2321 Theory & Practice 2: Lecture 5[1]

REALITY THERAPY: William Glasser (born 1925)

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'Essence of reality therapy . . . is that we are all responsible for what we choose to do. We may be the product of our past, but we are not victims of the past unless we choose to be' (Corey, 2001: 229).

[1] Notes come partly from Corey (2001) who has a recent exposition of William Glasser's later work. (See the footnote Corey, p. 230 which indicates that Glasser himself did much of the work on Corey's chapter.) Also from a chapter 2 of *Reality Therapy in Action* by Glasser.

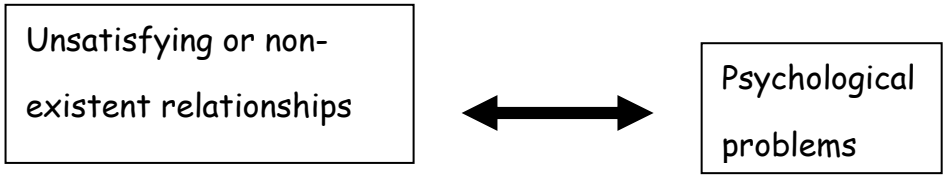
INTRODUCTION

William Glasser, the creator of reality therapy in the early 1960s, began to use *control theory* in the late 70s to more fully explain his work but later changed its name to *choice theory* in the late 90s. Choice[2] theory is now at the core of what Glasser is attempting to do.

Glasser believes that the underlying problem of all CTs is the same: either involved in an unsatisfying relationship(s) or lack what could be called a relationship at all. Therefore, for therapy to be successful, therapists must help their CTs to develop a satisfying relationship and teach them to choose more effective ways to behave.

Glasser's view is that:

[However, the process may also work in reverse. Psychological problems may actually lead to unsatisfying relationships.



Or, it may work either way in some cases.]

[2] I hope you can see how philosophical issues regarding 'free will' are inherent within counselling because 'choice' theory rests on an assumption that we are free to choose.

Hence, accoding to Glasser, to fix up psychological problems therapy must focus on bettering CTs' relationships.[3]

CTs, says Glasser, have problems because of what they are choosing to do. They are choosing to behave in these self-defeating ways because of the frustration associated with an unsatisfying relationship. Hence, these are not 'mental diseases' as such. Mental diseases or illness (e. g., epilepsy) are best treated by neurologists. If one suffers from depression or anxiety, one does not need to continue to say to oneself and others, 'I'm depressed' or, 'I'm anxious'. Instead, can say, 'I've been depressing myself because that was the best way I could see of dealing with the situation I was in but I'm going to now look for better choices'.

The relationship with the CT is pivotal in reality therapy (RT). As trust is developed between CTs and therapists so CTs learns to stop making destructive or self-defeating choices that have marred their lives. Therapists need to be able to teach CTs how to sustain satisfying relationships in their lives.

1. VIEW OF HUMAN NATURE

One of the predominant psychologies of the 20th C has been what can be called, an external psychology, namely applied behaviour analysis. This procedure stems from behaviourism and uses changes to antecedents and to consequences of behaviour to change behaviour. These changes are external and are only successful because a choice was made at an appropriate time to respond to the external influence.

Choice theory is an internal psychology. This theory assumes that all behaviour comes from within. We choose our behaviour and we choose the

[3] In passing, note the parallel with the Bobgans' view that problems arise because of an unsatisfying relationship with God. However, note that psychological problems can also *lead to* an unsatisfying relationship with God!

best behaviour for our need or needs[4] at the particular time. Because we choose, we must also accept the consequences of our behaviour. Some consequences are natural (such as overeating produces gains in weight), others are imposed (such as incurring a fine if one is caught breaking the speed limit).

We are born with 5 'genetically encoded needs – survival, love and belonging, power, freedom, and fun' (Corey 2001: 231). These vary in strength from person to person. Our brains constantly monitor whether these needs are being satisfied or not. If we are failing to meet one or more of these needs, we feel bad. Our pain drives us to find a way to feel better. Reality therapists teach CTs choice theory in order for them to identify unsatisfied needs and seek to satisfy them. Glasser believes the need to love and to belong is the primary need.

Choice theory also assumes that each of us has what is known as our *quality world.* In this world, we store everything or everyone we meet in life that makes us feel good or whom we imagine would make us feel good. Pleasurable experiences and beliefs that make us feel good are also stored there. However, people are the most important element in the quality world. Those coming into therapy are those who have no one in their quality world or who have people that they cannot satisfyingly relate to there.

