoever. After a hysterectomy 6 years ago, she had lost all sexual drive, and now she felt like a "neutered cat." She said her life was over. In her examination of personal values, the client talked about her Episcopalian parents, her early work in a parish church program, and her strong moral code which condemned suicide. Her theological beliefs were in conflict with her idea to suicide, but she really saw no hope for her future. For this client, it was necessary to talk about her values, her developmental stage in life, her notions of sexuality as related to femininity, and her physiology. Working with a female physician, this client chose estrogen replacement therapy. While she has yet to replace the picture of her husband from whom she is separated, she has taken the picture of herself as a neutered cat out of her head. And, she no longer considers suiciding.
Many case examples could be listed as testimonials to the concept of incorporating an explanation of the reorganization system and an exploration of the values filter in the reality therapy treatment plan with suicidal clients. My experience as a practicing therapist suggests that it is an efficient and enriching practice and one which clients appreciate.

SUMMARY

In addition to assessing lethality and implementing interventions as explained by Wubbolding, effective reality therapy in work with suicidal clients can be expanded to include an explanation of the reorganization system and an examination of the client’s values on the issue of suicide. These, combined with bibliotherapy in clients who find reading satisfying, and other techniques for assessing values and perceptions, enhance the therapeutic alliance and enrich the counseling process.

References


PROFESSIONAL ETHICS: INTERVENTION IN SUICIDING BEHAVIORS

Robert E. Wubbolding

The incidence of suicide has been repeatedly documented with statistics abounding as to failed and successful attempts. The increased publicity given to this widespread problem has helped the public change it’s perception of the type of person attempting suicide. Though formerly suicide was often thought to be a behavior of an insane person this perception has changed. Quinnett (1987) states that to consider suicide, "you don’t have to be crazy". Some have even asserted the right to die. Thus, Mary K. (1984) states that laws against "assisted suicide" should be changed. Persons with terminal illnesses should be allowed the option of suicide. Voluntary suicide in the case of terminal illness is not, however, a new idea. In the early part of the century, Alfred Nobel, who invented dynamite and who was the patron of the Nobel Awards, advocated that a system of homes be established in Paris to provide for a dignified assisted suicide. Thus, there would have been an alternative to throwing oneself into the Seine (Seiden, 1984).

Such "suicide institutes" have not been greeted with enthusiasm by the legal, medical, psychological, counseling, or social work professions. The codes of ethics of the helping professions uniformly and clearly state the obligation of the helper to intervene in any serious threat to self or others. No distinction is made as to whether the threat is a “rational” choice, or accompanied by depression, anger, or feelings of transcendence (Gernsbacher, 1984). For instance, the American Psychological Association has stated that though confidentiality is important, it does not bind “in those unusual circumstances in which not to do so (reveal information) would result in clear and imminent danger to the person or others”. Similarly, the National Board for Certified Counselors (1987) has reaffirmed the principle that “when a client’s condition indicates that there is a clear and imminent danger to the client or to others, the certified counselor must take reasonable personal action or inform responsible authorities”. In an almost identical statement, the National Academy of Certified Clinical Mental Health Counselors asserts personal information is communicated to others “in those circumstances where there is clear and imminent danger to the client, to others or to society”.

In a previous article on professional ethics, I outlined how to assess the lethality of the suicidal threat or the “clear and imminent danger to the client” (Wubbolding, 1987). The present article is a step-by-step narrative of one intervention conducted in a joint counseling practice. It also contains generalizable principles for the reader to consider.
It must be noted that an attempt has been made to write the case using language that is non-sexist. Thus, the names Jody, Lee, etc. can be male or female while the counselors are identified by initials.

7:30 A.M. Lee called the counseling center and described a friend, Jody, who was depressed. The friend had been sitting at home alone for several days having been laid off from a well paying factory job. Jody had been recently divorced, and a favorite pet of many years had been killed by an automobile. Besides sitting at home, Jody had been eating only sporadically and had slept very little in several days. Lee had asked Jody if suicide was possible. A commitment was made by Jody that no attempt had been or would be made. Lee then scheduled an appointment for Jody the same day with H., a counselor at the Center.

9:30 A.M. In the session with Counselor H., there was a detailed discussion of suicidal ideation which included asking appropriate questions. (Wubbolding, 1987).

1. "Are you thinking of killing yourself?"
   Jody stated that this thought was a preoccupation and that the situation would improve if I could only go to sleep permanently".

2. "Have you tried to kill yourself before?"
   No attempt had ever been made.

3. "Do you have a plan?"
   Jody thought pills would be effective.

4. "Do you have any pills at home?"
   Jody stated that there were "a few pills available but that taking them would not accomplish anything".

5. "Is there a person you can talk to?"
   "Yes, there is Lee who has been very patient with me" was Jody's reply.

6. "Will you make a unilateral contract i.e., a promise not to me but to yourself not to kill yourself accidentally or on purpose?"
    Jody answered, "Yes, I definitely won't kill myself for the next week".

