

Choice, Responsibility, and Recovery

Reality Therapy in Addiction Counseling

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Counselor Education

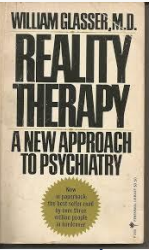
By the end of this training, you will be able to:

- Explain the foundational principles of Choice Theory and Reality Therapy
 - including the five basic needs, total behavior, and quality world
- Use the WDEP framework to structure clinical conversations with addiction clients across individual and group settings
- Identify how substance use represents a maladaptive attempt to meet basic psychological needs
- Integrate Reality Therapy with the Stages of Change model and motivational interviewing strategies
- Develop individualized RT-based treatment plans that balance client autonomy with accountability
- Demonstrate competency through interactive case studies and hands-on WDEP practice

Who Was William Glasser?

Groundbreaking psychiatrist who challenged the mental health establishment in 1965.
Moving away from psychodynamic and moving toward autonomy!

- Published Reality Therapy (1965)- argued problems stem from **inability to meet present needs**, not unresolved past conflicts
- Developed Choice Theory (1998)- provided the theoretical backbone for RT as we know it today
- Core question: *“What are you doing right now and is it working?”* Simple. Direct. Clinically transformative.
- Internal control psychology: we can only control our own behavior, not other people or events
- **All long-lasting psychological problems are relationship problems at their core** (Wubbolding, 2022)



1965
Reality Therapy
published

1998
Choice Theory
published

Today practiced
in 20+ countries
(Wubbolding et al., 2004)

CBT arrived a little
later in 1967

The Ten (10) Axioms of Choice Theory

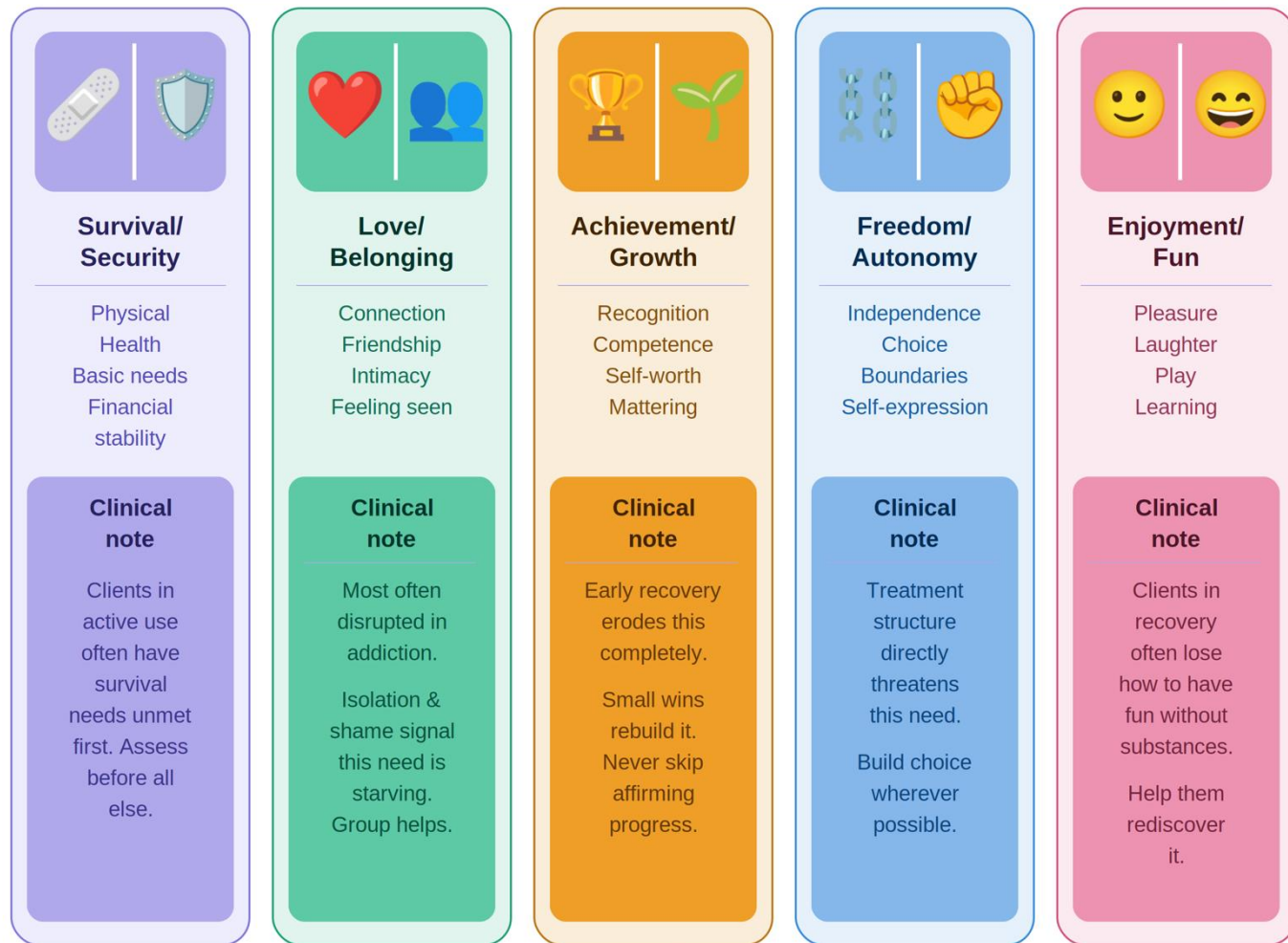
(the philosophy before the techniques)

