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Introduction to the Journal Editors and to the Editorial Board:

IJCTRT Editor:

The Editor of the Journal is **Dr. Thomas S. Parish**, who is an Emeritus Professor at Kansas State University in Manhattan, Kansas. He earned his Ph.D. in human development and developmental psychology at the University of Illinois at Champaign-Urbana, Illinois. He's

CTRT certified and has authored or co-authored more than 300 articles that have appeared in more than 30 professional refereed journals. Dr. Parish and his wife recently served as consultants for LDS Family Services in Independence, Missouri, and they currently co-own Parish Mental Health of Topeka, Kansas. Any correspondence, including questions and/or manuscript submissions should be sent to parishts@gmail.com You may also contact him by phone at: (785) 845-2044, (785) 861-7261, or (785) 862-1379. In addition, a website is currently available. It is www.ctrtjournal.com Plus the Journal is no longer password protected on the WGI website, so now anyone can gain access to it, anytime, 24/7!

Associate Guest Editors for This Issue of the Journal include the following:

Dr. Janet M. Fain Morgan, who is currently a Director of the William Glasser International Board and the Research Coordinator for William Glasser International. She is also a faculty member of WGI lectures on Choice Theory and Reality Therapy. In addition, Dr. Morgan has an extensive background in counseling and teaching with specialty areas in Military Issues, **Grief and** Loss, Marriage Counseling, and Domestic Violence Predator Treatment.

Dr. Anasuya Jegathevi Jegathesan, who earned her doctorate in counseling, and works with individuals, couples and families, and who specializes in Adolescence, Grief and Loss, Relationship Management, and Crisis Management. She applies both psychodynamic and CTRT techniques in her practice.

IJCTRT Editorial Board Members:

Editor: Thomas S. Parish, Ph.D., please see listing printed above.

Other Members of the Board:

Janet M. Fain Morgan, Ed.D., please see listing printed above.

Emerson Capps, Ed.D., Professor Emeritus at Midwest State University, plus serves as a Faculty Member of WGI-US.

Patricia Robey, Ed.D., Full professor at Governor's State University, Licensed Professional Counselor, and Senior Faculty Member of WGI-US and William Glasser International.

Brandi Roth, Ph.D., Licensed Private Practice Professional Psychologist in Beverly Hills, CA.

Jean Seville Suffield, Ph.D., Senior Faculty, William Glasser International, as well as President and Owner of Choice-Makers@ located in Longueil, Quebec, Canada.

Robert E. Wubbolding, Ed.D., Professor Emeritus at Xavier University in Cincinnati, Ohio, and is the Director of the Center for Reality Therapy also in Cincinnati, Ohio.

IJCTRT Technical Advisor: Glen Gross, M.Ed., Learning Technology Specialist from Brandon University in Brandon, Manitoba, Canada.

Since space is limited here, the reader is referred to nearly any and all of the earlier Choice Theory and Reality Therapy Journals that have been published since 2010, and are available on-line (go to ctrtjournal.com) for information regarding any of the following:

IJCTRT Mission
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Dear WGI members and friends—This is another special invitation for you from Tom Parish, the Editor of IJCTRT:

Welcome to the fifth in a series of various topically-driven issues of the *International Journal Choice Theory and Reality Therapy.* Basically, each topic is intended to be independent of the others, though they may be related to each other in various ways. While the remaining topics, their dates of each issue, and the guest editors of each, have appeared in previous issues, they will also appear below for the convenience of the readership.

Date of Issue Topic to be Covered	Guest Editors Assigned
Spring 2019—Religious and Spiritual Perspectives and How They are Connected to All Things Glasser	E. Perkins or T. Parish
Fall 2019—Past Contributors and Their Contributions to All Things Glasser	R. Wubbolding or T. Parish

Notably, the guest editors, listed above will be seeking to find authors who wish to contribute writings and/or research directed toward either of these topics. If the reader is interested in providing something pertaining to either or both of these topics, s/he is urged to send a one page "idea paper," or a completed report, to either of the guest editors associated with that particular topic. In addition, the guest editors will be inviting selected individuals to also submit items that seem to be well suited for inclusion in their issue of the *Journal*. For instance, Dr. Wubbolding and I recently co-wrote a paper that sought to describe the life and works of Dr. William Glasser (which was entitled "William Glasser, 1925-2013"). This paper was then published in 2015 in *The Encyclopedia of Clinical Psychology*. Spinning off from that model, the potential writers could also extoll the works of many other authors and/or innovators that have likewise contributed to either Reality Therapy and/or Choice Theory. To this end, the Fall 2019 issue of the Journal is directed. Of course, other papers, dealing with other topics, will also be included in these two remaining "Special Topics" issues, so be sure to send them along to us too!

Assuming that the submissions seem to be of interest to the Journal's readership, are prepared in accordance the guidelines for the Journal (see elsewhere), are submitted in a timely fashion (at least two months before the publication of each issue), and are found to be acceptable for publication following a thorough review by the members of the editorial board, such submissions will be accepted for publication in *The International Journal of Choice Theory and Reality Therapy.*

Guest Editors' Names and Other Essential Information:

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Special Announcement Regarding the Spring 2020 Issue of The International Journal of Choice Theory and Reality Therapy

This particular issue of the *Journal* will include a "Who's Who"-type listing of everyone who wishes to be included within the William Glasser International organization. Basically, a template has been created (see below), and will also appear in the next two issues of the *Journal*, and anyone who wishes is invited to complete this template and submit it to parishts@gmail.com so that it may be included in this special issue of the *Journal* in Spring 2020! Let's call this issue of the Journal . . .

"The International Who's Who of Choice Theory and Reality Therapy" . . .

since it will be inclusive of everyone around the world who has been involved with Choice Theory and/or Reality Therapy! This issue, in turn, will attempt to cast a light on all those who have been involved in CT/RT, and provide invaluable information regarding what they have done to utilize and/or advance the ideas and/or insights of "everything Glasser!" Notably, this service will be provided— as usual—at no charge to the readership, nor to those who are listed in this special issue of the *Journal*. Of course, beyond reflecting back upon what they've done, these brief reports may also provide the readership with glimpses into what these contributors/authors/presenters/practitioners could be working on in the future. Please note, however, that while there is no minimum length for each individual's capsulized summary, there is a maximum length of two pages per each biographical sketch. Thanks to one-and-all for your cooperation regarding this, and for abiding by the usual requirements laid out by the *Journal* elsewhere.

Proposed WGI Template for Members and Friends of WGI

Name of Individual and Current Affiliation (or most recent affiliation)
List of Degrees/Certifications, including institutions, degrees, majors, & completion dates.

Professional Positions Held To-date:
Positions Held Within WGI:
Positions Held Outside WGI:
Awards or Other Forms of Recognition Received:
Selected Books/Chapters of Books Authored or Co-authored Regarding CT/RT:
Selected Journal Articles Authored or Co-authored Regarding CT/RT:
Selected Workshops Presented or Co-presented Regarding CT/RT:
Glimpses Concerning Your Future Endeavors Regarding CT/RT:
Special note to each potential "brief bio" contributor:

Each "brief bio" will be left up to the contributor, with the only requirement being that each bio cannot exceed two pages in length. As stated above, each "brief bio" should be submitted to me at parishts@gmail.com and must be sent by February 15, 2020.

USING REALITY THERAPY WITH CLIENTS EXPERIENCING CHRONIC PAIN

Carol Seehusen, MS, TLMHC, NCC

Abstract

This article outlines the use of reality therapy (RT) with individuals experiencing chronic pain (CP). An introduction to individuals with CP and their unique characteristics, as well as clinical applications are discussed. General effectiveness research of RT is included, and implications for further research on the effectiveness of RT with individuals with CP is strongly recommended.

Chronic pain (CP) is characterized by the presence of physical pain for at least six months (Heckman & Westefeld, 2006), above and beyond the typical timeframe an injury's acute pain should subside (Beard & Aldington, 2011; Henriksson, Wasara, Ronnlund, 2016). It impacts roughly one-third of industrialized countries' populations (Heckman & Westefeld, 2006), making CP a global health issue. As noted in multiple research studies, CP can develop from physical or psychological trauma (Tesarz, Eich, Treede, & Gerhardt, 2016), which is an important distinction for counselors when working with individuals with CP, as this may alter necessary interventions during the therapeutic relationship. CP can become debilitating; rendering an individual unable to physically control his or her body, as well as psychologically unable to cope with the loss of freedom, intensity of symptoms, and changes in self-identity.

CP can have an influence on the individual, family members, and society at large (Heckman & Westefeld, 2006; Henriksson, et al., 2016; Jong, et al., 2016), making the treatment of CP very important. Healthcare services are used much more often by individuals with CP, which carries a large cost for loss of productivity in employment (Heckman & Westefeld, 2006; Henriksson, et al., 2016). At an individual biological or physical level, CP is associated with poor sleep, fatigue, lowered mobility, greater body mass index or weight, heart disease, and respiratory disease (Henriksson, et al., 2016). Effective treatment for CP has been elusive, and many interventions have been tried, including medications, occupational therapy, massage therapy, cognitive-behavioral therapy (amongst other psychological interventions), and acupuncture, to name but a few (Beard & Aldington, 2011; Henriksson, et al., 2016; Morone, Lynch, Greco, Tindle, & Weiner, 2008). A disability of this magnitude, which likely results from trauma outside of the individual's control, can have a great impact on the individual.

The world of an individual with CP is complex. Presenting issues, aside from somatic complaints, may include interpersonal relationship struggles, lack of healthy coping strategies, denial and/or grief over the loss of identity, and vocational difficulties. A holistic case conceptualization is necessary to truly understand the various needs of the client (Eccleston, 2001). Sometimes, counseling theory or intervention focuses much of its time in the past, or processing how an individual can come to terms with his or her new reality. Individuals with CP may wish to focus on the present and how to navigate current struggles and stressors for more immediate relief. Reality therapy (RT) is a theory that could benefit this population, and research studying its effectiveness for clients with CP is needed. RT can

help the client with solutions to here-and-now problems, as well as bring awareness to the unique challenges that individuals with CP face and help evaluate whether the client's behaviors are effective in obtaining what the client wants.

What is Reality Therapy?

RT was developed by William Glasser with a foundation in Choice Theory. Within Choice Theory, Glasser posits that individuals have a choice regarding their thoughts, feelings, and behaviors (Glasser, 1998). While impulsive feelings are part of life, in the long-term individuals consciously act on and control their feelings (Seligman & Reichenberg, 2014). RT focuses on five basic needs that comprise an individual's quality life, including love and belonging, power, fun, survival, and freedom (Seligman & Reichenberg, 2014). Glasser believes that mental health issues or impaired functioning in daily life is due to a lack in at least one of the five core areas. For example, someone who is diagnosed with depression may be lacking in their need for love and belonging and/or fun. The second major tenet of RT is that satisfying relationships are important to avoid negative symptoms, and having meaningful, significant, positive relationships can help facilitate a favorable fulfillment in the five basic needs (Seligman & Reichenberg, 2014).

How is Reality Therapy Used with Clients?

First and foremost, RT focuses on building a strong therapeutic alliance between the counselor and client, using the Rogerian core counseling tenets and aligning with other major counseling theories. RT practitioners focus on "empathy, congruence, and positive regard" (p. 198) to create a safe, trusting environment for the client (Wubbolding, 2015). An RT counselor strives to avoid toxic behaviors (arguing, blaming, criticizing, demeaning, excusing, finding faults, or giving up) and to provide helpful behaviors such as affirming feelings, showing acceptance and affection, providing action consequences, facilitating conversation around the Wants, Direction "Doing", Evaluation, and Planning (WDEP) intervention, and spending time with the client (Wubbolding, 2017). Once a strong therapeutic alliance is formed, the RT counselor moves into helping the client create their own quality world.

Through exploration of the individual's wants regarding their quality world, the RT counselor facilitates discussion around how the individual's perceptions and wants help shape behavior (Wubbolding, 2015). Throughout this discussion, the client becomes more committed to change regarding behaviors to get closer to the quality world (Wubbolding, 2015). This is where the WDEP intervention comes into play.

The counselor's role is to help the client to a place of awareness around the five basic needs and the individual's quality world. The quality world consists of people, possessions, experiences, ideas, and beliefs that an individual holds very dear and values within their life (Seligman & Reichenberg, 2014). Using interventions such as the WDEP system, counselors help the client become aware of the here-and-now, focusing on what the client is doing and how this aligns or detracts from what the client ultimately wants (Seligman & Reichenberg, 2014). The Wants come into the counseling session through the exploration of the quality world of the client (Wubbolding, 2015). From there, the counselor and client then look at the direction taken by the client, or what they are Doing. These can be literal behaviors and actions of the client, but could also include emotions surrounding the actions and/or the

goal (Wubbolding, 2015). Through discussion, the RT counselor helps the client connect the emotions to their actions/behaviors and this awareness helps elicit change. Changing actions is much easier than changing emotion and once an individual can successfully change a behavior and see alternative outcomes, emotions can then follow (Wubbolding, 2015). This discussion about how the emotions and behaviors are connected to the wants is part of the Evaluation stage, and where big connections are made for the client (Wubbolding, 2015). The final stage is creating a Plan. This plan must be "simple, attainable, measurable and mindful, immediately carried out, controlled by the planner rather than being dependent upon others, consistent or repetitive, and committed to in a firm and determined manner" (Wubbolding, 2015, p. 201). The WDEP system is flexible and can be tailored to working with any type of client and for a multitude of client presenting problems, including potential use with individuals with CP. Between bringing the client's awareness to the possible inconsistency between what they are doing and what they want, as well as to their quality world, the counselor can facilitate a process by which the client actively takes a choice and role in personal growth and problem resolution.

Clients with Chronic Pain

As noted earlier, CP is defined as the presence of physical pain for a minimum of six months past the injury's medical timeframe for healing (Beard & Aldington, 2011; Henriksson, et al., 2016). Recognition of this fact, that persistent pain and disability could not be explained by the specific damage or diagnosis of the individual, gave rise to the idea of a psychological influence on pain (Eccleston, 2001). Roughly 100 million individuals within the United States live with CP (Institute of Medicine, 2011). Physical or psychological trauma can also lead to development of CP symptoms (Tesarz, et al., 2016) and this underlying trauma could exacerbate the severity and frequency of symptoms as time goes on. As noted by Eccleston (2001), the damage inflicted to the body or the experience of an individual's pain are indicators of the individual's level of disability or the level of impact on daily life. Counselors working with clients with CP need to be aware of the multi-faceted stressors that impact the client's world.

CP can impact the client's sense of self. Losing control over one's body, having to cope with the loss of freedom, as well as the intensity of pain symptoms can wreak havoc on an individual's self-identity or self-concept. According to Eccleston (2001), the psychology of pain and the subsequent understanding of disability to the individual creates beliefs that influence "the extent of pain-associated disability" (p. 144). Physical symptoms other than pain can develop, such as sleep difficulties and chronic fatigue (Eccleston, 2001). Coping strategies often are reactive to pain and can lead to the development of depression or anxiety, or in some instances pain-related fear (Eccleston, 2001). Additionally, these individuals frequently have interpersonal stressors with family and friends, multiple medical appointments and associated stigma or financial burden and potential loss of income or job identity (Heckman & Westefeld, 2006; Henriksson, et al., 2016; Jong, et al., 2016).

Eccleston (2001) notes that often individuals with CP "become personally isolated" (p. 148) and develop "unsatisfactory family roles and responsibilities" (p. 148). Individuals with CP must navigate coping strategies related to pain symptoms, which does not always result in positive interactions with other people. Anger can be a common reaction to pain. When no specific reason for the pain is present, anger can be manifested through general frustration and irritation (Eccleston, 2001). Personal relationships tend to take the brunt of an

individual with CP's behavior and emotions and support systems can crumble under the pressure.

RT may be effective in helping with the interpersonal relationship issues for those with CP, as well as other contextual factors that influence the frequency and intensity of pain symptoms. McCracken, Carson, Eccleston, and Keefe (2004) argue that it is not enough to simply focus on gaining control over pain, but that further acceptance of the new reality and changes in the individual's life are equally important. Using RT, clients are brought to an awareness of the world they live in and the limitations of that reality due to CP. Goals are drafted to focus on what is realistic and attainable for the individual, given their wants and quality world, in context with meeting the five basic needs and one's level of disability.

Clinical Implications of Using RT with Clients with Chronic Pain

Utilizing the RT tenets of the five needs and the quality world are applicable to individuals with CP. RT counselors can help facilitate the discussion of how to connect wants and the quality world within the framework of satisfying the five basic needs, as well as with reasonable and obtainable goals. Sauerheber, Graham, Britzman, and Jenkins (2016) note that RT and Choice Theory are appropriate modalities to use when an individual is encouraged towards "self-responsibility and empowerment" (p. 176). RT aims to help individuals meet the five basic needs, "maintain activity, experience at least a sense of cognitive and emotional independence and serve as their own advocates" (Sauerheber, Graham, Britzman, & Jenkins, 2016, p. 176).