There was further discussion about the Total Behaviors of sitting at home "doing nothing", what Jody, in fact, was doing while "doing nothing", and whether the recent behaviors were helping. Jody felt at first that the situation was serious and nearly futile but not completely hopeless. The counselor helped Jody decide that feeling better was an ultimate goal or want. An immediate want was defined as getting a job and to get active, eat properly, go to the shopping center and look briefly at pets.

Evaluations about the genuine futility of "sitting around and waiting for something to happen" were made by Jody. Both Counselor H. and Jody agreed that to wait for better feelings to occur automatically would lead to more misery. Thus, a plan was formulated to follow through on eating and to go to the shopping center to visit a pet store for a few minutes.

The latter plan was formulated cautiously in that Jody was not sure whether seeing other animals at this early stage of grief would be helpful. If Jody felt the slightest bit upset the plan would be changed to move away from the store quickly.

If Jody felt suicidal to the point of taking steps, a call would be made to Lee who had some training on a hot line and who was willing to help. With the permission of Jody, Counselor H. called Lee to discuss this possibility and what Lee would say to Jody on the phone. An appointment was made to return to see Counselor H. the next day.

Most of the session was spent handling the suicidal ideation and planning alternatives by using reality therapy procedures: defining more positive pictures, discussing Total Behaviors pertaining both to suicide and to alternatives, evaluation of choices, positive planning and firm commitment to plans. Jody was determined to change the direction of Total Behaviors. Counselor H. decided that because Jody had made an unilateral contract (Gernsbacher, 1984) not to kill herself for a one week, suicide was not an imminent choice.

11:00 A.M. Counselor H. discussed the case with another therapist who agreed that all necessary precautions had been taken especially in view of the fact that Counselor H. was scheduled to see Jody again the next day. Counselor H. immediately recorded in the case notes a summary of the therapy session, quoting both client and counselor as well as specific comments made in the consultation session.

3:15 P.M. Counselor M. on duty to take phone calls, received a phone call from Jody's friend, Lee, stating that Jody had taken an overdose of pills but the exact type was not known. Counselor M. began to discuss a course of action with Counselor P. Counselor H. having just completed another counseling session, joined the consultation almost immediately. The following decision was made:

1. Counselor H. would call the client immediately to obtain a tentative assessment of the seriousness of Jody's condition.

2. If Jody would not answer the police would be called.

3. If Jody answers, an attempt would be made to determine what drugs were taken.

4. Jody's physician would be called for information and to consult regarding the effect of the drug.

3:20 P.M. Counselor H. called Jody several times only to get a busy signal.

3:23 P.M. Counselor M., P., and H. decided that the verification operator should be called to ascertain whether the phone is "out of order", i.e., off the hook or whether there is a phone conversation on the line.

3:26 P.M. Verification operator related that there are voices on the line. Counselors H., M., and P. then decide that there was not need to ask the telephone company to interrupt the call.
3:30 P.M. Counselor H. attempted to call Dr. A., Jody’s physician, to consult about the effects of the drugs, only to get a busy signal.

3:35 P.M. Dr. A.’s answering service said that he is unavailable and that they would contact him by way of his beeper.

3:37 P.M. Counselor H. called the Drug & Poison Information Center to consult about the effects of the drugs. The Center states that the drugs which Jody ingested were not lethal and that it would be perfectly safe for the friend to transport Jody to the hospital to be checked.

4:05 P.M. Lee called the counseling center from Jody’s apartment. Because Counselor H. was in session with another client, Counselor M. spoke to Lee and provided assurance that it was safe to take Jody to the Emergency Ward without involving the police. Counselor M. also spoke briefly to Jody and elicited a commitment to keep the counseling appointment with Counselor H. the next day.

10:00 P.M. Counselor H. called Jody’s apartment. The phone was answered by Lee who said that she would stay at Jody’s house overnight and that Jody was now relaxed after being released from the hospital.

10:30 A.M. next day. Jody kept the appointment with Counselor H. and agreed to remain in counseling to work hard at changing Behavioral Direction.

The purpose of this article is not to discuss the wide range of applications of reality therapy to a client in crisis. Thus, follow-up sessions are not discussed. The aim is to illustrate one way a suicidal attempt can be handled and to draw important conclusions from the description of this intervention.

1. The value of a joint counseling practice far exceeds the value of solo practice. A sole practitioner does not have the opportunity for quick consultations and mutual support which is needed in crisis intervention. Agency counselors can readily access the kind of input that is needed, but private practitioners have less opportunity for joint discussion unless they are involved in a joint practice.

2. Consultation is useful and even necessary. It provides not only support but offers the opportunity for increasing the number of alternatives. “Two heads are better than one” is a truism that summarizes why various codes of ethics emphasize the importance of consultation. None of the counselors’ decisions in the case described here was made in isolation. The National Board for Certified Counselors states, “Consultation with other professionals must be used where possible”. Such consultation, furthermore, serves the purpose of insuring that a counselor’s primary responsibility is fulfilled. “The primary obligation of Certified Counselors is to respect the integrity and promote the welfare of a client”. (NBCC, 1987).

It furthermore insures that the intervention or “assumption of responsibility” is appropriate, ethical, and thorough. Finally, and not insignificantly, consultation serves to protect counselors by insuring that they have taken reasonable steps to protect the client.

