W. Glasser (2000). Reality Therapy in Action. Harper Collins Publishers.

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Reality Therapy in Action Is Supported by Choice Theory

As long as clients continue to use the choice theory they've learned in the counseling, the therapy never ends.

For you to understand better the reality therapy I use with every client in this book, I would like to pause here to explain a little more about choice theory. Reality therapy, based on choice theory, is a unique counseling method. For example:

1. I believe people choose the behavior that has led them into therapy because it is always their best effort to deal with a present, unsatisfying relationship—or, worse, no relationships at all.
2. The task of the counselor is to help clients choose new relationship-improving behaviors that are much closer to satisfying one or more of their five basic needs than the ones they are presently choosing. This means improving their ability to find more *love and belonging, power, freedom,* and *fun. Survival* is also a basic need, and some people come for counseling when their lives are in danger.
3. To satisfy every need, we must have good relationships with other people. This means that satisfying the need for

love and belonging is the key to satisfying the other four needs.

4. Because love and belonging, like all the needs, can be satisfied only in the present, reality therapy focuses almost exclusively on the here and now.
5. Although many of us have been traumatized in the past, we are not the victims of our past unless we presently choose to be. The solution to our problem is rarely found in explorations of the past unless the focus is on past successes.
6. The pain or the symptoms that clients choose is not important to the counseling process. We may never find out why one lonely person may choose to depress, another to obsess, a third to crazy, and a fourth to drink. In fact, if we focus on the symptom, we enable the client to avoid the real problem, which is improving present relationships.
7. The continuing goal of reality therapy is to create a choice-theory relationship between the client and the counselor. By experiencing this satisfying relationship, clients can learn a lot about how to improve the troubled relationship that brought them into counseling.
8. To understand why the seven points just mentioned are integral to practicing reality therapy, it is helpful if clients read the 1998 book, *Choice Theory: A New Psychology of Personal Freedom,* and the 1999 book, *The Language of Choice Theory.* If clients can't or won't read these books, the therapist can teach them the choice theory they need to know as the counseling proceeds.

Although there are many misconceptions about therapy in general, most people believe it is slow and costs a lot of money. This is not true of reality therapy. In many instances, much can be accomplished in one session, and ten to twelve

sessions are often sufficient. If the client is willing to read the two earlier books I listed, the time for therapy can be substantially shortened.

Besides the availability of the books, what makes reality therapy so efficient is that we do not spend much time in the past, except to look for past strengths; we listen to, but do not focus on, the pain or symptom; and reality therapy gets quickly to the actual problem—improving a present relationship or finding a new, more satisfying one.

The length of the therapy is related more to how quickly the therapist can create a good client-therapist relationship based on choice theory than to anything else. The sooner this relationship is created, the less time will be needed for therapy. If therapists cannot create such a relationship, therapy will almost always fail. When using reality therapy, we do not pursue the following traditional strategies:

1. Dreams need not be explored or even mentioned. Time spent on dreams is time wasted.
2. Clients should not be labeled with a diagnosis except when necessary for insurance purposes. From our standpoint, diagnoses are descriptions of the behaviors people choose to deal with the pain and frustration that is endemic to unsatisfying present relationships.
3. We believe that the current accepted concept that clients are the victims of mental illness caused by a neurochemical imbalance *over which they have no control* is wrong. If it was true, no psychotherapy could be effective. The so-called neurochemical imbalance that is cited as the major causes of mental illness is a myth. The brain is not defective. Its chemistry is normal for the behaviors clients choose (see Chapter Four of *Choice Theory*). Brain drugs, such as Prozac, may make clients feel better but cannot teach them how to connect or reconnect with people they need.

4. What I call mental illness are conditions, such as Alzheimer's disease, epilepsy, head trauma, and brain infections, as well as genetic defects, such as Down's syndrome, Huntington's chorea, and autism. People with these conditions are suffering from brain abnormalities and should be treated primarily by neurologists. Although they may be not candidates for reality therapy, most will benefit from a relationship with a warm, supportive person.

The whole purpose of this book is to take you into my office as I counsel so you can clearly see what I do. I also suggest that you read *Choice Theory* and compare the theory in that book with any other theory you may know. When you do so, you will easily be able to appreciate the theoretical and practical differences between what I and others do. These differences do not mean that reality therapy is better than other therapies; that is for both readers and clients to decide.

An important difference between reality therapy and other therapies is that we teach choice theory to clients as part of their therapy. In this book I make an effort to show how we do so. Feedback from many people who have read *Choice Theory* has led me to believe that many people who read this book have learned to live their lives in a way that maintains and improves relationships. In much of counseling, when the actual visits with the counselor are over, the therapy is over. As long as clients continue to use the choice theory they've learned in reality therapy, the therapy never ends.

Finally, on a semantic note, if our behaviors are chosen, it is inaccurate to describe them by using nouns and adjectives. To be accurate, verbs are the only part of speech that should be used to describe behavior. For example, the commonly used terms *depression* (a noun) or *depressed* (an adjective) are inaccurate. Following choice theory, we would use the verb forms *depressing* (a gerund) or *choosing to depress* (an infinitive).

But using verbs is much more important than just using

correct grammar. It follows logically that if we *choose to depress,* we can also *choose to stop depressing.* Using verbs points us in the direction of choosing more effective behaviors. When we use nouns and adjectives (for example, *depression* and *depressed*) to describe our choice to depress, as most people and almost all therapists do, we tend to avoid the real problem: that what we are complaining about is *a choice.*

It is obvious that Jerry, like Melvin Udall in *As Good As It Gets,* is choosing what he does, and in the therapy he will begin to make better choices. In the first paragraph of the first chapter, you may have noticed that I used verbs, such as *to obsess* and *compulse* to describe his behavior. As you read further, you will see many examples of this usage, and after a while, I believe it will make sense to you.

For example, the next time you are a little "depressed," don't say to yourself or to anyone else: "I'm depressed." Instead, say, "I'm choosing to depress because a relationship in my life is not working for me right now. I'm going to try to figure out a better choice." If you take this suggestion, you will immediately begin to see how correct grammar may lead you to conclude, *If I choose all I do, maybe I can choose to do something better.*