With a declining sense of self and freedom or independence in the physical sense, individuals with CP can be helped by this sense of freedom inherent in RT's five basic needs. The WDEP intervention provides a structured tool that allows for all complex concepts of the client's worldview and unique issues to be addressed. The RT counselor can empower and encourage the client to be more active, to avoid detrimental behaviors to interpersonal relationships (including those with medical professionals involved), and have more immediate results to foster continued motivation for change. Needs assessment, as used through RT, can be adapted to work with individuals with CP easily and be done in a way that is not "medicalizing, pathologizing, or dehumanizing" (Rapport, 2007, p. 24).

Effectiveness of Reality Therapy

Lawrence (2004) suggested using RT in group therapy for individuals with developmental disabilities to empower the use of self-determination. Self-determination, Lawrence (2004) states, is composed of autonomy, self-regulation, psychological empowerment, and self-realization. Self-determination is accomplished through exploring how to meet an individual's needs (Wehmeyer, Sands, Doll, & Palmer, 1997). Additionally, Field and Hoffman (1994) added that self-determination is the interaction between external and internal forces. RT looks at both internal and external factors of behavior and can even be use within a group setting, as was demonstrated by Lawrence (2004).

What Lawrence (2004) found was that when a group using RT was compared to a group using "mutual support" (p. 9), the group using RT showed significant increases of self-determination from pre- to post-test. The four factors that comprise self-determination were looked at individually. Self-regulation was found to differ significantly between the two

groups. When comparing t-tests of pre- and post-test scores, self-regulation and self-realization were statistically significant improved for the RT group.

Renna, Kimball, Brescia, and O'Connor (1999) conducted a study that examined students with disabilities ability to gain employment upon graduation having been through a school curriculum that used tenets of RT and Choice Theory. Specifically, the researchers examined whether the students were able to gain "competitive employment" (p. 22). What they found was that students who had been involved with RT and Choice Theory were competitively employed at a rate of 68.3%, compared to 45.7% by those students who were not exposed to RT (Renna, Kimball, Brescia, & O'Connor, 1999). Additionally, they noted that students who had longer exposure to RT and Choice Theory had higher levels of competitive employment, but those who had short-term exposure still had higher rates of attaining competitive employment.

Future Research Implications

As the above discussion showed, research on the use of RT with clients with CP specifically has been generally missing from the existing literature. However, where its use with clients with disabilities has been studied as discussed it was found that this population could benefit from RT focused interventions. Future research examining the use of RT in both individual and group counseling for individuals with CP is needed. Additionally, studying specific therapeutic variables, such as pain or symptom intensity and severity would be helpful too.

Conclusion

Clients with CP have unique needs that are complex in nature. Counselors working with this population need to have a large worldview lens to conceptualize clients and understand how CP impacts the client's daily life. RT does this with the concept of the quality world. RT could be an effective helping strategy and provide relatively immediate results for the client, giving hope and empowering the client with CP to continue treatment and working towards their goals. Further research is necessary focusing on the use of RT with this population.

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Brief Bio--

Carol Seehusen is currently in her second year of doctoral study in Counselor Education and Supervision at the University of Iowa. She completed her Masters of Science in Clinical Mental Health Counseling and holds a temporary license in the state of Iowa as Mental Health Counselor and is a Nationally Certified Counselor. Carol's personal experience with the effects of chronic pain have fueled her passion for research with this population and hopes that through her research efforts she can bring more awareness and collaboration with the medical community to create more effective and efficient services to individuals with chronic pain.

ALIGNING REALITY THERAPY AND CHOICE THEORY PSYCHOLOGY WITH COGNITIVE PSYCHOLOGY

Sasha N. Cervantes, Ph.D.
Patricia A. Robey, Ed.D., L.P.C., CTRTC

Abstract

Cognitive psychology can aid in empirically validating aspects of choice theory and reality therapy. Choice theory psychology and cognitive psychology share many fundamental principles. Both arose from a desire to move beyond an external locus of control, as was popular in Behaviorism. Critically, both choice theory psychology and cognitive psychology describe a bi-directional relationship between our mental and physical worlds. These two schools of thought agree that people do not just take in the sensory information of their environment without filtering it through their inner world. More than this, our inner world impacts how we understand and interact with the outside world. We make behavioral choices, including our thoughts and actions, as a result of our past experiences. However, these past experiences do not have a fixed effect on our behavior. We can choose to recognize the difference between our external world and our inner experience of it, and in acknowledging this create change. This article will outline some of the key parallels between these two schools of thought and describe how the empirical research done in cognitive psychology can support aspects of Glasser's choice theory model.

Introduction

The Cognitive Revolution was a movement based in part on the critical need to recognize the role of each individual mind in interpreting our external environment (Gardner, 1985). With choice theory, Glasser emphasizes that our *perceived world* is not an exact objective representation of the *real world* (Glasser, 1998). This conceptualization is not unlike the common cognitive psychology adage that sensation does not equal perception. Glasser (1998) presents the fable of the Blind Men and the Elephant in his book on choice theory. As a cognitive psychologist, I (SC) have used this same fable to introduce the idea of perception as an interpretation of reality. Cognitive psychology posits that our perceptions are interpretations of sensory information filtered by our knowledge and experience, our expectations and biases. In choice theory, Glasser describes this same interpretation as occurring through sensory, knowledge, and valuing filters.

Top-down Processing and Glasser's Knowledge Filter

Choice theory describes filtering sensory information such that we perceive only a portion of the total external world. This corresponds with what cognitive psychology calls *top-down processing* (Schacter, 1999). Consider the first time you meet with a client who has been referred to you by another therapist. Did you review a file on them before-hand to best prepare to help them? How do you think reading any previous diagnostic information provided might have contributed to your identification and attention to key trigger words said by the client during your meeting? Did you listen for different trigger words based on that file? What if you prepared for the client with the wrong file? How might this have

affected your perception of the words stated by this individual? Even when we choose to listen carefully, our knowledge creates expectations that affect what we perceive.

Both choice theory psychology and cognitive psychology emphasize that the information that comes from the external world can capture our attention, but it is still filtered through our sensory system, knowledge, and experience. Our experience biases our perceptions. Bias is not synonymous with prejudice. Prejudice is baseless, not formed by actual experience. Conversely, bias represents the expectations which are formed as a result of our unique experiences and expertise. For instance, when an expert in psychology learns new information related to psychology, they perceive the information differently than the novice. Different aspects of the information attract the expert's attention and are interpreted based on their perspective. From the outset, every individual is experiencing the same moment very differently than the individual next to them.

Cognitive psychology further emphasizes that information provided beforehand has an enormous impact on how we process the information provided to us from the world. This influence exists even before we are trying to recollect our past experiences and the information in past events. In one experiment that perfectly illustrates this phenomenon, people were provided with a passage to read. Half of the people were instructed to read the "following passage" while the other half were instructed to read the "following passage about washing clothes" (Bransford & Johnson, 1972). Those who were informed that the passage was about "washing clothes" were able to recall two times the amount of detail accurately from the passage. Critically, if people were told it was about "washing clothes" after they read the passage, but before trying to remember the details, this additional information did not help them recall any better. The best memory performance is by people told the intent of the passage beforehand. Cognitive psychologists suggest that these individuals non-consciously activated their knowledge associated with this behavior (referred to as a schema), and thereby perceived the passage differently than those told the intent after, or not at all. It is necessary for us to activate the knowledge we hold prior to an experience for it to affect our perception of the sensory world. This provides empirical support for Glasser's assertion that the information held in our perceived world is influenced by our knowledge filter.

Top-down Processing and Glasser's Valuing Filter

Glasser (1998) also affirms that our perceived world can be inaccurate. This is another central tenant of cognitive psychology. Parallel to Glasser's valuing filter, cognitive psychology stresses that our emotions can result in an "attentional spotlight" on specific item information in any experience, usually at the expense of attending to the contextual details (Hirst, Phelps, Buckner, Budson, et al., 2009; Kensinger, 2009; Rimmele, Davachi, Petrov, Dougal & Phelps, 2011). This makes the item information present in the context vulnerable to alteration. Similar to how item information may have been assigned a positive, neutral, or even negative value based on its ability to meet our basic needs, as Glasser described in choice theory, information that is not deemed meaningful to us is typically not conferred the attention necessary for the process of encoding to our long-term memory. Without this additional processing, our experiences are left with 'gaps' that will be filled based on our knowledge, and as Glasser would probably say, our quality world values.

An emotional spotlight can increase the significance of certain details during an experience.

When all of your attention is on this item information, the details surrounding are not being prioritized. This de-prioritization could be the result of value judgments filtered when compared to what Glasser refers to as our quality world. The result is that we do not give these contextual details the processing necessary to transfer them to our long-term memory. There is some evidence that we can consciously make the choice to attend to peripheral details, shifting our attentional filter based on our priorities in that given moment (Kensinger, Piguet, Krendl, & Corkin, 2005). But without making that choice, we commit the information details of greatest personal significance, the most meaningful information, to memory and leave the rest open to alteration during and following the experience. This alteration can be your knowledge filter providing details "normally" present in the situation type. It can also be alteration that occurs later, when reflecting on the experience (Bartlett, 1932).

Biological Predisposition in Choice Theory Psychology and Cognitive Psychology

This is not a flaw in the system. Choice theory argues for a genetic component to our processing, a biological predisposition that establishes how we approach our world (Glasser, 1998). This predisposition is supported in theories of cognitive psychology. Our perceptions and memories are constructed from the who, what, where, and any other item information which, when combined, construct any given experience. It is critical that our system operate in this way, constantly constructing and reconstructing the whole so that we can flexibly use the pieces for new situations. When we need to plan for the future, we rely on parallel processing mechanisms and brain regions for remembering our past, constructing the same elements such as where we will be and what we will be doing in that future event (Addis, Wong, & Schacter, 2007; Buckner & Carroll, 2007). The neural signals in the brain for true and false memories greatly overlap at retrieval, particularly when filling in gaps with previously held knowledge (Webb, Turney, & Dennis, 2017). Our brain operates to support the cognitive functioning necessary for both flexible construction of our reality, and possibly fulfill our needs for power, love and belonging, fun, and freedom. In cognitive psychology, it has been argued that one important function of our imperfect memory is the maintenance of a healthy self-image (Conway, 2005; Conway & Pleydell-Pearce, 2000). It may very well be a blessing to "misremember" our past behaviors. Altered memories, an alleged side effect of this flexible construction of our experiences, can aid in meeting our need for love and belonging by helping to sustain relationships. These altered memories may be helping to meet our need for power by improving our sense of self-worth. Our need for freedom is centered around a freedom of will. Alterations of perception and memory can support our sense of control over the direction of our life.

Comparing our Quality World and Perceived World

In choice theory, Glasser (1998) describes an inner, quality world that is comprised of our unique values, beliefs, and priorities. This quality world represents our personal, ideal manifestation for how we can each meet our basic needs. It is not a replica of what we perceive from the real world, and therefore constant comparisons take place to assess how well we are living the life for which we currently aspire.

It is important for self-regulation, for those in and out of therapy, to remember that our perceptions and memories are so vulnerable to gaps and insertions such that they are only an approximation of the external world. Just as choice theory suggests we choose our

perceptions, we can choose to remember that our perceptions are imperfect as a first step in dealing with any frustration arising from a mismatch between our perceived world and our quality world. One behavior we can choose is to recognize that in continuously comparing our perceived and quality worlds, we are in fact altering both. When individuals need to break away from their familiar patterns of behavior, therapists can help them to realize the actions they are choosing may be premised on flawed information. This might make acting in accordance with their quality world values easier than perseverating on those behaviors that they perceive as having worked in the past, particularly when these behaviors are not working in the present.

In cognitive psychology, there is an established theory for what occurs when our actions and our beliefs do not match and the resulting stress this places on us as individuals. Cognitive dissonance theory was developed to represent the idea that action can precede belief change (Festinger, 1957), an idea that resonates with choice theory. While choice theory and reality therapy speak to what behavioral change can be encouraged to achieve greater satisfaction and better meet our basic needs, cognitive dissonance predicts what is the likely outcome when a mismatch arises. Here, there is some divergence in perspective. Choice theory posits that an individual will choose behaviors in an attempt to address the mismatch between what the individual wants and what that individual perceives he or she actually has (Glasser, 1998). Reality therapy can be used to aid individuals who do not engage in this pursuit (Glasser, 1998; Wubbolding, 2011). However, cognitive dissonance research indicates that the norm is to alter our beliefs before our actions. It would be logical to alter something we have more explicit control over, such as our actions. Yet, as human beings, we do not always choose the most logical option. Rather, we justify our actions by attempting to map our beliefs onto our action choices. Even if thoughts are considered a form of behavior under an individual's control, thoughts may not be a part of the quality world, whereas beliefs and values are.

When we reflect on our actions and compare them with our beliefs and values, any mismatch results in a reframing of our action choices. Imagine clients who sought work in one field but could not secure a job. If they find themselves working in another area, they may rationalize accepting the position to themselves by increasing the value of that form of work. Festinger and Carlsmith (1959) showed that people will alter their attitudes to justify choices, particularly when no clear external motivator is present. In this classic study, participants were given an acutely tedious task and then compensated well or poorly. Following receipt of the compensation, participants who were poorly compensated rated the task as more engaging than those who were well compensated. Cognitive psychologists conclude that in the absence of a satisfactory external motivation, people will alter their beliefs in an effort to create a satisfactory perception. Choice theorists might describe this as altering beliefs in their quality world in order to increase the match in the comparison of the quality and perceived worlds.

It takes a concerted effort to choose a change in actions instead of beliefs. This where a therapist can be so valuable. The therapist can encourage a client to make the more difficult choice to alter actions. Both cognitive dissonance theory and choice theory assert that these changes can result in positive change in thoughts and beliefs. A therapist can be instrumental in helping individuals recognize the value in other action choices. Dysfunction and perseveration on actions that do not benefit us or help us achieve a greater match between our quality and perceived worlds is common. Cognitive dissonance research has

demonstrated that once we engage in a course of action, we not only justify our choices, but are less aware of alternatives (Jermias, 2001). Committing to an initial course of action makes us resistant to change. Therefore, we keep engaging in what Glasser (1998) refers to as organized behavior, that is, particular actions that may be functional, but are not necessarily best for us. Rather than consider other actions which might better help us to achieve a closer match to our quality world, we cannot even recognize that these other actions are options available to us. Memory research supports this finding as well. In studies of eyewitness testimony, once individuals endorse a suspect they become committed to their choice. This action has such a strong influence that if they were compelled to endorse an innocent person, they will often persist in this endorsement when given the choice between the innocent suspect and the true perpetrator of the crime (Hinz & Pezdek, 2001). Perhaps our overconfidence in our choices comes from our needs for competence (power) and to believe in our perceived freedom of choice.

Significantly, cognitive dissonance theory suggests that action can transform beliefs (Festinger, 1957). This can be translated to suggest 'acting the way you would like to see yourself' (as pictured in your quality world). Choice theory and reality therapy take a similar stance by advocating that we can only directly control our actions and thinking. Unlike beliefs, thoughts are a behavior like actions. Any change we would like to make to our values and beliefs in an effort to eliminate discomfort must be accomplished indirectly through alteration of our actions or thoughts.

Cognitive dissonance can also impact our relationships with others. Since we cannot control the actions of others, we must justify and rationalize when we choose to remain in a relationship that is harmful to us and moves us further from our quality world. Further, different images in our quality world vary in intensity. The more intense features of our quality world create greater cognitive dissonance when compared to other quality world images. You witness this in many conversations where people admit to ignoring the bad actions of a partner. During the relationship, reframing of the intensity of the harm done or adjusting a belief in the harm of a behavior can be common. Following dissolution of the relationship, beliefs can be adjusted to better align with the present quality world. This adjustment can actually cause alterations of memory and permit greater recognition of those harmful behaviors previously dismissed.

Reflecting on the Past

It is important to acknowledge that even our memories are perceived through our knowledge and valuing filters. Speaking of memory does not equate with living in the past. Our recollections, and their accuracy, are entirely dependent on our present self. We alter our memories for past events, behaviors and beliefs to agree with the beliefs of our current quality world. Have you ever been asked by a partner about an action they recall you committing and you rejected the possibility outright because it didn't sound like something you would do? That evaluation is not based on the beliefs you held at the time of the action in question, but the beliefs you currently hold. This type of interaction and the belief biases which drive it, fit well with Glasser's assertion that our needs can conflict with others' needs. Each person will have different representations of the same past events based on his or her current quality world. Remembering this allows individuals to choose better behavioral responses in their relationships.
An emotional spotlight can make a detail that was assigned a negative value even more

salient. Reflecting on past events repeatedly leaves us vulnerable to greater and greater alteration of the context while leading us to develop a cycle of negative distortion. Our version of events may be altered to better serve our personal needs, or because we are unable to disengage our focus of attention from negatively salient details. Recognizing that our memories for past events are an imperfect record of a filtered perception can help break patterns and adjust behavior accordingly.

