



National Library of Canada

Cataloguing Branch
Canadian Theses Division

Ottawa, Canada
K1A 0N4

Bibliothèque nationale du Canada

Direction du catalogage
Division des thèses canadiennes

NOTICE

The quality of this microfiche is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us a poor photocopy.

Previously copyrighted materials (journal articles, published tests, etc.) are not filmed.

Reproduction in full or in part of this film is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30. Please read the authorization forms which accompany this thesis.

**THIS DISSERTATION
HAS BEEN MICROFILMED
EXACTLY AS RECEIVED**

AVIS

La qualité de cette microfiche dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de mauvaise qualité.

Les documents qui font déjà l'objet d'un droit d'auteur (articles de revue, examens publiés, etc.) ne sont pas microfilmés.

La reproduction, même partielle, de ce microfilm est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30. Veuillez prendre connaissance des formules d'autorisation qui accompagnent cette thèse.

**LA THÈSE A ÉTÉ
MICROFILMÉE TELLE QUE
NOUS L'AVONS REÇUE**

THERAPIST-CLIENT RELATIONSHIP AND GROUP DISCUSSION
AS ENHANCERS OF ASSERTION TRAINING

by David I. Chiappone

Thesis presented to the School of
Graduate Studies of the University
of Ottawa as partial fulfillment of
the requirements for the degree of
Doctor of Philosophy

Ottawa, Canada, 1978

© D.I. Chiappone, Ottawa, Canada, 1978

ABSTRACT

This applied clinical setting research addressed the question: Would an opportunity for facilitative conditions to develop between assertion training group members and their leaders enhance the effectiveness of a behaviorally oriented assertion training program? University students ($N = 45$) requesting assertion training at the University of Ottawa Counseling Service were given one of three treatments: control ($n = 14$), discussion ($n = 14$), and facilitative ($n = 17$). Control was the standard behavioral package of modeling, roleplaying, behavioral rehearsal, and coaching. Discussion, besides receiving the standard package, met as a group for the last 15 minutes of each session to discuss their feelings and thoughts about the session and assertion concerns. The facilitative group also received the standard package, but in the last 15 minutes of each session met as a group to allow the leaders to interact in a facilitative manner reflecting feelings, etc. to each group member individually. A manipulation check, using the Relationship Inventory, resulted in equivocal results, calling into question the strength of the manipulation. Self report measures of assertion discomfort and probability, subject ratings of leaders' attractiveness, expertness, and trustworthiness, subject risk taking based on roleplaying and

monitored situations, and subject openness to suggestion based on returned homework were dependent measures.

Within all three groups significant changes in assertion were noted from pre- to posttreatment which were maintained at the 4-week followup. However, the dependent measures appeared not to be affected by the independent manipulation. The null hypotheses were not accepted due to low power of the statistics, small sample size, reliability of measures, and a weak manipulation. Additional analyses were computed correlating perceived facilitative conditions, regardless of group (treatment) membership, with the dependent variables. Results indicated greater perception of the facilitative conditions were related to a decrease in self-reported discomfort and to client's perception of the leader as more attractive, expert, and trustworthy. High-perceivers reported a greater decrease in self-reported problematic situations. A tentative conclusion suggests client's perception of a supportive atmosphere may be related to self-reported change and, consequently, future research should investigate if fostering of high facilitative conditions (as measured in the session) by a leader, as opposed to low fostering, would influence outcome behavior change. Suggestions for further research were provided.

ACKNOWLEDGMENTS

This researcher would like to extend sincere thanks to all those without whose time and assistance this study would never have been possible. To Dr. Michael McCarrey as thesis advisor a special thanks for his continual guidance, criticism, and warm support. I would like to thank Dr. Serge Piccinin, Director of the Ottawa University Counselling Service, for his guidance in all stages of this project. Without his permission and support in utilizing the Counselling Service staff and resources, the study could not have been carried out. Thanks is extended to Dr. Dan Lee for his many helpful suggestions and encouragement throughout the project. Heartfelt thanks is extended to the staff members and interns who acted as group leaders. Finally, a special thanks is extended to my wife, Nancy, whose support, encouragement, and help made it all possible.

TABLE OF CONTENTS

Chapter	page
INTRODUCTION	xi
I. REVIEW OF THE LITERATURE	1
Assertion Training Literature	1
History of Assertion Training	3
Definition of Assertion	5
Treatment of Assertion	6
Components of Assertion and Behavioral Measures	7
Measurement of Assertion: Self Report	9
Treatment Procedures	11
Population, Personality Characteristics, and Sex Differences	33
Summary of Assertion Training Literature	35
Review of Therapist-Client Relationship Literature	37
Behavior Therapy and the Therapist-Client Relationship	42
Rogerian Theory and Assertion Training	47
Review of Discussion Literature	57
Summary of Literature Reviewed	60
Theoretical Basis for Project	64
Statement of Purpose and Theoretical Hypotheses	64
II. METHOD	66
Setting	66
Description of Sample	67
Procedures	77
Instruments	84
III. RESULTS	103
Preliminary Analyses	103
Tests of Hypotheses	110
Manipulation Checks	132
Additional Analyses	139
Need, Belief, Expectation	139
Age	145
Sex	145

Chapter	page
IV. DISCUSSION.	152
Significance of Change from Pre- to Posttreatment	152
Discussion of Nonsignificant Results	155
Recommendations for Future Research	163
SUMMARY AND CONCLUSIONS	167
REFERENCES.	169

Appendix

1. ASSERTION TRAINING CONTRACT	186
2. ASSERTION INVENTORY.	188
3. NEED, BELIEF, EXPECTATION QUESTIONS	193
4. COUNSELOR RATING FORM	195
5. RELATIONSHIP INVENTORY.	199
6. INSTRUCTIONS FOR USE OF MONITORING CARDS.	205
7. DISCRIMINATING ASSERTIVE, NONASSERTIVE, AGGRESSIVE BEHAVIOR [Assigned Homework]	207
8. DEVELOPING ASSERTIVE RESPONSES [Assigned Homework].	211
9. DISCRIMINATION TEST ON ASSERTIVE, AGGRESSIVE, AND NONASSERTIVE BEHAVIOR [Optional Homework]	214
10. ASSERTIVE EXERCISE [Assigned Homework].	219
11. PRACTICING ASSERTIVE RESPONSES [Optional Homework].	223
12. RESPONDING TO INSISTENT DEMANDS [Optional Homework]	227

LIST OF TABLES

Table	page
1. Number and Percentage of Subjects in Each Year of University.	70
2. Faculties Represented in the Total Sample.	71
3. Chi-Square: Comparing Faculty Representation of the Sample to the Anglophone University Population (First Year Registration).	72
4. Analysis of Variance: Age and Sex Characteristics of the Three Treatment Groups.	73
5. Faculty Representation in Treatment Groups.	76
6. List of Dependent Variables and Measurement Instruments.	85
7. Flow Diagram of Measurement Times	87
8. Analysis of Variance: Prescreening Assertion Discomfort Scores by Treatment Groups	105
9. Analysis of Variance: Prescreening Assertion Probability of Response Scores by Treatment Groups	107
10. <u>t</u> Tests: Within Groups Pre- to Posttreatment Measures of Assertion	109
11. Analysis of Variance: Posttreatment Assertion Discomfort Scores by Treatment Groups	111
12. Analysis of Variance: Posttreatment Assertion Probability of Response Scores by Treatment Groups.	113
13. Mean Discomfort and Probability Scores and Standard Deviations at Pretreatment, Post-treatment, and Follow-up.	115
14. Analysis of Variance: Counselor Rating Form Attractiveness Scale by Treatment Groups (Eighth Session).	120

