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: $8.00 for one year or $15.00 for two years. Foreign $10.00/$18.00 (U.S. currency) Single copies, $4.00 per issue. $5.00 per issue (foreign). Send payment order to the editor. Back issues Vol. 1-8, $3.00 per issue; Vol. 9- $4.00 per copy.

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

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1990 International Convention
Cincinnati, Ohio
July 4-7, 1990

Journal of Reality Therapy

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Editor's Comment

This second issue of Volume 9 follows the pattern set in the last issue, i.e. it is organized in sections. The first section deals with theoretical constructs of RT/CT. This section is built around two important feature articles. The first, by PALMATIER, compares RT and Brief Strategic Interactional Therapy. The second, by DENNIS, provides a thoughtful approach to the application of theoretical concepts to practice.

The second section continues to reflect the diverse practice of RT/CT. The article by CHANCE and his associates, coupled with the articles by BROADUS and BLAKEY, present the first Journal articles dealing with a prison population. The article by LAFONTAINE is also a first, dealing with a special needs population. The MALONEY article ties CT with crisis intervention. The HONEYMAN article follows the material in the last issue dealing with addiction. The FRIED article deals with a higher education setting. The CONNER article continues his application of RT/CT to pastoral counseling. The SULLO article ties in with the CHOICE model by dealing with cooperative learning groups.

The final section includes two unique contributions. The first, by WUBBOLDING, continues his professional issues series. The second, by COCKRUM, provides a highly creative wrap-up to the issue.

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REALITY THERAPY AND BRIEF STRATEGIC INTERACTIONAL THERAPY

Larry L. Palmatier

The author is Professor of Counseling Psychology at the University of San Francisco and was in the first reality therapy certified group in 1974-75. He has also served as a faculty member for IRT certification weeks.

Traditional psychology is based on a theory of repression and is labeled intrapsychic. The major hunt in that approach is for a past cause, and the primary purposes are to impact the personality structure by creating intellectual insight and smash through the barriers of repression through emotional catharses. (These ideas represent the writer's views. A reader seeking additional information may consult Corsini & Wedding (1989) for a discussion of the various theories referred to in this section.

With the advantages of historical perspective, there is little question that the early psychological theories and treatment methods fell short in many ways, were often oppressive and coercive and generated decades of tension in the mental health field. The fallout was not all bad though since these ideas spawned almost a century of more reasonable alternatives as one analyst after another opted for freedom, practicality, and a healthier view of sex. Aside from several variations on intrapsychic thinking, such as Jung's pathway to the stars and Rogers' self theory, the two new theories of change that have evolved as qualitatively different from Freud's notions have been behavioral and cognitive-behavioral and family or systems therapy.

Jung stayed cocooned in the psyche, but created a mini-religion of psychological onion layers of symbolism and new meanings. He countered Freud's negative determinism with challenges of choice for the individual struggling with his personal journey through life. It is likely that he would be confused if he were to visit the planet today and hear therapists referring to themselves as "Jungian" since the chief contribution of Jung's work was an affirmation of the uniqueness of each self. Strictly speaking, only Jung could be Jungian.

Adler infused his intrapsychic ideas with a surprising dose of practical creativity and common sense, defining insight, for example, as understanding turned into action and prescribing interaction with others as a pathway out of depression and posing power as an intrinsic need or drive. He is commonly credited as the forerunner of family therapy due to the high value he placed on social interest and his establishment of community-based family education centers.

Rogers reacted sharply to the nihilism of Freud and, as the son of a Methodist minister, developed three main principles and organized ten communication devices for affirming the value of all persons struggling with the existential battle of discovering and defining the self. Many therapists use his non-critical acceptance of everyone as a general framework for
Behavioral therapy was a reaction to the priority given to mentalism by the original psychoanalysts and as a disavowal of interminable intellectual massaging of the psyche. Classical conditioning was counterbalanced later by Skinner's operant conditioning: controlling consequences controls behavior. As an intellectual purist, Skinner externalized the psyche to such an extent that the only phenomena worth observing were specific behaviors described in their relevant context. Shaping, increasing, or extinguishing behavior through the control of consequences, contingencies and rewards has remained the chief topic of interest to the radical behaviorist.

Many believe that Skinner went too far in his attempt to distance himself from Freud's single-minded attention on the unconscious, arguing that he deleted that which makes human beings autonomous — their ability to make reasonable decisions and responsible choices. He discarded any reference to the individual's internal map or representation of reality and did not picture an individual behaving proactively, but only responding to outside forces and stimuli.

In Control Theory people are viewed differently — they do not live "at the effect" of a potpourri of stimuli. Explaining a passive process which assumes that we are not in the driver's seat of our lives requires a series of double takes as we tell our story from inside a hall of mirrors. Based on principles of Control Theory, a person's apparent response to outside forces can be explained only by putting the person back in the driver's seat. Instead of "responding" to a "consequent" (a smile, an M & M, a weekend pass from the home), one actively chooses a behavior because his experience tells him that this action is "need-satisfying" — that is, he thereby fulfills a want he had just pictured as unmet. If I value affiliation and picture myself wanting in that area, I will actively choose to interact with smiling people. And if I take an M & M, I could be searching for candy or it may be that I am actually controlling more for belonging than for chocolate as I choose to associate with a friendly dispenser of treats.

Imagine an explanation of behavior that is the inverse of choosing to associate with smiling people as a means of meeting internal needs for love and belonging. The opposite view of this interaction is that an external stimulus (a smile), elicits a behavior such as cooperating in school, from an empty-headed person devoid of needs and purposes. This makes little sense and tells only part of the human story. There's no one in the world who has not experienced knowing his/her own mind. No one could even call something a "reward" unless a positive value was assigned to it. Both operant conditioning and control theory require some elaboration in describing behavior and change. Why not present a story that reflects the experience of the average person? We are not tabulae rasae going about seeking whom to imprint us with reinforcement. We know what we want and when we don't have it, and we engage in need-satisfying behaviors that help us get the picture.

Probably it was necessary to move completely out of the head and the unconscious before psychiatrists and psychologists could return with a new arsenal of views and technologies. Of all the approaches today which acknowledge the value of both behavior and internal motivation or goals, two are featured in this paper —

Reality therapy, a cognitive-behavioral therapy emphasizing personal responsibility for choice (Glasser, 1980; Wubbolding, 1988) and Brief Strategic Therapy (Fisch, Weakland, Segal, 1982), an interactional or family systems therapy.

Family or systems therapy was developed about forty years ago (Bateson & Ruesch, 1951; Jackson, 1968), and emphasizes the interaction among people as the context of all behaviors labeled as problems. Brief Strategic Therapy, one of the most pragmatic of these interactional therapies, is a problem-solving therapy rooted in the pioneering work of Milton Erickson who developed these techniques during the late forties and fifties. Erickson applied his original brand of therapy over a forty year career and has been widely hailed as a very practical psychiatrist who accomplished a lot by tapping the creativity in his own behavioral system (Haley, 1973).

Erickson's work was later organized in more teachable form and his seminal thinking has been extended in some very practical forms (de Shazer, 1985, 1988; Haley, 1963, 1976, 1985; O' hanlon, 1987; O'Hanlon & Weiner-Davis, 1989; Watzlawick, Weakland, & Fisch, 1974). Probably the most systematic and straightforward adaptation of Erickson's ideas, though, is Brief Strategic Therapy, organized at the Brief Therapy Clinic of the Menial Research Institute in Palo Alto, California.

Neither reality therapy (Glasser, 1965), nor Brief Strategic Therapy take time searching for causes of behavior. Therapists applying reality therapy help the client examine the effect or outcome of behavior since it is the behavior which represents someone's best attempt to get what he wants and needs. (Glasser, 1985; Powers, 1973). A Brief Strategic therapist looks at what persons are doing to solve their stated problem and assumes that the attempted solution behaviors have not worked and must be changed. Strictly speaking, therapists applying BST do not look at the function of the symptom.

There are key points of concurrence in the therapeutic processes of both Reality Therapy and Brief Strategic Therapy and this paper will list some of those similarities and emphasize three major linkages:

(1) The role of pictures in a client's labeling a story a problem and the use of those same pictures by the counselor in redefining the problem so it is solvable.

(2) The value of prefacing a suggestion for change with a rationale which is a tailored match of the individual's own frame of reference or private logic.

(3) The view that the lever or levers for change are alternative behaviors, especially the action part of any total behavior.

There are three parts to the presentation: a general comparison of Brief Strategic Therapy and Reality Therapy/Control Theory; vignette samples...
of the three main points of connection between these two problem-solving models; and two cases depicting the linkage between a client’s subjective logic and the specific action steps a therapist may suggest as keys to change. The behavioral change, in turn, will produce a new picture for the person and, of course, solve the problem.

The writer's own development as a therapist has been influenced primarily by the ideas contained in reality therapy and control theory (Glasser, 1989). In those interactional and family areas where Glasser himself has explained that his work may be limited, it is the writer’s view that Strategic Family Therapy, sometimes called Directive Therapy (Haley, 1976; Madanes, 1981, 1984), and, more specifically, Brief Strategic Therapy have best complemented the principles of reality therapy and produced the most efficient and substantive changes.

REALITY THERAPY (RT) AND BRIEF STRATEGIC THERAPY (BST)

The following ten observations show some of the common elements of Reality Therapy and Brief Strategic Therapy. Next are examples of the three major points of this article — inner pictures of a problem, inner pictures as a rationale for change, and behavior as a lever for change. The paper concludes with two cases that demonstrates the points of connection in actual practice.

Some common considerations in both problem-solving models are:

- No one can force another to do anything.
- It is important to accept a person as is and to avoid criticism.
- Many feelings are transitory; they should not be reified or identified as the problem itself and treated directly. Focusing on the feeling component of a total behavior best fits a theory of repression, not a negative feedback, closed loop circular model.
- Only current behavior should be targeted for attention and change.
- The past cannot be changed and is most often used as an excuse.
- Everyone views the world through subjective glasses and watches the road through a windshield of private logic.
- The counseling process includes the actor’s own evaluation of the effectiveness of the behaviors chosen as solutions to problems or as steps toward the achievement of one’s goals.
- In the area of one’s vulnerability, one often develops a psychological blind spot. (Although counselors also experience this phenomenon, they generally do not mind it too much since they find their clients’ blindness to be good for their business and therefore, need satisfying for themselves).
- People behave from the inside out. They are proactive and not responders to external events, and they will not do anything unless their inner picture can accommodate a rationale for the behavior, especially so if that behavior is viewed as a change.
- Therapy can be done without throwing a hodgepodge of psychological jargon at the person who wants to change.

As we examine the elements of each therapeutic process, we should remain aware that, although these steps are presented in list form, neither method is a step-by-step process for producing a recipe from a psychological cookbook. Both methods require flexibility, spontaneity, and often risk-taking on the part of the practitioner-counselor. Please note that it is not the intention of the author to merge these two therapies so that the two somehow become one. Each has been independently developed and has attracted many therapists who have acknowledged the unique integrity of each model. And, naturally, each may have distinct applications at times.

REALITY THERAPY

1. Make friends and assess wants — i.e., check out the main picture the person is controlling for.
2. Focus on the current behaviors chosen by the person to match external reality with the internal picture.
3. Have the individual evaluate the effectiveness of the chosen behavior(s) in matching the internal picture.
4. Plan a new behavior by which the individual is more likely to realize the internal picture and thereby meet an inherent need. This may be initiated by the person, suggested by the therapist, or jointly developed.
5. Get a commitment from the client to complete the plan.

BRIEF STRATEGIC THERAPY

1. Work hard with the client to define the problem in very specific behavioral terms.
2. Find out all of the attempted solutions the person has already tried.
3. Have the person evaluate the effectiveness of these past behaviors.
4. Ask the client (often called a “customer” in BST), to describe the smallest change that would show improvement.
5. Assess the person's frame of reference, private logic or “position”. That is, try to determine the internal reference picture.

CAVEATS FOR THERAPISTS

6. No excuses.
7. No punishment and no blocking natural or logical consequences.
8. Never give up.
REFRAMING INNER PICTURES SO THE PROBLEMS ARE SOLVABLE

All of us call on our own private logic in the normal course of everyday life. It is the only logic we have. The more irresponsible the behavior, the more private or idiosyncratic the logic. For example, “If he can’t keep it (the car) locked up better than that, he deserves to have it stolen...” (by someone like me) (Glasser, 1976).

The more responsible and need-satisfying the person’s life, the more rational and “public” the private logic becomes, i.e., the more the individual’s private pictures conform to those shared by prudent people in society. A person in need of counseling is in theory buying the services of a supportive person of sound logic and prudent objectivity who can help that individual focus the camera more appropriately in order to get a clearer picture.

Personalized “lenses” on the outside world come with personalized filters by which an individual establishes a peculiar frame of reference. These valuing lenses go with the territory. When people are experiencing problems, the way they “logic” privately (to employ a Control Theory verb to convey the active aspect of the process), may guide the therapist in suggesting changes in pictures about the problem.

The defiant adolescent mentioned above feels that no rules apply to him if he can slip by undetected. If getting caught makes someone a bad criminal, he is a good example, but, in any case, he qualifies as a loose cannon who has somehow missed becoming fundamentally socialized. Any suggestions given to this mini-criminal about changing direction and acting differently would have to take into account his own valuing system.

A boy of 10 was referred to the school counselor by his mother because he apparently lacked control over stealing money from his mother. He reported these thefts with great shame, hanging his head and avoiding eye contact with the counselor. He also shamefully stated that his parents were not living together and when the counselor asked him the ages of his parents, the boy did not know. Finally, in the course of the chat the boy confessed to the counselor that he stole as a way of buying friendship from peers who pressure him for money.

The counselor was tempted to accept this explanation as valid since it was plausible and there was no question about the boy’s loneliness and the social pressure to give his peers money. The counselor decided instead to restate the problem so that she could help the boy view the context differently and could get a new handle on the problem by accessing new behavioral levers. She told him that his problem was more simple than peer pressure and social isolation at school. He lacked information about his family and that deficit led to his limited confidence. He was a stranger in his own home and needed to find out the ages of his parents. Once he became more of an expert about his family, his alienation at home would end and he could walk taller with new confidence. Mastering information about his parents would allow him to claim a familiarity at home that he had not known and in the process he would connect himself to important others there. When he is “at home” at home, his need for belonging is met at the core and he will be driven by less pain and will gradually lose interest in buying friends.

In order to complete the shift in the context of this problem, the boy and his mother were urged to take control of the money game. For a three or four week period, the mother was to hide a quarter here and there in a designated area in the house and the boy was to find it, “pretending” to steal it. Since the mother was in on the arrangement, there could no longer be pressure and shame.

A counselor may reframe pictures or relabel statements in at least two ways, one referring to meaning and the other to context (Bandler & Grinder 1982). In reframeing the meaning of a statement, the therapist does so directly: e.g., a highly anxious woman can be asked what she does with all that “energy”. Another forthright example of reframing the meaning is Glasser’s comment to a harried air traffic controller (Glasser, 1988), whose intense driving style prevented him from putting the brakes on his over-involvement with his job: “You could see yourself as a competent professional who does less” allows the man to see a way out of his quandary.

Additional examples of changes in the meaning may be:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Reframe</th>
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<tbody>
<tr>
<td>Withdrawing</td>
<td>Becoming meditative</td>
</tr>
<tr>
<td>Depressing</td>
<td>Sometimes that’s the only way</td>
</tr>
<tr>
<td>Procrastinating</td>
<td>Being overly sensitive to time, especially to the future.</td>
</tr>
<tr>
<td>Overly busy</td>
<td>Making up for lost time</td>
</tr>
</tbody>
</table>

A reframe puts a negative behavior in a positive light and provides a springboard for the client to take further steps toward improvement. In the psychological domain as in the physical sphere, the more one resists a problem, the more it persists and when one discontinues fighting a problem, one is free to overcome it. Picturing it differently often removes the tension and struggle.

Changing the context or setting of a problem behavior so that it can be viewed as useful and not a problem is another kind of reframe. An unresponsive, feisty teenage scrapper could be told that he would be a welcome companion if the therapist had to walk down a certain street that night. Who would not want such a bodyguard in a dangerous setting? And how can the adolescent take that expression of interest as a personal criticism of his own rebellious and self-focused behavior?

In a contextual reframe, the therapist shows how under other circumstances, a problem may be viewed as an asset instead of a liability. The “shy” person may be naturally inclined to display healthy “self-protection” when facing someone with bad intentions.
A woman who compulsively dragged out the vacuum cleaner (Bandler & Grinder, 1982), whenever she spotted a footprint on the carpet, was told by her counselor that many footprints meant that many family members had come together and spent some important and loving time there. The sterile loneliness of the uncleaned carpet could be replaced by the lively interaction of loved ones who leave their mark of care and involvement with their family. In this case, the woman breathed a sigh of relief as she assessed the meaning of flawless appearances and she recorded her new picture with a tear.

