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REALITY THERAPY

A New Approach to Psychiatry

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by

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With a Foreword by O. H. MOWRER, Ph. D.

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To G. L. Harrington, M.D.

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REALITY THERAPY

By the Same Author

THE IDENTITY SOCIETY
MENTAL HEALTH OR MENTAL ILLNESS?
SCHOOLS WITHOUT FAILURE

Foreword

This is an extraordinarily significant book. Readers will themselves discover that it is courageous, unconventional, and challenging. And future developments will, I predict, show that it is also scientifically and humanly sound.

For more than a decade now, it has been evident that something is seriously amiss in contemporary psychiatry and clinical psychology. Under the sway of Freudian psychoanalysis, these disciplines have not validated themselves either diagnostically or therapeutically. Their practitioners, as persons, have not manifested any exceptional grasp on the virtues and strengths they purportedly help others to acquire. And the impact of their philosophy of life and conception of man in society as a whole has been subtly subversive.

Because they were the main "losers," laymen were the first to become vocal in their discontent, distrust, and cynicism. But today there is a "shaking of the foundations" in professional circles as well. For example, a state hospital superintendent recently said to me: "Yes, we too think we have a good hospital here. At least we aren't doing the patients any harm. And that's progress. In the past, we psychiatrists have often *spread* the disease we were supposedly treating."

Late in his training as a psychiatric resident, Dr. Glasser saw the futility of classical psychoanalytic procedures and began to experiment with a very different therapeutic approach, which he eventually named Reality Therapy. Rather than a mere modifica-

tion or variant of Freudian analysis, this system is in many ways absolutely antithetical. At the outset of Chapter 2, six postulates are listed as characterizing most forms of professional psychotherapy now practiced in the United States and Canada, ranging from "simple counseling through nondirective therapy to orthodox psychoanalysis." These six postulates or presuppositions are: the reality of mental illness, reconstructive exploration of the patient's past, transference, an "unconscious" which must be plumbed, interpretation rather than evaluation of behavior, and change through insight and permissiveness. The extent of Dr. Glasser's break with this total tradition is indicated by the following simple but bold statement: "Reality Therapy, in both theory and practice, challenges the validity of each of these basic beliefs." Moreover, Dr. Glasser states that the "conventional therapist is taught to remain as impersonal and objective as possible and not to become involved with the patient as a separate and important person" in a patient's life. In Reality Therapy, the helping person becomes both involved with and very real to the patient in a way which would be regarded as utterly destructive of the transference as conceived and cultivated in classical analysis.

More concretely and positively, what then *is* Reality Therapy? Chapter 1 answers this question, in concise and nontechnical language; and Chapters 3 to 6 exemplify the approach as it has been applied in various contexts. In essence, it depends upon what might be called a psychiatric version of the three R's, namely, *reality, responsibility, and right-and-wrong.*

Dr. Glasser begins at the end of this formula and asks, early in Chapter 1: "What is wrong with those who need psychiatric treatment?" The answer is that they have not been satisfying their *needs.* Here it might appear that Reality Therapy and psychoanalysis have something in common, but not so. For Freud, the needs which are presumably unfulfilled, in the so-called neurotic, are those of sex and aggression. For Glasser the basic human needs are for *relatedness* and *respect.* And how does one satisfy these needs? By doing what is realistic, responsible, right.

Granted that it is not always clear precisely *what* is right and what is wrong, Dr. Glasser nevertheless holds that the ethical issue cannot be ignored. He says:

> To be worthwhile we must maintain a satisfactory standard of behavior. To do so we must learn to correct ourselves when we do wrong and to credit ourselves when we do right. If we do not evaluate our own behavior or, having evaluated it, if we do not act to improve our conduct where it is below our standards, we will not fulfill our needs to be worthwhile and will suffer as acutely as when we fail to love or be loved. Morals, standards, values, or right and wrong behavior are all intimately related to the fulfillment of our needs for self-worth and [are] . . . a necessary part of Reality Therapy.