Table	page
15. Analysis of Variance: Counselor Rating Form Attractiveness Scale by Treatment Groups (Fourth Session)	121
16. Analysis of Variance: Counselor Rating Form Expertness Scale by Treatment Groups (Eighth Session)	122
17. Analysis of Variance: Counselor Rating Form Expertness Scale by Treatment Groups (Fourth Session)	124
18. Analysis of Variance: Counselor Rating Form Trustworthiness Scale by Treatment Groups (Eighth Session)	125
19. Analysis of Variance: Counselor Rating Form Trustworthiness Scale by Treatment Groups (Fourth Session)	127
20. Chi Square: Roleplays--Actual and Potential by Treatment Groups	128
21. Chi Square: Monitoring Cards--Number of Asser- tive and Nonassertive Situations by Treatment Groups	130
22. Chi Square: Homeworks Returned--Assigned and Optional by Treatment Groups	131
23. Analysis of Variance: Relationship Inventory Total Scores by Treatment Groups	133
24. Analysis of Variance: Relationship Inventory Empathy Scores by Treatment Groups	137
25. Analysis of Variance: Prescreening Need Question by Treatment Groups	140
26. Analysis of Variance: Prescreening Belief Question by Treatment Groups	141
27. Analysis of Variance: Prescreening Expectation Question by Treatment Groups	142
28. Correlation Matrix of Need, Belief, and Expecta- tion Questions with the Assertion Inventory Discomfort and Response Probability Scores (Pre- and Posttreatment)	143

Table	page
29. Means and Standard Deviations of Pre- and Posttreatment Levels of Assertion by Sex. . . .	147
30. Internal Consistency: Split Half with Spearman Brown Correction on Assertion Inventory Discomfort and Response Probability Scales (Pre- and Posttreatment)	149
31. Internal Consistency: Split Half with Spearman Brown Correction on Counselor Rating Form Attractiveness, Expertness, and Trustworthiness Scales (Fourth and Eighth Sessions). . . .	151
32. Correlations of the Barrett-Lennard Relationship Inventory with the Outcome Variable Set for all Subjects (<u>N</u> = 45).	151a

LIST OF FIGURES

Figure	page
1. Mean Discomfort Scores of Treatment Groups at Pretreatment, Posttreatment, and Follow-up.	116
2. Mean Probability of Response Scores of Treatment Groups at Pretreatment, Post-treatment, and Follow-up	117
3. Mean Scores of Treatment Groups for the Relationship Inventory Total Scores.	135
4. Mean Scores of Treatment Groups for the Relationship Inventory Empathy Subscale.	138

INTRODUCTION

Assertion training, an ever-growing service provided by care givers, involves numerous treatment procedures, all of which seem useful, none of which stands alone as the sufficient procedure for change. Which procedure provides what benefit(s) for which client has continuously been addressed in the behavioral literature. The developed procedures for assertion training have emphasized the behavioral tasks of the client and/or therapist as the influential factor in instigating change. Little emphasis has centered on the therapist-client relationship as influential in training. The emphasis of the behavioral approach seemingly precludes investigating the relationship as influential in change.

However, the therapist-client relationship has been extensively investigated by some (Rogers, 1957, 1959, 1961; Truax, 1961; Truax & Carkhuff, 1965a; Truax & Mitchell, 1971) and consequently considered to be necessary and sufficient for change, or at least necessary. This relationship, besides providing an acceptable environment within which the client can work on changing, also seems to provide a powerful means of influence and as such seems to be an impelling factor in client change.

Recently, some behaviorists (Wilson & Evans, 1976; Wilson, Hannon & Evans, 1968) have suggested viewing the

therapist-client relationship in a social reinforcement framework, in order to discern tenable avenues of influence of this factor. That is, the relationship viewed from this framework appears to be influential in both a direct manner (e.g., counterconditioning of anxiety by providing unconditional positive regard) and in an indirect manner (e.g., development of interpersonal attraction by which the therapist becomes a source of reinforcement, developing trust to overcome resistance). Thus, the therapist, by fostering the development of a warm, accepting relationship, provides the basis for the change procedures to be optimally influential.

Consequently, would the development of facilitative conditions within a behaviorally oriented assertion training program enhance the already established effects of the behavioral procedures? That is, besides what the therapist does (behavioral procedure), is how he does it (facilitative conditions) an important variable in instigating change? To test out this question, the following research selected an applied behaviorally oriented assertion training program and added to it an emphasis on the relationship development within the training sessions.

In order to study the question, it is first necessary to explore the research literature in several areas to develop a theoretical basis for predictions. After that, the methods

used to test the theory and analysis of results are set out. Lastly, the theoretical and practical implications of the results are discussed along with suggestions for further research.

CHAPTER I

REVIEW OF THE LITERATURE

Assertion Training Literature

The aim of this review is to examine one of the neglected areas in assertion training literature. The question addressed is the importance of the therapist-client relationship to assertion training outcomes.

In order to explore this question, it is necessary to address several bodies of literature. First the assertion literature is explored, including a short history and definition review, followed by a more extensive presentation on treatment methods (i.e., components, measurement, and procedures for training). The review of the assertion literature provides the background for understanding the behavioral process involved in the treatment of assertion. Current directions and gaps evinced in the literature are noted.

From this review, it is apparent, one large gap in the behaviorally oriented assertion literature is the absence of attention to the therapist-client relationship. Consequently, the second portion of the literature review presents evidence primarily from the Rogerian research tradition demonstrating the therapist-client relationship as influential in therapy outcome. After establishing

the importance of the therapist-client relationship it seems logical to review the behavioral literature to see where it stands on this issue.

In doing this, anecdotal and empirical evidence in behavioral literature concerned with the therapist-client relationship is noted. Several theoretical articles are presented which explain why and how the relationship is influential in a therapy procedure. These articles generally support the idea of the relationship as an enhancer of the behavioral procedures used in therapy rather than as a necessary and sufficient condition in itself. This area of literature concludes with a synopsis of the Rogerian position showing how behaviorally oriented assertion training may be cast in the light of the therapist-client relationship, à la Rogers. The Rogerian facilitative conditions and the concept of the relationship as an enhancer provides the theoretical underpinnings for the inclusion of the treatment variable as proposed in this research. Because this research was carried out in a group setting, a review of group dynamics literature is presented showing that member-member interaction may affect outcome.

A second gap in the behavioral assertion literature is the absence of in vivo studies. The in vivo approach deals with actual clients and actual concerns, and it is

not necessary to hope for contrived involvement with the research. Also, the in vivo setting provides an optimum and natural setting to address the relationship issue. Generalizability of findings to a clinical population is greater for in vivo than analogue studies.

The chapter concludes with the statement of purpose. The starting point of this research is the already established efficacy of certain behavioral procedures in assertion training. However, the thrust throughout is to see if and how the therapist-client relationship may act to enhance these behavioral procedures to improve assertion training outcome. From the review of the literature there is good reason to believe that this question is a viable one and this research is an attempt to test this position.

History of Assertion Training

The history of assertion training is a relatively short one compared to more traditional psychotherapeutic methods like psychoanalysis (Freud, 1913). First mention of assertion is credited to Salter (1949), who hypothesized that nonassertive persons had a history of not being permitted to express "excitatory" behavior. Through a classical conditioning history such persons were inhibited in a variety of interpersonal situations and so developed a generalized trait of nonassertiveness. In treatment, the client was encouraged to express his feelings

("feeling talk"), talk about himself and accept compliments, for example.

Little interest was devoted to assertion training until the past 10 years. Wolpe has been a leading figure in using assertion training in therapy. Wolpe (1969) viewed assertive behavior as the "outward expression of practically all feelings other than anxiety" (p. 61) including aggressive behavior as well as friendly, affectionate, and other non-anxious feelings. Assertion training was indicated when anxiety precluded appropriate assertive responses in interpersonal situations; anxiety which, if unrelieved, could possibly lead to somatic symptoms. Treatment included the counterconditioning of anxiety (reciprocal inhibition: Wolpe, 1969; Wolpe, Salter & Reyna, 1964) and operant conditioning of assertive responses (Wolpe, 1970).

