GLASSER'S REALITY THERAPY

A Critical Evaluation

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A CRITICAL ANALYSIS OF THE PSYCHOTHERAPEUTIC METHOD OF WILLIAM GLASSER

by

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This thesis is a critical analysis of the psychotherapeutic method of William Glasser as presented in his book Reality Therapy (1965). Basically the thesis includes a review of Glasser's general theory of abnormal behaviour, a review of his psychotherapeutic method, and an analysis of reality therapy in terms of experimentally established behavioural principles. In the process of analyzing Glasser's method in terms of these behavioural principles three methods of treating erratic human behaviour, which are closely related to Glasser's reality therapy methods, were examined. The first two were the sociobehavioural techniques of operant conditioning therapy and behaviour therapy; the third was the non-directive therapy of Truax with his three therapist behaviours.

It was concluded, after a careful review of relevant literature, that basically reality therapy uses the same principles as operant and behaviour therapy. The merit of reality therapy is that there is far less difficulty generalizing behaviour change to the outside environment than would be involved in operant therapy methods, as they are now practised. It would appear that the combination of the experimentally established principles of behaviour therapy, with some variation, combined with Glasser's more "socially normal" application of these principles accounts, in great measure, for the very high rate of success he has reported.

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CHAPTER I

INTRODUCTION

In his book Reality Therapy (1965), Glasser purports to present a new and more effective kind of therapy for emotionally and mentally disturbed people. He rejects most of the tenets of the psychodynamic approach, and offers a simplified view of abnormal behaviour and its treatment. In a day when there is considerable questioning of the effectiveness of traditional forms of therapy Glasser reports impressive results with his method. Referring to his Ventura School for Delinquent Girls in California Glasser (1965) stated: "Naturally we do not succeed with everyone, but we do with about eighty per cent of the girls." With psychotic patients Glasser reports that well over ninety per cent succeed in leaving chronic wards and are discharged from hospital within one year of involvement with the methods of reality therapy. Such results with chronically disturbed people are impressive. Another notable feature of Glasser's approach is his claim that it may be used by the social worker, the teacher and others involved in the field of human relations.

That Glasser's theory and therapy merit serious consideration is attested by the following words of O. H. Mowrer, an eminent psychologist: "This is an extraordinarily significant book. Readers themselves will discover that it is courageous, unconventional, and challenging. Future developments will, I predict, show that it is also

scientifically and humanly sound."

This thesis will present a critical analysis of Glasser's view of abnormal behaviour and therapy, relating it where appropriate to behavioural principles and procedures established in experimental investigations.

CHAPTER II

GLASSER'S THEORY OF ABNORMAL BEHAVIOUR

Glasser's theory is not presented in a systematic and clear manner. Basic concepts and principles are presented in an interlocking fashion, often defined in terms of one another. Consequently the following attempt to make a systematic presentation may involve some loss or change in meaning and implication.

Reality Theory

Glasser's "reality theory" of abnormal behaviour reduces to three main propositions. First, man has two basic needs, relatedness and self-worth. In Glasser's own words (1965): "Psychiatry must be concerned with two basic needs, the need to love and be loved and the need to feel that we are worthwhile to ourselves and to others." Relatedness, then, involves the need to love and be loved by one or more people. Self-worth involves the need to feel worthwhile to oneself and to others, which is based on the maintaining of a satisfactory standard of behaviour.

The second proposition is that, when a person behaves in accord with the three principles of responsibility, realism, and right, the two basic needs will be fulfilled. When he does not, he suffers disturbed feelings and behaviour and may be labelled neurotic, psychotic, or delinquent. Responsibility is defined as the ability to fulfill one's

needs in a way that does not deprive others of the ability to fulfill theirs. It also means that the individual is indeed responsible for his own behaviour and its consequences. This is clearly stated by Glasser (1965): ". . . the relationship deepens because now someone who cares enough about the patient to make him face a truth that he has spent his life trying to avoid, he is responsible for his behaviour." The principle of realism apparently means that the individual perceives the world around him without distortion, and accepts its validity, and that he fulfills his needs as this real world dictates. The principle of right is a frankly moral concept according to which behaviour is right and adequate, or wrong and inadequate, as apparently judged by society. With this principle, Glasser faces up to the fact that a person has to deal with society's judgements of right and wrong. He says: "If we do not evaluate our own behaviour or, having evaluated it, if we do not act to improve our conduct where it is below our standards, we will not fulfill our need to be worthwhile and will suffer as acutely as when we fail to love or be loved. Morals, standards, values or right and wrong behaviour are all intimately related to the fulfilment of our needs for self worth . . .."

Glasser's third proposition is that the primary means for acquiring responsible, realistic, and right behaviour, and so satisfying one's needs, is by involvement with others who care and who will insist on responsible, realistic and right behaviour. He says: "Therefore, essential to fulfilment of our needs is a person, preferably a group of people, with whom we are emotionally involved from the time we are born

to the time we die." Glasser recognizes involvement as essentially an educational and training process, which ordinarily occurs as the child is involved with his parents. When this has not occurred and the adult's behaviour is disturbed, he must become involved with someone who will help him to learn responsible, realistic, and right behaviour.

Apparently Glasser settled on the term "reality" therapy, because the word reality seems to imply the other principles. Thus, he would say that it is realistic to act in a responsible, realistic, and right manner and so fulfill one's needs.

