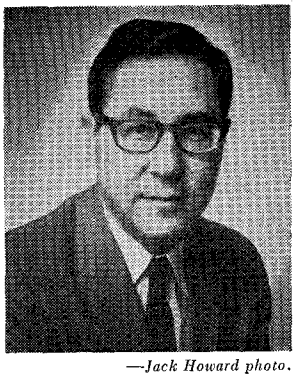
# THE RESEARCH FRONTIER



—Jack Howard photo.

**WHERE IS SCIENCE TAKING US?** *On many roads simultaneously, all leading back to the mind. The central position of the mind, as an organ of responsibility, becomes more rather than less decisive as the divergent paths multiply. And this rising need for responsibility has in recent years been forcing re-examination of Sigmund Freud's theories of psychoanalysis. There is a growing feeling, first expressed in these pages in June 1959, that the Freudian approach tends to weaken normal responsibility. Since the theory of evolution necessarily entails a built-in responsibility of living organisms to cope with their environment, Freud would seem to be wrong.*

*In SR/Research for December 1964 was published the gist of an alternate to the Freudian theory. "The Theory of Positive Disintegration," it had been developed for fifteen years in Poland by Dr. Kazimierz Dabrowski. The American Midwest's*

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CONVENTIONAL psychotherapy, based either strictly or loosely upon the psychoanalytic beliefs and teachings of Sigmund Freud, is taught in almost every major college and university in the United States and Canada. Whether it is practiced in an orthodox, Freudian setting in a Park Avenue psychoanalyst's office or in a loosely structured college counseling service, it embodies the following:

1. Conventional psychiatry believes firmly that mental illness exists, that people who suffer from it can be meaningfully classified, and that attempts should be made to treat them according to the diagnostic classification.

2. Conventional psychiatry holds that an essential part of treatment is probing into the patient's past life—searching for the psychological roots of his problem because once the patient clearly understands these roots he can use his understanding to change his attitude toward life. From this change in attitude he can then develop more effective patterns of living which will solve his psychological difficulties.

3. Conventional psychiatry maintains that the patient must transfer to the therapist attitudes he held or still holds toward important people in his past life, people around whom his problems started. Using this concept, called transference, the therapist relives the patient's past difficulties with the patient and then explains to the patient how the patient is repeating the same inadequate behavior with the therapist. The patient, through the therapist's interpretations of the transference behavior, gains insight into his past. His newly attained insight allows him to give up his old attitudes and to learn to relate to people in a better way, solving his problems.

4. Conventional psychotherapy, even in superficial counseling, emphasizes that if the patient is to change he must gain understanding and insight into his unconscious mind. Unconscious mental conflicts are considered more important than conscious problems; making the patient aware of them through the interpretation of transference, dreams, and free associations, and through educated psychiatric guessing, is necessary if therapy is to succeed.

5. Necessarily accompanying the conviction that mental illness exists, conventional psychiatry scrupulously avoids the problem of morality; that is, whether the patient's behavior is right or wrong. Deviant behavior is considered a product of the mental illness, and the patient should not be held morally responsible because he is considered helpless to do anything about it. Once the illness is cured through the procedures described in Points 2, 3, and 4, the patient will then be able to behave according to the rules of society.

6. Teaching people to behave better is not considered an important part of therapy in conventional psychiatry, which holds the patients will learn better behavior themselves once they understand both the historical and unconscious sources of their problems.

Reality Therapy in both theory and practice challenges the validity of each of these basic beliefs.

Before examining each concept individually, one over-all difference between Reality Therapy and conventional psychiatry must be emphasized. This is the difference between the involvement necessary for Reality Therapy and the involvement necessary for conventional therapy. The conventional therapist is taught to remain as impersonal and objective as possible and not to become involved with the patient as a separate and important person in the patient's life. Rather, he is to strive for the transference relationship briefly described under Point 3 above. In Reality Therapy achieving the proper involvement is absolutely essential. The way Reality Therapy differs from conventional therapy on each of the six points to be discussed may be considered briefly from the standpoint of involvement.