The wife of the politician in the middle of a campaign for an important public office was encouraged to use her and her husband's advantage her impulsive decision to have her hair cut and colored orange (Glasser, 1988). Glasser suggested that when she tells her husband what she had done, she should allow him to display his shock first and then should emphasize that this was her best attempt to be dramatic and playful in making some key points with him. That is, she wanted desperately to share with him her belief that he can take himself less seriously, separate himself from his political packaging, and enjoy his own wild and crazy woman. To use the bizarre behavior as a tactic for reorienting her husband and reentering his inner world is certainly more useful than tipping the scales in his head toward losing not only the race but possibly his good name as well.

Reframing an inner picture helps people relax about the matter they view as problematic and gives them some face-saving control over their own personal destiny. It is useful to suggest a reframe early in the session, as the client is presenting a problem, and again when the therapist is about to finalize the plan for a new behavior or to “issue a directive” (in the parlance of BST). For example, a young woman whose prostitution was managed out of an anonymous business office via credit card payments reported in her first counseling session that she had just been rejected by her boyfriend of two years. To make some sense out of her initial choice of symptom, the therapist framed the behaviors of depressing and prostituting as expressions of mourning. This rang a bell for her, and later she was able to view her options without a major focus on shame and self-criticism.

**MATCHING PICTURES FOR NEW BEHAVIORAL PLANS**

Before delivering an idea for a new alternative behavior, the therapist should present a client with an inner-picture rationale that will make the medicine easier to swallow. “Why don’t you do this? This may sound foolish to you, but why don’t you pretend to be good? Go through the motions, Con the living daylights out of us . . . and if I’m an example, you can do it” (Glasser, 1976). Here the counselor gives both a rationale and a directive to the defiant kid. Since the boy has just demonstrated thirty solid minutes of resistance and defiance, why not let him use that style of behaving to his advantage?

**WHY GRAB-BAG THERAPY IS TEMPTING BUT MAY NOT WORK**

There are two places for the counselor to focus energy and imagination — inside on the pictures in the person’s head and outside on the behaviors. Up to this point we have been looking inward, and now we turn outside and look at new behaviors that we select in an effort to control the pictures in our head.

There is a silent ongoing pressure in the mental health field to “name that therapy in one note”. All of a therapist’s efforts are aimed at creating change for the person. There are two places for the counselor to focus energy and imagination — inside on the pictures in the person’s head and on the outside, on their behavior. Control theory states that behavior controls perception and, if one follows this principle literally and exclusively, one need only list all of the unsuccessful behaviors the person has already attempted to reach a solution, acquire a want, or meet a need. These unworkable behaviors are then ruled out, and the therapist then “fills the bag” with any other behaviors, asking the person to draw one at a time and act on it. This process would automatically create new perceptions and would simultaneously move the person out of a recursive behavior loop. The pattern of selecting actions that have already failed would be broken and new perceptions would arise. This is known as “getting the picture.”

Unfortunately, it is very difficult to ask someone to take a step in a new direction without supplying a reason for doing so that matches the person’s own subjective picture. We humans have a way of behaving very irrationally at times, but we can often describe this same behavior quite rationally. We do things psychologically, but picture it all logically; and that logic is private. If problems were only matters of logic, Ann Landers and other columnists would be very successful in solving problems simply by giving advice. The value of such advice columns, however, is typically not for the person who wrote the letter, but more for a reader who does not have the problem and can thus see objectively what the problem and solution are for someone else. The bottom line, then, is to give clients a rationale in accord with their inner picture as a prelude to their taking a different behavioral step. A random grab-bag can do this only by chance. It helps to have a live therapist holding the grab-bag because when we choose misery, we usually need someone around who can give us a little credit for our suffering. The therapist also provides good old fashioned moral support and can be there to watch and see that the person actually does what the grab-bag item states.

A woman was desperately worried that her husband, a recent stroke victim is not following doctor’s orders that he exercise more; she believed that he would soon have another stroke and die. (Fisch, Weakland, and Segal, 1982). She prodded, cajoled, and nagged him, but to no avail. In fact, the more she pushed, the less he did.

The therapist asked her if she would agree that her husband was a proud man, and the wife nodded vigorously. To “pride” was added the word “stubborn” and once again the wife agreed. The wife was trying, almost at all costs, to get her husband to obey the doctor’s orders, and she seemed to have no limits to her willingness to sacrifice herself on her husband’s behalf. She believed the husband’s obstinacy was emotionally based. He called it a physical problem, and claimed that he could not exercise more because his legs would not cooperate.
The therapist suggested to the woman that she may have to “sacrifice even more” on her husband’s behalf. This suggested frame fit her own inner picture of herself and her feelings about her husband. It would not work to say, “Back off, lady, stop nagging!” This is not part of what was need-satisfying about her own picture of herself and her husband. Next, she was told that because of his stubbornness, she may have to challenge herself in a new direction, but that she would probably be able to do this because she cared so much for him and wanted to see him regain his health.

The husband’s pattern had been to get up late and saunter to the breakfast table for a ready-made meal, while his wife was urging him to hurry. The therapist suggested that instead of prodding him, the wife watch what happened if she absent-mindedly overlooked preparing his breakfast for him one day. To this oversight, she began adding words of caution that he probably should not do too much walking today because he might not be able to manage all of that.

In a very short time, of course, the wife’s new behavior — all done for reasons she could live with — began having an impact on her cantankerous spouse. He started coming out earlier for breakfast and walking around the block spontaneously. When his wife said not to go around twice, he told her to mind her own business, that he knew what he could manage. He doubled his regular distance and began finding some new alignments in his own head as he exercised new options. The conflict between his competing intentions were resolved as he discovered that he no longer needed to avoid walking as a way of proving to those around him that he was his own man.

A woman came alone to counseling and reported feeling like an emotional wreck. Her story included complaints about her husband’s unpredictability and his refusal to make a solid commitment to her. She also was anxiousing over her husband’s mother’s critical attitude toward her. The man refused to accompany his wife to counseling sessions and spent an excessive amount of time at his mother’s house. The client reported that her mother-in-law had removed their wedding picture from a wall in her living room and replaced it with a picture of her husband’s two children by a previous marriage.

After a discussion of exactly what she wanted, the steps she had already taken in search of a solution to her dilemma, and an evaluation of the relative effectiveness of all of those actions, the therapist reframed the story in the following terms:

It is a good sign that your mother-in-law has stopped featuring your wedding picture, and beyond that to get some interests going that would shift her own focus away from her husband and his mother. The best defense is a good behavioral offense.

Other steps followed later, but those were the key reframes and alternative behaviors suggested in the therapy. When the woman returned two weeks later, she reported feeling emotionally stronger, more confident and self-directed, and more in control.

Another case involves a couple still in the process of building a family after four years. When Peter and Teresa married, Peter brought Mark, his son by his first marriage. Together, Peter and Teresa, previously unmarried, have a son, Eric, who is now three, Teresa is pregnant with a second child. Mark is now ten and husband and wife are 35 and 32.

The main problems reported in their story is the wife’s view that her mother-in-law has stopped featuring her wedding picture, and beyond that to get some interests going that would shift her own focus away from her husband and his mother. The best defense is a good behavioral offense.

The next thing you can do is very difficult and may not be possible, but this is the challenge. You say to your husband, “I have been putting some expectations on you that I can’t really ask of you. I see clearly now that you have chosen to set a ceiling for what a relationship can be as your mother’s level of success in relationships and that for me to ask you to aim higher than that is asking the impossible.” The client confirmed the premise here when she reported that the mother-in-law had been married to an alcoholic and later had judged her marriage a complete failure.

Finally, the counselor suggested that the wife stop taking her psychological pulse every few minutes and refrain from constantly asking her husband about their relationship and their marriage. In place of these disruptive choices of behavior, she was reminded to celebrate their marriage by showing off the wedding picture, and beyond that to get some interests going that would shift her own focus away from her husband and his mother. The best defense is a good behavioral offense.

It is safe to say that everyone has a personal view of the problem. New wife Teresa has the idea that her husband’s mother is “just not a baby person” because she has “obviously” favored Mark, her husband’s first son, more than their son, Eric, when he was a baby. For the past three years, since her own son was born, she has been picturing the mother-in-law as a critic and a spoiler, favoring her husband’s son by his first marriage.

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Instead of viewing the husband's behavior "anti-wife," the therapist suggested it might be an attempt to protect his wife from having to parent his older son and from having to try to make up for all the son's past trauma and conflicts. The therapist added that, unfortunately, these efforts to protect his spouse from handling her own responsibilities may have backfired: his actions could be construed as siding with his son against his wife. Finally, the counselor suggested that it often takes about five years to "blend" a family and noted that this comment brought several sighs of relief from the couple.

The two reframes here were that the husband was trying to protect his new wife from the duties of redeeming his son's past, and that the mother-in-law was respecting the new wife's parenting skills by keeping out of the way. These set the tone for the counseling and established a new context in which it became safer to talk about differences in the context of both parties' good will. Everyone wins, and no one need spend another ounce of energy saving face or proving oneself worthy. As Glasser has so simply stated it, "You never build anyone up by tearing 'em down." In the terminology of the Milan systemic family therapy group, this is known as "positive connotation" (Boscolo, Cecchin, Hoffman, Penn, 1987).

The above two reframes, and possibly some others, helped to create a logical basis for some new personal directions and new behavior. The wife reported that she had never known her own life to be smooth before or after her marriage to Peter. Peter suggested that he had been caught in the middle, and in the course of the discussion it became clear that he felt safer in the eye of the storm.

Since Teresa had thought that her husband was accustomed to taking the side of his natural son, the counselor suggested that the husband's natural style was to be caught in the middle, and that whenever he found himself fighting this natural position, he ran into difficulty. This suggestion was the rationale, a reason that resonated with the man's own private picture. The directive can follow such a rationale, and the implementation of this new action is designed to produce a new perception.

For homework, the family was encouraged to use the dinner-time conversation as a way of changing their pattern of talking with one another. They were directed to help the husband by keeping him in his favorite place, the middle. Whenever anyone wanted to speak, the messages to anyone in the family had to go past the father. This move gave the family some control and brought out in the open exactly what was taking place within the family; it took the uncertainty out of the relationships between members. The husband could no longer remain distant and define the problem as something between his wife and his son. Also, Teresa and Mark could experience their problem in a more accurate social context, for Peter was now an important player in the game.

A second part of the plan was to have the wife become fully informed of the husband's schedule for visiting his former family. He could no longer simply slip out and leave his wife at home struggling with his son while he was free to go about doing good deeds for others, pretending to have nothing directly to do with the battle at home. His wife was going to participate directly in scheduling his time and actually make serious efforts to keep him in the middle. In this way, she also gained some direct control because she discontinued playing the role of passive observer of her husband's whimsical behavior. Since he had earlier agreed that he was most comfortable when stuck in the middle, he went along with this assignment.

All of these plans were behavioral changes that were based on reasons matching the persons' own inner pictures about the meaning and logic of their behavior. A more direct rational approach about the ideas themselves, such as Albert Ellis (Ellis, 1962, 1973; Maulsby, 1975), might employ, was not used because the counselor employed Control Theory in this case. The behavior change was designed to produce different pictures more easily and spontaneously than by bluntly hammering away at someone's logic or illogic in an effort to change ideas directly. It is clear that RET therapists vary in their style and sensitivity in applying Ellis' Rational Therapy, a more accurate name for his counseling. Rational-Emotive Therapy is a misleading title since all of the talk in the therapy about emotions is dispassionately logical and the only person allowed to emote is the therapist as he disputes vigorously all of the client's crooked thinking. Thus Rational Therapy is a more accurate descriptor for the approach. Cognition in Reality Therapy is used to evaluate the consequences or effectiveness of behaviors employed in going after a particular want. It is not an intellectualizing game played for its own sake. Using a person's own rationale and pictures as a way of influencing behaviors is much less coercive and more productive than pedagogical argumentation.

In a second session, Peter reported in precise detail exactly what Teresa expected of Mark — how he must fold the towels, clean himself, wash his own clothes, and, generally, toe the line. Strict as this regimen sounded, it was never fully implemented because of the husband's competing intentions in regard to his son and to his wife. He was choosing some self-cancelling behaviors. On the one hand, he wanted to support his wife; on the other, he did not believe that his wife's strict rules about washing, drying, and folding were fair for a ten-year-old. He felt that these rules needed to be adapted to the reality of this boy's life. What does the therapist say in this case?

Since the husband was resolving his inner competing intentions by choosing ineffective, compromising behaviors, the new plan suggested was to arrange a way that he could stop living vicariously as a ten-year-old by siding with his son against his wife's restrictive demands. In order to help Peter see that he was choosing those behaviors himself, he was asked to take on young Mark's view as a boy of ten and to spend a few minutes each day observing his son and deciding just how reasonable Teresa's expectations were. Spending some time focusing on his son and noticing details of Mark's bind would automatically create some new pictures for Peter. And it would have to offer more benefit than engaging in indirect guerilla warfare with his wife. For her part, Teresa, whose pattern was to resist her husband's criticism and to blame the boy for everything, was directed to encourage her husband to take on Mark's view of the world and to make sure he was spending the time with his son. Thus her usual watchdog role
was legitimized in a direction that proved helpful and gave everyone more control.

After a few days, when the husband had fully understood his son's position, he was to judge what was reasonable and what was unreasonable about the demands. He was then to make a case to his wife, after which they could talk together and arrive at a mutual conclusion about fairness.

In sum, the husband was invited to act his own way out of the conflict he had not yet resolved by redirecting his behavior from that of a vicarious ten-year-old boy who could behave with impunity to a responsible and caring father who spent time getting to know his son and assessing his responsibilities. Further, he could display caring and involvement as a husband who talked over parenting questions with his wife instead of circumventing her and criticizing her manner of handling his son.

FOCUSING OUR OWN CAMERAS THROUGH BEHAVIORS THAT WORK

Reality therapy is refreshing in its directness and its disinterest in gimmickry. But the limitations of this approach, when facing complex and heated interactive behavioral patterns within families may sometimes call for some different strategies and tactics. One of those methods, which is consistent with many of the basic premises of Control Theory and Reality Therapy is Brief Strategic Therapy.

The first part of this article contained a summary of two approaches to therapy — Reality and Brief Strategic — along with the linkages between these two models of counseling. The second part contained examples of (a) reframing inner pictures so that the client could perceive the problem at a different level and view it as solvable, (b) giving the client a suitable rationale, and (c) directing new actions by which clients could refocus their lives. Finally, case examples were given to show how reframing can be woven into the counseling process and showing that a session often ends with a reframe as a rationale aligned with the person's internal picture or logic and making the directive for new behavior plausible and attractive.

References
LIVING A BALANCED LIFE
Brent G. Dennis

The words in the title of this article: “Living A Balanced Life,” were selected for their specific meanings. A bit of clarification of terms will help to frame the discussion to follow.

Living denotes an active process. It refers to the choices we make on a minute by minute, hour by hour, day by day basis as we journey through our time on the planet. A means the life of the individual in his or her specific circumstance. The point here is that there is no “ideal” or “perfect” life. Each life is unique to the person in his or her situation. Balanced refers to the choices we make in each of the five life equities, and each in relationship to the others. Our need for balance changes with our stages of life and with our circumstances. What is a balanced life for one person, may be chaos for another. Balance, then, is the ability or capacity to remain dynamically stable in the midst of change and growth. Life is quantitative, in that it refers to our time on the planet, and to the time “afterlife” for those with such a spiritual orientation. Life is qualitative in the sense that our choices, and subsequent balance, determine our displeasure or enjoyment, our sorrow or joy, and our emptiness or our fulfillment. “Life ultimately means taking the responsibility to find the right answers to its problems and to fulfill the tasks which it constantly sets for each individual” (Frankl, 1963, p. 122).

As each term in “Living a Balanced Life” has specific meaning, so also does the term “equity” as used in this discussion. In business and financial terms, equity means: “The value of a property beyond the encumbrances on it: a home owner, for example, has equity in property to the extent of the value of the property less the amount of the outstanding mortgage” (Cook, 1985, p. 88). Similarly, when we speak of the five life equities, “equity” refers to the store of assets or to the reserve of strength to handle the stresses of daily living. Equity, or the lack of equity, results from our life-style choices by which we make negative or positive entries in the respective columns of our Life Equity Ledger Sheets. The task, then, is to strive for a positive balance in each of these five major areas of our lives. In other words, the agenda is “a balanced life” one that works and makes sense across the Spiritual, Intellectual, Psychological, Physical, and Financial equities.

Confucius (551-479 B.C.) made a statement many centuries ago that relates to this discussion. He said, “The proper man understands equity, the small man profits.” In other words, the person leading a balanced life understands the values and benefits of maintaining proportion and of having a list of positive entries on the assets side of the ledger sheet for each of the five life equities. The person choosing to lead an unbalanced life is focused on short-term gain, self-gratification, hedonism, and immediate profits, with entries on the liabilities side of the ledger sheet for each of the five equities.