Evaluation of Reality Theory

The logical and scientific status of Glasser's three propositions is not elucidated. He offers no evidence or argument that they are empirical generalizations or principles, but argues that they are largely self-evident truths. This would give them the status of assumptions, and as such they bear examination.

Glasser's assertion that man's basic needs are for relatedness and a sense of self-worth, is a rather arbitrary and narrow view of "needs". What of the needs for sexual expression, for aggression, for independendence, and indeed for a whole list of other "needs" that have been proposed by other authors and even identified by factor analysis. For example, Maslow (1954) developed a hierarchy of eight human needs, and argued that all human needs, whether physical or psychological, should be considered to be crucial only within the context of the cultural and environmental framework in which they are encountered.

Glasser seems to have adopted the same strategy as did Freud: Freud assumed all other needs under the two of sex and aggression, while Glasser selects relatedness and self-worth as his superordinate need concepts. Furthermore, he seems to think that his two needs have a self-evident and common meaning. However, presumably we could have a "need" for relatedness of different kinds, or a need to feel worthwhile in different ways! These differences will be as many as there are groups, social systems, or cultures.

Glasser's second assumption is an assertion of the relationship between behaviour and need fulfilment: when a person's behaviour is responsible, realistic, and right, his basic needs will be fulfilled. While this has some face validity, it is not based on logic or evidence. For one thing, the behaviour that satisfies a person's needs presumably depends on the nature of those needs, which may be many, and which may be short-term or long-term.

The three principles of responsibility, realism, and right, are not really principles or laws of behaviour at all. Rather, they are criteria for judging the adequacy of behaviour. In this sense they are value criteria or judgements. Who is to make the value judgement as to what is responsible, realistic, and right? This is not entirely clear, although it is implied that psychiatry, the law, and in some sense, society, have the gift and power to do this--he says: "usually the law is psychiatrically right . . . because human beings with human needs have made the law according to their needs." There is an undercurrent of authoritarianism here, which accepts the status quo. But the status

quo in what society or culture?

Glasser's third proposition was that the means of acquiring responsible, realistic, and right behaviour is by involvement with others. There are two assumptions here: first, that responsible, realistic, and right behaviour is learned, and second, that simple involvement with others who care and who will insist on responsible, realistic and right behaviour will ensure that the appropriate behaviours are learned. Again, there is some face validity and perhaps folklore to support this assertion, but surely the learning of given behaviours is not all that simple. Indeed, as a theoretical system, there is no presentation of empirically established principles or laws of learning.

CHAPTER III

GLASSER'S PSYCHOTHERAPEUTIC METHOD

Glasser's therapeutic method apparently involves five main features: involvement, a focus on current behaviour, rewards and restrictions, gradualism and practise. For Glasser involvement is clearly related to the fulfilment of our basic needs for it is only through emotional involvement with other people that we are able to fulfill our basic needs. Failure to gain emotional involvement results in the use of erratic or irresponsible ways of meeting these basic needs. Glasser formally defines involvement only in terms of the qualities a therapist must have if he is to be successful in developing an emotional relationship with his patient. But involvement apparently means to express attention and interest in, caring for, and valuing the individual as a person, and expecting better performance from him. In relation to this concept Glasser (1965) stated: "The patient is looking for a person with whom he can become emotionally involved, someone he can care about and who he can be convinced cares about him, someone who can convince the patient that he will stay with him until he can better fulfill his needs." Not only is involvement the most difficult phase, but it is also the most crucial part of Reality Therapy. Glasser says: "Usually the most difficult phase of therapy is the first, the gaining of the emotional involvement that the patient so desperately needs but which he has been unsuccessful in attaining or maintaining up to the time

he comes for treatment. Unless the requisite involvement exists between the necessarily responsible therapist and the irresponsible patient, there can be no therapy."

For Glasser, current behaviour must always be the emphasis of reality therapy. Contrary to the psychodynamic approach to the treatment of erratic human behaviour, he argues that knowledge of the patient's past can never be a crucial determinant in starting a successful treatment plan. In fact, he argues that delving into the patient's past often causes irreparable harm to his personality, for, relating to past failures will simply reinforce the patient's present unacceptable behaviour. This happens because the patient is permitted to convince himself that he is incapable of changing his irresponsible behaviour. Glasser states: "Working in the present and toward the future, we do not get involved with the patient's history because we can neither change what happened to him nor accept the fact that he is limited by his past." Clearly Glasser rejects the value of illusive concepts imbedded in so-called mental illness and in the individual's unconscious motives and complexes. He also rejects the value of transference, insight and attitudes; he focuses entirely upon current behaviour.

Glasser clearly advocates that responsible patient behaviour be rewarded and that irresponsible behaviour leads to restrictions. Irresponsible behaviour is simply not tolerated; an irresponsible person must obey the rules of the institution or he is denied the rewards which are an inherent part of the treatment structure. The following quotation from Glasser's Reality Therapy (1965) shows this clearly: "We reward

them (delinquent girls) when they accept responsibility and explain that they are not yet ready to go further in the program when they do not accept responsibility." Thus, by using a built-in system of rewards and restrictions Glasser directs patient behaviour in a way that is defined as acceptable by his staff.

