Psychotherapy Guidebook

Reality Therapy

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DEFINITION

In simple terms, Reality Therapy is based on two principles. They are that man is driven by 1) a need for love, a meaningful and reciprocal relationship with a responsible person. According to Dr. William Glasser, the founder of Reality Therapy, "In all its forms, ranging from friendship through mother love, family love, and conjugal love, this need drives us to continuous activity in search of satisfaction." 2) A need for a feeling of self-worth, self-esteem, self-respect. "Equal in importance to the need for love," Glasser adds, "is the need to feel that we are worthwhile both to ourselves and to others. Although the two needs are separate, a person who loves and is loved will usually feel that he is a worthwhile person, and one who is worthwhile is usually someone who is loved and who can give love in return." The reality therapist works actively with the client to help him meet these needs, and the emphasis in treatment is on here-and-now events in the clients' life, rather than on past events (as in psychoanalysis).

HISTORY

Dr. William Glasser received his psychiatric training at the West Los Angeles V.A. Neuropsychiatric Hospital and UCLA. During his internship he began to question the basic tenets of classical psychoanalytic theory and practice. Building 206 of the VA hospital, which was directed by Glasser's mentor, Dr. G. L. Harrington, exposed Glasser to a typical chronic ward of psychotic patients. The patients in this ward were confined an average of seventeen years, and the average discharge rate was about two patients a year. When Harrington and Glasser introduced the nuclear concepts of Reality Therapy, the ward was quickly transformed from a custodial storage tank for people waiting to die into a lively therapeutic community that returned most of the patients to a constructive existence in the community.

Glasser's first important assignment (in 1956) as a full-fledged psychiatrist was with the Ventura School for Girls, an institution operated by the State of California for the treatment of seriously delinquent girls. Here he introduced and refined the ideas and techniques used in Building 206, with the same gratifying results. In 1961 Glasser published his first book, Mental Health or Mental Illness?, which laid the foundation for the emergence of Reality Therapy.

Glasser first used the term "reality therapy" in April 1964, in a formal paper delivered at a criminological convention, and a year later Glasser's seminal volume, Reality Therapy–A New Approach to Psychiatry, was

published by Harper & Row. The book is notable for its scrupulous freedom from jargon, its dedication to common sense, and a clear and determined rejection of the prevailing psychodynamic mode of psychotherapy. Soon after its publication, Glasser established the Institute for Reality Therapy in Los Angeles, where he conducts training programs for qualified practitioners.

Students of Reality Therapy note that a spiritual ancestor was Paul DuBois, a Swiss physician who urged in 1909 that the doctor treat his patient as a friend rather than a “case,” and provide him with a positive, healthy outlook on life. Dejerine and Gaukler (1913) in France and Joseph H. Pratt, the group therapy pioneer in this country, expressed many of the same ideas. Alfred Adler and the founder of the so-called psychobiological school, Adolph Meyer, likewise echoed a number of Reality Therapy sentiments. However, it should be recognized that at the time Glasser began to formulate his theories and techniques, he could not have been directly influenced by these people.

TECHNIQUE

Although Glasser’s theory has become increasingly complex during the period 1962–1977, the technology of practice has remained relatively consistent, easy to understand in principle, but devilishly hard to do.

1. **Involvement.** A warm, friendly, personal relationship is the foundation for the successful practice of Reality Therapy.

One cannot crack the lonely armor of the failure/identity person by being aloof, impersonal, or emotionally distant. The client must become convinced that another human being cares enough about him to discuss his life philosophy, his values, his hopes for the future as well as politics, sports, sex, and religion in an honest and transparent fashion. Any subject that both therapist and client consider worthwhile and interesting are appropriate for conversation. When the therapist can get the client to joke and laugh with him, progress is being made.

Very soon the client presents a problem that is bothering him. The therapist listens as the client usually thrashes about, blaming his miserable childhood, his unfeeling parents, his boss, his wife, society, fate, etc.

2. **Behavior.** The therapist does not argue about the client's self-serving analysis of his troubles. Instead he firmly moves (once the involvement is strong enough to stand the strain) to get the client to examine his behavior. "What are you doing?" is a favorite RT question. Glasser proposes that no one can gain a success identity without being aware of his current behavior.

