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Recognitions Offered: Remember, how will anyone ever know unless we tell them?

In the last issue of the *International Journal of Choice Theory and Reality Therapy* (i.e., Vol. XXXII, No.1) everyone was invited to write and submit a tribute to the person of their choosing in an effort to recognize him/her/them for what s/he/they have done for you, others, and/or the WGI organization.

The reason for this invitation was two-fold:

First, it gives each of us an opportunity to say "thanks" for what they have already done, and . . .

Second, it gives them a "reputation to live up to," so that they might more likely do other good deeds for others for many more years to come!

Unfortunately, however, I haven't heard from anyone, so I'll invite you again to write and submit your letters of recognition for anyone that you deem to be so honored by you and the WGI organization! These letters, in turn, will be included in the **fall, 2014** issue of the Journal! Just submit them by September 1, 2014, to my attention at parishts@gmail.com

Kindly indicate in your letter heading or subject area "recognition letter."

Notably, though, I won't let this opportunity pass without highlighting those who have been my greatest assets!

First and foremost I must recognize **Bob Wubbolding** as my greatest inspiration, mentor and friend, since he has never let me down, in fact, he's done yeoman's work on more occasions than I can count!

Second, though **Bill Glasser** has passed, his unwavering assistance, support, and direction was always greatly appreciated.

Third, **Gary Applegate**, from many moons ago, introduced me to Reality Therapy, and all that I needed to know about it. Notably, he was the single best teacher that I had ever had, and for his Herculean time and effort, I have always been very, very glad.

Fourth, **Gary Maloney** comes in here, for he always expressed great confidence in me, and he made that crystal clear. In addition, there's no one on this planet that is as cheerful as Gary, therefore, I'll remember his smile forever, or at least until I get buried!

Fifth, I would say is **Bruce Allen**, who always ably assisted me in so many ways, so he belongs on this list of "my top five," what more can I possibly say?

To each of these individuals, and to everyone else within the WGI organization, too, I would like to gratefully thank each and every one of you!

Sincerely,

Thomas S. Parish

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Introduction to the *Journal*, its editor, editorial board, and essential info regarding the Journal

***IJCTRT* Editor:**

The current editor of the *Journal* is **Dr. Thomas S. Parish.** Dr. Parish is an Emeritus Professor at Kansas State University in Manhattan, Kansas. He earned his Ph.D. in human development/developmental psychology at the University of Illinois in Champaign-Urbana, Illinois, and subsequently became CTRTC certified, specializing in the areas of mental health, educational counseling, and marriage and family counseling. He has authored hundreds of refereed journal articles (many of which having focused on CT/RT) that have appeared in more than thirty different professional refereed journals. He has an extensive background in designing and conducting research studies as well as developing strategies for the implementation of Choice Theory and Reality Therapy. He is currently serving as a consultant for LDS Family Services, which is located in Independence, Missouri. This organization provides various psychological and family services to much of Kansas and Missouri. Any correspondence, including questions and/or manuscript submissions, should be sent to Dr. Parish at: parishts@gmail.com You may also contact him by phone at: (319) 230-9970, (785) 215-3012, or (785) 862-1379. In addition, a website is currently operational for the Journal. It is www.ctrtjournal.com. Plus the Journal is no longer password protected on the William Glasser Institute (WGI) website, so anyone can now gain access to it.

***IJCTRT* Editorial Board:**

Besides **Dr. Thomas S. Parish**, who serves as the editor of the *Journal*, there is also in place an outstanding team of individuals who have agreed to serve on its editorial board. They are:

Thomas K. Burdenski, Ph.D., Licensed psychologist and Associate Professor of Counseling Psychology at Tarleton State University in Ft. Worth, Texas.

Emerson Capps, Ed.D., Professor Emeritus at Midwest State University, plus serves as a member of the William Glasser Institute Board of Directors, and as a faculty member of the William Glasser Institute.

Janet Morgan, Ed.D., Licensed private practice professional counselor in Columbus, Georgia.

Joycelyn G. Parish, Ph.D., former senior research analyst for the Kansas State Department of Education in Topeka, Kansas.

Patricia A. Robey, Ed.D., Associate Professor at Governors State University, University Park, Illinois, Licensed Professional Counselor, and Senior Faculty of WGI-US and William Glasser International

Brandi Roth, Ph.D., licensed private practice professional psychologist in Beverly Hills, California.

IJCTRT Mission:

The International Journal of Choice Theory and Reality Therapy is directed toward the study of concepts regarding internal control psychology, with particular emphasis on research, theory development, and/or the descriptions of the successful application of internal control systems through the use of Choice Theory and/or Reality Therapy.

Publication Schedule:

The *International Journal of Choice Theory and Reality Therapy* is published on-line semi-annually in the fall (about October 15) and spring (about April 15) of each year.

Notice to Authors and Readers:

Material published in the *International Journal of Choice Theory and Reality Therapy* reflects the views of the authors, and does not necessarily represent the official position of, or endorsement by, the William Glasser Institute. The accuracy of the material published in the *Journal* is solely the responsibility of the authors.

Permissions:

Indices of Previous Authors and Titles:

Indices of Previous Authors and Titles are Located in the Following Volumes:

Vols. 1-5 in Vol. 6.1; Vols. 6-10 in Vol. 10.2; Vols. 11-15 in Vol. 16.2; Vols. 16-20 in Vol. 20.2; Vols. 21-24 in Vol. 25.2: Vols. 26-30 in Vol. 31.2.

Answers to Key Questions Regarding Choice Theory and Reality Therapy—

Are YOU interested in finding past research, ideas, and/or innovations regarding Choice Theory and/or Reality Therapy? If so, you might do the following:

Check out the last sections of the 2011 issues of the *International Journal of Choice Theory and Reality Therapy*, as they summarize CT/RT research, ideas, and innovations, which are categorized by topic and by author.

Are YOU interested in acquiring past issues of CT/RT-related articles? If so, you might note the following:

All issues of *IJCTRT* from 2010 until present are available at "http://www.ctrtjournal.com." Notably, future issues of the Journal will also be made available at this website, too, all without charge. Yes, it's available to anyone, be they members or not!

Anything prior to 2010 can be acquired by going to http://education.mwsu.edu then under the Links Area, click on the hyperlink "International Journal of Choice Theory and Reality Therapy," which will take you to the Journal page. On this page there will be hyperlinks to abstracts and a form to request a copy of any full article(s), which is (are) available to you free-of-charge.

This service is being provided by Dr. Matthew Kapps, Dean, West College of Education at Midwestern State University in Waco, Texas. Notably, WCOE at MWSU is the sole sponsor of the *International Journal of Choice Theory and Reality Therapy* and has agreed to provide this service **free** for the foreseeable future!

Are YOU interested in submitting a paper that you have authored/co-authored to the *International Journal of Choice Theory and Reality Therapy*? If so, you need to attend to the following:

For published guidelines regarding manuscript preparations for submissions to *IJCTRT*, kindly refer to any of the following past issues of the *International Journal of Choice Theory and Reality Therapy:*

Spring, 2012, Vol. 31, #2, pp. 5-6.
Spring, 2011, Vol. 30, #2, pp. 4-5.
Fall, 2010, Vol. 30, #1, pp. 6-8.

Finally, To submit your paper for possible publication in the *IJCTRT*, just send it to:
"parishts@gmail.com"

THE WORK OF BRANDI ROTH

Robert E. Wubbolding and John Brickell

Abstract

This article, the fourth in a series describing the work of many members of William Glasser International organization, formerly The William Glasser Institute, focuses on the work of one outstanding instructor, Brandi Roth, PhD. For instance, she has written about how to help parents and students select appropriate schools for the students' further education as well as utilizing reality therapy with clients whose reputations are known to the general public. In addition she has co-authored with Carleen Glasser a book about using role-plays as instructional tools. On a personal level, she has provided consistent support and encouragement for other instructors and trainees who seek to teach and practice reality therapy.

This article is the fourth in a series that provides information about the wide variety of contributions made by many talented individuals to the teaching of reality therapy and choice theory. The exclusive focus of the current article is the work of Brandi Roth, Ph.D., Los Angeles psychologist, and senior faculty member of William Glasser International (WGI).

The series' first article reviewed books and articles on using measurement instruments, reality therapy applied to alcohol abuse, student achievement and responsibility, and various aspects of choice theory (Wubbolding & Brickell, 2010). The second article in the series explored educational resources for use with elementary school students, parenting applications, the value of role-play and choice theory applied to relationships (Wubbolding & Brickell, 2012). Part III of this 4-part series reviewed several resources for parenting, student motivation, choice theory with addictions and elementary school resources (Wubbolding & Brickell, 2013). The authors state, "This series . . . serves the purpose of demonstrating the (great) number of authors that have contributed to the theory and practice of choice theory and reality therapy founded by William Glasser, MD in his groundbreaking work beginning in the 1960's, especially his book *Reality Therapy* (Glasser, 1965)" (Wubbolding & Brickell, 2013, p. 51).

Continuing the Legacy

The fact that the work of so many dedicated teachers, counselors and therapists remains unknown or at least undocumented and underutilized is hardly a secret. We believe that if reality therapy, the life work of William Glasser, is to survive, grow and flourish in the future both within and outside of the William Glasser Institute the recognition of the continuous work and contributions of many professional people will be required.

Brandi Roth provides the institute with a quiet, enthusiastic model for the members of her generation and the next. Her determination for teaching reality therapy and using it in her unique psychology practice illustrates the diverse applications of reality therapy and its theoretical basis choice theory.

Brandi's Contributions

In the book *Contemporary Issues in Couples Counseling* (Robey, Wubbolding, & Carlson, 2012), Brandi describes issues faced by a therapist working with prominent people: their possible exposure to the public, the possible involvement of children, the impact of adverse publicity and the possible referral to other professionals, such as mediators.

The self-perception of high profile clients can be a special issue. Their fawning fans might see them differently from the way they see themselves. She states, "Celebrities can live in a smaller universe with a big power differential. Their prominence can mean they are highly recognizable, highly valued, or in a position where people submit and acquiesce to them" (p.159). On the other hand, the partner of the celebrity may not enjoy the same notoriety and feel like an outsider to the spotlight thereby creating jealousy.

While few therapists provide services to internationally known celebrities, many counselors encounter people who are well known on the local level: politicians, business and community leaders, and others well known to the public. Consequently, many of the same issues emerge. In the words of Brandi Roth, "The therapist's goal in couples counseling is to facilitate a happier, more satisfying, and better functioning relationships through increased understanding of one another and positive changes in behavior" (p. 171). Her excellent insights based on decades of experience can therefore be generalized to many other counseling and therapeutic relationships.

In the introduction to Brandi's masterful handbook *Role-Play Handbook* (Roth, 2006), Glasser states, "The core of teaching students to counsel with choice theory is practicing role-play under the supervision of a faculty member of the William Glasser Institute", (p. 3). Beginning with role-play demonstrations by a reality therapy instructor and proceeding to small group or one-to-one practice of counseling or conferencing skills, a creative supervisor reinforces the principles of choice theory and helps workshop participants extend their knowledge and skills in the use of reality therapy. Brandi and her co-author Carleen Glasser have given us a comprehensive treatise for teaching basic and advanced intensive trainings. For instance, she presents an activity for teaching the quality world that she calls "Quality World Mapping". Workshop participants identify their quality world pictures of the fine arts, e.g., the visual arts. She mentions her own such pictures: the Impressionists, such as Monet and Manet, and her favorite musicians, Debussy, Rachmaninoff and others. Her creative activities abound for teaching choice theory and reality therapy.

Her system of multilevel self-evaluation is especially insightful: asking the student specific questions to aid in his/her self-evaluation, offering feedback and *then* taking the process to a deeper level by asking the participant to evaluate the feedback by deciding what part of the feedback was most useful. Regarding the content of role-plays, the authors provide a wide array of possible starting points, ranging from school situations and mental health issues to management concerns, such as an employee denied a promotion, an employee chronically late for work, and others.

Especially striking is her innovative way of triggering role-plays: begin with an obituary from the newspaper, or an article from a magazine that focuses on relationships. These starting

points can be played out in an unlimited number of ways depending on the ingenuity of the student.

A special value of this eminently useful book is her distinction between choice theory and reality therapy. She accurately labels choice theory as the explanation of human behavior and reality therapy as the method. She foreshadows the Glassers' description of choice theory as the train track and reality therapy as the train (Glasser C., & Glasser, W., 2008).

This down-to-earth and comprehensive handbook deserves official recognition by the WGI as a training instrument for supervisors and instructors. It illustrates the fact that the accomplishments of Brandi Roth add to the achievements of all of us in William Glasser International and they contribute to the legacy and life work of William Glasser.

In the book *Secrets of School Success* (Roth & Van Der Kr-Levinson, 2002), Brandi and co-author Fay Van Der Kar-Levinson provide parents with practical information and tools to better help their children have a positive and enjoyable school experience – from Kindergarten through High School. Refreshingly, the emphasis is as much on developing self-respect, emotional well-being and social success, as it is on academic achievement.

Included are tools and ideas for supporting the child more effectively in their teenage years; including tackling issues related to homework, time management and extracurricular activities, as well as dealing with the inevitable emotional ups-and-downs of "teenagerhood", and in conjunction with this, helping to foster independence and develop problem-solving and conflict resolution skills.

Indeed, the same provision of practical tools, ideas, information and resources is also to be found in *Choosing the Right School for Your Child*, a book by the same two co-authors, written first in 1995, it was revised in 1998, and again in 2008. It delivers a guide for parents to become more knowledgeable and better resourced about their children's schools and, further, empowers parents with the information – in a very systematic and organized way – to learn to evaluate schools, their priorities and their teaching styles, and most importantly, to ascertain which kind of setting would be best for their child, whether it be in a private, public or alternative school, and even in consideration of special programs offered by many of the public schools; such as magnet schools.

Again, the provision of experienced and knowledgeable ideas, practical tools, detailed information, valuable resources, and well-researched references, is absolutely outstanding.

Interview with Brandi

Below are five questions we asked Brandi to respond to. The answers are in her own words.

1. What do you think is your contribution to the WGI and to other professional endeavors?

   I have been implementing Bill's ideas since my college years. My husband, Bruce Clemens, and I, discussed using Reality Therapy concepts on our first date. When Bill wrote School's Without Failure I taught first-grade students ways to collaborate with class meetings. It has been a pleasure to be a long time student and then faculty

member of the William Glasser Institute. I have made a number of contributions that I feel proud about. My greatest joy with the Institute is the collaboration and collegial nature of the faculty and the participants. I have lasting friendships and memories from WGI trainings, conferences, and seminars that I have taught. I have applied these brilliant ideas in four domains: personally, in counseling, in the workplace, and in school settings.

2. What do you think your contribution is to Dr. Glasser's legacy?

   I have the privilege of co-authoring a role-play handbook with Carleen Glasser. Bill Glasser and I gave a role-play demonstration at the Evolution of Psychotherapy Conference. The role-play, a woman who was depressing, was videoed and presented to a sold-out audience of colleagues. Bill commented to me that he felt the role-play went very well (high praise indeed). It is a lasting joy that I will always be able to show that videoed role-play. I have written a number of articles and handbooks for parents, couples and individuals. I wrote a relationship counseling seminar handbook with Dr. Clarann Goldring, *Relationship Counseling with Choice Theory Strategies*. Of all the professional training that I have had as a teacher and as a psychologist, Choice Theory is what I use most. Clients frequently express appreciation as they implement these helpful ideas based on Bill's work.

3. You have been one of Carleen and Bill's best friends. How do you think this relationship has impacted you?

   The opportunity to be long-time friends with Bill and Carleen has been and will always be a treasured part of my life. Bill demonstrated his ideas best by living them. Traveling the world and teaching with Bill and Carleen was always interesting, enriching, creative, and an opportunity to grow personally and professionally. I have always been endlessly curious, often generous, and delighted with life, especially living in the world with family, friends and wonderful people. The cornerstone of Choice Theory and Reality Therapy is relationships and connections. The opportunity to study Choice Theory ideas, to teach them, to use them, to enjoy them and to build confidence in them by knowing and working with Bill, Carleen and the WGI faculty has been incredible.

4. Describe what you think the direction of the Institute should be.
   The brilliance of Bill Glasser's Choice Theory and Reality Therapy has also been enhanced and extended by many other contributors. The WGI is comprised of talented and devoted faculty and participants who continue to learn and promote Bill's ideas and teach them with integrity. The greatest tribute and gift to Bill's legacy will be the members of the WGI staying connected, collaborating, and continuing their commitment to teaching these helpful ideas. Present and future neuroscience and research will inevitably validate and perpetuate Bill Glasser's genius.

5. Who in your life has contributed the most in helping you to achieve your happiness and goals?

Without the love of Bruce Clemens, the happy life I have led would not have been possible.

Summary

By writing extensively about instructing and practicing choice theory and reality therapy Dr. Brandi Roth continues to contribute to the continuation of choice theory and reality therapy and the legacy of Dr. Glasser. Moreover, her psychology practice is unique in that she has counseled a wide variety of clients, including celebrities. Her guidelines for working with well-known people can be generalized to the work of other therapists and counselors. On a personal level she provides support and encouragement and is a pre-eminent example for other faculty members of William Glasser International.

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Brief Bios

Robert E. Wubbolding, senior faculty and former director of training for the William Glasser Institute, psychologist, licensed clinical counselor, board certified coach, Professor Emeritus Xavier University, Cincinnati Ohio.

John Brickell, senior faculty William Glasser International, director of training Institute for Reality Therapy United Kingdom, Director Centre for Reality Therapy, United Kingdom

WAYS TO EXAMINE THE ATTITUDES AND BEHAVIORS OF ADOLESCENTS & YOUTH

Thomas S. Parish, Ph.D., CTRTC

Abstract

The need to develop "empirically-based practices" to assess/evaluate individuals' attitudes toward themselves and others, as well as how they act toward others, and/or how others act toward them, have been something that the WGI membership have sought to find for almost fifty years. Notably, Parish (2013) presented methods to achieve these ends for surveying adults with the Personal Attribute Inventory and the Love/Hate Checklist, respectively. Of course, many among the WGI ranks work with adolescents and children, and they need to be validly surveyed too. To achieve this end, other scales will be described in the present paper which should prove to be invaluable for those seeking to survey these areas among adolescents and youth.

In a recent article by Parish (2013), two forms of psychological assessment inventories were described that could validly assess adults' attitudes toward themselves and/or others (see the Personal Attribute Inventory), as well as how they perceived their own actions toward others, and how they perceived others' actions toward themselves (see the Love/Hate Checklist). It was further reported that these two assessment inventories have already been successfully used for many years, and that these scales have been reported by various researchers to validly provide accurate findings regarding adults' responses to them. The reader may wish to peruse the Social Sciences Citation Index (which can be accessed at the reference desk of most university libraries), and/or just "Google Research" these titles for more information regarding how these survey questionnaires have been successfully used in various studies and found to be both reliable and valid too.

Thus, ways of effectively assessing adults' attitudes and actions have already been developed and shared with the WGI membership, but what about psychological assessment instruments that could be similarly used to examine children's and adolescents' attitudes toward themselves and others, and/or how they, too, would describe their loving and/or hateful actions toward others, or how others' are perceived to act toward them. To these ends the present report is directed.

The Personal Attribute Inventory for Children

The Personal Attribute Inventory for Children (PAIC) was originally developed in 1978 by Parish and Taylor and has been often used by many researchers to assess respondents' (i.e., children's and/or adolescents') self-concepts, as well as their evaluations/perceptions of others (e.g., mothers, fathers, families, teachers, and others). More than sixty citations appear in the Social Sciences Citation Index over the years citing researchers that have successfully used this scale in various settings. Furthermore, a recent "Google Search" of this scale (see Google Search, 2014) revealed that it has been used in numerous research studies as well. Finally, the PAIC has appeared in books reprinting various tests and measures (e.g., Corcoran & Fischer, 1987, 2013; Fischer & Corcoran, 1994, 2006), as well

as having been described in other sources too (e.g., Bickman, Nucombe, Townsend, Bell, Schut, & Karver, 1999).

Notably, the PAIC is made up of 48 words (i.e., adjectives) that are alphabetically arranged and consist of 24 "positive" descriptors of people, as well as 24 "negative" descriptors of people. On each form the respondent (i.e., child, adolescent, student, athlete) is asked to describe someone, himself/herself, or some other person. This instrument has been often used both as an intake and as an exit instrument so that counselors, teachers, coaches and administrators can gain a glimpse as to how much respondents might have changed over the course of a class, several counseling sessions, and/or some other noteworthy experience. Each time the instrument is given respondents are asked to check exactly **15** words that best describe the person in question (themselves or someone else), and one's score on each occasion is simply the number of "positive" words checked as descriptive of the person in question. See Table 1a to see the "Personal Attribute Inventory for Children," and then see Table 1b to see its scoring key, plus the presentation of additional information regarding this particular psychological assessment instrument.