The fourth feature of Glasser's psychotherapeutic method is a form of gradualism. Glasser's patient is placed in a controlled environment which makes specific demands upon his behaviour. As a result he gradually ceases to behave in a manner which is defined as unacceptable by those in control of his environment and adopts those behaviours which are defined as being acceptable with increasing frequency. In office practice, Glasser starts with involvement. Then the relationship he has established permits the use of "gradualism" in teaching the patient to behave in a more socially acceptable manner. This is possible because, after involvement has been achieved, the therapist becomes a respected, important person whose expectations will carry considerable weight for the patient. In Glasser's own words: "Along with the emphasis upon behaviour and as a continuing part of the involvement, the therapist freely gives praise when the patient acts responsibly and shows disapproval when he does not. The patient demands this judgement, which is a natural expression of faith between two people, as a test of sincerity of the relationship."

Glasser rejects the traditional concept of mental illness as an explanation for erratic human behaviour. He objects to the use of the medical model in psychiatry and interprets behaviour only on the basis of whether it is responsible or irresponsible. Responsibility is equated

with mental health and irresponsibility with mental illness. Glasser argues that calling a person mentally ill and treating him as though he is incapable of rational behaviour simply reinforces his tendency to behave in an erratic fashion, because he then attempts to conform to some nebulous concept which supposedly distinguishes him from all rational men.

With Reality Therapy there is an unqualified denial of the importance of unconscious mental processes of the personality in treating erratic human behaviour. Glasser does not deny the existence of such motivations, which may manifest themselves in our dreams. However, his patients are never given the opportunity to excuse their present behaviour on the basis of unconscious conflicts. Glasser (1965) stated: "We do not look for unconscious conflicts or the reasons for them. A patient cannot become involved with us by excusing his behaviour on the basis of unconscious motivations."

Glasser emphasizes that the therapist should relate to a patient as himself, rather than as a transference figure. His rejection of the psychodynamic concept of transference is attested by his own words (1965): "We relate to patients as ourselves, not as transference figures." He argues that psychiatric patients are not seeking to repeat unsuccessful involvements past or present; they are looking for satisfying human involvement through which they can fulfill their needs now.

That current behaviour is more important in therapy than attitudes or insight is one of Glasser's basic tenets: "In Reality Therapy we emphasize behaviour; we do not depend upon insight to change

attitudes because in many cases it never will. Once we become involved with a patient and teach him new ways of behaviour his attitude will change regardless of whether or not he understands his old ways, and then his new attitude will help promote further behavioural change. What starts the process, however, is an initial change in behaviour."

The fifth main feature of Glasser's psychotherapeutic method is practice. He does insist that patients make a try with new behaviour, and try it repeatedly, and he uses differential reinforcement in the sense that he rewards successful behaviour or improved behaviour on the one hand, and either does not reward or imposes sanctions when the individual does not improve or gets worse on the other.

Evaluation of Reality Therapy Methods

Glasser's psychotherapeutic methods are not always spelled out in detail. This is especially true of his concept of involvement which is defined primarily in terms of the qualities a therapist must have if he is to be successful in therapy. Consequently, if one asks what the actual definition of involvement is, the answer must be: that concept which is related to, and dependent upon, the positive qualities a therapist must have if he is to be successful in therapy. But in the final analysis involvement is not defined in clear operational terms. However, what he apparently means by involvement is expressing attention, interest in, caring for, and valuing the individual as a person. Presumably such an attitude and behaviour on the part of the therapist serves three functions: (1) it gives the patient an immediate sense of some self-worth. By taking a genuine interest in the patient and by

expressing a caring attitude, the therapist conveys the message that he sees the patient as a person of real worth. Being valued by another person, then the patient feels the beginnings of self-worth. This is rewarding in itself, and provides the beginnings of confidence and hope; (2) it enables the therapist to impose strong expectations on the patient in terms of responsible, realistic, and right behaviour. When a person is involved with and valued by a second person, the former is subject to the expectations of the latter--as a child is responsive to the expectations of a loving parent. According to Glasser, the patient actually looks for and welcomes the imposition of strong expectations as a means of strengthening his newly found relationship and involvement. Glasser argues that most patients realize that their behaviour is deviant, that they are different. In a sense they are looking for ways out of their dilemma and despair, and the positive expectations of a therapist give them support toward that end; (3) the third function of involvement is that it enables the therapist to become a model of a man who is responsible, realistic and right, from whom the patient can learn. As the therapist is open and honest in confronting problems and doing something about them, so can the patient. When genuine involvement is attained, Glasser maintains, it is inevitable that the irresponsible patient will look to the responsible therapist for guidance in finding acceptable ways of behaving; (4) the fourth value of involvement is that it enables the therapist to tell or instruct the patient what he must do, offering him incentives of feeling better, getting more privileges, gaining greater freedom, etc. Such advice and instruction has

more meaning when it comes from a person with whom one is deeply involved. Then this is to challenge and motivate the individual to make an effort to try.

It was stated previously that Glasser rejects the value of knowing the patient's past, that he focuses on current behaviour. Those of psychodynamic orientation would probably argue that the more knowledge the therapist has about his patient's history, the more effective he will be in treating the patient. However, the contribution of such knowledge to successful treatment is little more than a supposition, without supporting evidence. And on the other side, behavioural psychologists such as Eysenck (1960) and Ullmann and Krasner (1965) have clearly demonstrated the scientific validity of treating the disturbing current behaviours, or symptoms, of neurosis rather than attempting to get at the psychodynamic causes which may well be incapable of specific isolation. Glasser's approach with regard to current behaviour is not amoral and non-judgemental but is frankly evaluative.