- The only person whose **behavior you can control is our own.**
- All we can **give or get from other people is information.**
- All long-lasting psychological problems are **relationship problems.**
- The problem relationship is always part of our **present lives.**
- What happened in the past that was painful has a great deal to do with what we are today, but **revisiting this painful past can contribute little or nothing to what we need to do now:** improve an important, present relationship.
- We are driven by **five genetic needs:** survival, love and belonging, power, freedom, and fun.
- We can **satisfy these needs** only by satisfying a picture or pictures **in our Quality Worlds.**
- All we can do from birth to death is behave. All behavior is **Total Behavior** and is made up of four inseparable components: **acting, thinking, feeling and physiology.**
- **All Total Behavior is designated by verbs,** usually infinitives and gerunds (*-ing*), and named by the component that is most recognizable.
- All Total Behavior is chosen, but we have **direct control over only the acting and thinking components.**

(Glasser Institute of Choice Theory, n.d.)

The Five Basic Needs

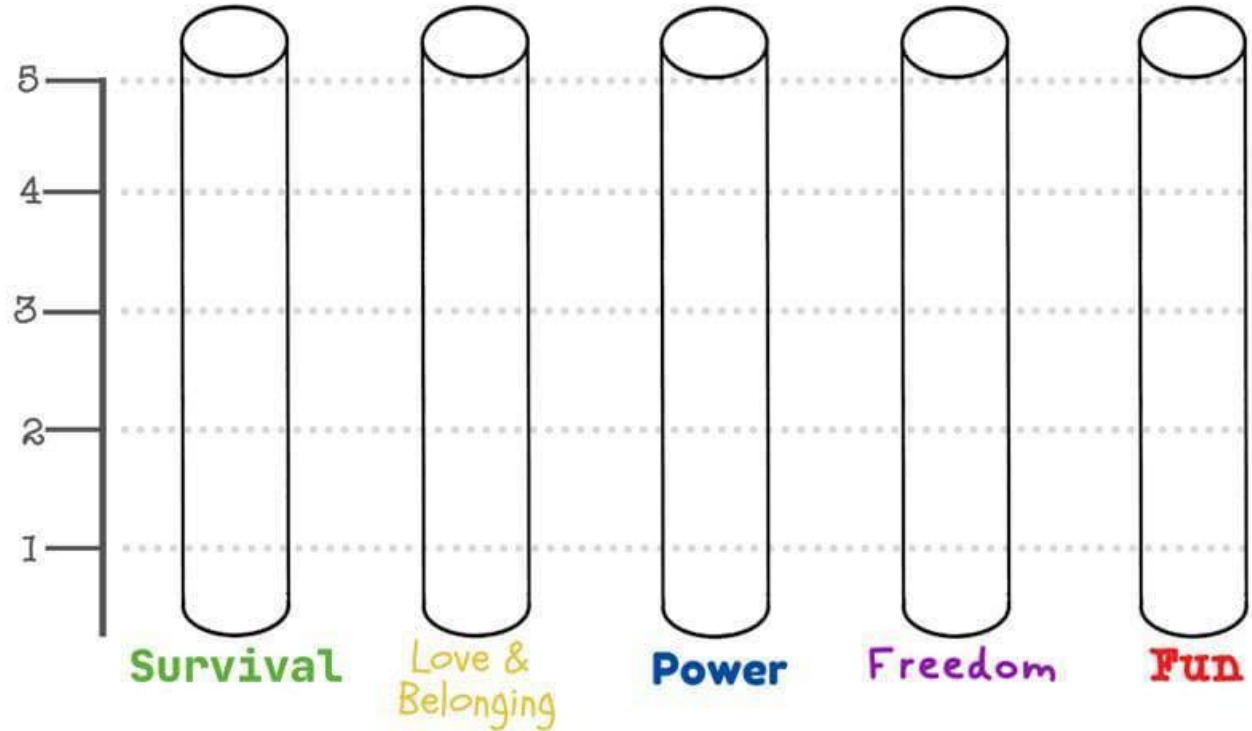
These are not preferences, they are universal genetic instructions driving all human behavior (Wubbolding, 2022)