Table 1a. The Personal Attribute Inventory for Children

Instructions: Please read through this list of words. Then put an X in the space beside the 15 words that best describe you (or any other specified individual or group).

___ Afraid	___ Complaining	___ Good	___ Lazy	___ Strong
___ Angry	___ Cowardly	___ Great	___ Lovely	___ Sweet
___ Awkward	___ Cruel	___ Greedy	___Mean	___ Ugly
___ Bad	___ Dirty	___ Handsome	___ Nagging	___Unfriendly
___ Beautiful	___ Dumb	___ Happy	___ Nice	___ Weak
___ Bitter	___ Fairminded	___ Healthy	___ Polite	___ Wise
___ Brave	___ Foolish	___ Helpful	___ Pretty	___Wonderful
___ Calm	___ Friendly	___ Honest	___ Rude	___ Wrongful
___ Careless	___ Gentle	___ Jolly	___ Selfish	
___ Cheerful	___ Gloomy	___ Kind	___ Show-off	

Table 1b. The Personal Attribute Inventory for Children (scoring key):

___ Afraid	___ Complaining	___ Good*	___ Lazy	___ Strong*
___ Angry	___ Cowardly	___ Great*	___ Lovely*	___ Sweet*
___ Awkward	___ Cruel	___ Greedy	___ Mean	___ Ugly

___ Bad	___ Dirty	___ Handsome*	___ Nagging	___Unfriendly
___ Beautiful*	___ Dumb	___ Happy*	___ Nice*	___Weak
___ Bitter	___ Fairminded*	___ Healthy*	___ Polite*	___ Wise*
___ Brave*	___ Foolish	___ Helpful*	___ Pretty*	___Wonderful*
___ Calm*	___ Friendly*	___ Honest*	___ Rude	___ Wrongful
___ Careless	___ Gentle*	___ Jolly*	___ Selfish	
___ Cheerful*	___ Gloomy	___ Kind*	___ Show-off	

*Denotes "Positive" word/adjective.

The number of POSITIVE words check equals one's score. The range of scores is from 0-15.

Notably, the PAIC was actually derived from the Gough Psychological Inventory (Gough, 1957), and was reproduced with special permission from Consulting Psychologists Press, Inc, which holds the original copyright. The Personal Attribute Inventory for Children, as presented here, was originally published by Parish and Taylor (1978). Of course, any use of this particular psychological inventory, and subsequent publication of the results, should specifically cite this reference in said publication.

The Nonsexist Personal Attribute Inventory for Children

Besides the PAIC, which was described above, the WGI membership who wish to assess the attitudes of younger children have yet another source available to them that was actually derived from the PAIC, i.e., the Nonsexist Personal Attribute Inventory for Children (NPAIC; Parish & Rankin, 1982). This scale, too, has been used in various research studies that can also be accessed via the Social Sciences Citation Index or by simply doing a "Google Search" regarding this scale. In addition, it, too, has also appeared in various sources, much like the PAIC noted above (e.g., Beers, 1990; Corcoran & Fischer, 1987, 2013; Fischer & Corcoran, 1994, 2006), plus it has also been described in other sources too (e.g., Bickman, Nucombe, Townsend, Bell, Schut, & Karver, 1999).

Notably, the NPAIC is made up of 32 words (i.e., adjectives) that are alphabetically arranged and consist of 16 "positive" descriptors of people, as well as 16 "negative" descriptors of people. On each form the respondent (i.e., child, adolescent, student, athlete) is asked to describe someone, himself/herself, or some other person. This instrument, too, has often been used both as an intake and as an exit instrument so that counselors, teachers, coaches and administrators can gain a glimpse as to how much respondents might have changed over the course of a class, several counseling sessions, and/or some other noteworthy experience. Each time the instrument is given respondents are asked to check exactly **10** words that best describe the person in question (themselves or someone else), and one's score on each occasion is simply the number of "positive" words checked as descriptive of the person in question. See Table 2a to see the "Nonsexist Personal Attribute Inventory for Children," and then see Table 2b to see its scoring key, plus the presentation of additional information regarding this particular psychological assessment instrument.

Table 2a. The Nonsexist Personal Attribute Inventory for Children

Instructions: Please read through this list of words. Then put an X in the space beside the 10 words that best describe you (or any other specific individual or group).

___ Angry	___ Fairminded	___ Helpful	___ Nice
___ Awkward	___ Foolish	___ Honest	___ Polite
___ Calm	___ Friendly	___ Jolly	___ Rude
___ Careless	___ Gentle	___ Kind	___ Ugly
___ Complaining	___ Good	___ Lazy	___ Unfriendly
___ Cowardly	___ Greedy	___ Lovely	___ Wise
___ Dirty	___ Happy	___ Mean	___ Wonderful
___ Dumb	___ Healthy	___ Nagging	___ Wrongful

Table 2b. The Nonsexist Personal Attribute Inventory for Children (scoring key):

___ Angry	___ Fairminded*	___ Helpful*	___ Nice*
___ Awkward	___ Foolish	___ Honest*	___ Polite*
___ Calm*	___ Friendly*	___ Jolly*	___ Rude
___ Careless	___ Gentle*	___ Kind*	___ Ugly
___ Complaining	___ Good*	___ Lazy	___ Unfriendly
___ Cowardly	___ Greedy	___ Lovely*	___ Wise*
___ Dirty	___ Happy*	___ Mean	___ Wonderful*
___ Dumb	___ Healthy*	___ Nagging	___ Wrongful

*Denotes "Positive" word/adjective.

The number of POSITIVE words check equals one's score. The range of scores is from 0-10.

The Love/Hate Checklist for Children

The Love/Hate Checklist for Children (L/HCC) was developed by Parish and Necessary (1994) in order to assess children's and adolescents' perceived actions toward others, and/or others' actions toward them. This psychological assessment instrument, unlike the Personal Attribute Inventory for Children and the Nonsexist Personal Attribute Inventory for Children, however, has not been well used over the last several years, nor has it been widely reprinted and/or described in other sources. Nevertheless, it should provide essential

insights for counselors, teachers, and therapists regarding the self-reported actions of children and youth. This is primarily so because CT/RT-certified individuals truly understand that we are always responsible for what we do, i.e., we are basically as we act, and the L/HCC provides an invaluable way to assess the perceived nature (be they loving or hateful) of our actions. In addition, like the PAIC and the NPAIC, the L/HCC is simple and quick to administer, easy to score, and provides ratio-type data in every instance, and is available free-of-charge to those who choose to employ it.

The L/HCC consists of 30 words (i.e., adverbs) that are alphabetically arranged, and consist of 15 "loving" action words, and 15 "hateful" action words. One's score on this instrument is the number of "loving" words checked by the respondents who complete it. The instrument may be administered multiple times to individual(s) in order to ascertain changes over time or as a result of some experience or event. The children and youth who have completed this instrument, for various reasons, have generally ranged from 10-18 years of age, though it could also be meaningfully used by those who are older too. The L/HCC, and its scoring key, are presented for the reader's perusal below (see Table 3a and 3b, respectively):

Table 3a. The Love/Hate Checklist for Children

Please read through this list and select exactly 10 words that best describe how _____ act toward _____. Indicate your selection by placing an X in the appropriate space next to each chosen word.

___ Abusively	___ Fantastically	___ Nastily
___ Accusingly	___ Gently	___ Negatively
___ Badly	___ Happily	___ Peacefully
___ Belovedly	___ Harshly	___ Pleasingly
___ Blessedly	___ Impolitely	___ Thoughtfully
___ Coldly	___ Inconsiderately	___ Trustingly
___ Cruelly	___ Inhumanely	___ Truthfully
___ Damnably	___ Lively	___ Unappreciatively
___ Delightfully	___ Loyally	___ Violently
___ Faithfully	___ Miserably	___ Wonderfully

Table 3b. The Love/Hate Checklist for Children (scoring key)

___ Abusively	___ Fantastically*	___ Nastily
___ Accusingly	___ Gently*	___ Negatively
___ Badly	___ Happily*	___ Peacefully*

___ Belovedly*	___ Harshly	___ Pleasingly*
___ Blessedly*	___ Impolitely	___ Thoughtfully*
___ Coldly	___ Inconsiderately	___ Trustingly*
___ Cruelly	___ Inhumanely	___ Truthfully*
___ Damnably	___ Lively*	___ Unappreciatively
___ Delightfully*	___ Loyally*	___ Violently
___ Faithfully*	___ Miserably	___ Wonderfully*

*Denotes "Loving" word/adverb

The number of "LOVING" words checked on this scale is equal to one's score. The range of scores is from 0-10.

As with the PAIC and the NPAIC, any use of this particular psychological inventory, and subsequent publication of the results, should specifically cite the original reference (i.e., Parish & Necessary, 1994) in said publication.

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All three of these psychological assessment scales (i.e., the PAIC, NPAIC, & L/HCC) shown in this brief report are very likely to be useful to researchers and/or practitioners who are interested in developing "empirically-based practices," that will enable them to assess children's and adolescents' attitudes and perceived actions and/or their perceptions of others' attitudes and perceived actions. Since all three scales, described in this paper, should provide findings that are reliable, valid, and comply with the requirements of ratio scaling, these scales should be found to be very useful to anyone who uses them in order to gain needed insights regarding the children and/or adolescents surveyed.

Of course, other researchers and practitioners need to be kept informed regarding one's findings, so those who use these scales should also plan on sharing their empirically-based findings by publishing them, if at all possible. It's long been said that it really isn't research unless we share what we find with others.

Finally, all three of these scales (plus others also developed by the author) will soon be translated into other languages as well. If the reader would like to be involved in this translation effort, they are invited to e-mail me of their interest at parishts@gmail.com

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Brief Bio

Thomas S. Parish is the editor of the *International Journal of Choice Theory and Reality Therapy*. In addition, he has authored or co-authored scores of articles that have provided support for both choice theory and reality therapy. Finally, he is an emeritus professor at Kansas State University (where he taught for thirty years), and is currently serving as a life coach consultant for LDS Family Services in Independence, MO, plus he maintains a private practice in Topeka, KS.

Multicultural Sensitivity Enhancement Scale

Thomas S. Parish, Ph.D., CTRTC
Joycelyn G. Parish, Ph.D., CTRTC

Abstract

We all have unique perspectives and different world views. This brief article will assist the reader in recognizing some differences that might exist between counselors and clients, as well as between teachers and students, and then offer some ideas regarding how one might best deal with these differences in order to ensure that our counseling and/or teaching efforts are respectful of differences and thus more likely to be successful.

In the present paper we will examine several "rules" that we have often heard of, but have never discovered who actually said them. They are as follows:

The 80% Rule (a) proposes that it is likely that we will communicate well with others 80% of the time (1) if they are like us, or (2) if we like them.

The 80% Rule (b), however, proposes that we will actually communicate poorly with others about 80% of the time (1) if they are unlike us, or (2) if we don't like them.

These "rules" may seem to be "spot on," but there are several other rules that need to be considered before we can assume that we will often be able to communicate well with some people (see 80% Rule a), but rarely with others (see 80% Rule b).

First, and foremost, there's **the "100% Rule,"** which proposes that "Anyone can communicate well with others 100% of the time if s/he is willing to carefully examine the other person's wants, needs, and focal issues and do his/her level best to address them completely, or at least seek to do so to the very best of his/her ability. In so doing, those being appreciated in this way could become quite grateful, and may subsequently seek to listen more intently to what the other person might have to say, in turn (Author[s], unknown).

There are also two other rules that we should consider as we seek to communicate better with others in nearly every setting, (e.g., the counseling cubicle, the home, the classroom). They are:

The "Golden Rule" (as derived from Matthew 7:12; Luke 6:31), which states that "We should do unto others as we want done unto ourselves."

The "Platinum Rule," which states that "We should actually do unto others as they want done unto them" (Author, unknown).

So, the next question is, which of these rules, stated above, are truly going to best assist us as we seek to communicate with others in various settings?

Our personal favorites are the "100% Rule" and the "Platinum Rule," since they help us to help others as we engage in various actions that show that we have become acutely aware

of the other person's wants and needs and are doing all in our power to help them to achieve goals they have set for themselves. In Reality Therapy, for instance, we typically ask clients "What do you want?" Once we're told what it is, we then assist them in evaluating what they want, what they are doing to get what they want, whether or not what they are doing is working, and then help them to develop plans to effectively and responsibly work toward getting what they want.

Some would say that it is a question of ethics, while others would simply say that all things being equal, we need to strive to be respectful of others. To achieve this end, the Respectful Model was proposed by Ivey, D'Andrea, Ivey, and Simek-Morgan (2002). This model lines out multicultural characteristics and attributes that we need to be comfortable with that our clients manifest, and help our clients to be more comfortable with our own multicultural characteristics and attributes, in turn.

To assist counselors, teachers, and others in accomplishing this task the following "MULTICULTURAL SENSITIVITY ENHANCEMENT SCALE" is presented, which we should ideally review soon after meeting our clients, students, and others for the first time.

Table 1

The Multicultural Sensitivity Enhancement Scale

	Similar to YOU.	Dissimilar to YOU.	+	N	--
R--RELIGIOUS/Spiritual Identity	_____	_____	___	___	___
E--ECONOMIC BACKGROUND (SEC)	_____	_____	___	___	___
S--SEXUAL IDENTITY/PREFERENCE	_____	_____	___	___	___
P—PERSONAL/Philosophical views	_____	_____	___	___	___
E--ETHNIC/RACIAL IDENTITY	_____	_____	___	___	___
C--CHRONOLOGICAL/Develop. Challenge	_____	_____	___	___	___
T--TRAUMA's to one's well being	_____	_____	___	___	___
F--FAMILY BACKGROUND	_____	_____	___	___	___
U--UNIQUE PHYSICAL CHARACTERISTICS	_____	_____	___	___	___
L--LOCATION or LANGUAGE DIFFERENCES	_____	_____	___	___	___

These characteristics/attributes, included in the survey noted above, were largely derived from those addressed by Ivey, D'Andrea, Ivey, and Simek-Morgan (2002). The scaling is introduced here to assist counselors/teachers in identifying those attributes that are similar/dissimilar, and then help them to assess whether those similarities/dissimilarities are helpful, neutral, or a deficit to good communication with those that we are seeking to communicate with in various ways. That is, do the similarities/differences foster a "positive environment" (+), a "neutral environment" (N), or a "negative environment"?

Obviously, if the counselor or teacher perceives that a "positive environment" exists with the client, and/or the student, there may be little need for change. However, if the situation is deemed "neutral," or "negative," the counselor or teacher might consider implementing the following recommendations:

Seek to adjust his/her views so that a more positive alignment is achieved regarding whatever concern(s) or variance(s) have been identified. In other words, we have to resist experiencing any "hardening of our categories," and avoid being tripped by either of the 80% Rules, but move instead toward successfully implementing the 100% Rule.

However, if differences/dissimilarities seem to be insurmountable, then it might be most advisable to refer the client/student to work with someone else who is more compatible with the client or student in question. Either way, everyone benefits. For in so doing, miscommunications are more likely to be avoided if we successfully implement alternatives that assure that clients/students are truly going to be assisted, rather than struggle with resistance based on dissimilarities that might interfere with communication.

Clearly, then, the use of CT/RT will likely be improved if and when counselors/teachers strive to be flexible as they seek to better relate to clients'/students' diverse backgrounds, past histories, and/or cultural teachings. This conclusion is in keeping with the remarks offered previously by Holmes, White, Mills, & Mickel (2011), Lennon (2010), Mickel (2005), Renna (2000), and Sanchez & Thomas (2000).

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Brief Bios

Thomas S. Parish, Ph.D., CTRTC, is the editor of the *International Journal of Choice Theory and Reality Therapy*. In addition, he's authored or co-authored scores of articles regarding choice theory/reality therapy. He's an emeritus professor at Kansas State University, and is currently serving as a life coach consultant for LDS Family Services in Independence, MO, plus he maintains a private practice in Topeka, KS.

Joycelyn G. Parish, Ph.D., CTRTC, LCP, is currently on the IJCTRT Editorial Board, and is a former senior research analyst for the Kansas State Department of Education in Topeka, Kansas.

THE REALITY AND RESPONSIBILITY OF PREGNANCY PROVIDES A NEW MEANING TO LIFE FOR TEENAGE FATHERS

Joshua Kirven, Cleveland State University

Abstract

Fathers generate positive social development when they are actively involved. Enhanced initiative, purpose, maturity, responsiveness and interpersonal ties are all noted strengths derived from father presence and involvement, but it is the internal values and strengths that define who the new father is or who he will become. This paper will not only address the challenges and psychosocial stress teenage fathers face, but will explore how an optimal worldview rests in the paradigm of reality therapy offering counseling considerations in meeting the needs of this unique group.

Introduction

Quality of life should not be an ambition, but an entitlement to all, regardless of one's background. But that is not the reality for many. Growing up today as an adolescent is a challenging period comprised of peer pressure, sexual curiosity, academic expectation and multimedia platforms. Dilemmas and hard choices are made regularly. Sometimes, mistakes are made and teenage pregnancy surfaces. This not only impacts the future mom who often has more services available, but it also impacts the future dad who may feel isolated. This predicament moves away from the William Glasser premise that every person deserves the five basic tenets of survival, power, belonging, freedom, and fun (Glasser, 1998). But these tenets may be overshadowed by the sudden awareness and new phenomenon of becoming a teenage father. This paper will explore not only the challenges of becoming a teen father, but more importantly, will highlight how this added dimension to the adolescent male's life can serve as a new beginning to purpose, responsibility and acceptance. Clinical strategies for practitioners will be offered in helping teenage fathers identify their internal strengths and motivation from within making them responsible fathers with strong self-worth directed towards the future. This will be exhibited through a real-life case example.

Stress Factors of Teen Pregnancy

Unfortunately for many, being an adolescent comes with ongoing pressures of trying to fit in, body changes, multimedia messaging and academic expectations. A typical day can feel overwhelming in trying to successfully manage time and emotions. When adolescents act on emotive impulse without thinking of the consequences, mistakes can happen that may have long-term effects like teenage pregnancy (Patel & Sen, 2012). To be sure that both new teen mothers and new teen fathers take personal responsibility and understand the future life adjustment, it is important that they recognize the stigma and difficulty of having a child when they are quite young themselves. This circumstance is even more prudent for the new father. In addition, teen fathers face a unique set of challenges: stereotypes that label them as opportunists, womanizers, predators, absent, or uncaring (Kiselica 2008; Paschal 2006; Wall & Arnold, 2007; Weber 2012). Then again, teen fathers are also unique relative to teen mothers in that they can more easily deny their paternity and, in turn, their accountability. Being a parent is a challenging responsibility that can have an impact on future plans and

aspirations. This fact is amplified when teenagers become parents while they are grappling with peer pressure, acceptance, social development, family issues, inner values and fear. Research supports that without proper education, support and preparation, many pregnant teens may feel that their life dreams and aspirations are over, not just for the female who carries the baby, but also the male who wants to be responsible and active in the pregnancy and birth of their child (Forste & Javis, 2007). But even with the bombardment literature and marketing campaigns ranging from abstinence to practicing safe sex across multimedia messaging, social networks and instant internet findings, it is still just information. This information whether, positive or negative, is a prelude to action. The information we receive is just digested in to the brain for us to process and discern how we choose to respond (Glasser, 1998).

Once the child is conceived, the future teenage father can often feel alone, as if he doesn't belong, increasing the risk of him not taking responsibility and staying involved. In working with this group, psychosocial stressors need to be identified and followed up with positive coping strategies (Duncan, 2007). Focusing more closely on the needs of young fathers may strengthen the bonds and engagement with their children.

The Learning Curve of the New Teenage Father

The current economic climate still fosters mental and financial hardships for low-income males in their efforts to become effective fathers. Many dads feel validated when they are able to provide for their children. Although, this "breadwinner" stigma is being diluted with so many women being active workers, still most male parents want to be the provider for their family, if at all possible (Bryan, 2013). The likelihood of this social gender role being materialized is rare for the teenage father due to their age and their ability to be gainfully-employed. With these relevant factors being identified, the concept of being a parent may be defined through the terms of "investment" and "involvement" (Belsky et al., 2007; Gray & Anderson, 2010). But to achieve these two benchmarks, these new teen dads, who many have grown up without a father, need to know what they mean and how does one become a positive dad. In addressing self-identity in their new role, young fathers should not only look at external supports for validation, but also consider an optimal worldview in looking at internal strengths, such as being part of a new life coming into the world, having a healthy baby, reassessing personal values, having a new purpose in life, and being a proper role model (Kirven, 2000). This optimal perspective shows a connection to Choice Theory in recognizing that every individual requires the five basic needs of survival, love and belonging, power/achievement, freedom/independence, and fun (Glasser, 1998, 2001). Many of these basic needs can feel marginalized when a teenager is facing becoming a new father. To offset these feelings of ambivalent detachment, practical life strategies need to be offered in fostering positive adolescent development and coping, responsible parenting, and future goals setting and achievement.