Glasser's use of rewards and restrictions has been demonstrated to be highly effective in the treatment of neurosis, psychosis, and delinquency. Presumably dynamic therapies involve rewards and restrictions, in subtle ways, in therapy, and outside of therapy, when the patient makes a successful "try". The merit of Glasser's method is that he spells out the rewards and restrictions that will follow different behaviours, hence enabling the patient to use such information. Thus he rejects the psychodynamic approach of learning with minimal and vague cues, and instead gives the patient explicit and realistic information so that he can anticipate consequences, set goals, and look forward to better things.

Glasser's program has the additional merit that it uses concepts, methods and social reinforcers that are familiar to the patient, and that exist in society at large, hence facilitating generalization to other real life situations. And it is a fact of life that a good part of social structures is built around the function of administering rewards or providing restrictions or negative sanctions.

Glasser's use of gradualism is certainly a valuable part of his psychotherapeutic method. Requiring the patient to behave in a realistic way in graduated steps and rewarding each successful step with new freedoms and privileges facilitates the learning of socially desirable-behaviour. This is essentially the method that is used in a wide variety of teaching and learning situations in our society. It is especially important in formal education practices, in schools and apprenticeship programmes. In rejecting the medical model for behaviour disturbances, Glasser rejects the idea of a quick "cure" and selects the method of graduated steps as a means of correcting erratic behaviour and developing more responsible behaviour.

CHAPTER IV

ANALYSIS OF REALITY THERAPY IN TERMS OF BEHAVIOURAL PRINCIPLES

Experimental psychologists have established the main principles which account for behaviour and in the last ten years or so have translated a number of these into practical procedures which can be used for the modification, elimination and acquisition of behaviours in human beings. (Bandura, 1965; Eysenck, 1960; Krasner, 1962; Ullmann and Krasner, 1965; and Wolpe, 1958). In another area of research, Truax and his associates (Truax and Carkhuff, 1967) have experimentally isolated some of the elements in therapist-patient interaction which produce measurable behaviour changes. In this section, Glasser's therapeutic methods will be examined in relation to these experimentally established behavioural principles.

For the purpose of clarification it may be of value at this point to establish a working distinction between three methods of treating erratic human behaviour which are closely related to Glasser's reality therapy methods. The first two, operant conditioning therapy and behaviour therapy are sociobehavioural techniques and the third is the non-directive therapy of Truax with his three therapist behaviours: accurate empathy, nonpossessive warmth and genuineness. Operant conditioning therapy and behaviour therapy techniques are closely related to Glasser's psychotherapeutic method due to their emphasis on current behaviour. Truax's non-directive therapy is related to Glasser's

methods by virtue of his demonstration of the crucial nature of relationship in therapy.

Operant conditioning therapy is a form of learning wherein the organism becomes progressively more likely to respond to a given situation with that response which, in previous similar situations, has brought about a rewarding or satisfying state of affairs, or wherein a stimulus, having evoked a response that brings into view a rewarding stimulus or prevents or removes an obnoxious stimulus, thereafter is more likely to evoke that response. Six operant techniques will be described here: positive reinforcement, extinction, differential reinforcement, shaping, punishment and negative reinforcement.

(1) Positive reinforcement may be defined as the use of stimuli following a response in such a way that the future rate of responding is increased. Any stimulus that is used following a response and serves to increase the rate of responding may therefore be called a positive reinforcer. Some reinforcers--called primary--function innately to increase the rate of responding. Food, sex, and water are examples. Other reinforcers, commonly called secondary (or learned) reinforcers, have acquired their capacity to increase the rate of responding because of a learning history in which they have beeen paired in time with a primary reinforcer. Money, approval, attention and affection are generally examples of such secondary reinforcers.

(2) Extinction has two features. Its operation consists of withholding the reinforcer when a response, previously reinforced by that reinforcer, is emitted. The consequent of this operation, if completely

and steadfastly maintained, is to reduce the rate of responding to the original level. It is important not to confuse extinction with punishment. The extinction process simply involves the withholding of the reinforcing stimuli that previously sustained the rate of responding. No aversive stimuli are presented.

(3) Differential reinforcement consists of a particular combination of positive reinforcement and extinction. Positive reinforcement is used to strengthen a particular desirable behaviour, while the extinction technique is used to reduce or eliminate a problem behaviour. An example of differential reinforcement is the positive reinforcement of rational speech with the concurrent use of extinction procedures for a patient's psychotic talk.

(4) Shaping involves the differential reinforcement of successive approximations of a desired behaviour. It is based on the behavioural phenomenon of induction. When a response is reinforced, it is strengthened in the sense that it is more likely to occur. At the same time, responses which are very like it become more probable, while those less like it suffer a decrease in strength or probability. Thus if one is attempting to reinforce audible speech for a person who speaks too softly, the reinforcement of higher levels of volume will tend to increase the probability of speech responses having higher volume more than of responses having lower volume. By means of shaping, the differential reinforcement of only closer and closer approximations of desired terminal behaviour progressively strengthens these approximations while it simultaneously weakens more remote responses. In this

way new responses can be developed in graduated steps.

(5) Punishment is a consequence of responding that reduces the future rate of that response. There are two operations following an operant response that may have this effect. One is the presentation of a stimulus that is usually "aversive", and the other is the removal of a positive reinforcing condition, such as is illustrated in time out from reinforcement. The reduction of the rate of responding may be temporary, or it may be a continuing partial reduction or even complete suppression. Thomas (1968) points out that there are many misconceptions about punishment in our society. He argues that real life is rarely devoid of naturally or socially induced adversity and that on this basis it is not unethical to use various forms of aversive stimuli. He also contends that perhaps the crucial question regarding the use of punishment should be the effects of aversiveness. In this respect he argues: "The research literature indicates that only under highly restricted conditions are there likely to be any of the dire effects sometimes alleged to accompany punishment."

