Misconceptions About Reality Therapy
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ABSTRACT

Experience has revealed that reality therapy is often misunderstood as a counseling and educational tool. This article describes several myths about the system and explains why they are erroneous. Readers’ comments to the authors are invited.

Reality therapy is one of the more misunderstood counseling theories. One author of a text states, “From a reality therapy standpoint, counseling is simply a special kind of teaching or training that attempts to teach an individual what he should have learned during normal growth in a rather short amount of time.” The problem with such a statement is that there is a slight element of truth. Reality therapy does include teaching clients choice theory (Glasser, 1998a). But there is much more to the system. It involves listening, reflecting, and knowing when and how to intervene. The purpose of this article is to briefly list several misconceptions which have emerged in the training sessions and discussions which I have conducted in the past few years. Included is a brief comment on the rationale for describing these as misconceptions.

REALITY THERAPY IS A SIMPLIFIED VERSION OF OPERANT CONDITIONING

In the 1970’s and early 1980’s, this misconception was widespread due to its presentation in several widely used texts on counseling principles. While behaviorism or operant conditioning is not an entirely external control system, it does emphasize external rewards more than choice theory. On the other hand, choice theory is a system of motivation based on the internal origin of human behavior and the principle that need satisfaction, more specifically human wants, is the reason people choose their behavior.

REALITY THERAPY IS AN EURO-AMERICAN SYSTEM WHICH ENCOURAGES CONFORMITY TO THE SOCIAL STATUS QUO

This is an objection which is directed toward many counseling theories. But reality therapy can be used to help clients formulate plans to eliminate social injustice. Also reality therapy provides a clear delivery system for working for systemic change (Glasser, 1990, 1993, 1994, Wubbolding, 1997).

Often the label “Euro-American” is used in a derogatory way. It is true that reality therapy began in North America, but it is now taught in Asia, the Middle East, South America, as well as in the Euro-American cultures.

REALITY THERAPY IS SIMPLISTIC IN ITS IMPLEMENTATION

In developing the ideas underlying reality therapy, i.e., choice theory, Glasser has attempted to use language which is easily understood. There is very little technical language other than such phrases as “quality world,” “genetic instructions,” and a few others.

Also, because of the emphasis on relationship building as the core of reality therapy, it is possible to erroneously conclude that the delivery system is simplistic. Yet the contrary is true. There is an 18-month training program designed to help interested people become proficient in the theory and practice. Wubbolding (2000) has spelled out in detail the procedures described by Glasser (1998b), identifying 22 types of self-evaluation from which a teacher or therapist could choose in working with students or clients. The use of down-to-earth language does not imply that skillful practice of reality therapy should be seen as flimsy, put downs, simplistic or easy.

REALITY THERAPY HAS NO RESEARCH BASE

This misconception has been promoted because we, as an institute, have not emphasized the importance of validating our work. But in the 21st century, we will be held accountable to the public as never before.

The fact is that there is research which provides credibility for the practice of reality therapy. Wubbolding (2000) has summarized research in reality therapy applied to education, mental health, substance abuse, and corrections. Still, he states that more tightly controlled research studies are needed and greater visibility in the professional world of the effects of reality therapy would dispel this myth.

REALITY THERAPY IS THE SAME AS BRIEF THERAPY

One of the past criticisms of reality therapy was that it was a short term problem-solving therapy. A more current mistake is to think that it is identical with brief-solution-focused therapy. There are many therapies that have been adapted to the current demands of managed care, emphasizing a problem-solving approach. The uniqueness of reality therapy is that it is based on solid theory and is not merely a problem-solving model which has been formulated to meet the external demands of managed care. Furthermore, though some brief therapists stress “do more of what works and less of what does not work” the explicit use of self-evaluation as a prerequisite for change is not stressed. These are but several differences between these systems.

REALITY THERAPY DOES NOT DEAL WITH EMOTIONS

Some reality therapists refuse to discuss feelings and immediately steer the conversation toward actions or cognition. However, it is quite justifiable to discuss each aspect of total behavior, not merely actions or thinking. Feelings are seen as important, but they are analogous to the lights on the dashboard of the car. When they ignite, the driver is alerted to something more fundamental about the car’s direction, operation, efficiency and possible problems. Besides, if feelings are the most prominent presenting issue, it hardly makes sense to disrespect clients’ perceptions of what troubles them.
Still the artful use of reality therapy allows for helping clients gradually move from the perception of themselves as enslaved by feelings to the hopeful position of choosing more effective actions.

Additionally, the mere discussion of feelings does not automatically change them. Discussion of hunger, thirst, or fatigue does not alleviate them. Similarly, discussion of depression, guilt, anger and other emotions is changed only when it is linked to the action component of total behavior (Glasser, 1998a).

REALITY THERAPY IS HARSH

In a training workshop for probation officers one told me he "did reality therapy." He said, "When the probationer comes into my office for the first time I sit opposite him, confront him eye to eye, slam down the handcuffs on the table and ask in a loud voice, "OK, (pletive deleted), is there any doubt about who is in charge here?" While this is an extreme example, even the rapid fire questioning or the refusal to answer a direct question on the part of the helper can be off-putting to the client. Accurate and effective reality therapy is compassionate, empathetic as well as straightforward.

REALITY THERAPY IS SYNONYMOUS WITH THE USE OF CONSEQUENCES

While reality therapy incorporates common sense notions of consequences ("If you bring a gun to school you leave school") there is a theory which underlies the detailed system of interventions known as environment and procedures. When these are used, the need for consequences, though not eliminated, is diminished. This misconception, the opposite of the one below, is the result of exaggerating one principle concerning the legitimate use of the fact that human beings make choices and decisions which impact themselves and the world around them.

REALITY THERAPY HAS ABANDONED THE USE OF CONSEQUENCES

If reality therapy is used properly and if an institution such as a school adopts choice theory as a philosophy, staff members need not concern themselves with the imposition or use of consequences. But, the contrary is true. When students of the Schwab school were unable to succeed in the mainstream classroom they were taught in separate classrooms. (Glasser, 1998a). In The Language of Choice Theory, 52 vignettes of which 8 or 15% utilize consequences are described. For example, when the child refuses to clean his/her room, the parent, using choice theory, says, "If you want some help form me, ask and I’ll be glad to pitch in. But I’m not going to clean it for you any more" (P.7). Clearly reality therapy has not abandoned the common sense real world principle that behavior has consequences.

REALITY THERAPY IS SYNONYMOUS AND COEXTENSIVE WITH THE NAME WILLIAM GLASSER

There is no doubt that to teach reality therapy is to teach the ideas of the founder. Still reality therapy and The William Glasser Institute are not cults. Others have contributed to the expansion and application of reality therapy (e.g. Greene, 1996; Sullo, 1997; Wubbolding, 1997). The system is wider than even the charismatic personality of one man.

CONCLUSION

Persons come to training in choice theory, reality therapy or lead management with many pre-formed ideas. They have often studied counseling methods and have a comprehensive and accurate picture of the system. However, many often have incomplete and inaccurate information about choice theory as well as the delivery system, reality therapy. I have attempted to list several misunderstandings I have encountered and to describe why they are inaccurate. I believe these might be controversial as some readers might disagree that one or the other is, in fact, a misconception. Your comments are invited.

References