Creating a Positive Reality

In applying Choice Theory to practice, Reality Therapy highlights the therapeutic rapport and its importance in addressing the issues presented. Reality therapy does not downgrade the influence of the environment that the client comes from but instead builds from the premise of the individual navigating one's own environment (Robey, 2011). The ability of

the practitioner to apply active listening techniques can serve as an invaluable tool in capturing and neutralizing the fears and concerns of the new dad. The more practitioners are able to convey positive traits of openness, warmth, sincerity, compassion, acceptance and objectivity, the more likely the client will be able to make a breakthrough of hopefulness to attach on to. The practitioner can achieve the most success by being authentic, respectful and understanding (Corey, 2009). When this occurs, the practitioner can more likely direct change in thought of how the problem is perceived, and that there are multiple options that are more likely to exist (Mason & Duba, 2009).

Diversity of Services for Young Fathers

Trying to navigate through new fatherhood and their future aspirations can cause these young men to shut down emotionally. During this period, helping professionals need to be effective in keeping them engaged and part of the pregnancy process (Deslauriers et al., 2012). It is important that practitioners introduce participatory action steps that connect them with the young fathers. Practitioners should strive to include the young men in a cadre of services that should become a part of their life experience. Notably, though, it is always their choice on how they wish to define and direct their lives.

Implementing a H.I.T. of Reality

The goal of clinical practice within an optimal framework is to bring attention to the success tools and capacities the client possesses within. Traditional counseling methods often put emphasis on the past which is counter-productive to a Reality Therapy paradigm. The goal of the Reality Therapy practitioner is not to be driven by the problems of the past but instead highlight the strengths of the client and his positive forecast for the future (Watson, 2005). This approach of forging a therapeutic alliance based on empowerment can be very useful for new teenage fathers. The inclusion of this optimal framework is introduced in five (5) steps called *Holistic Integration Techniques* or the H.I.T. The purpose of these steps is to help the client find meaning and to build a spiritual affiliation with a Higher Power by helping the client confront hardships and turn them into positive outcomes despite difficult current circumstances. This approach offers some congruence to Glasser's (1998) tenets of survival, power, belonging, freedom, and fun and Wubbolding's (2000, 2011) WDEP model in the clinical counseling setting focusing on the here and now and the client's future. The WDEP system offers practicality and empowerment in moving the client forward towards desired goals. This approach emphasizes inner control and perspective which aligns with an optimal worldview. When the client lives with these values, life is more fulfilling and hopeful because the client believes that he is in control of his own destiny.

> Wubbolding works with his clients through applying the WDEP (Want, Doing, Evaluation, Plan) system. Wubbolding (2006) defines the system by first, clients identify a particular ***want*** that serves to fill a basic need. Clients then describe what they are ***doing***, their behavior—their current actions and thought processes of what they want. Next, Wubbolding helps them ***evaluate*** the ways in which their behaviors impact progress toward their goal. Lastly, clients formulate a realistic, measurable ***plan*** to change their behavior and progress towards their goal (p. 8).

Once a solid therapeutic alliance is established between the practitioner and client, the stage is set for success strategies "in real time" to be created for the future that puts the client in control of his actions, behaviors and future outcomes on his own terms (Wubbolding, 2000). It is also the intention of the optimal H.I.T. to help the clients to accept strengths and limitations within one's self and the environment and work towards a holistic method of decision-making, functioning and coping that fosters happiness and wellness. Clients are encouraged by the practitioner to tell their stories that exalt their capacity of self-determination towards coping with obstacles such as the example of teen pregnancy and being responsible for another life. Lastly, the H.I.T. seeks to motivate clients to think freely towards a positive life that is strength-based and holistically-centered, focusing on the betterment of all within each client's community, instead of just the client. This is not more evident than an expecting father (or parent) who can no longer afford to be solely self-focused, but now must begin to think about caring for another life, preparing for the future, showing unconditional love and creating the best possible environment for the child to grow. Love is a powerful vehicle that can stimulate clinical change in working with clients with difficult situations (Parish, 2007). The new teen father will soon realize that he may not be solely judged on what he accomplishes for himself, but will also be judged on the type of father he becomes. So although this dad faces a challenging life adjustment that impacts his future, he functions via in an inspired way of thinking. This new way of thinking promotes an active coping lifestyle that addresses fears and perceptions, utilizes one's community resources and supports, fosters an interconnected life framework, creates purpose, and builds self-sufficiency and responsibility.

Case Dialogue Example

The dialogue referenced below represents excerpts from a session that took place in 2013 when I met with a 16 year-old male who was enrolled in a summer literacy school. After meeting with him and facilitating weekly life skills training with him and other teenagers for about a month, he and I sat privately to discuss his anxiety-provoking situation of soon becoming a father and not knowing what to expect.

Practitioner: Wow, if you want to meet one-on-one, something must be up? I am only accepting good news today. So tell me what's going on.

Stax: I can't believe I'm gonna be a daddy. I know, I know, don't say it Dr. K. It just happened. I mean, she is still my girl and all and I don't regret it, but I'm not trying to be a daddy right now. (Client internalizes issue as something that happened in the past and is out of his control.)

Practitioner: How is your girlfriend doing? (Moving to the present and not focusing on past.)

Stax: She is doing okay. She said we had sex we took the risk and now we need to take responsibility. She said it will be hard, but she is going to reach her goals with or without me. That really hurt. I told her don't worry, I ain't trying to be another deadbeat dad, but I ain't trying to just settle and work all my life either! I still want to go to college, even if I have to bring 'lil stax' with me. (Using active listening in empowering his present situation

and future plans. Client applies WDEP system by identifying his **want** and his goal of **doing** it.)

Practitioner: How do you feel about what she said? (Reflective question from H.I.T. in addressing hardship.)

Stax: It sounded like she is prepared for me to walk away. But I wouldn't do that. My parents would be disappointed if I did that, especially my grandma. (Client internalizes situation from inside out in looking at the future, the type of dad he is going to be and how his family would want him to respond and be responsible.)

Practitioner: Do both your parents know? Wait, wait, before you answer that, tell me what's your plan? (Moving the current situation forward. Creating a **plan**.)

Stax: First, I need to pray about how I am going to get through this. You know, going to school, playing ball, working and being a daddy. That's a lot. When I told my mother I was going to be a dad, she said playing sports should be the last thing on my list right now. I'm not feeling that. I'm going to find a way to make it work.(The client identifies with spirituality, the reality of the situation and his pursuits reflective of Glasser's attributes of survival, belonging, freedom & fun.)

Practitioner: Sounds like you have your mind made up, now you just need a plan of action. (Initiate future planning.)

Stax: No we need a plan**.** I'm going to need some of those life skills real soon that you've been preaching about. But in a weird way, I am excited about being a dad because now I need to be more focused and responsible. I know a lot of people don't think I can do it, or that I'm just gonna walk away, but it will be fun to prove them wrong. My future child will never have to wonder who his dad is. (Creating a plan for the future and taking power over it.)

Practitioner: I am proud to hear you say that. You appear to be up for the challenge. But remember this is not any small task. This is a lifetime commitment for many years to come. (Using reality testing through reaffirming, empowerment language.)

Stax: Yeah, I know. But I can't go back and change it now. It's time to *"man up"*. Plus I think my parents, and maybe even my new in-laws (*laughing*), will be there to support me if I show that I am taking responsibility for my actions and staying on track with my education. It is all up to me. (Evaluating situation, taking ownership of its outcome and being present and future-focused.)

Practitioner: Yes, it is young man. It is important that you control your situation, not let the situation control you. So I suggest that we begin building a roadmap to success with some benchmark goals. (Empower future plans and help client embrace role as an active member in community.)

Stax: Bring it on! I'm going be a good 'baby daddy' and I'm going to get an athletic scholarship to go to college. Remember this date. (Glasser's tenets of survival, power, belonging, freedom, and fun are embraced by client.)

Practitioner: I like your motivated spirit. I want us to continue to have a meeting every month to do a check in assessment of your roadmap progress and what we need to do to stay focused on your goals. It is important that we celebrate small victories every step of the way to stay inspired. How do you feel about that? (Strategy to keep client engaged through active benchmarks and positive reinforcement.)

Stax: I'm ready. The question is, are you ready (*smiling*)?

Practitioner: It's all up to you young blood, it's all up to you. I believe in you! (Reaffirming)

End of Session

Cultural Competent Practice:

Reality therapy and an optimal worldview serve as a therapeutic focal point in meeting the unique needs of highly sensitive problems and vulnerable populations. People who suffer from terminal illness, PTSD (Post-Traumatic Stress Disorder), racial-profiling or other cultural challenges can benefit greatly from this clinical approach. Racial disparities, social injustices, sexual identity crises, and cultural clashes are all topics that can cause oppression and psychosocial stress. Reality therapy can help close the gap between ignorance and prejudice through education and equality, resulting in a more inclusive culture and society.

Future Implications and Recommendations

There are many benefits of using a client-centered first approach. The Reality H.I.T. fosters a supporting clinical paradigm to help the client identify his/her internal strengths and community assets in reaching his/her potential and goals. Also to keep the clinical process moving forward, it is important to explore and integrate the areas of the WDEP system: 1) Wants, 2) Doing, 3) Evaluation and 4) Plan (Brickell & Wubbolding, 2007; Wubbolding, 2006) in facing the client's presenting issue. One of the biggest benefits of engaging in this intervention technique is to empower the client to operate as a free thinker with inner strengths who has a responsibility to be a contributing microcosm to his environment.

Conclusion:

The impact of Reality Therapy endorses the client's thinking as being independent and logical towards fostering self-determination and freedom of choice. Through a client-centered, not problem-centered approach, the teenage father can better envision his future, individually and as a parent. This adopted optimal worldview will provide an added sense of self-worth, power, belonging, inner peace, and self-confidence. Applying this joint *reality*-

optimal approach in a community-based practice setting may show some promise in providing positive choices and direction for clients such as teenage fathers.

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Brief Bio

Dr. Joshua Kirven is an educator, practicing social work clinician and community consultant in the areas of community-based care, public health, strengths-based interventions and inclusion practices. He continues to work with communities, municipalities, schools, health centers, child welfare agencies and private and non-profit organizations. Dr. Kirven is currently an Assistant Professor in the School of Social Work at Cleveland State University in Cleveland, Ohio.

School of Social Work
Cleveland State University
2121 Euclid Avenue, CB 321
Cleveland, Ohio 44115
Phone: 216.687.3987
Fax: 216-687-5590
j.kirven@csuohio.edu

CHOICE THEORY AND REALITY THERAPY: APPLIED BY HEALTH PROFESSIONALS

Mary E. Watson, MSCP, EdD
Lauren A. Dealy, MSCP
Irina L.G. Todorova, PhD
Shruti Tekwani, MSCP

ABSTRACT

The purpose of this study is to determine long-term outcomes of learning that occurred in a reality therapy course and the specific ways that past participants incorporated choice theory (CT) and reality therapy (RT) concepts into their personal and professional health fields. A web-based survey was completed by seven cohorts of past students (N=91) between 2006 and 2012 with a response rate of 29% (n=27), and 13 of the 27 professionals were interviewed to gather more information. One hundred percent of respondents used at least some of the concepts personally and professionally. The components most relevant for more than 75% of the respondents in their personal lives were goal-setting (85.2%); thinking differently to make better choices (81.5%); emphasizing positive behaviors (77.8%); considering how basic needs were met (77.8%); and clarifying what was wanted and what was attainable (77.8%). The components most relevant professionally for 74.1% of respondents in their professional lives were developing action plans; creating involvement with their clients (66.7%); emphasizing positive behaviors (66.7%); using Quality World concepts, clarifying wants; and, helping the client self-evaluate both (63%). Thirty-three percent of respondents indicated they used the concepts daily in their work and 25.9% used the concepts weekly. Five major themes from the qualitative data included the relationship between choice theory and the reality therapy process and the integration of RT with other approaches to practice; the importance of relationship building and supporting clients; the value of RT for clients and for professional fulfillment; barriers and tensions to using RT identified by practitioners; and areas and techniques for using the RT process. Results and recommendations for future research and teaching were discussed.

Background of the Study:

A call for evidenced-based research on choice theory and reality therapy has been a focus of The William Glasser Institute for many years (Litwack, 2007, 2008, Parish, 2010, 2012, Wubbolding, 2012, and Olver, 2013). Dr. Glasser's vision statement (2010) included a request that his work be independently researched and documented to validate the effectiveness of reality therapy and choice theory. In describing the 2013 goals for the WGI-USA, Kim Olver, Executive Director (2013), indicated that one of the goals of the Institute is having reality therapy listed as an Evidenced-Based Practice (EBP).

Choice theory has been taught all over the world and there have been numerous publications showing the benefits of improved mental health, overall happiness and well-being. As teachers and practitioners, we have experienced the perceived value from clients and participants who have expressed that learning CT/RT has changed their lives. Designing and reporting studies that show positive behavioral changes in our clients will help us to continue validating that the practice of CT/RT is rooted in research-based interventions. This becomes even more essential as managed care calls for "fiscal responsibility and

accountability - cost-effective treatment," resulting in positive outcomes that are researched-based (Allen, 2013). Continuing efforts to study the effectiveness of CT/RT practice is important for working toward securing our position as an evidence-based profession.

The research done by Watson and Arzamarski (2011) helped add to the evidenced-based practice of choice theory and reality therapy by asking past participants from an interdisciplinary graduate course of their perceptions of what worked in their experience. Results indicated that 88.6% of the participants who responded to the survey used CT/RT to better their personal lives and 100% indicated parts of CT/RT were relevant professionally. These findings were independent of the health profession practice of the past participants and provided evidence in support of teaching CT/RT to an interdisciplinary group of health professional graduate students.

Questions remained about the longer-term outcomes of learning CT/RT and the specific ways of *how* past participants were using and CT/RT concepts and *how* clients were actually helped by the process. To gather data on longer-term outcomes of practice, the research designed and reported in this paper used a mixed methods study to gather both quantitative and qualitative data of the practice of choice theory and reality therapy.

Purpose of the study

The purpose of this study was to determine long-term outcomes of learning that took place in a health professional interdisciplinary graduate course. The research asked specific questions about *how* past participants were incorporating CT/RT concepts into their personal and professional lives; *specific* ways they have used the concepts as practicing professionals; barriers they have encountered; and to solicit interviews that related to the above goals. The purpose of conducting interviews was to elaborate more in-depth insights regarding their attitudes and impressions about using the RT concepts personally and professionally.

Survey Methods

A 10-item, web-based survey was conducted followed by interviews of past students who had taken the graduate level reality therapy course at Northeastern University. Over the seven years studied (between the years 2006 and 2012), 120 students enrolled in the RT class; for which 91(76%) email addresses were available. The survey was sent to these 91 participants representing 22.5% of all students who took the course over the 7-year period. Twenty-seven students (29.6%) responded to the survey. Survey items inquired about enrollment in RT; area of professional study; what components were used personally; what components were used professionally; how often concepts were used in their work; specific ways of using the CT/RT concepts personally; their detailed experiences using concepts professionally; barriers experienced in using the concepts; feedback from clients; and finally their willingness to be contacted for an in-depth interview.

Qualitative Methods

This study integrated findings from quantitative and qualitative data. The purpose of the qualitative interviews was to gather more information about practitioners' theoretical

orientation toward helping people; how they were using the CT/RT concepts in their profession; client feedback; detailed experiences and their evaluation of its applicability; and effectiveness of the theory and process. To encourage participation in the interviews, two randomly selected $50 Amazon gift cards were awarded at the completion of the study.

The qualitative analysis was conducted through a Thematic Analysis approach (Braun & Clark, 2006). Each interview was coded by one of the authors; however, all authors met regularly to discuss each interview and come to an agreement on the identified codes and the development of the relevant themes. The aim was to develop these inductively, as grounded in the data rather than determined by the framework used to structure the survey questions. Nevertheless, the interviews addressed topics similar to those in the survey. Therefore, some of the identified themes are similar to the topics asked in the quantitative part of the study and thus elaborate upon them. When achieving a common understanding and interpretation of the relevant themes, the authors finalized the result presented in this paper.

Participant Respondents

As indicated in the **Chart 1: SURVEY REPONDENT PROFESSIONAL AREAS**, participants represented an interdisciplinary group of health professionals: Public Health (n=13, 48.1%); Counseling Psychology (n=5, 18.5%); Health Administration/Management (n=5, 18.5%); College Student Development (n=4, 14.8%); Speech Pathology and Audiology (n=4, 14.8%); Medicine (n=3, 11.1%); School Psychology (n=1, 3.7%); Nursing (n=1, 3.7%); Exercise Science (n=1, 3.7%). The survey response rate was 29.6% (n=27), and 14 of the 27 (48%) were interviewed for more in-depth qualitative data. The majority of the practitioners, participating in the interviews, came from the Public Health professions (N = 13) with some in combination with another profession e.g., Medicine (N=2), Early Intervention (N=1) and Exercise Science (N=1); followed by counseling related professions (N=10) with some in combination with another profession e.g. school counseling and psychology (N=2); college student development and counseling psychology (N=1). The participants responding to the survey represented all of the health professions taking the course over the seven years studied. With the exception of Speech-Language Pathology and Audiology, all disciplines were represented in the interviews (see TABLE 1). The range of health professional participation illustrates the interdisciplinary nature of the course.

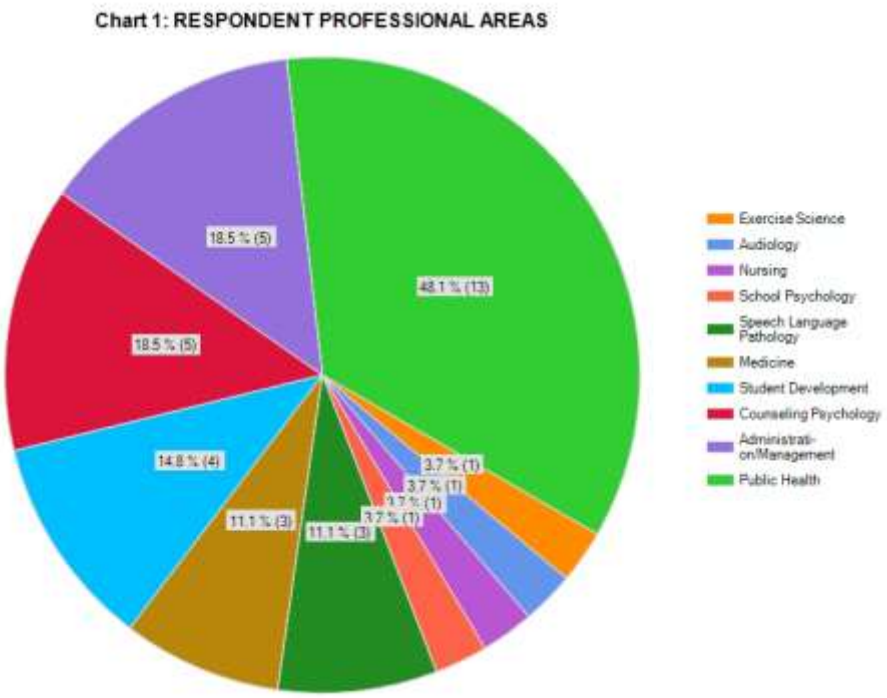


Table 1: INTERVIEW PARTICIPANTS

Participant ID	Degree and # of years since course	Gender
SPA	School Psychology, 4	F
CPB	Counseling Psychology, 5	F
PHC	Masters in Public Health & Exercise Science, 1	M
PHD	Masters in Public Health, 3	F
PHE	Masters in Public Health, 1	F
MDF	MD, Masters in Public Health, 1	F
PHG	Masters in Public Health & Early Intervention, 3	F
PHH	Masters in Public Health, 4	M
MDI	MD, Masters in Public Health, 3	F
CPJ	Counseling Psychology, 6	F
PHK	Masters in Public Health, 3	F
SCL	School Counseling, 6	M
NRM	Nursing, 1	F
CPN	Counseling Psychology, 7	F

Quantitative Results

Chart 2 illustrates the specific components of CT/RT used by respondents in their personal lives. All of the respondents used at least some of the concepts personally. The top five, with greater than 75% responses, were: using the theory and process for planning their own behavioral changes (i.e. goal-setting); thinking differently to make better choices; emphasizing positive behaviors in their own life; considering basic needs being met or not being met; and clarifying what they want and what is attainable. Over 55% also indicated that creating involvement, using the scales to balance perceptions of what they have and what they wanted; and understanding how their past relates to the present were also relevant to them personally.