In presenting the concepts of the balanced life to clients, two tools are helpful. The first tool is the “Post Card, Living A Balanced Life” (Figure 1). The second tool is “Life Equity Ledger Sheet” (Figure 2). During the presentation of the concepts and the working through of the issues and homework assignments, clients are given copies of both sheets.
Post Card
Living A Balanced Life

The “Post Card, Living A Balanced Life” form is used to present the “big picture,” or overview of the concepts. It is also a helpful review tool, and a means to visualize the “balance” in the clients’ equities.

**Figure 1**
Post Card/Living A Balanced Life.

<table>
<thead>
<tr>
<th>CHOICES</th>
<th>LIVING A BALANCED LIFE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spiritual Equity</td>
<td>Intellectual Equity</td>
</tr>
<tr>
<td>What Do I Need?</td>
<td></td>
</tr>
<tr>
<td>What Am I Choosing To Do?</td>
<td></td>
</tr>
<tr>
<td>To What I'm Belonging?</td>
<td></td>
</tr>
<tr>
<td>What Is My Goal?</td>
<td></td>
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</tbody>
</table>

Looking at the Post Card, we see the five equities across the horizontal bar at the top of the page. In the left side vertical column, we see four of the basic questions used in the practice of reality therapy. In the upper left hand corner box is the word “Choices” and a two directional arrow. It seems to flow most smoothly to present the ideas on the Post Card in the order just given, though by no means is this a necessity. We begin with definitions of the five equities and with a “Power Phrase” for each.

**Spiritual Equity**

In the context of the balanced life model, spiritual equity refers to what we believe about why things happen. More than that, it refers to what we believe about why things happen in the larger scheme of things. There seems to be an intrinsic need in human beings to explain their relationships in terms of something outside of and spiritually larger than themselves. The author has developed the idea of “faith” as a basic human need more fully elsewhere (Dennis, 1989). Conversely, Glasser (1989) has argued that faith is not a need, but a behavior. For those of us who do not accept faith as a basic need, that's an OK choice. For those of us who are convinced that faith is, as Paul Tillich put it, “the ultimate concern,” (1957, p. 105) it is the author's hope that these ideas, and others similar to them, would be viable complements to our practice of reality therapy. Certainly, the reader will have to make an independent decision in this regard; however a distinction between “belief” and “faith” may inform this discussion.

The terms belief and faith are often used interchangeably, but in the context of this discussion, they are not the same. By definition, belief has to do with what we are able to directly experience. On the basis of our personal experiences with a generally predictable world, we are able to “believe” in the likely occurrence and recurrence of many events. This is, in fact, how we learn as infants. Erik Erikson has stated that, based on a trustworthy environment, the emerging strength of “hope” in the infant is a cornerstone of faith in the adult (1968, p. 287). Clearly, we engage in “believing behaviors” as we develop our faith.

But, faith is more than belief and more than believing behaviors. As defined by the writer of Hebrews 11:1, “... faith is being sure of what we hope for and certain of what we do not see.” This moves us out of the realm of direct experience and into the domain of the future and of things not seen. Humans, of all the animals on the planet, are conscious. That is, we alone can think of the past, present, and future simultaneously. More than that, we can visualize and narratize ourselves and others in numerous scenarios past, present, and future. We alone can ponder ourselves in relationship to the universe, in relationship to the Creator.

There is a consistency here! All human cultures, for which we have any recorded record, have created systems of religion that sought to explain their relationship with that which is outside of their immediate perception and awareness, and that which is spiritually larger than themselves. All human societies have gone beyond what they could immediately apprehend by direct experience and “belief,” and have sought communion with that which was not and is not accessible to one's immediate perception by behavioral interaction with the environment. This consistent striving of humans to seek a relationship and knowledge of the Creator, who is not directly known or seen, is our built-in “need for faith.” This is a unique and consistent characteristic of we humans. A recent Newsweek poll reported that, “... 94 percent of Americans believe that God exists and 77 percent believe in a heaven” (Woodward, 1989, p. 52). This is consistent with statistics reported by Bellah, Madsen, Sullivan, Swidler, & Tipton. (1985) who found that about 95 percent of Americans, from 1950 to the present, when asked whether they, “believe in God or a universal spirit, said “Yes,” and that four out of ten attend church regularly (p. 63, 324). In this regard, Francis Schaeffer (1972) has raised the question as to whether we would quest so consistently for something that is not there? This author thinks not.

We reality therapy types are in the “choice business.” Human choice implies volition and will for which we need more than just awareness. If not for choice, volition, and will, would we even bother with the basic needs of Belonging, Power, Fun, and Freedom? But, we do bother with these, some-
times to our hurt, and other times to our help. We “believe,” on the basis of our experience, that we can figure out how to meet these learned needs. However, does it not take “faith” to lend coherence, perspective, and encompassing meaning as to why, what, and how we choose to meet our other basic needs? Harold Kushner (1986) has written, “Take God out of the picture, let events force a person to admit that the fundamental assumptions of his life are false, and the whole world seems meaningless” (p. 119).

This, then, is what spiritual equity means in the balanced life model. From where do we derive ultimate meaning and purpose in our lives? In what do we choose to place our faith: money, sex, power, ourselves, the Creator? The point is, it is a universal characteristic of human beings to need to have an overall explanatory system. We do, one way or another, put our faith in something. Obviously, some systems work more positively than others. We have a need for faith. It’s our individual decision as to where to vest our faith and what type of spiritual equity to develop. The choice is always ours. But, the need to make that choice is present in each of us.

Power Phrase: It makes a difference what you believe. For example, consider the atheist, the agnostic, the deist, or the person who believes that one’s life is a daily walk with the Creator. Each has a different world view, a different sense of cause and effect, a different sense of meaning and purpose in one’s life. Depending on how we choose to meet our need for faith, it makes a difference in what we believe about why things happen, which in turn, determines how we make choices and decisions on a daily basis.

A few words about the ordering of the five life equities on the Post Card are relevant here. Several years ago, when these ideas were in their embryonic stages spiritual equity was in the far right hand column. It became increasingly clear, however, that the other life equities could not be fully explored unless they were examined against the backdrop of the ultimate systems concept-spiritual equity. It is this author’s experience that meaning and purpose, and choices in the other life equities are best understood in an over-arching framework of spiritual equity.

**Intellectual Equity**

Our intellectual equity is our stock of information and knowledge. It refers to how many words, concepts, facts, and ideas we have in our minds. One of the things that we know about people is that the more information and knowledge we have stored in our memories, the better we are at problem-solving by seeing alternatives, options, and consequences. With many of our clients, particularly those in the criminal justice system, we see many persons who have very limited stores of information and knowledge. We’re not talking about IQ scores or intelligence, but about how much they have taken the energy to learn. When it comes time to make decisions, it’s tough to figure out what to do if we don’t have a solid store of information and knowledge in our memories.

Power Phrase: You are what you know. We know from control theory, that we can’t think about something that we don’t know. To know about anything, we must first have the referent information and ideas in our brains. What we choose to learn determines how we then think about and perceive our worlds. The mind, in many ways, works like a map maker. From what we choose to put into our brains, our mind constructs the map or the blueprint of the world as we’ve chosen to perceive it. Clearly, it’s important what we choose to put into our brains. We know that what we pay attention to becomes important to us. And, that what becomes important to us drives our behavior. It can’t happen any other way!

The message here is that we help ourselves by being very selective about what we put into our brains. We need to be selective not only about information and ideas, but also about any mind-altering substances we choose to put into our brains. If we ingest substances that alter how the brain perceives and processes information, then we necessarily affect our choices of total behaviors. Partly for this reason, there are many persons in the reality therapy network that eschew any artificially mind-altering substances, including tobacco, alcohol, and caffeine.

The skills, abilities, and talents we develop are due in large measure to how much we choose to learn and apply throughout our lives. The building of a reserve of intellectual equity is a life-long process. We know that we need not fear overloading the system. Even the most efficient and effective intellectual equity builders among us utilize, at most, 10 percent of our intellectual potential. To continue to develop intellectual equity requires that we discipline ourselves to maintain an open mind so that we may continue to learn and mature into persons with large reserves of information and knowledge. Then, through our values, our intellectual equity, and our living, we may develop a bit of what Denis Waitley (1983) calls, “Wisdom . . . the combination of honesty and knowledge applied through experience” (p. 97).

**Psychological Equity**

Psychological equity refers to a delicate balance to be struck between knowing, understanding, and liking ourselves and knowing, understanding, and liking other people. We know that we can never totally understand ourselves, much less someone else, but within these limits, we do the best we can using the methodology of reality therapy and control theory.

Our multi-media culture encourages us, on all fronts, to be egocentric, narcissistic, and self-indulgent. If we are not careful, we are all vulnerable to getting more wrapped up in ourselves than we are concerned about other people. It is a reliable clinical indicator that the more a person cares about one’s self, and the less a person care about others, the more dysfunctional and unhappy the person is.

Power Phrase: Happiness is found in relationships with other people. This is a difficult equity to master because it requires ongoing attention to both sides of the equation: Scripture enjoins us to, “Love thy neighbor as thyself” (Ex. 19:18). In a related manner, Shakespeare wrote in Hamlet,
"This above all: to thine own self be true... Thou canst not then be false to any man." Part of what is required in the development of positive psychological equity is that we strive to become a person we like. Think of it this way: of all the people on the planet, with whom do you spend the most time? Yourself! If we don’t like the one person we must, of necessity, spend all of our lives with, then it’s tough to get along well with other people. On the other hand, when we can reach that level in our personal maturity when we can look at ourselves and conclude: ‘I’ve got some weaknesses and some strengths; some warts and some attractive features; some things about me I’d like to change, some things I’m kind of neutral about, and some things about me I really like; but in all, I’m OK with me,’ then we’ve developed a reserve of psychological equity.

Psychological equity is liking oneself, and keeping an eye on oneself to maintain positive personal growth, but not allowing oneself to get preoccupied with and wrapped up in oneself. At this juncture, one can then devote the bulk of one’s time, energy, and talents to others. On the other hand, it’s not conducive to building psychological equity to totally neglect oneself in one-sided self-martyrdom at the behest of others. It’s an admittedly difficult task, but there is a balance of interests in self and others to be struck.

Physical Equity

Our physical equity is reflected in our own bodies, our own physical plants, and how we choose to take care of them. Cardiologists are saying more frequently, that barring genetic disorders, injury, or disease, if persons have serious heart trouble before age 60-70, they probably brought it on themselves. This makes sense because we know that the two main killers of adults, heart disease and cancer, are more often than not brought on by the life-style choices of the patient.

As we think about the development of physical equity by caring for our physical systems, it is important that we recognize our animal nature. Like other animals on the planet we have needs for food, shelter, procreation, and exercise. In our neat and tidy, perfumed and deodorized culture, it’s easy for us to deny our basic animal nature and neglect the care of our bodies. The point is that our bodies, like our minds, function according to the “use it or lose it” principle. If we take good care of our bodies by making physically positive life-style choices, most of us can be healthy throughout most of our lives.

Power Phrase: You can grow older at a slower rate. As we move through our life spans from birth through old age, we all experience the normal and natural decrements of aging. Most of these decrements, in a physically healthy person, are minor and are compensated for easily. We’re talking about heading off the big stuff, like heart attacks at age 40. It seems to be a realistic goal that, if we make the correct life-style choices, we can be physically younger than our chronological age! Several examples come to mind: Ronald Reagan, George Burns, Pablo Casals, Mother Theresa, and Vladimir Horowitz, to name a few.

With the average life span now well into the 70s, most of us are confronted with life-style choices in regard to our physical well-being. If we are likely to live seven decades or more, how good do we want to feel while we’re doing it? The truth is, that if we live long enough, we’re all going to get old. No way around this. This raises the question of the “ideal life span.” Consider the ideal life span this way. A person lives to be 70-80 years old, but throughout life makes positive life-style choices in the areas of: diet, smoking, alcohol, other drugs, exercise, and stress management. The person experiences the normal and predictable decrements of aging, but they pose no major problems. All in all, the person is pretty healthy throughout life until the last 12-24 months when the system normally and naturally wears out, runs down, and proceeds toward a state of entropy and death.

Contrast the above realistic scenario with the all too common situation of the person who makes negative life-style choices in the same areas of diet, smoking, alcohol, other drugs, exercise, and stress management. This person may be actively dying, or bringing on an accelerated entropy process for 15, 30, even 40 years, and existing in a very compromised physical condition before he or she actually dies at age 70-80. The obvious point here is that the difference between being physically ill and physically healthy has to do, for the most part, with our personal life-style choices.

Financial Equity

Financial equity has nothing to do with how much or how little money we have. It has to do with our values about money. In our culture, particularly for men, and increasingly for women as their career paths more closely parallel those of men, we are identified and valued by our jobs and how much money we make. It’s easy to think that we are: what we wear, what we drive, where we live, or how our investment portfolio performs.

There is no argument against money here. Beyond providing for the basic necessities of life, money is actually a neutral commodity. The value that money has for us is the value that we attach to it. We are reminded of the biblical warning that, “money is the root of all evil.” But what the apostle Paul actually said was, “The love of money is the root of all evil” (1 Ti. 6:10). It is our attachment to money - our mistaken idea that money will make us happy - that is the risk, not money itself.

Power Phrase: It’s important to separate your financial worth from your self worth. The author’s friends in Southern California tell him that the criteria remains, “When you die, the one with the most toys wins.” Actually, as we know, that’s a common criteria for lots of folks in our culture. An issue here is, “When is enough, enough?” If we decide to earn more money, the process may never stop unless we think through ahead of time, how much money do we want to make? With each increase in income, we tend to raise our reference level, again and again. It also helps to think through ahead of time, what we want to do with our money? Do we want to make $10,000, $50,000, $1,000,000, and for what purpose?
Some people actually decide they want less money. They may not want the pressures of wealth, or may realize, that for them, money is an ego or status trap. Other people may decide they want a six or seven figure income so they can buy more stuff, more “toys” than their neighbor. Others may want a high income so they may use it for altruistic and philanthropic purposes. The point is, it’s OK to honestly and ethically get as much or as little money as you decide to want - just don’t let your money get you.

In reviewing the five life equities with clients, it’s important to share with them the bad news, and the good news. The bad news is: there is no quick fix. Quick fixes (with the exception of the generally discouraged option of suicide) are by definition short fixes. The issues discussed here are life-long, life-style choices. They require commitment and hard work over the long haul. The good news is: the balanced life model offers a holistic perspective that helps clients make positive life-style choices. Using the balanced life model, we also teach clients to make positive plans across the five life equities that will help them with the hard work involved in making and sticking with positive life-style choices to achieve and maintain a balanced life. The rewards are worth the hard work.

**The Four Questions**

The four questions in the left vertical column are central to the practice of reality therapy. If the client is familiar with the concepts of reality therapy, the questions are acknowledged as such. However, if the client is not familiar with the concepts of reality therapy, the questions are presented as problem-solving format, and/or as a means to think through any decision making process.

The author routinely incorporates the Post Card as part of the standard psychosocial assessment format. It’s instructive for the client, if the therapist and client select at least two of the less salient, or less problematic issues from the assessment and work through one or two life equities using the four questions. At this point it is preferable to select issues which the client has dealt with successfully. This tactic makes for a more positive learning experience for the client and helps to set the pattern of building on the client’s strengths for subsequent interventions.

**Choices**

Following a review of the five life equities, and the four questions, the client’s attention is directed to the box in the upper left hand corner which contains the word “CHOICES” and a two-directional arrow. If the therapist thinks it relevant to the client, it can be noted that the horizontal arrow pointing to the five life equities represents “content,” and that the vertical arrow represents “process.” The important point is that choice is the crucial variable in both directions. It is emphasized here that, “Choice is your most important tool.”

In this regard, one is reminded of Victor Frankl’s experiences in Auschwitz and other Nazi prisons. In those most dehumanized and brutal of environments, Frankl concluded that, “... everything can be taken from a man but one thing: the last of the human freedoms - to choose one’s attitude in any given set of circumstances, to choose one’s own way” (1963, p 104). The goal is two-fold: to help clients recognize negative choices and to “Say No” to them and, perhaps more importantly, to help clients recognize positive life equity choices and to “Say Yes” to them.

**LIFE EQUITY LEDGER SHEET**

As the Post Card is initially used to present the ideas and concepts of reality therapy and the balanced life model, the Ledger Sheet is the medium for the more applied and focused work of therapy. The Ledger Sheet is used during therapy sessions, and also as the basis for homework assignments. Noting the box in the upper left hand corner of the sheet, the importance of “CHOICES” and the two-directional arrow are reviewed, as are the four questions from reality therapy in the left hand vertical column. Attention is then directed to the “ASSETS” and “LIABILITIES” columns. It is noted how our choices in each of the five life equities, as revealed by the four questions, contribute to our entering credits or debits, strengths or weakness, deposits or withdrawals, in the positive or negative columns of our individual Life Equity Ledger Sheets. In other words, by virtue of our personal choices, how are we contributing to our weakness, or how are we choosing to develop strength to handle stress?