(6) Negative reinforcement involves the imposition of an aversive situation and then its removal contingent upon a particular response. It is really a form of escape learning.

Operant conditioning principles have been applied therapeutically primarily in institutional settings, and have been used mainly for the acquisition of new and more disirable behaviours.

The second sociobehavioural technique is that of behaviour therapy which is based largely on the frame of reference of Joseph

Wolfe (1958). Here the focus is primarily on the treatment of individuals, and the different methods are mainly designed to extinguish or eliminate various undesirable reaction tendencies or habits like anxiety, transvestism, temper tantrums, inadequate sexual performance, excessively submissive behaviour. Principles are systematic desensitization, counter-conditioning with gradualism or successive approximations, practice (with reference to sexual and assertive behaviour, and exposure to phobic stimuli), gradualism, negative reinforcement, and punishment.

The third treatment technique, the non-directive therapy of Truax, is primarily based upon the three "central therapeutic ingredients of relationship": accurate empathy, nonpossessive warmth, and genuineness. In effect, Truax, on the basis of scientific investigation, considers these three ingredients to be the most crucial aspects of any therapeutic relationship.

(1) Accurate empathy involves both the therapist's sensitivity to the client's current feelings, and his verbal facility to communicate this understanding in a language that is "received" by the client. It is not necessary for the therapist to share the client's feelings in the sense that would require him to feel the same emotions. Instead, accurate empathy involves an appreciation and a sensitive awareness of those feelings. When a high level of accurate empathy is operative the message "I am with you" is very clear. Basically accurate empathy means being "with" the client, step by step.

(2) Nonpossessive warmth or unconditional positive regard, ranges from

a high level where the therapist warmly accepts the patient's experience as part of that person, without imposing conditions; to a low level where the therapist evaluates a patient or his feelings, expresses dislike or disapproval, or expresses warmth in a selective and evaluative way. Nonpossessive warmth for the client means accepting him as a person with human potentialities. It also involves a nonpossessive caring for him as a separate person and, thus, a willingness to share equally his joys and aspirations or his depressions and failures. Further it involves valuing the patient as a person, separate from any evaluation of his behaviour or thoughts.

(3) Genuineness is the quality a therapist has when he is freely and deeply himself. This does not mean that the therapist must overtly express his feelings but only that he does not deny them. "Being himself" simply means that at the moment the therapist is really whatever his response denotes. It does not mean that the therapist must disclose his entire personality, but only that whatever he does show is a real aspect of himself, not a response growing out of defensiveness or a merely "professional" response that has been learned and repeated.

These three therapist behaviours tend to be used selectively as differential "humanistic" reinforcers which gradually change the patient's thinking, feelings, and attitudes in a constructive direction. The focus is primarily on attitude change, defined as a change in verbal habits, self awareness, and an awareness of relations with others. Nondirective therapy is practised primarily with individuals, and is not applied on an institutional basis.

Glasser's therapeutic methods are not couched in the terms or principles of operant, behaviour or non-directive therapy. However, an analysis of those methods reveals that he is in fact using procedures which are similar in basic ways.

For Glasser "involvement" is a necessary method in reality therapy. Basically involvement means to express interest and attention, caring for and valuing the individual as a person, and expecting improved behaviour from him. In contrast, the general concept of emotional involvement with the patient is not emphasized as a primary means of changing behaviour in reports of operant and behaviour therapies. Indeed, in some reports of operant therapy, e.g., Ayllon and Azrin (1965) emotional involvement and even social interaction is minimized and held constant, albeit with the intention of controlling out this variable as a means of demonstrating the efficacy of explicit reinforcement techniques. On the other hand, behaviour therapists who follow Wolpe's (1958) methods, now use emotional involvement as a means of getting the full cooperation of the patient. However, involvement is not stressed as a particular method or means which, as such, is useful for changing behaviour. Truax, on the other hand, emphasizes what might be generally called emotional involvement as a basic condition which produces behaviour change. However, he does not use it as a general concept and method, but has experimentally analyzed the concept into the specific therapist behaviours which contribute to demonstrable changes in behaviour.

Glasser's concept of emotional involvement is too broad and

vague to be very helpful as such. It will therefore be analyzed--beyond Glasser's presentation--into the different ways by which it may contribute to behaviour change, and these different implications will be related to behavioural procedures. First, emotional involvement presumably gives the patient an immediate sense of some self-worth, hope, and at least a glimmer of confidence. The function of this may well be to encourage or motivate the patient to make a try with new behaviour. Wolpe's form of behaviour therapy holds out hope in the sense that his methods are explained as new, based on experimental findings, and tested in practical experience. However, enhancing the patient's sense of self-worth is not an explicit goal of involvement and it is confidence in the therapist rather than self confidence which seems to be encouraged. Thus, behaviour therapy does not emphasize the individual's freedom and responsibility to change himself, as does Glasser's approach, but conveys the view that behaviour change is a result of explicit procedures which the therapist will implement. Operant conditioning methods are sometimes used, notably in an institutional setting, without reference to the patient's wishes and indeed without his knowledge. In such cases, there is no consideration of the patient's self-worth, hope, and confidence, at least in so far as these depend on any emotional involvement and interaction in which the patient actively participates. Truax's methods, on the other hand, do have the purpose and function of developing a sense of self-worth in the patient, together with hope and self-confidence. All three of his therapist behaviours, accurate empathy, nonpossessive warmth, and

genuineness, probably contribute to the patient's sense of self-worth. Accurate empathy conveys the message that the patient is expressing something meaningful which the therapist can understand; nonpossessive warmth and unconditional caring probably convey the message that the patient is valued as a real person who is not judged, and who had the right and freedom to work out his own destiny; and therapist genuineness may convey the impression that the patient has self-worth and is not an object of manipulation by a professional and detached authority figure.