3. Whether in sole practice or joint practice, the counselor should have a list of possible consultants to contact whenever serious crisis occurs. These should be contacted ahead of time so as to be willing to provide input and validation to the requesting counselor. The list of colleagues should be extensive as other professionals are often inaccessible because of case load and other duties.

4. Counselors in sole practice, joint practice, or agencies should have a policy which can be implemented in times of crisis. Thus, when there is a suicide threat within counseling, key questions are asked (Wubbolding, 1987), and when there is a situation such as the one described here, the counselors can implement and apply a set of flexible procedures.

5. Written records should be kept. Counselors should keep a written record of any suicide threat. Both the client’s words and the counselor’s comments should be summarized and even quoted. An appropriate notation is “... asked client to make contract not to kill self accidentally or on purpose”. Client replied, “I’ll promise for two weeks”. A summary of the consultation session should be kept with the date and time noted.

In summary, when the inevitable suicide attempt becomes known to a reality therapist, action or intervention is ethically required. Exploration of alternatives, definition of pictures, evaluation and plans are necessary. But more than this, direct questioning about the suicide threat is required so as to assess the degree of intervention required. Consultation implements the assessment and is seen as a way to protect both the client and the counselor, and is easily accomplished if other counselors are handy. Subsequent action taken by a counselor should follow a predetermined, agreed upon, and flexible policy.

Bibliography

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REALITY THERAPY SUPERVISION WITH A COUNSELOR FROM A DIFFERENT THEORETICAL ORIENTATION

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Supervision of counselors has always been considered to be a significant and vital part of the essential process of helping them to become skillful and efficient therapeutic agents in the helping process. It is generally understood and accepted that the object of the supervisory process is to facilitate not only counselors' professional skills, but also their personal growth and development, since an integration of these areas is crucial to the developing process referred to as counseling.

The history of the rather broad and loosely defined field of counselor supervision dates from the late 1920's and the beginnings of the acceptance of psychoanalysis (Burns, 1958). Since that time, many approaches to counseling and psychotherapy have emerged, thus calling into question the adherence to only one theoretical model/approach to supervision.

The supervisory relationship provides a unique opportunity for the application of the principles of reality therapy. These principles have been applied in counselor supervision since the development of the Institute for Reality Therapy in 1968 (Glasser, 1984*).

Schaughency's (1977) research has demonstrated the effectiveness of reality therapy in group supervision, and Appel (1985) has developed a model outlining the process of applying reality therapy in individual supervision. Although the principles have been shown to be effective when applied to the supervision of reality therapy oriented counselors, applying reality therapy supervision to situations where the counselor has adopted a different theoretical orientation, such as person-centered counseling, has not been addressed in the literature. The focus of the following script is to provide practical evidence of the effectiveness of the RT model in supervising a person-centered counselor.

In this script, the supervisor is a reality therapist applying the principles of Control Theory as outlined in Control Theory (Glasser, 1984*). The counselor-trainee is enrolled in a counseling practicum class and is striving to adopt the person-centered therapy of Carl Rogers. She is very motivated to change certain behavior patterns that interfere with her counseling process. The observations were conducted through a one-way mirror with audio capabilities. Through her written self-analysis, goal statements and the conducted observations, she seemed to manifest the following: (1) She described herself as an impatient person (without control); (2) She wants to apply the principles of the person-centered approach in her counseling process (pictures); (3) She wants to identify her major strengths and weaknesses (self-awareness); and (4) As demonstrated through the following sessions, she manifests a low self-confidence in which she doesn't trust her immediate replies to the client's needs.

In the following script, the counselor, designated by "C", has been given the name of "Linda" to maintain confidentiality. The supervisor, designated as "S", applied the principles of reality therapy supervision as adapted by Appel (1985) in each session, and across the supervisory process. The supervision occurred once a week for six weeks. During the five-hour counseling practicum each week, the counselor conducted three counseling sessions. The supervisory process was conducted for 15 minutes after each session with a total of 45 minutes each week. The content of these supervision sessions is summarized as narrative scripts in the following pages across the six-week period.

Getting Acquainted and Making Friends

To develop a trustful relationship with Linda, in which both supervisor and counselor can work together to meet their respective needs (wants), both participants have to recognize each other, talk openly, and communicate clearly along the supervision process as a vehicle toward a productive relationship (Glasser, 1984*). To do this, the supervisor introduced himself, stating his theoretical orientation and his basic assumption that Linda wants to become a professional counselor which will give her a sense of control and allow her to satisfy other psychological needs such as love, power, fun and freedom (Glasser, 1984*). The supervisor added that his goal could be summarized as to help Linda reach her goals personally and professionally. Then, he asked Linda to introduce herself.

C: My name is Linda, I am striving to become a person-centered therapist (want). I have been working with children for twelve years. I enjoy working with kids, I feel as though every one of them is mine. I also do counseling outside. I enjoy counseling. I am scared a little when I am watched through the one-way mirror. I really expect you to watch my skills and help me to locate my deficiencies (want). I will go home and develop personal goals and bring them next week.