The Ledger Sheet is easily recognized as a refinement of the “split page” technique used routinely as a help in decision making. As such, it is an easy and familiar format for many clients. The client selects one of the five life equities and writes the term on the blank line at the top of the Ledger Sheet. The therapist and client then work through the questions helping the client to determine, “Am I making choices that are negative or strength-building? Am I entering Credits or Debits?” This is a simple book-keeping or accounting format. As a result it has considerable visual impact for the client and for the therapist. One can literally tally the results!

In determining whether or not wants, choices, behaviors, and plans are positive or negative, clients may make judgments differently than therapists. This is frequently the case with substance abusers and persons with long histories in the criminal justice system. In these cases, the author has found it instructive to run two sheets with an explanation like the following: “Looks like we’re seeing things differently here. You want to take drugs . . . are choosing to take drugs . . . think it helps . . . and plan to continue to take drugs. Let’s both do a Ledger Sheet and make the entries as we see them. Then we can compare our pictures, not to argue, or to change your mind, but just to compare how each of us sees the situation. We don’t need to make any judgments now.” This is a relatively non-threatening way for the client and the therapist to compare perceptions. It’s a very effective means to help clients identify their own perceptions according to their own value filters and perhaps to begin to see the cause and effect relationships of their total behavioral choices. Importantly, this
approach keeps the decision making control with the client, thereby increasing the probability that the client may decide to make more positive, strength-building choices in the future.

The integration of the four questions from reality therapy with the balanced life model suggests some points of emphasis in their application. Though the following applies equally to the Post Card, the fine tuning of the questions is vital to the detailed and hard work of the Ledger Sheet.

What Do I Want?

Because this is a holistic, life span approach, the author has found it important to ask clients not only what they want now, but also what they wanted at a particular point in the past, and what do they want in the future? The ordering of the questions is important: now-past-future. This keeps the focus on the “what” and the “how” and the consequences of the clients’ choice-making over time, but helps guard against getting mired in the “why” of a negative past. This line of questioning also helps clients to learn from cause and effect relationships over time and to see how choices in one life equity effect the negative and/or positive balance in the other life equities.

It is not unusual to encounter clients who honestly don’t know what they want in one or more of the life equities. This is an indication that they have lost control or have given control of that area of their lives to something or to someone else. They may be unsure of their abilities, interests, values, and choices. Clients may get a clearer picture if we ask: “What do you want-ideally, impulsively, childishly, maturely? What will you get and what will you have to give up if you choose one want over another-now, in the past, in the future?” Specific life equity questions may be: “What do you believe . . . did you believe . . . would you like to believe about why things happen? What do you . . . did you . . . would you like to learn, know, understand? What type of person do you . . . did you . . . would you like to be? How healthy do you . . . did you . . . would you like to be? What do you . . . did you . . . would you like to think about money?” From these types of questions, clients may be able to more clearly distinguish their own wants from those of others, and to take more active, positive control over their choice of wants in the five life equities.

What Am I Choosing To Do?

Certainly, the above comments about the value and importance of personal choice are relevant here. Additionally, reality therapists ask clients if their choices are against the law, or against the rules? The balanced life perspective would suggest that we also ask if the clients’ choices are against the laws of nature, the laws of God, or do they violate rules of just plain common sense?

In terms of current life equity choices, clients are asked: “What are you choosing by making this choice? What are you choosing by not making a choice? What is interfering with your decision?” In regard to past choices that inform the current situation, clients are asked: “How did you come to that decision? How did you decide to choose that alternative?” About future life equity considerations, clients are asked, “What do you think you might do? What would you like to see happen? If you did want to do something differently, what do you think that might be?”

In regard to choices, the author has observed an interesting dynamic in the area of psychological equity. When helping clients to explore their self-originating feedback, two lines of questioning seem paramount: 1) “Are you choosing to live the kind of life ___________ . . . ?” 2) “In regard to ___________ . . . What are you choosing to do to become the kind of person you want to be?” The therapist, or the client, fills in the blanks depending on the equity issues under discussion. These seem to be linch pin questions in the balanced life model. They tend to surface in the area of psychological equity, but cut across the other four life equities. The initial link seems to loop back to spiritual equity in terms of ultimate values and purposes, then to loop again throughout the other life equities.
The exploration of the clients' choices in the five life equities increases the clients' and the therapist's awareness of the alternatives and consequences of life-style choices. It also helps to enlarge the clients' pictures of their individual freedoms and their choices of total behaviors.

Is What I'm Doing Helping?

For clients to recognize their freedom to choose their total behaviors sounds great, but to assume the responsibilities for the outcomes and the consequences can be frightening. We know from control theory that we do what we know how to do. This helps explain the often used adage in reality therapy, "If something doesn't work, we keep doing it." A benefit of the application of reality therapy to the balanced life model is that by working the, "Is what I'm doing helping? . . . now . . . in the past . . . in the future . . . ?" questions back and forth across the five life equities, clients often see the possibilities and needs for change. They begin to see how choices in one life equity affects the balance across all the life equities. It is in this area, where clients make the value judgments about their choices and the resulting balance in the five life equities, that the process of positive change accelerates.

We've paid particular attention to the types of questions and their phrasing for a reason. Therapy progresses on the basis of time and tactics used. The type of questions we ask of ourselves and of our clients determines the character and content of the answers generated. It's likely that most, if not all, of the answers to our questions in living preexist. A crucial task in the therapy process is to ask the most open-ended and incisive questions we can think of. The integration of reality therapy and control theory into the framework of the balanced life model is offered as an additional step in this direction.

What Is My Plan?

The intent of the plan is to enable clients to choose to take positive action in their own behalf and on the behalf of others. The goal of the plan is to help clients get what they really want for themselves and for others. An effective plan is a concrete tool to emphasize the clients' control over their own situations. There are several excellent discussions of the methodology of positive plans (Applegate, 1985, Ford, 1989, and Wubbolding, 1988).

It's important when designing plans with clients that clients are reminded not to try to make major changes in all five life equities at once. It's a judgment call between the client and the therapist as to whether they select the most problematic area or the area that offers the most chance of success to work on first. Clients are taught by instruction and by the modeling of the therapist to think in terms of: "I choose to . . . I want to . . . I plan to . . . " not, "I have to . . . " Cousins (1979) and Siegel (1986), emphasize the importance for patients to remain in control of their medical regimes. Similarly, in the balanced life model, and in the practice of reality therapy, control of the plan for improvement must be vested with clients. Clients are, in fact, encouraged to, "Question authority."

From the balanced life perspective, the only true progress of individuals is that which is achieved by self-discipline and by self-reliance. When we, and our clients know what we believe, have carefully chosen what to learn and to understand, have the skills to like ourselves and to like others, take good care of our bodies, and understand the distinctions between our financial worth and our self worth, then we are striving towards living a balanced life. These are the goals of the planning process.

In seeking clients' commitments to negotiated plans, the author has found the following quote by Goethe invaluable:

Until one is committed there is always hesitating, the chance to draw back, always ineffectiveness. Concerning all acts of initiative, there is one elementary truth, the ignorance of which kills countless ideas and splendid plans: the moment one definitely commits oneself, Providence moves too. All sorts of things occur to help one, that would never otherwise have occurred. A whole stream of events issues from the decision, raising in one's favor all manner of unforeseen incidents and meetings and material assistance which no man could have dreamed would have come his way." Wisdom and Experience

In regard to the therapeutic plan, it seems a truism and a paradox that the more committed we are to living a balanced life, and the more effectively we can stand alone-the more we stand best with other persons.

SOME OBSERVATIONS AND IMPLICATIONS FOR PRACTICE

The application of the balanced life model to the practice of reality therapy contributes to a holistic, life span conceptualization of therapeutic intervention. Building on the control theory variation of systems theory, older forms of linear, deterministic, and mechanistic interpretations of human behavior are seen, at best, to be only partial explanations of the complexities of human choice.

A major strength of the questions from reality therapy is their insistence on the objectivity of the therapist and the focus on the self-determination of choice for clients. However, there is no claim that the balanced life model represents a "value free" therapy. The fact that one chooses reality therapy as the primary modality, and then chooses to integrate it into a balanced life framework, implies a number of value choices about what types of interventions work best with clients and in what areas of living are these interventions most efficiently and effectively targeted.

The visual impact of the Post Card and the Ledger Sheet make for effective teaching tools in helping clients to focus on their personal choices and responsibilities. The philosophy inherent in the balanced life model, that clients are dealing with life-style choices over the course of their life spans, encourages an ongoing working back and forth across the five life equities.

An obvious implication of the balanced life model is that the therapist must be in, at least, reasonably good balance in his/her own life. Certainly, the therapist must be in stable balance in those areas in which he/she is working with clients. Therapists need to be clear in their own minds about
their ethics, values, and from where they derive ultimate meaning and purpose in their lives. Therapists need a clear inventory of their knowledge, skills, and their personal stance towards open-mindedness and learning. To be effective, therapists need to have reached the stage of personal maturity where they like themselves and like, at least, most types of people. Considering one’s age, and illnesses and injuries beyond one’s control, therapists need to maintain their physical health at optimal levels to have the energy and stamina to work effectively with clients. Finally, therapists need to understand in what proportion they are in the “therapy business” to make money and to help clients. All of the above are areas in which therapists make life-style choices and subsequently, model those total behavior choices for clients.

If we choose reality therapy, control theory, and the balanced life model as the organizing principles of our lives and practices, then, we realize that we are in control of our own lives. By making positive choices in the five life equities, we can maintain balance in the form of stability based on planned change and growth. We can help our clients to do the same. We act as “choice coaches” to help our clients to become skillful “equity builders” by making personal choices that work.

References


Author Note

1. The author is grateful to Alan W. Boal, Idea Transfer Inc., San Clemente, California; and to Marsh Phelps, Growth Support Systems, Tusin, California, for our sharing of ideas and for our mutual support in the implementation of the life equities principles in our personal lives and in our careers.

LIFELINE: A DRUG/ALCOHOL TREATMENT PROGRAM FOR NEGATIVELY ADDICTED INMATES

Edward W. Chance
Robert F. Bibens
Jack Cowley
Mohsen Pouretedal
Paul Dolese
Dick Virtue

Chance is Assistant Professor and Bibens is Professor in the Dept. of Educational Leadership in the College of Education, University of Oklahoma, Norman, Oklahoma. Cowley is Warden and Pouretedal is Administrative Assistant at the Joseph Harp Correctional Center in Lexington, Oklahoma. Dolese is Director of the Lifeline Program at the same center. The Reverend Dick Virtue is Executive Director of the Norman, Oklahoma Alcohol Information Center.

Negative addictions are perhaps the hardest issues to effectively deal with in reality therapy counseling. The pain/pleasure assured by the addiction is so intense and so cyclical that it takes all of the skills of the counselor to assist the client in overcoming the addiction. The picture of drugs and/or alcohol which negatively addicted individuals hold eventually represents the way to meet all of their basic needs, becoming the predominant picture as the addiction increases. Certainly, this is especially true for those who are not only negatively addicted but incarcerated as well. The “escape” provided by the addiction becomes the very source of all that is good in the inmate’s life and conversely represents all that is bad at the same time.

This article reports the results of a treatment program established for drug and alcohol addicted inmates at a medium security prison. The cost of maintaining an inmate in a prison setting is estimated to be approximately $15-25,000 per year. Financially, the cost is excessive but the human cost is even greater.

Prisons are not places that are drug free. Many inmates can not — and will not — just say no to drugs. The addiction for far too many is worth the temporary escape from the prison setting that drugs provide. This program was started with the understanding of the human cost and with the acknowledgement that those who are negatively addicted represent a massive counseling challenge.

The Program

In the fall of 1988, several groups working in concert decided that a drug/alcohol treatment program, to be known as Lifeline, would be initiated at the Joseph Harp Correctional Facility in Lexington, Oklahoma. The facility holds primarily medium security inmates, although forty percent of the inmates are identified as in need of maximum security. The total population is approximately 800 to 900. Overcrowding is a constant concern at
Joseph Harp, as it is at every prison in the United States. Drug abuse and addiction is a similar concern. To address this, the Norman Alcohol Information Center (NAIC) and its director The Reverend Dick Virtue, the Episcopal Diocese of Oklahoma, the Oklahoma Department of Corrections, officials at Joseph Harp, and NAIC's Board of Directors felt a new program was needed that would assist inmates to meet their needs as best as possible given their situation, without the use of drugs or alcohol.

The launching of the program owes a special note of thanks to the United Thank Offering of the National Episcopal Church Women. The women provided the "seed" money necessary for the program initiation. Additionally, the support, assistance, and guidance of the Right Reverend Robert Moody, Bishop of the Oklahoma Episcopal Diocese, and his predecessor, the Right Reverend Gerald McAllister were instrumental in program development and implementation.

Lifeline was designed as an intensive counseling program which utilized a present and future oriented methodology. Reality therapy was identified as the primary counseling mode. Inmates selected to participate in the treatment received individual and group counseling as well as participated in self-help programs, such as Narcotics Anonymous and Alcoholics Anonymous.

Twenty inmates were selected to participate in Lifeline after an extensive and intensive screening process. They represented the same broad multicultural and ethnic mixture of the general prison population. The general priorities set for admission to the program were:

1. the inmate had to recognize that his drug/alcohol addiction wasn't helping him;
2. the inmate had to agree to attend and participate in all counseling sessions;
3. the inmate was to submit to a weekly, as well as to any random urinalysis deemed necessary;
4. the inmate had to agree to accept the consequences both programmatically and institutionally if found using drugs; and
5. the inmate had to agree to be segregated into a living unit with others selected for the program.

It is important to note that the consequence for any drug use was termination from the Lifeline program.

Inmates selected for the program were required to complete a weekly self-perception profile that addressed attitudes towards oneself, the program, and others within the program. A similar instrument was completed weekly by counselors, teachers, supervisors, and any other personnel who had contact with the inmate in the treatment program. Each participant was required to keep a diary which was then discussed during the individual counseling sessions. The director of the program, Paul Dolese, was selected because of his commitment to the Lifeline concept, his willingness to pursue reality therapy certification, and the fact that he understood how prisons worked and functioned. This level of understanding allowed him to deal with inmate frustrations and concerns in a better manner than that often chosen by outsiders. It also meant that he recognized and acknowledged inmate attempts at manipulating the prison system for their personal benefit. Other personnel, as they were hired, also received reality therapy training. Additionally, the lead author of this piece was reality therapy certified and provided ongoing training and support for program personnel as well as the inmates when they became peer counselors.

It was important to have quantifiable data in addition to qualitative data to ascertain the program's success or failure. To accomplish this, a randomly selected control group of forty inmates was identified. This group was monitored in much the same manner as the treatment group. Forty were chosen for the control group because of the transitory nature of much of the prison population as inmates make parole or are moved to different institutions. This mobility problem was not deemed a concern for the treatment group because the majority would be at their current site for at least a year.

The counseling delivery method for the Lifeline treatment group was reality therapy and control theory. The chosen counseling model was not kept a secret from the inmates. Indeed, many had spent years in counseling and understood much about the process. Thus, it was decided that they should not only be clients but active learners and eventually, as they graduated from the program, proactive teachers. Meeting one's needs, making better choices, recognizing pictures, experiencing more pleasure than pain, and becoming more fulfilled were daily programmatic counseling goals. As inmates remained clean and recognized that their old behaviors had not really worked for them, they increasingly gained greater control over their lives. They began to discover that they could survive in prison at a much greater and need-satisfying level than before. Both correctional personnel and other inmates began to recognize the changes and respond to them. As this was happening, those in Lifeline began to establish a family-type network that provided support and assistance to those in the program. This allowed them to draw upon each others' strengths.

When the inmates had achieved sobriety and had gained a greater control over their lives regarding drugs and alcohol, they were graduated from the program. There was no pre-established length of time established for one to be deemed successful in the program. This was an individual issue but generally ranged from six to eighteen months. However, graduation did not mean abandonment or total freedom from Lifeline. Instead, graduation was simply a programmatic transition to a more intense program. Graduation ceremonies were periodically scheduled and were purposefully designed to be full of pomp and circumstance. Inmates' families were invited, correctional officials attended, politicians spoke, and each graduate was given the opportunity to speak about the program and his personal growth. The total graduation ceremony was planned to allow the inmate to further realize how needs could be met without resorting to the destructive negative addictions to drugs and alcohol.

