

Using the WDEP System of Reality Therapy to Support Person-Centered Treatment Planning

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Formulating a written treatment plan is now required by most 3rd-party payers and is standard practice in mental health agencies throughout the United States. Treatment plans include the formulation of goals, objectives, and treatment interventions. Congruent with diagnostic categories, the WDEP (wants, doing, evaluation, and planning; Wubbolding, 2000, 2011) system of reality therapy provides a useful structure for fulfilling these requirements. This structure can be readily integrated into other modalities used by counselors for a person-centered approach to treatment planning.

Keywords: treatment planning, person-centered, WDEP system, choice theory, reality therapy

Treatment plans consist of goals, objectives, treatment interventions, and treatment outcome measures. Most third-party payers, including private insurance, Medicaid, and Medicare, currently require the submission of treatment plans prior to approving reimbursement for clinical intervention. Many third-party payers are now managed care organizations (MCOs). The National Conference of State Legislatures (2013) noted, "Over the past 20 years, managed care has become the predominant form of health care in most parts of the United States" (p. 1). Seligman (2004) observed, "MCOs have helped promote the use of diagnosis and treatment planning" (p. 11) in counseling, noting that "Many treatment providers also express considerable concern about the paperwork required by MCOs, difficulty dealing with their bureaucratic structures, and delays and denials of payments" (p. 11). According to Danziger and Welfel (2001), "Treatment plans must conform to MCO protocols" (p. 138) in order to get reimbursed under managed care. In their survey of counselors across several states, Danziger and Welfel found that 60% of the 108 respondents reported "revising treatment plans to fit MCO protocols" (p. 146). Danziger and Welfel concluded that counselors are seldom free to plan and implement treatments independently. Treatment planning in counseling has been, and is being, affected by managed care.

Despite managed care's influence, Townsend (cited in Adams & Grieder, 2005, p. xiii) observed that counselors and others "who have developed skills in person-centered

planning appreciate the importance of treatment plans beyond reimbursement and administrative requirements" and also that "a person-centered approach can and does make a real difference for individuals and supports their growth and recovery." We suggest that choice theory and the WDEP (wants, doing, evaluation, and planning) system of reality therapy offer one avenue for approaching person-centered treatment planning in counseling (Glasser, 1998, 2000; Wubbolding 2000, 2011). Furthermore, this approach can both support and facilitate person-centered planning. In this article, we describe case conceptualization and treatment planning using choice theory and reality therapy. To do this, we present relevant tenets of choice theory and aspects of the WDEP system of reality therapy and also address the research base for reality therapy.

Case Conceptualization

Writing an effective treatment plan involves a prior conceptualization of the case. The case conceptualization is a report based on acquired data structured and analyzed to provide an interpretation of client behavior. Vandenberghe (2015) stated that case conceptualization often "provides for attuning interventions to clients' problems and goals" (p. 442). Case conceptualization is also the description and interpretation of client behavior seen through the lens of a theoretical perspective. A cognitive therapist attends to cognitive distortions voiced by the client because cognitive

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theory views such distortions as the source of the client's problems. A behavior analyst may recognize certain antecedents and reinforcements as the source of the client's issues, whereas an object relations therapist may see the parent-child relationship as the blueprint for most future relationship issues.

A reality therapist conceptualizes the client's behavior through the lens of choice theory. According to Glasser (1981, 1998), one of the major principles of choice theory is that people are motivated to fulfill wants (which Glasser referred to as *quality world pictures*) related to one or more of the five basic needs, including survival/self-preservation, love/belonging, power/achievement/inner control, freedom/independence, and fun/enjoyment. The reality therapist uses these basic needs as a diagnostic schema to assess the strengths and areas for improvement (Fulkerson, 2015). More specifically, the reality therapist helps clients identify quality world pictures or wants that are satisfied, as well as pictures or wants that are unsatisfied, vague, unclear, or in conflict with other quality world pictures (Wubbolding, 2015). In the context of treatment planning, Fulkerson (2015) noted, "The objectives are related to quality world pictures, while the needs are more related to goals. This makes sense because it is through our quality world pictures that we satisfy our basic needs" (p. 22). By accessing clients' quality world pictures or wants, in addition to basic needs, the reality therapist gathers client input for the treatment plan and avoids sending the message, "I know what is best for you." Instead, clients are perceived as experts on the content of their own quality worlds. In other words, the reality therapist at least begins with the assumption that clients know what is good for them. However, a cautionary note is needed here. Clients' quality worlds (i.e., their desires and wants) are often harmful to themselves and others. Effective reality therapists are always aware of the necessity to work within the boundaries of ethical requirements, by sometimes intervening to prevent destructive behaviors.