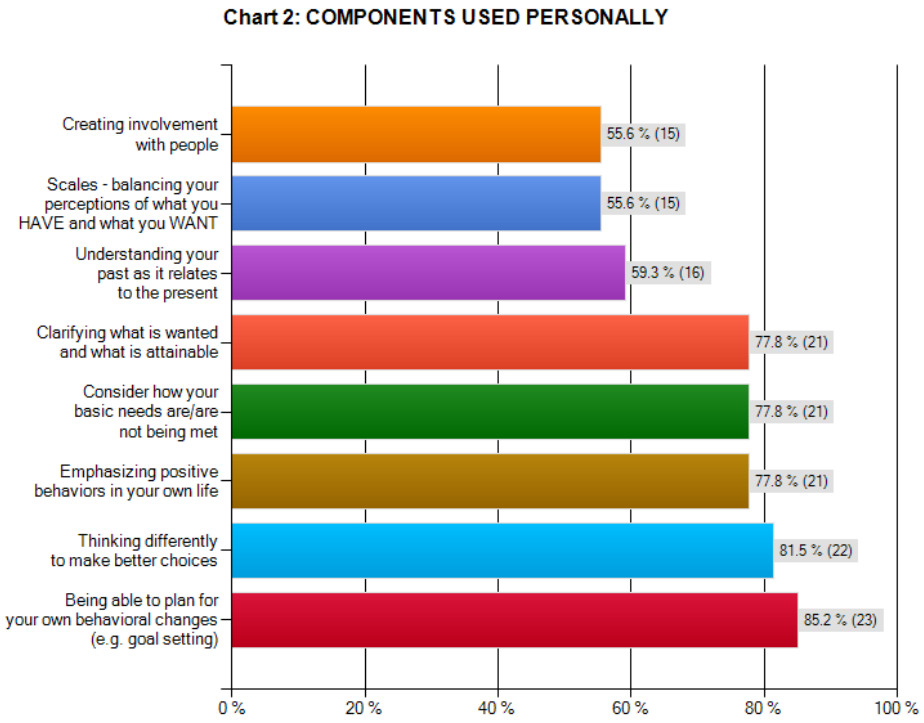


Chart 3 illustrates the specific components of CT/RT used professionally. All of the respondents used at least some of the concepts professionally. As with the use personally, the top component used professionally was helping to develop a plan of action (74.1%). Other relevant components found with 63% or more of the respondents included: emphasizing positive behaviors; creating involvement with the clients and establishing rapport; helping clients self-evaluate; and using the Quality World concepts and clarifying wants and what is attainable. Over 55% found identifying basic needs and using the WDEP system (asking about wants, doing, self-evaluation and plan) to be relevant professionally.

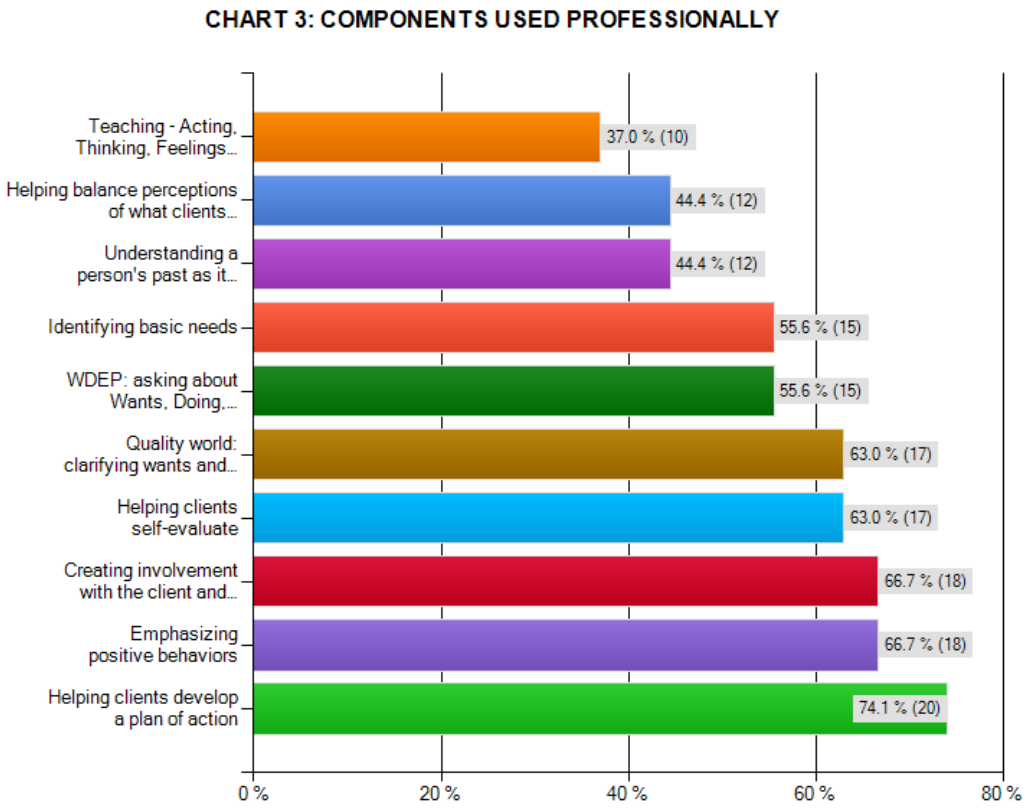
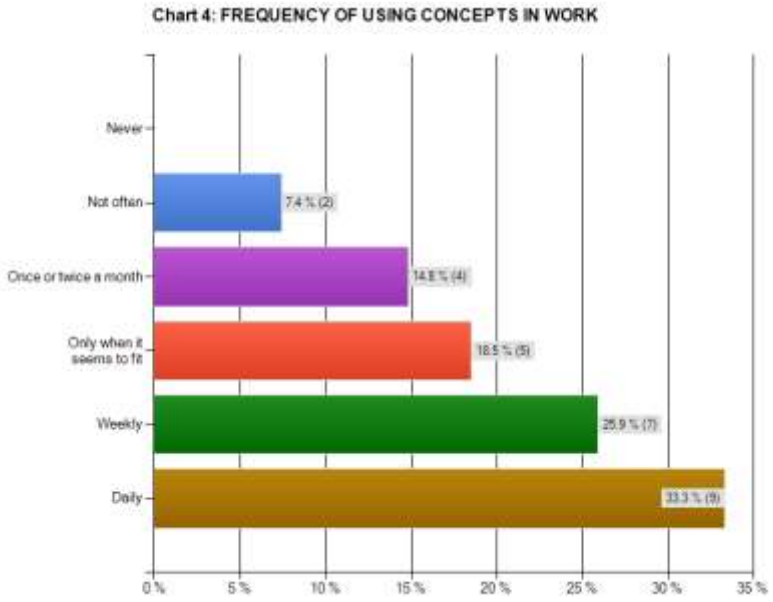


Chart 4 illustrates the frequency in which participants used choice theory and reality therapy concepts in their work. Results indicate that 33% use the concepts daily, while another 25.9% use the concepts weekly. All others use them only when they fit (18.5%); once or twice a month (14.8%), or not often (7.4%).



Qualitative Results

Five major themes developed from the interviews are listed below and subsequently described:

1. Elaboration of the relationship between the theory and process of RT
2. The importance of relationship building and empowering clients.
3. Value of RT for clients and for professional fulfillment
4. Barriers and tensions to using RT identified by practitioner
5. Areas and techniques of use of RT

Theme 1: Elaboration of the relationship between the theory and process of RT

Integration and distinctions with other approaches

In describing how they understood and used RT, some participants in the interviews attempted to find its place in their orientation to practice and the overall groups of skills that they apply when they work with clients. Thus, they spoke of how they integrated RT with other approaches to practice**,** and how they identified RT as distinct from others and underscored these distinctions. In such cases, work with clients was seen as involving several identifiable approaches, which were used more separately and distinctly, depending on the circumstances and client needs.

Other practitioners did not make obvious distinctions between separate approaches and their descriptions revealed more seamless integration of theoretical frameworks and skills acquired through the use of such approaches. For example, several practitioners were using RT and Cognitive-Behavioral Therapy interchangeably – sometimes clearly identifying RT, yet calling it CBT. According to CBA, "RT aligns really well with CBT; fits nicely with the CBT triangle – thoughts, feelings and behaviors – like RT you are trying to help clients change how they think – and avoid thinking about the past (especially their negative past). Trying to help them to change their behavior to align with what they want – their goals."

In other cases, it was clear that they do not stop to identify what approach they are using in their practice, yet when reflecting on the process during the interview, the practitioners clearly identified using the model and elements of RT. Often during their interaction with clients, some of the participants found that the value of RT was high, and that the skills and techniques were so often applicable, that they recommended it should be part of any therapeutic or counseling process. For example, one participant stated that "[RT] should be incorporated into general therapy" (MDI). We want to note that this reflection on the distinctions and integration between RT and other theoretical approaches to practice and their techniques is most often evident for students who were in counseling programs when taking the RT class and currently work as counselors. Thus, many felt they apply the concepts and techniques of RT often, but do not necessarily name them either to themselves or to their clients. Or as CPB states, "I think I just naturally use it." Sometimes practitioners were aware of which technique they wanted to use in a particular case, but made the judgment not to be explicit about it with the client, and as PHG says, "Used a backdoor approach," specifically meaning using an indirect way to introduce the Choice Theory Chart (Glasser, W., Glasser, C., 2002). MDF said s/he uses it often, but "not as a

method," and PHG also stresses that s/he uses the concepts "but not step-by-step." PHK and CPN also say they use it without realizing it, both personally and professionally. "Personally, too, I use it and don't even think about it" (CPJ).

As participants described their use of RT, they were also involved in illustrating ***how*** reality therapy operationalizes choice theory in the process of practice. This was evident in both the quantitative and the qualitative data. For example, as shown in **Charts 2 and 3**, when practitioners used CT/RT in personal as well as professional situations, they employed many theoretical concepts. For example: creating involvement; self-evaluation and Quality World pictures– clarifying what is wanted and balancing that with what is attainable; and identifying basic needs and whether they are being met through the pictures in their Quality World; developing a plan of action; and emphasizing positive behaviors.

Several of the choice theory concepts were also evident in the narrative data. For example, working with a client, NRM noted that the client was trying to convince her that she was fine. NRM used the concept of balancing the scales to understand what the client had and what she wanted. The patient was trying to convince NRM that she was fine, as a result, NRM was helping the patient to evaluate her state of being. In order to move forward, the practitioner asked her patient what she could do in order to help her in that moment. This turned out to be a transformation for the client, as she communicated, "You know what, nobody has ever really said that to me." NRM went on to ask her: "What is it that I can help you with and how can you change this negative situation?" This helped the client take responsibility for her actions and helped her to reframe her negative thinking into a positive outlook that's more ready for change. In addition, this new positive outlook helped the client to realize that she was in control known as internal locus of control.

Flexibility: Using concepts in different ways

As practitioners described how they applied RT, it also became clear that they saw it as a **flexible process** and used it in creative ways. As they became more and more experienced with time, they also became more creative with the process and concepts. They more confidently adjusted the process and techniques for specific clients. Participants CPB and PHH both adapted the concepts to the stage of readiness of their clients. For example, they were flexible in giving their client the right amount of time needed to describe and vent about their situation before proposing concrete activities or problem-solving steps. Practitioners also said that they adjusted the process or chose specific techniques depending on the learning style of the client – after a while the practitioner can sense what will fit (for example visual or written exercises) (MDF, PHD).

Others added new elements, such as the use of the creative process and interpretation of drawings, and integrated them into the conceptual framework of RT. As one person pointed out, "It's important to be skilled in order to use the concepts creatively." Another practitioner helped pediatric patients uncover quality world pictures by having them draw a tree, and then on every branch and leaf they wrote down what's important to them. This helped to uncover their quality world and what mattered in their lives (MDI). In working with young children who are not cognitively able to connect their behaviors with what they want – "I would use more of play therapy; art therapy." When working with adolescent students who are reluctant to engage in counseling, a different practitioner found that

diagrams were helpful in order for them to visualize their quality world, especially with those students who were more introverted (SCL).

In summary, as CPN stated, "It depends on the client a lot of times. Using other therapies with RT go well together at times. I don't use all parts of the process with every single client. It's flexible and fits in with other modalities." Another practitioner stated that, "RT is one of those therapies you can practice so effectively that it does not appear as therapy in its application." (SCL).

Adaptability: Using concepts in different contexts and purposes

Participants were also positive about the fact that they saw RT as highly **adaptable to different situations**. They gave numerous examples of how they had used it in different contexts and explained the relevant adjustments they felt were made in the process. For example, participants PHE and PHH used the concepts in health management with staff members and managers in order to facilitate organizational change. This same practitioner, PHH, working as a management consultant, saw the concepts of RT as a communication strategy that can be useful in non-counseling situations. Practitioner, PHE, working in an administrative position, found the concepts relevant in her work. For instance, she found it helpful to "keep in mind that people are behaving to achieve something they want, and that it's helpful to ask what they think their actions will achieve." In addition, she might say, "If you are going to follow this path, what do you see as the outcome? Are there other options?"

A practicing counselor, CPJ, used RT-related techniques in a psychiatric hospital with resistant clients. With one particularly depressed and neglected adolescent client, who had been through a myriad of mental health services, she was able eventually to have a breakthrough as a result of using the concepts of CT/RT. After months of working with her, she finally realized the client's deep interest in poetry and used that to get into her quality world. Poetry inspired the client and the practitioner found it to be a subject that finally allowed a relationship to develop. She described it as a powerful way to bring about change, Consequently . . . "She underwent a total personal transformation. She became this really sweet girl who moved away from darkness, moved away from the drugs and the alcohol and the swearing, and the cutting, and all the less effective behaviors in her life." From the client's point of view, she described having more "self-control," and "how positive her life had become."

MDI stressed that CT/RT may be used systemically – through working with families, or working with parents and observing the impact that resonates with their children. Many others also stressed the applicability of the mindset of RT to daily life and to daily conversations, pointing out it is "helpful when applied in casual and informal ways" (CPJ).

An observation often made by practitioners was about the relevance of the RT approach to working in different settings with people from diverse backgrounds and past history. Participants discussed its wide applicability in that sense. Participants commented that from their perspective, even in situations of limitations, there are possibilities of choice within those, or as CPJ expressed it, they have choices even in a "boxed-in life style." With these discussions, participants echoed some of Glasser's sentiments, which emphasized teaching

RT to everyone. This is consistent with The William Glasser Institute's Mission Statement (Wm. Glasser Institute website: 2014) and supports the idea that RT is more than a therapy technique, but rather a mindset which people can use themselves to achieve positive changes, no matter what their specific situations.

Theme 2: The importance of relationship building and increasing client success.

A topic which almost all of the participants discussed in one way or another was that of developing a meaningful and productive relationship with the clients. They felt that RT's approach allows for strong relationships to develop, which are at the core of its positive outcomes. To emphasize its centrality, PHE says that RT allows for the integration of the relationship into the whole process of RT. Clearly the development of trust was pointed out as being at the core of the process and crucial for any successful work. Many participants emphasized the development of rapport with clients through listening and being available to them, or as CPJ called it, "walking with them" through the counseling process. Through active listening, the practitioner can understand the values of the clients, what is important to them and can choose at least "one positive thing" to discuss further with the client. As CPJ framed it, through listening, the practitioner can "be added to the client's quality world," which can contribute to practitioner-client trust.

MDI describes the development of the relationship as a process of "getting my goals enmeshed with client goals." CPN also emphasizes that, "Something I really use now is 'What's ***our*** goal'?" "What do you want, basically?" Thus, as setting goals and moving toward them is one of the cornerstones of RT, the commonality of those goals for practitioner and client becomes a symbol of a close and productive relationship. Others see the process of RT as valuing what the client values and helping clients achieve what they want in concordance with those values (PHE).

Participants emphasized the importance of empowering clients through the relationship and illustrated the strengths of RT in that respect (PHC; PHE). SPA refers to RT as "client-centered therapy," or an approach that is humanistic in theory. Similarly, PHE refers to the process as "helping clients to get what they want." In particular, they believe that RT allows a client to be central in the decision-making, in the sense that the process "helps them to find the answers," or "lets them come to conclusions on their own," rather than the practitioner giving answers or solving their problems (PHK). In other words, there is an acknowledgment of the skills and experience of the client and the fact that they already know about what works for them. This ultimately helps the client "move forward" – thus the process is seen as transformational (PHH). Practitioner PHC also states that this process "gives the power back" to the clients.

An important part of the relationship is also the feedback received from clients regarding the process and the outcomes. Direct and verbal feedback from clients helped practitioners witness "amazing transformations" (NRM). One practitioner, in describing her work counseling a resistant client in school reported that the client was really receptive to the fact that she had been asked what she wanted. The client went on to say that "no one had ever asked me what I wanted before." In the words of the practitioner, the process had an "amazing impact on the client," and the client went on to do "amazing things." (CPJ).

At other times, the feedback was indirect and practitioners inferred from use of the process significant positive behavioral changes in their clients (PHE). Positive feedback was gained from observing that the client adhered to the action plan and "everyone was doing what they had planned" (PHG). According to CPN, clients don't need to give explicit verbal feedback, but exhibit feedback through their behavior. "They don't say they don't like it [homework]; they just don't do the work or the agreed upon plan" (CPN).

Theme 3: Value of RT for clients and for the practitioner

The value for clients

The practitioners whom we interviewed emphasized what they saw as the strengths of the RT approach and the value that it brought for clients. Some practitioners described its effects as "powerful" and "transformative" (CPJ). In most cases, as PHK stated, "It is well received by clients."

An aspect of the RT approach, which many practitioners stressed, was that it helped clients and increased their independence. The RT process was seen as a way to give clients tools, which they could then use themselves. As SCL states, the clients may become "self therapists" or "self-advocates," and thus become independent of the therapist in the long run. This is possible through the focus on choices and the increased awareness of the existence of options, even in situations involving limitations. In this process of gaining a sense of confidence and independence, the clients also "begin to value self and work more," and thus there is a forward movement in their lives (PHH).

"Yes, it leads to more open-ended questions. Once the student gets comfortable with that, it opens it up for discussion. It leads to "ah ha" moments and they realize what they want and what would be helpful" (PHD).

From the perspective of the clients, what they often mentioned as the main value of RT, was that they were asked what *they* wanted, something that they felt does not happen very often. Ultimately, practitioners felt that the sessions gave clients something concrete to take out into their lives, such as goals and tools to help them move them forward.

Practitioners saw a benefit in the fact that RT gave a framework for working with clients, i.e., "a systematic way of going about it" (PHH), as well as a structure for the clients. Several practitioners emphasized that clients like the structure that RT gives to their goals and activities.

Practitioners also found value in the fact that RT was seen as a very practical and applicable approach. It was relevant to their clients and their own daily life and easily integrated into it. The value was also seen as permeating one's life and working behind the scenes, "I would also say in times of anxiety, and after you get past the emotional piece, when you become like a thinking human again, and you can think clearly, and you feel like you can get a solid night's sleep, Reality Therapy seems to be what happens the next morning" (PHH).

Participant CPJ stated that, "Its principles can be used in daily conversations and in casual situations in an informal way. I think about the needs and I appreciate that Dr. Glasser

included fun as well." In addition, CPN stated that, "Even when I discuss RT with people, I see that they think it's cool that fun is a part of it."

Others emphasized its practicality in that it was a brief form of therapy, particularly important in regard to insurance coverage. As CPN stated, "It's helpful especially with my job right now and how it offers short-term work. A lot of short-term therapy goes that way because of insurance issues." This practitioner also stated, "One more thing to add ~~on~~ is that the job I'm doing is a lot of piloting of medical homes, where a healthcare center gets X amount of money to take care of a patient. It incorporates behavioral health and I think it's a great place to incorporate RT because it's so short term" (CPN).

Professional fulfillment

Practitioners valued RT from the perspective of how it contributed to their sense of professional fulfillment. The points described above regarding how they felt it impacted clients, such as "seeing an amazing impact" or "amazing transformations" for clients, led to a sense of fulfillment for practitioners. The feedback they received from clients helped them continue to work as practitioners.

Many talked about the `fit' that they felt between their personal orientations and philosophies of life and practice with the philosophy of RT. Many of them believed that they were attracted to RT since its principles are in resonance with their personality and style of working, "I think I just naturally use it" said CPB. PHD also stated, "It resonated with me because that's how I think." Or as CPJ stated, "I was living it before doing it." Thus, for them, RT seems to give a name to what they have been doing already in their personal lives and even professional lives, if they were later exposed to the approach. In this way, it supports their existing approach and provides structure to their practice. On the other hand, with more experience, one internalizes the concepts and the process and "it becomes part of you" (PHD). CPN said: "I use RT often and don't even think about it anymore. I think I like RT because it's more natural."