Values Alignment



Basic Needs Scale



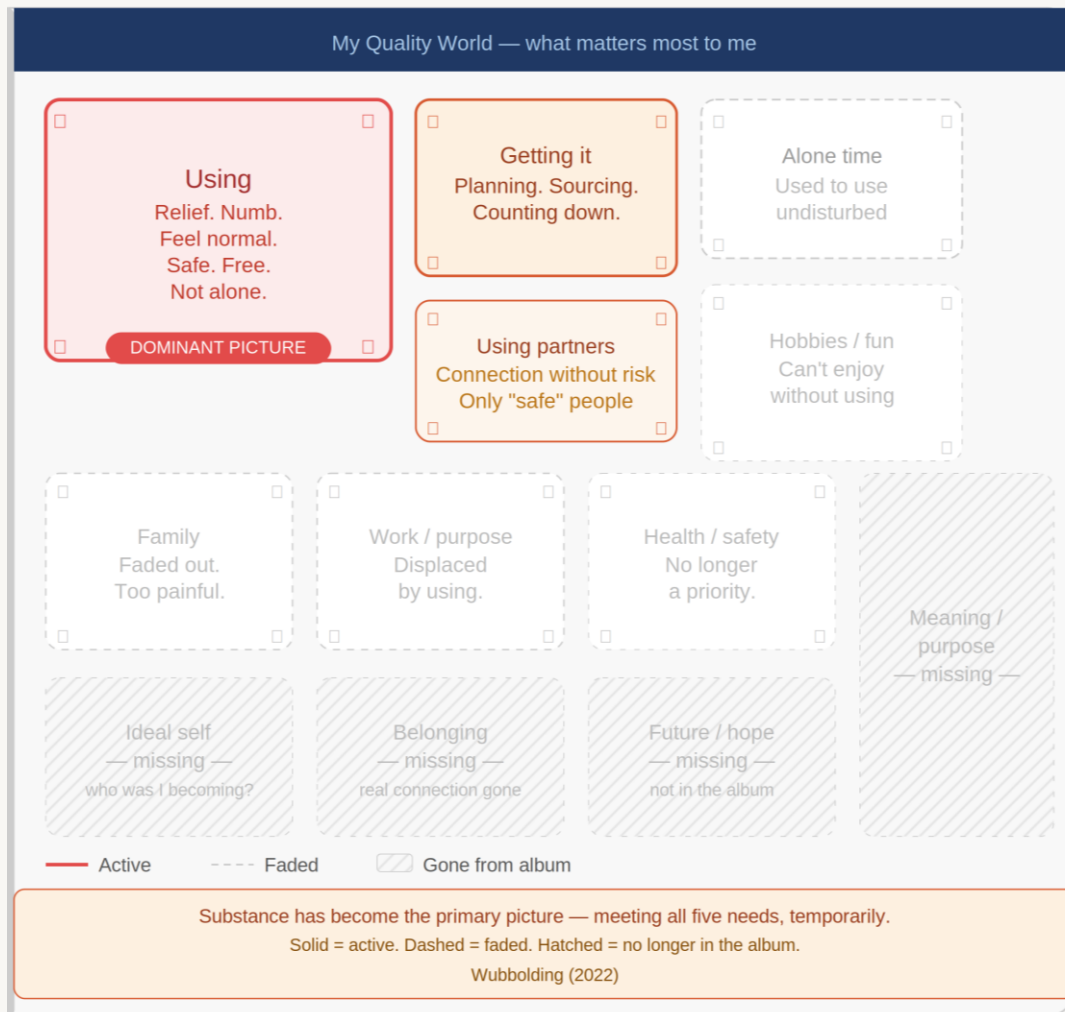
Handout

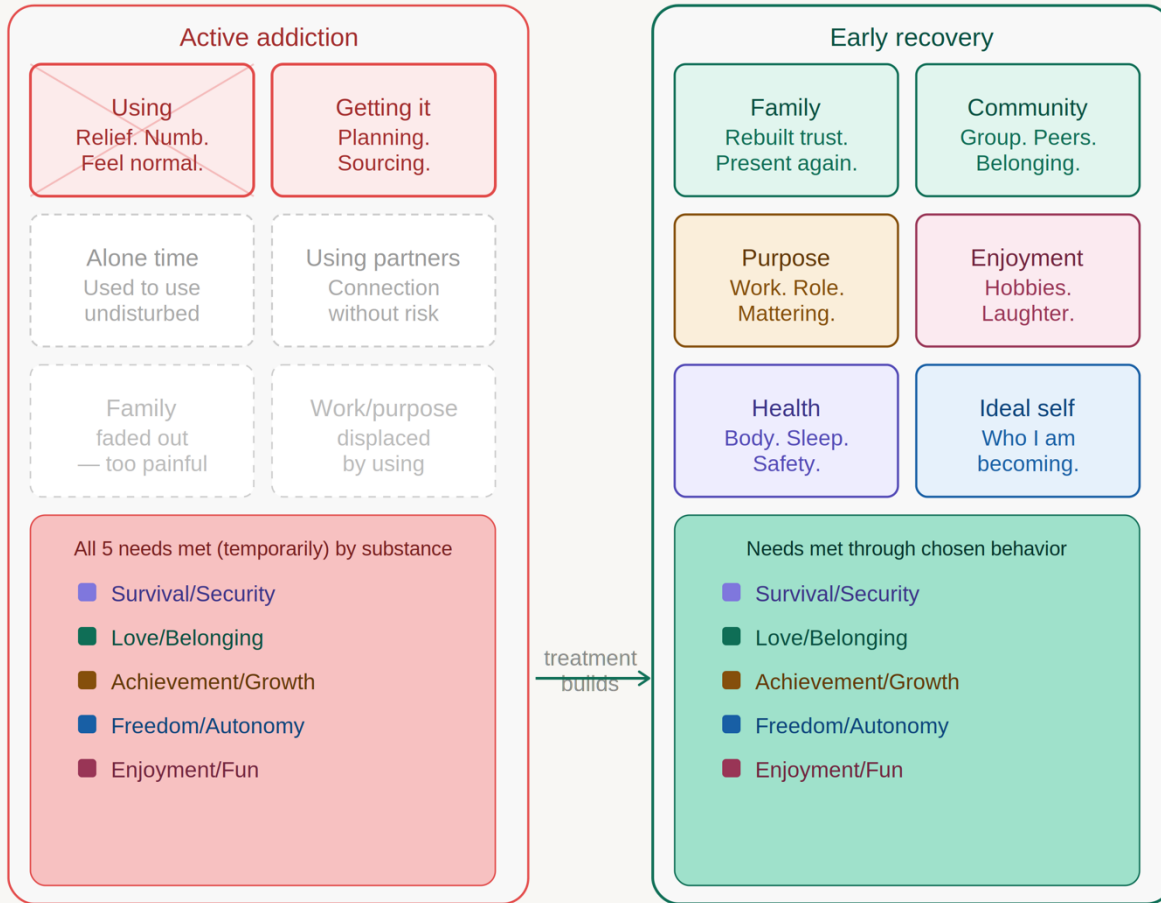
The Quality World

Your personal mental photo album — the pictures you carry of a life worth living.

- Every person has an **internal album of pictures**: people, places, things, experiences, beliefs, and an ideal self
- These pictures **drive all behavior**
 - We are always moving toward or away from our quality world
- **Substance use becomes a quality world picture when it reliably meets one or more basic needs**
- The pictures changes over time
 - pre-addiction, active use, treatment, recovery, and maintenance
- **The clinical work: understand what is in the album, then help build healthier pictures that meet the same needs**
- Quality world pictures are culturally shaped
 - explore with curiosity, never assume (no matter time you've work with the client!)