Conclusion

Reality therapy utilizes Glasser's model of choice therapy to help an individual make behavioral changes. But the goal is not just about the behaviors; it is also about recognizing what comprises our internal world, including the values of our quality world. Reality therapy emphasizes recognition of what defines an individual's ideals, acknowledging how those ideals are influencing and conflicting with perceptions and behaviors. Reality therapists help their clients understand how the values of the quality world can create discomfort surrounding behavioral choices as a path towards resolving this discomfort.

Cognitive psychology is a field focused on understanding our mental representations of the external world, how we process and interpret stimuli. One goal of psychologists educating themselves and others about research in cognitive psychology is to help people recognize that our internal world can have an enormous impact on how we perceive the external world as well as how we respond to it. Synthesizing cognitive theory with choice theory can inform better therapeutic techniques. Through this comparison of research that already exists in the field of cognitive psychology, this article supports the similarity of cognitive psychology theory with many aspects of Glasser's choice theory model for how the brain works and why we make behavioral choices.

*Author's note: Choice theory and Reality Therapy were spoken of interchangeably since they are so intertwined (Glasser, 2000, as cited in Dermer, Robey, & Dunham, 2012).

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Brief Bios—

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USING LEAD MANAGEMENT PRINCIPLES TO DECREASE THE ACADEMIC ACHIEVEMENT GAP IN P-12 SCHOOLS

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Abstract

This study was designed to examine the perceptions of school administrators, school counselors, school teachers, parents, and concerned citizens toward the academic achievement gap in P-12 schools. Participants in each category were asked to indicate their level of education and what they perceived to be important to decreasing the academic achievement gap in schools. In addition, space was provided for each to identify what he/she thought would be most effective in decreasing the academic achievement gap and to make comments, suggestions, or express concerns regarding the academic achievement gap in P-12 schools. Together, these findings suggest that most educators and citizens are concerned about the achievement gap in P-12 schools and they also feel that more can be done to diminish it. Lastly, implications for lead management training and suggestions for additional research are explored.

Keywords: achievement gap, school administrators, specific training, lead management

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This study examines the perceptions of school administrators, school counselors, school teachers, parents, and concerned citizens toward the academic achievement gap in P-12 schools. Achievement gap refers to the observed, persistent disparity of educational measures between the performance of groups of students, particularly groups defined by socioeconomic status (SES), race/ethnicity, and/or gender. Despite an excess of school reform efforts, legislative interventions, increased testing, and an unprecedented number of charter schools across the nation, African-American students continue to underachieve in comparison to students from other different racial and ethnic backgrounds (Braun, Wang, Jenkins, & Weinbaum, 2006; Campbell, Hombo, & Mazzeo, 2000). The results of the achievement gap can be observed in different academic measures. These measures include standardized test scores, grade-point averages, dropout rates, and college enrollment and completion (Engle, Bermeo, & O'Brien, 2006; McDonough, 2005; Public Agenda, 2010).

Studies to determine the causes of gaps in student achievement between low-income minority students and middle-income white students have been ongoing since the 1966 publication of the report, "Equality of Educational Opportunity," which was commissioned by the U.S. Department of Education (Equality of Educational Opportunity, 1966). Trend data from the National Assessment of Educational Progress (NAEP) has indicated that attempts to eliminate the gap have been numerous (Achievement Gap, 2011). These undertakings have included reducing class sizes, creating smaller schools, expanding early-childhood programs, raising academic standards, improving the quality of teachers provided to poor and minority students, and encouraging more minority students to take high-level courses (Editorial Projects in Education Research Center, 2011).

With every passing year, however, the damage continues to mount. The lower rates of high

school graduation lead to less employment, higher rates of incarceration, substance abuse, ill health, and intergenerational poverty (Washington State Legislature, 2008). It seems reasonable to suggest that other efforts should be considered.

It is important to note that a growing body of research suggests the importance of school culture, school climate, and school leadership. For instance, Freiberg (1999) who worked extensively in this area, described school climate as the heart and soul of the school and the essence of the school that draws teachers and students to want to be a part of it. Also, Strong (2002) reported that the classroom environment can either improve or impede a student's ability to learn. He further reported that classrooms that encourage emotional well-being also create an atmosphere for both learning and emotional development. He suggested that a warm classroom environment with an atmosphere of mutual respect, where students feel relaxed in expressing their thoughts and feelings, can lead to increased academic achievement, in addition to a sense of pride and belonging in the school. Moreover, DuFour and Baker (1998) concluded that the reform efforts of the last 30 years have failed because they did not adequately address the importance of the culture and climate of schools. This position was supported by Sarason (1996) who observed that structured changes made to improve schools without addressing the culture and climate of schools have predictably not been successful.

Consequently, there has been an increased emphasis on the importance of school culture, school climate, and school leadership. School culture and school climate describe the environment that affects the behavior of teachers and students. School culture is a concept which refers to the unwritten rules and expectations among the school staff. Schools where educators feel supported by their peers and administrators tend to have better student academic and behavioral outcomes (Brown & Medway, 2007). School climate, a related concept, is a product of the interpersonal relationships among students, teachers, families, counselors, and other school administrators. Positive school climate is cultivated through a shared vision of respect and engagement across the educational system and is an important target for improving behavioral, academic, and mental health outcomes for students (Thapa et al., 2013).

Dufour and Marzano (2011) noted the importance of school leadership. They examined how district, school, and classroom leaders can improve student achievement in *Leaders of Learning*. Dufour and Marzano named a major section of this work "Leadership is an Affair of the Heart," to illustrate the significance of leading by example and helping others to develop a sense of self-efficacy by becoming more capable. They asserted that leadership's dispositions and attitudes are contagious and will spread throughout an organization if the leader addresses pertinent issues and holds others accountable for growth and improvement. Also, Blase and Blase (2000) surveyed 800 American educators to gather information about the significance of effective school leadership. They asked teachers to pinpoint and describe characteristics and actions of principals who had contributed to the improvement of their classroom instruction and the impact this experience had on instructional practices.

Method

The design of this study emerged in response to the prevalence of the academic achievement gap in P-12 schools. The investigators developed a survey to gather

perceptions of the academic achievement gap in P-12 schools from educators and concerned citizens. The participants were school administrators, school counselors, school teachers, parents, and concerned citizens. They were asked to complete a self-report survey using an electronic platform (Qualtrics). Participants were contacted by e-mail and social media.

The survey instrument requested responses to two demographic items: (a) position as parent, school teacher, school counselor, school administrator, or concerned citizen; and (b) level of education. In addition, the last two items on the instrument requested written responses from participants. Each participant was asked to identify what he/she thought would be most effective in decreasing the academic achievement gap in P-12 schools and to make any comments, suggestions, or concerns regarding the academic achievement gap in P-12 schools. The investigators computed an item-analysis for the data from the instruments to provide percentages for analysis and comparison.

The investigators were particularly interested in the feelings of educators and concerned citizens who shared similar experiences and concerns. Consequently, they formulated these four research questions:

Does it appear that participants believe that more can be done to decrease the academic achievement gap in P-12 schools?

What are the basic themes perceived as important to decreasing the academic achievement gap in P-12 schools?

Do the perceptions of these themes differ significantly by specific participants (parents, school teachers, school counselors, school administrators, concerned citizens)?

Do the perceptions of these themes differ significantly among participants by their educational level?

Results

A questionnaire was designed to collect data from the study participants. A total of 136 respondents completed the survey. Of these 136 respondents 39 (28.68%) were parents; 17 (12.50%) were teachers; 2 (1.47%) were school counselors; 5 (3.68%) were school administrators; and 73 (53.68%) were concerned citizens. Moreover, of the 135 respondents who provided information about their educational attainment, 54 (40.00%) indicated they had a high school or G.E.D. diploma; 14 (10.37%) indicated they had a certificate or some college education; 14 (10.37%) indicated they had an associate's degree; 16 (11.85%) indicated they had a bachelor's degree; 21 (15.56%) indicated they had a master's degree; and 16 (11.85%) indicated they had an advanced degree.

Participants were asked to indicate their level of agreement with statements related to the Achievement Gap in P-12 Schools. For the first statement, "I believe more can be done to decrease the academic achievement gap in P-12 schools," 67 (49.26%) respondents indicated that they strongly agreed; 46 (33.82%) indicated they agreed; 13 (9.56%) indicated they somewhat agreed; 5 (3.68%) indicated they neither agreed nor disagreed; 2 (1.47%) indicated they somewhat disagreed; 1 (0.74%) indicated disagreement; and 2 (1.47%) indicated that they strongly disagreed.

For the second statement, "I think the required professional development for teachers should focus primarily on enhancing academic achievement," 57 (41.91%) respondents indicated that they strongly agreed; 38 (27.94%) indicated they agreed; 33 (24.26%) indicated they somewhat agreed; 5 (3.68%) indicated they neither agreed nor disagreed; 1 (0.74%) indicated somewhat disagreement; 1 (0.74%) indicated disagreement; and 1 (0.74%) indicated strong disagreement.

For the third statement, "I think teachers' annual evaluations should reflect the academic achievement of their students," 42 (30.88%) respondents indicated that they strongly agreed; 37 (27.21%) indicated they agreed; 37 (27.21%) indicated they somewhat agreed; 6 (4.41%) indicated they neither agreed nor disagreed; 7 (5.15%) indicated they somewhat disagreed; 2 (1.47%) indicated they disagreed; and 5 (3.68%) indicated that they strongly disagreed.

For the fourth statement, "I think school administrators should be specifically trained to impact the academic achievement gap in their schools," 61 (45.19%) respondents indicated that they strongly agreed; 49 (36.30%) indicated they agreed; 20 (14.81%) indicated they somewhat agreed; 4 (2.96%) indicated they neither agreed nor disagreed; 0 (0.00%) indicated somewhat disagreement; 0 (0.00%) indicated disagreement; and 1 (0.74%) indicated strong disagreement.

For the fifth statement, "I think each school should provide after-school tutoring in reading and math in grades 1-5," 77 (57.04%) respondents indicated that they strongly agreed; 37 (27.41%) indicated they agreed; 17 (12.59%) indicated they somewhat agreed; 2 (1.48%) indicated they neither agreed nor disagreed; 1 (0.74%) indicated somewhat disagreement; 0 (0.00%) indicated disagreement; and 1 (0.74%) indicated strong disagreement.

For the sixth statement, "I think elementary teachers in grades 1-5 should be trained to evaluate academic performance consistently, communicate necessary information to parents, and involve parents in writing enhancement programs for their children," 78 (57.35%) respondents indicated that they strongly agreed; 42 (30.88%) indicated they agreed; 8 (5.88%) indicated they somewhat agreed; 5 (3.68%) indicated they neither agreed nor disagreed; 2 (1.47%) indicated they somewhat disagreed; 0 (0.00%) indicated disagreement; and 1 (0.74%) indicated strong disagreement.

For statement number seven, "I think school counselors should lead the efforts to decrease the academic achievement gap in P-12 schools," 46 (34.07%) respondents indicated that they strongly agreed; 47 (34.81%) indicated they agreed; 21 (15.56%) indicated somewhat agreement; 9 (6.67%) indicated they neither agreed nor disagreed; 5 (3.70%) indicated they somewhat disagreed; 4 (2.96%) indicated they disagreed; and 3 (2.22%) indicated that they strongly disagreed.

Similarly, for statement eight, "I think it is important for school principals to support the efforts of school counselors as they work to decrease the academic achievement gap in P-12 schools," 77 (57.04%) respondents indicated that they strongly agreed; 42 (31.11%) indicated they agreed; 10 (7.41%) indicated they somewhat agreed; 2 (1.48%) indicated they neither agreed nor disagreed; 2 (1.48%) indicated they somewhat disagreed; 0 (0.00%) indicated disagreement; and 2 (1.48%) indicated that they strongly disagreed.

The first qualitative statement on the questionnaire asked participants to identify what they thought would be most effective in decreasing the academic achievement gap in P-12 schools. Results of the analysis of the responses from educators and concerned citizens indicate that most comments seem to fit into three basic themes. The basic themes for activities suggested for decreasing the academic achievement gap in P-12 schools were professional development or training for educators, relationship building, and student assistance. Statements that supported the need for professional development or training theme for educators were comments about the need for administrators, counselors, and teachers to complete specific training to impact the achievement gap; comments about the need for a system that involves everybody helping children to reach their goals; suggestions for stronger teacher preparation programs; and suggestions for more diversity and sensitivity training for educators.

Statements that contribute to the relationship building theme were comments about better teacher/parent relationships; collaborative and supportive culture among faculty and staff; and consistent, effective communication with parents. Meanwhile, statements that contributed to the student assistance theme were comments about more tutoring for students who need it, more help for students who are struggling, new teaching strategies, and more hands-on assistance for students on a regular basis. In addition, one comment suggested a need for teachers who genuinely want the achievement gap to decrease.

Responses to the second qualitative statement, "Please feel free to make any comments, suggestions, or concerns regarding the academic achievement gap in P-12 schools," and the responses to the first qualitative statement were similar and most seem to fit the same themes. For instance, comments that indicate a need for professional development or training are "specific training for school counselors and school teachers" and "train administrators, teachers, parents, and students for building interpersonal relationships to enhance achievement for all." Comments that seem to fit the relationship theme were "teachers need to communicate more with parents," "parents need to be more involved with the education of their children," and "teachers need to communicate all concerns about student progress to parents and not wait until February." In addition, comments that seem to fit the "student assistance" theme were "provide tutoring and keep parents informed," "provide tutoring, counseling, and educational resources for students," "students should receive individual assistance from school counselors when they are not doing well," and "some kids just need extra help with studying and learning the material that is being taught."

Results of the educators and concerned citizens' responses to all eight items on the survey indicate strong agreement with statements related to the Academic Achievement Gap in P-12 Schools. These responses suggest that educators and other citizens are concerned about the achievement gap in schools and feel that more can be done to decrease the gap. For instance, 92.64% of all respondents indicated that they strongly agreed, agreed, or somewhat agreed that more can be done to decrease the achievement gap in P-12 schools; 94.11% of all respondents indicated that professional development for teachers should focus primarily on enhancing academic achievement; and 85.22% of all respondents suggest that teachers' annual evaluations should reflect the academic achievement of their students.

In addition, 96.30% of all respondents strongly agreed, agreed, or somewhat agreed that

school administrators should be specifically trained to impact the academic achievement gap in their schools; 97.04% strongly agreed, agreed, or somewhat agreed that each school should provide after-school tutoring in reading and math for grades 1-5; and 94.11% of respondents strongly agreed, agreed, or somewhat agreed that elementary teachers in grades 1-5 should be trained to evaluate academic performance consistently, communicate necessary information to parents, and involve parents in writing enhancement programs for their children.

Moreover, 84.44% of all participants indicated that they strongly agreed, agreed, or somewhat agreed that school counselors should lead the effort to decrease the academic achievement gap in P-12 schools and 95.56% of all participants strongly agreed, agreed, or somewhat agreed that it is important for school principals to support the efforts of school counselors as they work to decrease the academic achievement gaps in P-12 schools. These results indicate that educators, parents, and other citizens are genuinely concerned about the academic achievement gap in P-12 schools and they believe that more can be done to decrease the gap. These results also suggest that school administrators should be specifically trained to impact the academic achievement gap in their schools and that they should support the efforts of school counselors as they work to decrease the academic achievement gap in P-12 schools.

The first research question asked, "Does it appear that participants believe that more can be done to decrease the academic achievement gap in P-12 schools?" Results of data analysis indicated that 92.64% of participants strongly agreed, agreed, or somewhat agreed that more can be done to decrease the academic achievement gap in P-12 schools.

The second research question asked, "What are the basic themes perceived as important to decreasing the academic achievement gap in P-12 schools?" Results of data analysis indicated that most comments seem to fit the basic themes of "professional development or training for educators, relationship building, and student assistance."

The third research question asked, "Do the perceptions of these themes differ significantly by specific participants (parents, school teachers, school counselors, school administrators, concerned citizens)?" The number of participants in each group is not the same; however, the results of the responses from all participants indicated strong agreement on the basic themes perceived as important to decreasing the academic achievement gap in P-12 schools (96.30% professional development or training for educators; 94.11% relationship building; 97.04% student assistance). This seems to indicate no significant difference by specific participants.

The fourth research question asked, "Do the perceptions of these themes differ significantly among participants by their educational level?" The number of participants in each group is not the same; however, the results of the responses from all participants indicated strong agreement on the basic themes perceived as important to decreasing the academic achievement gap in P-12 schools (96.30% professional development or training for educators; 94.11% relationship building; 97.04% student assistance). This seems to indicate no significant difference by educational level.