S: Regarding the evaluation process, I trust you very much. Therefore, I will share with you the grading process through this form (the supervisor hands her the evaluation form adapted from Fuhrman, 1978). Each week you are to go home and listen to each of your audio-tapes and fill out this form for each session. By the end of the supervision, I will review your scores and give you your mid-term grade (the supervisor gives the counselor a sense of power and responsibility).

C: Wow, I can see some radical change in the grading system. This will help me to be myself and stop worrying about the grade. I am really looking forward to it (tears coming out of...
her eyes which may represent joy because she experienced some control.

S: I will be working with you from tonight until the mid-term. This means that we are going to work together for a six-week period. Therefore, it is your time and it is up to you in terms of how much you want to grow. (The supervisor assures Linda that he really cares about her.)

What do you really want, what are you doing, and how can you do it better?

This week Linda brought in her well-organized personal file in which she placed her operational goals (wants) and a basic draft of her personal counseling theory (perceptions). Her goals included her want to develop a deeper understanding of person-centered therapy as outlined by Rogers (want), to develop the basic attending skills (want), to conceptualize clients in Rogerian terms (want), and to have the supervisor serve as a consultant for her whenever necessary (feedback loop).

S: Linda, I need you to help me identify how we are going to achieve these goals, and how I can help you to do it better.

C: Please watch my sessions, and observe how I am doing in terms of these goals. Also, I want you to help me identify some other things that I am not aware of. I need to have an objective viewpoint.

S: That is why I am here.

(Linda started her session. The supervisor observed many behavioral patterns, such as she cuts the client off and takes over, finishes the client's work, is very anxious, and runs overtime.) The following communication occurred following the conclusion of her third counseling session for the evening.

S: What do you think about your session, Linda?
C: I think it was O.K.
S: What do you mean by O.K.? Be specific.
C: I did a lot of reflection, interpretation and rephrasing.
S: What do you mean by these terms?
C: I analyze and conceptualize what the client is experiencing and reflect it back to him so he can gain insight to what he is feeling, thinking and doing.
S: Is that Rogerian? Do you think Rogers analyzes and conceptualizes what the client is experiencing?
C: I don't really know.
S: I really would like you to find out what Rogers would say, and how he would do it. (The supervisor gave her references on person-centered theory and a case-book to read as assignments to report by the week after). She made plans and a commitment to study a person-centered therapy book over the weekend and a case study the following week.)

C: What else did you observe?
S: What time did you get out of the session?
C: I got out at 6:25 the first session, 7:30 the second session and 8:45 the third session.
S: What is your standard time?
C: 45-50 minutes.
S: That is not what you are doing.
C: That is right, I am contradicting myself (she made a value judgment).
S: What are you going to do about it?
C: I will bring a wall-clock and put it on the shelf in front of my face behind the client.
S: When are you going to do this? (making plan).
C: Next week.
S: Are you making a commitment to me?
C: Yes, I am. (She wrote a note in her file.)
S: What else?
C: I guess I was a little anxious.
S: What makes you feel anxious?
C: It is my second night doing counseling.
S: So what?
C: You are right. It doesn't really make any difference to be the first, second or hundredth if I become myself (perceptual change).
S: What are you going to do about it?
C: I guess I should stop worrying and just be more of myself.
S: When are you going to do that? (making plan).
C: Tonight, I am making a commitment to you. (Since then, she seems to have become more open and relaxed)

How can you do what you really want?

S: I studied your goals (wants) carefully which can be summed up as to become a person-centered counselor, and I developed fifteen hypothetical clinical situations you might face in your profession. You and I are going to role-play these situations — you will be the prospective client and I will be the counselor, then we will shift roles, and you will be the person-centered therapist and I will be that particular client. These roles are self-explanatory. All you need to do is
just read the written directions, so whenever you are available we can do the role-playing. (The supervisor is trying to expand her behavioral repertoire.)

After the sessions were over, we continued. (Linda brought this time, the stop-watch.)

S: How did it go?
C: I was much more relaxed. I can say that I became more of myself.
S: What did you do with last week’s assignment? (follow up).
C: (Linda had brought a report about her readings, she listened to the tapes and brought the evaluation forms.)
S: What did you learn from these forms?
C: I found out that I was doing their work. I talked more than the client (self-evaluation).
S: What are you going to do about it? (How will you do it better?)
C: I need to listen more to what they (clients) say and reflect it back to them. I do not need to interpret for them. I will let them reach their own conclusions (value judgment).
S: How would you do that?
C: I need to “shut-up” my mouth.
S: When are you going to do that? (making plan).
C: Starting next session.
S: How are you going to remember that?
C: I will write it down on my hand, “shut-up.” (Since then Linda changed her job from talker to listener except on certain occasions.)
S: What else did you learn? (reinforce positive movements).
C: I can now conceptualize the client’s problems more accurately in Rogerian terms.
S: Can you give me an example?
C: Yes, I can. (Linda explained all her clients’ behaviors in Rogerian terms. Her explanation reflected her understanding of person-centered therapy.)
S: But how would you deal with these behaviors from the Rogerian view?
C: Through trust, respect, listening, reflection, and confrontation in genuineness.
S: When are you going to apply these techniques?
C: Whenever they (clients) demonstrate that they need reinforcement.