Quality Word During Active Substance Use





Quality Word Shift During Early Recovery

The needs never change. The pictures that meet them do.

Recovery = replacing substance pictures with healthier ones — without leaving empty frames.

Wubbolding (2022) — dashed frames = faded pictures during active use.

Total Behavior — The Four Wheels

ACTING — Front wheel

What you physically do
Direct control — this is where change starts

FEELING — Back wheel

Your emotions
Indirect — follows the front wheels

THINKING — Front wheel

What you tell yourself
Direct control — thoughts you can redirect

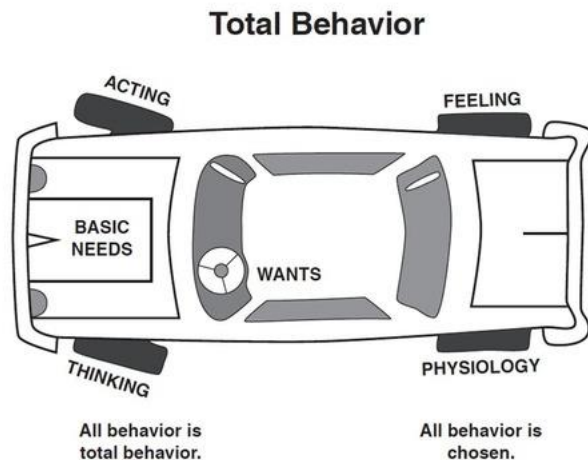
PHYSIOLOGY — Back wheel

What your body does
Indirect — follows the front wheels

You can indirectly choose to feel better by choosing what you do next (we all know this is true already!)