A second function of emotional involvement with the patient is that it enables the therapist to impose expectations which will have some force, to set goals, and to point out incentives, all of which will tend to motivate the patient to make an effort, with particular goals and standards in mind. Goal setting and attention to incentives are widely used methods of motivating effort and learning in educational practices and in the world of work. The power of expectations in altering behaviour, and even in altering the intelligence quotient has been experimentally demonstrated by Rosenthal (1966). Operant conditioning therapy depends on the use of incentives, with their provision as reinforcers, for modifying undesirable behaviour. However, as noted before, the incentive-reinforcement system has been used to date largely without the patient's knowledge and with the specific goal of modifying a given behaviour rather than developing a general attitude and orientation toward improvement in the patient. Thus, the imposition of expectations, together with goal setting, have

been little used in this kind of treatment procedure. In behaviour therapy, although the emphasis is on the use of learning procedures to modify behaviour, there probably is a good deal of implicit imposition of expectations, as well as explicit goal setting in terms of behaviour change, with knowledge of the more satisfactory outcomes as incentives. However, the behavioural goals are relatively circumscribed habit tendencies rather than larger social adjustment habit patterns with which Glasser deals. As for Truax, he does not make explicit use of expectations, goal setting, and incentives. The patient probably has a general expectation of solving his problems, but these are little used by the therapist in any specific manner. Glasser's use of imposed expectations, goal setting and incentives, when it is based on genuine emotional involvement, is probably a powerful motivating force for behaviour change.

A third function of emotional involvement is that the therapist puts himself in a position where he can in fact offer advice and instruct the patient, pointing to the behaviours that he should try, specifying the situations where this may be done, and cushioning the effects of failure by making the patient aware of the process of change with its ups and downs. Without emotional involvement, advice and instruction typically have little real impact on another person. Operant conditioning therapy has made little or no use of instruction and advice giving thus far, primarily because of the research emphasis which would control out such interaction variables until other factors have been identified. Behaviour therapy makes explicit use of advice and

instructions in the above manner. Truax's method is largely non-directive and hence avoids open advice and instructions. On the other hand, the patient's thoughts and emotional responses may be shaped up in particular directions without the patient's knowledge that he is being thus manipulated. Some people have argued that the non-directive method is most ethical in the sense that the individual is absolutely free to choose his own ways and means. However, this view may be questioned in the light of such an analysis: when open instructions and advice are used, the patient is free to accept and try them, or not, whereas with the shaping procedures of Truax he does not have this opportunity and freedom.

The fourth function of emotional involvement is that it enables the therapist to use aversive stimuli like restrictions, disapproval, and even punishment, without alienating the patient. This is very important when patients are receiving individual treatment and are free to come or not come, as in office practice. Aversive stimuli are sometimes used in operant conditioning treatment. But in so far as the patients have been institutionalized in most instances, the problem of holding them and maintaining their cooperation has generally not arisen. However, when aversive stimuli are used in an operant or behaviour therapy manner on private patients, the patient is usually strongly motivated by other considerations and the therapist usually does seek to develop a good relationship. The Truax method develops emotional involvement but makes little or no use of aversive responses and controls.

The fifth function of emotional involvement is that the therapist puts himself in a position to become a model for the patient. Human beings have a strong tendency to model a well liked, admired, and respected other person and this can be a powerful instrument for change in a patient. Most operant conditioning studies make little or no use of modelling, at least with adult patients. However, Bandura (1965) has used this method with children. Some modelling may be involved in behaviour therapy, although the interaction between patient and therapist is more formal and focused on specific situations and procedures, rather than on more general feelings, attitudes, and values. In so far as the Truax method involves a good deal of emotional involvement, it provides a basis for modelling. However the patient can hardly adopt the non-directive, reflecting role of the therapist, although he may seek to emulate the general attitudes of the therapist such as open genuineness and positive valuing of others.

Glasser's focus on current behaviour as the basis for helping and changing people is consistent with any rational view of causation: it is impossible to change history. However, present behaviour can be changed and thus it is possible to create a different future. This is also the view of therapists who use operant conditioning or behaviour therapy. Advocates of the traditional dynamic therapies have warned that changing or eliminating the "sympton", that is, the undesirable behaviour, will lead to "symptom substitution". Behaviour therapists have taken this warning seriously, and have effectively countered it on the basis of theory and empirical demonstration. Glasser largely

ignores the symptom substitutuion hypothesis, and simply gets on with the job of trying to modify the patient's undesirable behaviour. The non-directive method of Truax, in contrast, does involve considerable self-exploration on the part of the patient, and often gets into his history. Apparently this is not designed to produce insight as such, and consequent behaviour change, but to promote self-awareness and awareness of one's relationships with other people and of new ways of perceiving these relationships, which may lead to modification of attitudes and hence of behaviour. In this sense the Truax method is focused primarily on attitude change. The fact that Truax reports significant behaviour change in a wide variety of patients is rather surprising in the light of the many experimental studies on attitude change which generally report no correlated behaviour change. However, Truax's form of therapy is much more long-term than most attitude studies. Moreover, it may mediate behaviour change by producing changes in the way the individual perceives his world. Finally the cognitive element in Truax's method may be much more important than we now realize--there is little good research on the manner in which cognitive variables control behaviour.