1. Because we do not accept the concept of mental illness, the patient cannot become involved with us as a mentally ill person who has no responsibility for his behavior.

2. Working in the present and toward the future, we do not get involved with the patient's history because we can neither change what happened to him nor accept the fact that he is limited by his past.

3. We relate to patients as ourselves, not as transference figures.

4. We do not look for unconscious conflicts or the reasons for them. A patient cannot become involved with us by excusing his behavior on the basis of unconscious motivations.

5. We emphasize the morality of behavior. We face the issue of right and wrong which we believe solidifies the involvement, in contrast to conventional psychiatrists who do not make the distinction between right and wrong, feeling it would be detrimental to attaining the transference relationship they seek.

6. We teach patients better ways to fulfil their needs. The proper involvement will not be maintained unless the patient is helped to find more satisfactory patterns of behavior. Conventional therapists do not feel that teaching better behavior is a part of therapy.

With the over-all difference of involvement in mind, let us now examine in detail the six major beliefs of conventional psychiatry and compare them to the theory and practice of Reality Therapy.

First, and very important from a treatment standpoint, both the theory and practice of Reality Therapy are incompatible with the prevalent, widely accepted concept of mental illness. We believe that this concept, the belief that people

# "Reality Therapy"

*Dr. Karl Menninger has written to remind us that support for Dabrowski's idea can be found in Dr. Menninger's recent book, "The Vital Balance."*

*If the Freudian treatment of emotional crisis is wrong, what treatment is right? A book offering a vigorous answer to that question will be published by Harper & Row just after this issue of SR goes to press. Written by Dr. William Glasser, a privately practicing psychiatrist in California who teaches psychiatric method to school teachers at the University of California in Los Angeles, this volume is titled "Reality Therapy." Below is an exclusive SR preview.*

can and do suffer from some specific, diagnosable, treatable mental illness, analogous to a specific, diagnosable, treatable physical illness, is inaccurate and that this inaccuracy is a major road block to proper psychiatric treatment. Our scientific and lay literature are both filled with the idea that anyone who behaves and thinks in a way unacceptable to the majority of the society is mentally ill or, in popular terms, "sick." Every conventional psychiatric approach to the treatment of these people is based upon the belief that they are suffering from mental illness, a concept as prevalent to our culture as the flatness of the earth was to the Middle Ages.

Those who believe in mental illness assume incorrectly that something definite is wrong with the patient which causes him to be the way he is. Most psychiatrists believe that the patient was all right at one time and then fell victim to a series of unhappy life experiences which now cause his deviant behavior. When these experiences are exposed and resolved through conventional psychotherapy, the mentally ill person will recover in much the same way that the physically ill person recovers from a strep throat when the penicillin kills the streptococcus. We believe this concept misleads the doctor, the patient, and those concerned with him into the false belief that the doctor's job is to treat some definite condition, after which the patient will get well.

If there is a medical analogy which applies to psychiatric problems, it is not illness but weakness. While illness can be cured by removing the causative agent, weakness can be cured only by strengthening the existing body to cope with the stress of the world, large or small as this stress may be.

By dispensing with the idea of mental illness and calling a man irresponsible, and then describing how he is irresponsible, Reality Therapy defines the situation much more precisely. Using the latter description, it is apparent that the cause of the psychiatric patient's condition is different from that of a patient with a physical illness, who is more truly the victim of forces outside himself. Regardless of past circumstances, the psychiatric patient must develop the strength to take the responsibility to fulfil his needs satisfactorily. Treatment, therefore, is not to give him understanding of past misfortunes which caused his "illness," but to help him to function in a better way now.