Technique: Rather than saying “I am depressed” (which implies a static state happening to you) Glasser suggested to say, “I am depressing” or “I am choosing to depress.”

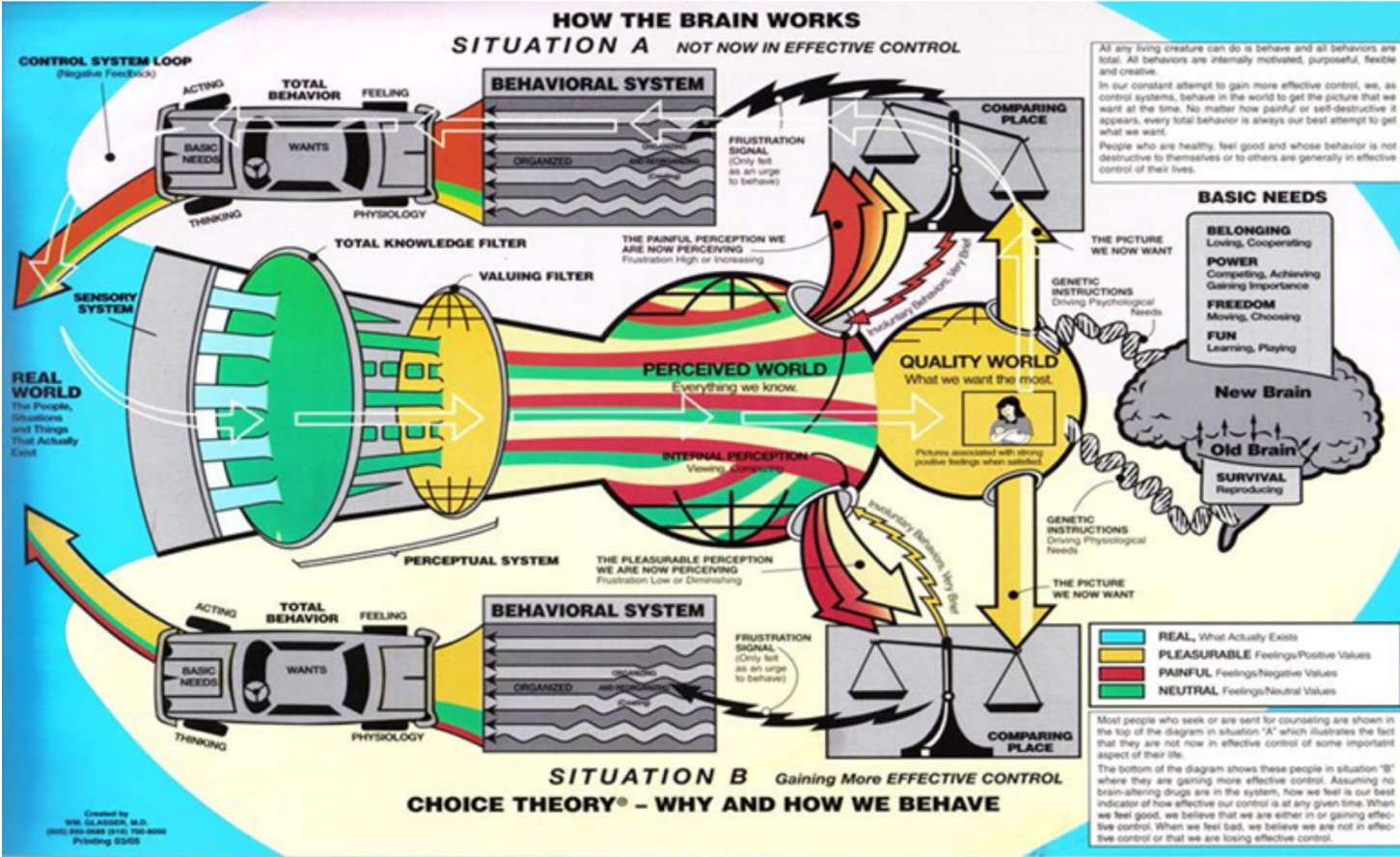
All behavior has four inseparable components. You can only steer the front wheels directly.



Represents everything a person knows or has experienced in THEIR life.