Relevance for personal life

Many of the practitioners had found the concepts and techniques of RT relevant to their personal lives. They had found it helpful to apply what they knew about RT when working through issues and problems in their own daily lives. For example, many shared that they go through their own needs assessments, and use it for goal-setting. "I use it on myself all the time! I think it's a good tool to pull out" (MDF). Some of them stressed that in order to apply it to one's personal life, it has to fit with one's orientation and personality. PHH stated that RT fits with particular people, which she described as "more rational, less emotional." CPJ particularly used the positive psychology aspects and the positive affirmations, while PHE used the WDEP system personally. PHH found the application of RT to one's personal life to be calming. Some of the situations in which they found RT helpful to apply to one's personal life were for problem-solving (SCL), for help in decision making (PHH), for self-evaluation, self-actualization, moving toward action (SCL, PHE), and generally for helping clients realize that they have a choice. For example, CS shared the following, "So I know that I have a choice to make, to make the best of those moments, when I have free time, and really begin to go back and re-learn or reiterate all the things I've learned to be more

effective at whichever profession I find myself. I realize it's my choice. Changing my thought process, and realizing that I have my knowledge of choice theory to make my life better, it's my choice to continue to be busy and I know that. I have a choice to continue to be more effective but even more so when there is nobody marking my papers, it's all my own choice in life. I need to mark my own papers and set my own limits. I need to really push myself because there is nobody that's going to do it for me. So that's a choice I have to make" (NRM). This illustrates the individual trust in one's self and responsibility perspective of CT/RT, and exemplifies the benefit of teaching the theory and process for personal as well as professional practice.

Practitioners found the principles of RT helpful not only for one's self, but also for others, such as family members, to whom they taught the ideas. CPJ says it has been helpful in the daily life of bringing up her daughter, but also helps her to living a "life with purpose." CPB has taught it to her husband, as well as to her father, sister and brother in-law. The teaching is not formalized, but people who are close to them appear to pick it up. Referring to her husband, she says, "I don't know, and I have taught him some of these concepts sort of indirectly or in conversation in the way that he talks about work or the people he works with. So I think in some ways it's rubbed off on him." …" And I think it's really been helpful in my marriage" (CPB).

On the other hand, PHG acknowledges that "everyone needs someone else to encourage them," and working on your own limits the resources and motivation for the work, as well as the accountability. She was not successful in stopping smoking on her own, and thus illustrates the limitations of being only self-driven. She feels that "the relationship piece" is important and emphasizes the supporting aspects of the interactions.

In summary, regarding the value that people found in RT, PHD said, "I had no idea when I took the class how valuable it would be and it's really helped me professionally and personally so I'm really glad I can use it" (PHD).

Theme 4: Barriers and tensions to using RT identified by practitioners

While finding immense benefits of applying RT in their personal and professional lives, practitioners also identified some difficulties in using it. They mentioned several concepts of RT in which they found were difficult to explain to clients or that clients were having a hard time understanding, such as the car concept and the Choice Theory diagram (MDF) (Glasser & Glasser, 2002). On the other hand, CPB said that the diagram is not helpful to some clients since they find it too simple to be applicable to their lives. MDF said that "RT is easy to practice, but hard to describe."

While some participants, as we saw in the first section, underscored the adaptability of RT to different situations, others highlighted the difficulties in this adaptation. For example, they felt that it is difficult to work when the personality or preferences of the client that do not 'fit' with the RT orientation. Practitioner PHH felt that it is less applicable to clients who are more emotional and is not equally applicable for clients with different learning styles. CPN said that if the client is not action-oriented, they do not respond well to the RT approach, in which case she uses other models, such as a narrative process. On the other hand, in some cases the client wants to move forward quickly – a situation which can create

tension for the practitioner, particularly when working with culturally diverse clients. In such a case, CPB, one needs time to understand the culture and history, yet the client would rather not look back. Other clients want to be given an answer or solution, and it is a struggle for the practitioner not to respond (PHH). Thus, some practitioners highlighted the difficulties with applying RT with different clients and reiterated the critique of RT in relation to its applicability to clients who feel they have options and possibilities of choices, and its less relevance to clients living in situations of structural inequalities and limitations (PHE). Basically, then, reality therapy may need to be adjusted based upon different cultural orientations (Peterson, 2005; Corey, 2005).

Other challenges that practitioners brought forth had to do with the applicability of RT techniques to different situations and when working in different roles. SCL, for example, discussed worrying about keeping the boundaries between using RT for therapy and for advising, i.e. struggled to compartmentalize between the different helping roles in which he found himself.

On the practical side, while some practitioners above stressed its usefulness as a brief therapy, others felt the time constraints. This was particularly relevant for medical doctors who were applying RT concepts and techniques with their patients, but found the time limits of the visit very constraining if they wanted to conduct in-depth work (MDI, MDF, NRM). Others, who applied it in organizational and work settings, found the absence of privacy a barrier to working successfully (SCL; PHC).

Some of the practitioners highlighted the limitations of training in RT. They felt that as time goes by some of the ideas and techniques are easily forgotten (PHE); furthermore, continuation of training in RT is not readily available. Others also underscored the difficulties with retention of information either about the theory or the process (PHG; PHD). In summary, several people felt that training in RT is limited, it is not taught in enough programs and counselors do not necessarily receive exposure to this approach, or have difficulties finding continuing education opportunities. CPB recommended that articles related to RT need to be more visible in mainstream counseling journals so that they are available to counselors with different training backgrounds.

Theme 5: Areas and Techniques for using RT

Practitioner Orientation

The interviewees represented the variety of health professionals who participated in the RT course and are now practicing in their fields of study. The professions represented were counseling, including college advising, and school counseling and psychology as well as those practicing counseling psychology and nursing. Other participants, who had studied public health, were practicing medicine, management, exercise science, early intervention and higher education student advising.

There were themes regarding professional orientation that were independent of the particular health profession being practiced. Practitioners talked about their orientation to practice with descriptions that are clearly RT, although not necessarily named as such. For example, they described themselves as being "client centered," "person centered," "being in the present," being "goal-oriented" (PHG). CPB described using CBT and humanistic

(techniques) both having characteristics of CT/RT. Lead management was cited as a professional orientation and the difference between Boss versus Lead Management was mentioned by CPJ. CPB talked about having a teaching orientation and using a teaching model toward practice i.e. teaching CT/RT to clients, rather than using it as a process with them.

Purposes for Which RT is Used

The purposes for which RT was used represented the variety of fields in which participants practiced. A physician (MDI) who uses RT to encourage healthy lifestyles stated – "it's good feedback for me knowing that they (patients) come back and do a return visit and when they tell me that they are eating more fruits and vegetables." In the application to exercise, one practitioner works with reality therapy in helping clients modify their behavior (PHC).

Advisors and counselors used RT to help clients with anxiety around test-taking, as well as anxiety and somatic complaints (CPB). The CT/RT principles were used with trauma experiences in nursing care (NRM) and in school counseling – working with students who have traumatic issues at home. Regarding crisis intervention, in overwhelming situations CT/RT can be helpful in developing rapport with the clients (SCL). Managers used RT in leadership, management (PHH; PHE) and in organizational change, as well as in difficult workplace situations (PHH). Managers from the public health fields used CT/RT in program planning and in higher education student advising (PHD; MDF).

Techniques found most helpful and used most often

How impressive it is that many of the concepts that we teach, learn, and practice in CT/RT were expressed in the interviews. Using problem-solving strategies and seeing incremental successes by starting with small successes was found valuable. Helping clients to self-evaluate, taking a step back and re-evaluating and being results-oriented was also important (MDF). Helping clients reframe what's possible, reframing their wants was an important strategy, too, according to PHD, as well as helping them come to their own conclusions. Listening carefully and noting that everyone wants to be heard was mentioned. Finally, meeting the clients where they were (MDI) and then reflecting back to the client was meaningful in helping the client move forward.

The power of the Questions

The approach of asking questions was talked about in many ways. For example – asking open-ended questions, leading to "ah-ha moments" (PHD). Helping the clients to self-evaluate and coming up with their own answers was also thought to be beneficial. Using the WDEP system to draw out the stressors and in planning (PHK) was mentioned by several practitioners. One participant talked about following up her RT training by taking a Motivation Interviewing class "which I know is quite similar" (PHK). Questions around learning styles and personality styles were described as helpful. Asking questions about strengths and emphasizing positive psychology was a significant part of practicing CT/RT. Asking, "whose behavior can you control" – was thought to be a useful question too (PHE).

Approach to the clients

The idea of looking forward and being non-directive was thought to be a valuable concept. Helping clients change negative thoughts, shifting to positive energy and using positive psychology was important in working with clients. There were many specific strategies used in the practice of CT/RT for example: using visual pictures; asking the client to draw what they want or draw quality world pictures; writing a pro-con list; helping clients make plans and to adjust their plans when something wasn't working. Teaching the car metaphor in terms of total behavior was found helpful for some practitioners, contrary to others who thought it was too difficult for some clients to understand.

In summary it is clear that practitioners are using the CT/RT techniques in a way that fits their professional fields. Techniques found valuable are many and include the major concepts that we teach about CT/RT. They understand the power of the questions and asking them in a way that helps clients to self-evaluate so that they can come up with the answers and make more effective choices (CPN).

Discussion and Recommendations

The purposes of this study were met in determining the outcomes of learning that took place in a reality therapy course which helped practitioners describe the specific ways past course participants had incorporated CT/RT personally and professionally.

In summary, health professionals practicing reality therapy value the concepts and used them in both their personal and professional lives. The data showed the degree to which many concepts were significant to participants in the practice of RT. What follows is some of the important discussion points and recommendations.

Empowering the client

The data emphasized many concepts in CT/RT that were central to successfully working with clients. Several of the same perceptions were included within more than one theme and by several participants. For example – the importance of emphasizing positive psychology was evident and building involvement with the clients was essential in helping empower clients to find their own answers and decide what was really important to them. Involvement helps build trust between the helper and the client. As the helper engages in active listening, values what the client values, and really walks with them, they are more likely to disclose what they really want, leading to a true "transformation." Seeing this "amazing transformation" was important in the professional fulfillment felt by practitioners using CT/RT. The significance of getting involved with clients and showing concern throughout the helping process is consistent with the concept that the most important part of practicing Reality Therapy is to become connected to the client (Glasser, 2000; Wubbolding, 2011).

Self-evaluation and goal setting

Self-evaluation and goal-setting are possible with strong relationships between the client and the helper. Goal-setting and being results-oriented were significant to practicing CT/RT. Self-evaluation is one of the cornerstones of CT/RT and was evident in several themes in this study, as well as the supporting quantitative data. Helping clients self-evaluate what is

possible and ultimately moving them forward to setting-goals and making plans for behavioral changes were significant (Chart 2 - Components used Personally). Self-evaluation and goal-setting are truly very important concepts to teach clients. Perhaps having a variety of materials and/or forms to help clients document their goals and a process for working toward them would make their goals more visible and thus more real.

Follow-up for integrating concepts

Participants talked about the need for a way to integrate CT/RT concepts they learned in the reality therapy course. Their experience was that, as time goes by after the class, it was easy to forget things about RT (PHE). This might be noteworthy especially for those not practicing counseling as a profession.

There are a variety of ways to suggest that might facilitate integration of CT/RT including: participating in the reality therapy blogs on the Institute website (plus other notable inclusions are often found in the WGI journal, i.e., the *International Journal of Choice Theory and Reality Therapy*, that is available to anyone free-of-charge on the WGI website or at ***ctrtjournal.com***, as well as other sites available on the internet; encouraging the process of certification; setting up groups of people interested in sharing similar cases and supporting each other as they continue to use the theory and process in their different health professions.

The need for integration of the concepts for clients, as well as practitioners, is very important. This is particularly true when we teach RT to our clients as part of the helping process. Teaching choice theory and the reality therapy process should be our goal for all clients we work with whenever possible. The value of teaching the concepts has been part of the emphasis in the literature and counseling practice. If clients can learn the theory and process, they can use the concepts in their personal life as well as their professional life. This was evident in the quantitative data of this study (see Chart 2: Components used Personally; see Chart 3: Components used Professionally), as well as the qualitative data. Having a variety of materials available for clients to take away from the sessions, and books for suggested readings for them to refer to later, will supplement and support what we are teaching them as suggested by several practitioners (CPB, PHK, CPN).

Practitioners talked about the value of CT/RT as a process for brief therapy. Some practitioners, who did not have enough time with their clients to work through the CT/RT process, found the process to be a barrier. Perhaps in such situations, it becomes even more important to emphasize teaching the clients self-evaluation strategies to help them use the process themselves. Additionally, it will be helpful to have appropriate CT/RT materials to give to clients for their independent learning in situations when time is a barrier.

Teaching in Counseling Programs

Several participants noted that RT is rarely taught in counseling programs (MDF). Figuring out why this is true may be difficult for those of us who easily gravitated to CT/RT after learning it in our respective counseling programs. This study did *not* ask the question about why practitioners thought RT was not taught in counseling programs, but might be a question for further research. Possibly CT/RT might be thought of as too simple, or the

perception that there is not enough evidence of efficacy for CT/RT. If so, the investigation of such claims would also align with the need for more research.

Creativity, Adaptability and Flexibility

When we *do* have the opportunity to teach CT/RT in training programs, or in counseling programs, it would be important to emphasis its adaptability to different clients. Data from this study indicated that practitioners found a way to adapt the theory and process for a variety of types of situations, across different health professions. They noted the flexibility in using CT/RT with diverse cultures, backgrounds and past histories, which is consistent with the literature on adapting RT for different multicultural situations.(Sanchez, & Thomas, (2000); Mickel, (2005); Kim, (2007); Lennon, (2010); Holmes, White, Mills, Mickel, (2011).

Participants also found creative ways to use and teach the concepts and made the connections with other theories such as Cognitive-Behavioral Theory, as well as client-centered and humanistic theories. Therefore, when teaching RT it might be useful to make these connections for students to help them integrate other theories and processes that they have also learned.

The systematic way of working with clients that is inherent in the CT/RT process provided a structure that was appealing to the practitioners and for the clients. Many practitioners suggested that they were attracted to CT/RT because it fit their style and, in some cases, it provided a name for what they were already practicing. What is interesting to note is that they see the "fit" with the structure of the RT process and philosophy and yet they also find ways to adapt to the needs of clients. This may suggest that in our teaching of CT/RT we might emphasize that it is not necessary to be a "purist" in using the Reality Therapy process. In fact, teaching how to incorporate CT/RT with other theories and processes in a constructive way might be very valuable. Perhaps this might be best done after students have learned and practiced CT/RT and have a good grasp of the concepts.

Also, a beneficial suggestion from one interview was to ask students to develop an "elevator talk" about CT/RT for the purpose of describing it briefly to others. Perhaps there could be two such "talks." There may be one discussion for counseling professionals, who can connect the theory and process to other techniques they have learned, and one for non-counseling professionals who do not have the same knowledge base.

Summary: This research shows the benefits of teaching CT/RT to an interdisciplinary health professional group of college students. All participants found the theory and process relevant both personally and professionally independent of their health profession. Of significance is that 33% of the participants used the concepts daily in their work and another 26% used the concepts weekly. They have experienced the benefits of relationship building and how clients were empowered in many ways through the process of CT/RT. From the perspective of the clients, one of the main values of RT was that they were asked what they *want(ed)*, something they hadn't experienced previously. This is clearly the reality therapy process in action. Practitioners value RT and feel professional fulfillment in using these concepts with clients. They were flexible in working with different types of clients and found ways to be creative in helping clients work toward their goals to get more of what they wanted in their lives.

Recommendations for future research

Future research might include the following more qualitative studies related to:

1. How people from different cultures react to reality therapy and are helped by the process from their own perspective as well as that of the practitioner.

2. A more in-depth study from clients who can be descriptive of how they were helped by the RT process; what they learned that was applicable to their lives beyond the therapy sessions. This would help support the idea that teaching RT is an essential part of the process.

3. Research on professionals trained in lead management techniques and how they use the concepts in business practice.

4. Understanding the motivational reasons for professionals who pursue RT certification, from a qualitative perspective. Specifically, what was it about the concepts of CT/RT and their professions that encouraged them to pursue certification and how that process helped them. This may assist us in learning ideas to encourage others to pursue the certification route.

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Brief Bios

Mary E. Watson, MSCP, Ed.D., CTRTC, is an Associate Emeritus Professor of Health Sciences and has an appointment in the Counseling and Applied Educational Psychology Department at Northeastern University. She is an instructor of The William Glasser Institute. Contact information: Mary E. Watson at m.watson@neu.edu

Lauren A. Dealy, MSCP, is a graduate of Northeastern University and practicing mental health practitioner, working towards CTRT certification.

Irina L.G. Todorova, PhD, is an Associate Clinical Professor of Health Sciences and Interim Director of the MPH Program at Northeastern University, and an expert in qualitative research methods.

ShrutiTekwani, MSCP, CTRTC, is a graduate of Northeastern University and is a mental health practitioner.

CONSTRUCTION OF AN ENGLISH VERSION OF THE QUALITY OF MARITAL RELATIONSHIPS (QMR) SCALE BASED ON THE GLASSER'S 'SEVEN DEADLY HABITS'

Sahar Mohamadi, M.A., CTRTC
Ali Sahebi, Ph.D., MAPS, CTRTC, WGI Senior Faculty member

Abstract

The seven deadly habits are all the basic behaviors of external control psychology that harm and destroy relationships and, in doing so, cause almost all the problems with which people struggle. The main purpose of this research was to construct an instrument that operationalizes Glasser's constructs of seven deadly habits in marriage. The theoretical principles of the deadly habits in marriage based on the Choice theory perspective were studied first. Then, the researchers designed a questionnaire based on the framework that resulted from studying the achieved resources. Five couple therapists who work based on CT/RT and five faculty members associated with the William Glasser Institute provided consensual evidence of face and content validity. The results of this study showed that judges concurred that the 77 items retained were valid indications of the deadly habits as defined by Glasser.

Keywords: choice theory, external control psychology, Glasser, marriage, seven deadly habits

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Introduction

Glasser's (1999) view of man's basic problem can be summed up quickly: failure to fulfill certain genetically programmed needs, lack of close relationships, and external control psychology.

External control psychology is the source of the unsatisfying relationships afflicting humans throughout the world today (Glasser, 1998; 2000c; Robbins, 2005). Long-Lasting human problems are considered relationship problems by choice theory and reality therapy proponents. These relationship problems occur in one or more setting: (a) marriage, (b) family, (c) school, and (d) work. Glasser (1998) cites researcher that supports his thesis.

Glasser (1998) considered all relationship problems to be one or more variants of an external control-type psychology based on the following four ideas: (a) I want you to do something that you don't want to do, (b) You want me to do something I don't want to do, (c) We both want each other to do something neither of us wants to do, and (d) I'm trying to force myself to do something I don't want to do, and I'm doing this partly to please someone else.

Conversely, choice theory states that humans are driven by internal motivations rather than external factors in making choices to meet basic needs (Glasser, 1998; Wubbolding et al., 2004). This focus on internal forces creates conditions for motivation and responsibility (Ervin, 2003).

External control psychology is exacerbated by the use of the seven disconnecting behaviors (Glasser and Glasser, 2000; 2007; Robbins, 2005). Glasser and Glasser (2000; 2007) maintain that there are "seven deadly habits of human relationships" characterized by: criticizing, blaming, complaining, nagging, threatening, punishing, and bribing. These are the things that spouses do to one another, parents do to children, teachers do to students, bosses do to employees. All of these are the behaviors that harm the relationship and they are also the main source of all human unhappiness (Glasser, 2000b; Onedera & Greenwalt, 2007).

Glasser states that if relationships are healthy, then you don't try to change people around you; you try to adjust your life to theirs (Onedera & Greenwalt, 2007). Good relationships nourish us and support our health, while toxic relationships can poison us (Cliphton, 2011). Glasser maintains that the seven deadly habits result in resistance which leads to disconnection (nelson, 2002).

These disconnecting behaviors can be replaced, however, with the seven connecting behaviors. These behaviors include caring, trusting, listening, supporting, negotiating, encouraging, and accepting (Glasser, 2000b; Glasser & Glasser, 2000; 2007). Through these behaviors, strong and supportive relationships can be established and maintained (Robbins, 2005).

People do disconnecting behaviors in hopes of changing another's behavior into something that will satisfy them enough to bring them closer together, not realizing that these behaviors only push people away, further facilitating the vicious cycle of pain, anger, and bitterness in a relationship (Glasser, 1998).

Interestingly, this notion seems to fly in the face of most people's typical responses. That is, many are always ready to find reasons for the manner in which their lives are going and those reasons will usually be externally-oriented and blame-related. They may say the only reason I haven't a happy life now is because of the actions of someone else, e.g., my spouse. This is the blame syndrome illustrated by a marriage relationship. In truth, the illustration could have used the work setting, the neighborhood, or any other situation where other persons are involved with one's life (Perkins, 2012).

A problem for partners in relationships is that when difficulties arise, many people repeat centuries-old mistakes. They attempt to control their partner's behavior through external control behaviors, such as the seven deadly habits. Glasser (2000b) proposed that relationship partners can be harmed with these behaviors. Although Glasser and Glasser identified seven deadly habits in any relationship, especially in marriage, presently there are no measurement tools that are widely available for couples or counselors that can operationalize Glasser's constructs.

Construction and validation of such a scale that measures the strength and presence of each deadly habit in partners' relationships will provide invaluable support of choice theory as it applies to relationships. More specifically, the Quality of Marital Relationships Scale is intended to add a dimension to the existing knowledge we have regarding reality therapy.