Philosophically, as well as practically, from the patient's standpoint there is a world of difference between being cured of an illness and helping oneself. With typhoid fever, one may be as motivated as possible and still die unless some capable physician gives the proper medical treatment. A car-stealing juvenile delinquent, however, treated by a psychiatrist for years on the basis of mental illness, will not change as long as he is allowed to play the misunderstood or mistreated child who doesn't understand all that has happened to him. He and all other irresponsible people now wrongly labeled "mentally ill" must clearly understand that they must help themselves regardless of what has happened to them in the past (and we should be the last to deny that they have suffered). As long as the mental illness concept prevails and patients continue to see themselves as the recipients of help, we will make little progress in psychiatry. With the hazy conception that most patients and their families have of mental illness, the responsibility for change lies less with them than with the treating agency—be it doctor, social worker, correctional institution, or hospital.

PSYCHIATRISTS discovered long ago that as much as they would like to follow the medical parallel and cure the patient of his brain disease, they were unable to do so because no brain pathology existed. Instead of giving up the illness concept, psychiatrists seized on the discovery of unconscious conflicts as the cause of mental illness. It was the conflicts which caused patients to be the way they are, mentally ill. Patients are led on long, expensive trips back through their childhood, often discovering that mother was the cause of it all. Once the patient is helped to wrest his childhood resentments against mother from his unconscious mind, cure is theoretically in sight.

For example, an obese young woman who has a compulsive overeating problem may find out through psychotherapy that her mother wanted a more beautiful daughter. Because obesity in a young woman is never desirable, she overeats in order to avoid facing the truth that her mother would reject her even if she were slim. She can accept the mother's rejection because she is indeed fat and unattractive, perhaps so much so that her mother and others may have given her sympathy, if not acceptance. In traditional therapy, being accepted as mentally ill and having learned why, the patient will attempt to throw herself upon the therapist. Learning from him that the source of the problem is past and present unresolved conflict with her mother, she continues to eat, her appetite undiminished by this knowledge. This not uncommon situation, where the unchanging fat and miserable patient damns her mother for years in psychotherapy has discredited psychiatry in the minds of many people. Under these too familiar circumstances, where the mental illness is accepted and the cause is sought and discovered to be outside herself (in this case her mother's rejection), the patient is relieved of the necessary responsibility for her part in the therapy. The fat girl's only chance of being helped is to learn that she is irresponsible, not that she is mentally ill, and that her unattractiveness is important primarily to her. Her mother is only an excuse for her irresponsibility.

Necessarily closely related to eliminating the concept of mental illness is the somewhat more radical idea of dispensing with any major inquiry into the patient's past history, ordinarily considered as essential to psychiatry as the scalpel is to the surgeon. The most complete history possible, perhaps a sound motion picture of the patient's whole life plus a tape recording of every unconscious thought, would be no more helpful in treating a patient than a short description of his present problem.

In Reality Therapy we emphasize immediate behavior. Once we become involved with a patient and teach him new ways of behavior his attitude will change regardless of whether or not he understands his old ways. What starts the process is *an initial change in behavior*, and it is toward this that the therapist must work.

Conventional psychiatrists, led by Freud, have also learned that insight derived from the past is not by itself an effective instrument for change. They have, therefore, developed another concept through which they implement the insight gained through a study of the past. This concept, called *transference*, is an attempt to tie the insight more closely to the

present and hopefully make it more useful to the patient.

Although a conventional psychiatrist tries to stay personally uninvolved with the patient during therapy, he certainly does not avoid involvement completely. Instead of a single, intense, personal involvement of doctor with patient, he attempts to gain a series of involvements such as mother to patient, father to patient, brother to patient, teacher to patient, and employer to patient. He does so, according to Reality Therapy, in the mistaken belief that the patient must re-experience in therapy his attitudes toward the important people in his life, past and present. Using transference, the conventional psychiatrist does not tell the patient that he is afraid to assert himself because his father treated him harshly. Instead, he goes halfway toward becoming personally involved with the patient by saying, "You are treating me as if I were your father and blaming your failure to assert yourself upon me." Ironically, the patient is indeed blaming his failure to assert himself upon the psychiatrist, but not because the psychiatrist is like his father. It is because of the difficulty of becoming involved with a therapist who, instead of establishing a close personal relationship with the patient in his own capacity, sometimes plays the role of someone else and sometimes acts as himself.