Arnold Lazarus (1973), as well as Wolpe (1969), refined the concept of assertion by pointing out that the unqualified expression of anger could incur counter-aggression from the other person. Lazarus recommended that the expression of anger be prefaced by remarks which offer recognition of the other's position and feelings, for example, "I recognize you've had a tiring day, but . . .". Such remarks are termed commendatory and are designed to elicit supportive and reinforcing behavior from the recipient of the assertion. Rathus and Ruppert (1973) corroborated

Lazarus' and Wolpe's ideas in their clinical experience and warned therapists that the instigation of assertive behavior in a client will often be met with aversive social control feedback from those close to the client. Accordingly, it is important to recognize that the client's family and friends may have a stake in the client remaining timid and nonassertive.

Definition of Assertion

A strong concern of these early researchers was distinguishing between assertive, nonassertive, and aggressive behavior (Alberti & Emmons, 1974; Jakubowski-Spector, 1973). Assertion was recognized as acting in your own best interest, standing up for your own rights without undue anxiety and without denying the rights of others, in a direct and open expression of feelings. Nonassertion was the failure to assert oneself when another infringed on your rights. Aggressive behavior involved standing up for one's own rights but in a way that violates the other's rights. These early definitions used broad, layman-like terms to discuss large classes of behavior.

Recent definitions tend to utilize more technical terminology and identify specific behaviors engaged in by the person. Schwartz and Gottman (1976) concentrated on intrapersonal behaviors that transpire in situations calling

for assertion. Their study showed that nonassertive persons make more negative self statements than do medium or high assertive people. Rich and Schroeder (1976) defined assertion as "the skill to seek, maintain or enhance reinforcement in an interpersonal situation through an expression of feelings or wants when such expression risks loss of reinforcement or even punishment" (p. 1082). These more recent definitions add a precision and testability to earlier conceptualizations.

It can be seen that the early history of assertion training has been characterized by an interest in the conceptualization of assertion, a conceptualization that was expressed in broad, simple terminology. More recent literature has striven for more precision and experimentation with the aim of developing and refining treatment techniques.

Treatment of Assertion

This interest in the treatment of nonassertion has manifested itself in a number of ways. A variety of training manuals has been published (Alberti & Emmons, 1974; Bower & Bower, 1976; Galassi & Galassi, 1977; Lange & Jakubowski, 1976) with the aim of teaching professionals methods of training assertive responding in clients. These manuals utilize a variety of techniques, such as traditional

behavioral methods like modeling and roleplaying, cognitive behavioral methods such as self talk and irrational ideas, and recent publications have begun casting assertion training within an humanistic orientation (Colter & Guerra, 1976).

In research, this interest in treatment has led to raising concerns directly relevant to the treatment process, for example, identification of the behavioral components of assertive behavior, measurement of assertion, and the development and testing of techniques designed to instigate assertion.

Components of Assertion and Behavioral Measures

Although the literature has yielded several definitions of assertion, it is necessary to identify the target behaviors or central components of the assertive response in order to know exactly what behaviors are to be modified. These component behaviors fall into two classes: verbal and nonverbal.

By verbal component is meant the actual words that the client uses in the assertive response. Winship and Kelley (1976), for example, delineated three parts of the verbal content of any assertive response: empathic recognition of the other's feelings, followed by a conflict statement which communicates the rationale for action, ending with the action statement.

A variety of behaviors are subsumed under the non-verbal class. Serber (1972) identified six behaviors: loudness of voice, fluency of spoken words, eye contact, facial expression, body expression, and interpersonal distance. Eisler, Miller, and Hersen (1973) differentiated assertive and nonassertive subjects on the basis of latency of response, compliance (acquiescing to the demands of another), loudness of speech, requests for new behavior from the other person, and appropriate affect. No difference between the groups was noted in speech fluency, frequency of smiling, and eye contact. Although other research has confirmed these components (Arkowitz, Lichtenstein, McGovern & Hines, 1975; Eisler, Hersen & Miller, 1973; Gutride, Goldstein & Hunter, 1973; Hersen & Bellack, 1976), no single behavior or combination of behaviors seems to be consistently supported as most important. Instead, it appears that behaviors vary in importance depending upon the demands of the stimulus situation. This is one aspect of the situational specificity of assertive behavior, the recognition that different situations call for different behaviors from the person, although all the behaviors are termed assertive.

One advantage of using such discrete behavioral indices of assertion is that a high level of interrater reliability can be obtained on the target behaviors. The

ratings are made by trained observers who rate the behaviors in vivo, from audiotapes, or from audiovisual tapes. Generally, audio or audiovisual tapes are superior to in vivo ratings, as the observer can repeat the scenes and more precisely assess the target behaviors (Eisler, Hersen & Agras, 1973). Overall, interrater reliability runs from 0.8 to 1.0, with the majority of studies reporting 0.9 or better. The less reliably rated behaviors are those which demand subjective judgments, for example, appropriate affect, overall assertiveness, or facial expression.

Measurement of Assertion:
Self Report

While ratings on these behavioral components may be used for selection of clients for training and to measure the progress of a training procedure, self report scales have also been developed for the same purposes. These include the Constriction Scale (Bates & Zimmerman, 1971), College Self Expression Scale (Galassi, DeLo, Galassi & Bastien, 1974), Assertion Inventory (Gambrill & Richey, 1975), Adult Self Expression Scale (Gay, Hollandsworth & Galassi, 1975), Lawrence Assertive Inventory (Lawrence, 1970), Conflict Resolution Inventory (McEall & Lillesand, 1971), Rathus Assertive Scale (Rathus, 1973a), and the Wolpe-Lazarus Assertiveness Questionnaire (Wolpe & Lazarus, 1966).

Generally, these scales have acceptable reliability; for example, .77 for Rathus (1973a), .88 to .91 for the Adult Self Expression Scale (Gay et al., 1975), and .87 and .81 for the Assertion Inventory (Gambrill & Richey, 1975). On the other hand, validity has been low in some studies, .50 for the College Self Expression Scale (Galassi, DeLo, Galassi & Bastien, 1974) and .46 for the Assertion Inventory (Gambrill & Richey, 1975).

Several other criticisms have been directed at the scales. Most were developed on college populations, thus limiting their use on other populations. Many of the scale items have been too general, while research has tended to emphasize the situational specificity of assertiveness. Finally, norms are just being developed for these scales so that it is difficult to compare groups or interpret reported changes.

Exceptions to these general criticisms do exist. The Conflict Resolution Inventory (McFall & Lillesand, 1971) and the Assertion Inventory (Gambrill & Richey, 1975) were developed to tap situationally specific behaviors. The Conflict Resolution Inventory, in addition, has been validated on behavioral measures with acceptable validity ($r = .62$ to $.82$). A scale for the adult population has been developed by Gay, Hollandsworth, and Galassi (1975), but validity has only ranged from .5 to .2.

At this point there seems to be little need for new scales, rather a need to make present scales more situationally specific in measuring response classes; most scales treat assertion as a general trait instead of specific response classes. Also normative data should be established so as to make results more interpretable.

Treatment Procedures

The majority of research interest seems directed towards the development of techniques to shape up and increase assertive responding. The therapist has at hand several different procedures for the modification of non-assertive behavior, including, for example, modeling, role-playing, feedback, coaching, and relaxation. However, the choice of procedure is governed by the clinical observation that lack of assertive behavior can spring from several sources. The client may be nonassertive due to a lack of assertive behavior components in the response repertoire, to inadequate stimulus discrimination leading to a misuse of existing skills, or to anxiety which inhibits expression of assertive responses (Lazarus, 1973; Ludwig & Lazarus, 1972; MacDonald, 1975; Nietzel & Bernstein, 1976; Wolpe, 1969). Thus, some treatment techniques may be more appropriate for shaping up new assertive components in the behavioral repertoire, whereas others may be more effective in overcoming anxiety or teaching stimulus discrimination.

Assertion training often includes the simultaneous use of several therapeutic procedures. Few studies, however, have attempted to delineate the effect of a specific procedure on a particular response class. Thus, little information is available recommending specific procedures to train particular skill components.

Modeling. The use of modeling seems to be especially recommended when there is an excess of anxiety and/or a skill deficit (Hersen, Eisler & Miller, 1973). Modeling gives the client an idea of what to do and how to behave, as well as providing in vivo desensitization. Numerous variations of modeling procedures are seen in the literature.