Chinman et al. (1999) explored the difficulties inherent in truly collaborative treatment planning. According to the Institute of Medicine (2001), service delivery systems are failing to meet people's needs mainly because they are not person-centered. Research cited in the 2011 Commonwealth Fund report on patient engagement (see Adams & Greider, 2014) found that when persons are given the opportunity to provide input into their health care, such as treatment planning, they have better outcomes. McGuire, Oles, White, and Salyers (2016) noted in their study of veterans' perceptions of treatment plans that "treatment plans should be evaluated at the level of the individual goal rather than the overall plan" (p. 501). Using a choice theory-based case conceptualization and reality therapy in treatment planning is one way that a person-centered approach can be used during treatment planning and goal setting. We discuss this later in the article.

Diagnostic Descriptions

When conceptualizing client behavior from a choice theory perspective, the reality therapy approach to treatment planning utilizes diagnostic descriptions but places less emphasis on them than do many traditional approaches. For example, rather than stating that a client is bipolar, the reality therapist would state that the client is a person who generates behaviors described as bipolar or who exhibits features of a bipolar disorder. This people-first perception helps send a more hopeful message to clients, because it recognizes the diagnosis as only one aspect of their multifaceted being (Fulkerson, 2015). This view of clients' problems is also reflected in required terminology in the 2017 guidelines for submission of proposals by the National Association of Alcohol and Drug Abuse Counselors (2017), which requests, for example, using "person with an alcohol use disorder" instead of "alcoholic" and "person in recovery" instead of "former addict."

As a part of a case conceptualization, the reality therapist may ask how the client sees the outside world. For example: Does the client see other people as allies or enemies? Does the client see himself or herself as the problem or as a capable individual and part of the solution to the problem? What social, historical, or cultural factors are influencing the client's perception? Does the client view the issue from a perception that is nonjudgmental or from a perceptual level characterized by either/or judgments? How much responsibility does the client assume for the treatment issue and the treatment plan? The answers to these questions help counselors assess a client's perceived locus of control (Wubbolding, 2000, 2011).

Reality Therapy and Case Conceptualization

Although reality therapists do not emphasize the language of diagnosis to the extent many other behavioral health practitioners do, they find value in an accurate diagnosis as described in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. [DSM-5]; American Psychiatric Association, 2013) and the *International Statistical Classification of Diseases and Related Health Problems* (10th rev. [ICD-10]; World Health Organization, 2015). These diagnoses provide therapists with a solid description of the organized total behaviors generated by their clients' behavioral systems. Total behavior, in the context of reality therapy, is composed of four parts: action, cognition, feelings, and physiology (see later for further discussion). Accurate DSM-5/ICD-10 diagnoses help counselors become aware of the most recognizable symptoms of a client's total behavior. For example, a diagnosis of generalized anxiety disorder indicates that the feeling component of the total behavior is the most recognizable symptom exhibited by the client. In today's care health system, it is also important for clinicians to maintain professional credibility with peers by ensuring that treatment goals and objectives are related to DSM-5/ICD-10 diagnoses that describe clients' total behaviors (Fulkerson, 2015).

Choice theory provides a comprehensive explanation of human behavior and motivation and is compatible with the practice and necessity of providing a client diagnosis. Once a case is conceptualized, the stage is set for developing a treatment plan. At this point, reality therapy offers a delivery system for person-centered planning. Credible counseling practice requires theory and practice. Completing the triad of credibility requires evidence for the efficacious use of reality therapy, which enjoys a long history of research across disparate settings. Lojk (1986) conducted a 12-year follow-up study of former prisoners, for example, and found that 84% were completely or partially rehabilitated. In the context of juvenile arthritis, Maisiak, Austin, and Heck (1995) reported that the total health status of the treatment group improved significantly ($p < .01$). According to Casstevens (2011, 2013), use of the WDEP system of reality therapy in focus groups at community-based Clubhouse Model programs contributed to health and wellness programs for adults diagnosed with severe mental disorders. Tinsley, Giffin Wiersma, and Lease (2016) noted, "We include only theoretical approaches that, in our judgment, have demonstrated adequate validity" (p. 466), observing that "Representative samples of mental health service providers appear to agree as repeated surveys have shown the theories covered in *Contemporary Theory and Practice in Counseling and Psychotherapy*" (p. 466). Tinsley et al. included reality therapy and the WDEP system in their text.