CLOSELY allied to transference is the concept of the unconscious. Conventional psychiatry contends that the unconscious motivation is highly important and that for successful therapy the patient must become aware of previously unconscious reasons for the way he behaves. Certainly patients, like everyone else, have reasons of which they may be unaware for behaving the way they do. Talking in one's sleep, slips of the tongue, phobias, and compulsions are examples of behavior obviously based upon unconscious mental processes. But patients have been treated with conventional psychiatry until they know the unconscious reason for every move they make, but they still do not change because knowing the reason does not lead to fulfilling needs.

What is really below the level of consciousness is what the patient is doing now. In a sense the patient is aware of his present behavior, but it is only a meager awareness. Incorrectly assuming that the patient is fully conscious of his present behavior, the conventional therapist *misses the extent to which the patient lacks awareness of what he is doing now.* The Reality Therapist insists that the patient face his present behavior.

A further important difference between Reality Therapy and conventional psychiatry concerns the place of morality or, to be more specific, the place of right and wrong in the process of therapy. Conventional psychiatry does not directly concern itself with the issue of right and wrong. Rather, it contends that once the patient is able to resolve his conflicts and get over his mental illness, he will be able to behave correctly. We have found that this view is unrealistic. All society is based on morality, and if the important people in the patient's life, especially his therapist, do not discuss whether his behavior is right or wrong, reality cannot be brought home to him. It is unrealistic to ask a delinquent girl why she stole a car, why she is pregnant, why she smokes marijuana, hoping that once she discovers the reasons she will be able to resolve her conflicts and change her behavior. We believe that to stop her unsatisfactory behavior she must fulfil her needs, but that to fulfil her needs she must face the real world around her that includes standards of behavior.

Admittedly, the introduction of morality into psychotherapy may draw criticism from many sources. Some people argue that a great strength of conventional psychiatry is that it does not involve itself with this age-old question. It would be easier for us if we could avoid the issue also, but we cannot. People come to therapy suffering because they behave in ways that do not fulfil their needs, and they ask if their behavior is wrong. Our job is to face this question, confront them with their total behavior, and *get them to judge* the quality of what they are doing. We have found that unless they judge their own behavior, they will not change. We do not claim that we have discovered the key to universal right or that we are experts in ethics. We do believe, however, that to the best of our ability as responsible human beings, we must help our patients arrive at some decision concerning the moral quality of their behavior. To do so, we have found that for the purpose of therapy the following definition seems to be extremely useful:

*When a man acts in such a way that he gives and receives love, and feels worthwhile to himself and others, his behavior is right or moral.*

(Whether our definition could stand the test of scholarly debate with the great moral philosophers of the world is questionable, but at least it has provided us with some framework upon which to focus our therapy discussions.)

WHEN a person is able to fulfil his need to feel worthwhile to himself and others, there is little conflict over whether his behavior is right, but in many instances the needs are in conflict and it is much more difficult to arrive at the correct course of behavior. For example, when a chief of state gives up his position or a potential chief of state reduces his chances for election because of love, who is really to say that he did right or wrong? Both Edward VIII of England and, more recently, Governor Nelson Rockefeller of New York faced a problem in which there is no absolutely responsible course. In a famous historical example, Socrates chose death rather than life with diminished self-respect, even though he had the assurance of love from friends who urged his escape. A more common situation is one in which a man, discovering his son to be guilty of a crime, is torn between reporting his child or losing his own self-respect.

It is possible to think of hundreds of these moral dilemmas, but it must be made clear that responsible people who are caught in a serious conflict of needs rarely consult a psychiatrist. They recognize that it is up to them to decide.