It is most important for the CT that the CR is able to get into this quality world for therapy to be successful. 'Getting into the clients' quality world is the art of therapy' (Corey, 2001: 232).

[4] Reality therapy is a needs-based and needs-driven therapy. Hope you can appreciate again the large part that 'getting one's needs met' plays within both the therapeutic and wider human world within western society.

2. CHOICE THEORY EXPLANATION OF BEHAVIOUR

A gap exists between our needs and what we are getting (our wants). Behaviour occurs to close this gap between needs and wants. Corey likens our behavioural choices to the image of a motor car. The motor is our basic needs, the steering wheel allows us to steer our lives in the direction of our quality world. Thinking, acting, feeling and physiology are the 4 wheels of the car. The first two are like the front wheels of a car and control the other two. The first two are under our personal control more so than the last two.

Being depressed, being anxious, having a headache are expressions which avoid our responsibility in behaving in these ways. We choose to be depressed and hence, when depressed, we are depressing. We choose to have a headache, and hence, when we have a headache, we are headaching.

When CTs are faced with this approach they are likely to say that they are suffering and that they can't understand how anyone can say that they are choosing to suffer. Glasser would answer that CTs don't choose *directly* to suffer but that it is part of a total behaviour. To the question of Why? Glasser would give three possible explanations:

1. frustrating relationships lead us to choose anger but angering behaviour is also dangerous for others and for oneself (because other person may be stronger or one may be dependent on that person). So, to reduce that risk, depressing and other immobilising symptoms are chosen to neutralise the anger;
2. depressing is one way of getting help without having to beg. Depressing enables us to retain our self-respect and our sense of power;
3. depressing and other types of mental illness enable us to avoid doing what we are afraid to do. Losing a job will often be followed by depressing because, in that way, we don't have to face another rejection.

Depression can be understood within the RT paradigm using the acronym ACHE. Depressing can do four things for us: helping us deal with anger, an

emotion that is more dangerous than the passivity associated with depression; giving us a measure of control over circumstances that may seem out of our control (e. g., death or illness); securing help from friends, doctor, and/or institutions; providing an excuse 'for not doing what we should' (O'Morain, n. d.: n. p.).

3. THE CHARACTERISTICS OF RT

First, find the unsatisfying relationship or the lack of a relationship which is the root cause of the problem. CT will tend to bring this up. What is characteristic of CTs is that they will blame the other person(s) for the failure of their relationships or for the pain they are suffering.

RT does not get involved with blaming or finding fault. The CT cannot control the behaviour of others. Therefore, RT concentrates on what the CT can control: her own behaviour. Complaining, blaming and criticising are given short shrift by Reality therapists as these are self-defeating behaviours. The CT may complain that being unable to control the behaviour of someone else is unfair the therapist will respond that life is often unfair and we cannot go through life demanding that it be fair.

Involve the CT in meaningful activities that will draw them closer to the people he wants in his quality world because work is a way of gaining the respect of others. Also, work enables us to gain self-respect. A greater sense of self-respect leads to less need to choose irresponsible behaviours.

Glasser rejects the notion of transference and certainly chooses not to use transference as part of therapy. Glasser would respond to a CT's assertion that he reminds her of her father by saying that he (Glasser) is not her father or anyone else but himself. Glasser asserts that Freud developed the notion of transference as a way of avoiding getting personally involved with his

patients.[5] RT 'welcomes responsible involvement' (p. 234). RT understands the therapeutic relationship as the central way of teaching CTs 'how to relate to others in their lives' (p. 234).

RT is a therapy of present. Glasser believes that although problems may have started in the past we cannot change our past. He believes that many CTs grasp the opportunity to visit their past believing that they must understand the past in order to change their present. However, he sees this manoeuvre as an avoidance of the present problem they have: an unsatisfying *present* relationship.

Past traumas cannot be changed in their consequences by visiting them in their original form even if we could know infallibly that we have found them in their pristine form. 'All we can do is try to change our present behaviour so that we can get along with people we now need' (p. 235). Although the RTh does not accept that visiting the past is helpful she will allow the CT some time to peruse that area if there is a real risk that the CT will feel deep rejection if that examination is not allowed.

Nevertheless, she does not encourage this process and at some convenient time will say that the past cannot be changed because it is over. The time we spend there, is time we take away from dealing with the present problem of finding a satisfying relationship here in the present.