Discussion

This study examined the perceptions of school administrators, school counselors, school teachers, parents, and concerned citizens toward the academic achievement gap in P-12 schools. Achievement gap refers to the observed, persistent disparity of educational measures between the performances of groups of students, particularly groups defined by socioeconomic status (SES), race/ethnicity, and/or gender. The results of the achievement gap can be observed in standardized test scores, grade point averages, dropout rates, and college enrollment and completion (Engle, Bermeo, & O'Brien, 2006; McDonough, 2005; Public Agenda, 2010). Trend data from NAEP indicated that numerous attempts have been made to eliminate the gap; these undertakings have included reducing class sizes, creating smaller schools, expanding early childhood programs, raising academic standards, improving the quality of teachers provided to poor and minority students, and encouraging more minority students to take high-level courses (Achievement Gap, 2011; Editorial Projects in Education Research Center, 2011).

Although the achievement gap seems to have narrowed somewhat in recent years, the damage for minority students continues to mount (Achievement Gap, 2011). The lower rates of high school graduation lead to less employment, higher rates of incarceration, substance abuse, ill health, and intergenerational poverty (Washington State Legislature, 2008). Presently, most minority students in this country are denied the education they need to find meaningful and well-paying jobs, to thrive in colleges and universities, to participate fully in this nation's economic and civic life, and to join and continue the fight for a more just society (Wilkins, 2006).

Results of the responses from educators and concerned citizens indicate that 92.64% of participants strongly agreed, agreed, or somewhat agreed that more can be done to decrease the academic achievement gap in P-12 schools. Moreover, the first qualitative statement on the questionnaire asked participants to identify what they thought would be most effective in decreasing the academic achievement gap in P-12 schools. Results of the analysis of responses from participants indicate that most comments seem to fit into three basic themes. The themes for activities suggested for decreasing the academic achievement gap in P-12 schools were professional development or training for educators, relationship building, and student assistance. These data are important. The implication seems to be that different approaches must be considered to decrease the academic achievement gap in P-12 schools. These findings are consistent with a growing body of research that suggests the importance of school culture, school climate, and school leadership.

Freiberg (1999) described school climate as the heart and soul of the school and the essence of the school that draws teachers and students to want to be a part of it. In addition, Strong (2002) reported that classroom environment can either improve or impede a student's ability to learn. He further reported that a warm classroom environment with an atmosphere of mutual respect, where students feel relaxed in expressing their thoughts and feelings, can lead to increased academic achievement in addition to a sense of pride and belonging in the school. Moreover, Dufour and Baker (1998) concluded that the reform efforts of the last 30 years failed because they did not adequately address the importance of the culture and climate in schools.

These concepts are supported by Bulris (2010) who stressed the significance of school leadership. He clarified the role of school administrators by stating that "we must understand how a principal can shape the mediating factors such as school climate, school culture, and instructional organization, ranging from school policies and norms, to the practices of teachers" (Bulris, 2010, p. 29). In addition, Royle and Brown (2014) explored the significance of school leadership. They conducted a study that included an analysis of principals' perceptions of the academic achievement gap between African-American and white students. The three themes that developed from structural analysis of interview data were: (a) staff must build authentic relationships to increase students' intrinsic motivation, (b) needs driven instruction generates higher individualized student achievement, and (c) staff members require professional development to meet student needs. Furthermore, Dufour and Marzano (2011) noted the importance of school leadership. They asserted that the dispositions and attitudes of school leaders are contagious and will spread throughout an organization if the leader addresses pertinent issues and holds others accountable for growth and improvement.

Therefore, because of the documented significance of school culture, school climate, and school leadership, it seems reasonable to recommend the implementation of lead management principles in P-12 schools to focus on changing the school environment and enhancing academic achievement for all students (Wubbolding & Brickell, 1999). Lead management is the term William Glasser (1990, 1991, 1996) used to describe a democratic style of management and its accompanying communication skills. The lead manager is, in many ways, the opposite of the boss manager. A significant difference in the management styles of boss and lead management is that instead of relying on external stimuli of rewards and punishment to keep control; the lead manager involves students, faculty, and staff in decisions which affect them directly and indirectly. Lead management principles and the concepts of quality will not flourish in schools unless they are implemented at the level of the school principal (Glasser,1990).

The lead management system is based on choice theory which contends that all humans have five sources of internal motivation. These needs are:

Survival (physical needs),
Belonging,
Freedom,
Power or achievement, and
Fun or enjoyment (Glasser, 1996).

When these needs are fulfilled at school, students behave better, learn more, and see education as valuable and important to them (Glasser & Wubbolding, 1997).

Educators create an environment that is fun, friendly, and fair when they utilize the lead management approach. They implement the following three principles:

Elicit students' input. Use class or group meetings to get students' input on subjects relevant to a classroom or organization. Seat the students in a circle and ask them about what they think quality work is and how they would recognize it. Ask them about quality behavior and what rules should be established for the classroom (Glasser, 1990, 1991, 1992). It is important for students to feel that the teacher/counselor listens to them.

Moreover, eliciting student input helps to meet students' needs for power and freedom.

Learn and use the WDEP system of reality therapy (Glasser, 1965; Wubbolding, 1988, 1991, 1996). Reality therapy is a practical method of counseling used to help people take better control of their lives. This approach assists people in identifying what they want and what they need and then in evaluating whether they can realistically attain what they want or need. It allows them to examine their own behaviors and evaluate them with clear criteria. The acronym WDEP was developed by Wubbolding (2000) and is used to describe the basic procedures for this approach. Each of the letters in the system refers to a cluster of strategies: W=wants, needs, and perceptions; D=direction and doing; E=self-evaluation; and P=planning. These strategies are designed to promote change (Cory, 2013).

Focus on meeting students' needs rather than on controlling their behavior. Lead managers abandon questions about how to control students' behavior and ask more fundamental questions about how to help students meet their five basic human needs. When these needs are met for students, their experiences at school are more positive. At faculty meetings, lead managers relate the eagerness students feel for athletics, school clubs, art, and drama to the academic curriculum. They ask why students are eager to learn and work hard in some areas but not in others. Lead managers believe that with encouragement and support, students can be excited about learning and working hard in academic areas as well.

Lead management assumes that individuals in positions of authority avoid the seven deadly habits of criticizing, blaming, threatening, nagging, complaining, punishing, and bribing or rewarding for control. They are expected to replace them with the seven choice theory habits of caring, listening, supporting, contributing, trusting, encouraging, and befriending. Lead managers know that caring "costs nothing" and has a "huge return" (Glasser, 1998).

In summary, although further research is required to gain a more complete understanding of the reasons for the academic achievement gap in P-12 schools, findings from this study suggest that perhaps the problems with academic achievement for African-American and other minority students have more to do with a lack of intrinsic motivation than with external factors. This is consistent with the findings of Ohrt who worked extensively with groups of students who were struggling academically and at-risk of falling behind or dropping out of school (Meyers, 2015). He and his team researched which elements were most predictive of students' academic success or failure and found that social and emotional factors played larger roles than GPA's and test scores.

Therefore, with the understanding that school districts usually require in-service training for employees each year, it is recommended that school districts provide lead management training for all school personnel including school administrators, school counselors, school teachers, and school staff to enhance the school environment. It is also recommended that professional school counselors learn and use the WDEP system of reality therapy. These proposed changes have the potential to significantly decrease the achievement gap in P-12 schools. Perhaps, more important, there is reason to believe that these proposed changes have the potential to enhance academic achievement for all students while also creating a better educated and more equitable society.

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Brief Bios--

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HOW TO DELIBERATELY GET PEOPLE SEVERELY (POSITIVELY) ADDICTED!

Dr. Zachary Rapport

Abstract

This article describes an emotional/total behavior challenge I overcame by developing a positive addiction. It also presents an 8-step process to help create the conditions for anyone to potentially get addicted, 1-step to check on progress, and 1-step to verify an addiction.

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How to Get Everyone You Know Severely (Positively) Addicted!

I was living in Michigan when I decided to move to California. As the time to move drew closer, I started experiencing anxiety and panic attacks. The emotions were intense and unpleasant. To calm myself, I would temporarily decide not to move.

Then, for a number of reasons, I decided I was going to move to California no matter what! Since I made that decision, my next task was to deal with the anxiety.

I decided to put myself on a meditation program. I purchased several meditation cassette tapes. Every morning, as soon as I woke up, I meditated for 30 minutes. Every evening, just before I went to sleep, I meditated for 30 minutes again.

During the meditation, I laid on my back, listened to music, and focused on my breath. While I was meditating, I would get a pleasant “buzz” or “high”.

Within two weeks, I no longer experienced panic attacks or anxiety. I didn’t even feel mildly nervous about moving to California. In fact, at this point, I felt very strong mentally.

As I drove across the United States—from Michigan to California—I continued to meditate twice a day. When I arrived in California, I had no “adjustment pains”. It was a smooth and pleasant transition.

Hence, I believe that I had developed a positive addiction to meditation. That addiction gave me the strength to overcome my serious emotional obstacle to relocating.

Given my own experience with a positive addiction, I, in turn, wish to encourage others to also acquire a positive addiction. Notably, I have created a step-by-step process for helping people create the conditions that can lead to such a positive addiction. This process is entirely based on William Glasser’s writings.

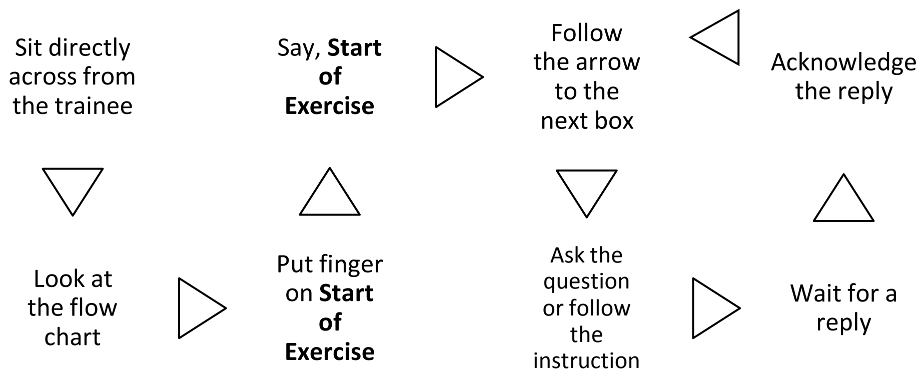
To start, define positive addiction for whomever you are working with. Then go through the questions in the order they are presented below. Adapt this process in whatever way works best for you and/or the people with whom you work.

General Instructions for This Exercise

Coach: A person who teaches and trains students and others (Webster's, 2011).

Trainee: "A person who is being trained in something" (Webster's, 2011, p.950).

How to Do the Exercises, Coach:



Tips for the Coach:

Anything in **bold**, say out-loud to the Trainee; Anything *not* in bold, quietly read to yourself.

In any exercise, your purpose is (1) to increase the trainee's abilities to do something and, (2) to have the trainee leave with the feeling that he or she has accomplished something. You are not trying to trick the trainee, make him or her wrong, or accomplish anything other than the above two purposes.

When the trainee is having a hard time answering a question, remain silent. Give the person space to think and struggle a bit with the question.

Ask the trainee the questions in bold. Follow the instructions listed underneath the question.

If needed, discuss how the person might overcome any challenges to meeting any step. If after a reasonably detailed discussion, the person just isn't going to meet the step, return to the first question to find a new activity. If the person can't meet the same step for any activity, then use your counseling skills to help the person self-evaluate and problem solve.

The Exercise

Positive addiction: a life-enhancing activity from which you experience a "high" and gain mental strength.

If you meet the 8 conditions below with an activity, you increase your chances of developing a positive addiction to that activity. Steps 9 and 10 help confirm whether you have a positive addiction.

The purpose of this exercise is to go through a step-by-step process to help you meet the conditions for developing a positive addiction.

Start of exercise:

Name an activity that involves no competition.
(If the trainee names an activity that involves no competition, move to question 2.

If not, repeat the question until you get an appropriate answer.)

Are you willing to devote about one hour each day to that activity?
(If yes, move to question 3. If no, return to question 1. If the person won't set aside one hour for any activity, then use your counseling skills to problem solve and have the person self-evaluate the value of gaining mental strength)

Would you sincerely choose to engage in that activity—as opposed to feeling forced to do it?
(If yes, move to question 4. If no, return to question 1)

Can you do this activity well with minimal mental effort?
(If yes, move to question 5. If no, return to question 1).

Can you do the activity alone?
(If yes, move to question 6. If no, return to question 1).

Do you believe the activity will benefits you physically, mentally, or spiritually?
(If yes, move to question 7. If no, return to question 1)

Do you believe by persisting in the activity you will improve at it? (Only you measure that improvement.)

(If yes, move to question 8. If no, return to question 1)

Can you engage in the activity without criticizing yourself? (Can you can observe yourself in the activity without concern as to whether you perform well?)

(If yes, do the activity. If no, discuss how the person might do it without self-criticism or return to question 1)

End of exercise

Follow–up Question to Check Progress

After the person has performed the activity on a regular basis, ask: **As you perform the activity, do you regularly go into a trance-like state?**

Follow-up Question to Verify Addiction

If you want to test whether you have a positive addiction, stop engaging in the activity for a

period of time and go back to the activity. **Did you experience withdrawal, pain, discomfort, anxiety or guilt that was only relieved by resuming the activity?**

(If so, the person has a positive addiction to the activity)

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Brief Bio—

Dr. Zachary Rapport has experience counseling people who take drugs. He has taught courses at colleges and universities since 1996. He has worked as a crisis counselor, and as a Chair for the Department of Counseling, Psychology, and Social Sciences. He holds a graduate certificate in Alcohol and other drugs from Western Michigan University and the following degrees: B.A. in Psychology, Michigan State University; M.S. in Mental Health Counseling, Nova Southeastern University; M.A. in Education, San Francisco State University; MPA in Public Administration, Kaplan University; and Ed.D in Education, Leadership, and Management, Alliant International University. He trained in Choice Theory with Carleen Glasser and Robert Wubbolding—Reality Therapy Certified in 2001. When he is not researching, writing, or teaching, he's hiking the trails and taking photographs of our beautiful regional, state, and national parks.

COUNSELLORS IN CRISIS MANAGEMENT: A MALAYSIAN CASE STUDY

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Lim Qiu Qin, and Douglas Teoh Shang En

As a country located on the Sunda Plateau, and a titular member of ZOPFAN, Malaysia has historically had few challenges that have required extensive and massive deployments of emergency social services. Yet, in recent years, notably since the Boxing Day Tsunami, the need for effective mental health crisis interventions is slowly being acknowledged in the field of disaster management. With increasing deforestation, urbanization and environmental change, various incidents, such as landslides and prolonged flooding have increased in recent years (Chan, 2012). This can be seen in the case of the Cameron Highlands landslides and separate cases of floods occurring on the East Coast of West Malaysia, and in East Malaysia in the last three years as reported by the media, where all support services were incredibly overwhelmed (Azim & Tharanya, 2014; AFP, 2014; The Borneo Post, 2014; Yu & Chua, 2014; Bernama, 2014; News Straits Times Online, 2015; Geraldine, 2015; Bernama, 2015; Daily Express, 2015).

2014, a painful year for Malaysians, and a turning point in the crises intervention field

On March 8, 2014, a Malaysian Airlines Boeing 777, with 239 passengers on-board, disappeared mid-flight, and is still unaccounted for more than four years after that event. In a separate incident, all 298 passengers on board Malaysian Airlines Flight 17 were killed when the plane was shot down over Eastern Ukraine. Adding to these airline tragedies, AirAsia's Flight QZ8501 crashed into the Java Sea on the 28th of December 2014 killing all 162 people on board.

Notably, the first two airline disasters have had a profound and tremendously negative impact on the intertwining ecological systems that make up the Malaysian society: on an economic level, a socio-political level, as well as on a psychological level. In fact, with its deeply traumatizing impact, it is not far-fetched to say that both the MH370 and MH17 events are entrenched in the Malaysians' psyche as a national trauma: as Chung et al. (2001) pointed out, disasters that occur on such a large scale can easily affect an entire community, and not simply the primary and secondary victims. Inevitably, aviation incidents also attract overwhelming public attention, particularly in cases where there is loss of life (Howell, 2015).

The short time frame in which both incidents occurred, the length of time spent on active searching and investigations, as well as the inexplicable mystery surrounding the disappearance of MH370 had an immense emotional and psychological impact on the next of kin, support personnel, mental health workers, as well as the whole Malaysian public.

In the case of MH17, when the caskets finally reached Malaysian shores, the victims were honored as patriots, and respect shown to their families in the wake of their demise. Yet, for the victims and of MH370 and their families, there has been nothing but silence. As there is no absolute evidence with regards to the fate of MH370, many counselors and psychologists who were responding to the crisis on the frontline found that the sense of ambiguous loss,

complicated grief, aerophobia and post-traumatic stress disorders emerged as a result of the disaster.