People in trouble often avoid facing their present behavior by speaking at length about their feelings. Of course, feelings are important, but for a relationship to be successful, how we behave is what counts. So, if a depressed woman comes to Dr. Glasser's office and laments at length about how upset, worried, and miserable she feels, he might

respond, “I believe you. You have convinced me that you are depressed, and I appreciate that you are upset. But what are you doing?”

3. **Evaluation.** After his behavior has been held up for scrutiny and described in detail, the therapist gently asks, “Is it doing you any good? ... Is it the best available choice for you? ... Is it in the interest of your wife, your children? etc.” This self-evaluation feature of Reality Therapy is frequently misunderstood. The therapist does not act as a moralist; he does not deliver sermonettes; he does not tell a patient his behavior is wrong and that he must change. The judgment “I ought to change” belongs solely to the patient.

4. **Plan.** It is not sufficient that the person declare that his behavior is counterproductive. The therapist must help him work out a plan that will bring him involvement and self-worth. The tact, creativity, and ingenuity of the therapist is tested at this stage of the therapeutic process. He must avoid a plan that is beyond his client’s ability. A failing person needs success. Glasser says, “The plan should be ambitious enough so that some change, small though it may be, can be seen, yet not so great that failure is likely.” A plan that calls for small, success-assured increments of change is better than one that is grandiose. The plan should be concrete, specific, with no loose ends or uncharted contingencies.

5. **Contract.** The legal profession discovered centuries ago that a commitment, a contract, helps a wavering client stick to his resolution. Glasser was a pioneer in adapting this notion to

his therapeutic technique. It is characteristic of people with failure identities that they avoid committing themselves, initialing a contract. Perhaps, in their loneliness they are convinced that no one cares, and if they fail they will be exposing themselves to more pain. But insisting on a verbal commitment, even a written contract, intensifies involvement. It verifies that the therapist is concerned about him and provides him with the strength to carry out a minimal plan that may lead to more ambitious projects in the near future.

6. **Follow-up.** It is well that we recognize that the failure identity person may agree to a plan, make a commitment — and then do nothing. Therefore, the reality therapist leaves as little as possible to chance. He may say, "You have this plan, and you've made a contract to carry it out. But how will I know that you did it?" This approach is an additional sign of the therapist's concern and involvement. He may accept the suggestion that the client will telephone, or report in person about fulfilling the contract.

7. **No excuses.** In the course of the follow-up, the reality therapist is not amazed if the chronic failure person does not carry out the plan. Invariably this client will present a whole array of excuses. In Reality Therapy, once a commitment has been made, the therapist does not accept excuses. He does not discuss excuses. He does ask why; he says, "Let's not waste time arguing about excuses. What counts is accomplishment. Do I still have your commitment? Perhaps the plan was too hard for you. Should we make it easier or leave it as it is?

When will you carry it out? Will you initial this contract? How will I know if you've carried out the plan?" Excuses and rationalizations disrupt involvement and have no place in Reality Therapy.

8. **No punishment.** Successful people have an exaggerated regard for the value of punishment because they believe that a great deal of their own success stems from a fear of punishment. But the reality therapist is aware that with failure-oriented individuals, punishment, the use of mental or physical pain to modify behavior, generally does not work. Incompetent and irresponsible people are punished over and over again throughout their lives, but instead of changing for the better, they tend to become even more fixed in their failure identity. The rule of Reality Therapy is: no punishment, but no interference with natural consequence. Therefore, the therapist does not scold, curse, ridicule, or denigrate people; he uses praise in large measure instead.

9. **Never give up!** Finally, the reality therapist must appreciate that his clients are often content with failure and want him to give up on them. Then their world view will be confirmed: "I'm no good. It's no use trying. Nobody expects me to accomplish anything." The reality therapist mobilizes his own strength and patience to persist in maintaining an involvement despite failure after failure.

Although these steps are presented here in a somewhat mechanical form, their correct application in real life requires great flexibility, creativity,

patience, and humor on the part of the therapist.

APPLICATIONS

In contrast to conventional psychodynamic therapy, which seems to be effective only with people who suffer from what may be called the YARIS syndrome (Young, Articulate, Rich, Intelligent, and Successful), Reality Therapy frequently works with those populations that are beyond the parameters of conventional treatment: the failures, the criminals, the addicts, the whole army of poor and ineffectual people that most therapists will not touch.