As previously indicated, graduation did not mean that one was sudden-
ly on his own. Graduates continued to receive counseling and remained in self-help organizations. Graduates also began to help others who were still in the program. Currently, all of Lifeline's graduates who remain in prison are being trained to serve as co-facilitators in the counseling process. They have received over sixty hours of training in reality therapy and control theory. They have read extensively, viewed R.T. videotapes, have practiced role plays, and have discussed and debated reality therapy and control theory among themselves and with others. In addition to the reality therapy training for the graduates, correctional staff also received several hours of similar training. Graduates have realized that the sense of powerlessness that often pervades a correctional facility has less impact on them because they have gained power, recognition, belonging, and a greater sense of control through new behaviors and knowledge. Lifeline establishes a reinforcing cycle of success for each and every participant.

For those few inmates who have been paroled or have completed their time, an aftercare program was established that would assist in the maintenance of new behaviors and choices. This aftercare program consists of mandated attendance at counseling sessions. It also includes involvement in A.A. and N.A. programs. Family counseling is available as is the support of the Episcopal Church in its Adopt A Family program. Monthly meetings also take place with Lifeline's project director to ascertain status and needs relating to job, family concerns, educational aspirations, and involvement in support groups. The aftercare program is an integral component in the total picture of client assistance and growth.

The Results

Data on both the Lifeline treatment group and the randomly selected control group were gathered throughout the first thirty weeks of the program. The data were then analyzed to ascertain whether or not the participants in the Lifeline program showed any significant positive changes in their attitudes toward self and others, their dependency on drugs, and prison life in general as compared to the control group.

A Likert-type instrument was designed to assess several descriptive characteristics of the treatment and control groups such as behavior, future orientation, responsibility, and degree of involvement in improvement-related activities. Data on both groups were collected on a weekly basis. Subjects in the treatment group additionally completed a weekly self-assessment instrument. Correctional employees completed perceptual surveys on subjects in both the treatment and control groups.

The Lifeline program began with twenty inmates. Five inmates completed the program and were paroled or completed their sentences. They are currently in the aftercare program. Nine inmates are still in the program as graduate peer counselors and are receiving continued treatment and training. Only one inmate from the original treatment group has not graduated, but he continues to work at choosing new behaviors. Five inmates were terminated from the Lifeline program for drug abuse but are receiving counseling and assistance via other counseling formats. The control group which began with forty now numbers twenty-seven.

The results of the data collection can be analyzed quantitatively and provides some very interesting information. The program must also be viewed in a qualitative manner. Overall, with 30 weeks of data collected, it was found that the control group results remained constant in essentially all areas. The treatment group in the Lifeline program exhibited an incremental improvement in almost every area. The inmates generally ranked themselves higher than did the unit team or work supervisors but this was expected. However, inmates rankings, as well as those selected to rank them, indicated consistent improvement. When t-tests were run on the data comparing the inmates' responses from the first week of the program to the thirtieth week of the program, it was found that the results were not statistically significant at the .05 level in all items except one. That one item reflected the inmates response to speaking out against drugs and their resolve to stay away from those who chose to use drugs. Those involved in the program do not believe that this reflects a failure on the part of Lifeline. An analysis of mean responses indicates incremental and consistent positive change in the inmates' self perceptions. Qualitatively, the program is a success when looking at inmate behaviors, attitudes, future orientation, drug usage, and disciplinary referrals.

It was recognized from the very beginning that when one deals with human beings that any change — positive or negative — could be the result of a great many variables. It was also accepted that the instruments themselves were perceptual questionnaires and that variables such as personality, motivation, and a variety of external events could impact the results. However, it was believed that because data would be collected from several sources and tabulated over an extended period of time that such issues would be essentially neutralized. The fact remains that the Lifeline program — even if it was successful at a lower rate than expected — would be better than nothing. It is also important to note that those involved in the program design fully recognize that the successful completion of the Lifeline program did not mean that one would never again have a drug or alcohol related problem. A great many variables exist when working with a program such as this that can never be fully controlled. However, this is true of any such project such as this one. The true degree of programmatic success will be reflected as the inmates remain free of drugs and begin to live productive, fulfilled lives.

Overall, this program has been successful. Fifteen inmates have been drug-free — some after years of abuse — for an extended period of time. The program will eventually be expanded to forty inmates. There are numerous inmates waiting for openings in the program. The graduates of Lifeline will fully begin peer counseling by April, 1990. The program has the potential of becoming a model for other prisons to adopt. In human terms, the program results represent an important level of success.

Conclusion

Inmates in prisons in this country often find little to hope for or to work towards. The Lifeline program as initiated in the fall of 1988 provides an opportunity for negatively addicted inmates to learn how to make better
choices as well as to learn how to get their needs met in a way that is more socially acceptable and useful. Although still in its infancy, the Lifeline program utilizing reality therapy and control therapy has proven to be a success.

The focus of the program on recognizing inappropriate, non-working behaviors and on learning new skills provides those in Lifeline a more powerful way to meet their needs. The future will appropriately ascertain the degree of success of this program. But to paraphrase a recent graduate, sobriety for a year — after ten years of choosing progressively self-defeating, addictive behaviors — has taught him that he can make better choices and that it is possible to meet his needs without drugs.

Postscript: This article is dedicated to the memory of Robert F. Bibens who passed away suddenly in January. His support, guidance, and belief in such a program helped bring the dream to a reality. His love of humanity and belief in everyone's unique goodness was inspiring to all who worked with him. He will be sorely missed but fondly remembered. The Lifeline program is part of his legacy.

GAINING CONTROL: MY STORY
By Soloman Broadus

The idea of my joining the Pilot Drug Program was conceived on my job. My supervisor and I were sitting at this desk discussing the reasons of my prior incarcerations and my problems with drug addiction. As my supervisor (Mr. Joe Fred Wortman) listened to me admit and discuss my lengthy use of drugs and my weakness of not being able to abstain from their use, he informed me that we had to "figure out a way to get me off drugs and a way to help me stay off them". To me, that was a profound statement when coupled with the realization that someone really cared. I asked him what he suggest that I do about the problem, because I surely didn't like the possibility of spending the remainder of my life as an addict in the penitentiary. Mr. Wortman informed me that there was a Pilot Drug Program here at the institution called Lifeline and it seemed to him that I needed that kind of long range drug therapy that they would provide. I agreed. I asked if it was possible to get into the program considering the lengthy sentence that I was serving, and he replied that few things are impossible.

Approximately two weeks later I was summoned by Mr. Paul Dolese, Director of the Lifeline Program. After a lengthy discussion I was given a contract to sign, a handshake, and a wish of good luck. A couple of days later I was moved into the drug program quad.

Little did I realize that this move would begin for me an eleven month odyssey which would and has had a tremendous effect on my life, and would and still does present challenges to me morally, spiritually, and emotionally that I would have never thought possible. It would also enable me to meet face to face and interact with people who would help me learn a lot about myself. In turn, I would learn a greater lesson about people.

My first challenge was to accept the SERENITY PRAYER:

GOD GRANT ME THE SERENITY
TO ACCEPT THE THINGS I CANNOT CHANGE,
THE COURAGE TO CHANGE THE THINGS I CAN
AND THE WISDOM TO KNOW THE DIFFERENCE.

My addiction had brought me to the point of such cynicism that my mental process automatically placed every relevant thing in the category of sarcasm. Almost to the point where I had become an invisible man.

I grappled with the serenity prayer for three months or more until I realized that my problem was not so much with the prayer as it was that I didn't have anything spiritual in my life, that I had no idea of what I perceived as a higher power. With this realization I began attending the religious service of my choice; things in my life began slowly to change. Now mind you, nothing happened or changed me over night, but over a period of a month I began to realize that I was making a change in my life and I could see some of the participants in the program making a change also. We were all learning how to make better choices. Many of us had
REALITY THERAPY: IMPROVING MY LIFE

Tom Blakey

My name is Tom Blakey and I am 32 years old. I have been a practicing alcoholic and drug addict for most of my adult life. I began smoking marijuana, using drugs and drinking when I was 12 years old, in the late 60's. Drugs were very plentiful in Norman, Oklahoma at that time, and as a teenager I was part of a subculture that used drugs daily and excessively. I was out of control from the beginning and experienced problems at home and school, as well as socially and legally. I overdosed more than three times, once requiring hospitalization. In one year's time, three teenage friends of mine died; all drug-related deaths.

In 1975, at age 18, I was in the chronic stages of alcoholism. After my father's death, I was persuaded to enter Alina Lodge Treatment Center in Blairstown, NJ. There, I learned about the disease concept of alcoholism and was exposed to the 12-step AA program for the first time.

After leaving Alina Lodge, on my own volition, I returned to Norman and drug usage. I found that treatment had "ruined" my drinking for me and I made the transition to narcotics at that time: namely heroin and dilaudid.

I became addicted to heroin and was sent to prison one year later with a 4-year sentence for drug-related crimes. I was released on parole and three months later was convicted of drugstore robbery and drugstore burglary and sentenced to 27 years in prison.

After serving three years, I was granted a medical leave to obtain drug treatment at Twin Town Treatment Center in St. Paul, MN. While there, I had a spiritual experience and made a decision for sobriety for the first time in my life. I worked the first five steps of the AA/NA program.

When my medical leave was over, I voluntarily returned to Lexington Correctional Center. In December, 1980, I went to the Enid, Oklahoma work-release center where I stayed for six months. I enrolled in Phillips University and did volunteer work at the Garfield County juvenile shelter.

On the negative side, I fell in love — with three or four different women. I began going back to Norman on weekend passes, seeing old using friends. Although I stayed abstinent from drugs, I began to compromise my sobriety. My need to belong was extremely strong at this time.

I was released from work-release in June, 1981. Three months later, I began shooting dilaudid again. The effects of that relapse were terrible and the self-destruction cycle with its pain/pleasure syndrome lasted for eight years. I had a choice in my life and I'd chosen drugs and death. I had turned my back on God and His will for me. I'd let down my mother, my brother and everyone else who cared about me. I thought I was both powerless and hopeless. I went about my addiction in a selfish, fatalistic, and luxurious abandoned fashion.

I went through more than two hundred thousand dollars, from my inheritance and criminal enterprises. I began using cocaine along with dilaudid. At last, I went on a robbery spree.

In November, 1982, I came back to prison with sentences totaling 40 years. I spent a year and a half at the state prison in McAlester and arrived at Joseph Harp Correctional Center in 1984. I used marijuana daily and narcotics whenever possible. In 1987 and 1988, I received large shipments of narcotics in prison and frequently resumed my physical addiction.

In chronicling the events leading up to and following my admittance into the Lifeline pilot prison drug program in January, 1989, I must describe a few other circumstances. In March, 1989, Teresa A. and I had resumed a relationship which had begun and lasted for a short period of time while I was at work-release in Enid in 1981. After my release and relapse a month later, I had introduced Teresa to narcotics and crime. Consequently, she served two years in prison and moved to Kansas upon her release in 1985. She visited me in March and April of 1989, and moved nearby in May. I had connections for heroin and pharmaceutical narcotics at the time and she began using again and bringing drugs to me. As narcotics addicts with generous supply, we were fairly successful; meaning that we were alternately high and miserable for days, weeks and months. As one who felt responsible for her present situation, I assumed the guilt. As addicts, our usage increased.

In October, I met Paul Dolese, the Project Director, for the first time. He stopped by the newspaper office, where I worked, and told us about the planned inception of the drug problem. I was interested in regards to its creation but, as I told Dolese, I was unwilling and unable to change.

I wrote a newspaper article on the program (Ex-Con to Head New Treatment Program- CONCEPTS Nov. '88) Twenty inmates were selected and the program began.

In December, Teresa and I were using heroin daily. She planned, verbally, to go to treatment in January. I gave her the card Dolese had given me and she was referred for treatment. I encouraged her to go, although as a dependent addict I didn't want her to do this.

In turn, Teresa encouraged me to get into the Lifeline drug program. When one of the program participants was paroled, and another terminated, I was told Dolese wanted to see me. I talked to him and admitted my heroin addiction. Nonetheless, he made plans to accept me into the program.

The next day, I received two misconduct reports (Individual Disruptive Behavior and Disobedience to a Direct order) resulting from smoking marijuana. I went to lockdown with a 40 day sentence and transfer papers were drawn up to send me back to McAlester.

Dolese arranged with Warden Jack Cowley, unit managers George Lindley and Sam Preston for a secondary contract to be prepared, allowing me to stay at JHCC and enter into the drug problem. On Jan. 6, I was released from lock-up and entered the program, one day after its official beginning.
Teresa entered treatment a few days later, after self-imposed heroin withdrawal. I moved into a single-cell on E unit, which was therapeutic in itself. For the first couple of months, I remained single-celled, giving me time for reflection and self-examination. Getting off the yard and away from the unit I’d lived on for three years was a tremendous help.

I couldn’t quit using. By sheer will-power I would go for three, four, five days before giving in to my addiction; heroin, marijuana. Each time I did, it would cause me guilt and frustration.

By program design, I began going to AA and NA meetings for the first time in nine years. That was difficult; I was full of hatred and intolerance. Soon, I realized how much I had missed the program and fellowship. I had forgotten the basics: One can’t quit on will-power alone. The denial system became apparent to someone who had learned the disease concept at an early age, and forgotten it with relapse. Cunning, baffling, powerful.

I began to see things in a different way, maybe God, knowing what the future held for Teresa and me, had brought us together to save one another later. I saw, in retrospect, how immature I was, even in my sobriety, how inappropriate my choices had been. I felt that if all things had not worked together in the past years and months just as they did, when they did, that I could never have recovered. I also experienced a spiritual reawakening.

On Jan. 25, 1989, I did my last shot of heroin. Teresa got out of treatment in late February. In March, she relapsed which was a growing experience for us both. I had begun to experience good things for myself at the time. When she relapsed, and I didn’t use it as an excuse to do the same, I knew that I was doing it for myself. I began to learn to choose better behaviors and get my needs met in a better way.

Dolese began to work with us both, addressing the co-dependency issue. Our relationship has evolved over the past year to one that is healthy, honest and very supportive in a constructive manner. We both know that by taking control of our lives and by recognizing that our past behaviors were not helping us, we can change for the better.

The Lifeline program helped me to change and improve my relations with JHCC staff. Their perception of me and mine of them has changed dramatically in one year’s time. I have found structure and freedom in my life like I have never experienced before. I am in control — even in prison.

I am editor of the prison newspaper which employs seven people and has gained outside recognition. I am involved with the Straight Talk program, which conducts tours of the prison, weekly therapy sessions with delinquent teenagers, and travels to schools, churches and other organizations in the community to share our experiences. In six month’s time, I’ve made six outside trips, once talking to 800 people. I am getting my needs met in a much more positive way.

In addition, I’m receiving weekly training in peer counseling using reality therapy. I am actively involved in a bible study instruction program. I also am chairperson of NA.

I list these accomplishments only to illustrate the possibilities in one man’s life, affected by the drug treatment program. Less than 13 months ago, I was on lockup, going through heroin withdrawals, being transferred to maximum security at McAlester. Were it not for the creation of the drug program, and the intervention of the program, I would today be at McAlester, on 23 hours a day lockdown.

With the help of the program, the guidance of the counselors, the support of JHCC administrators, and the care and fellowship of other program participants, I am very grateful to be alive today. There’s a saying in NA: “I know I have another high left in me, but I may not have another recover.” From past and recent experience, I am full of hope for today. I can’t change the past but I can deal with the present and the future.
CONTROL THEORY AND THE LEARNING TEAM APPROACH FOR SPECIAL NEEDS STUDENTS

Louise Lafontaine

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William Glasser (1986) states that:

... a good school could be defined as a place where almost all students believe that if they do some work, they will be able to satisfy their needs enough so that it makes sense to keep working (p. 15).

This statement is a logical corollary of a basic tenet of control theory which relates behavior to the individual’s attempt to satisfy strong basic needs. In our classrooms we are dealing with behavior, and much of the theorizing about effective education is stated in terms of the most efficient, productive, and reliable system for bringing forth behavior that is conducive to learning. Educators want a classroom climate where teachers teach and students learn, a simplistic but paradoxically profound view of the educational process.

These goals are not different for the special educator. What has been different, especially in the first half of this century, has been the view as to what the most effective approach is to attain such goals for the special needs student. Special needs students may be defined as students who differ from the average child in cognitive abilities, sensory abilities, communication skills, social skills, and physical characteristics. The differences in one or more of these areas require some type of moderation or additional services in school. Prior to the passage of federal legislation mandating the mainstreaming of special needs students (PL 94-142, 1975), the majority of these students were in substantially separate classes or institutions for their entire education. Although similar goals of teaching and learning were considered applicable to these students (at least those who were more mildly involved), the techniques used were frequently seen as, of necessity, radically different from those used with the “regular” class student. With the emphasis on integration of special needs students with non special needs students, the view as to what was appropriate methodology for teaching these students began to be seen more in the context of techniques that were used for the student in the regular class.