In response to that particular incident, the groups that were actively deployed to provide support and mental health services were the Malaysian International Counselling Association (PERKAMA) and the Tzu Chi Foundation. Teams from these two groups were involved in supporting the next of kin, caregivers and those impacted by the disasters; members were on duty initially for 24-hours, hours reduced to 14 hours after the first week. Between the periods of 11th March and 2nd April 2014, some volunteers clocked more than a hundred hours on site of their own volition. The challenge of supporting disasters of this scale, seemingly one after another, has been daunting for the relatively underdeveloped mental health units in Malaysia.

The safety net of hope

In thinking of the chaos that emerged in the wake of such incidents, imagine, for a moment, the initial moment of panic upon hearing the news of the plane's disappearance. Imagine a situation in which the families of the missing passengers have waited fruitlessly for many weeks, hoping against hope for some good news, even with little credible information on the safety, location or status of their loved ones. Imagine then, their hope slowly ebbing away as despair sets in, as harsh pain and reality sets in upon them.

They often asked of us, "I know they are alive... what can we do?"

How does one answer a question such as this? How can we, who must provide them with mental and emotional support, begin to frame a comforting yet realistic reply, and all without imposing our thoughts and beliefs on them? What could we do to provide them with a safety net, some semblance of hope against all hope, to prevent them from further crashing into despair and trauma?

These were important questions we had to consider. In their study, Chung et al. (2001) noted that secondary victims of an incident involving a derailed train did poorly in terms of psychological wellbeing and their ability to function normally even 15 to 18 months after the incident. In the case of MH370's secondary victims, that is, the families and friends desperately waiting for word of the missing passengers, it was only natural for them to experience a sense of ambiguous loss: when faced with a situation outside normal human experiences without any closure, victims are likely to be traumatized, immobilized and unable to understand what has happened, leading to a blockage of their normal coping mechanisms (Boss, 2009).

Given a situation in which the responders were faced with clients who had no access to any meaningful information, little to no control over their situations, and in every practical sense, had almost no rational hope of a positive outcome, there were moments when all we could do was pray with them, regardless of religious and personal beliefs. There were numerous instances when I simply sat with Buddhist, Muslim and Christian clients in respectful silence, as they chose to take comfort in prayer. In this way, in the absence of a secure external refuge for comfort, their belief systems contributed to meaning making, which allowed for the processing of cognitive, social and existential adjustments that was needed in managing their losses (Hibberd, 2013).

As the sense of disempowerment and hopelessness was extremely high, the ability to pray together despite cultural and religious differences appeared to provide relief and gave them a strange sense of hope in the face of an overwhelming situation. Hopelessness is a predictor of suicidal behavior; thus, even though prayer seems to be a small respite in the face of the larger ordeal, generation of hope activities such as these is exceedingly important in preventing abject hopelessness from setting (Klonsky et al., 2012). The physical act of praying together assisted them in relaxing tensions and normalized breathing patterns. In fact, cognitively speaking, their awareness is shifted from its focus on helplessness to focusing on a chance at hope; this helped the clients to step away from the sense of being overwhelmed, in turn helping them to reduce stress. In this way, belief and faith scaffold the experience of trauma and loss, allowing for meaning to be reconstructed internally (Kurknel et al., 2014; Neimeyer et al., 2014) in an externally senseless situation.

Through my experience on the frontline, I find that a critical factor in applying prayer in crises is to ensure that the prayer is carried out in a way that fits with the clients' belief system. While it is not the only tool nor absolutely necessary, it is potentially a very effective means of offering support to receptive clients. This means allowing the client to lead the prayer, while the counsellor moves into a listening or supporting role. In the Malaysian context, respectfully and gently asking for the client's faith is socially acceptable. However, if the client does not believe in a supreme entity nor in any form of the supernatural, responders should drop the topic of religion altogether. Instead, breathing techniques, physical movements and formula repetitions, secular techniques that have a similar biological and cognitive impact as praying, can be utilized.

Furthermore, this is not limited only to the people directly affected by the incident: the setting up of well-wishing message boards in public spaces, and the creation of Facebook pages calling on Malaysians to pray for MH370 allowed Malaysians to face the trauma collectively, in

solidarity. As the US National Center for PTSD (2016) observed, resilience grows in the wake of all disasters, and can be taken as a challenge to learn to handle crises effectively. One way of increasing this resilience is to build connections to bridge gaps between groups and communities (Aldrich & Meyer, 2014). As Aldrich and Meyer (2014) have pointed out, social capital, that is, the sense of fellowship, good will, mutual sympathy, and social interaction amongst families and individuals, have a deep impact on the resilience of a community as a whole, by becoming the framework upon which communal cohesion can grow. In fact, they also concluded that social capital is equally, if not more important in a crisis as physical and infrastructural preparations against disasters.

Malaysian counsellors working during the crisis: key learnings

Having logged just over a 100 hours during the MH370 crisis, as well as involving myself in crisis work during the East Malaysia floods, responding to suicide incidents and familial crisis situations these are some key learnings that I would like to discuss further:

Firstly, on the matter of lending presence. Presence, in this sense, indicates not merely being physically and cognitively available to clients, but rather an empathetic presence which encompasses components of active listening, employing silence, and emotionally supporting the other (Altmaier, 2011). A crisis situation is not a normal therapy situation;

thus, crisis responders should not apply only the usual techniques or interventions during the crisis management phase. The task of the responder is to be there for the clients, to provide support and link the clients to the services available for them during this turbulent period. Simply put, crisis interventions are crafted around the idea of returning those who are overwhelmed to an acceptable level of functioning, not for the responder to conduct mental health interventions. In this way, the responders' positions as an empathetic presence who can support the clients' return to calm and control is essential.

Secondly, crisis response requires responders to have a variety of skills to be effective. This is of particular note, as those who are in the grip of stress may not seek out support on their own. Responders should be pro-active in identifying those in need, as well as be able to effectively provide accurate and necessary support. As an example, in a case that particularly stood out, I found an elderly man pacing in the corridors while waiting for a situational briefing. He was angry, frustrated, and obviously agitated. Given his emotional state and profile as an elderly male, we requested support from a senior male counsellor, and took the opportunity to observe him in action.

Notably, my colleague chose to stand near, but not in the client's personal space, directing his attention to his mobile phone, and appearing to be uninterested in the client. Keeping himself visibly relaxed, he slowly inched into the client's space, radiating a sense of calm, despite the tension coming from the latter.

This continued for about 10 minutes, while we kept other well-intentioned--but less mindful volunteers--from interrupting. Feeling the supportive presence the client on his own accord decided to turn to the counsellor and greet him, the latter immediately put his phone away and engaged with the client. In this way, he was able to circumvent a potentially strongly emotional incident. I cite this case as an example of the numerous levels and varieties of skills that should be applied in such situations: team work between responders, a basic, but strong understanding of human nature, and above all, the ability to exude that calm sense of presence while being able to fit their intervention skills in a way most beneficial to the client.

As victims of trauma are more likely to experience acute stress, it may result in a situation where those undergoing trauma end up ignoring their basic needs. Conversely, there is also the possibility of them focusing entirely on their own needs while ignoring the needs of those around them. A check for the fulfillment of these needs and further observations of client behavior to identify other unspoken needs is required to manage a situation that is highly prone to stress. For instance, during the peak of a crisis, many often get too tense to sleep. Crisis responders must be able to identify these individuals from their physical behaviors, as well as know ways of approaching them tactfully and be able to convince them that a 'break' will not disrupt their work. The responders may then also need to lead the client into a session of relaxation with breathing techniques, especially with those who are too stressed to sleep or unwilling to go off their duties. This can be carried out in whatever location that is available and suitable provided that their methods are effective enough to give immediate physical relaxation.

Acute stress may cause clients' internal coping mechanisms to be overworked, resulting in intense emotional outbursts and feelings of being overwhelmed. Face-to-face sessions with a counsellor allows for a safe space for clients to express their emotions (Vlasto, 2010). It is

necessary for those who have experienced such incidents to not suppress these emotions and extreme feelings in order for them to work on returning to a "normal state," so that they can continue to function without breaking down further. It is also necessary to assure clients that complex and overwhelming emotions during disasters are normal, and that their heightened emotions do not mean that they are crazy, but instead that they are normal human beings attempting to cope with an extremely abnormal situation. Indeed, it must be emphasized that growth can take place even in the face of trauma, and help to further cultivate positive elements in individuals, such as altruism, coping and resilience (Disaster Mental Health Response Handbook, p. 28, as cited in National PTSD Center, 2016). This concept is referred to as 'posttraumatic growth' by authors such as Calhoun (2000, as cited in National Center for PTSD, 2016).

One particularly critical ability that is necessary for those who supported the victims during the various crisis in Malaysia was the ability of the responders to hold a safe emotional space for the client. From my experience in managing the crisis situations, holding a client's emotional space refers to the ability to empathize without being overwhelmed, by using silence to provide a space for the victims to express, connect and relax. In this sense, holding a client means that even with chaos occurring in the background, the responder should give their client their full attention, and provide a space for them to tell their stories, with the full trust that they will be heard without judgement. Finally, holding a client emotionally also means that the responders must be able to manage the clients' intense emotions as they confide in them, until they are finally able to distance themselves from the situation and return to some level of functioning (Elrod et al., 2006). In short, the counsellor must convey the message, "It is safe for you to share and express, trust me to respect your emotions, and together find a way to manage the emotionally overwhelming event."

On teams and team leadership

Having discussed the skills and expectations required of a crisis responder, I would now like to discuss the other duties that counsellors and responders have to take on, in addition to their role as mental and emotion support to clients. I am referring to, of course, the way in which teamwork should be organized, and what can be done to ensure that work done in the background goes smoothly, so as to keep everyone's workload to a manageable level. For example, in their paper, Elrod et al. (2006) discussed the challenges of forming a cohesive disaster mental health service team, noting that teams are often formed from individuals of varying levels of experience and backgrounds. In this sense, if issues such as confusion, boundaries, gaps in communications, in addition to the stressful nature of the work, limited resources are not dealt with, team morale may suffer and thus interfere with the prompt delivery of service (Elrod et al. 2006). Case in point, I would like to emphasize that while it is important to note that individuals dealing with crises must to be able to think on their feet, they must, at the same time, always bear in mind they are part of a team. Many practices that seem unimportant on their own, instead form a firm foundation for a system that can run with minimal complications; these include logistics planning, such as responder scheduling, the assignment of team leaders and their duties, and establishing reliable methods of contacting and verifying team members' identities. In terms of counselling practices, a consistent client contact record system must be created. Even the practice of using consistent formatting is important, as is maintenance of the records and logs, which must include records of handovers, incident reports and responder support

activities, complete with case notes. Of course, this all requires careful attention and coordination.

Additionally, team leaders play a very important role in holding a team together, and ensuring that the intervention is carried out as smoothly as possibly. While it is human and understandable for mental health responders to wish to help and work with clients directly during a crisis, those who are in a position to lead must prioritize the management of their teams. For example, the task of a team leader in these situations is to ensure that the system functions to protect clients, volunteers, the management teams, as well as any other organizations involved in dealing with the crisis. All paperwork, from scheduling sessions, monitoring of responders' health and well-being, to incidents such as potential individual altercations should be directly under the area of team leader responsibility.

To complicate a crisis situation further, with high profile cases, the media is often a very strong presence, to say nothing of visiting dignitaries. Managing the needs of various departments and bodies in complicated emergency situation is a delicate balancing act on its own, and as such, if team leaders are not available to make important decisions when necessary, it can potentially lead to situations where other team members are forced to make decisions on their own. As regular volunteers rarely have a clear understanding of the over-all situation, the repercussions of uninformed decisions made by those with a limited understanding of the bigger picture may negatively impact the system as a whole. It is imperative that team leaders be aware that their main task is to manage the team, not individual clients. While this may not be the most interesting nor fulfilling of duties for mental health workers who prefer to see clients, leadership is amongst the most important role, and necessary to ensure that the whole system can operate with as few issues as possible.

Besides team management, inevitably, the team leader's duties include the unenviable task of dealing with paperwork. This is of particular note, for, during crisis situations, paperwork serves two important purposes: Firstly, to ensure that clients (who may be seeing different counsellors) have some consistent form of records of services that have been provided to them. Secondly, service providers and volunteers need to be able to protect themselves from complaints or accusations, in order to avoid potential litigator issues. In a prolonged crisis situation, it is imperative for all management teams to ensure that they have consistent, complete and clear records of the services provided to clients and/or their family members. This is no different from standard practice, where clients' records must be made, in order to be able to track the history of all services related to physical and mental health provided. However, during a crisis, victims and family members may refuse services for numerous reasons; in cases such as these, given rising litigations, especially in high profile incidents, it is advisable that a record of the services recommended, offered and duly refused by victims be kept. This step aims to develop a comprehensive profile of the victim, as well as serving as a means of protecting the responders by providing proof of steps taken to offer assistance.

To reduce the responders' stress and workload, the basic paperwork structure must be simple, consistent and straightforward. For example, a single record sheet with tick boxes for each client with a space for short notes or feedback may be easier to fill in, rather than an open-ended blank form. As part of their role, team leaders should also watch out for burnout and compassion fatigue amongst their teammates. Team debriefing conducted in a

friendly, rather than formal spirit, adequate breaks and meals can also help to promote a sense of camaraderie and mutual support that is important for the responders' well-being.

Conclusion: expectations for responders

In the case of inexperienced responders, in order to avoid a negative psychological impact on their psychological well-being, it is imperative for them to receive pre-crisis training. This is to prepare them by providing them with realistic expectations of what to expect during the crisis, information on the situation and psychological preparedness gives volunteers a sense of predictability and control over the situation, resulting in less burnout.

Crisis and disaster response is not an area for enthusiastic, if well-intentioned, individuals who have little to no experience or knowledge of crisis management and in working with those in trauma. Numerous published accounts have noted that well-meaning, but unsolicited volunteers have become one of the main sources of chaos in disaster-struck settings (Elrod et al., 2006). This is a situation often seen in the case of crisis responses; for example, despite the massive deployment of thousands of mental health professionals and volunteers during the 2008 Sichuan Earthquake, the responders were still overwhelmed, primarily because a vast number of them had no specific training and experience to handle the post-disaster chaos in a collaborative and coordinated manner (Ng et al., 2009).

Naturally, this was also a problem faced by the Malaysian crisis teams: what we lacked was not the numbers willing to offer support; rather, it was the overwhelming number of volunteers who did not have the skill to match their enthusiasm, leading to the necessity of spreading out resources to manage these untrained volunteers.

In cases such as these, I would like to suggest a closer look at the competencies of our crisis response support systems, as inappropriate interventions, however well meaning, can often be counterproductive, and even result in further traumatization of the victims (Ng et al., 2009). In this sense, mental health and support personnel must always be able to maintain a sense of calm and professionalism, so as to reduce their clients' stress. While innocent enough under *normal* circumstances, some volunteers' behaviors, such as taking selfies and group photos, as well as cracking in-jokes at the wrong moments, actively annoyed and upset observing victims who were already highly stressed. My own observations noted that the general state of high spirits and excitement of new untrained teams which upon entering the situation half-way *increased* the tension of the situation. What semblance of calm that had been achieved was overturned in mere moments by these responders' high energy, and this was enough to cause the victims' own sense of tense energy to overflow. In no way does this contribute positively to managing a crisis situation. Instead, the ability to exude a calm presence, to work cohesively in a team, adhere to disaster protocols, skilled application of techniques and flexibility in identifying and responding to changing needs are the skills essential crisis intervention.

As such, I will conclude that one of the main learnings that has arisen from this situation is that pre-training is absolutely essential for all volunteers brought into a crisis hot-zone area. To achieve this end, I also suggest a closer look at mental health training programs designed to manage large scale disasters, such as the national disaster mental health training program conducted in Sichuan, which included a mix of workshops, lectures, panel discussions, role play, as well as direct supervision (Ng et al., 2009). Also, as responders

themselves are not immune to post-traumatic stress and sense of disruption, interventions need to be tailored to the different responder groups managing different roles, especially in relation to countertransference and secondary traumatization, as it is just as important to facilitate the well-being of our mental health providers, as well as our clients (Levy et al., 2004).

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GRIEVING THROUGH ART EXPRESSION AND CHOICE THEORY: A GROUP APPROACH FOR YOUNG ADULTS

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Abstract

Grief, part of human development, is a result of loss and/or change. Counselors have understood emerging adults as an age group that may struggle severely with the management of grief. Helpers geared towards assisting adolescents are highly encouraged to provide ample support to grieving individuals. Research supports that the application of expressive arts in combination with group therapy and Choice Theory may be a suitable therapeutic approach used to best support grieving young adults. The following article outlines the implementation of a grief art therapy group that integrates Choice Theory while focusing on young adults, ages 18-24 years old.