Conventional psychiatry and clinical psychology assume that neurosis arises because the afflicted individual's moral standards are unrealistically high, that he has not been "bad" but *too good,* and that the therapeutic task is, specifically, to counteract and neutralize conscience, "soften" the demands of a presumably too severe superego, and thus *free* the person from inhibitions and "blocks" which stand in the way of normal gratification of his "instincts." The purview of Reality Therapy is, again, very different, namely, that human beings get into emotional binds, not because their standards are too high, but because their performance has been, and is, too low. As Walter Huston Clark has neatly put it, the objective of this (radically non-Freudian) type of therapy is not to lower the aim, but to increase the accomplishment. Freud held that psychological disorders arise when there has been a "cultural" interference with the instinctual, *biological* needs of the individual, whereas Glasser and others are now holding that the problem is rather an incapacity or failure at the interpersonal, *social* level of human functioning.

This categorical reversal of both the theory of neurosis and the intent of psychotherapy has far-flung implications. Freudian therapists and theorists concede, of course, that not everyone suffers from over-development of the superego. At least certain kinds of delinquents and criminals, they admit, have too little rather than too much conscience; and in the case of the very young and inexperienced, their problem is similarly a deficit of character rather than a presumed excess. Thus, in the psychoanalytic frame of reference, two types of "therapy" are called for, the one essentially educative, the other re-educative or "corrective" in the sense of

undoing the effects of past efforts at socialization which have presumably been "too successful." Dr. Glasser's view of the matter is quite different. He assumes that so-called neurotic and psychotic persons also suffer (although not so severely as do delinquents and frank sociopaths) from character and conduct deficiencies; and if this be the case, then all therapy is in one direction, that is, toward greater maturity, conscientiousness, responsibility. Glasser says:

> Using Reality Therapy, there is no essential difference in the treatment of various psychiatric problems. As will be explained in later chapters, the treatment of psychotic veterans is almost exactly the same as the treatment of delinquent adolescent girls. The particular manifestation of irresponsibility (the diagnosis) has little relationship to the treatment. From our standpoint, all that needs to be diagnosed, no matter with what behavior he expresses it, is whether the patient is suffering from irresponsibility or from an organic illness.

Not only does this author assume that all "psychiatric problems" are alike; he also regards their treatment as of a piece with the educational enterprise in general. Thus in Chapter 6 it turns out that Reality Therapy is congenial to and readily applicable by classroom teachers in conjunction with their regular pedagogical activities (rather than contradictory to them); and it is also apparent that here is an approach to "child rearing" and "mental hygiene" which is *for* parents rather than against them. In a recent issue of *The Saturday Evening Post,* a housewife and mother complains bitterly (but justifiably) that psychiatrists have produced a "generation of parent-hating children." It could hardly have been otherwise, for the basic premise of psychoanalytic theory is that neurosis arises from too much training of children by their parents (and other teachers), so that this condition is patently the latter's "fault." Far from helping children to become more mature and accountable, this philosophy has steered young people toward ever deeper delinquency, defiance, and rejection of parents and authority.

Thus Reality Therapy is not something which should be the exclusive preoccupation or "property" of a few highly trained (and expensive) specialists. It is the appropriate, indeed the necessary,

concern of *everyone,* for its precepts and principles are the foundation of successful, satisfying social life everywhere. Although Freudian psychoanalysts have been arch-critics of our mores, morals, and values, it is doubtful that they could themselves design and direct a viable society, for the very conventions and moral standards which analysts so freely criticize are precisely what keep groups and persons from "falling apart." As Professor C. Wright Mills (the sociologist) and Dr. Richard R. Parlour (a forensic psychiatrist) have recently pointed out, ethical neutrality and anomia cannot provide the *structure* of organization and power and the context of personal identity and meaning which are as essential to individuals as they are to groups. The work of the psychologist, Dr. Perry London, and of anthropologist Jules Henry adds further weight to this opinion.