S: (The supervisor praised Linda for her excellent job and pointed out her fast growth.)

Later, using the situations on the typed index cards, further training was conducted in which Linda dealt with situations such as suicidal clients, an abusive parent, abused children, violent clients, sexually attractive clients, AIDS clients, homosexuals, and others. In the role playing, Linda demonstrated appropriate application of person-centered therapy and achieved a great amount of self-awareness.

Uncontrolled behaviors

Linda went to her session very relaxed and confident. Her client was an abusive parent. Linda became frustrated and anxious because the presented picture was not what she perceived as her ‘wants.’

S: What was going on?
C: I don’t know . . . he is a weird client. I guess I could not hear him . . . I was so involved within myself.
S: Last week we role-played the same situation. What was surprising, Linda?
C: I guess because this is an actual client.
S: What difference does it make?
C: I guess it is my problem . . . I need to work on . . .
S: Time out . . . Let us stop for a few minutes . . . Relax and take a deep breath . . . again . . . and again . . . O.K. Think about it for a while and conceptualize what was going on with this client and tell me how he feels . . .
C: I think because he is an abusive father he experiences the feelings of guilt that resulted from the rejection of his family, kids, and even himself. He is angry with the family and even with himself. This anger blocks the man from perceiving himself as a worthy person . . . he mistrusts himself and the world around.
S: In your reaction to what he was saying, are you helping him?
C: I guess he experienced some rejection one way or another even when I withdrew into myself (value judgment).
S: What does this tell you about your counseling session with him, more specifically, about the outcome he got?
C: The session was reinforcement to what he thinks about this world . . . except one difference in which I listened to him in a time when no one else would listen to him.
S: What you are saying is that he got something out of the session, but it was not perfect; he got someone to talk to but no experience of trust of therapy.
C: Exactly.
S: How can we provide him with better service where he can feel that he got his money's worth? (How you can do it better.)
C: I need to trust, care, and respect the man and communicate that to him.
S: How would you do that?
C: Accept him the way he is . . . through avoiding my value judgments.

The use of paradoxical injunction in metaphor language: How can you do it better?
Linda did not trust what she was doing, nor did she trust her supervisors. She kept running from one supervisor to another and lastly to professors. Linda received the same feedback as she herself had mentioned . . . this indicated to the supervisor that she was not getting the picture of what she really wants to do with this client; because of the frequency of this frustration she became less confident of what she is doing. Therefore, the supervisor ‘wants’ to restore self-confidence in Linda. To achieve this, the supervisor designed a paradoxical injunction package as explained by Soper and L’Abate (1977). In this package, Linda is placed in a double-bind situation in which she has no where to go except to give up the symptoms (doing) or to maintain it by choice and awareness (new perception). Also, the injunction is started in metaphor language as demonstrated by Milton Erickson (1985), in which the supervisor attempts to make the situation sensible and obvious for the counselor to perceive so she can make a choice. To do this the whole situation is put into a story that fits the counselor’s case.

C: By the way, you were right . . . I called the instructor and consulted with him, and I called Dr. X, my psychologist, and he also told me the same as you did.
S: What do you think of the whole situation?
C: I think that I was doing what I am supposed to do.
S: Then, why did you make all these consultations?
C: I like to make sure that what I am doing is right.
S: What does that tell you about yourself?
C: What do you mean?
S: I am going to tell you a story. Once upon a time, there was a fox out in the field. The fox liked the way in which the pheasant walked. Within himself, the fox decided to learn the ‘pheasant walk.’ He started practicing back and forth, and after a few hours he became hungry and psychologically drained. He decided to look for a bird to hunt so he could have a nice dinner. Unfortunately, the fox had forgotten his original way of walking, and he could not achieve the “pheasant walk”. Now what would you conclude about the fox?
C: The fox was dissatisfied with his walk, himself, and his skills.
S: Can you relate to this story?
C: What you are saying is that I should trust my first response?
S: Exactly . . . I am sorry if you perceive it as if you have to make sure. In our profession we call it low self-confidence.
C: I was not aware of it
S: What are you going to do about it?
C: I will try to stop that.
S: I am sensing that you are not sure because you did not say that you will do, but you said you will try.
C: I really like to make sure.
S: O.K. That is fine with me. I have an assignment for you since we have not carried any assignment for almost three sessions. You have a choice of whether to do it or not. It is an optional one.
C: What is it?
S: During this coming week, see if you can talk to supervisors regarding one of your cases and ask them if you can try on their shoes. Keep running from one supervisor to another until you see all of them. Your second option is to be satisfied with your own shoes and rely on them.
C: I can hear what you are saying . . . It is clear . . . I will never be more than myself . . . . . . . I will never consult with someone whenever I really know the answer, but I would like to keep consulting whenever I could not give a professional answer.
S: Whenever you do not know what to do, that is a different story. But I am talking about when you have got something to offer.
C: Well, I will choose to rely on myself. I will stop running for second, third opinions when I really know the answer.
S: When are you going to stop?
C: From this moment.
S: Good luck.