Glasser's third main therapeutic method is the use of rewards and restrictions. Glasser clearly advocates that responsible behaviour on the part of the patient must be rewarded in order that the treatment process can be effective. He states: "Our interest must emphasize the positive, never reinforce the negative"; and "We reward them (delinquent girls) when they accept responsibility and explain

that they are not ready to go further in the program when they do not accept responsibility"; and finally "When they (delinquent girls) tell us how unfortunate they have been, we accept this uncritically; but from the beginning, in a warm, firm manner, we tell them that while they are here they are responsible for what they do, regardless of how miserable, inconsistent, or unloving the past may have been." When Glasser's patient acts in a manner which he considers appropriate, that desirable behaviour is encouraged by rewarding the patient so that there is a probability that he will continue to exhibit that desired behaviour. Clearly there is little distinction between Glasser's use of the reward system and the operationally defined behavioural principle of positive reinforcement.

Glasser's use of restrictions within the institutional setting closely parallels the behavioural principle of negative reinforcement. Negative reinforcement involves the imposition of an aversive situation and then its removal contingent upon a particular response. Glasser is in a position to use negative reinforcement, within the institutional setting, and he uses it extensively. The following quotation from Glasser illustrates this point: "The girls are locked in a special cottage with an in-cottage program which excludes them from the regular school and their cottage. When they show enough responsibility, they are allowed to leave this cottage and return to the school program."

Operant conditioning methods for treating people make extensive use of rewards. Indeed reinforcers, as they are called, are the primary means for producing behaviour change. However, they are used

in a more technical and precise manner than Glasser advocates. For instance, the principle of immediacy of reinforcement is taken seriously by operant conditioning therapists. Because many of the reinforcers which patients desire, such as having a nice bed, being in the front of the meal line, having a walking pass, etc., cannot be delivered immediately after some of the behaviours which are being learned (for example, self-grooming, doing dishes, or clerical work), tokens are established as conditioned reinforcers and provided closely contingent on the desired behaviour. Then the patient may exchange these tokens for a good bed, for an interview with the Chaplain, etc. Conditioned reinforcers like tokens are probably necessary for shaping up some kinds of behaviour, especially those which are almost extinct in a long term patient. Moreover, they provide a currency for behaviour that is rather like our economic reinforcement system in society at large. The primary reinforcers which the tokens will purchase are the common things and activities which people desire in society at large, and hence the treatment programme is in close touch with social reality in this regard. Glasser does not use mediating secondary reinforcers, but moves directly to the positive reinforcers of real-life social rewards, such as privileges, freedoms, and so on. Moreover, Glasser makes it clear to the patients that these are the natural consequences of responsible, realistic, and right behaviour. In this way he probably does something to re-establish a cognitive frame of reference that may facilitate generalization of adjustment to society at large.

With regard to restrictions, Glasser uses open and explicit loss of privileges when a patient behaves in an undesirable manner. Again this is communicated to the patient, and it is applied on a rather global level. In operant conditioning, loss of privileges is "naturally" contingent on inability to pay for them with the requisite number of tokens. Furthermore, "time out" from reinforcement, that is, being isolated in a small room for a few minutes, is used to discourage and suppress specific undesirable behaviours like temper tantrums, aggression, etc.

In so far as behaviour therapy tends to be concentrated on the elimination of reaction tendencies like anxiety, undesirable habits, and inappropriate habits, there is less room for the use of rewards or reinforcers--the latter are primarily useful for the learning or acquisition of new behaviours. This emphasis on eliminating particular reaction tendencies may in fact limit the effectiveness of such a treatment programme. The reason for this is that a habit may be dealt with more effectively by training in a substitute habit. On the other hand, behaviour therapy is used to develop some forms of desirable behaviour, such as assertive responses and adequate sexual performance. In these instances no explicit effort is made to manipulate the rewards that will follow successful behaviour, but they do tend to follow as a natural consequence of the behaviour--providing something like intrinsic reinforcement. Aversive stimuli are used in behaviour therapy, either as punishment or negative reinforcement. Again, the objective is to eliminate a particular response tendency.

A major difficulty with the use of punishment and negative reinforcement is the problem of generalizing the response changes to the patient's "natural" environment--a problem that Glasser does not face to the same extent because he in effect utilizes the social environment to impose sanctions.

The non-directive therapy of Truax does not use sanctions either, in the form of punishment or negative reinforcement. Rather, the treatment hinges on the therapist providing "humanistic" reinforcers to shape up more adequate behaviour. These reinforcers are applied selectively to provide differential reinforcement and shape awareness, desirable attitudes, and hopefully more desirable behaviour.

Glasser's use of gradualism for changing the behaviour of patients is explicitly planned and programmed with the appropriate rewards. As a procedure it is much like the method of "shaping" that has been experimentally established and is used extensively in operant conditioning treatments, behaviour therapy, and non-directive therapy. As a method, it contrasts with the use of drugs in the medical model, which are designed to "switch out" an undesirable behaviour and allow a desirable behaviour to emerge. Traditional dynamic therapists would probably accept the principle of gradualism, but they do not invoke the principle of differential reinforcement and explicitly provide for the conditions which will increase the strength and frequency of the desired behaviour. Again, Glasser moves his patients forward in steps of behaviour that are rather global, rather than focusing on particular habits as do the operant and behaviour therapies.