Now we come to the second of the three R's, *responsibility.* What is it? Glasser says:

> Responsibility, a concept basic to Reality Therapy, is defined as the ability to fulfill one's needs, and to do so in *a way that does not deprive others of the ability to fulfill their needs.* . . . A responsible person also does that which gives him a feeling of self-worth and a feeling that he is worthwhile to others. He is motivated to strive and perhaps endure privation to attain self-worth. When a responsible man says that he will perform a job for us, he will try to accomplish what was asked, both for us and so that he may gain a measure of self-worth for himself. An irresponsible person may or may not do what he says, depending upon how he feels, the effort he has to make, and what is in it for him. He gains neither our respect nor his own, and in time he will suffer or cause others to suffer.

In a recent article, Dr. Glasser has expressed the same general point of view by saying: "People do not act irresponsibly because they are 'ill'; they are 'ill' because they act irresponsibly." This is an emphasis which has been almost totally absent in classical psychoanalysis. For Freud and his many followers, the neurotic's problem is not irresponsibility but lack of "insight." However, many clinicians have discovered that years of analytic questing for this objective often results in less concrete change in a patient's life than a few weeks of work on the problem of personal responsibil-

ity, consistency, accountability. (This is confirmed in the writings of Dr. Steve Pratt on the concept of *social contract* and its relation to what Professor Leonard Cottrell has termed "interpersonal competence.") In other words, it's not "insight," "understanding," and "freedom" that the neurotic needs but *commitment.* In the words of an old hymn, our petition can appropriately be:

> Holy Spirit, Right Divine, Truth within my conscience reign,
> Be my King that I may be, firmly bound, forever free.

In keeping with this way of thinking about responsibility, what is to be said about honesty, truthfulness, and integrity? As long as one assumes that the neurotic is typically over-trained in moral matters and that his condition is not in any way dependent upon decisions he himself has made and actions he has taken but is rather an expression of things that have been *done to* him, then the very possibility that dishonesty enters into the picture in any very significant way is excluded, both logically and practically. But when the so-called "sick" person is himself seen as accountable for much of his malaise, dishonesty begins to figure much more prominently. In this book there is not a great deal of explicit emphasis on getting persons who are undergoing therapy to speak the truth; but the therapist himself sets an example of personal openness and integrity, and it is hard to imagine that anyone can learn to be either responsible or realistic without also being truthful. In fact, anyone who makes a practice of misinforming others (and thus being irresponsible), eventually begins to lie to himself, in the sense of rationalizing and excusing his own deviant behavior; and when this happens, he begins to be unrealistic, to "lose contact" with reality.

In light of the widespread and growing interest today in *group* therapy, it may appear to some readers of this book that Dr. Glasser is still too much wedded to individual treatment. Such an impression is misleading. Most of the work at the Ventura School for Girls which is here described involves group methods, as does the work of Dr. G. L. Harrington at the Los Angeles Veterans' Administration Hospital and that of Dr. Willard A. Mainord at the Western State Hospital, in Washington, which are also prominently featured in this book. One of the great advantages of the

group approach is that it encourages the development of rectitude, responsibility, and realism so much more rapidly than do the conventional forms of individual treatment.

Now what *is* realism, reality? Although this concept is crucial to Dr. Glasser's approach, in some ways it is the most difficult of all to pin down specifically. Two statements which bear directly on this problem follow:

> In their unsuccessful effort to fulfill their needs, no matter what behavior they choose, all patients have a common characteristic: *They all deny the reality of the world around them.* Some break the law, denying the rules of society; some claim their neighbors are plotting against them, denying the improbability of such behavior. Some are afraid of crowded places, close quarters, airplanes, or elevators, yet they freely admit the irrationality of their fears. Millions drink to blot out the inadequacy they feel but that need not exist if they could learn to be different; and far too many people choose suicide rather than face the reality that they could solve their problems by more responsible behavior. Whether it is a partial denial or the total blotting out of all reality of the chronic back-ward patient in the state hospital, the denial of some or all of reality is common to all patients. Therapy will be successful when they are able to give up denying the world and to recognize that reality not only exists but that they must fulfill their needs within its framework.
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> . . . The therapist who accepts excuses, ignores reality, or allows the patient to blame his present unhappiness on a parent or on an emotional disturbance can usually make his patient feel good temporarily at the price of evading responsibility. He is only giving the patient "psychiatric kicks," which are no different from the brief kicks he may have obtained from alcohol, pills, or sympathetic friends before consulting the psychiatrist. When they fade, as they soon must, the patient with good reason becomes disillusioned with psychiatry.