However, the psychiatrist does see hundreds of patients who have some conflict between their needs and would like to use this as an excuse for irresponsible behavior. For example, a man who is unhappily married gives lip service to continuing the marriage for the sake of his children, but he begins to drink heavily and neglect his work. His income falls off, his family suffers, and his self-respect disappears.

No outsider could solve the problem of such a patient's marriage. The patient must do that alone. But the psychiatrist who helps him to face the cause of his behavior, curtail his drinking, and resume his adult responsibility toward the support of his family can make a real contribution to this man's development. Reality Therapy does not try to lessen the pain of irresponsible actions, but to increase the patient's strength so that he can bear the necessary pain of a full life as well as enjoy the rewards of a deeply responsible existence.

The final major difference between Reality Therapy and conventional therapy is our emphasis upon the therapist's role as a teacher. In conventional therapy teaching is limited to helping the patient gain insight into the causes of his behavior. From then on it is assumed that he will either learn better ways himself or from someone else. In Reality Therapy we spend much time painstakingly examining the patient's daily activity and suggesting better ways for him to behave. We answer the many questions that patients ask and suggest ways to solve problems and approach people. Patients who have not been able to fulfil their needs must learn both how to approach people so that they can become more involved and how to accomplish enough so that they can gain an increased feeling of self-worth. Once involvement is gained and reality is faced, therapy becomes a special kind of education, a learning to live more effectively, that is better and more quickly achieved if the therapist accepts the role of teacher.

# Narcotics

*Continued from page 25*

*Addict in the Street*, a remarkably illuminating collection of tape-recorded interviews with some thirteen young New York City addicts. Gathered between 1957 and '64 by Ralph Teffer-teller, assistant director of the Henry Street Settlement, they have been carefully and intelligently edited by Jeremy Larner, an able journalist who has also provided an introduction. The book has in addition a preface by Helen Hall, director of the Settlement.

Mr. Larner reveals how narcotic addiction affords escape from the boredom, confusion, and frustration of underprivileged life for urban youth:

> Addiction is a sort of cop-out. Without heroin there will be pain and uncertainty, the empty anonymity of people at the bottom. But as nearly every subject in this book explains: *when you are high on heroin, you don't feel a thing; nothing bothers you.* . . .
>
> Drug addicts stick together because they need each other to recreate the games of hide-and-seek, cops-and-robbers they enjoyed as children, when they first learned to act in groups of male cohorts. Addicts search for money together, wait for the pusher together, take off together, go to jail together, and—like other playmates—spend endless hours talking about their adventures. Prison, for the addict, is a place where he can exchange information and anecdotage with a large range of lodge-brothers—find out who has what kind of stuff where, learn the latest twist in lifting, pilfering, mugging, boosting and burglary. It is an exciting life, a dangerous life. . . . Addiction is a poor boy's university. One addict calls it "the Wild West," and "the New Frontier."

So far as I am aware, there is nothing in previously published literature on the subject that so vividly and factually describes the mental reactions, social patterns, and pathological behavior of youthful addicts. Nothing surpasses, if indeed equals, this collection of interviews for providing insight into the addiction problem in its most serious and challenging manifestation today. From the book it appears that even the removal of narcotic cases from the realm of criminality and applying to them our best medical knowledge will not solve the problem of underprivileged urban youth.

If the latter can no longer get the excitement they crave through the complicated game of addiction they are likely to turn to juvenile gang warfare or other more serious forms of deviant behavior. Addiction is only one avenue of escape. What is needed are broad social reforms which will provide an urban living pattern that does not invite violence or rebellion.