The researchers constructed an objective measure of the intensity of an individual's deadly habits based on Glasser's work in choice theory/reality therapy. The operationalization of

these constructs will be useful to counselors who work with pre-marital couples and partners with relationship difficulties.

A review of the tests and measurement literature, as well as consultation with reality therapists, revealed that the 1999 Four Horsemen subscale of Gottman's Sound Relationship House (SRH) scales, is the instrument that comes closest to measuring Glasser's constructs.

John Gottman has spent years studying marriages (both marriages that have endured, and marriages that have eventually ended in divorce). He studied marriages based on over 3000 couples with the intent of uncovering the reasons why some marriages work and why other marriages fail (Hughes-Brand, 2007). After studying marriages for 16 years, he has learned to predict which couples will eventually divorce and which will remain married. He can make this prediction based on the ways couples argue, after listening to the couple for just five minutes, with 91% accuracy (Gottman & Silver, 1999).

Using four observational variables, Gottman (1994a, 1994b) identified and hypothesized a process cascade that he named the Four Horsemen of the Apocalypse: (a) complain and/or criticize, (b) contempt, (c) defensiveness, and (d) stonewalling, which signified a trajectory toward marital failure. This hypothesized process of marital and relationship decline has been used to identify couples at risk.

Each of these four horsemen can predict divorce by themselves, but typically they are found together in an unhappy marriage (Gottman & Silver, 1999).The presence of the four horsemen alone predicts divorce with only 82 percent accuracy, but when you add in the failure to repair attempts, the accuracy rate reaches into the 90's (Buehlman, Gottman, & Katz, 1992).

Gottman (1993) states not all negativity of interactions is equally corrosive: There were some negative acts that were more predictive of dissolution than others. A structural model supported a process cascade in which criticism leads to contempt, which leads to defensiveness, which leads to stonewalling. The results suggest that these four processes are particularly corrosive to marital stability.

The Four Horsemen questionnaire (30 items) assessed an iterative, cascading sequence of responses in which Partner A expresses criticism, Partner B responds with defensiveness, Partner A reacts to defensiveness with contempt, sarcasm, and/or hostility, with Partner B eventually withdrawing from, or stonewalling, the conversation (Gottman, 1999).

It seems that the four horsemen of deadly communication in Gottman's approach have much overlap with the seven deadly habits in Glasser's perspective; hence, investigating the relationship between these two categories of disconnecting behavior is necessary. But generally there are some major differences between them. "The four horsemen" identifies a cascading process, for example, criticism leads to contempt, whereas this process of cascading does not exist in the seven deadly habits schema. Also they have another difference; Gottman and Silver (1999) consider Contempt as the worst of the four horsemen, but Glasser (Nelson, 2002) states that Criticizing is the most dangerous of the deadly habits.

Wubbolding (2011) explains about application of Choice Theory and Reality Therapy in counseling with couples and families and he states one important characteristic in family systems is communication, and one thing that we can teach and emphasize in counseling is how you talk to each other, and avoid what Glasser calls the deadly habits or the toxic habits (Robey, 2011). It means releasing and reducing these deadly habits in all relationships is important, especially within the family and marriage.

Quality of Marital Relationship (QMR) Scale

The need for a loving relationship is one of Glasser's basic themes (Glasser, 1965). In addition, marriage is the basis for civilization, yet, almost half of all marriages end in divorce, and those spouses who stay together are not necessarily happy. Many creative and innovative approaches have been used to counsel individuals, couples, families, and group over the last century (Becvar & Becvar, 1996); yet problems remain unresolved in many relationships.

A new way of looking at the old problem of relationship dissatisfaction was proposed by Glasser and Glasser (2000; 2007). They hypothesized that there are seven disconnecting behaviors that can destroy relationships such as marriage. If Glasser's hypotheses were supported by research, then a choice theory/reality therapy approach to relationships would be valuable to counselors working with client(s) on marital relationship issues.

To test his hypothesis, it was necessary to construct and validate a Quality of Marital Relationship (QMR) Scale that measures the presence and intensity of these seven deadly behaviors in marital relationships.

The aim of the current study was construction of the English version of this scale. For this purpose, a Quality of Marital Relationship (QMR) Scale was designed that operationalized Glasser's constructs of Criticizing, Blaming, Complaining, Nagging, Threatening, Punishing, and Rewarding to control/Bribing. Further research is necessary to test Glasser's (2000) hypothesis that each of these habits can destroy and disconnect relationships, such as marital unions. In addition, Glasser stated that some of these behaviors are more dangerous than others. The creation of the QMR scale would therefore be useful to reality therapists in assessing the deadly habits in partner's communication and helping them to replace these habits with connecting behaviors.

Scale Construction

The original scale consisted of 81 Items, 10 for criticizing, 10 for Blaming, 10 for Complaining, 11 for Nagging, 10 for Threatening, 20 for Punishing, and 10 for Bribing/Reward to control.

The QMR scale is comprised of items that were generated from theory and on Glasser's extensive writing on choice theory and some related articles and books.

Using criteria from Dawis (1987) as a basis, the researchers selected a subject-centered measure as opposed to either a stimulus-centered or response-centered scale. According to Dawis (1987), subject-centered scales are frequently used in counseling psychology research. They reflect differences among the respondents in terms of their standing on the

scale's dimensions. A Likert-type scale was chosen because of its traditional use in developing subject-centered scales (Dawis, 1987). In turn, an 81-item scale was developed that included seven subscales to assess each of the seven deadly habits. In the final draft of the QMR Scale, item anchors were modified to "Never, Seldom, Sometimes, Often, and Always".

Item Validity Estimates

QMR scale items drawn from Glasser's hypothesis about seven deadly habits were submitted to judges to determine face and content validity. To devise a set of items for the seven subscales corresponding to Glasser's seven constructs, concepts were taken from his written descriptions of theory and others' writings as well.

In the first step, a total 81 items were designed in Persian and English version. In second step, the Persian version of questionnaire was sent to 5 couple therapists in choice theory framework in Iran for evaluating its face and content validity. Judges rated the items on a scale anchored by (5) totally interrelated and (0) not at all.

During step #2, items were added to both versions of the questionnaire, and 2 items were eliminated from these versions too. Consequently, the two final versions of the questionnaire included 81 items each.

In the next step (i.e., step #3), the revised English version of QMR scale was sent to 5 faculty members of William Glasser Institute in USA and Australia. Items reaching consensual agreement, as demonstrated by an average rating of 3.0 or above were retained; those reaching less than 3.0 were eliminated. In sum, only 77 items remained in this version of the QMR scale.

Criticizing

Glasser maintains that, of the seven deadly habits, criticizing is the most dangerous (Nelson, 2002). Rapport (2007) defines this behavior as judging someone or something as bad and communicating that judgment. Glasser (2000a) sometimes calls that constructive criticism, that is an oxymoron because all criticism is destructive, and it is least accepted when it is accurate.

Ratings on the Criticizing subscale ranged from 3.8 to a high of 4.6 (M=4.12). The ratings on the Criticizing subscale are depicted in Table 1.

Table 1. Criticizing Subscale Items

Items	Item Description	Average Rating
1	I attack my spouse's style if she/he doesn't wear clothes according to my tastes	3.8
2	I put down my spouse if she/he doesn't act according to my demands	4.6

3	I criticize my spouse's manners if I don't like his/her attitude toward my family	3.8
4	I put down my spouse's behavior if I don't like it	4
5	I criticize my spouse if she/he doesn't perform as I want in our sexual relationship	4.4
6.	I warn my spouse about his/her behavior if he/she doesn't act as I like in his/her personal activities (job, education, social behavior, etc.)	4.2
7	I criticize my spouse if I don't like his/her appearance	3.8
8	I attack my spouse's attitude if I don't like the way she/he eats or drinks	4.4
9	I criticize my spouse's talking if I don't like the way she/he talks	4.2
10	I correct my spouse if he/she is doing a task wrongly	4

Blaming

Blaming is ranked second in being dangerous/destructive to any relationship (Nelson, 2002). Definition of this habit is by communicating that someone has caused something undesirable to happen or not happen to them or to others (Rapport, 2007).

Ratings on the Blaming subscale ranged from 3.6 to a high of 5 (M=4.28). The Judge's ratings for the Blaming subscale are shown in Table 2.

Table 2. Blaming Subscale Items

Items	Item Description	Average Rating
1	I blame my spouse for all the mistakes she/he has made	4.6
2	I blame my spouse if she/he makes any mistakes in her/his attitudes toward my family	4
3	I reproach my spouse for his/her behavior if she/he comes home late	4.6
4	when we have financial problems, I tell my spouse it is her/his fault	5

5	If our child does something wrong, I tell my spouse that it is her/his responsibility to teach/correct our child and I blame her/him of our child's behavior	4.6
6	If some problem comes up between me and my spouse, I blame my spouse and I tell her/him so.	4.8
7	When I have an argument with my spouse in which he/she uses offensive words, I reproach him/ her for this behavior	3.6
8	I put the blame on my spouse, if he/she is not able to do duties like someone else	4.2
9	If I feel dissatisfaction in may marital relationship I accuse my spouse of making me so annoyed	3.6
10	I believe our love is not strong enough, because my spouse doesn't try in our relationship sufficiently	3.8

Complaining

The third dangerous habit is complaining, which Rapport (2007) defines as a feeling of dissatisfaction or frustration with someone or something and, in turn, communicating those feelings.

Ratings on the Complaining subscale ranged from 3.6 to a high of 4.8 (M=4.24). The ratings on the Complaining subscale are depicted in Table 3.

Table 3. Complaining Subscale Items

Items	Item Description	Average Rating
1	I show my spouse my dissatisfaction of her/his behavior in our relationship	3.6
2	I express my despair of any improvement in our relationship to my spouse	4
3	I express my dissatisfaction of my spouse's attitude to her/him	4
4	Sometimes, I feel deep regret that I married my spouse and I express this feeling to her/him	4.6
5	If my spouse's behavior disappoints me, I will express my disappointment to her/him	3.8
6	I show my dissatisfaction of our sexual	4

	relationship to my spouse	
7	I tell my spouse that her/his attitude toward my family is annoying	4.8
8	If I don't like the way my spouse behaves socially I express this feeling to her/him	4.8
9	I feel my spouse doesn't understand me and I express this feeling to him/her	4
10	When I compare my marital relationship to others I feel disappointed and let my spouse know this feeling.	4.8

Nagging

The fourth habit that could be dangerous is nagging, and the definition of this habit is: repeatedly criticizing, complaining, threatening, or blaming (Rapport, 2007).

Ratings on the Nagging subscale ranged from 3.6 to a high of 4.8 (M=4.31). The ratings on the Nagging subscale are depicted in Table 4.

Table 4. Nagging Subscale Items

Items	Item Description	Average Rating
1	I remind my spouse over and over about her/his mistakes	4.8
2	I repeatedly warn my spouse about the consequences of her/his actions	3.8
3	I keep telling my spouse how he/she should wear his/her clothes	3.6
4	I tell my spouse of my negative feelings about her/his personality again and again	3.8
5	IF my spouse doesn't act according to my demands, I nag her/him to make her/him do what I want	4.8
6	As soon as I see my spouse make any mistake, I continually remind her/him it was her/his fault	4.8
7	I attack my spouse about his/her behavior repeatedly	4.2

8	I frequently remind my spouse not to forget to do a task	4.2
9	I frequently correct my spouse and direct him/her to do a task my way	4
10	I repeatedly complain of my spouse's sexual function	4.6
11	I keep telling my spouse that "You don't understand me"	4.8

Threatening

The fifth habit is threatening. Rapport (2007) defines "threatening" as an attempt to force someone to do or not do something by communicating that an undesirable result will occur unless the person complies.

Ratings on the Threatening subscale ranged from 4 to a high of 4.8 (M=4.34). The ratings on the Threatening subscale are depicted in Table 5.

Table 5. Threatening Subscale Items

Items	Item Description	Average Rating
1	When I get into an argument with my spouse, I threaten her/him that I will divorce her/him	4.8
2	I threaten my spouse to make her/him do what I want	3.8
3	I warn my spouse to act according to my demands; otherwise, I won't do what she/he wants	3.6
4	I threaten my spouse not to do anything against my interests or I limit her/his freedom of action	3.8
5	I warn my spouse that if she/he doesn't do what I want, I will limit/end our sexual relationship	4.8
6	When I get into argument with my spouse, I threaten to throw her/him out of the house	4.8
7	I threaten my spouse to beat him/her if she/he doesn't do according to my demands	4.2
8	When I argue with my spouse, I threaten him/her	4.2

	to disrespect his/her family	
9	When I get into an argument with my spouse, I threaten him/her that I will leave the house forever	4
10	I warn my spouse to act according to my demands; otherwise I will limit her/him in connecting with her/his family	4.6

Punishing

Punishing has sixth rank in deadly habits. This habit is defined as: imposing a disadvantage on another (Rapport, 2007).

Ratings on the Punishing subscale ranged from 4.2 to a high of 5 (M=4.65). Judges recommended that four of original items in this category will be eliminated, because those items were very similar to one of the other items. So, those items were discarded, even though they were well over the cut-off rating 3.0. The ratings on the Punishing subscale are depicted in Table 6.

Table 6. Punishing Subscale Items

Items	Item Description	Average Rating
1	When I have an argument with my spouse, I stop visiting her/his family	5
2	When I am annoyed with my spouse, I stop having sex with her/him for a while	5
3	When I fight with my spouse I leave the house/room to punish her/him	4.6
4	When I have problem with my spouse, I don't answer to her/him in order to show I am ignoring her/him	4.8
5	When I am angry at my spouse, I purposefully try to be dirty and messy to punish her/him	4.8
6	When I fight with my spouse, I yell at her/him and use offensive words	5
7	When my spouse annoys me, I try to limit her/his connection with her/his family	4.4
8	When I am irritated with my spouse, I intentionally do things she/he doesn't like to hurt her/his	4.8

	feelings	
9	When my spouse touches my personal things without my permission, I don't let her/him use them again	4.2
10	When my spouse doesn't come to parties that I want, instead I limit her/his social relations	4.8
11	When I argue with my spouse , I escalate the argument to fight with her/him physically	4
12	When I am annoyed with my spouse's behavior, I ridicule her/him in retaliation	4.4
13	When I am irritated with my spouse, I limit her/his friendly/social connections	4.6
14	When my spouse doesn't respect my family, I disrespect her/his family in response	4.6
15	When I am angry at my spouse, I don't tell her/him frankly. Instead, I am stubborn	4.6
16	When I am annoyed with my spouse, I talk to her/him sarcastically	4.8

Reward to Control/Bribing

The seventh and last habit is bribing that Glasser calls it "rewarding to control" (Nelson, 2002). Bribing is punishing by rewards, partners may like the reward, but then often resent the rewarder (Glasser, 2000b). Rapport (2007) defines bribing as attempting to induce someone to do or not do something in exchange for something desirable.

Ratings on the Bribing subscale ranged from 4.2 to a high of 5 (M=4.62). The ratings on the Bribing subscale are depicted in Table 7.

Table 7. Bribing Subscale Items

Items	Item Description	Average Rating
1	If my spouse does what I want I'll make love with her/him	4.8
2	I tell my spouse she/he must act according to my demands if she/he wants me to do something for her/him	4.6

3	I tell my spouse if she/he does the things I tell her/him to do, I will give her/him more freedom of action	4
4	If my spouse conforms to my interests, I express romantic feelings to her/him	4.2
5	I tell my spouse if she/he wants to continue her/his relations with her/his relatives, she/he must give me absolute freedom	4.6
6	I tell my spouse I will do what she/he wants only on the condition that she/he does what I want	4.8
7	When I have some demand that requires my spouse do something for me, I pay more attention to her/him	5
8	When I want my spouse to do something for me before I ask her/him I buy some gift for her/him	4.8
9	In order to convince my spouse to fulfill my demands I give her/him what she/he wants before that	4.8
10	I remind my spouse our love should motivate him/her to act according to my demands	4.6

Five members of the William Glasser Institute faculty concurred that these 77 items should be retained since they were valid indications of the deadly habits as defined by Glasser.

Conclusion

A review of the literature supports the development of a Quality of Marital Relationships (QMR) Scale as a tool in the establishment of an empirically-based choice theory program.

Glasser and Glasser (2000, 2007) have hypothesized a new look at the problem of relationship failure, but it has not been empirically investigated. At the present time, there is little reality therapy research with couples and no validated measurement instrument to operationalize Glasser's concepts. As stated earlier, the goal of the current paper was development of an English version of QMR scale. To achieve this end, five marital counselors who work based on choice theory/reality therapy and five members of the William Glasser Institute faculty concurred that the 77 items retained in the scale presented here were valid indications of the deadly habits as defined by Glasser.

The Quality of Marital Relationships (QMR) Scale could be a useful tool that could be employed in the application and research of Choice Theory in the marriage setting. Counselors and reality therapists could administer the QMR scale to determine how well

couples communicate with each other. The QMR scale is also useful for researchers who need a quantitative measure of how well spouses are communicating to answer a variety of research questions. Such a measure could be used to determine the effect of different behaviors (e.g., criticizing) on marital satisfaction. In addition, the QMR scale provides subscale scores for each of the seven deadly habits and by comparing them, it could be found which one of these habits is truly the most dangerous. QMR scale scores could also be correlated with other measures, such as The Four Horsemen of Deadly Communication subscale of the Sound Relationship House (SRH) scale to determine their relationship.

Acknowledgment

The authors wish to thank the work of the William Glasser Institute faculty and reality therapists who provided face and content validity for the Quality of Marital Relationships Scale. We gratefully acknowledge Dr. Robert Wubbolding and Ms. Judy Hatswell for their feedback and critique regarding this article.

Please note: The Quality of Marital Relationships (QMR) Scale follows immediately, followed by item organization by construct, and finally the reference section for this paper.

The Quality of Marital Relationships (QMR) Scale

Fill this form out thinking about your present marital relationship status. Please read each statement and place a check mark in the appropriate NEVER, SELDOM, SOMETIMES, OFTEN or ALWAYS box.