- 1 of 3 things happens:
- 1) it gets discarded as meaningless
 - 2) flagged for further investigation
 - 3) or passed through to the **Valuing Filter** where it is assigned a positive, negative, or neutral value.

We do not all live in the same "real world." We live in our perceived worlds!



The WDEP Framework

A structured clinical conversation , not a script, but a framework (Wubbolding, 2022)

W Quality World	D Total Behavior	E The Cornerstone	P SAMIC ³
Wants	Doing	Evaluate	Plan
<p>What do you want? What does your ideal life look like?</p> <p>Explore the client's quality world pictures.</p>	<p>What are you actually doing and what direction is it taking you?</p> <p>All four wheels: acting, thinking, feeling, physiology.</p>	<p>Is what you are doing getting you what you want?</p> <p>Client self-evaluation — not the clinician's judgment.</p>	<p>Simple Attainable Measurable Immediate Controlled (client) Committed Continuous</p>

Why Reality Therapy Works with Addiction Clients

Substance use is need-satisfying behavior

Not broken or immoral — a strategy that worked until it didn't. Understanding this enables genuine empathy.

Present-focused by design

Redirects from “why am I stuck” to “what am I doing today?” Purposefully, without dismissing trauma.

Responsibility without shame

If behavior is chosen, it can be re-chosen. Reducing blame, increasing liberation!

Integrates with what you already do

MI, Stages of Change, trauma-informed care — RT enhances all of them (Wubbolding & Brickell, 2005; Miller & Rollnick, 2013).

The Research Base in Addiction Counseling



Metacognitive awareness
improved significantly
(Jahromi & Mosallanejad, 2014)



Hope
increased significantly
in addiction treatment
(Jahromi & Mosallanejad, 2014)



Self-efficacy in decision-making
improved (Law & Guo, 2015)



Self-efficacy in coping skills
improved
(Law & Guo, 2015)

How Reality Therapy In Culturally Responsive

Quality world exploration is client-defined, not clinician-imposed. The W component **imports no assumptions about what a good life looks like.** The clinician refrains from deciding what should change, the client's own values and cultural frame define what belongs in their album (Wubbolding, 2022; Hunter, 2024).

The five basic needs are universal; how they are met is not. RT is practiced and researched across 20+ countries including Taiwan, Iran, Malaysia, Korea, and Japan. The needs are consistent across cultures; the **quality world pictures that fill them are culturally specific** and must be treated as such (Wubbolding et al., 2004).

The non-coercive stance reduces institutional harm for marginalized clients. For clients from communities with histories of coercion by systems, RT's explicit **rejection of clinician authority and external control directly addresses a clinical barrier** that other frameworks often ignore (Furukawa & Hunt, 2011).

RT can be integrated with relational frameworks that center cultural context. Haskins and Appling (2017) propose that RT's assumptions are consistent with Relational-Cultural Theory, together providing a culturally responsive approach that **extends quality world examination to include societal-level disconnection**, not just personal behavior.

Where Reality Therapy Needs More Cultural Awareness/Adaptation

Internal control psychology assumes individual agency is the primary unit of change. For clients from collectivist cultures where family obligation and relational harmony are central to identity, framing behavior as individually chosen can pathologize culturally grounded decision-making (Zamarripa, 2022).

"Choice" language minimizes structural barriers for racially and economically marginalized clients. RT's personal responsibility frame must be applied alongside explicit acknowledgment that **behavioral options are not equally available across contexts** of poverty, racism, or legal system involvement (Hunter, 2024; SAMHSA, 2014).

RT's direct questioning style conflicts with indirect communication norms. The E and W components assume clients will state wants and evaluate behavior directly and explicitly, a communication norm that does not hold across many Asian, Middle Eastern, and Indigenous cultural contexts, **where directness can register as confrontational** (Hall et al., 2011).

The empirical base excludes key populations. RT's cross-cultural research largely omits Black American clients, Indigenous populations, and communities from the Global South, meaning cultural adaptations for these groups remain clinician-generated rather than empirically validated (Hunter, 2024).

Trauma Informed Care (TIC) through Reality Therapy

- **Your caseload is a trauma caseload.** Between 85–100% of adults in SUD treatment report at least one adverse childhood experience, and 30–50% meet criteria for lifetime PTSD (Brady et al., 2021).
 - *RT's non-coercive therapeutic environment is not a stylistic preference it is a **clinical necessity**.*
- **Comorbid PTSD and SUD produces worse outcomes across every measurable domain** — higher suicide rates, more legal problems, worse treatment adherence, and less improvement during treatment than either disorder alone (McCauley et al., 2012).
 - *RT's present focus and self-evaluation framework keep clients anchored in what they can influence now (without requiring trauma excavation before the relationship is established).*
- **In most cases, PTSD precedes the SUD.** Longitudinal evidence consistently shows that PTSD typically develops before SUD onset, substances become the most effective available strategy for managing unmanaged trauma symptoms (Tran et al., 2023).
 - *When you ask, "what do you want?" you are not just exploring goals, you are uncovering what the substance has been providing. **The answer is almost always a trauma-related need.***
- **Integrated treatment works.** Clients receiving a trauma-informed model alongside SUD treatment showed significant reductions in substance involvement, depression, anxiety, and PTSD compared to treatment as usual (Mefodeva et al., 2024).
 - *RT does not replace trauma-specific treatment, it provides the relational and behavioral container within which trauma-informed care can operate.*