A package utilizing modeling, roleplaying, and social reinforcement was superior to a no training control group in instigating social interaction among psychiatric patients (Gutride et al., 1973). Hedquist and Weinhold (1970) found that a social learning group in which the therapist modeled the response process with effective problem solving was as effective as a group that received modeling, coaching, and behavioral rehearsal. In addition, both treatments were superior to an attention placebo control group at posttest. Eisler, Hersen, and Miller (1973) showed that an audiovisual taped model was more effective in promoting assertion in psychiatric patients than was practice

alone. Likewise, it was found that modeling was superior to no modeling in developing independent behavior in psychiatric patients (Goldstein, Martens, Hubben, VonBelle, Schaaf, Wiersma & Goedhart, 1973, experiments I, II, & III). It was also concluded that independent models encouraged independent behavior but that dependent models encouraged dependent behavior in women only. Presenting the model as a warm person (sympathetic, friendly) did not enhance the effectiveness of the modeling, although presentation of the model as a cold person substantially decreased the modeling effect. Finally, Young, Rimm, and Kennedy (1973) found that modeling alone was as effective as modeling with verbal reinforcement, both of which were superior to a placebo control group. It is clear, then, that modeling is better than no treatment or placebo conditions, especially when the modeling is not only represented by an actor or therapist but also practiced and acted out by the client (Rachman, 1976).

Some evidence suggests that modeling is enhanced by the addition of other procedures. For example, Friedman (1971) found that modeling with directed roleplaying was more effective than directed roleplaying alone, improvised roleplaying alone, or modeling with observation of roleplaying. Hersen, Eisler, and Miller (1974) found that modeling with instruction was superior to rehearsal, placebo control, and test-retest groups. Hersen, Eisler,

Miller, Johnson, and Pinkston (1973) reported that modeling with instruction was superior to modeling alone, or instruction alone. The authors found that instruction had the singular effect of increasing loudness of verbal response, while modeling had the effect of decreasing compliance content in the response. Foy, Eisler, and Pinkston (1975) utilized a single case multiple baseline design to treat explosive rage. Modeling and modeling with instruction were used and the conclusion was drawn that modeling was responsible for actually starting assertive responding, but modeling with instruction tended to establish and stabilize the target behaviors. Finally, Edelstein and Eisler (1976) reported a single case multiple baseline study in which modeling with instruction and feedback increased three target behaviors (eye contact, gestures, overall affect), while modeling alone only increased one behavior, overall affect.

It can be seen that the combination of modeling with instruction seems to be an extremely effective treatment method. This instruction may take the form of directing the client's attention to specific aspects of the behavior being modeled as well as coaching, in which the client's attention is directed to aspects of his own behavior. The increased effectiveness of modeling with instruction may be due to the fact that the two procedures have different effects, which when combined, tend to form

a more complete and stable assertive response. Unfortunately, the unique contributions of each procedure are not yet clear.

The modeling studies mentioned so far have all utilized overt modeling procedures. However, research has been directed to the effectiveness of covert modeling as well. Kazdin (1974) found that covert modeling was more effective than either placebo control or test-retest groups. The addition of favorable consequences in the covert modeling condition did not enhance the effectiveness of covert modeling alone, perhaps, as the author suggested, because subjects tended to add favorable consequences on their own initiative. Kazdin's further research (1975, 1976b) supported the effectiveness of covert modeling while recommending the inclusion of favorable consequences in the covert scene and the use of multiple rather than single models. Kazdin (1976a) also found that having subjects verbalize the scene which the therapist presented did not enhance the modeling effect in increasing assertiveness. Nietzel, Martorano, and Melnick (1977) reported that having subjects covertly respond assertively was more effective than covert modeling without a response or merely visualizing the scene.

McFall and Lillesand (1971), while reporting that covert and overt rehearsals were equally effective as long

as modeling preceded rehearsal, suggested that the covert procedure could protect the client from external evaluation and so decrease inhibiting effects on learning. Rosenthal and Reese (1976) corroborated the equivalence of covert and overt modeling, and added that the use of stimulus scenes tailored to the client's particular situation should be further researched, although such scenes were not found to be more effective than standard scenes in their experiment. From this evidence, a general conclusion seems warranted, that covert modeling is as effective as overt modeling in reducing anxiety and promoting assertion.

Behavioral rehearsal. The literature generally does not distinguish between behavioral rehearsal, roleplay, and response practice. In this research, rehearsal will refer to all three of these techniques. The techniques may be considered similar because they all concentrate on the refinement and strengthening of available behavioral skills, whereas modeling, for example, is more responsible for initiating new behaviors not present in the repertoire. In behavioral rehearsal, the client practices a response that has already been modeled, instructed, or prompted by another person.

Lazarus (1966) compared behavioral rehearsal, non-directive therapy, and advice procedures as means of increasing assertiveness. This clinical population was gathered from

the author's practice; treatment was administered by the author also. Self report results showed improvement for 32% of the nondirective group, 44% of the advice group, and 92% of the behavioral rehearsal group. Twenty-seven clients from the nondirective and advice treatments who did not report a change were afterwards treated by means of behavioral rehearsal; 22 of these reported increased assertiveness. Lazarus credits the active participation of the clients as mediating the success of the behavioral rehearsal treatment.

McFall and Marston (1970) compared a behavioral rehearsal treatment and behavioral rehearsal with feedback condition via an audiotaped recording of the client's rehearsed response. Both treatments were superior to test-retest and placebo control groups across posttest and follow up based on behavioral, self report, and autonomic measures. However, audio playback of the client's response did not significantly add to the effect of behavioral rehearsal. In a similar experiment, Melnick and Stocker (1977) found that neither client's knowledge that his response was being recorded nor audio playback of the client's response improved effectiveness of behavioral rehearsal alone, either on self report or behavioral measures. Aiduk and Karoly (1975) investigated whether videotape feedback or videotape feedback with self evaluation added significantly to a behavioral

rehearsal package. All treatment effects were equal, indicating that neither videotape feedback nor self evaluation improved upon the behavioral rehearsal effects.

From these studies, it appears that mere playback of response does not add significantly to a treatment program. However, feedback which specifically comments on the behavioral production (termed coaching) does seem to help. Turner and Adams (1977) reported that coaching with behavioral rehearsal was more effective in treatment than behavioral rehearsal with modeling. Coaching with behavioral rehearsal was as effective as a combination of coaching, modeling, and behavioral rehearsal. It was concluded that modeling added little to treatment effectiveness except when severe skill deficit was noted; in this case, modeling was instrumental in initiating assertive behavior, a conclusion supporting the earlier mentioned study by Foy, Eisler, and Pinkston (1975). Similarly, Rimm, Snyder, DePue, Haanstad, and Armstrong (1976) found that behavioral rehearsal alone was not as effective as a training package consisting of rehearsal, feedback, role reversal, reinforcement, and coaching. At posttest, subjects were placed in a role-play test with a live prompter. Half of the subjects in each treatment condition were instructed to respond to the prompt with appropriate behavior; the other half were to watch but not respond to the scene. Subjects who received

the complete training package reported a significant decrease in negative affect and increased feelings of well-being, irrespective of responding or not responding in the prompted scene. Thus, it appeared that completion of training was sufficient to reduce anxiety. In the behavioral rehearsal condition, there was no significant decrease in negative affect either for responders or nonresponders. Thus, it appears that when feedback (coaching) accompanies the behavioral rehearsal procedure, greater gains in assertion are noted.

Like the modeling procedures, behavioral rehearsal has utilized covert as well as overt procedures. In one study, covert and overt rehearsal seemed equally effective, provided that modeling was also present in the training package (McFall & Lillesand, 1971). McFall and Twentyman (1973) likewise reported no difference in effectiveness between covert and overt rehearsal procedures, but found that modeling added little to the rehearsal with coaching package. This was true whether the model was presented audiovisually or on audiotape only, or whether the model was tactful or abrupt. The authors suggested that rehearsal with coaching mediated acquisition of new behavior, along with strengthening and integrating the behavior into the repertoire.