Therefore, in the past 25 years there have been great changes in the education of special needs students. Mainstreaming, which was heatedly debated prior to the passage of PL 94-142 and which is still being debated, is now an accepted part of the educational process, and must be considered in any concern for the most effective means for achieving the educational goals stated above for the special needs student. The principles described by Glasser (1986) in his discussion of the use of control theory in the classroom appear to have important implications for the special needs students.

MacMillan (1982) in his discussion of mainstreaming says:

The concept of mainstreaming is derived from the notion that the handicapped should be educated in the mainstream — the regular program — whenever possible (p. 512).

One of the major techniques used to accomplish this goal has been behavior modification. In Kneedler’s description of educational methodology (1984), she defines behavior modification as:

... the use of reinforcement and/or punishment to increase or decrease behavior. Behavior modification is used with virtually every type of exceptional child” (p. 64).

A key concept in this methodology is punishment, and this has become the focus of a major controversy in the field of special education. The controversy has been primarily in terms of the type of punishment that is acceptable to use with special needs students; specifically aversive or non-aversive methods.

Aversive methods involve the use of restraints, and inflicting pain and discomfort for specified periods of time. Because of specific cases where such techniques have been seen as harmful to the individual, there are laws in some states prohibiting the use of aversive techniques and there is ongoing litigation regarding these procedures.

It would seem more appropriate to look at the efficacy of any type of punishment and then consider the possibility that the problem is not the type of punishment being used but rather the desirability of using punishment in any form, especially with the more mildly involved student. Behaviorists believe that a response will be either strengthened or weakened, and this is a result of the consequences the response has on the environment. Thus, the major emphasis in behaviorist theory is on the stimuli that follow responses. Punishment is one specific type of consequence and it must, therefore, be used to achieve a desired response or behavior in this particular framework.

As stated above, most disagreement about punishment as a technique to be used with special needs students has focused on the specific nature of the punishment and also on the long term effects and general ability of the response achieved as a result of the punishment. Glasser (1965-1986) looks at the role of punishment in the classroom and the relationship to traditional views of learning as exemplified by stimulus-response theory and a reward-punishment approach to learning. Punishment has become more frequent than reward in our schools based on the belief that students will exhibit the desired behaviors in order to avoid the discomfort and pain of
The use of a learning team model as proposed by Glasser (1986) has applicability to special needs students. In fact, it is a model already used in many programs especially with students who are in resource rooms for part of the school day. The resource room is used primarily for students who require help beyond that available in the traditional classroom structure. Communication between the regular classroom teacher and the resource room teacher is essential if the program is going to work for the student. In addition, for many special needs students input is made from a variety of ancillary personnel in the schools, including speech and language pathologists, counselors, nursing staff, and any other persons actively involved in the students' program. Therefore, a team approach is seen as effective and necessary for working with special needs students, and the learning team approach of Glasser may offer ideas that could enhance models currently being used in the schools.

Long term motivation is crucial for a satisfactory and productive learning environment. This has been a specific problem with special needs students since the time that it was decided such students could function effectively in a learning situation. The federal and state legislation of the past 25 years has given educators the mandate to provide this education to all students equally, including all special needs students, but the mandate has not provided the methodology for doing so. Glasser's approach, as described in certain aspects of control theory, seems appropriate and potentially more productive than some of the current approaches which are rooted in a punishment-avoidance model.

The use of a learning team model as proposed by Glasser (1986) has applicability to special needs students. In fact, it is a model already used in many programs especially with students who are in resource rooms for part of the school day. The resource room is used primarily for students who require help beyond that available in the traditional classroom structure. Communication between the regular classroom teacher and the resource room teacher is essential if the program is going to work for the student. In addition, for many special needs students input is made from a variety of ancillary personnel in the schools, including speech and language pathologists, counselors, nursing staff, and any other persons actively involved in the students' program. Therefore, a team approach is seen as effective and necessary for working with special needs students, and the learning team model of Glasser may offer ideas that could enhance models currently being used in the schools.

The different emphasis in the control theory learning team approach is in terms of structuring the classroom environment to fulfill the student's basic needs and thus motivating the student to learn. There has been less emphasis, generally, with the special needs student on the importance of satisfying intrinsic needs and more emphasis on modification of extrinsic behaviors and the use of a reward-punishment paradigm. If Glasser's statement about what constitutes a good school is accepted then the ways in which the learning team approach may effectively work toward this goal for the special needs student should be considered. Structure is basic to this model and structure is also basic to most educational models for special needs students whether in the resource room or the regular classroom setting. Grouping of students in small teams of two to five students is also basic to the learning team approach together with encouraging stronger students to work with weaker students which may be beneficial to both groups. This is another basic aspect of special education today as seen in mainstreaming regular and special needs students to provide an integrated and mutually enriching learning experience.

In conclusion, it is proposed that many of the principal ideas of control theory and the learning team approach may be valuable for the education of special needs students, most specifically for those having a mild to moderate degree of involvement. The importance of motivation and satisfaction of intrinsic needs as factors in the learning environment together with integration of students with different abilities have been briefly reviewed. There are similarities with existing program models for special needs students but the emphasis is somewhat different and this difference merits further investigation in a variety of settings for special needs students.

REFERENCES
Education of All Handicapped Children Act (1975). PL 94-142
CONTROL THEORY PSYCHOLOGY AND CRISIS INTERVENTION COUNSELING

J. Jeff Maloney

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According to Belkin (1988), crisis intervention is to counseling what first aid is to medicine, a temporary but immediate relief of an emergency situation presented by a highly distressed client. Like first-aid procedures, crisis intervention procedures are specific and clear cut, and the interviewing professional should have more than a passing acquaintance with them.

In many respects, crisis intervention utilizes basic therapeutic strategies. However, in other respects it differs markedly. In a traditional counseling session, clients usually admit to having a degree of control in their life even if they may be experiencing pain and confusion. To the contrary, clients in a true state of crisis have reached the stage where they are immobilized and seemingly unable to control themselves or their environment. Consequently, crisis intervention therapy is more oftentimes aimed at helping the client resolve the immediate problem at hand rather than in dealing with intermediate or long-range goals.

Persons in crisis are in a situation where they face a problem they cannot readily solve by using coping mechanisms that have worked in the past. As tension and anxiety increase, they then become less able to find a solution, feel helpless, and are caught in a state of great emotional upset. This issue in inner tension and anxiety contributes to their inability to function in their normal routine (Belkin, 1988).

Glasser (1984) has helped the mental health professional get a better picture of what the client in crisis is experiencing by defining the process in control theory terms. According to Glasser (1981, 1984), people act on their world in an attempt to meet basic physiological and psychological needs that are rather well defined by both genetic instruction and experience with the environment. Glasser further maintains that all human beings are constantly striving to control the real world in an attempt to satisfy the picture of how they want things to be in their internal world. When a discrepancy exists between what they want (internal world) and what they are perceiving to be happening to them (real world), the behavioral system is driven to find a behavior to rectify the dissonance they are experiencing.

In most instances, a quick search of the organized portion of the person's behavioral system will result in the satisfactory resolution to the problem. Occasionally, if the discrepancy or frustration is more severe it is quite possible that the reorganizing portion of the behavioral system will be engaged. When a person is in true crisis, the behavioral system is being run "wide open", and the resultant behavior that emanates from the reorganization process may be anything from very unique to highly dangerous. About the only certainty is that it will be very difficult if not impossible to predict.

The goal for the interviewing mental health professional involved with clients experiencing this heretofore uncharacteristic behavior is two fold. First, the counselor needs to help clients recognize and resolve the immediate crisis and help restore them to their previous level of functioning. Second, the counselor needs to be active in promoting the development of new problem-solving skills on the part of the clients.

The first objective in meeting the aforementioned goal is for the counselor to assess why the client is in crisis. Specifically, what physiological or psychological need or needs that the client is controlling for are suddenly being threatened or going unmet. Counselors can best assess the client's need at this point in the intervention process by joining with the client and attempting to "see the picture" as much as possible from the client's frame of reference.

After counselors have been able to get enough of the picture to enable themselves to understand the clients' need, the focus then turns to the management of the situation. Things to consider at this point may include assessing the clients' ability to make rational and responsible decisions, while at the same time trying to determine if backup support to handle some potentially volatile situation that may erupt due to the general state of chaos that often times surrounds the individual in crisis is needed. In any event, management throughout the encounter is the key to successful resolution.

Specific guidelines for the counselor to consider when managing clients in crisis include:

1. Accept what is said and treat it seriously.
2. Do not give advice.
3. Do not say everything will be all right.
4. Do not back off or try to delay dealing with the person.
5. Help the person explore feelings; however, be careful not to add to the person's guilt.
6. Ask if the person is considering suicide. It is OK to talk about suicide, and it will not give the person an idea he or she has not thought of.
7. Try to focus the problem. What does the client really want.
8. Help determine what needs to be done or changed.
9. If you have them, trust your suspicions that the person may be self-destructive or dangerous to others.

The crisis counselor should be very much aware of the following issues while dealing with the danger problem alluded to in the last guideline cited by:
1. Not allowing yourself to be isolated with a potentially violent person.
2. Having security backup.
3. Not having lethal material present, meaning instruments that could be used to harm self or others.
4. Not assuming that you can "talk it out" with individuals who are potentially violent. They may not be responsive to normal talk.

By being aware of these guidelines and issues throughout the assessment and management phase of the intervention, counselors will hopefully be taking good care of themselves and consequently affording the client in crisis better professional care as well.

As was previously stated, when the client has recognized and resolved the immediate crisis, the emphasis then turns to developing new problem-solving skills. The counselor should focus on the following as a means of helping the client gain a greater sense of control:
1. Get a verbal or written commitment that the client will not take action to harm self or others.
2. Check on what available support clients have. Specifically, what can they count on, do or think of in respect to fulfilling the survival and belonging needs immediately.
3. Help identify the resources needed to improve the present situation.
4. Help clients recall specific behaviors they have used in the past that may have worked when they were in a similar situation.
5. Get a commitment from clients that they will agree to pursue constructive change through therapy.
6. Develop a plan for a systematic follow-up within a specified time frame to check out clients' progress in resolving the crisis situation.

It should be emphasized that while the strategies presented in this article are generally accepted as appropriate and usually successful in dealing with a client in crisis, there are, nonetheless, times when the most skillful crisis intervention counselor armed with the most up-to-date arsenal of techniques will not be successful in helping the client recover from the crisis. In fact, it is possible for the counselor to be affected just as much as the client in any crisis intervention situation whether or not it is successfully resolved. Therefore, it is incumbent on mental health professionals who work in an environment where crisis intervention is a possibility to ensure they have the necessary support system available so that their needs are adequately met. In fact, the final step in crisis intervention is for caregivers to acknowledge how their life is impacted by the crisis and to then follow much the same treatment plan they specify for their clients.

**Bibliography**


### MEASUREMENT OF CHANGE

The measurement of change in clients undergoing treatment has been of long standing interest to the helping professions (Eysenck, 1968, Wolpe, 1969, Bergin, 1971, Rachman, 1971, Smith & Glass, 1977, Bergin & Lambert, 1978, Langer, 1983, Kamfer & Goldstein, 1986), and the general overall conclusion that one can draw, despite the initial disconcerting results of Eysenck's work which seriously challenged the value of psychotherapy, is that psychotherapy is generally effective in about 70% of cases, achieving results superior to no treatment or various placebos, with deterioration occurring in 10% of cases.

The question of what kind of change to look for and what instruments to use is still controversial. The polarity has tended to be between the use of objective psychometric instrumentation and projective or anecdotal types of approaches. For the purpose of this study I selected the Personal Questionnaire Rapid Scaling Technique (P.Q.R.S.T.) - a relatively recent addition to the field of human inquiry (Mulhall 1978). It can be used to monitor fluctuations in the intensity of personal perceptions. The logic of the P.Q.R.S.T. is that quantification is a feature of our perceptions, thought and communications. The instrument draws on this by using a set of adjectival phrases conveying different magnitudes from "almost none" to "maximum possible". Assessing change as a result of R.T. and the potential use of the P.Q.R.S.T. for such, was the primary focus of interest in this study.

### TREATMENT CONTEXT

The treatment context in which the assessment was conducted will be briefly outlined. Rutland Centre is a residential treatment program for chemical dependency treating the social, psychological and behavioral concomitants of addiction in both addict and family. The context of treatment is a drug free therapeutic community which supports and facilitates the
client's own motivation. Intensive group therapy coupled with educational input and a highly structured treatment program involving both client and family are vehicles for change.

This approach is markedly successful with high remission rates and recovering addicts, recognizing a need for continuing personal social development as crucial components of sobriety.

Reality therapy forms the basis of the treatment program facilitating change in the thinking, doing and feeling components. Daily lectures on aspects of addiction help the client grasp the primary nature of the dependency and make the initial identification with fellow addicts. Survival tactics for recovery form part of this learning. The therapeutic community provides the initial catalyst for emotional and behavioral change as a sense of acceptance and growing rapport replaces the client's isolation and fear. Indeed this notion of "acceptance" or unconditional positive regard appears fundamental to our understanding of addiction and recovery. Glasser (1988) likens the powerful feeling the alcoholic gets when he drinks to what people experience when they receive unconditional positive regard. Unconditional acceptance is highly need satisfying, and is an integral part of the caring community into which the addict enters when he or she comes for treatment. This is replaced in time by the appropriate fellowship (e.g., A.A., N.A., etc.) where there are no requirements other than perhaps an assumption of a desire to stop drinking. It is genuinely a place where the addict can substitute "people" for the "bottle".

The intensity and high visibility of the community provides experiences which minimize distortions of reality, foster increasing self esteem, and mobilize social responsiveness. This process is intensified in group therapy where straight talk, conflict resolution, and confrontation of defense mechanisms and of unrealistic perceptions of self and social relationships take place. Information about the addiction is provided by family members and close friends who participate in the group one day per week in an attempt to change the position of the clients' pictures - by telling them how they see it. Non-defensive admission and acceptance by the client of the full impact of the addiction on his or her life are sought and written commitments are utilized at varying stages of treatment to encourage self evaluation on the part of the client.

Addicted persons arriving at the center are usually operating on a motivational basis of avoidance i.e., they are avoiding coercive influences which have led them to make the decision to come into the center. Thus addicts upon arrival are hostile but compliant, fearful and angry, and have a very low sense of self esteem. In summary, the function of the treatment program is to change the emphasis of their internal motivation so that they will begin to work on their own recovery - from wanting to be in the center for family, spouse, job or other - to wanting to get well for self primarily.

It is within this context then, that the P.Q.R.S.T. was employed to shed light on the nature of change in clients currently undergoing reality therapy based group treatment.

**HYPOTHESIS**

The main hypothesis that was tested was that there would be changes in intensity of particular perceptions as a client proceeded through treatment.

**METHODOLOGY/PROCEDURE**

An attempt was made to focus on a cohort of consecutive admissions going through treatment. Of thirty clients thus selected, twenty four satisfied the conditions of the research. Each of these clients completed the P.Q.R.S.T. on four separate occasions which coincided with particular treatment exercises. That is, the clients were asked to make their own value judgments in regard to particular statements on each of these assessment occasions. This occurred on admission, three worst drinking experiences (second week), first step (fourth week), and life story (sixth week). The particular statements employed are shown in Table 1 below.

<table>
<thead>
<tr>
<th>STATEMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My belief that I am a good person is __________</td>
</tr>
<tr>
<td>2. The destructive effect that drinking and/or drugs has had on my work is __________</td>
</tr>
<tr>
<td>3. My belief that I am an addict is __________</td>
</tr>
<tr>
<td>4. My belief that I am living in a responsible way is __________</td>
</tr>
<tr>
<td>5. My ability to care for other people is __________</td>
</tr>
<tr>
<td>6. My belief that I can control my drinking when I want to is __________</td>
</tr>
<tr>
<td>7. The feeling of fear I have at this moment is __________</td>
</tr>
<tr>
<td>8. The importance I attach to God (Higher Power/Spiritual Being) in my life is __________</td>
</tr>
<tr>
<td>9. My belief that this treatment center is the best place for me to be right now is __________</td>
</tr>
<tr>
<td>10. The destructive effect that my drinking/drugging has had on my family is __________</td>
</tr>
</tbody>
</table>

As can be seen from the above, these statements were framed in such a way as to be meaningful to the clients undergoing treatment. Hence, the absence of direct reference to the basic needs in control theory language. We will return to this in considering the results.