Although implied by and embedded in Reality Therapy as a whole, there is a way of thinking about the question of what is and what is not "realistic" which can and perhaps should be made more explicit. From one point of view, it can be argued that all experience is reality of a kind. Phenomenologically, there is certainly nothing *un*real about illicit or perverse sexual behavior,

criminal activities, or the total life style of persons we call neurotic or even psychotic. Literally everything that happens is reality. Therefore, some special principle or dimension is needed to make the distinction between reality and irreality fully meaningful. In short-run perspective, there is something "realistic" and "good"—in the sense of pleasurable—about all perverse, criminal, or defensive behavior. Otherwise it simply would not occur. But more precisely speaking, action can be called realistic or unrealistic only when its *remote* as well as immediate consequences are taken into consideration and compared, weighed. If the evil, pain, suffering which ultimately occur as a result of a given action exceed the immediate satisfaction which it produced, that action may be termed unrealistic; whereas, if the satisfaction which ultimately occurs as a result of an action is greater than the immediate effort or sacrifice associated with it, such an action can be called realistic. In the final analysis, it is the capacity to choose wisely between these two types of behavior that we call *reason;* and it is, I think, what the Chicago columnist, Sidney Harris, had in mind when he once characterized the truly educated man as one who knows and can properly appraise the *consequences* of his actions. It is what Alfred Korzybski meant when he spoke of the human capacity for *time-binding;* and it is what I have previously denoted by the expression, *temporal integration.* It is also, I believe, what Dr. Glasser implies when he says, in one of the passages already quoted: "A responsible person . . . is motivated to *strive* and perhaps *endure privation.* . . . An irresponsible person . . . gains neither our respect nor his own, and *in time* he will suffer or cause others to suffer" (italics added).

In a paper entitled "Formations Regarding the Two Principles of Mental Functioning" which appeared in 1911, Freud made a clear distinction between what he called the pleasure principle and the reality principle; and again the distinguishing criterion was a temporal one. However, while praising the reality principle, Freud propounded a therapeutic technique which, paradoxically, glorifies pleasure and permissiveness. It was not that Freud recommended that we totally surrender to the sway of pleasure and live entirely in the present. Rather, his argument was that "conventional morality" is unrealistic in the sense of making more de-

mands for restraint and "repression" than are actually necessary. Thus he pleaded for what he termed an "intermediate course." He said:

> We [analysts] are not reformers . . .; we are merely observers; but we cannot avoid observing with critical eyes, and we have found it impossible to give our support to conventional morality [which] demands more sacrifices than it is worth. We do not absolve our patients from listening to these criticisms . . . and if after they have become independent by the effects of the treatment they choose some intermediate course . . ., our conscience is not burdened whatever the outcome.

Thus the crucial question is: Was Freud's conception of neurosis correct or incorrect? For a generation we have assumed that his diagnosis of the problem was essentially sound. Today we are not particularly pleased with the results of treatment predicated on this view; and Dr. Glasser has given us what I believe is the best description to date of a radically different approach. Here the assumption, as we have already seen, is that all "clinical types" represent *under*-socialization and that therapy, to be consistent and effective, must in all cases be directed toward getting the individual to be *more* responsible, *more* realistic, in the sense of being willing to make immediate sacrifices for long-term (one may almost say lifelong) satisfactions and gains. Some persons do not live long enough to reap the full harvest of their virtue—and this we all recognize as a form of *tragedy*. But the reverse situation is *folly*. The trouble with "Eat, drink, and be merry, for tomorrow we die" is that we usually *don't* die tomorrow but instead live on to reap only too fully the negative consequences of shortsighted pleasure seeking. The habitual drunkard does not have to be very old to have lived too long, and it is no accident that he so often either attempts or successfully commits suicide.