Clinical Treatment Planning

Generally, clinical treatment plans follow a basic format and identify clients' long-term view along with shorter term treatment goals and objectives (see the Appendix). The clients' overarching long-term view states where they would like to be in their life in the future, often identified as "about 1 year from now." Goals, and objectives that support the attainment of each goal, are also established. Fulkerson (2015) described how semantics can be one of the most confusing aspects of treatment planning. Various funding sources may define goals and objectives differently. To bring more clarity and reduce confusion, Fulkerson recommended defining goals as the desired "outcome" and objectives as "steps in the goal attainment process" (p. 17). Agencies and organizations often provide clinicians with standardized treatment plan templates that meet reimbursement requirements.

Treatment plan templates can be completed in an almost formulaic way by a counselor on behalf of a client, following an initial assessment/therapy session. Such completed templates are generally reviewed briefly with the client at a subsequent session and, after being signed by the client, are filed to meet insurance billing and reimbursement requirements. However, the rigid completion of formulaic templates

can become an obstacle to treatment and a lost opportunity for developing therapeutic rapport and client empowerment. Well-constructed collaborative plans, in contrast, can assist both clients and counselors to track progress in treatment (e.g., Myers, Sweeney, & Witmer, 2000). The WDEP system, developed as a teaching tool and summary of the procedures used in reality therapy (Glasser & Glasser, 2008; Wubbolding, 2000, 2011), can also offer a client-centered approach to treatment planning.

The skillful use of the WDEP system of reality therapy can enhance client involvement in, and commitment to, treatment (Glasser, 1998, 2000; Wubbolding 2000, 2011, 2015; Wubbolding & Brickell, 2015). Corey (2017) stated, "Clients are helped by the therapist who does not easily give up believing in their ability to make better choices, even if they are not always successful in completing their plans" (p. 326). Reality therapy, based in choice theory, proffers this framework.

Glasser (1965, 1998, 2000) originally developed reality therapy in a correctional facility and mental hospital in the 1960s. In the 1980s, Glasser discovered a theory of brain functioning known as control theory, or control system theory (Powers, 1973). Glasser (1998) appropriated control theory, with significant alterations, applying it to both education and counseling. With these alterations and the added principle that human beings choose their behavior, Glasser (1998) determined it was fitting to rename the theory choice theory. Counselors using reality therapy, based in choice theory, are relentless in helping clients discover and pursue a life of satisfying choices.

Within the choice theory/reality therapy model, Glasser (1998, 2011) formulated the principle of total behavior. As noted previously, total behavior comprises four parts: action, cognition, feelings, and physiology. A central premise of choice theory is that individuals can only control their own behavioral choices, not those of others. Furthermore, counselors are conscious that effective control of behavior is generally limited to actions and thoughts. Thus, a client needs to actively and cognitively participate in the clinical treatment for it to be successful. This does not imply that reality therapy is inappropriate for mandated clients, although clinical experience indicates that clients are more likely to actively engage and participate in treatment if they collaborate with the counselor at the outset and in developing goals and objectives.

Wubbolding (2000, 2011) developed the WDEP system to assist counselors with learning reality therapy. The system emphasizes the use of the following explorations and questions (hence the WDEP acronym):

- W: What do you *want* from the world around you? From your family? Friends? Job? Judge? Describe what you are getting and what you are not getting from your surroundings and even from yourself.
- D: What are you *doing* to move in a desirable direction? Talk about what you have chosen to do lately; in other



words, how have you been spending your time? Is what you are doing moving you closer to, or further from, what you want?

- E: Summarize how your actions are getting you closer to or further away from the important people in your life (*self-evaluation*). Include a few comments about the people around you who could help you or could hurt you in your effort to make better choices.
- P: What is your immediate and specific *plan* for satisfying your wants—that is, for achieving your shorter term goals, and your long-term view? Keep in mind that plans should be simple, attainable, measurable, immediate, and controlled by you the planner and not by other people.

Counselors can use these exploratory suggestions and questions to develop formal, written treatment plans collaboratively with clients, regardless of their preferred model or approach to counseling.

Clients enter counseling because of unmet human needs, that is, because of motivators described by Glasser (1998, 2011) as survival or self-preservation, love and belonging, power or inner control, freedom or independence, and fun or enjoyment. Clients also want something from the counseling process. They often come willingly, but sometimes unwillingly. Their want may be to satisfy a court order, or as they often say “to get them off my back.” A court-ordered client’s overarching long-term goal is often stated as “to complete my probation satisfactorily.”