Termination and follow-up
The last week of the formal supervision is an evaluation point. Linda has completed her file. She was asked if we met the goals stated by her in the beginning of the supervision. She stated that she got more than what she
expected. She developed and grew a lot. She knew her weaknesses and was working effectively. Her major strength is the motivation to work hard in order to grow. She has been working with children for twelve years. Therefore, she chose to explore child therapy so she signed up for a course of play therapy.

Summary

In summary, reality therapy supervision proved to be practically successful in helping a counselor to adopt a different theoretical orientation such as person-centered therapy as demonstrated in this narrative. Although this in only one situation, there seems to be no reason why this same approach would not work in other similar circumstances.

References


P.A. AND RUNNING: A REPORT ON A REPLICATION STUDY

Hiram T. Perkins

For centuries human beings have been concerned with the interrelatedness of mind and body. The ancient Greeks believed that in order to achieve ideal health there must be a balanced state of well-being between mind, body, and spirit. In accordance with the quest of spirit through the body, Spino (1976) focused on running as a means of self-understanding, and as a form of meditation. Several other researchers (e.g., Albin, 1978; Cooper, 1968; Leonard, 1975) reported on positive psychological effects of running. Their conclusions all point to a trance-like mental state that runners seem to obtain.

Glasser (1976) published his initial work in the area of running and this associated state of mind. He created a label for the transcendental, trance-like state called positive addiction (PA). Glasser explained that when we experience a PA state of mind, we gain strength as individuals. “Our brains ‘grow’ in this spinning, free, mentally relaxed state (p. 67).” The key to the process of gaining mental strength through running is self-acceptance to the point where individuals leave their thinking processes alone long enough to experience the PA state.

Glasser (1981) expanded his thoughts about PA and running. He explained that self-accepting, meditative runners relax their minds and gain access to creative thinking behavior that we are otherwise unable to tap into.

Purpose of the Study

The replication study was specifically designed to look at the thinking behavior of college students engaged in running behavior. The researcher hypothesized that those who are positively addicted to running reach the associated meditative and creative state of mind, called the PA state. This article is a highlight of that published work.

The study was important because running is publicized in popular running literature as a way to alleviate anxiety, lift depression, enhance self-esteem, gain self-confidence, and achieve self-actualization. Because of the evidence concerning the psychological benefit of running, some therapists use running as a psychotherapeutic modality or as an adjunct to treatment (Brown, Ramirez, & Taub, 1978; Greist, Eichens, Klein, & Faris, 1979). Since there are claims made about possible general benefits of running but no research on the relationship between running and PA, the researcher felt it important to gather reliable and descriptive data on PA runners.

What “pictures” do today’s relaxed runners have in their heads? For example, when faced with a stressful situation which causes average people to give up, those who are strong reach for new, different, and complex
options and manage to take care of themselves in strange situations. This is significant as a sign of creative in-control time.

**METHODOLOGY**

A college population was targeted. A survey format (similar to the one used by Glasser in 1974) was used to gather descriptive data on a sample of runners who represented a wide range of experience and abilities. The revised instrument had an alpha of .87 for internal consistency. This coefficient alpha is significant because it means that the instrument questions were consistently measuring the hypotheses questions. It added credibility to the study and strength to the concept of control theory in general. The specific areas of investigation discussed in this article are: (with control theory terminology in parentheses)

1. Do people enjoy their running? (being in good control = choosing fun, freedom)
2. Are there any negative effects if running is missed? (the picture = the total picture in the comparing station)
3. Do runners tend to achieve the positive addiction (PA) state of mind while running? (creative incontrol = pure pleasure)

If running could be shown to have an effect on depression and anxiety as has been suggested (Brown, et al., 1978; Glasser, 1976; Greist, et al., 1979), running programs could become a useful modality of therapy or adjunct to therapy. In control theory terms this would allow clients to take effective control of their lives.

In reality therapy terminology, clients who perceive themselves initially as weak and inept (private attitude) may, after participating successfully in jogging (public behavior), resolve the resulting “gap” by relabeling themselves as strong and competent (Glasser, 1981).

**PROCEDURE**

The study was a descriptive one and used a survey format. Seven components in the questionnaire dealing with the runner’s attitude and state of mind while running were generated from behaviors identified by Glasser (1976). Affirmative responses reflected a PA attitude and were believed to characterize runners who were positively addicted. Conversely, “no” responses reflected a negative attitude and were believed to characterize runners that were not positively addicted to running.

Sample

The sample consisted of 100 runners that volunteered to participate drawn from the University of South Florida, a medium sized university located in the Southeast comprised of four campus locations. In an effort to obtain responses from the USF student body, the researcher placed an advertisement in the student newspaper, the *Oracle*. This publication is distributed without cost and has appeal to the general student body. This procedure was considered parallel to the procedure Glasser used by placing his advertisement in *Runner’s World*.