It can be seen from these studies that behavioral rehearsal is superior to no treatment in promoting assertive behavior. The procedure gains power when combined with coaching and feedback on the subject's performance. In this respect, behavioral rehearsal is similar to modeling which also achieves greater effectiveness when feedback (instructions) about the response is added.

Galassi and Galassi (1976) investigated different rehearsal variations to see whether there were differential effects on assertion. They compared single rehearsal versus multiple rehearsal (i.e., several responses to same stimulus scene) and live versus taped prompting. On the basis of self report and behavioral measures, the live prompted group reported more anxiety than the taped prompted group, while the single rehearsal group gave longer assertive responses than the multiple rehearsal group. However, no differences among the groups were noted on assertive content. Thus, although a variety of modeling variations are available to the therapist, little direction from the research can be given as to the most effective mode of modeling. Further studies could be directed towards this area.

Instructions, coaching, and feedback. Bandura (1969) hypothesized that after adequate language development, social learning may be promoted not only by behaviorally modeled cues but also by verbally modeled cues. Even complex

behaviors can be produced by matching one's own behavior to responses described in instructional manuals. In assertion training, such "verbal modeling cues" as instruction, coaching, and feedback are seen as similar since they all provide directives to the client from the therapist to attend to designated target components of the assertive response. The three procedures differ principally in the time of their occurrence. Instructions, which may be as simple as an exhortation to "try harder" or as specific as directing attention to particular components, usually occur before the assertive response. Coaching refers to suggestions by the therapist to the client to use particular behaviors while the response is being performed. Feedback is given to the client after the response is completed and consists of evaluative statements and constructive criticism on the performance. At the present time, only a few studies have been directed to the unique contributions of instructions. Usually, these procedures are used as adjuncts to other procedures, such as modeling or rehearsal.

Nietzel and Bernstein (1976) showed that general instructions to clients to "act as the most assertive person would" (high demand group) was effective in raising the level of assertive responding compared to instructions to "act as you would in real life" (low demand group). When low demand instructions followed high demand instructions, a resultant

decrease in assertion was noted. Conversely, high demand following low demand increased assertion. The implication was that clients may often have assertive behaviors in their repertoire but fail to exhibit them. A similar conclusion was drawn by Schwartz and Gottman (1976) who asked subjects to write assertive responses to hypothesized scenes and then to respond orally to another set of scenes in order to "show a friend" how to make a good assertive response. Both sets of scenes involved refusing an unreasonable request. This procedure assessed knowledge of appropriate responding as well as capability of delivering an assertive response in a safe "hypothesized" setting. Results showed no significant differences between low, medium, and high assertive subjects on either the writing task or in oral responding. However, differences were noted between the high and low assertive subjects in a roleplay situation designed to simulate reality. Goldstein et al. (1973, experiment III) found that instructions alone increased independent behavior in chronic schizophrenic patients. Treatment effects of instruction alone were equivalent to modeling alone and to modeling with instructions. As these studies point out, instructions alone are sufficient to change assertive responding in some instances, especially when the clients already possess skills in their repertoire to respond assertively. In light of this, it

seems wise to assess whether skills are already present in the client's repertoire, indicating whether skill deficit or anxiety inhibition is to be treated.

Often, instructions are used in combination with feedback in training assertion. In a multiple baseline study, Eisler, Hersen, and Miller (1974) demonstrated that instruction with feedback was effective in changing six target behaviors: increasing eye contact, voice loudness, speech duration, requests for change of behavior, appropriate affect, and decreasing compliance behavior. Hersen and Bellack (1976) also used a multiple baseline design in two case studies and found both instruction with feedback and instruction with feedback and modeling were able to change eight target behaviors in a more assertive direction. Edelstein and Eisler (1976) further suggested that the effect of instruction with feedback is to maintain and stabilize behavior learned from the modeling process. These studies indicate that instruction with feedback is an effective package in clinical use, and that these procedures are capable of addressing a variety of the components of assertive responding.

Feedback alone has also been investigated. Gormally, Hill, Otis, and Rainey (1975) reported that microtraining of assertion was effective with or without videotape replay. The authors suggested that such video replay may overload

the subjects with information, while not necessarily increasing assertion. McFall and Marston (1970) and Melnick and Stocker (1977) likewise noted that audio playback of the client's response did not add to the effectiveness of a rehearsal procedure. It should be pointed out that such playback did not contain constructive criticism or suggestions for improved responding, as is usually the case in more complete training packages, and this lack may account for the seeming ineffectiveness of feedback.

It is often desired by some researchers to have some taped form of pretest, since taping provides an objective and easily repeatable basis for rating the client's behavior. Galassi, Galassi, and Litz (1974) suggested that a video pretest can also provide feedback information to the client before treatment actually begins and as such may reduce self reported anxiety. Thus, the pretest may be viewed as a training session because the client may gain information about his performance, generate ideas for alternative behaviors by seeing his performance played back, and receive in vivo desensitization. As such, further research using video pretests should be aware of this possible confounding.

Further research should be directed towards delineating the effects and contributions of video or audio playback, instructions, coaching, and complete feedback.

Presently, the area lacks guidelines on how coaching, feedback, and instructions should be presented, what types of criticism and suggestions are most useful, and at what stage of response acquisition or stabilization such criticism and suggestions are most effective.

Systematic desensitization. Wolpe and Lazarus (1966) hypothesized that anxiety in interpersonal situations inhibited the expression of appropriate assertive behaviors which are already part of the person's repertoire. Systematic desensitization was proposed as a means to countercondition anxiety with expression of assertive behavior as the result. Overall, though, systematic desensitization is not singularly used for instigating assertion. This is consistent with Wolpe's (1970) position that lack of assertion is due to skill deficit as well as to anxiety. Systematic desensitization deals with anxiety, leaving a need for acquisition procedures.

Wright (1976) compared systematic desensitization to a social skills training package with undergraduates who reported discomfort and lack of interaction in class discussions. Groups were not equal initially on an assertiveness measure, but it was still reported that on a behavioral measure taken in the lab, the social skills training package was more effective than systematic desensitization. Both groups responded equally well in in vivo

settings. Likewise, Weinman, Gelbart, Wallace, and Post (1972) compared social environmental training, systematic desensitization, and relaxation in instigating assertion in chronic schizophrenics. On behavioral measures the social environmental training group performed significantly better than the other two groups. It may be suggested, however, that chronically hospitalized patients may lack assertive behaviors in their repertoire and so systematic desensitization and relaxation would not be expected to be effective since these procedures assume inhibition of already present behaviors.

Piaget and Lazarus (1969) utilized a modified systematic desensitization procedure to deal with behavioral rehearsal anxiety. Systematic desensitization was indicated, but the problem behavior (interpersonal anxiety) was not clear-cut enough for a standard hierarchy. The new procedure, rehearsal desensitization, consisted of first roleplaying approachable neutral scenes until a comfortable anxiety level was attained, after which scenes which provoked higher anxiety were introduced. After successful expression of appropriate assertive behavior in these scenes, a hierarchy of scenes in the problem area was constructed and the usual systematic desensitization procedure followed. Thus, although systematic desensitization may not be directly applicable to training assertive behavior, this technique

seems to be an effective way to preface assertion training for very anxious clients.

Ascher and Phillips (1975) developed a guided behavioral rehearsal package which used peer models and behavioral rehearsal. They suggested that when clients watched their peers model assertive behavior, the effectiveness of the procedure was due to in vivo desensitization in which the client's anxiety is reduced as well as to modeling. Such overlap of procedures has been noted in a variety of assertion training techniques. For example, rehearsal may have in vivo desensitization effects and coaching may encompass instruction and reinforcement as well as evaluation (Rachman, 1976). Such overlap, of course, makes it difficult to predict and understand the unique contributions of any single procedure upon the development of assertive behavior in the client.