Depending on client circumstances, short-term goals for a reluctant or court-ordered client might include completing a court-ordered batterers’ class, staying drug and alcohol free to satisfy probation requirements, or having positive relationships with children even though the client might be separated or divorced. Goals can be identified and processed with a client during initial counseling sessions. Using the WDEP system of reality therapy helps facilitate client engagement as well as the development of goals and objectives that support a client’s overarching long-term worldview. These WDEP questions and explorations are congruent with cognitive therapy, Adlerian therapy, and brief therapy, to name just a few.

For example, a treatment plan for mandated clients might include objectives that support a goal of completing a class for batterers, including (a) registering for the class; (b) attending classes as scheduled; and (c) discussing successes and barriers encountered, such as their own resistant thoughts and feelings. Objectives that support a goal of staying drug and alcohol free might include (a) identifying unmet basic needs; (b) defining total behaviors—that is, actions, self-talk, and feelings—that help meet these needs without substance use; and (c) implementing specific behaviors. Similarly, objectives supporting a goal of developing positive relationships with children might include (a) identifying tonic or healthy

behaviors, such as spending time together, and toxic or unhealthy behaviors, such as arguing, blaming, and criticizing; (b) discussing children’s likely responses; and (c) role-playing the use of specific helpful behaviors during clinical sessions. A brief discussion about basic needs and total behaviors (both tonic and toxic) constitutes effective psychoeducation during the treatment planning process. Consequently, developing a complete treatment plan in a collaborative manner with a client can take more than one session.

■ Diagnosis, Treatment Planning, and Counseling

Using the *DSM-5* and/or the *ICD-10* in diagnosing mental disorders is required in the United States for third-party reimbursement. A common objection to providing a psychiatric diagnosis is that it can be countertherapeutic because clients often perceive it as disabling, disempowering, or stigmatizing (Glasser, 2003; Read, Mosher, & Bentall, 2004). When counselors provide a diagnosis, it needs to accurately reflect observed or reported symptoms. This can be a sensitive area for clients. If clients are concerned or distressed by a diagnostic label, it is important to help them understand that the label is required for managed care purposes, and more importantly, that the label only reflects what is reported or observed at that time. Finally, the counselor can empathically explain that these reports and observations often change over time and therefore demonstrate possible progress in the treatment. In our experience, based on client file reviews, diagnostic labels can change repeatedly with the passage of time, even for clients adjudicated by the federal government as psychiatrically disabled with serious and persistent mental illness.

Treatment planning usually needs to address symptoms associated with the primary psychiatric diagnoses assigned to clients, for both clinical and reimbursement purposes. For example, if a substance use diagnosis has been assigned, the second goal of staying drug and alcohol free directly relates to this diagnostic label, and it is likely that the first and third goals indirectly relate to the label. Treatment planning processes using the WDEP system of reality therapy can incorporate the diagnostic components required by managed care, while facilitating person-centered planning and thereby promoting positive treatment outcome.

■ Summary

Choice theory, developed by William Glasser, takes its roots in control system theory, which explains how the human mind functions in ways similar to that of a computer. The input is the information a person receives from the outer world; the output constitutes behavior that a person generates. Choice theory emphasizes human behavior as a choice generated to satisfy innate human needs. The five human needs are universal in that

the behavior of every person, regardless of cultural background, springs from these genetic needs or motivators. Reality therapy is based in choice theory, and as summarized in the acronym WDEP, provides a practical and usable system for developing a treatment schema.

Treatment plans include a statement of goals and specific objectives required to meet those goals. This requirement is quite congruent with the practice of helping clients identify and clarify their goals or wants; examine their behaviors, especially their actions; evaluate the effectiveness of their behaviors; and formulate specific steps to achieve desirable wants or goals. This entire process is congruent with many other theories and methods and is compatible with the requirements of managed care and treatment planning. Recent research has shown that current delivery systems are not meeting people's needs mainly because they lack a person-centered care perspective. Using choice theory case conceptualization and reality therapy treatment planning is one way of providing a person-centered care approach.

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APPENDIX

Basic Treatment Plan Format

| TREATMENT/SERVICE PLAN for Client X | | | |
|--|-------------------|----------------|----------------|
| DSM-5/ICD-10 DIAGNOSIS & DIAGNOSTIC CODE | | | |
| Client X's Overarching Long-Term View: _____ | | | |
| Problem Statement: _____ | | | |
| Goals | Objectives | 3-Month Update | 6-Month Update |
| Goal 1: _____ | (a) (b) (c) | | |
| Goal 2: _____ | (a) (b) (c) | | |
| Goal 3: _____ | (a) (b) (c) | | |

Note. DSM-5 = *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013); ICD-10 = *International Statistical Classification of Disease and Related Health Problems* (10th rev.; World Health Organization, 2015).