SAMHSA TIC Principle	What it Requires Clinically	Where RT Delivers
Safety	Physical and psychological safety in every interaction	RT's non-coercive environment; relationship precedes framework; clinician models that evaluation is not punishment
Trustworthiness & Transparency	Clear communication; no hidden agendas; consistent follow-through	WDEP is named and explained to clients; plans are the client's own; clinician does not secretly evaluate and direct
Peer Support	Lived experience as a vehicle for safety, hope, and healing	RT's Peer self-evaluation in group normalizes the process and reduces shame
Collaboration & Mutuality	Power differences actively leveled; healing happens in relationship	RT explicitly rejects clinician-as-authority; plans are never the clinician's prescription; self-evaluation belongs to the client
Empowerment, Voice & Choice	Client agency is primary; clinician's role is to facilitate, not direct	WDEP's entire architecture — W, D, E, P — returns agency to the client at every step
Cultural, Historical & Gender Issues	Cultural context actively addressed; historical trauma named	Quality world exploration honors culturally shaped wants; RT requires adaptation for collectivist, Indigenous, and historically marginalized clients.

MI and RT-Hand in Hand

O-open questions

Use open questions when exploring (W)ants (& more) (activity coming up!)

A-affirmations

Use affirmations to reinforce the client's strengths and past successes as you discuss what they are (D)oining.

R-reflections

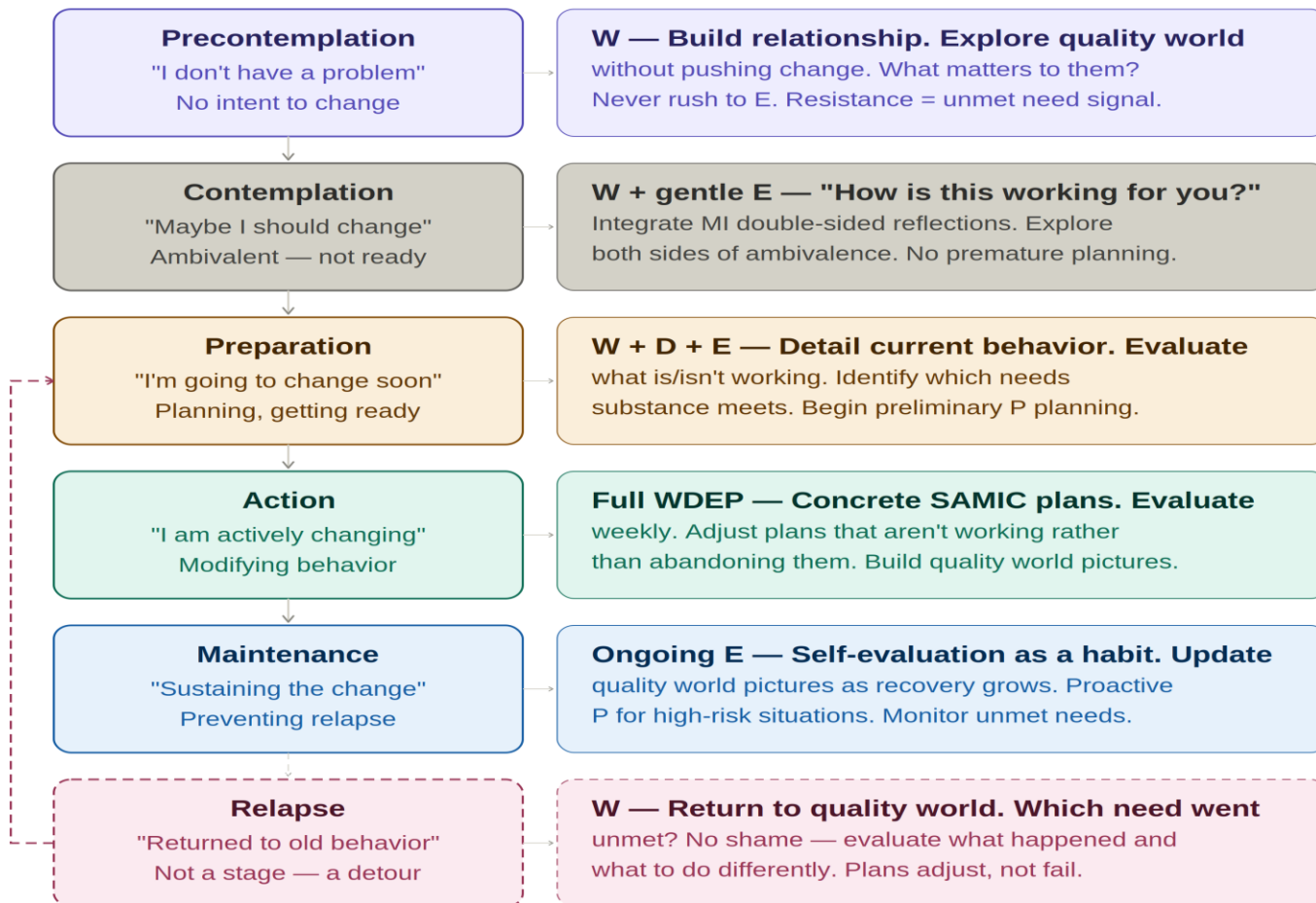
Use double-sided reflections during (E)valuation to help clients hear their own ambivalence.