The narcotics mess is as appalling today as Prohibition was in the early 1930s, but the situation with respect to change is quite different. There is no effective lobby of a multi-million-dollar industry, as in the case of liquor, to battle against illegal drugs. Yet legalizing drugs would wipe out the drug racket overnight. A few large drugstores or public health centers could supply at a relatively trivial cost all the heroin needed for an even larger body of addicts than now exists. The bureaucratic self-interest of the repressive régime finds common ground here with the narcotics racketeers in wishing to continue the present system.

The medical world, after enunciating a sane professional approach to the narcotics problem, refuses to unite and protect doctors when individual practitioners seek to apply the tenets of the American Medical Association program, even though crucial court rulings have given doctors at least a limited right to do so. Few doctors wish to face the prospect of expensive trials and damaging publicity to demonstrate their legal rights and express their professional convictions.

Buried under an avalanche of misleading information and sensational propaganda, the public is abysmally ignorant regarding the realities of the narcotics problem. However, while the facts about the situation are the indispensable basis of all needed reforms, any scholar or journalist who has dared to set them forth has placed himself in personal and professional jeopardy; as the experience of so restrained and distinguished a scholar as Professor Lindesmith provides ample evidence. A rational solution of the narcotics problem is likely to be long delayed. The extensive circulation of his book and *The Addict in the Street* would constitute a strong push in the right direction.

**FRAZER YOUNG'S**
**LITERARY CRYPT No. 1126**

*A cryptogram is writing in cipher. Every letter is part of a code that remains constant throughout the puzzle. Answer No. 1126 will be found in the next issue.*

VKM DOMGNGPVMNV ZRPFCV-

CRP RL OCLM CN CP CPZRTPCVR.

ZRUOMA

***Answer to Literary Crypt No. 1125***

*Clever liars give details, but the cleverest don't.* —ANONYMOUS.

# Letters to the Editor

*Continued from page 21*

characterizes most fables, and such a sharply defined duality is the essence of most folk philosophy.

The thousands of Berkeley students who continued their regular activities; the student editorials denouncing the tactics of the demonstrators; the student petitions supporting administrative actions; the influence of the faculty senate, which provided a forum for widely varied faculty opinions; interaction between the local Berkeley administration and the university-wide administration; these and many other untidy elements of the kaleidoscopic reality appear to have been discarded by N.C. for the sake of black-and-white allegorical impact.

The two stylized antagonists are then described by N.C. as motivated by primal vengeance. "The students violated a school regulation. . . . The authorities acted to punish the violators." The fact that the authorities acted originally not to punish, but to restrict certain prohibited student activities, then in an effort at compromise to modify those restrictions, and only as a last resort, and for quite different reasons, punitively—all this is apparently neglected as too complex for the basic lesson in human conduct which N.C. is illustrating.

His simplistic account continues, "Then ensued a grim escalation of force on both sides. . . ." To mention the many hours of meetings among administrators, faculty, and students attempting to formulate compromises, heal wounds, and avoid further use of force would seemingly confuse his Aesopian story.

In a violent denouncement, N.C. has the administration of the university "bringing in the police and putting large numbers of students in jail." It is a matter of public record that the Governor, not the university administration, was responsible for the involvement of off-campus police.

To illustrate the "flailing" inadequacy of his inimical administration, N.C. describes the student actions as "shenanigans" which could easily be dealt with through the application of a little elementary student psychology. In his next paragraph, however, he glorifies the student protagonist by exclaiming that "American students have erupted into action . . . not all of [which] is tidy or proportionate."

The elemental characters which people N.C.'s parable misrepresent both by omission and commission the many reasonable and conscientious participants who worked ceaselessly to minimize the trauma of these events. N.C. "wonders what would have happened if the administration had tried to isolate the subsurface factors in moving toward a constructive result." Such factors were, indeed, recognized by the administration, and it is frightening speculation to consider what would have happened had the efforts toward a constructive result been less successful than they were.

The "impersonality of modern higher education" and "atmosphere of disconnection and even dehumanization" which N.C. implies were not comprehended have been a deep and constant concern to the administration for a long time. The design of new