Cognitive modification procedures. A recent trend in assertion training has been the use of cognitive modification procedures. Such concepts as positive self talk (Meichenbaum, 1972; Meichenbaum & Cameron, 1973; Meichenbaum, Gilmore, and Fedoravicius, 1971) and confronting irrational beliefs (Ellis, 1962) regarding being assertive have been suggested in recent training manuals (for example, Bower & Bower, 1976; Lange & Jakubowski, 1976), but so far few studies have tested out the effectiveness of the cognitive techniques. Ludwig and Lazarus (1972) were the first

(within the assertion literature) to suggest challenging irrational cognitions regarding assertion.

Schwartz and Gottman (1976), in their task analysis of assertive behavior, found that low assertive subjects could be distinguished from high assertive subjects by making more negative self statements. When the low assertive subjects did use mixed positive and negative self statements, the final self statements tended to be negative. Thus, assertive and nonassertive persons can be distinguished by the nature of their cognitive self statements, which in turn suggests other training methods. For example, Glass, Gottman and Shmurak (1976) used response acquisition consisting of modeling with behavioral rehearsal, and cognitive self statements in which coping and reinforcing statements were modeled after each problem situation in investigating male dating behavior. Results indicated that on trained scenes response acquisition and cognitive self statement treatments were equally effective, while cognitive self statement was a superior procedure compared to response acquisition on nontrained scenes. It was suggested that the response acquisition package was more useful with persons of low skill levels.

Wolfe and Fodor (1977) compared modeling with behavioral rehearsal to modeling and behavioral rehearsal with rational therapy (consisting of coping self statements

and confrontation of irrational ideas). Both groups were equally effective at posttest based on behavioral measures but only the rational therapy treatment decreased situational anxiety.

Thus, cognitive behavioral methods have initially proved useful in delineating assertive from nonassertive clients in terms of cognitive structuring of events and self talk, and in providing methods to change these cognitive elements. However, further research is needed to determine whether such cognitive modification procedures add significantly to a more traditional behavioral package, and what the unique contributions of such techniques are in promoting assertion.

Training for generalization. An important issue in any therapy procedure is generalization of the target behavior across time and place and possibly person and behavior. Most of the assertion literature has not directly addressed the issue of generalization, especially in vivo. Several studies speak of transfer of training in a post-treatment test within the lab (Eisler, Hersen & Miller, 1973, 1974; Hersen, Eisler, Miller, Johnson & Pinkston, 1973; Kazdin, 1974, 1975, 1976a, 1976b; McFall & Lillesand, 1971; McFall & Twentyman, 1973), but such follow-up fails to establish that assertion training has effected change in the client's day-to-day life.

A few studies have built procedures for generalization into the training package. Self monitoring, for example, permits training and generalization across time and place (Aiduk & Karoly, 1975; Rathus, 1973b). Similarly, Hedquist and Weinhold (1970) introduced a generalization procedure by having clients perform homework assignments in the form of diaries.

Other studies have addressed the issue even more directly. Hersen, Eisler, and Miller (1974) instigated generalization by instructions ("See if you can stand up for your rights on and off the ward also.") to a placebo control group and a modeling with instructions group. On a behavioral measure of generalization in the lab, the modeling with instruction and the modeling with instruction and programmed generalization performed better than any control group, yet the two modeling groups were equivalent in performance on the generalization measure. The same results were noted for a live refusal task of generalization; the two experimental groups were superior to the controls but equivalent to each other. The lack of effectiveness of the generalization procedure was explained by the authors who mentioned that the live refusal task may not have been sensitive enough to pick up differences between the groups. Also, the generalization training may not have been effective due to a lack of concrete

instruction in generalization in which specific situations and responses are outlined. This criticism is suggested by the situational specificity concept of assertive behavior, which states that assertive behavior is specific to persons and situations so that modification of behavior must be attended to in specifics, not globally (Wolpe & Lazarus, 1966).

Galassi, Kostka, and Galassi (1975) reported successful transfer of assertive skills at a 1-year follow-up on two self report measures and two out of four behavioral measures. The long-lasting effects were attributed to an intense, long, and complete treatment program. The follow-up test was administered in the lab because in vivo tests are often difficult to interpret due to distractions (i.e., persons passing by, or interruption) which could not be controlled. It should be realized, however, that lab follow-up only tests generalization across time. In order to assess generalization across place, the task must be in vivo. For example, McFall and Marston (1970) and McFall and Lillesand (1971) used surreptitious phone calls as an in vivo follow-up.

Kirschner (1976) addressed generalization by having nonassertive college males in the experimental condition trained in a number of different situations and responses (extensive group). Another group was trained intensively in one situation and response mode. On a behavioral and a

self report measure the experimental groups performed superior to a placebo control. On a 3-week follow-up, maintenance was noted for both intensive and extensive groups in situations very similar to training scenes. Yet, both groups were equivalent in assertive responding, indicating the extensive group did not show more generalization. These results could be expected from the situational specificity hypothesis of assertive behavior, which suggests that a subject must be intensively trained in each problem area.

Edelstein and Eisler (1976) reported a case study in which generalization was trained for and probe tests (involving introduction of a novel behavioral task and a novel stimulus person) were utilized during and after treatment. A generalization effect was evident at both measurement times, during, and post. Although few studies have utilized this procedure, it seems to be a valid clinical and research technique to keep in mind. The need to program generalization is consistent with the Baer, Wolf, and Risley (1968) comment that "generalization should be programmed, rather than expected or lamented" (p. 97). That is, besides probing or assessing generalization in the lab, one should also plan for generalization. However, since most studies have short training times, the lack of generalization outside the lab is predictable.

Population, Personality Characteristics,
and Sex Differences

From the previous review it is evident that the college population and the psychiatric population have been utilized extensively in assertion training research. However, assertion training has been applied to numerous problem behaviors, for example, homosexuality (Russell & Winkler, 1977), homosexual pedophilia (Edwards, 1972), sexual deviance (Stevenson & Wolpe, 1960), dependency in children (Patterson, 1972), crying spells (Rimm, 1967), anger outbursts (Rimm, Hill, Brown & Stuart, 1974) hysterical globus (Macpherson, 1972), training paraprofessionals (Flowers & Goldman, 1976), women's groups (Carlson & Johnson, 1975; Liss-Levinson, Coleman & Brown, 1975), old age (Corby, 1975), and marital interaction (Eisler, Miller, Hersen & Alford, 1974; Fensterheim, 1972).

Despite the variety of target behaviors and populations, some research has been directed towards determining personality characteristics associated with assertion and nonassertion. The principal methods of investigation have been correlational studies. For example, Borgatta (1964) found that the perception of assertion was positively correlated with such attributes as active, initiative, talking most, and authoritarianism. An inverse correlation between assertion and neuroticism, trait anxiety, and

interpersonal anxiety has been reported (Orenstein, Orenstein & Carr, 1975), while a positive relationship (.53) has been noted between assertion as measured by the Rathus Assertion Schedule and extraversion as measured by the Eysenck Personality Inventory. Finally, Schwartz and Gottman (1976) found that low assertive subjects report negative self statements and more self perceived tension than medium or high assertive subjects. From these studies it seems clear that the nonassertive person is characterized by more tension, interpersonal anxiety, and negative self evaluation than the assertive person.

In addition, some sex differences in assertion have been investigated. Tolor, Kelley, and Stebbins (1976) reported assertion to be positively related to favorable self concept for both sexes. As part of the study, subjects provided self ratings of the extent to which they conformed to sex role stereotypy. Females low in sex role stereotypy were more assertive (as measured by the Rathus Assertion Schedule) than were males comparably low in self rated sex role stereotypy. Within each sex, no differences in assertion were noted between high and low sex role stereotypy. Orenstein et al. (1975) reported males to be more assertive than females based on self report (Rathus Assertion Schedule). Males saw themselves as more assertive than females in dealing with bosses and supervisors, stating

opinions, and in initiating contacts with the opposite sex, while females saw themselves as more assertive than males in expressing love, affection, compliments, and anger towards one's parents (Hollandsworth & Wall, 1977). Lastly, Hartsook, Olch, and deWolf (1976) found that females in assertion training were concerned with approval from others and were moderately emotionally inhibited.