Instrumentation

The questionnaire used included 26 items that were written to correspond directly to one of eight research questions. The questions related to time and duration of running, thoughts while and after the running behavior, and whether or not the respondents could be considered PA runners. For example, if individuals only ran for two or three minutes once every six weeks or so, they would not be considered regular and consistent runners and not appropriate for the study. Each item was answered on a NCR form to facilitate entry into the computer system for statistical manipulation on magnetic tape.

**RESULTS**

One hundred runners completed the questionnaire. The questionnaires were statistically analyzed by computer. Of this number, (63%) were from male respondents and (37%) were from females. The respondents ranged in age from 18 to 55, with a modal age of 25 for 14% of the respondents.

Geographical locations by campus were as follows: Tampa, 66%; St. Petersburg, 26%; Fort Myers 2%; and Sarasota, 6%.

Forty-nine of the respondents listed student as their occupation, while the next two categories consisted of professional/technical/managerial and service by 42 respondents or 42% of the total. The average runner had been jogging 5 days a week for 5-6 years and ran between 45 and 59 minutes at a time.

Of the 99 subjects who felt they could describe their state of mind while running, 100% described the PA state. The most common response on that item was “euphoria”. The next most-often listed category was that of “feeling like floating” category.

**DISCUSSION**

The demographic data obtained during the study were consistent with findings from other similar studies (Carmack & Martens, 1979; Glasser, 1976; Runners World, 1980; Sachs & Pargman, 1979). Most runners surveyed were in their twenties. In the past, the majority of runners have been male, but the findings of this study show that the number of female runners is on the increase.

Sixty-six percent of the sample usually run alone, which was consistent with the hypothesis that running is a solitary sport. Most of those surveyed stated they used the time spent running to think through problems, meditate, and organize their thoughts. A number of runners stated that in their daily run they enjoyed taking the time for themselves. Of those surveyed, an overwhelming majority (78%) reported they always enjoyed their day’s run. The remaining 22% answered in the affirmative, with no one selecting the negative categories. People who ran regularly were involved with giving noncritical attention to their pleasurable activity. This is consistent with Glasser’s belief that craving for pleasure and creativity is the basis for obtaining the PA state.
Ninety-eight percent of the subjects stated they experienced discomfort if their planned running had been missed. The types of uncomfortable effects most experienced included irritability, depression, bad mood, guilt, sluggishness, and feelings of anxiety. Interestingly, these effects coincided with the symptoms of withdrawal cited to be components of the addiction to the running process (Morgan, 1979; Sachs & Pargman, 1979).

The large percent of subjects who experienced depression, bad mood, irritability, guilt, and anxiety (giving up behaviors) when they missed a run suggests that running could be a valid treatment modality (exercising in-control behavior) for those symptomologies. This corresponds exactly with the results other researchers in the field have been reporting for some time (Brown, et al, 1978; Greist, et al, 1979).

Whatever the outcome of further research, it seems clear that running in a relaxed, meditative manner does help and is an inexpensive and easily accessible activity when compared to other forms of organized physical/ sports activity. It also allows individuals to exercise control over what they do, and is an important control-theory concept that is well worth knowing for those that are looking for ways to add strength to their lives.

References

**WHY REALITY THERAPY WORKS**

Thomas S. Parish

Reality therapy is an educational/psychotherapeutic approach that fosters personal responsibility within individuals. In accordance with this notion, Parish (1987a) has stated that while we may not be responsible for what happens to us, we are responsible for the way we deal with what happens to us. That Glasser (1980) advocates the use of intrinsic control is also evidenced by his comment that "People don't learn what they don't want to learn, but teaching becomes effective as soon as people who hurt discover that they can learn a better way" (p. 52).

Reality therapy can be contrasted to various behavioral approaches which use extrinsic rewards (e.g., candy, praise from others, token economies) in order to modify and/or control people's behaviors. As pointed out by Lepper (1983), while the use of extrinsic rewards has been increasing in our schools, such rewards are antithetical to the development of intrinsic motivation. Glasser (1986) has noted that the use of extrinsic rewards is unlikely to motivate many students, but that reality therapy would be more universally applicable as a source of motivation since it relies on intrinsic and not extrinsic control. This is so both in the classroom as well as in the psychotherapeutic setting. For instance, Brehm and Smith (1986) pointed out "that therapies will be effective and therapeutic progress maintained to the extent that clients attribute their improvement to internal, personal factors and minimize attributions to external factors such as drugs or the therapist" (p. 97). Since reality therapy seeks to foster intrinsic control and personal responsibility, it certainly seems to be in accordance with Festinger's (1957) theory of cognitive dissonance which suggests that once a judgment is made and a personal commitment is declared, that internal pressure to follow through and fulfill that commitment is almost a certainty (Parish, 1987b).

Another major advantage of reality therapy over the various behavioral approaches is that it avoids the creation of psychological reactance, or the moving away from a position one is being externally pressured to take (see Brehm & Brehm, 1981). More specifically, reality therapy does not seek to intrude on others and make them do anything they don't want to do. The behavioral approaches, however, frequently focus on what the teacher, parent or therapist wants, and this desire is often conveyed to the student, child, or client, whether or not they want it. As a result, the person being externally intruded upon may subsequently experience psychological reactance and, instead of adopting the teacher's, parent's or therapist's desired position or engaging in some compliance behavior, may simply move away from that position he/she is being externally pressured to take. Interestingly, this reverse action has been found to occur more often if the pressure is applied to individuals who feel
they are highly competent and able to make their own good judgments (Epstein & Baron, 1969).