Glasser's fifth therapeutic method, namely, practice, is an old basic principle for changing behaviour. He uses it explicitly, pointing to the behaviours which the individual must try, and try again, and he takes the final step of providing differential reinforcement for successful steps of improvement. Operant therapy likewise utilizes practice extensively. However, the patient is usually not instructed in what he must try, but that behaviour is "brought out" by shaping procedures with differential reinforcement. Nevertheless, it is recognized that there will be no change in behaviour unless there is some behaviour in the form of a try. Behaviour therapy likewise uses practice explicitly and does not wait for the desirable behaviour to "emerge". Even when the problem is to eliminate some undesirable reaction tendency like anxiety, using systematic desensitization, the patient is encouraged to practise exposing himself to the situations which evoke anxiety. Truax's non-directive therapy is unique among the three therapies considered here in that practice of some desired behaviour is not explicitly encouraged. In this respect, non-directive therapy seems to be about half-way between traditional dynamic therapies on the one hand and operant and behaviour therapies on the other. It is assumed, and confirmed in controlled studies, that desirable behaviour will be practised when the individual has experienced a change in awareness and attitude. However, this neglect of the practice principle may be one reason why non-directive behaviour therapy often takes a long time.

It is clear that Glasser's reality therapy makes use of the most basic principles involved in operant, behaviour, and non-directive therapies. Each of the therapies' somewhat different emphasis on some

aspects of method, may well be a function of the different clients that they deal with. Reality therapy is admirably suited for dealing with socially deviant behaviour, when the patient is institutionalized. It may also work well in office practice with individuals, utilizing, as it does, strong emotional involvement to establish a binding relationship. Operant conditioning methods are admirably suited for ward management and the development of desirable behaviour of patients in institutions. Indeed, reality therapy as practised in an institution is rather like a "natural" operant therapy regime. It is likely that reality therapy would have less difficulty generalizing behaviour changes to the outside environment than would operant therapy methods, as they are currently practised. However, this may merely reflect a stage in the development of the more precise and measured programmes of operant therapy. In dealing with individuals, operant therapy may need to stress relationship and emotional involvement as a means of maintaining the patient in treatment. Moreover, operant therapy may well be handicapped by the difficulty of manipulating the reinforcement contingencies in the environment. Behaviour therapy is primarily an individual oriented treatment, seeking to alter the reaction tendencies of the individual, and thus enable him to cope in more functional ways with his environment. It has proven very effective with anxiety based habits, and looks promising in terms of certain specific habits like transvestism, gambling, and alcoholism. However, although it can often stop these behaviours, the problem of making the behaviour changes permanent still looms large. For instance

the other environmental factors and dysfunctional habits in the alcoholic may contribute to the re-emergence of the drinking behaviour. In so far as behaviour therapy focuses on specific dysfunctional behaviours, it is not too suitable for institutional practice. Group desensitization of phobias has been carried out successfully, but undesirable behaviours are usually idiosyncratic to the individual and hence behaviour therapy is not too suitable for group or institutional usage. Truax's non-directive therapy is essentially an individual kind of treatment and has been little used on a group or institutional basis--although sensitivity training in groups would seem to involve elements of the Truax approach. Moreover, non-directive therapy works best with patients who are reasonably intelligent and verbal, while reality, operant, and behaviour therapy are suitable for use with a wider range of patients. Operant and behaviour therapy, with their precision and focus on controls and measurement, and with their explicit use of well defined principles and procedures, may well be easier to teach to the variety of professional and non-professional people who are involved in the treatment of human behaviour. However, in so far as reality therapy uses basically the same principles, the more intuitive approach of reality therapy presumably could be made more explicit and teachable. Finally, operant and behaviour therapies emphasize the research nature of their programmes, and with their precision and technology will probably contribute more to reliable knowledge about human behaviour, its controls, and methods for changing it.

REFERENCES

Ayllon, T. and Azrin, N. The measurement and reinforcement of behaviour of psychotics. J. exp. anal. Behav., 1965, 8, 357-383.

Bandura, A. Psychotherapy conceptualized as a social learning process. Centennial Psychotherapy Symposium and Workshop, University of Kentucky, April, 1965.

Eysenck, H. J. (Ed.) Behaviour therapy and the neurosis. New York: Pergamon Press, 1960.

Glasser, W. Reality therapy. New York: Harper and Row, 1965.

Maslow, A. Motivation and personality. New York: Harper and Row, 1954.

Rosenthal, R. Experimenter effects in behavioural research. New York: Appleton Publishing House, 1966.

Thomas, E. J. Selected sociobehavioural techniques and principles: an approach to interpersonal helping. Journal of the National Association of Social Workers, 1968, 13, 12-25.

Truax, C. B. and Carkhuff, R. R. Toward effective counselling and psychotherapy. Chicago: Aldine Publishing Company, 1967.

Ullmann, L. P. and Krasner, L. J. Behaviour therapy: Its origins and achievements. Centennial Psychotherapy Symposium and Workshop, University of Kentucky, April, 1965.

Wolpe, J. Psychotherapy by reciprocal inhibition. Palo Alto, Calif.: Stanford University Press, 1958.