Summary of Assertion Training Literature

It is apparent from the review of the literature that the bulk of research thus far is devoted to the development and evaluation of treatment methods (see review articles by Hersen, Eisler & Miller, 1973; Rich & Schroeder, 1976). Several treatment procedures have been found to be effective in training of assertive behavior. Modeling has been shown to be more effective than test-retest or placebo control (Eisler, Hersen & Miller, 1973; Goldstein et al., 1973; Rachman, 1976; Young et al., 1973). Likewise, behavioral rehearsal has been found to be more effective than test-retest or placebo control (Aiduk & Karoly, 1975; Lazarus, 1966; McFall & Marston, 1970; Melnick & Stocker, 1977). A treatment which combines evaluative performance feedback and suggestions for improvement seems more effective than modeling alone or behavioral rehearsal alone (Edelstein & Eisler, 1976; Hersen, Eisler, Miller, Johnson & Pinkston, 1973;

Friedman, 1971; McFall & Twentyman, 1973; Rimm, Snyder, DePue, Haanstad & Armstrong, 1976; Turner & Adams, 1977).

The effectiveness of these combinations may be due to the fact that different procedures modify different aspects of the final assertive response. For example, modeling is seen to initiate new behaviors in persons with skill deficits, as well as reducing anxiety (Foy, Eisler & Pinkston, 1975; Hersen, Eisler & Miller, 1973; Turner & Adams, 1977), whereas instruction with feedback (Edelstein & Eisler, 1976) or modeling with instructions (Foy et al., 1975) tends to stabilize and maintain behaviors in the repertoire. Overall, covert modeling and rehearsal techniques seem to be as effective as overt techniques (Kazdin, 1974, 1975, 1976a, 1976b; McFall & Lillesand, 1971; McFall & Twentyman, 1973; Nietzel, Martorano & Melnick, 1977; Rosenthal & Reese, 1976).

Some procedures have not been found to promote assertion by themselves, such as playback of response (Gormally et al., 1975; McFall & Marston, 1970; Melnick & Stocker, 1977) or systematic desensitization, which seems more appropriate for helping overly anxious clients (Weinman et al., 1972; Wright, 1976). The area of cognitive modification procedures is only beginning to be applied to assertion training, so that further research is needed in this area; so far, such techniques seem promising (Glass et al., 1976; Schwartz & Gottman, 1976; Wolfe & Fodor, 1977).

One problem in research, and one that has not been directly approached so far, is that it is often difficult to assess the unique effects of some procedures, since they include overlap with other procedures (Rachman, 1976). For example, to assess coaching, behavioral rehearsal must be present. Behavioral rehearsal includes practice as well as some aspects of in vivo desensitization. It seems especially important to understand the contributions of each procedure individually because assertive behavior is viewed as consisting of specific response classes toward which treatment should be directed. But, in order to do this, it is necessary to establish which treatment procedures affect which response class. If all the respective procedures affect the response classes, it seems necessary to establish to what extent each procedure is effective (Frazier & Carver, 1975; Hersen, Eisler & Miller, 1973; Rich & Schroeder, 1976). This emphasis upon specific response classes is connected to an emphasis on situational specificity which states that behavior is dependent upon conditions of the situation (Eisler, Hersen, Miller & Blanchard, 1975).

Review of Therapist-Client Relationship Literature

From reviewing the assertion literature, it is apparent that behavioral techniques such as modeling, rehearsal, coaching, feedback, and instructions are effective in producing assertive behavior. That is, the

behavioral techniques in themselves are effective in producing changes in behavior that are consistent with the goals of therapy. So far, the research shows little concern about the way in which the therapist, as the deliverer of the techniques, affects the success or lack of success of the therapeutic endeavor. Specifically, little attention has been directed to characteristics of the therapist-client relationship which enable the client to be receptive to the therapist's techniques and support the client as he risks practicing new behavior.

This gap in the assertion literature (as well as in behavioral research as a whole) is quite surprising in view of the fact that other schools of treatment, particularly the client-centered method, have found that both process and outcome of therapy are intimately related to the quality of the therapist-client relationship (Carkhuff, 1969a, 1969b; Rogers, 1957, 1959, 1961, 1965, 1966, 1975; Rogers, Gendlin, Kiesler & Truax, 1967; Truax & Mitchell, 1971). Rogers (1957) specified six characteristics of the therapist-client relationship that result in constructive personality change, especially unconditional positive regard, empathic understanding, and congruence, the three therapist attitudes. These core conditions, as they are known, are seen as the basic elements of therapy and, as such, have been heavily researched.

For example, Truax (1961) reported that the depth of intrapersonal exploration was significantly positively related to therapist core conditions. Also, Schauble and Pierce (1974) concluded that clients who are successful in therapy have therapists who exhibit high levels of the core conditions while unsuccessful clients have therapists with lower levels of conditions. Further, compared to the unsuccessful clients, the successful clients exhibited higher levels of depth of exploration, owned their feelings more, and were more committed to change by the end of therapy, although the discrimination of groups was not as clear in earlier sessions. Truax and Carkhuff (1965a) noted that within a therapy session the client's depth of exploration level followed the changing levels of accurate empathy and unconditional positive regard from the therapist. Truax (1966) had observers rate the core conditions on a tape of Carl Rogers in therapy and found that certain client behaviors, i.e., discriminating feelings, clarity of expression, expression of insight, expressing self in manner similar to therapist, and on-target problem orientation, increased as core conditions increased, while other client behaviors, i.e., blocking, negative feeling expression, and catharsis, did not correlate with the high levels of therapist core conditions. Van Der Veen (1961) found that hospitalized schizophrenic clients who had perceived higher

therapist conditions talked about their problems more, referred these problems to themselves more, and spoke of their own experiences more than clients who perceived lesser degrees of the conditions.

It has also been established that the amount of change in therapy is related to perceived as well as actual levels of core conditions. Thus, the client's perception and experience of the therapist as an interested, understanding, accepting person significantly affects the client's in-therapy behavior, his depth of exploration, expression of feelings, commitment to change, and the outcome of therapy (Bergin & Suinn, 1975; Rogers, 1965; Strong, 1968).

Some research has indicated conceptual problems in measuring client perceived empathy. In the Rogerian literature, the individual core conditions have been presented as separate, independent concepts. Empathy is presented as different and distinct from congruence, and the same for unconditional positive regard. However, these core conditions, as measured in therapy sessions seem to be highly related to an overall, general impression of the therapist by the client. In a factor analytic study, Mills and Zytowski (1967) analyzed ratings of counselors on the Barrett-Lennard Relationship Inventory and found a general component accounted for approximately two-thirds of the variance amongst the core

conditions. All three core conditions loaded on this same initial general component. Consequently, investigating one of the core conditions (independently of the other two) might be quite difficult since the other core conditions may well be inadvertently influenced and/or influential.

Muehlberg, Pierce, and Drasgow (1969) corroborated this general component finding. Data from a therapy session, rated on the core conditions, was factor analyzed. The resultant first factor loadings, which included the core conditions, ranged from .92 to .94. This general component accounted for 89% of the variance. This finding was based on data from sessions considered low in facilitative conditions. Factor analyzing data from a session considered high in the conditions resulted in very similar loadings and similar accounted-for variance. The authors concluded that a counselor high on one condition would be high on the others and vice versa. That is, a general factor, or overall impression may well be perceived, although one is only measuring or manipulating one of the core conditions.

Factor analyzing 19 therapist variables, Mintz, Luborsky, and Auerbach (1971) reported a first factor accounting for 24% of the variance. Although lower than the other cited studies, this first component is consistent with the other findings in that all core conditions were

represented. Such therapist variables as secure, reassuring, warm, accepts the patient, and empathic were accounted for.

These factor analytic studies suggest, when investigating one of the core conditions, it would do the researcher well to be aware that the other, ostensibly unmanipulated core conditions may be also operative. The result may be that a general facilitative condition is actually what is being operationalized.