Thus, reality therapy procedures can effectively lead to change in either a counseling and/or educational environment since they are able to create a great deal of cognitive dissonance through the therapist, teacher, and/or parent asking questions and allowing individuals to make judgments and give commitments. Furthermore, reality therapy is able to avoid psychological reactance principally through establishing friendships and not punishing those who fail to fulfill their commitments. Once we have made friends, asked relevant questions, and gotten judgments and commitments, we as therapists, teachers and/or parents should simply need to “step aside.” After all, our goal should be to help others discover what they need to do in order to get what they say they want, and we can accomplish this best by utilizing cognitive dissonance and avoiding psychological reactance. That is, in essence, why reality therapy works.

References

CHOICE
A NEW DRUG EDUCATION PROGRAM
developed by
Dr. William Glasser

Why use CHOICE to prevent drug abuse?

People use drugs in an attempt to gain the feeling that life is good or getting better; that their needs are being satisfied — especially the need for power. While the desired feeling can be achieved chemically, there is no actual improvement in the user’s life; just a drug-induced illusion. The problems and pain will return as the body metabolizes the chemical, but drug users know how to feel good again — just do more drugs. It’s this desire to feel better that prompts their continuing choice for drugs and leads toward addiction.

Students who are trying to “say no” while others around them are saying yes, will find that CHOICE is a sound program that teaches them the knowledge and skills they need to create a successful and responsible lifestyle. As they put control theory to work in their lives, they will be better able to gain the real feelings of success that result from growth and achievement. They won’t need artificial “highs” because the good feelings will come naturally. When they “say no” they will mean no — and make it stick.

The CHOICE program

CHOICE is a total program of education. Teachers, students and parents work cooperatively to prevent drug abuse in the young adolescent age group. Based on control theory, CHOICE is the result of Dr. Glasser’s belief that “if students are to benefit from education, it must be a fulfilling experience.” Therefore, he designed CHOICE to provide students with:

1) positive and supportive relationships that make them feel important;
2) successful learning experiences that add meaningful knowledge and skills to their lives;
3) opportunities for enjoyment through purposeful interaction and achievement;
4) and the chance to make some thoughtfully planned decisions that will enrich their lives through responsible behavior.

CHOICE has been designed to teach control theory as a life-strengthening program — a natural and effective alternative to drug use. Viewing, thinking, listening and speaking activities are used to develop the content and skills that are learned by the students. Reading and writing skills are used to guide interactions and report the outcomes of learning team work sessions. Thus, a rich mixture of teaching processes are used to meet the wide range of learning styles that exist in every classroom. In the
three-phase teacher training program, the \textit{CHOICE} instructor/mentor will conduct discussion and strategy sessions to help teachers use the various methodologies effectively.

The text for \textit{CHOICE} is unique. It is a viewing, listening and thinking experience. Control theory is presented to students in a 45-minute videotape entitled "Sam's Brain." Sam is a contemporary teenager. By the ripe old age of 14½, he seems to have all the answers. As the control theory story opens, Sam is surprised by a friendly voice from somewhere nearby. He quickly identifies the source as his own brain when it appears beside him and engages him in a conversation. In short order, Sam's brain interests him in learning how it does its work — helping him to live his life. What Sam learns from his brain is control theory and in this way, the viewing students receive their first lesson — complete with edifying graphics and a few chuckles mixed in for good measure.

In their next lesson, the class is formed into carefully planned learning teams composed of three students. Directed by their teachers and a Student Learning Team Guidebook, the teams then undertake a course of study that will give them ownership and use of control theory. By meeting twice each week, the teams will complete the program of eighteen lessons in one semester.

Toward the end of the semester, students will also plan as teams to implement Part I of the Student-Parent Guide. The goal of this section is to produce a comfortable and effective discussion environment with parents at home. Part II, where students share their knowledge of control theory with their parent(s), will be conducted as second semester activity — a follow-up to the classroom study phase. Again, student teams will meet and discuss strategies and plans for using the Student-Parent Guide effectively. The goal of Part II is to create a family knowledge-base to support the student's use of control theory at home.

Studied and used both at school and at home, control theory will produce common concepts, practices and vocabulary that teachers and parents can use to help students create success in their lives and to learn to solve the problems that are part of growing up in today's world.

\textit{CHOICE} is a solid package of knowledge, skill and partnerships that combine to produce the strength students need to make their own good life and thereby avoid the false satisfactions and dangerous results of drug abuse.

\textbf{FOR SCHEDULING AND PROGRAM INFORMATION:}

Call \textit{CHOICE} Program Coordinator
\begin{center}
1-800:421-3743
\end{center}

In California call collect
\begin{center}
1-213:432-1448
\end{center}

Or write: \textit{CHOICE},
\begin{center}
Educator Training Center
117 East Eighth Street, Suite 810
Long Beach, California 90813
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