In an attempt to assess how representative this sample was of addicts coming through the center, they were compared on a number of variables with an admission census of addicts admitted to the center over an eighteen month period. Tables 2 to 5 compared the sample (N = 24) to the census population (N = 302) on sex distribution, age, intelligence, and degree of addiction. It will be noted that the sample is largely representative of addicts coming through the center.
TABLE 2

Distribution by measured intelligence Standard Progressive Matrices Percentiles

<table>
<thead>
<tr>
<th>Standard Progressive Matrices Percentiles</th>
<th>Intellectual Category</th>
<th>% Sample</th>
<th>% Census</th>
</tr>
</thead>
<tbody>
<tr>
<td>5th, 10th and 25th Percentiles</td>
<td>Below Average</td>
<td>16.6</td>
<td>26.0</td>
</tr>
<tr>
<td>50th to 90th Percentile</td>
<td>Average to above average</td>
<td>58.4</td>
<td>58.2</td>
</tr>
<tr>
<td>At or above 95th Percentile</td>
<td>Superior</td>
<td>25.0</td>
<td>15.8</td>
</tr>
</tbody>
</table>

TABLE 3

Distribution of Degree of Alcoholism
General Alcoholism rating on Alcohol use Inventory

<table>
<thead>
<tr>
<th>Sten Score</th>
<th>% Sample</th>
<th>% Census</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.4</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>1.2</td>
</tr>
<tr>
<td>3</td>
<td>12.5</td>
<td>6.1</td>
</tr>
<tr>
<td>4</td>
<td>8.2</td>
<td>14.8</td>
</tr>
<tr>
<td>5</td>
<td>37.5</td>
<td>23.0</td>
</tr>
<tr>
<td>6</td>
<td>25.0</td>
<td>23.0</td>
</tr>
<tr>
<td>7</td>
<td>4.2</td>
<td>9.0</td>
</tr>
<tr>
<td>8</td>
<td>4.2</td>
<td>5.3</td>
</tr>
<tr>
<td>9</td>
<td>4.2</td>
<td>1.6</td>
</tr>
</tbody>
</table>

TABLE 4

Distribution by Sex for both sample and Census Population

<table>
<thead>
<tr>
<th>Sex</th>
<th>% Sample</th>
<th>% Census</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>79.2</td>
<td>79.8</td>
</tr>
<tr>
<td>Female</td>
<td>20.8</td>
<td>20.2</td>
</tr>
</tbody>
</table>

TABLE 5

Distribution of ages for both sample and Census.

<table>
<thead>
<tr>
<th>Age</th>
<th>% Sample</th>
<th>% Census</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 or less</td>
<td>0</td>
<td>3.3</td>
</tr>
<tr>
<td>21 - 30</td>
<td>8.3</td>
<td>23.0</td>
</tr>
<tr>
<td>31 - 40</td>
<td>62.5</td>
<td>34.7</td>
</tr>
<tr>
<td>41 - 50</td>
<td>16.7</td>
<td>12.0</td>
</tr>
<tr>
<td>51 - 60</td>
<td>12.5</td>
<td>12.0</td>
</tr>
<tr>
<td>61 - 70</td>
<td>0</td>
<td>3.0</td>
</tr>
</tbody>
</table>

Mean Age Census = 38.18
Mean Age Sample = 38.45

Figure 1
P.Q.R.S.T. DATA SHEET (MEANS & OUTCOME)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Assessment 1</th>
<th>Assessment 2</th>
<th>Assessment 3</th>
<th>Assessment 4</th>
<th>Occasions (Mean Scores)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belief in being a good person (1)</td>
<td>6.0</td>
<td>6.5</td>
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<td>Adm. of Being Addict (3)</td>
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<td>Responsibility (4)</td>
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<td>Ability to Care (5)</td>
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<td>Ability to Control Drinking (6)</td>
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<td>Level of Fear (7)</td>
<td>7.8</td>
<td>6.1</td>
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<tr>
<td>Importance of Higher Power (8)</td>
<td>10.4</td>
<td>10.5</td>
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<td>Acceptance of Place (9)</td>
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<td>12.7</td>
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<td>Dest. Effect on Family (10)</td>
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RESULTS/DISCUSSION

Figure 1, which is a series of graphs showing fluctuations in perceptual change over the assessment occasions, illustrates the self reported changes in clients undergoing treatment.

It will be noted that there is a general tendency towards self reports of improved functioning in accord with the theoretical expectations of the treatment program, which overturns our null hypothesis.

It is clear that clients going through treatment report changes in intensity of their perceptions significant for treatment outcome i.e., there are significant changes in the client’s perception of him or herself. These are:

1. A sense of increased self esteem (No 1). This can be seen to represent a core component of the power need.
2. An awareness that within the therapeutic community they are living in a more responsible way (No 4) - indicating that they have absorbed skills that promote growth. This variable underscores the freedom need to a great extent. An individual who assumes personal responsibility is indeed truly free.
3. Furthermore the clients as they go through treatment become more aware of their inability to control drinking (No 6). Again addicts who recognize this existential fact gain greater freedom and in turn more effective control over their own life.
4. Clients perceive themselves as having the ability to adopt the altruistic mode of relating rather than the narcissistic mode more common to addicts (No 5). The belonging need is being actualized here, as the addict begins to have satisfying relationships with others.
5. A greater awareness of the addict-identity is apparent from the data (No 3). Power, belonging and freedom needs are all being assessed on this dimension.
6. There is a significant difference in regard to the importance being attached to a “Higher Power” as a client proceeds through treatment (No 8). So a spiritual need is regarded with quite high value among addicts seeking recovery.

As a measure of concurrent validity, the Minnesota Multiphasic Personality Inventory (M.M.P.I.) profiles of the twenty four clients were inspected. It was noted that there is a general reduction in symptom behavior indicating that clients are in more effective control of their lives at the time of discharge.

CONCLUSION

In conclusion, this study offers support for the use of reality therapy in the treatment of addiction and for the P.Q.R.S.T. as a sensitive instrument for detecting changes. It therefore has merit as an aid to the reality therapist and/or researcher.

References


CORRECTION

Addendum to Honeyman article, Fall 1989, p. 23, end of first paragraph

However, it appears to me to be somewhat reductionistic in its argument. First, having a genetic/biochemical predisposition does not necessarily imply its manifestation, e.g. obesity and some forms of bi-polar mood disorder. Second, in trying to make sense of apparent confusion, current thinking has recognized that the discovery of an exclusive explanatory variable for alcoholism is highly improbable in spite of the potential 'total' explanations offered.
REALITY AND SELF-CONTROL: APPLYING REALITY THERAPY TO STUDENT PERSONNEL WORK IN HIGHER EDUCATION

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Behavior has been described by William Glasser as "the constant attempt to reduce the difference between what we want and what we have." (1984, p.32) The behavior of college students has always been the subject of scrutiny on the part of parents, teachers and the larger society. The president of Harvard instructed the faculty to "take care that their (the students') conduct and manners be honorable and without blame." (Rudolph, 1965, p.6) Public concern about student behavior has waxed and waned since 1636 when Harvard was founded, but it entered an especially acute phase during the mid-1960's with the outbreak of protests on campuses throughout the United States. In response to the violence and destruction which occurred during that period, university administrations became extremely concerned about the control of student behavior. Many began developing policies and procedures to protect themselves from potential liabilities incurred as a result of student behavior, as well as from countersuits from students who believed that their rights had been violated. Litigation related to higher education concerns has escalated dramatically in the past decade. (Barr, 1983)

Recent college student behavior as described in the press has been disturbing. Incidents of acquaintance rape, other forms of sexual and racial harassment, academic dishonesty, violence related to drug availability, assault as a method of solving interpersonal conflicts and the self-destructive behavior of substance abuse and eating disorders have been rampant. It appears that the revised conduct codes of many universities have allowed them to keep public disturbances to a minimum but have left self-control and self-destructive behavior out of range. If, as Glasser contends, behavior is the attempt to reduce the differences between what we want and what we have, how can the general framework of reality therapy and control theory lead to some insight about this "out of control" student behavior and what to do about it?

"What do college students want?" The results of an on-going national research project (CIRP, 1988) indicate that the majority of students want financial success, the status associated with becoming an authority in their own field, to get married and remain married at least long enough to raise a family. Most are not particularly interested in community action work or influencing the political system. They want the government to protect the consumer. In general, they are attending college in order to increase their life-long earning power (CIRP, 1988). They believe themselves to be mature adults, and they are legally responsible for their own behavior, able to sign contracts, to enlist in the military and to vote. They want to meet their basic needs as Glasser describes them, to have power and recognition in their own lives, to be loved and feel as if they belong to family and friendship groups, to experience the freedom of adulthood and to have fun. (Littwack, in conversation, 1989) They seem, to the on-campus observer, to be most adept at having fun.

In contrast, what do college students in the 18-24 age cohort have? According to Arthur Levine (1980), many have weak academic preparation for college and, as a result, have difficulty in meeting the expectations for academic success laid out by professors and parents. Many are inadequately prepared in reading, writing, calculating, problem-solving and speaking. They do not believe that the college bureaucracy cares about their welfare and many students have few qualms about cheating on tests or out of class assignments. (DeLoughrey, 1989) They are often heavily dependent on their family of origin for financial and emotional support and frequently come from families which have been disrupted by divorce, geographic mobility and various kinds of dysfunction. They tend to have a "picture in the mind" of marriage as temporary or dysfunctional and often do not see home as a safe place emotionally or physically.

They have probably been exposed to drugs from their early teen years. They are experienced in using alcohol and other drugs to suppress painful emotions and assist in managing the typical problems and difficulties associated with adolescence in the United States. They use the term "party" as a verb and the activity of partying is defined as the simultaneous presence of some mind altering substance and other people. They have grown up during the 1980's. In general, they assume that politicians are corrupt and that corruption is permissible as long as you don't get caught. Finally, most study on campuses where the administration uses legal counsel whenever necessary to help protect itself in a wide range of liability issues related to student behavior and often looks at liability issues as being more important than educational ones. Today's students see themselves as consumers with as much right to sue their university as they have to sue any other service provider. Education is a commodity and a means to an end.

How can the principles of reality therapy assist in improving this painful situation? Today's students know how to take care of themselves in a defensive and life-enhancing manner but they do not know how to meet their basic needs in a life sustaining manner, specifically their needs for power and control, for belonging in a community and for real freedom. It is the role of student personnel workers to help students learn how to meet those needs in a non-defensive and life-enhancing manner. (Crookston, 1975)

The procedures described by Glasser (1986) provide an excellent "road-map" for use with students in any higher education context. He suggests that the initial step is to make friends with the client. The legacy of the 70's has left student personnel workers, along with other college administrators, in a defensive and legalistic posture vis a vis students and student groups. The time to begin rebuilding trusting, humane relationships has arrived. This does not imply placing university interests in jeopardy by ignoring clearly offensive or dangerous student activities like hazing, abusive drinking or substance abuse, or sexist or racist behavior. It does imply that student personnel administrators, who often have the closest relationships...
with students, go the extra mile to develop trustworthy relationships with students, including those who are frequent violators of student conduct codes. What is required is a return to the basic counseling skill of accepting the student while rejecting the behavior.

Reality therapy focuses on current time and specific behavior. Spend time with students helping them analyze their own behavior in specific detail. Help them describe their own behavior objectively, without blaming others. Help them learn to observe themselves dispassionately, to connect behavior and consequences and to feel the power of their own ability to change. They appear to have few conflict resolution skills other than fight or flight. As children of dysfunctional families they are often merciless in their self-judgment or are in a chronic state of rebellion against the perceived authority. By joining with students in self-assessment activity and focusing on accuracy of description, student personnel workers can help students feel as if they are part of the campus community, contributing to the solution of some important personal and campus problems.

When individuals feel powerless to control their lives, they are often unable to identify the connections between their behavior and its logical consequences. Teach them how to track behavior to its consequences and determine if they are doing things that will actually help them improve their own situation now or in the future. Teach students how to set personal and group goals - what do they really want to achieve by engaging in the particular behavior or activity? The legitimate perspective and concerns of the university administration can be introduced into any discussion of student activities, real liability and responsibility issues, the real complexities of decision-making in an institution which has many constituencies with competing and equally legitimate concerns. As students assess the effectiveness of their own behavior, they can begin to meet their needs for power and involvement in the university community. 18-21 year old's are in a stage of "transitional adulthood." They picture themselves as responsible adults but often do not have the resources (emotional, intellectual or financial) to act in that manner. Consequently, they are often treated as minors and revert to childish methods of getting the attention they desire. Although in loco parentis is no longer an official policy, students who act irresponsibly often evoke parental, defensive and judgmental behavior from the administrators whose respect they crave.

Individual students can learn how to identify and prioritize goals. If their present behavior isn't getting them what they want, they can learn how to plan alternate strategies which will get them what they want. This applies to students who are in trouble with the discipline system, students who are lonely for intimacy or a broader circle of friends as well as students who wish to achieve more academically. On the group level, advisors can engage groups in goal setting and action planning, using the opportunity to help the group achieve its own goals and learn the planning process simultaneously. As individuals and groups learn how to plan responsibly and realistically for goal attainment, they will inevitably begin to meet needs for power, belonging and freedom.

People who feel powerless have difficulty making commitments because they lack confidence in their ability to succeed. Students who are depressed because of developmental and emotional problems often experience this difficulty. Students who are frustrated and feel excluded from the decision-making apparatus of the university will not believe, initially, that they can do anything to change things. Students who have chronic academic or interpersonal problems often feel powerless to change them. Students who are used to blaming others for life's difficulties will not easily risk the vulnerability involved in making a commitment. The best way to manage this part of the learning process is through continuing support and trust. Teaching persistence and unwillingness to accept excuses are also crucial. Students and student groups are the same as anyone else when it comes to excuses and the same principles apply. Student personnel workers are the same as most counselors in this regard. The desire to help and support individuals with difficulties often makes accepting excuses the course of least resistance.

People who easily accept excuses are also prone to protecting people from the consequences of their behavior. In the field of alcohol treatment people who act this way are referred to as "enablers." No responsible counselor wants to see a client exposed to dangerous consequences, but Glasser has consistently stated (1984) that people do not learn responsibility if they are protected from the reasonable consequences of their own behavior. In student affairs it is sometimes difficult to determine which consequences are reasonable and which are not. If consequences are dangerous, they are generally not reasonable. If they embarrass a lot of people, they are probably not reasonable. If they cause students to bankrupt their organizations or render the university liable for negligence like permitting liquor to be served to minors or permitting fire hazards to exist in residence halls, they are not reasonable. If more will be lost than gained by permitting behavioral consequences to occur, then the counselor or advisor probably should take action.

Applying RT principles to working with young adults in college takes a great deal of patience. Student personnel workers are often overloaded in their work situations, under pressure to appear on top of numerous difficult situations simultaneously and to keep students under control. Jobs which have high levels of responsibility and low levels of control are the ones where burnout occurs most quickly. Teaching "Transitional Adults" to be responsible for themselves, to feel control over their own lives and to become fully engaged members of a university community takes a great deal of patience and does not happen quickly. The only way to remain patient is to keep one's frustrations in perspective and that means maintaining balance in one's own life.

There are a number of settings in a college community where the RT approach can be applied. The process of teaching groups how to function responsibly can occur in student organizations and in informal residential groups. Freshman orientation programs and courses can teach new students a process to use as they make the transition to college life with its challenges and discouragements. All student staff including orientation advisors,
residents and peer counselors can be trained in the RT approach and can use it with the students under their jurisdiction. This "action oriented" approach to peer counseling is very likely to be effective because the process is easy to describe and the results, however small, are quickly visible. In the traditional approach to peer counselor training which focuses on communication skills, the counselors themselves typically object to the non-directive methods used and the ambiguity of outcomes. The types of problems which student peer counselors usually handle with their student advisees are quite amenable to the RT process because these problems are usually a matter of teaching a student how to persist, set goals and solve problems. Students who have serious problems are generally referred to professional counselors. Finally, RT methods can be used in their most traditional context, with students who have violated the student conduct code. Since the purpose of most university disciplinary proceedings is to educate students about the consequences of their behavior and to help them improve their decision-making skills in high risk situations, the RT approach is far more relevant than the adversarial legalistic approach which is in place in many colleges at the present time.

American colleges currently find themselves in the difficult and uncomfortable situation of having controlled most public student behavior and not being able to get a firm grip on the private behavior which is most out of control. Students are experiencing a painful gap between what they have and what they want. By applying RT principles as described above, students can learn to get most of what they want (a good career foundation, a spouse and the ability to maintain a marriage), thus reducing the discrepancy between what they want and what they have. By joining with students and making the problem the "enemy", student personnel workers can begin to overcome the adversarial, low trust relationship which has developed over the past few years between students and administration. Students will graduate with the life skills which almost all college catalogues promise to deliver along with academic education, and all of us will benefit.

References
CIRP, (1988). "Cooperative Institutional Research Program" Los Angeles: University of California, Graduate School of Education, Laboratory for Research In Education

CHANGING THE QUESTION: A MODEL FOR PASTORAL MINISTRY AMONG SICK OR SHUT IN PERSONS
Richard W. Conner

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One of the duties of a pastor is to visit the homes of those church members who are unable to attend worship or other activities in the church. For example, the pastor visits in the homes of persons suffering from physical illness, feebleness of old age, emotional trauma, etc. Before RT became a part of who I am, in some ways I used to dread such visits. There were so many people to visit, and for the most part, such persons were truly sick or hurting. I would ask, "How are you feeling?", and they would tell me, "bad . . . sickness, hurt, loneliness, or pain." These visits dragged on forever.