Keywords: grief, young adults, art expression, Choice Theory, group therapy, non-profit agency

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Grief, an acceptable response to loss, is often mistakenly approached by society through the lens of the medical model (Zaslow, 2005). The medical model continues to be the leading standard used to manage psychotherapy. This model views psychotherapy as a clinical treatment in contrast to a healing interpersonal relationship (Elkins, 2016). When managing grief, it is important to recognize that grief is a part of human development across the lifespan. Healing through what may be an extremely difficult process is often stimulated by the presence of rapport between humans and not strictly through modalities and techniques (Elkins, 2016). While modalities and techniques should be addressed, counselors are highly advised to validate and emphasize human factors when establishing a treatment plan for assisting individuals managing grief (Elkins, 2016).

One theoretical foundation that aligns with the validation and emphasis on relationships and connections is Choice Theory. According to Glasser (1998), Choice Theory is an approach that focuses on the development of support and quality relationships with self and others. Grief, a process that is individually unique in nature and exists without an identifiable timetable or process of completion (Centre for Palliative Care, 2000), may be approached within a group setting with the implementation of Choice Theory principles and art expression (Ferszt, Heineman, Ferszt, & Romano, 1998; Glasser, 1998; Hart, 2012; Rogers, 2007; Zaslow, 2005). Basically, it appears that grief work within a group setting can provide a unique and meaningful experience.

The processing of grief is influenced by personality, cultural norms, religious and spiritual beliefs and values, relationship to the deceased, and meaning-making (Doka, 2007). Research suggests that counseling groups may focus on the process of each group member's grief within a context of personal growth and recovery (Bochino, 2009; Ferszt et al., 1998; Geron, Ginzburg, & Solomon, 2003; Rogers, 2007). The use of creative arts and

Choice Theory as a therapeutic avenue for individuals to communicate that which cannot be communicated through words makes for an ideal integration to group therapy when working with grieving clients from all backgrounds. This process and therapeutic framework aids to foster healing, love and belonging (Ferszt et al., 1998; Glasser, 1998; Hart, 2012; Molina, Monteiro-Leitner, Garrett, & Gladding, 2005; Rogers, 2007; Zaslow, 2005). The combined efforts of group, Choice Theory, and art therapy encourage a more inclusive model that may potentially address healing using interpersonal connection and interaction through expressive arts while not placing the emphasis on modalities and techniques prescribed by the medical model. The following provides a framework of art, Choice Theory, and group therapy to support grieving individuals, ages 18-24 years old.

Grief and Choice Theory

Life contains much opportunity for loss. Death, divorce, relocating, job loss, changing schools, and chronic and terminal illnesses are a few of the many examples of loss. Grief, part of human development, is a result of loss and/or change (Hart, 2012). Grief is defined as the internal reaction to loss, while mourning is the outward display of grief (Rogers, 2007). The engagement of the two is known as bereavement (Rogers, 2007). Notably, grief is generally believed to affect individual functioning, work ability and interpersonal interactions (Hart, 2012; Rogers, 2007).

As a loss may be difficult to understand and reconcile, helping individuals rationalize, cope, create memories and interpret, can be challenging in individual therapy. Establishing a group setting provides the opportunity for diverse dialogues around the complexity of processing grief and lends itself to creating healthy and supportive relationships. A group setting, in conjunction with Choice Theory principals, can fosters the basic need of love and belonging, which is needed for individuals seeking to cope with loss (Gladding, 2016; Glasser, 1998).

The processing of emotion, thought, and behavior may become more difficult while grieving. During a time where the goal may be to resolve confusion and pain, individuals may benefit from self-assessment of their total behavior. Dr. Glasser (1998) identified all behavior as total behavior. All parts of total behavior, actions, thoughts, emotions and physical movements, are driven by the hunger to fulfill individual needs and wants (Glasser, 1998). Groups integrated with the therapeutic principles of Choice Theory may seek for an opportunity to engage in this much-needed self-reflection and planning. These groups offer emotional support, encourage self-reflection, commitment, inspire the describing of difficult emotions and behaviors, provide empathy from members, and increase self-help experiences through the helping of others (Gladding, 2016; Glasser, 1998).

Often, individuals may try to manage grief independently, fearing the lack of understanding from their peers or others. They may attempt to disengage or let go. However, doing so may prematurely interrupt the process of grief and can inhibit the need for closure (Rogers, 2007). Disengaging neglects the need for any form of continued relationship with the person that has passed and dismisses self-reflection. Support navigating how to best satisfy one’s needs during a time of grief may be necessary. Choice Theory believes that people are internally motivated (Glasser, 1998). To identify needs, one must engage in self-reflection and distinguish between what is happening internally and externally (Glasser, 1998). Only then can people act on this acquired information and best achieve their needs. While there

are no set rules or steps that one must work through or achieve, people are encouraged to process grief to establish long-term well-being (Centre for Palliative Care, 2000; Ferszt et al., 1998; Geron et al., 2003; Hart, 2012; Rogers, 2007; Zaslow, 2005).

The process of bereavement involves the use of coping skills responsible for the expression of behavior, cognition and emotion (Bocchino, 2009). Having these readily available to help process the loss of a loved one can often become a difficult task, especially for young adults who are already fully occupied by managing various other concerns that accompany the ripening phase of adolescence (Arnett, 2000; Janowiak, Mei-Tal, & Drapkin, 1995). When collaborating with grieving young adults, helpers are highly encouraged to promote an adequate grieving experience that will yield positive psychological functioning and assumptions of self and the world (Bocchino, 2009; Rogers, 2009; Wallace, n.d.). Group counseling, Choice Theory, and art expression are all valuable resources to consider when working with young adult clients managing grief.

Group Therapy

Groups, an important part of everyday life, are defined as in-person or virtual gatherings between two or more people collaborating interdependently, conscious of mutual membership, who hold a focus on achieving mutually agreed upon objectives (Gladding, 2016). Groups have been an ideal resource for individuals managing issues that may come with depending upon various life events, such as grief. They help individuals manage transitions and/or life events and changes. Groups serve diverse purposes and may cater to diverse individuals. Most importantly, counseling groups focus on providing members with preventative and remedial techniques, and are growth-oriented in nature (Gladding, 2016). For decades, group counseling has been a sought-after technique to assist individuals managing grief (Geron et al., 2003; Gladding, 2016; Hart, 2012; Rogers, 2007; Schwartzberg & Jannoff-Bulmon, 1991; Wallace, n.d.). Their objective to eliminate mental disorders and excessive stress that may impair functioning is certainly important to individual well-being (Hart, 2012; Rogers, 2007; Wallace, n.d.).

Groups become involved in grief work because it provides the potential for members to experience feeling loved and being understood while providing participants the opportunity to exchange support between their peers (Ferszt et al., 1998; Geron et al., 2003; Gladding, 2016; Glasser, 1998; Rogers, 2007). They offer an environment that promotes the processing of personal growth and recovery (Ferszt et al., 1998; Geron et al., 2003; Gladding, 2016; Rogers, 2007; Wallace, n.d.). Groups encourage the expression of complex emotions following the death of a loved one are an ideal learning environment for the acquisition of various coping skills (Bocchino, 2009; Ferszt et al., 1998; Geron et al., 2003; Gladding, 2016; Hart, 2012; Rogers, 2007; Schwartzberg & Jannoff-Bulmon, 1991; Wallace, n.d.; Zaslow, 2005). They serve as a support system where a sense of universality is established (Geron et al., 2003; Gladding, 2016). Implementing Choice Theory principles within a group setting has the potential of fostering love and belonging while restructuring an individual's quality world (Glasser, 1998). Quality world is defined as an individual's idea of how their world ought to look and be (Glasser, 1998). Generally, an individual's quality world will influence behavioral choices to preserve what one has enjoyed most in life (Glasser, 1998). Application of Choice Theory principles within a group setting fosters an environment of self-evaluation and increases the likelihood of responsible goal achievement (Gladding, 2016; Glasser, 1998).

Young adults ages 18 to 24 tend to seek groups to meet remedial needs, address concerns, and establish emotional support and growth (Bocchino, 2009; Gladding, 2016). Young adulthood is a time of much transition and change. Groups are an invaluable resource that may aid struggling individuals through the difficulties that come with daily living, including grief. When working with young adults who may be challenged by grief, it is highly advised to get them connected to some form of counseling and/or support services. Grief groups provide a safe environment in which members may discuss issues related to bereavement, mourning, loss, separation, coping and adaptation (Geron et al., 2003; Rogers, 2007; Wallace, n.d.). The group process serves as a place in which members' feelings may be validated, fears are understood, and needs are justified (Wallace, n.d.).

Art Therapy

Human experiences, and their portrayal through creativity and the arts, are vital. Across cultures, individuals search for their sustained connection with others and their meanings of life (Molina et al., 2005). The arts can promote healing despite their lack of power to cure. Art may serve as a tool to express what may often seem as inexpressible (Rogers, 2007). Creativity is a tool that allows individuals to dig deep into the unconscious and explore this complicated concept. Art therapy is described as a profession that blends therapy and the creative expression to promote individual development and processing of concern and/or conflict (Edwards, 2004). It can establish a safe environment where individuals may express complex emotions, gain a sense of control, and reshape how one sees the self (Ferszt et al., 1998; Hart, 2012; Molina et al., 2005; Rogers, 2007; Wallace, n.d.).

Studies support the notion that art expression within a group counseling setting establishes a natural path for members to express complex emotions associated with grief safely (Ferszt et al., 1998; Rogers, 2007). A pilot study by Ferszt et al. (1998) supported that running a grief group using an arts expression curriculum empowers members to manage complex emotions, such as anger, in a more acceptable manner after an eight-session commitment. Members of this study reported that the experience was a great way to incorporate bliss and spontaneity to the group process, establishing a balance to the seriousness of traditional self-help groups (Ferszt et al., 1998). The art activities were reported to help create a safe environment, which encouraged the expression of sorrow and anger. Outside of the group setting, art creation became an outlet for many of the members. The products became something to reflect upon for comfort during difficult days.

Revalidating individuals across cultures with their impact and capacity to live and enjoy a more fully human experience seems to be provided by multicultural creative art interventions, while at the same time creating an opportunity to disconnect from unhealthy and superficial dynamics (Molina et al., 2005). Processing grief, though it may be extremely difficult, is a need to promote individual well-being (Luecken, & Appelhans, 2005). Mental health concerns such as depression, decreased self-esteem, and a lack of locus of control have been reported in children who have experienced the loss of a parent (Lutzke, Ayers, Sandler, & Barr, 1997). Helpers are highly encouraged to identify resources that may best support individuals having trouble coping with loss. Support groups whose curriculum incorporates principles of Choice Theory and art expression are an invaluable resource that young adults may use to achieve the following: (1) come to accept the loss; (2) process and grow through pain and grief; (3) adjust to the new environment that exists without the departed; and (4) emotionally relocate the deceased and reconstruct a future and quality

world (Gladding, 2016; Glasser, 1998; Rogers, 2007).

Group Model

Group Participants

The Choice Theory and art expression grief group participants should include eight to ten pre-screened young adults from community mental health/counseling agencies. The participants, male or female, ideally will be between the ages of 18 and 24 and have experienced the death of a loved one in the last three years. All participants should meet the following criteria:

Experiencing waves of painful feelings blended with positive memories of the deceased.

Experiencing difficulty talking about the deceased.

Identify a lack of support processing painful feelings associated with the loss.

Express interest in modifying patterns of grief expression, improving well-being and increasing emotional stability.

Report feelings associated with grief that contribute to life hardships and/or setbacks.

Appear comfortable working in a group setting.

Do not report suicide ideation.

Do not experience complications in their grief or demonstrate other psychological symptoms.

Group leaders are professionals who are fully versed in the process of grief counseling and are knowledgeable of ways to best serve group members (Gladding, 2016). It is also imperative that group leaders be experienced with the use of therapeutic art activities and have a working understanding of the concepts of Choice Theory and the integration of the theory in group counseling with therapeutic arts activities.

Group Format

Ideally, the group will meet for a total of eight sessions during the span of two months. The group will utilize a mixture of art and narrative therapies. Research supports that art expression may establish a natural avenue for individuals to express complex emotions safely (Ferszt et al., 1998; Hart, 2012; Molina et al., 2005; Rogers, 2007; Zaslow, 2005). Engaging in the process of art creations requires a great deal of cognitive and aesthetic concentration. Due to the many complex emotions that accompany grief, individuals may experience a difficult time being able to concentrate or feel a lack of control. Nonetheless, the requirement of shaping and exploring one's artistic creations can provide individuals with a feeling of achievement and agency during a time in which other parts of life may seem chaotic (Ferszt et al., 1998). The use of oral and written communication techniques are helpful tools that may help manage grief and loss because they allow individuals to

process and reconstruct their "meaning of life" (Rogers, 2007).

Group Session Plan

The following is a layout of the curriculum that will be covered during each one of the eight sessions. The authors would like to credit Dr. Glasser for the theoretical foundation of Choice Theory used in the group along with Stangline's 2015 *Creative Counseling 101* publication and the Emerlye's *Opulent Arts* website published in 2015 for the creative ideas that helped shape the group curriculum. Detailed citations may be found in the reference section.

All sessions will begin with a brief check-in using a rounds approach to address how members have been processing during the last week (Gladding, 2016). Art activities will take place for 10-30 minutes while the remainder of the 90 minutes will be spent processing and sharing. All members will be given the opportunity to share on a voluntary basis. Group leaders will proactively maintain a safe space for all participants.

Session 1: Welcome: Understanding grief: How the group defines grief.

Introductions and sharing of personal goals will be followed by an overview of the Confidentiality Statement. Discussion will revolve around the following questions: What is my definition of grief? How has my quality world changed since losing my loved one? The last ten minutes of session 1 will be reserved for the Mandala coloring activity. Materials for the Mandala creation activity include: various Mandala drawings on 8.5 by 11-inch paper, coloring pencils, and piano music playing softly in the background. The activity aims to introduce members to art expression while providing members with an opportunity to focus on the present, reflect on first session experience, and engage in a relaxing activity prior to ending session one.

Session 2: Looking in the mirror: Let us portray how others think "I" am processing and how "I" am processing.

On a cardboard cutout in the shape of a mirror, participants will be able to place color, text, pictures, etc. to depict how they feel others see them processing the loss of their loved one. On the opposite side of the cutout they will depict a self-reflection of how they perceive they may be processing. Participants may share orally and/or by demonstrating their finished product to the rest of the group. Participants are encouraged to identify what they need and how they plan to achieve their basic needs in relationship to processing grief. Participants will be guided though this activity following the WDEP framework. The acronym WDEP stands for W=wants and needs; D= direction and doing; E= self-evaluation; and P= planning (Wubbolding, 2000). The WDEP framework originates from reality therapy, a counseling approach using Choice Theory, and serves as a tool to assist clients in realizing how to effectively take control of their lives to best achieve their needs (Wubbolding, 2000).

Session 3: Letting ships take sail: Identifying which emotions to anchor and which to set free.

Members will be asked to focus on the statement: I grieve by… and are asked to write down their emotion/s on pieces of paper cut out in the shape of a ship. Some will have anchors

and others will not. The anchors will symbolize emotions that individuals are struggling with, while ships without anchors will symbolize emotions individuals have learned to manage. Members will then be given the opportunity to share as they wish. The activity aims to get members to name their emotions while identifying which are helpful to release and which are painful and/or difficult to do so. This activity aims to explore the idea of total behavior, another principle of Choice Theory. Total behavior represents all behavior and is made up of four mechanisms: acting, thinking, feeling and physiology (Glasser, 1998). Total behavior is purposeful and aims to achieve personal needs and/or desires (Glasser, 1998).

Session 4: From start to finish: Narrating our stories and introducing those we have lost.

Participants will be asked to share a short memory/story that they feel represents the relationship he or she shared with the departed. The narrating of the story may be done through text, orally, and/or pictures. Participants will be encouraged to share the impact that the story had on them as it took place and how it has shaped their present situation.

Session 5: Big enough questions: Remembering our loved ones.

Members will be asked to focus on the following three statements regarding the departed:

Our fondest memory is…

I wish we could have…

My biggest regret is...

Participants will all then be asked to draw and/or write down their completed statements on a large piece of construction paper. Drawing will be encouraged for the expression of emotions, cognitions, or behaviors which individuals may not be able to express through text.

Session 6: Memory box: Honoring our loved ones.

Individuals will be provided with shoe boxes. The shoe box may be decorated as each member desires. On the inside of the box, members will be asked to store objects that they feel are a good representation of the following:

Relationship shared with the loved one.

Identity of the departed.

Treasured gifts.

Thoughts and/or words they wish to share or shared with the departed.

Participants will only need to share about their experience engaging in the activity.

Sharing of the contents in the box will be voluntary. This activity is used to foster the sense

of love and belonging in the group.

Session 7: Good bye letters: Moving towards finding closure.