1. I put down my spouse's behavior if I don't like it
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

2. I threaten my spouse to beat him/her if she/he doesn't do according to my demands
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

3. I put down my spouse if she/he doesn't act according to my demands
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

4. As soon as I see my spouse make any mistakes, I remind her/him it was her/his fault continually
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

5. I blame my spouse for all the mistakes she/he has made
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

6. I frequently correct my spouse and direct him/her to do a task my way
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

7. When I have an argument with my spouse, I stop visiting her/his family
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

8. When I get into an argument with my spouse, I threaten him/her that I will leave our house forever
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

9. If some problem comes up between me and my spouse, I blame my spouse and I tell her/him so.
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

10. I show my spouse my dissatisfaction of her/his behavior in our relationship
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

11. I put the blame on my spouse if he/she is not able to do duties like someone else
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

12. I attack my spouse's attitude if I don't like the way she/he eats or drinks
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

13. When I am annoyed with my spouse, I stop having sex with her/him for a while
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

14. I criticize my spouse's talking if I don't like the way she/he talks
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

15. I keep telling my spouse how he/she should wear his/her clothes
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

16. In order to convince my spouse to do as I demand I give him/her what he wants before that
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

17. When I am irritated with my spouse, I intentionally do things she/he doesn't like to hurt her/his feelings
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

18. I criticize my spouse if she/he doesn't perform as I want in our sexual relationship
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

19. I remind my spouse over and over about her/his mistakes
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

20. When my spouse touches my personal things without my permission, I don't let her/him do it again
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

21. I warn my spouse to act according to my demands; otherwise, I won't do what she/he wants
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

22. I believe our love is not strong enough, because my spouse doesn't work on our relationship sufficiently
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

23. I warn my spouse that if she/he doesn't do what I want, I will limit/end our sexual relationship
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

24. I reproach my spouse for his/her behavior if she/he comes home late
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

25. I remind my spouse of our love to motivate him/her to act in accordance with my demands
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

26. I tell my spouse that if she/he wants to continue her/his relations with her/his relatives, she/he must give me absolute freedom
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

27. I threaten my spouse to make her/him do what I want
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

28. When I am annoyed with my spouse's behavior, I ridicule her/him in retaliation
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

29. I tell my spouse that her/his attitude toward my family is annoying
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

30. If my spouse's behavior disappoints me, I will express my disappointment to her/him
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

31. When I get into argument with my spouse, I threaten to throw her/him out of the house
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

32. I repeatedly warn my spouse about the consequences of her/his actions
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

33. I tell my spouse of my negative feelings about her/his personality again and again
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

34. I express my dissatisfaction with my spouse's attitude to her/him
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

35. I criticize my spouse's manners if I don’t like his/her attitude toward my family
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

36. When I fight with my spouse I leave the house/room to punish her/him
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

37. I frequently remind my spouse not to forget to do a task
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

38. I feel my spouse doesn't understand me and I express this feeling to him/her
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

39. When I fight with my spouse, I yell at her/him and use offensive words
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

40. If our child does something wrong, I tell my spouse that it is her/his responsibility to teach/correct our child and I blame her/him for our child's behavior
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

41. When I am angry at my spouse, I don’t tell her/him frankly.instead, I am stubborn
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

42. If my spouse does what I want I’ll make love with her/him
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

43. When I am annoyed with my spouse, I talk to her/him sarcastically
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

44. I express my despair of any improvement in our relationship to my spouse
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

45. I blame my spouse If she/he makes any mistakes in her/his attitudes toward my family
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

46. I warn my spouse about his/her behavior if he/she doesn't act as I like in his/her personal activities (job, education, social behavior, etc.)
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

47. I warn my spouse to act according to my demands; otherwise I will limit her/him in connecting with her/his family
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

48. When we have financial problems, I tell my spouse it is her/his fault
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

49. When I am angry at my spouse, I purposefully try to be dirty and messy to punish her/him
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

50. When my spouse doesn't come to parties that I want, I limit her/his social relations
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

51. Sometimes I feel deep regret that I married my spouse and I express this feeling to her/him
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

52. I threaten my spouse not to do anything against my interests or I will limit her/his freedom of action
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

53. When my spouse annoys me, I try to limit her/his connection with her/his family
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

54. I show my dissatisfaction with our sexual relationship to my spouse
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

55. When I have some demand that requires my spouse to do something for me I pay more attention to her/him
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

56. I correct my spouse if he/she is doing a task wrongly
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

57. If I feel dissatisfaction in my marital relationship I accuse my spouse of making me so annoyed
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

58. I tell my spouse if she/he does the things I tell her/him to do, I will give her/him more freedom of action
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

59. When I want my spouse to do something for me, before I ask her/him I buy some gift for her/him
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

60. If I don’t like the way my spouse behaves socially, I express this feeling to her/him
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

61. When I compare my marital relationship to others I feel disappointed and let my spouse know this feeling
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

62. I keep telling my spouse "you don't understand me"
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

63. I tell my spouse that I will do what she/he wants only on the condition that she/he does what I want
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

64. I criticize my spouse If I don’t like his/her appearance
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

65. I repeatedly complain of my spouse’s sexual function
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

66. When I have a problem with my spouse, I don’t answer her/him in order to show I am ignoring her/him
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

67. When my spouse doesn’t respect my family, I disrespect her/his family in response
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

68. When I have an argument with my spouse, in which he/she uses offensive words, I reproach him/ her for this behavior
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

69. IF my spouse doesn’t act according to my demands, I nag her/him to make her/him do what I want
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

70. I attack my spouse's style if she/he doesn’t wear clothes according to my tastes
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

71. When I get into an argument with my spouse, I threaten her/him that I will divorce her/him
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

72. When I argue with my spouse, I threaten to disrespect his/her family
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

73. I attack my spouse about his/her behavior repeatedly
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

74. If my spouse conforms to my interests, I express romantic feelings to her/him
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

75. I tell my spouse that she/he must act according to my demands if she/he wants me to do something for her/him
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

76. When I argue with my spouse, I escalate the argument to fight with her/him physically
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

77. When I am irritated by my spouse, I limit her/his friendly/social connections
☐Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

Questions applicable for each construct:

Items number 1, 3, 12, 14, 18, 35, 46, 56, 64, and 70 addressed Criticizing; numbers 5, 9, 11, 22, 24, 40, 45, 48, 57, and 68 addressed Blaming; 10, 29, 30, 34, 38, 44, 51, 54, 60, and 61 assessed Complaining; 4, 6, 15, 19, 32, 33, 37, 62, 65, 69, and 73 measured Nagging; numbers 2, 8, 21, 23, 27, 31, 47, 52, 71, and 72 addressed Threatening; 7, 13, 17, 20, 28, 36, 39, 41, 43, 49, 50, 53, 66, 68, 76, and 77 assessed Punishing; and 16, 25, 26, 42, 55, 58, 59, 63, 74, and 75 addressed Bribing .

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Brief Bios

Sahar Mohamadi has a Master's Degree in Psychology from Allame Tabataba'i University and was certified in CT/RT in November 2013 in Iran. Any questions or comments regarding this article are welcomed and the author can be reached at Mohamadi.s.1985@gmail.com.

Ali Sahebi, PhD, MAPS, CTRTC, is a Clinical Psychologist and the director of Pars Psycho-Educational Institute (Center for Teaching & Practicing Choice Theory & Reality Therapy) in Australia. Dr.Sahebi is the founder of William Glasser Institute in Iran (Reality Therapy Institute-Iran). He is a senior faculty member of The William Glasser Institute.

REALITY THERAPY COUNSELORS USING SPIRITUAL INTERVENTIONS IN THERAPY

Dr. David Jackson

Abstract

This article is a summary of the author's doctoral dissertation on the use and effects of spiritual interventions in therapy by counselors who are reality therapy certified. It includes the observation of 144 reality therapy counselors on five different spiritual interventions used in counseling sessions and the degree of success observed in the improved well-being of clients.

Nature of the Problem

Basically, the present study sought to examine the effectiveness of counseling when implementing various kinds of spiritual interventions into their therapy sessions.

Methodology

The sample for this study was obtained from the membership directory of the William Glasser Institute. One hundred reality therapy-certified counselors were selected from each of the six regions of the WGI in the United States. An initial email was sent to them introducing the researcher and informing them of the study and the reason for it. The only criteria required was that the respondents be in a people-helping profession and have an email address. Of the 600 counselors contacted 216 responded for a respectable 36% response rate. A questionnaire was emailed to each of the 600 respondents that addressed four problems.

1. What is the percentage of respondents use spiritual interventions in their counseling?
2. Which spiritual intervention(s) do they utilize most?
3. Which spiritual intervention(s) is/are most successful?
4. Does integration of biblical counseling through spiritual interventions in counseling sessions by reality therapy counselors appear to improve the well-being of clients? A copy of the questionnaire is included at the end of this article.

Results

1. What is the percentage of counselors trained in Dr. William Glasser's (1997) reality therapy[1] who use spiritual interventions in counseling sessions? To ascertain this percentage, the number of respondents from the survey who indicated the use of spiritual intervention was divided by the total number of respondents. 144 by 216 = 66.6% used spiritual interventions.

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2. Which of the spiritual interventions was most utilized and in what order are the five spiritual interventions most often utilized (See Table 1.)

Table 1

	No success	**Little success**	**No change**	**Much success**	**great success**			
						Mean	Std dev	Total
Prayer	6	0	6	54	36	20.4	23.46913	102
Scriptures	12	0	12	30	30	16.8	13.00769	84
Meditation	0	6	6	84	36	26.4	35.13972	132
Forgiven	0	0	6	72	48	25.2	32.97272	126
Self-Disc l.	6	0	0	78	30	22.8	33.24455	114
Total	24	6	30	318	180	111.6	134.8733	558
Percent	4.3%	1.1%	5.4%	57.0%	32.3%			

Notably, meditation was utilized in 132 spiritual interventions. Forgiveness was second with 126 spiritual interventions. Self-disclosure was third with 114 spiritual interventions. Prayer was fourth with 102 spiritual interventions. Finally, use of scriptures was fifth with 84 spiritual interventions.

Success of implementation, on the other hand, was based upon the level of success of the spiritual interventions (see Table 1). For instance, Forgiveness had much success (72 times) and great success (48 times), which totaled 120. Meditation also had much success (84 times) and great success (36 times), which also totaled 120.

3. Looking at it more broadly, though, which spiritual interventions appear to have been most successful and in what order? The difference is found in the number of no success, little success and no change the two spiritual interventions exhibit. Meditation, then, had 12 such cases, while forgiven had only 6.

In comparison, Self-disclosure had much success (78, 68.4%) and great success (30, 26.3%), which totaled 108, while Prayer was next with much success (54, 52,9%) and great success (36, 52.9%), which totaled 90. Finally, Scripture study was found to rank last, with much success (30, 35.7%) and great success (30, 35.7%), which only totaled 60.

4.The integration of biblical counseling through spiritual intervention in counseling sessions, as reported by reality therapy counselors in the present study, revealed a higher percentage of responses for much success and great success responses than no change, little success and no success, therefore indicating possible improvement in the well-being of clients by the use of spiritual interventions in counseling sessions.

In Table 2, in perusing the data as a whole, much success showed 57.0% and great success showed 32.3%. No change, in comparison showed 5.4%, little success showed 1.1%, and no success showed 4.3%. It is evident that much success and great success were much more often chosen by the counselors surveyed, compared to those who indicated no change, little success and/or no success.

Table 2

Rate of Success	Prayer	Scripture	Meditation	Forgiven	Self-Discl.	Total
No success	5.9%	14.3%	0.0%	0.0%	5.3%	4.3%
Little success	0.0%	0.0%	4.5%	0.0%	0.0%	1.1%
No Change	5.9%	14.3%	4.5%	4.8%	0.0%	5.4%
Much success	52.9%	35.7%	63.6%	57.1%	68.4%	57.0%
Great Success	35.3%	35.7%	27.3%	38.1%	26.3%	32.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

The reader should note that "Much success" and "Great success" were selected much more often (i.e., demonstrated higher percentage rates) regarding the level of demonstrated change in their clients attributed to the use of various spiritual interventions. In fact, few counselors chose to describe their use of various spiritual interventions as having been "No change," "Little success," and/or "No success."

Interestingly, mediation was apparently a favorite of reality therapy-trained counselors. Why might this be so? While the data cannot satisfactorily explain why this might be so, the investigator would like to offer some ideas concerning this matter. Specifically, Richards and Bergin (2004) offer four general types of meditation for consideration. The questionnaire in the present study does not distinguish between meditation, contemplation or self-imaging. In addition, it does not differentiate between the other forms of meditation found in Hinduism, Jainism, and Buddhism. This may account for the high usage of meditation in this study since it would include all forms of mediation being employed by the present sample of reality therapy counselors.

Implications of Findings

The five spiritual interventions selected for use in the present study were listed as predominate ones by Richards and Bergin (1997). As reported in this study, Meditation and

Forgiveness were found to be the most popular ones used, as reported by the sample of reality therapy counselors studied. Self-disclosure, Prayer and Scripture followed in that order.

Applications of Findings

The examination of the descriptive data provided by the sample of reality therapy counselors indicated a possible relationship between the use of spiritual interventions and improved client well-being. Notably, however, further study is warranted if we are to more fully understand what these findings mean.

Questionnaire

DIRECTIONS: Dear Colleague: Hi, I'm David Jackson, a Senior Instructor for Dr. Glasser. I am asking you and many other RTC people for help with my dissertation. This research in which you are about to participate is designed to explore the rate and successful use of spiritual interventions in consulting, counseling/ therapy, or any other kind of advice-giving or supportive activity used by counselors. Any information you provide will be held *strictly confidential,* and at no time will your name be reported, or identified with your responses. *Participation in this study is totally voluntary and you are free to withdraw from the study at any time.* By your completion of this survey you are giving informed consent for the use of your responses in this research. Please complete and return to me **AS AN ATTACHMENT.** Thank you, David Jackson

Please mark your answers with an X and return to David Jackson at jave77755@hotmail.com. Thank you.

Spiritual Interventions Assessment Scale with anonymity.

Your Gender: Female___ Male___

Do you include any spiritual interventions in your sessions with the person(s) you are helping? Yes ___ No ___. If no, please return now. Please rate the success you observe of each of the following spiritual interventions you use ranging from 1 to 5,

1= **No Success**: 2=**A Little**: 3=**No Change** 4=**Much**: 5 = **Great Success**.

II. Prayer. (Including individual, or together, and/or homework).
1. _____ 2. _____ 3. _____ 4. _____ 5. _____

III. Sharing scriptural passages with the client (including homework).
1. _____ 2. _____ 3. _____ 4. _____ 5. _____

IV. Meditation (in any form, including homework).
1. _____ 2. _____ 3. _____ 4. _____ 5. _____

V. Helping the client to forgive.
1. _____ 2. _____ 3. _____ 4. _____ 5. _____

VI. Counselor spiritual self-disclosure to client.
1. _____ 2. _____ 3. _____ 4. _____ 5. _____

VII. Any other spiritual intervention (Please describe).

_____

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

This assessment instrument was created by David Jackson and Thomas S. Parish (8.9.12).

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Brief Bio

David Jackson is a senior instructor for the WGI and past director of the Mid-America Region.

ENHANCING SELF-EFFICACY OF COLLEGE STUDENTS THROUGH CHOICE THEORY

Niño Jose Mateo, Ph.D.
De La Salle University, Manila, Philippines

Gabriel Ngombedua Makundu, MA
De La Salle University, Manila, Philippines

El Anelio R. Barnachea, MA
De La Salle-College of Saint Benilde

JN Junille S. Paat, MA
De La Salle University, Manila, Philippines

Abstract

This research study examined the efficacy of a psycho-educational program based on choice theory to increase self-efficacy among college students in Manila, Philippines. Twenty five freshmen students identified as at-risk for developing psychological problems by the counseling center participated in the present study. Participants underwent three one-and-a-half hour intervention sessions with a counselor who utilized choice theory principles in the program. Results showed a significant difference in the pre-test and post-test scores on the General Self-efficacy scale of the 12 participants who completed the program. The results were discussed in the light of self-efficacy and choice theory.

Academic performance has been found to be positively correlated with success and well-being (Gilman & Huebner, 2006; Verkuyten & Thijs, 2002; Padhy et al., 2011). Individuals who do well in schools are happier and more successful. Unfortunately, there has been in recent years a steady decline in the academic performance of college students. This may be attributed to distractions, lack of motivation, and the increased workload for both academics and extra-curricular activities. This observation about the decline in academic performance is neither recent nor isolated in specific areas. Zephyrhawke (2011), in an unpublished dissertation, indicated the complaint by Harvard professors, as early as 1896, about the poor writing quality of their freshman class. According to Zephyrlawke (2011, p. 1), "teachers unfailingly find each incoming class more academically impoverished than the previous one." This is similar to the observation of Lippincott (1975, p. 753) wherein he stated that "there is ample evidence of a significant and accelerating decline in the aptitude and academic achievement of college-bound students and of young people generally". A research study by the University of Gothenburg (2010), in Sweden, found that Swedish school children performed worse compared to 20 years ago. Degue (2012) also had the same observation in students in the basic level in Ghana. In addition, other studies and international competitions in recent years have shown that Filipino students are lagging behind many of their Asian counterparts in academic performance. This decline is so serious that a bill about the amelioration of academic performance in the Philippines was passed in the Congress with a quote from the Undersecretary of the Department of Education saying: "The quality of Philippine education has been declining continuously for roughly 25 years". There is a need to immediately address this growing concern about the decline in academic

performance of students, especially those who have just entered the university or college, as new stressors and demands are likely to shake their overall well-being.

A body of studies discussed thus far has pointed to a strong relationship between self-efficacy and academic performance. Self-efficacy is conceptualized by Bandura (1997) as personal beliefs or an individual's confidence in his own ability to perform effectively special tasks. Self-efficacy has been found by many empirical studies to be associated with positive outcomes. In the school setting, research studies have indicated that students' self-efficacy is related to higher academic achievement or performance (Bandura, Barbaranelli, Caprara, & Pastorelli, 1996). Turner, Chandler and Heffer (2009) found that self-efficacy was a significant predictor of one's academic performance and a similar study by Lent, Brown and Larkin (1986) pointed to self-efficacy as a reliable predictor of one's educational performance. Many other empirical research studies have shown the effects of self-efficacy on students' academic accomplishments (Chemers Hu & Garcia, 2001; Eastin & LaRose, 2000; Tamara & Koufteros, 2002) suggesting that if students' self-efficacy can be enhanced, the end result will translate into better academic or educational accomplishments.

Besides studies that have established the correlation between self-efficacy and positive academic outcomes, some researchers have looked at how the former affects the latter. Chemers et al. (2001) argued that the effects of self-efficacy are mediated by cognitive, motivational and affective processes. Important in cognitive processes are the appraisal and control of one's cognitive activities and the use of available resources to achieve goal attainment. Motivational processes refer to goal-setting that can provide the context for self-regulation and a standard for self-evaluation, self-direction and performance. More importantly, the affective processes consist of attention to, and construal of, the environmental demands prompting the choice of actions to be taken. According to Lazarus and Folkman (1984), the way environmental demands are construed determines the perception of these demands as challenges or threats. Chemers et al. (2001) asserted that the effects of self-efficacy give the ability to manage the stressors created by demanding situations by means of a more positive analysis of more extant risks and available coping resources, which results in the tendency to see demanding situations as challenges rather than as threats. According to Chemers et al. (2001), the situation is perceived as challenging or threatening depending upon how the individual experiences the relationship between the situational demands and the coping resources. If the coping resources are seen as insufficient to meet the demands, then threat occurs. If the coping resources are seen as adequate to meet the demands, however, challenges occur. This leads to the assumption that people high in self-efficacy have the confidence of possessing adequate resources to meet situational demands. Increasing students' self-efficacy therefore should be a concern for those involved in improving students' academic outcomes.

Tsang, Hui & Law (2012) argue that research evidence supports timely and strategic cultivation of positive self-efficacy in early adolescence. They also mentioned the themes included in promoting self-efficacy such as enhancement of skills, responsibility training, supportive relationships, and belonging.

Aligned with the works of Bandura (1997), Schunk (1995) stated that self-efficacy affects choice of activities, effort, persistence and achievement. He further showed that interventions had been designed to affect self-efficacy. The three types of interventions he

mentioned used models, goal setting, and feedback to influence self-efficacy. More specifically, an individual who observes a competent and successful model getting the information about the sequence of actions leading to success and his/her belief in knowing what it takes to succeed, raises one's self-efficacy. Goal-setting affects self-efficacy in several ways: by fostering commitment, by directing attention, through the properties of proximity, specificity and difficulty, by linking success with effort, and by sustaining motivation. As for the feedback, be it attributional, ability, and/or effort, it influences self-efficacy in the form of a persuasive force. From all the three types of interventions Schunk (1995) found the implementation of these processes, and the results thereof, showed changes in self-efficacy.

On the bases of Schunk's (1995) theory, as also supported by other researchers, self-efficacy has been found to be related to academic outcomes and that self-efficacy can be improved, this research conceptualized a program intended to enhance self-efficacy of college students. Unlike the interventions mentioned by Schunk (1995), however, this program, presented here, was based on choice theory.

Choice theory is one of the counseling theories that can help an individual increase the chance of his/her endeavors' success by focusing on his/her potentials instead of depending upon external manipulations (Glasser, 1998). Choice theory coaches the individual to become aware of his/her abilities and to tap into them in order to reach his/her objectives. Adopting choice theory as a way of living means to distance one's self from an external psychology and to embrace an internal psychology (Glasser, 1998) instead. With internal psychology the individual gets clarity about the needs that contribute to the formation of his/her "quality world" and positions himself/herself within it. This "quality world," according to Wubbolding (2000), is a file of wants in each person's mind made up of specific images of people, activities, treasured possessions, events, beliefs, and/or situations that are need-fulfilling. These wants are unique, dynamic, conflictual, and removable (Wubbolding, 2000). In their momentum to live according to their "quality world," individuals use what Choice theory calls "total behavior," which includes actions, thinking, feeling, and physiology. Though all four components of the" total behavior" are important, Glasser (1998) argued that we have more direct control over our actions and thoughts. The motive behind every behavior is to have the most effective control over our lives. An appropriate handling of our actions and thoughts is thought to lead to an effective control that, in choice theory terms, is tantamount to being able to behave in a way that reasonably satisfies the pictures in our "quality worlds" (Glasser, 1998).

Choice theory encourages the all people to take charge of their respective lives. In the school setting, choice theory can be helpful in getting students to embrace better academic performance in their quality worlds and, in turn, cultivate an appropriate handling of their actions and thoughts in a way that facilitates the satisfaction of the pictures in their "quality worlds." This approach also focuses on thoughts and actions, consistent with literature on self-efficacy which proposes that cognitive appraisal is an important component of self-regulated learning.

This psycho-educational program sought to increase the level of self-efficacy among students by familiarizing them with choice theory. This program is composed of three one-hour sessions spread out over two weeks. The first session focused on establishing rapport

and the introduction of the basic tenets of choice theory. The students were given the explanation of terms such us "choice theory," "differences between external control and internal control, needs," "total behaviors," etc. The second session emphasized total behavior, needs and wants, and the importance of our quality worlds. The objectives were to help students become aware of their total behavior, explore their basic needs and wants, and develop an understanding of their quality world. The third session concentrated on the WDEP system as a questioning framework that guides our attempts to make the actual world correspond to our quality world. The WDEP system (as described by Wubbolding, 2000), which stands for Wants, Doing, Evaluation and Planning, represents ideas that constitute a step-by-step path toward getting more efficient control of our lives. This session sought to help students clarify and articulate their wants, look at the attainability of their wants, and the actions that need to be taken in relation to those wants, as well as examining whether or not their actions were taking them closer to their wants, and to plan eventual needed changes in view of setting one's self on the right path toward the realization of one's wants.