For the past five years there has been a change in the pastor. Now I understand that asking persons to evaluate 'feelings' is asking for information about just one component of a total behavior and the part over which they have little control. Yes, 'feelings' more easily rise to the surface, especially when I would come along and ask . . . "He's asked me how I feel. I guess he's expecting an answer of sickness, hurt, loneliness, or pain. So I'd better give him one."

As RT became part of who I am, I asked myself, "Can changing the question, change the behavior?" Why not ask persons to share with me the part of their behavior over which they do have control and enough control to change their lives. Obviously, the question to ask is "What are you doing?"

In one instance a person was doing little more than moving from bed to chair, chair to bed, depressing. I am no longer willing to sit and encourage him to depress. So I changed the question. Now when I visit, we always do something. As a first step, I insisted that we move to the kitchen table to talk. It was then easy to get out a checker board. Now we are taking walks together outside. The next time I will visit, he promised to plan some of his own activities because he knows that I'm going to ask, "What are you doing?"

Then I discovered that some of these same persons, who at one time were telling me that they were feeling badly, at the same time were 'doing' some interesting, need fulfilling activities in life, activities that I didn't know about because I was asking the wrong question.

All this comes into focus in a visit I made recently to 'Sam'. Sam is a widower in my church who has been alone for eight years, suffering from what I perceived to be depression . . . "life is lonely . . . it hurts . . . nobody cares about me, etc." Physically, Sam is healthy for his 70+ years.
Before RT, when I visited him and asked, "How do you feel?", the visits were awful. Sam never had a good day.

Then one day the question changed, and I asked, "Sam, what have you been doing?" I believe that this was a difficult question for Sam to answer. He had a decision to make. Maybe he was thinking, "Doesn't the pastor expect me to be suffering?" or "How can I suffer when he's asking me what I am doing?"

It happened. Recently I broke into Sam's "all-we-want" world, a world that I didn't know existed! He invited me downstairs into his basement, remodeled as a den. There on a table were dozens of golf club handles that Sam was woodworking into clubs for a golf course. On the sofa was a five string banjo.

"What is this, Sam?"
"A banjo. I take banjo lessons."
He started to play.
He started to sing.
He invited me to sing.
I did.
Awful noise! (Fortunately, we were in the basement so no one could hear us, I think.)

Such a wonderful visit. Sam is doing some need fulfilling things in his life. However, if it were not for RT and the right question to ask, I still would be sitting upstairs with Sam. He would be telling me how badly he felt, hoping all the time that I'd soon leave so he could go downstairs.

INTRODUCING CONTROL THEORY AND REALITY THERAPY PRINCIPLES IN COOPERATIVE LEARNING GROUPS

Robert A. Sullo

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While Control Theory and Cooperative Learning were developed by different individuals working independently, the two are complementary and their effectiveness is enhanced when they are linked. That Control Theory and Cooperative Learning are compatible is well documented. Glasser (1986, 1987) is a strong advocate of using cooperative learning groups in schools. Johnson, Johnson and Holubec, leading experts in the field of Cooperative Learning, refer to Glasser and the compatibility between their ideas and Control Theory (1986, 1988).

The purpose of this article is to outline some of the benefits of Cooperative Learning and to suggest that practitioners in the field of control theory can improve their own effectiveness by introducing control theory and reality therapy principles in cooperative learning groups.

Cooperative learning groups are successful, in part because well structured cooperative learning groups foster the creation of a needs-satisfying environment. The social nature of group work enables individuals to satisfy their needs for Love and Belonging as well as Fun with relative ease. Cooperative learning groups involve a variety of specifically defined tasks. Group leaders can suggest that roles be rotated and shared, providing an element of choice which will allow group members to satisfy their need for Freedom.

Furthermore, because well functioning groups work efficiently, they frequently complete even complex tasks more quickly than individuals working in isolation, providing additional Freedom to group members. Finally, a large body of research suggests that cooperative learning leads to increased achievement. Whether the group be one based in school or be comprised of adults in a non-school workshop setting, the attainment of goals and sense of accomplishment which characterize cooperative learning groups allow individuals to satisfy their need for Power. Clearly, effective cooperative learning groups succeed because they provide a rich, needs-satisfying experience for group members.

Cooperative learning experiences are not valuable simply because they are consistent with the principles of control theory. A significant body of research exists which supports the notion that cooperative efforts are typically more successful than competitive and individualistic efforts in terms of achievement and productivity. In Circles of Learning (Johnson, Johnson, & Holubec, 1986), the authors report on their analysis of 122 studies conducted between 1924 and 1981 concerning the relative effects of cooperative, competitive, and individualistic efforts. "Results indicate that
cooperative learning experiences tend to promote higher achievement than do competitive and individualistic learning experiences. These results hold for all age levels, for all subject areas, and for tasks involving concept attainment (and) verbal problem solving” (p.24). The authors go on to state that the research consistently suggests that “there is no type of learning task on which cooperative efforts are less effective than are competitive or individualistic efforts” (p.24).

Furthermore, the oral repetition of information common in cooperative learning groups leads to more efficient storage of information in long-term memory and generally increases achievement. Finally, “cooperative learning promotes the use of higher reasoning strategies and greater critical thinking competencies than do competitive and individualistic learning strategies” (p.25). In conclusion, cooperative learning has proven to be an effective educational strategy, one which can be skillfully employed by individuals wishing to teach basic control theory principles.

Many practitioners of control theory and reality therapy are asked to introduce these topics to interested groups. Regardless of where we generally work, or how we ordinarily define our roles, when we are asked to introduce control theory and reality therapy to a group, we become teachers. The fact that our students may or may not be in classrooms, may or may not be earning grades or credit, is irrelevant. For that period of time, we are teachers and it makes sense to utilize sound educational practices. For that reason, I suggest the use of cooperative learning groups to introduce control theory and reality therapy whenever possible.

Introducing these concepts in cooperative learning groups should not be done indiscriminately. Some groups will be more receptive to such an approach and some will be somewhat resistant, at least initially. The experience will likely be most successful if the participants will be working together for some time. The cooperative experience can then serve as a vehicle to build involvement for future meetings. Availability of adequate time is also a crucial factor. Since group work initially is more time consuming than a lecture format, be sure you have sufficient time or both you and the group will likely feel pressured and leave the experience less than satisfied.

Perhaps the single most important variable in the success or failure of utilizing this approach is the willingness of the participants to learn in a way that may be new for them. Teachers, especially, can be resistant to this approach, particularly if they sense that their more traditional methods of teaching are being indirectly criticized. Presenters need to be especially sensitive to this issue or they run the risk of alienating their audience and compromising the effectiveness of their presentations.

It would be wise for presenters to prepare participants for a different type of learning experience. If participants arrive prepared to hear a lecture from a reality therapy “expert,” and are unexpectedly thrust into a cooperative learning group, their perception of the experience will be radically different from the picture they brought with them to the presentation, and a less than satisfactory experience will likely follow. If, instead, they are prepared for and receptive to gaining information in a cooperative group, even if they have never had such an experience before, there is a much greater chance of success.

There are special reasons for using cooperative learning groups when speaking to classroom teachers. First, it models the needs-satisfying environment we would encourage teachers to create in their classes. Second, I have found that I essentially never discuss control theory to school personnel without advocating the use of cooperative learning. By utilizing a cooperative learning activity as a vehicle to introduce control theory and reality therapy to teachers, I have teachers actively experience the benefits of cooperative learning groups. An additional benefit to using cooperative learning groups is that it is an effective way to create involvement and teachers can experience how involvement translates into increased learning. Finally, in-service programs are frequently held after teachers have already put in a full day of work with students. It is easy for workshop participants to be less than fully attentive. Teachers are more likely to be alert, awake, and actively involved in a cooperative learning experience.

Even in non-educational settings, the use of cooperative learning groups to introduce control theory and reality therapy is effective. While it is true that the participants won’t necessarily have as many opportunities to use cooperative learning in their professional lives, they still will enjoy the benefits of a presentation which is involving, promotes active learning, encourages critical thinking, and is needs-satisfying.

Is there a place for more traditional teaching or lecturing in this model? Clearly there is. After the participants have been through the cooperative learning experience, they will be in a position to profit from a short lecture, but one which can now be more substantive than would have been possible without the cooperative learning experience. Ideally, this lecture would immediately follow the cooperative learning experience, giving the presenter an opportunity to clarify any misperceptions, emphasize particularly important concepts, and discuss selected issues from a control theory perspective, safe in the knowledge that the audience is now acquainted with basic control theory/reality therapy principles. In essence, therefore, the use of cooperative learning groups does not take the place of the more traditional lecture format. Instead, it creates a setting in which the participants can profit fully from a short, in-depth lecture. Ultimately, such an approach should result in participants being able to effectively integrate control theory and reality therapy principles into their personal and professional lives more quickly and successfully.

In conclusion, practitioners may want to consider utilizing a cooperative learning experience when asked to introduce control theory and reality therapy principles to interested audiences. Cooperative learning is based upon sound educational principles and has been shown to be an effective teaching strategy. The cooperative group is useful in creating an environment characterized by increased involvement. Finally, the well structured cooperative group experience will allow all group participants to satisfy all of their basic psychological needs. Under these conditions, participants are more likely to actively pursue more information about both control theory and reality therapy.
PROFESSIONAL ISSUES: CONSULTATION AND ETHICS PART I
Robert Wubbolding

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The 1980's witnessed a startling increase in the number of consultants who service public and private agencies as well as companies. Jonas (1989) reported in the United States alone in 1980, there were 50,000 such people constituting a $32 billion industry. By 1989 the world of consultants had grown to a $160 billion industry with 250,000 people claiming the title.

In view of the fact that control theory constitutes a description of human behavior which is universal, and since reality therapy comprises a delivery system for equally universal human interactions, many practitioners of these ideas not only counsel individuals and groups, but they also train others to apply these principles. This latter effort, the delivery of indirect services, constitutes "consultation." Serving as a basis for consultation are many sources. Thus, Glasser and Karrass (1980) have described a comprehensive system for applications to the world of work. Wubbolding (1984, 1986, 1988, 1989) has developed a system for supervision and management and has applied the "WDEP" metaphor to business and industry including applications to wellness, lifestyles, and time management.

Because the extensive training program of the Institute of Reality Therapy includes many trainers, and because many RTCs work as consultants, it is useful to insure credibility and competence by understanding and adhering to ethical standards as they apply to consulting.

Therefore, the purpose of this article is to provide an overview of ethical principles that govern such consultation. In the future I will discuss other professional issues related to consultation such as presenting oneself to a potential client and questions to explore with the potential client.

Below is contained an ethical case to be examined. Please identify the ethical issues involved and decide whether Leslie acted appropriately or not. Then after reviewing the principles, reread the case and reevaluate Leslie's behavior.

Leslie and Lee, A Case Study

Leslie received a Masters degree in Personnel and then worked in personnel departments for rural mental health programs and for the mental health board. Leslie then became certified in reality therapy and opened a private practice in counseling and consulting in a state that has no law for licensing counselors or social workers. Dr. Glasser came to the community and spoke to a large group about schools and referred to the "teacher as manager."
Lee, the president of a company with 500 employees, was present at this lecture and later approached Leslie saying that the ideas might apply to the business. The company, it was stated, needed to lower health care costs, streamline the paperwork which seemed to be excessive, lessen turn-around time for incoming orders, decrease interdepartmental turf fights between the sales, production, accounting and credit departments. In addition, many recently promoted first line supervisors lacked interpersonal skills and seemed to have personal problems.

Leslie guaranteed Lee that reality therapy applications would solve the problems and that Leslie alone could handle the problems. The plan would include:

1. Developing an exercise program for employees.
2. Conducting group meetings of representatives from various departments. These meetings would help participants clarify their wants.
3. Reviewing the paperwork procedures and providing better alternatives to their current practices.
4. Initiating a training program for first line supervisors in which they would learn reality therapy.
5. Counseling the first line supervisors and department heads about their “personal issues” which he was certain were at the root of the organizational dysfunction and which he assured Lee could be resolved quickly.
6. Providing personal therapy for Lee so that he can be more aware of his own interactions with employees.

Types of Consultation:

In order to understand the ethical principles involved in consulting and to apply them to the above case and other real life cases, it is first useful to be aware of the various types of consultants under three labels: technical consultants, clinical consultants, and process consultants.

1. Technical consultants: Such professional persons provide advice and attempt to solve the problem for the client. Computer consultants are examples of such individuals. If a computer fails, an “expert” is brought in to fix it. The auto mechanic can be called a technical consultant in a wide sense of the term. This consultant fixes the problem with minimal involvement of the client. The motto of the technical consultant is “I will do it for you.”

2. Clinical consultants: Physicians are examples of clinical consultants. They too, work with people to help them solve problems. The client, however, is more personally involved than in the case of the technical consultant. And, while the medical profession is attempting to utilize the third type of consultation, still their motto is “I will do it to you.”

3. Process consultants: Organizational consultants, personnel workers and psychological trainers constitute this type of consultant. The emphasis is on working with the client to identify problems, search for alternatives, change behavior and most importantly to help the clients themselves take both the “ownership” of the problem and the credit for the solution. The motto of the process consultant is “Together we will work it out.”

Summary of Ethical Principles

Corey, Corey & Callanan (1988) have identified 20 ethical principles which pertain to consultation. I have selected and expanded upon those that are most relevant to reality therapy training. (Process Consultation.)

1. The interests of the consultee comes first. While this sounds obvious and easy to implement, it can be a difficult norm to follow if the potential contract is large and if another service option is more beneficial to the consultee. Nevertheless, if the services offered by the consultant do not match the wants of the consultee, the latter should be referred to an appropriate consultant.

2. Consultants represent themselves accurately. They do not present themselves, for instance, as having degrees which they don’t have. Vague statements such as “I studied psychology” can be potentially misleading if the potential client is led to make unwarranted inferences about the background and competency of the consultant. Wubbolding (1989) states “It is the responsibility of reality therapy counselors to present their credentials to the public in such manner that does not indicate or even imply that the counselors have a skill or specialization that they are lacking.” Robert Woody (1988) who is a psychologist and a lawyer, strongly urges practicing “onestowns- manship”. It is far better to be modest in describing one’s credentials than to attempt to dazzle and beguile the potential client, or to make guarantees. He states that scrupulous attention to accuracy if not underselling one’s ability puts the professional on a solid ethical footing and lessens the danger of accusations of malpractice. My suggestion is that anyone seeking to function as a consultant first examine his/her own skill level and experience, then carefully work within the boundaries of these limitations and be careful not to offer “one of a kind” services. In the long run very little is lost when consultants decline to conduct a program for which they are not well qualified. For in describing what the consultant can do and cannot do, he/she usually enhances his/her professional reputation and with appropriate follow-up discussions with the potential client can discover opportunities which fit his/her qualifications.

3. Consultants are aware of possible conflicts. Thus if a consultant has a value that conflicts with that of the consultee, this should be explored. If the clash is significant the consultant should not accept the contract. For instance, consultants who encourage trainees to act against the policies of the company or agency which hired the consultant open themselves to charges of unethical conduct. Consultants who feel they cannot support the general practices of the agency are advised to decline such employment. Accepting such
employment is rarely in the best professional or ethical interests of both parties.

4. Consultants remain in the consulting role with their clients and avoid dual relationships. Thus they do not provide therapy for the consultee. Teachers of reality therapy might be asked by a consultee to serve as personal therapist. The consultant/consultee relationship should not be clouded by another relationship.

In summary, it is important to note that each time a professional person presents him/herself to the public, ethical principles must be considered. Important among such principles is the “standard of practice”, i.e., what professionals view as appropriate and inappropriate behavior. Thus, it behooves the teacher of reality therapy to be aware of ethical principles as they apply to consultation. At this point, please reread the case of Lee and Leslie and identify the many ethical violations by Leslie.

Bibliography
When what we want we do not have
then, look out! — we're in pain.
And that's about the time we start
to drive our cars again.

Sometimes we go down lots of roads
that don't make lots of sense.
And you can bet there'll be some times
we all have accidents.

So point out to your clients
that choices do abound.
They're never ever down so far,
you can't get off the ground.

You cannot solve their problems, but
ideas you can give.
You'll surely never help them die.
So teach them how to live.

And when they start to tell you
how they "just feel bad" or rave—
don't forget to teach them that they
totally behave.

Just question them, and treat them kindly—
lead them through the weeds.
But don't say "try" and don't ask "why"
and don't deny your needs.

And don't forget those V.J.'s
that really must be made.
If you forget to ask for them,
you'll get a lousy grade.

So all you helping folks out there
remember Billy G.
He says we'll all relate to growth
if we just use R.T.

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