Thus the therapeutic problem, basically, is that of getting another person to abandon what may be called the *primitive* pleasure principle and to adopt that long-term, enlightened, *wise* pursuit of pleasure, satisfaction, joy, happiness which the reality principle implies. An immediate, assured source of pleasure is never willingly given up for a larger but uncertain remote satisfaction. And

an essential aspect of therapy, as of all education, all socialization is that of providing the immature person with some compensation, some substitute satisfaction for the one he is being asked, in his own long-term best interests, to give up. In the ordinary socialization of children, parental love serves this function. In his description of Reality Therapy, Dr. Glasser calls it *involvement,* of which he says:

> Usually the most difficult phase of therapy is the first, the gaining of the 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. The guiding principles of Reality Therapy are directed toward achieving the proper involvement, a completely honest, human relationship in which the patient, for perhaps the first time in his life, realizes that someone cares enough about him not only to accept him but to help him fulfill his needs in the real world.
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> . . . How does the therapist become involved with a patient so that the patient can begin to fulfill his needs? The therapist has a difficult task, for he must quickly build a firm emotional relationship with a patient who has failed to establish such relationships in the past. He is aided by recognizing that the patient is desperate for involvement and is suffering because he is not able to fulfill his needs. 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.

For some readers, the foregoing discussion of involvement will be reminiscent of the psychoanalytic concept of transference, but there are marked differences, both in regard to method and objective. Psychoanalytic transference is said to be best achieved when the therapist remains inexplicit and shadowy as a person, onto whom the patient can "project" his neurotic, harsh, unrealistic, anxiety-arousing expectations of all authoritative "father figures." The therapist then, at strategic points, "reveals" himself as really kind, accepting, permissive, and in this way supposedly brings

about the needed modification, or "softening," of the superego. By contrast, the objective of Reality Therapy is to support and strengthen, never to weaken, the functioning of conscience; and the method of choice involves honesty, concern, personal authenticity, and confrontation of the kind Dr. Glasser describes.

But is there not an ultimate and fatal paradox here? How can one hold that a neurotic or otherwise "delinquent" person is "responsible" and at the same time take the position that such a person needs or can benefit from treatment? Does not the very concept of treatment, or help, imply a certain helplessness and *lack* of responsibility on the part of the person who is "in trouble"? Language can at this point play an insidious trick on us if we are not extremely careful. The difficulty in the case of the irresponsible (neurotic, delinquent) person is precisely that he is *not* acting responsibly; and his great need is that of learning to behave *more* responsibly and thus *better* fulfill his own long-term needs—as well as those of society as a whole. In the present volume, Dr. Glasser is not saying that patients are *responsible for* what has happened in the past; instead, he is saying that they have not been, and are not now, *living responsibly*. There's a great difference between these two statements. And therapeutic (educative) influence from whatever quarter ought to be in the direction of helping patients improve their capacity and desire to live more responsibly, prudently, wisely from now on. Thus the concept of responsibility, far from implying or stressing the evil in man is rather one which sees and builds upon his potentialities *for good*; and it is therefore decidedly optimistic and hopeful rather than cynical or pessimistic.

Enough has now been said to show that Reality Therapy is "different." Now we must ask: Is it also *better?* Clinical evidence from several sources is cited in this book which strongly suggests an affirmative answer. No one, at this point, is claiming that the evidence is definitive. But as a research psychologist I can attest that there is today much additional supporting data of a thoroughly empirical nature and that the premises of Reality Therapy are rapidly gaining credence in many quarters. Its promise for the future therefore seems to be very bright, and the present volume fills a real need for a simply written and yet clinically informed and sophisticated description of this approach and its working assump-

tions. The reader will enjoy the author's clear, lively style of writing and will profit from an account which, I predict, is destined to arouse much popular as well as scientific interest.

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