Members will be asked to write a good-bye letter to the departed. The letter may include text and/or pictures. There will be an open format, and participants are encouraged to be as creative as they wish. Final products may be shared as individuals wish. However, reflecting on the process itself will be enough to fulfill the remainder of the session.

Session 8: Re-constructing our futures: My future, present and past hold activity.

Members will be asked to draw three large baskets and label each as followed: past, present and future. The baskets must be large enough to be filled with words and/or symbols that tell what their past with their loved one holds, how their loved one has shaped their present and what their future may look like without the departed. Materials for the art component of the session will include: colored-pencils, markers, recycled magazines, scissors, as well as large pieces of 11 by 14-inch construction paper. Members will be asked to share their final products as they wish. The last fifteen minutes of the session will be used to close the group, provide resources/referrals, and sharing of skills learned to help with future coping. This activity aligns with reconstructing the quality world after the loss of a loved one.

Evaluation of Group

The goal of this group experience is to reduce the negative processing of grief by enabling members to engage in effective coping mechanisms that can facilitate grief expression and coping using art and Choice Theory. To measure the effectiveness of the group, all participants will be asked to complete a pre-assessment, a mid-sessions evaluation (Figure 1), and a post-assessment. The pre- and post-assessments used will be the Complicated Grief Inventory by Prigreson et al., 1995. The assessment should be administered by a trained professional using an interview technique a week prior to the onset of group sessions and a week after the closing group session. Assessment results will be evaluated by the interviewers with a focus on any changes in the participants' responses. The results will help determine the effectiveness of the intervention. A mid-term evaluation will be administered during session four. The results of this evaluation will seek to gain participants' feedback regarding the effectiveness of the group structure and activities. This evaluation will be anonymous to encourage honesty and constructive feedback.

Conclusion

While managing a life stage that is filled with instability, young adults may face extreme difficulty processing the loss of a loved one (Arnett, 2000; Janowiak et al., 1995). Young adults who are grieving face much difficulty and pain. It is essential that resources that may aid in the processing of grief are made more available. Community organizations geared to enable young adults towards success may be a great place to establish such a resource. Despite the nature of a young adult's loss, community atmospheres are hardly conducive to grieving (Janowiak et al., 1995). Often, community organizations focus primarily on assisting young adults navigate academic and social responsibilities with very little to no support managing the grieving process.

Overlooking the need to process loss would be highly counteractive when the focus is on individual well-being and personal advancement (Ferszt et al., 1998; Geron et al., 2003; Hart, 2012; Janowiak et al., 1995; Rogers, 2007; Zaslow, 2005). While individual counseling may be an option, it does not lend to the building of healthy relationships or the fostering of support plus love and belonging with others experiencing similar circumstances. Bereavement groups are also quite efficient for they offer a great deal of support with the need of very little staff and/or volunteers. Establishing group counseling integrated with the principles of Choice Theory for young adults offer a powerful avenue of healing, as well as fostering all the basic needs in grieving clients.

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Figure 1. Mid-sessions Evaluation

Please complete the following statements:

1. From this group I have learned…
2. I would like to see more of…
3. Something that has been challenging for me is…
4. Something that has been unhelpful for me is…
5. Additional comments or questions:

CONTEMPORARY CONTROVERSIAL ISSUES AND HOW TO USE REALITY THERAPY IN AN ETHICAL AND MAINSTREAMED MANNER: THOUGHTS TO PONDER

Robert E. Wubbolding, Ed.D., CTRTC, Former Director of Training (1988-2011) William Glasser Institute, Emeritus Professor, Xavier University

The genius of William Glasser, MD, is illustrated in his many writings from 1960 until his death in 2013. He gave the world a 3-fold legacy (Wubbolding, 2017a).That is, choice theory provides the explanation for human motivation: it explains why people do whatever they do, and why they make choices – both effective and ineffective. Human beings generate behaviors to satisfy their 5-fold need system. Many behaviors are explicitly chosen. Many others are at least partially chosen. Practitioners are advised to treat behaviors "as if" they are choices.

The 2nd component of his legacy is the delivery system – reality therapy. It is a practical, usable system applied to psychotherapy, counseling, education, management, parenting and virtually every human relationship. These two components are inextricably linked. "Choice theory is the train track. Reality therapy is the train" (Glasser & Glasser, 2008).

The 3rd component of the legacy is an organization originally known as the Institute for Reality Therapy, and then subsequently known as the William Glasser Institute. This streamlined entity consisted of William Glasser president, Linda Harshman executive director, and Robert E. Wubbolding director of training. The membership elected an advisory board which provided feedback and suggestions to the official board of directors represented by Dr. Glasser and Ms. Harshman, (Wubbolding, 2017a). Regarding Dr. Glasser's teaching, Wubbolding states, "His listeners expressed astonishment at his non-technical, forthright language and the apparent simplicity of his ideas. However, he always stressed that though the ideas are simple, their implementation requires effort and a commitment to make more effective choices" (p. 17).

The monumental work of Glasser, summarized in his many books (1965, 1981, 1998, 2011) has been applied to a plethora of human relationships and systemic issues by Glasser himself and many others such as (Rice, 2011) addictions, (Buck, 2013) parenting, (Robey, Wubbolding & Carlson, 2012) couples counseling, (Olver, 2011) diversity, (Wubbolding, 1996) (Pierce, 2007) management.

Personal Disclosure

For many years, my professional goal has been to preserve, maintain, and further develop Glasser's legacy so that his name and the systems he developed achieve their rightful place in the history of the helping professions. My second goal is to facilitate the placement of reality therapy within the mainstream of counseling and educational systems. To expedite this process I have contributed over 40 chapters in textbooks and presented papers at a countless number of national and international conferences. And though I am not the center of what I do, I have likely been the primary vehicle for the promotion of Glasser's legacy in the professional world of psychology, counseling and mental health (Wubbolding, 2014, 2015, 2016a, 2016b). This article is an extension of my presentation at the International Conference of William Glasser International in Bogota, Colombia, South America June 29, 2018.

Background

I affirm the elevated status and ideas of Glasser and the essentials of his theory and practice. I do *not* advocate a cultic-like blind mimicking of ideas peripheral to his elegant theory. I would diminish respect for his contribution if I were to merely echo his words. The reason is that the 4th contribution of Dr. Glasser is a process. He continually developed his ideas and extended them and even altered them. Consequently, this paper (and presentation) extends, but does not contradict, a few of his principles. His theory remains intact and his delivery system, reality therapy, occupies a unique place in the constellation of theory and practice in the helping and education professions.

Issue I – Choosing Behavior

It is easy to see that most actions are chosen in that the agent of the action explicitly selects it. And yet, responsibility for actions can be diminished by intense feelings. Anger can lessen a person's control of choices. And so the question arises. In order to mainstream reality therapy is it more accurate to describe some actions as partially chosen and as *generated from within a person*? I invite discussion of this idea.

Glasser always allowed for feelings that were not chosen – he saw these as pure feelings (Glasser, 1981). They last a short time and can be a burst of disappointment or exhilaration. The question for discussion is how long can they last and can they overflow, impact, or even overwhelm action choices. Some theoreticians and practitioners argue, "Yes" and describe it as temporary insanity, a term now limited to legal vocabulary and medically obsolete. It implies that a person lacks criminal responsibility and capacity and is not responsible for his acts (Miller-Keane, (2003) (https://medical-dictionary.thefreedictionary.com/insanity). Phrases such as "diminished capacity", "Twinkie defense", "abuse excuse", and "heat of passion" (LAW.COM https://www.law.com/) have also been used. The question for discussion is: Does choice theory accept or reject the above principles? Can you make any distinctions?

Issue II – Use of Medication

This delicate issue has implications for educators, counselors, social workers, psychologists, parents, and all who seek to learn choice theory and reality therapy. I asked the participants in my presentation whether they had heard the recommendation that it is acceptable to tell students and clients to cease taking their psychiatric medication. Virtually everyone in the room replied that they have heard this recommendation.

And yet, regardless of one's personal opinion about the helpfulness or damage caused by psychiatric medication, it is safe to say that there are ethical principles that govern professional behavior. Elliot Cohen, co-author of *Counseling for the 21st Century*, (2019) stated that such action is unethical, unempirical, and irresponsible (personal correspondence, June 25, 2018). The reason is that regardless of the helper's values, in the broad picture of practice the use of psychiatric medication is a legitimate form of therapeutic intervention (keep in mind the standard practice in the professions is broader than individuals' private opinions). The standard practice in the helping professions allows for physicians to prescribe such medication. To instruct clients to cease taking medication is tantamount to and opens the possibility of the accusation of practicing medicine. However,

it is acceptable to encourage clients and students to seek a second opinion or with a signed release to discuss behaviors with the prescribing physician. Even the choice to intervene in this manner, however, should be taken with great caution and with consultation.

Issue III – Dealing with Past Behavior

William Faulkner, the great American novelist stated, "The past is never dead, in fact it is not even past." The events of our personal histories, i.e., actions, are indeed past and yet the impact of past actions often collides with current total behavior. A person suffering from past trauma realizes that the traumatizing event is indeed past. Yet it often casts a cloud over present thoughts, actions, physiology and even action choices. For instance, Wubbolding (2017b) describes the case of Vivian, a military veteran, who had endured severe attacks in Iraq. For a period of 5 years she refused to go out of her house except for grocery shopping. She expressed the belief that she was afraid of people who she thought might attack her and so she mistrusted everyone. She remained fearful, anxious and depressed. She recognized that the actions of her enemies took place years ago but her current feelings and thoughts confined her to a prison of loneliness, anguish and distress.

Current standard practice allows for at least two approaches to Vivian's trauma, e.g., trauma centered therapy and present centered therapy. Notably, though, reality therapy actually allows for both approaches. And so, the skilled reality therapist might choose to listen to the recounting of the trauma but as quickly as possible help the client focus on current controllable behaviors.

The point of issue III is that behaviors that first appear to be historical or past are actually current in that past actions influence current feelings, thoughts and even physiology.

Issue IV – Mental Illness

In Glasser's lectures he frequently stated that he did not believe in mental illness. When he explained what he meant by mental illness it became clear that his viewpoint was congruent with current psychiatric and psychological practice. He believed that mental illness was the result of organic brain dysfunction. What is popularly described as mental illness consists as a collection of total behaviors that are out of the mainstream of effective behavior. They are labeled "Situation A" on the choice theory chart popularly known as *How the Brain Works* (Glasser, 2015). They include many ineffective, dysfunctional and "not now in effective control" behaviors, such as debilitating emotions, enervating and negative self-talk, as well as actions injurious to self or others. It is worthy of note that the *Diagnostic and Statistical Manual of Mental Disorders* (2013) does not refer to mental illness, but rather labels many ineffective behaviors as disorders. For instance, the diagnostic criteria for separation anxiety disorder includes actions, feelings and cognitions such as excessive worry, reluctance to go out away from home, school or work, fear of being alone, refusal to sleep, nightmares, and other symptoms (pp. 190–191). From the perspective of choice theory such behaviors are seen as generated from within a person in order to satisfy unmet needs. Anyone wishing to help such individuals assists them to find more positive behaviors, i.e., situation B behaviors. My suggestion about this topic is that reality therapists realize that using the *DSM-5* is, for the most part, compatible with choice theory and reality therapy. Finally, if reality therapy is to achieve wide acceptance and be perceived as a mainstream and respected theory and practice it should interface with standard practice such as the use of

diagnosis. This does not mean that every disturbed client or student is automatically labeled with a diagnosis. In many agencies and schools, counselors help clients and students assess their need satisfaction, evaluate their behavior, and select options designed to satisfy their inner motivations more effectively. In other words, they practice reality therapy and spend less time diagnosing and labeling behaviors as pathological. Such counselors or educators encounter many behaviors that hey label ineffective or even harmful choices. In summary, the world of choice theory and reality therapy does not gain the respect it deserves by ignoring standard practice and by discarding the standard tools used by professionals.

Summary

Glasser's lasting and towering legacy deserves close study and scrutiny. Allegiance to his memory and his prodigious contributions to the helping professions, to education, and to virtually all human relationships requires that honor be given to his total legacy. He taught choice theory, reality therapy, and formed a streamlined and efficient organization. At the root of these contributions lies a process: an ongoing, developmental and dynamic willingness to change his theory, to extend and adapt the principles of internal control to an ever-changing external world.

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Brief Bio—

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REALIZING HEALTH: THE PATH OF MINDFULNESS AND CHOICE THEORY

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Abstract

The premise of this paper is that the ongoing practice of mindfulness based on choice theory is a method of prevention and a way to realize improved health. Mindfulness practice has not only been shown to decrease stress but also serves to increase awareness. In accordance with choice theory (Glasser, 1998), when we are more aware of what we are doing and its consequences to our health, the more conscious choices we can make to practice healthier patterns of self-care. In the following article the authors will define *Mindfulness Based Choice Theory* and how it serves to naturally help a person realize health. A case example will illustrate how the approach can be applied.

"We cannot solve our problems with the same thinking we used when we created them."
Albert Einstein

We are living in a highly stressful time. It is common for most people to try and do more and more in a limited amount of time while ignoring physical signs that show they are overdoing it (Freidman & Rosenman, 1959). Research suggests that chronic stress leads to physical illness or worsens pre-existent health problems (Martin & Brantley, 2004). The pervasive nature of collective stress has led to an overutilization of health care and rising healthcare costs (U.S. Centers of Disease Control and Prevention, 2016), which only leads to greater stress and ill health. Our ways of solving the problems of health only lead to more problems.

A new way of thinking of health and health care is greatly needed. According to the Surgeon General (2018), the most economical approach to addressing the issue of health care is prevention. Recent studies examining the relationship between adverse childhood experiences (ACES) and health outcomes suggest that stress is a major factor in prevention of chronic disease and even premature death (Brown, Anda, Tiemeier, Felitti, Edwards, Croft, & Giles, 2009; Larkin, Shields, & Anda, 2012). Prevention can reduce the significant economic burden of disease, in addition to improving the length and quality of people's lives.

Many of our public health problems are the result of compensatory behaviors like smoking, overeating, and alcohol and drug use, which provide immediate comfort from the emotional problems caused by traumatic childhood experiences but never really address the root cause (Felitti, 2009). Avoidant and compensatory behaviors are major contributors of mental and physical illness (Edwards, Holden, Anda, & Felitti, 2003; Flederus, Bohlmeijer, & Pieterse, 2010). Prevention practices that address avoidant and compensatory behaviors are particularly relevant in order to address the root traumas and distress and begging a path towards wellness (Benson & Stuart, 1993; Glasser, 2005).

Mindfulness Based Choice Theory and Health

In a prevention approach, health is not about preventing illness but is a process of realizing "well" being. Health is seen as a process and a matter of individual responsibility. Traditional medicine views the physician as the expert who decides what treatments are necessary when disease occurs. The "patient" is passive and simply receives the treatment. In mindfulness and choice theory, the "patient" is a practitioner who is mindfully aware and continues to practice awareness of the present moment and makes wise choices to optimize health (Glasser, 2005). In this approach, the physicians are consultants to the practitioners and provide information to help improve health and heal disease. The focus of authority is on practitioners as they are empowered to become more aware and make conscious choices toward greater healthiness.

Another important aspect of prevention is the holistic perspective, or as Glasser explains in his book *Choice Theory* (1998), total behavior. In both the mindfulness tradition and in choice theory, health involves the actions, thinking, feeling, physical, psychological, social, and spiritual dimensions of the person. In health psychology this has sometimes been referred to as the biopsychosocial model. Buddhist psychology also includes the spiritual dimension and actually views disease as a psychosocial/spiritual phenomenon that can result in physical disease. According to the Buddhist approach (Trungpa, 2013), we all have an original nature, which is inherently whole and well (not taking into account congenital diseases). The original nature is naturally connected and sensitive to others and the environment as well as playful and creative (Trungpa, 2013). Especially as we are younger, our primary attachment figures are crucial to our experience of feeling safe and secure, and staying in tune with our original nature (Bowlby, 1988). The developing brain and nervous system of the child requires the help of an attachment figure to help understand and resolve fearful experiences so he/she/they can return to the original wholeness. It is only as experiences of fear occur and are not remediated by our attachment figures that the nervous system stays in a survivalist, defensive mode in which consciousness becomes overly focused on not being hurt again. A disconnect also occurs in the mind between experiences identified as "good" or "bad", and avoiding feelings and behaviors that bring out the "bad" in the attachment figure. The process of separation causes a disconnect with one's original nature and puts the nervous system in a state of stress and "ill being." One's sense of self often develops around the disconnection, at least to some degree, creating a consciousness and a perceived self that is now separate from the original wholeness. In our confusion, we identify with the perceived self as if it were who we really are and learn to maintain and defend it at any cost. In Buddhist psychology, the dividedness of our perceived self is the root of our illness and learning to return to the original nature is crucial for healing.