RT avoids focussing on the nature of the symptoms. RT does not ask CTs how they are feeling because such a focus takes up time that is better spent focussing on the reality of unsatisfying present relationships. Symptoms cannot be improved until the quality of relationships is improved. Hence, minimising time spent on hearing about symptoms and avoiding going into the past to focus on present problems are two ways of reducing the time

[5] Somewhat gratuitous dismissal of transference I think.

spent in therapy. Corey (Glasser) contends that something can be done in 2 sessions and much can be done in 10 sessions.

a) The Relationship in RT

From the beginning Gasser has maintained the importance of the therapeutic relationship and particularly the need for the CR to be involved in the cng process with the CT. Qualities that the CR needs to have are 'warmth, understanding, acceptance, concern, respect for the client, openness, and the willingness to be challenged by others' (p. 237).

The art of cng is the ability to successfully establish a relationship with a wide variety of people who would not ordinarily be part of one's life. Glasser has been able to do counselling with those who at first would not speak to him. He did this in one case by telling the CT he would ask questions and would answer them the way he thought the CT would. After 10 minutes the CT broke into Glasser's session by saying, 'I would not have said that!' After that, all went well.

b) The 'WDEP' system

The WDEP was developed by Robert Wubbolding (Justice, 2003: n. p.) and sums up much of Glasser's philosophy in a summary form.

i) W = wants (exploring wants, needs, and perceptions)

'What do you want?' is a major question that the reality therapist asks the CT. CRs assist CTs to explore their quality world and 'how their behavior is aimed at moving their perception of the external world closer to their inner world of wants' (Corey, 2001: 240). A non-critical and accepting CR manner helps the CT to reveal what is in her quality world. This exploration will involve many sides of the CT's life and will include expectations she has of the CR and of herself. This investigation of the wants, needs, and perceptions should continue throughout the counselling process as the CT's quality world changes.

To identify what the CT may want the question, 'What kind of person would you be if you were the person that you wish you were? could be asked.

ii) D = direction and doing

According to Justice, 'the person being helped describes the current situation and related details' (2003: n. p.). RT stresses current behaviour and therefore, asks the question, What are you doing now? What did you do during the past week? What would you want to do differently this last week? What stopped from doing what you say you wanted to do? Even if most problems are rooted in the past, the past is only discussed if that helps to plan a better tomorrow. Early in therapy, it is desirable to discuss with CTs the overall direction of their lives: What do you see for yourself now and in the future? It may take some time before this perception of the future becomes clear but it needs to be worked on.

RT aims to change total behaviour not just attitudes and feelings. Listening to a CT talk about feelings is only productive if it leads to change in what he is doing. To use an analogy of oil red warning light on a car's dashboard: We don't immediately assume that the light is at fault but that the oil level in the car's engine is too low. Similarly, inappropriate emotional displays are an indication that something needs to be changed in the thinking and doing areas of life. We try to change thinking and doing because these functions can be controlled relatively easily.

iii) E = evaluation

'The core of reality therapy, as we have seen, is to ask clients to make the following evaluation: "Does your present behavior have a reasonable chance of getting you what you want now, and will it take you in the direction you want to go?"' (p. 241). This process of evaluation is considered central to the success or otherwise of therapy. Corey presents a list of other questions that are helpful in assisting CTs to evaluate their present behaviour. For

example, 'Is what you are doing helping or hurting you?' Is what you are doing what you want to be doing? Does you behaviour match up with what you believe? Is you behaviour against the rules? Is what you want in your best interests and in those of others?

Confrontation is important at this point of evaluation so that the consequences of behaviour are clearly understood by CTs. 'The process of evaluation of the doing, thinking, feeling, and physiological components of total behaviour is within the scope of the client's responsibility' (p. 242). Reality therapists may be more directive with CTs who are in crisis, alcoholics, and children of alcoholics as these CTs seem to lack the thinking behaviours to make evaluations of 'when their lives are out of effective control' (p. 242). Such CTs often do not know what their wants are and whether their wants are realistic. However, with time spent in therapy they learn to make the needed evaluations with less CR intervention.

iv) P = planning and commitment

Once what the CT has identified what she wants to change there is need to develop an action plan of some sort. If a plan doesn't work then another can be substituted. Rigidity is outlawed in RT; flexibility is a necessary virtue.

Wubbolding uses the acronym SAMIC3 to elucidate the characteristics of a good plan:

(A) simple

easy to understand

(B) attainable

CT should be able to do what is specified

(C) measurable

Immediate (to be carried out as soon as possible

(D) involving for the client

(E) the 3 Cs

controlled by the planner,

committed to (plans are useless if there is no commitment to carry them out), &

continuously practised (Corey, 2001: 242).

CRs need to be persistent with CTs so that the latter know that the CR will not give up on them. CRs need to consult with other RT practitioners to improve their practice of RT and develop themselves professionally.

REFERENCES

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