S-summaries

Use summaries when transitioning from (E)valuation to (P)lanning to consolidate what the client has expressed.

The spirit of MI (partnership, acceptance, compassion, and evocation) aligns naturally with Reality Therapy's emphasis on a non-coercive, warm therapeutic relationship.

Reality Therapy and the Stages of Change



RT in Individual Counseling

The WDEP process is not linear. Follow the client.

Early sessions

Relationship first. W exploration. Build quality world map. Do not rush to evaluation.

Middle sessions

D examination. Gentle E — “Is this getting you what you said you want?” Introduce planning when E is genuine.

Later sessions

Full WDEP. Plans that are SAMIC³. Ongoing evaluation of plans. Adjust, never abandon.

Maintenance

Self-evaluation as habit. Quality world as living document. Early warning sign planning.

RT in Group Counseling

Group is not individual counseling with an audience. It is a quality world laboratory.

The group is itself a quality world picture

- For isolated clients, group may be the first experience of genuine belonging in treatment

Use WDEP to structure group check-ins

- **W: What did you want to change this week?**
- **D: What did you do?**
- **E: Did it work?**
- **P: What's the plan?**

Peer self-evaluation is often more powerful than clinician evaluation

- When a group member asks, “*Is that working for you?*” — that is the E component doing its best work

Normalize the diversity of need profiles in the room

- One member's primary need is belonging; another's is freedom. Both are right, neither is wrong. How can they support each other?

Group as a testing ground for new behaviors

- The front wheels (acting and thinking) can be practiced in session before they are tried in the world

Activity 1: Needs Assessment Card Sort

Time: 30 min

Format: Small groups of 4–5

Materials: Card sort decks (20 cards)

- Each group receives 20 client vignette cards — read each one and sort by **dominant basic need**
- There are no single correct answers — reasonable clinicians will disagree and that disagreement is the clinical value but try to come to consensus for the next step!
- Pick one group (based on need). Discuss how your group would use RT principles to help each client address that need right now, based on their specifics (e.g., level of treatment, other areas of clinical attention, etc.).

Debrief questions: Which card was hardest to categorize, why? Where did the group disagree most strongly? How might your own need profile influence which need you identify first?

Activity 2: The Evolving Case of Nadia

Time: 30 min

**Format: Groups of 4–5,
mixed experience levels**

**Materials: Case document +
consultation worksheet**

Phase 1

First contact & incomplete disclosure

Phase 2

Level of care based on new disclosure

Phase 3

Thick of treatment

Phase 4

Maintenance risk factors

Don't peek ahead, focus on each phase at a time on the worksheet!

Key Takeaways

1

RT is not about telling clients they chose their addiction. It is about empowering them to choose differently.

2

The five basic needs are your clinical compass. Substance use is always serving at least one.

3

WDEP is a clinical framework, not a script. Let the client's responses guide where you spend time.

4

RT integrates and enhances with motivational interviewing, Stages of Change, and trauma-informed care.

5

Cultural competence in RT is continuous. The needs are universal. The pictures that fill them are not.

Want More?

Email me at jillmkrahwinkel@gmail.com

Today's Slides

Today's Worksheets

New Material:

200 WDEP Question Bank; RT Treatment Plan Template; Client-facing Worksheets

Do the work yourself.

What do you want from your clinical practice? What are you doing to get there?
Is it working? What could you do differently?

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