In many ways, Western and Buddhist approaches to health and well-being operate in opposite ways. Western medicine takes a physical symptom approach in which the person passively receives treatment and the Buddhist approach begins with a psychosocial/spiritual approach in which the person works with his/her mind to be free from the perceived self, which frees up the person to experience the healing nature of the original self that is safe and compassionate.

The Physiological Component of Stress, the Polyvagal Nerve, and the Three Poisons

One of the ways to view "stress" is as the experience of not feeling safe. The anxiety of stress is really the fear of life. Recent research of the polyvagal nerve suggests that many of us respond to stress by shutting down (Stephen Porges, 2011). The polyvagal nerve is sometimes referred to as the "wandering nerve" because it travels through the nervous system and includes major organs of the body such as the heart. In contrast to the sympathetic nervous system that serves to intensify the stress response, the vagal nerve is center part of the parasympathetic nervous system that decreases stress. Yet it may operate in either of two ways. The first way occurs when we do not feel safe. In this case, we first try to either fight or to get away from the situation. If we cannot escape through fight or flight, we move into dorsal vagal shut down. However, the second way to decrease stress occurs when we feel safe. In this case we do not need fight/flight or shut down and the ventral vagus nerve can allow us to relax.

Three important findings about the research on the polyvagal nerve are important in understanding its role in health and illness (Porges, 2011, 2017, 2018). First, the polyvagal nerve is critical in terms of attachment and social engagement. According to Glasser (1998), difficult relationships with self and others are the source of most long-term unhappiness. When we are in "shut down" or in fight/ flight mode, the social engagement system de-activates so we also disconnect from others, which creates the additional stress and alienation.

Second, because there are so many situations that we cannot escape on a day to day basis, the "stress" often leads to dorsal vagal shut down (Porges, 2011, 2017, 2018). And since stress has become more common, it feels "normal," what Glasser (1998) refers to as an *organized behavior*. This is such a common social situation that individuals who are sensitive and feeling-oriented may be perceived as abnormal or even weak.

The third, and the most significant point for wellness, is that when we stay shut down or in fight/flight mode, we are in the most danger of becoming ill or worsening our illness(Porges, 2011, 2017, 2018). Researchers have found that coronary heart disease, asthma and rheumatic diseases, antibody responses to vaccines, cancer progress, susceptibility to colds and flus, dermatological conditions, diabetes, gastrointestinal problems, blood pressure, HIV progression, and immune system functioning are all affected by stress (Snooks, 2009). Learning to disengage from shut down, aggression, and avoidance are all important for our own health.

In Buddhist psychology, when we are stuck in the perceived self we are stuck in ill-being, and actually can become physically ill (Trungpa, 2013). Buddhist psychology addresses three poisons of the body-mind to emphasize how what we do internally can be viewed as harmful as poison (Pedigo, Robey, & Christiansen, 2016). The three poisons are ways we are reacting internally, which include passion, aggression, and ignorance. Each of these can be compared to stress responses of avoidance, aggression, and shut-down, respectively. First we try to get away from a situation by turning to something that feels better (avoidance/ passion), and second if we cannot get away, we fight against whatever feels threatening (aggression). Finally, if we can neither get away nor overcome the feared object with aggression, we try to ignore or dissociate from the situation (shut-down/ ignorance). The heart of mindfulness practice is to stay open without resorting to the poisonous reaction

of the stress response (Chodron, 2003, 2009).

Mindfulness Practice, Openness, and Wellness

Mindfulness can be viewed as the practice of freeing the mind and body of the three poisons and therefore from the development of physical illness. If during meditation practice, we notice our thoughts racing and return to focusing on our breath, we are using our vagal brake. If we drift too far from the present, we are potentially moving into dorsal vagal shut-down (Wagner, 2015). If our thoughts tell us to escape, we return to the breath. When we are angry, we let ourselves be calmed by the breath. When we stay attentive to what we feel in our body, and continue a focus on the gentleness of breathing, we are encouraging ventral vagal calming rather than dorsal vagal shut-down (Ogden and Pain, 2006, Vanderkolk, 2016).

When fears do arise, if we watch our fearful bodily sensations, see that they pass, and see that we are actually safe enough, and then we encourage our social engagement system functioning. When we are using our social engagement biology, even if our hearts are beating fast, we have a sense of safety. The active feeling in our body feels playful. Our rest replenishes us. We return to our original nature, which is creative and connecting.

Just as stress and fear are socially contagious, so are safety and playfulness. For example, a fearful dog at a dog park can watch the other dogs from a distance. If the behaviors of the other dogs are playfully active rather than vicious, the fearful dog can experiment with joining the interactions. Human beings are no different. We can sense the atmosphere we walk into. Whether it is home or work or any other group of people, how the group is interacting and how we interact with the group affects our mind, body, and wellness.

Loving-Kindness Meditation and Social Connectedness

Choice theory teaches that relationships are damaged through attempts to control others. The antidote to this is for individuals to accept that they can only control themselves, so relationship change must be based on the use of caring behavioral habits that are likely to bring people closer together (Glasser, 1998). Among these behaviors is the practice of Loving-kindness Meditation (LKM) which can help a person realize a sense of safety and connectedness. In LKM, a phrase is repeated with the breath such as *"May all beings be free from suffering and the root of suffering. May all beings experience happiness and peace."* The phrase is repeated for oneself, loved ones, neutral individuals, and finally for people we find difficult. The aim of using this practice is to evoke an awareness and empathy for others. LKM has been found to increase social connectedness (Hutcherson, Seppala, & Gross, 2008). Two studies found LKM to reduce intergroup bias and prejudice (Kang, Gary, & Walach, 2013; Parks, Birtel & Crisp 2014).

Stellar, Cohen, Oveis, and Keltner (2015) found that compassion practices and LKM seem to de-activate dorsal vagal shutdown and activate relaxed openness. These practices directly work with our fear of others, can have a more immediate impact to help us move out of the ego-mind and reconnect with our original nature.

Living Mindfully, Living Healthy

Practices such as breath meditation or LKM are designed to help us live mindfully. Living mindfully means staying engaged and open to others and ourselves with gentleness and empathy. While this way of living has inherent value, it is also correlated with the realization of health and happiness (Killingsworth & Gilbert, 2010; Loucks, Britton et. al., 2015). The following case study illustrates the use of reality therapy and choice theory within the process of using mindfulness to get past the triggering effect of the perceived self and opening to the connectedness and creativity of original nature.

Case Study

E. came to therapy to address her depression and stress in her role as clergy in the local church that she serves. In this interview the therapist (T.) helps E. reflect on the growth that she's made in response to therapy.

T: Thank you for doing this interview. To begin, I'm wondering if you feel that you went through something when you were young that formed a sense of yourself that was out of fear and has caused you stress.

(The practice of reality therapy, which is based on choice theory, usually focuses on what clients can control, that is, present total behavior. However, in some cases, when the past is alive in the present, the therapist may explore past history to get a sense of how to move forward, as the therapist does in this statement.)

E: So, I had a lot of fear as a young child, and I had a lot of fear about my father's anger as a young child and about it being directed at me. So I silenced myself out of fear and became invisible in my response to fear, I shut down. And that was the way that I handled things which was a survival method of being a child was to shut down emotionally and try to be perfect not make any moves and not be seen.

(In this response E shares the feeling and acting components of her total behavior that very early activated her dorsal vagal nerve response and shut down her emotions as a part of her survival system in response to fear.)

T: Now you have also talked about how your Mother has been an influence on you. Can you say a little about that?

E: Well with my mother I always felt I was sort of in charge of her well-being and protection although but yet could not protect her. Like when her and my father were in conflict, I was there to clean everything up and make her feel better afterward. I needed her to be okay.

(Glasser (1998) explained how we all have quality world/ideal pictures of the people, places, and things that lend value to our lives. This includes pictures of ourselves. Here E explains how she began to develop her picture of herself as the protector.)

T: So you learned to take care of her and comfort her.

E: I was very much a comforter, an emotional fixer. I was the one to fix her problems for

her. Help her feel better. Try to give her managing skills as a nine-year-old.

T: Yes. So you were some combination of shut down and a mother manager?

E: Mother managing. Managing my own and others feelings.

(E's shut down and survival system was related to her attachment system in which she needed to make sure her mother was ok. She became her mother's emotional manager and comforter instead of being cared for by her.)

T: Now do you feel that this had something to do with how you then adopted your understanding of what it meant to be a priest?

E: Very much so. I think as a child I felt that I had an incredible amount of power and control over helping people behave appropriately and making them happy. That from my non-being [*E. refers to feeling numb as non-being, which relates to the polyvagal theory of Stephen Porges (2011, 2017, 2018)*] I was able to calm my father down, or I knew what to say to my mother in order to make the house okay again. And so, especially in the early times of my career, I had a lot of impulses to try to make everything okay for everybody and try to fix things for people and feeling overly responsible for basically everything that went on in the community.

(According to choice theory we are all born with basic needs for love and belonging/connection to others; power in the form of control and self-significance; freedom of movement and to make choices; fun which comes from play and learning; and survival/safety. Early in life, E. chose behaviors that helped her meet her needs for power and control and survival. The mother caretaker pattern established when she was young has continued in her professional life in taking responsibility for others and making them happy.)

T: And do you feel like it also has something to do with how you've been a wife and mother?

(The therapist links past behavior to the present.)

E: I mean definitely in my marriage, yes that's true… as a Mother, let me think about that. I definitely feel the way I want my daughter to feel okay about things is an appropriate way. I've done a lot of work. I mean once I had her.

T: So with your daughter you wanted it to be different, but perhaps in your marriage, you had a similar role

E: I think early on in my marriage I feel responsible for how I want to fix things for him. Fixing and taking responsibility for everybody's feelings and management. I do a lot of management, family management.

(E. felt that with her daughter, she was determined to make it different. So often we have a natural wisdom for what happened to us that shows itself in how we want our children to experience a better upbringing. In her marriage the pattern became an organized behavior and repeated itself as she became the fixer.)

T: Okay. Now this way of operating in the world, did this cause you stress?

E: Um yes. This caused me much stress because I actually don't have a lot of power to control other people. And it also meant that anytime anything happened it was all my fault. And it was because I was wrong in some way or defective in some way. It was a lot of pressure to try to maintain this idea of perfection in relationships in particular.

T: And a lot of internal negative consequences?

(The therapist helps E. evaluate the results of her total behavior of perfectionism.)

E: A lot of negative inner talking a lot of ... so it was a lot of pain turned inward and negative thinking turned inward… not necessarily outward but always back onto me which then caused depression.

T: Do you feel it ever affected your physical health?

(The therapist identifies the physiological and feeling components of total behavior associated with negative inner talking/thinking.)

E: Yes, very much so. Let's see. It definitely affected weight gain because turning to food for comfort. I had a liver tumor which I think was about my anger actually. I think it has impacted for sure. High blood pressure.

(E. definitely feels the pattern she developed has caused stress and health problems. In previous sessions she has disclosed how her eating patterns have been a great source of comfort from stress.)

T: When did it start to change for you?

E: I think first it was realizing that I didn't really know what I was feeling. I think that was my first realization. And then, then trying to put words to feelings that opened me up to having them I guess and experiencing them. And then having to have them and almost forcing myself to feel, to experience it.

T: I remember you saying that you were practicing non-suppression.

E: Non-suppression, right. So it was having the feeling and fully experiencing whatever it was or trying to figure out what it was.

T: Was it also physical?

E: Yes, it was very physical. It was a very physical experience. So the feeling wasn't just in my head it was my whole body. It was in my whole person. In my heart, in my body, it hurt at times almost physically hurt.

(E. describes the total behavior that she experiences as she was trying to eliminate the suppression of her experience.)

T: It sounds like it was difficult?

E: Yes, that was very difficult. And I remember saying that my therapist says to stick with it and he better be right because if he's not, I'm going to be super pissed.

T: So, did you end being pissed at me then?

E: No because I know this is going to lead somewhere. I did have an intuitive feeling that it was leading somewhere. But at the beginning it was super, it was a lot of work... it was a lot of energy.

T: You really had to give a focus to it... an intention

E: Because I didn't really know why I was doing what I was doing and so observing myself in that became time consuming. And also energy, it took a lot of energy.

T: Yeah just to stay with the feelings or go back to numbness.

E: Right!

(E. describes how hard it was to stay with the feelings as she was learning to not suppress and not go back to numbness.)

T: Do you think having empathy and compassion for what you were going through made a difference?

(The therapist helps E. recognize how a change in her behavior makes a difference in her life.)

E: Oh, absolutely. I mean yeah, this was a major place of comfort. Yes of course, I'm sorry.

T: Did your relationship with yourself change at all during this?

(According to Glasser (1998), relationship problems are at the source of most human problems, including relationship with self. The therapist helps the client evaluate how her change in behavior influenced her relationship with herself.)

E: Yeah that was the big change.

T: Can you say more about that?

E: Because I think I came to terms with part of myself that I didn't like being that it was causing me so much stress it became very visible to me and I think having compassion for myself and also realizing my own limitations; that I had limits where before I didn't.

T: And then the changes occurred so that you had more compassion but more acceptance.

E: More acceptance.

T: That you had limits?

E: That I had limits and also understanding what it was about. So getting to the root cause and helping me see why it was about did help me to have compassion for myself or why I reacted the way that I reacted. And then it helped me come back to the current situation to see it more as it is rather than through the eyes of say my younger self. Which got triggered at that point or why I reacted the way that I did. And so then at that point I think when I have been triggered or reacted I still feel it but I have compassion for it but I don't necessarily need to act on it.

T: So you still have the feeling?

E: I still have the feeling.

T: But you're able to comfort yourself with compassion and kind of just let it go through.

(The therapist emphasizes that E.'s practice of self-compassion influenced her.)

E: Yeah. I just try to sit with it try to find out what it is trying to tell me. Especially anger. Working on anger a lot. What is wrong? Why am I? So I am trying to use the experience to help me figure out how to navigate the now. Or if it has minded it for something or for some wisdom. Also just letting myself have it and just deal with it.

T: Do you feel any better now?

E: Yes. Yes, I feel much better. I don't feel trapped. Where I think I always felt trapped before. Like I was in this endless cycle and I will always have to suffer. I will always be in this suffering place. My anger was turned inward. Now that it doesn't happen anymore it still happens. I am able to handle it easier sort of understand what's going on for me in that moment. I feel free!

(With the help of the therapist, E. remembers that much of the core change has come in how she now relates with herself: She is able to have much more awareness and compassion. Also, though, for the first time in her life she really felt angry.)

T: So, returning to where we began. How is your stress now?

(The therapist asks E. to self-evaluate the efficacy of the changes she has made.)

E: My stress now is about feeling pulled I think to the way I used to be. And sometimes thinking I should go back to that. Feeling pulled that way institutionally and people's expectations of acting in that role in a particular way. And now sort of exploring you know… using all my energy sources so that when I am actually feeling something and I can tell what I am feeling its telling me something and that feelings sometimes I need to express it also to the community. It is not just an eternal thing; it is a piece of wisdom now that I can use and have that helps me to do my job better.

T: Are you saying that's less stressful?

E: I think that it is less stressful. I more feel less stress around like how I use my energy. I am managing so much better. I used to think I had to do everything for everyone. Now, I realize my own limitations. I have more energy at home because I don't have to manage x, y, z at church.

T: Imagine you get backlash in probably at churches and maybe at home too now that you have limits, and don't engage that level of care taking that you used to?

E: Correct. I don't feel guilty about it anymore.

T: You don't feel guilty about that?

E: Yes, I feel less stress around that.

T: How are you in your body now? How is your body doing in terms of what you were describing before?

E: I don't have that same physical reaction. I still feel things in my body but it is not painful. I think my health has improved a little bit. I don't feel as needing of comfort and craving all the time. I mean it still happens but I recognize when it's happening and I can make a choice. Do I want to do this? And I'm like yes I do. I can make a choice: It is more conscious.

T: Are you feeling any more relaxed?

E: Yeah, maybe. I feel more relaxed. I don't necessarily experience stress the same way I used to. Well, I think part of is that if things are a mess it's okay they are a mess. To be able to sit with that rather than having to think about how I have to fix it all.

T: You can let it be a little more.

E: I can let things be not okay with other people. I can let it be. Things are not okay and it's okay.

T: Yeah, which is a little less stressful.

E: Still have the reactions but then I sit and I think as a leader what do I need to do now?

T: It sounds like it is a work in progress.

E: Very much a work in progress.

(E. feels less pain, guilt and stress, and more relaxation. She has less of a need for using food for comfort and she feels less of a need to fix. She is more ok with the "mess of life" and allows for herself to be a "work in progress.")

The interview with E. reveals that realizing health is an ongoing journey of mindfulness and

choices. While E. clearly experienced a great deal of change she continues to be on a journey toward greater health. She is free and less stressed than ever in her life but at the same time she has to continue on her path of mindfulness, and awareness, and making choices.

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