We assumed that the use of choice theory would facilitate the increase in the level of self-efficacy by focusing on the students' quality worlds and the application of the WDEP system. In turn, it is hoped that this would result to several positive benefits; chief among them would be improved academic accomplishments.

Method

Research design

A pretest-posttest experimental design was used for this research study. Data collections for both the pre-test and post-test were each done in a single point in time, during the third trimester of the academic year 2011-2012. The present study differs from previous studies in that it focused on the use of choice theory in attempting the enhancement of self-efficacy.

Participants

Twenty five freshmen students in a private university in Manila participated in this study. The students were identified from the pool of students identified by the guidance office of the school as high risk for low performance. Of the original twenty five students, only twelve completed the three sessions of the program. They were nine female and three male students. The age of the participants ranged from 15 to 18 years of age, with a mean age of 16.75 years, SD = 0.866.

Instrumentation

After the informed consent was obtained, a pre-test of the General Self-Efficacy Scale (GSES) were administered to the students. A post-test of the same measure was administered after the last session of the program. Students were asked to keep the same pseudonyms on both the pre-test and the post-test forms.

The General Self-Efficacy Scale (GSES; Schwarzer & Jerusalem, 1995) consists of a 10-item self-report questionnaire that assesses a general perceived self-efficacy. Examples of items

are: "I can always manage to solve problems if I try hard enough", "I can solve most problems if I invest the necessary effort", and "If I am in trouble, I can usually think of a solution". Item responses were obtained using a 4-point Likert-type scale, ranging from 1 (Not at all true) to 4 (Exactly true). For the present study, Cronbach's alpha coefficients were 0.744 at pre-test and 0.634 for post-test scores.

Besides the General Self-Efficacy Scale, the students were given a short demographic profile assessment to determine their age and gender.

Results

Data from the twelve participants who completed the three sessions were analyzed using the Statistical Package for the Social Sciences (SPSS) version 20. The t-Test for dependent samples was applied to evaluate the effects of the Choice Theory psycho-educational intervention on the participants' level of perceived self-efficacy before and after the intervention. The results of this analysis are presented in Table 1.

Table 1.

Comparison of Perceived Self-Efficacy pre and post sessions

Variable	Pre-test mean	Post-test mean	t-value	Df	Significance
Self-efficacy	3.1000	3.6250	6.733	11	.000*

*t-test is significant at the .05 level, 2-tailed.

As mentioned in the beginning, initially twenty five participants were selected and participated during the first session. However, only 12 were able to attend the succeeding sessions and to complete both the pre and post-testing for the General Perceived Self-Efficacy scale. Results indicated that there was a significant increase in the self-efficacy mean scores after completing the three sessions ($t(12) = 6.733$, $p = .000$). It clearly denotes that there was a statistically significant improvement in the participants' perceived self-efficacy as a result of the choice theory psycho-educational intervention from a mean of 3.100 before implementing the program to 3.6250 after completing the three sessions. Among the ten items of the General Perceived Self-Efficacy, it was noted that item # 3 "I am certain that I can accomplish my goals", yielded the highest pre-test mean score ($\mu = 3.50$) compared to the overall pre-test mean score of $\mu = 3.1000$. The post-test mean score of the same item was $\mu = 3.67$, which is also consistent with the overall post-test mean score of $\mu = 3.6250$ for the perceived self-efficacy. This indicates that most of the participants believed that they were capable of setting realistic and attainable goals. Furthermore, these participants demonstrated a certain degree of confidence that there will be a high success rate in implementing their objectives or goals in life. On the other hand, the item #7 "I can remain calm when facing difficulties because I can rely on my coping abilities", registered the lowest mean score during the pre-test phase ($\mu = 2.75$) as compared to the overall pre-test mean score of $\mu = 3.1000$. The post-test mean score of this item was significantly increased to $\mu = 3.58$. This signifies that participants initially perceived themselves as very anxious when facing a challenging task or being stuck in a

difficult situation because of doubt in their coping abilities. However, the results from their post-test scores on the General Self-Efficacy Scale indicate that the choice theory psycho-educational intervention did improve the participants' confidence in their coping abilities.

Discussion

Based on the common observation that college students' academic performance in general and particularly in the Philippines is in decline, and on research findings that self-efficacy is related to positive academic outcomes, the present study sought to implement a program using choice theory to enhance college students' self-efficacy to stimulate better academic

performance. The results of the present study agree with Schunk (1995) that self-efficacy can be enhanced. Our finding with a sample of twelve freshmen college students suggests that a psycho-educational intervention using choice theory can effectively enhance students' self-efficacy which, in turn, improves their academic performance. The comparison between participants' mean scores of the General Perceived Self-Efficacy before and after the intervention indicated a statistically significant improvement in students' self-efficacy scores. This implies that the intervention succeeded in introducing academic performance in the quality worlds of the students who, helped by choice theory intervention, gained confidence in their abilities to take more effective control over their lives. The results of the study are in line with the work of Wubbolding (2000), which asserts that the wants in the quality world are, among other things, dynamic. Wants or needs in the quality world are not static, they can evolve even to the extent that new ones can be introduced and some old ones can be removed. This dynamism explained the effectiveness of choice theory in assisting students improve their academic performance. With better academic performance in their quality worlds, students deal with academic requirements not as threats but as challenges and the practice of the WDEP gives them the confidence of having adequate coping resources to face the challenges.

Another advantage of helping students introduce studies or academic performance in their quality worlds is that they become internally motivated to master their subjects. The wants or needs in the quality world are considered as personal values and their pursuit becomes a personal commitment. According to Story et al. (2008), intrinsic motivation is positively associated with a belief in one's ability to succeed. By assisting students to integrate studies or academic performance into their quality worlds, choice theory encourages them to become intrinsically motivated and that increases their confidence in their abilities to succeed.

The present study supports not only that self-efficacy can be enhanced for better academic outcomes, but also shows that choice theory is an effective approach in dealing with the academic decline of college students. Future studies with larger samples and longer interventions are encouraged to further corroborate the results of this study.

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Brief Bios

Niño Jose Mateo, PhD is an associate professor at the Counseling and Educational Psychology Department, De La Salle University, Manila Philippines. He is a licensed Guidance Counselor and Psychologist. He is currently undergoing Basic Instructor Training and is the current president of the William Glasser Institute Philippines.

Fr. Gabriel Ngombedua Makundu is a member of the Congregation of the Immaculate Heart of Mary (CICM) and hails from the Democratic Republic of Congo. He served as a missionary in Taiwan for 10 years and is currently completing his PhD in Counseling Psychology from De La Salle University, Manila, Philippines

El Anelio R. Barnachea is a licensed guidance counselor and currently working as a university counselor at the De La Salle – College of St. Benilde, Manila, Philippines. His is currently completing his PhD in Counseling Psychology from De La Salle University, Manila, Philippines

JN Junille S. Paat is a psychology clinical instructor from the National Institute of Mental Health. He has a Master of Arts degree in Health Social Sciences. He is currently completing his PhD in Counseling Psychology from De La Salle University, Manila, Philippines

All communication may be directed through the first author's email at *nino.mateo@dlsu.edu.ph*

LIVING AND LOVING EVERYTHING CHOICE THEORY:

An Interview with Kim Olver
Patricia A. Robey Ed.D., LPC, CTRTC

Abstract

This article presents an interview with Kim Olver, Executive Director of William Glasser International, Executive Director of William Glasser Institute – US and senior faculty member of the WGI. In this interview Olver shares a history of how she became interested in Glasser's ideas and how the integration of these ideas helped to transform her both personally and professionally.

Biography: Kim Olver, M.S., licensed counselor and board certified coach, is the part-time Executive Director of William Glasser International and WGI – US. She is also a Senior Faculty member and as such Kim teaches all phases of Institute training. Kim is the owner of two businesses, Coaching for Excellence, and her publishing company, InsideOut Press. Kim is the author of the award winning, bestselling *Secrets of Happy Couples* (2010) and the co-author of *Leveraging Diversity at Work* (2006). Kim speaks on various topics throughout the world, including workshops for the US military's Yellow Ribbon program, Cook County Probation, a Drug & Alcohol program in Pennsylvania and several children's foster care and residential programs. Formerly, Kim worked with mental health clients in a residential program and with children and families in foster care.

Interview

Robey: I appreciate that you're taking some time to chat with me today, Kim. I am looking forward to learning some things about you that maybe I don't know, or maybe that some other people do not know about you! So I would like to start by asking you to tell me a little bit about your professional and personal background; whatever you would like to share.

Olver: My background is in Psychology. I earned a bachelor's degree in Psychology and then I worked in the field for a while. I was a program counselor with mental health clients for about five years. I knew that wasn't the right fit for me so I looked for a new job and there were three possibilities. One of them was with a foster care agency that taught us choice theory/reality therapy. At the interview they asked me if I knew anything about reality therapy. I had a background in Psychology, but I had never heard of reality therapy. This was in 1987. I was very interested in learning more because I couldn't go to graduate school at that time. I had little kids. I didn't want to devote my time to graduate school, but I wanted to learn more about Psychology. So I took that job at the foster care agency and in the first month I had my basic intensive training with Nancy Buck. I was impressed by her. I couldn't tell you much of what I'd learned that week; I just recall that at the end of the week I said to myself, "When I grow up I wanted to be just like her" (laughing). I loved what she did, it was just so cool. And now I do what she does. It was just a journey, you know, and I loved reality therapy. Reality therapy for me was something that helped me make sense of everything I had learned in school, because you learn a little bit about a lot of things. They say be eclectic, which is another name, in my opinion, for "flying by the seat

of your pants." I can do that, but I liked having the structure of choice theory and reality therapy. It just made so much sense and it kind of gave me a map of how to work with people. If what I was doing wasn't working, I now had a map to say, okay, now try this. It was never try this, oh it doesn't work, I don't know what to do next. There's always another thing you can do if you understand Choice Theory psychology. So that is how I got involved.

Robey: Prior to that, what kind of training did you have with different counseling methods? What had you been taught to use when you were in your undergraduate training?

Olver: I would say what was most emphasized was Rogerian therapy. I learned psychoanalytic theory, but that was not for me. I learned some CBT [cognitive behavioral therapy]. It was pretty new at that time. It made sense to me, but reality therapy is a thing that really helped me. Both CBT and Rogerian therapy work with highly intelligent clients and people who are motivated to change, however, most of the clients that I had been working with were what might be called non-voluntary clients. They were clients that other people sent to counseling. They would much rather have you out of their life than be talking to you and trying to fix something they didn't think was broken. Reality therapy really helps, better than anything else I ever learned, to work effectively with people who are non-voluntary clients.

Robey: Would you share a particular success story, a time when you used these ideas and it really made a difference?

Olver: I could share many. I mean, I worked with foster kids. Reality therapy gave me permission, not only permission, but actually prescribed that I needed to be involved with them. Whereas many other counseling techniques tell you to be aloof and you have to be apart from your clients and there are boundaries you don't cross. Of course reality therapy doesn't say throw out all the boundaries. Certainly you still have to have boundaries, but if you don't really care about your clients I don't know how effective you could be. Reality therapy taught me that, so when I was working with those kids if they really needed some time, I would put them in my car and take them out to get something to eat or we would go shopping if they were teenage girls and they liked to shop. I would go play basketball. Whatever it was that they were into, I would do with them. It was more of an active kind of counseling, than just sit down and talk to me, because teenagers are not really into sitting down and talking to grown-ups. I think that was the main thing that I got from reality therapy.

As I am sitting here, I am thinking fondly of many of the kids. There was a boy named Tim and a girl named Amy, and some of them have even been in touch with me as adults. Many had to go through a stage of feeling some consequences of their choices. Some of the boys did some time in jail and they would call me afterwards and say they have learned their lesson and aren't going back there, and they haven't. Some of the girls were in bad relationships, single moms, raising kids by themselves, but the thing that I was most impressed about was that even though they made bad relationship choices they were good moms. Their kids weren't in foster care, and they had that desire to do it differently than their parents did. I loved working with foster kids; I can't pick one out and say this was it. I just felt like I had an overall better connection with my clients because of the relationship.

Robey: In my own life experience these ideas changed the way I worked with people outside of my family, but it also really significantly changed the way that I was as a mother, as a wife, and even the way I felt and thought about myself. I am wondering if these ideas changed your personal life at all.

Olver: Definitely, but I have to say that didn't come till later. When I first learned reality therapy, I thought of it as a tool for my toolbox. That was how I looked at it, it was something I did at work with the foster parents and foster kids, and sometimes the biological parents and I used lead management when I was managing my staff. But, later my husband got sick. My husband and I had what I would say is a fairly stereotypical relationship. He was the strict dad and I was the push-over mom. When he got sick, he had to bow out of a lot of parenting responsibilities and then later on he passed away. I had two teenage boys, a 13 and 15 year old. I couldn't be the push-over mom and raise responsible boys. I had to do something different.

So, when my husband died, I had to change how I parented. I had no power over him getting sick. I had no control over that. I knew that I could get lost in the anger and frustration and the unfairness of it and really lose myself in that and I didn't want to do that. Choice theory gave me a model for how to do it differently. So, I focused on the things I did have control over. I focused on work, I focused on taking care of him the best way I could – I focused on my family. I actually lost weight during that time and it wasn't because I was under so much stress I couldn't eat – it was a way of getting my power needs met at that time. It balanced out the lack of power I had from him being sick. And then after he died, I had to shift my parenting style and I went to choice theory parenting, or as Nancy Buck calls it*, Peaceful Parenting* (2002). She was my personal advisor during that time, because no one else I knew thought I was parenting the boys properly. Everybody thought those boys need a good swift kick in the butt. I was thinking "Hasn't life kicked them in the butt enough? Their dad is dead! I mean really what more has to happen?" My kids needed someone to be there and understand, yet hold them accountable for the choices they made. That is what I learned how to do. I didn't really know how to do that before because I was too busy trying to balance out my husband's overly strict nature and, if he were here today, he would say he was only overly strict to balance out my permissive nature. So I don't know who started it, him or me, but we ended up at opposite ends.

So that [learning peaceful parenting] really helped me. Recently my oldest son (my kids are now 30 and 29) said to me, "Mom, I was talking to Stacey'' (that is his wife), and he said "you know the difference, Stacey, between your mom and my mom?" and Stacey said "What?" and he said "Your mom tells us what to do and my mom makes suggestions." (Laughing) I really thought that was a testimony to my use of choice theory because I really do believe it is their decisions as to how they raise their children and if I see something that I think could be different, I may say something or I may not, but if I do say something it is always in the form of "What do you think about this?" Basically, I would never say what *you have to* do, or what *you should,* or what *you must do*. I've tried to eliminate those words from my vocabulary.

The other time when it was really helpful for me was when my youngest son went to Iraq . . . twice. This was another time of having no control. When I teach caring habits I talk about support and how easy it is to support people when they are doing what you want. It

is not so easy to support people when they are doing something that somehow frustrates your needs. Kyle going to Iraq definitely frustrated my ability to meet my needs the way I used to meet them, but I had to support his right to do it his way. That was a challenge, a huge challenge in my life. But I knew what I needed to do was take control over what I could control and create an environment here that I could live through while he was serving our country in Iraq, and I think I did it pretty well.

Robey: You make it sound so easy! (Laughter)

Olver: People accuse me of that in training and I say this is not easy, but it's certainly worth it. It is like anything else you have to practice. I have been practicing for twenty-five years! I ought to be a little better at it now than I was when I started. I think it's like anything else. Dr. Glasser talks about organized and reorganizing behavior and I had organized behavior. I had a lot of external control behavior and I have been practicing and working on reorganizing it. Sometimes it is easy now. It is much easier than it used to be because those behaviors have become more organized. It is like anything else; if you want it to get easier you need to keep practicing and working at it.

Robey: I hear how learning these ideas changed the way you worked and your personal life, but it seems like it also shifted your life focus in other ways. How did your professional life develop to where it is now?

Olver: Sometimes I think there is a path for us that kind of unfolds as we take steps. That job at the foster agency changed my life because it taught me choice theory. I worked there for seventeen years. When my husband died, I told my boss that I would be leaving in five years and she laughed at me. But five years was going to be when my children were going to be out of high school and I wasn't going to uproot them during high school. My older son then was in college and he wasn't coming back to the town we lived in and my younger son was in Iraq and he was engaged to be married so when he came back he was going to go to school and get married. So I said, "I could do anything I want now and I knew I wanted to be my own boss." Truly, I wanted to have my own business – that was really important to me. I didn't want to do it in the house I lived in on a dirt road where I couldn't get cable TV or pizza delivered. I wanted to be in a more metropolitan area. So I moved to Chicago and I started a coaching business. I didn't know anything about coaching when I started, but everything I learned helped me to understand that really I had been doing coaching my whole life. Reality therapy is so in line with the ideas of coaching. Coaching doesn't deal with the past, coaching talks about the present; coaching doesn't deal with pathology, it deals with wellness. It's just so in-tune with the tenets of choice theory. We also know the client has the answers so we are not trying to give them answers, we are asking questions, which is what we do in reality therapy. So I started my own business.

I learned that my love was in teaching when I got certified in reality therapy and continued on to become an instructor so I that I could train our staff at the foster agency. As I took those steps my job created the title of "Director of Training and Development," specifically for me. We never had that before, but that was my job. Then I trained everybody. I just loved it so much; I knew that's just what I wanted to do.

Now, in my business the main activity I do is public speaking. Some of that is in workshops, some of that is training through The Institute. I honestly can't tell you how I became the executive director (of WGI). I didn't ask for it, I wasn't looking for it. Linda called me and asked me if I would do it and the only thing I never thought to say was "No." It was just such an honor first of all and also an opportunity to give back to the ideas and to the man who created them. I felt very indebted to Dr. Glasser and The Institute for all of the ways his ideas had enriched my life. So, that is how it happened and I don't regret it. I have actually gotten better at what I do because I am the executive director. The challenges are bigger so I have to get bigger to manage those challenges, and it really has been an amazing journey.

Robey: As another example of how life unfolds and presents opportunities and amazing journeys, I know that you have been using choice theory and reality therapy to help vets and their families. Tell us a bit about your work with them.

Olver: I became involved, of course, because my son was a vet. He was a vet that wanted to protect his mom. He did not share his experience a lot and I didn't want to probe or pry. I did have a need as a mom and as a counselor to understand better what he was going through so I became what's called an MFLC. That stands for military family life consultant. In order to be an MFLC, you have to be a licensed mental health professional. I went through the training process and they hire you to go to Yellow Ribbon events. The general public doesn't know a lot about Yellow Ribbon. It's a congressional mandated program for all veterans who have served in combat zones. When they come back home (and even before they leave), there are programs for the vets and their families. There are programs during their deployment for the families. There are three programs after they return for reintegration. We focus on disseminating information, things that people really need to know; things about what to expect, the emotional cycle of deployment, suicide prevention information, anger management, family reintegration, trying to help the service members in the families understand what it was like for the families while they were gone, and trying to help the families understand what the service members will need when they get home. It's new, we just celebrated the 5 year anniversary of Yellow Ribbon. It's been gradually gaining momentum. I think it is a great program. I have had some people in the audience who are parents that served in Vietnam. They will come to me after I speak and say, "This is such a great program, I wish they had something like this when I came back." Sometimes, the service members don't always appreciate it because they are ordered to go to Yellow Ribbon programs. Again it's like those non-voluntary clients. They are given their orders, told they have to go, it's going to be good for them and they better like it. So they start with a little resistance. I noticed over the five years, though, the resistance is diminishing and people are recognizing that it can be very helpful. I'm not an MFLC anymore, but I am one of the speakers. There are fifty professional speakers around the country who speak at these events and that's one of the things I do. I do about one of those a month on a weekend. It just feels so good to give back to the people who have given up so much for our country – families and vets.

Robey: Sounds like you have integrated your entire life's career into one package. You still have a foot in the counseling world, in the coaching world, and in professional speaking. It also sounds like you are enjoying your work and your life at this moment.

Olver: I do, I love my life.

Robey: That's awesome. We talked about a lot of things right now and I want to be respectful of your time. So I am wondering if there is anything you would like to add that I have not asked you about already.

Olver: I'd really like to thank all the members of WGI-US and abroad who have been supportive of me over the years, especially since I became the executive director. Without the help of others, I wouldn't be able to do what I do, so thank you. I hesitate to mention people specifically because if I do, I'm sure I'll leave someone out. But there have been people around the world who have provided support and encouragement for which I will always be grateful.

Robey: A few months after we completed this interview, Dr. Glasser passed away. Would you like to add something related to this?

Olver: What can I say about a man whose ideas had such a profound impact on my life? The world lost a great leader and our Institute lost its mentor and friend. I believe the best way we can honor him is through our work. There is much to do if we are going to realize Dr. Glasser's dream of teaching the world Choice Theory.

References

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