While it is evident that the therapist-client relationship has been emphasized by the client-centered research, it has not often been directly addressed by behaviorally oriented research. Although some behaviorists (for example, Eysenck, 1960; Wolpe, 1962) feel the relationship is not an essential factor in treating neurotic disorders, most current researchers do not explicitly comment on the relationship as having a part to play in treatment. Still, some attention is beginning to be paid to the importance of the therapist-client relationship in behaviorally oriented therapy outcome (Bent, Putman, Kiesler & Nowicki, 1976; Feldman & MacCullough, 1965; Gormally, Hill, Otis & Rainey,

1975; Kanfer & Phillips, 1966; Lieberman, 1968; Morris & Suckerman, 1974a, 1974b; Ryan & Gizynski, 1971; Sabatasso & Jacobson, 1970; Sloane, Staples, Cristol, Yorkston & Whipple, 1975; Staples, Sloane, Whipple, Cristol & Yorkston, 1976).

Nonetheless, this research is limited in several ways. First, there is little statistical data to support the observations. Second, even in those studies which seem designed to study the effect of therapist variables on therapy process and outcome, little interest seems devoted to relating the findings to the larger body of Rogerian theory and research. Thus, within the behavioral literature, the findings on the therapist-client relationship are not well documented and often not theoretically integrated into other current research.

Looking now at assertion training literature, Gormally (1976) suggested that relationship variables needed to be investigated in behavior therapy. This was a reiteration of an earlier anecdotal observation (Gormally et al., 1975) in which he found that clients exposed to an insight oriented control group (averaging 3.5 on the Carkhuff empathy scale) seemed better able to profit from later behavioral assertion training than the subjects in the standard behavioral group. Slaney (1977) designed an analogue study in which 200 subjects read one of two

randomly distributed transcripts. For both transcripts, the first eight client-therapist interactions were designed to represent facilitative responses. The ninth interaction for the behavioral condition, instead of being facilitative, made the suggestion that the client could benefit from assertion training. In the facilitative condition, the ninth interaction represented a facilitative response from the therapist. Results showed that the behavioral treatment counselor was perceived as more expert and appealing than the facilitative counselor. Both counselors were perceived as equally understanding of the client. Slaney (1977) has suggested that facilitative conditions may be perceived as a mediating variable to be used in conjunction with a more specific treatment mode and not as effective treatment in itself. This conclusion is consistent with others (Bergin & Strupp, 1972; Bergin & Suinn, 1975; Lazarus, 1971) who recommended that the Rogerian conditions be seen as relationship enhancers which make clients more receptive to a particular technique.

Behavior Therapy and the Therapist-Client Relationship

Some authors (Feather & Rhoads, 1972; Lazarus, 1976; Sloane, Staples, Cristol, Yorkston & Whipple, 1975; Wilson & Evans, 1976; Woody, 1968) have questioned the belief that one therapy procedure or theory provides a

complete explanation of all the factors influential in the therapeutic process. It is well known that different theoretical approaches have been used to treat similar problems. Also, to say a therapist utilizes a specific technique, for example, assertion training, does not mean that other factors not encompassed by the assertion training model (such as the therapist-client relationship) may not be operative in the therapeutic interaction. Bergin and Suinn (1975), in reviewing individual psychotherapy and behavior therapy, commented that the variables of empathy and warmth, as developed out of the client-centered camp, "are not as prepotent as once believed; but their presence and influence is ubiquitous even showing up strongly in behavior therapies" (p. 521).

In a theoretical paper, Woody (1968) proposed that "the effects of behavior therapy are contaminated by unmeasured influences from the therapist-client relationship" (p.200). In suggesting guidelines to merge psychotherapeutic (dynamic) and behavior therapy, Woody suggested, besides the development of new techniques in behavior therapy, therapists should initially strive "for an empathic, nonpossessive, sincere therapist-client relationship" (p. 202). It seems through the relationship the therapist acts as a model for the client thus engendering change in behavior from the client. Thus, this warm and

understanding relationship may be viewed as a facilitator of change procedures (Johnson & Matross, 1975).

Speaking from a behaviorist viewpoint, Wilson, Hannon, and Evans (1968) suggested traditional understanding of the therapist-client relationship has been obscure at best and can be better understood from a social reinforcement framework. That is, the relationship is one aspect of a social influence process. This lends operationalism to the concept providing means for subjecting it to research procedures. In highly structured behavior therapy techniques (systematic desensitization) which do not so heavily rely on the therapist as a reward giver, the relationship seems less emphasized, while for other behavior techniques (relaxation), the relationship may augment anxiety inhibiting qualities. When the client relates highly anxiety laden material to a warm uncritical therapist, reciprocal inhibition of anxiety results. Thus, when the therapist is a major source of social reinforcement in a behavioral procedure (e.g., feedback in assertion training), the relationship is more influential.

Wilson and Evans (1976) saw the therapist-client relationship as having both direct and indirect influences, but also recognized that the therapist has certain skills which influence treatment independent of the therapist-client relationship. For example, the therapist can

influence the selection of treatment goals, especially when the presenting concern is nebulous (unhappiness), and guide the identification of factors involved in the client's concerns, i.e., unexpressed or unidentified thoughts and feelings. The therapist-client relationship may have direct interpersonal influences when the therapist is seen as: (1) a counterconditioner, i.e., providing unconditional positive regard, (2) a personal role model, either implicitly or explicitly, and (3) helping to develop therapeutic expectancies, i.e., positive and realistic ones. In an indirect manner the relationship is seen as influential in (1) providing the basis for interpersonal attraction; if the client views the therapist favorably, it is hypothesized that the therapist's emotional value, reinforcing properties, and ability to elicit specific behaviors from the client are increased (see Staats, 1968), (2) providing the basis for social reinforcement, specifically from the therapist, and (3) overcoming resistance by obtaining the client's compliance, i.e., if trusting of the therapist, the client would more readily attempt steps suggested by the therapist.

Of particular interest to this research is the direct influence of the therapist as: (1) counterconditioner, and the indirect influences of (2) interpersonal attraction, and (3) overcoming client resistance. The

first influence, being a counterconditioner, is relevant to the proposed use of the therapist-client relationship in assertion training. In this study, some of the leaders of the assertion training groups provided specific group time where clients revealed anxiety laden material, i.e., thoughts and feelings about their assertion concerns, and the therapist responded in a warm and accepting manner. This would seem to countercondition, in particular, fears connected to expressing such material and, in general, fears in attempting to become more assertive. Also, the indirect influence of interpersonal attraction is hypothesized to affect assertion training outcome. That is, as the leaders build the relationship, the therapist will be seen by the client as being a source of reinforcement and the therapist will be better able to elicit specific assertion behaviors on the part of the client. Finally, the indirect influence of overcoming resistance speaks to the need to build the relationship. That is, the relationship and the manipulation time in which the relationship was emphasized fostered trust between the two (therapist and client) while also helping to identify areas of resistance, i.e., unexpressed feelings such as fear.

Emphasis upon development and maintenance of positive therapist-client relationship may be important in order to increase trust in the therapeutic exchange

reflected by increased risk taking, communication, and persuasibility (Johnson & Matross, 1975; Kanfer & Goldstein, 1975). The level of trust has been seen to influence the discussion of clients' problems, client openness to influence, effectiveness of client-therapist communication, the success of cooperative problem solving, and the frequency and depth of disclosures (Colson, 1968; Deutsch, 1962; Friedlander, 1970; Gibb, 1964; Johnson, 1971; Johnson & Matross, 1975; Johnson & Noonan, 1972; Taylor, Altman & Sorrentino, 1969; Walton & McKersie, 1975).

In conclusion, this area of literature, although limited, sets the theoretical stage to bridge the gap between behavior therapy and the relationship therapies. As Wilson and Evans (1976) state, "the essence of behavior therapy . . . does not lie merely in a set of techniques" (p. 788).

Rogierian Theory and Assertion Training

The thrust of this literature has been to clarify the reasoning behind the assumption that the therapist-client relationship affects therapy process and outcome, and has identified the psychological processes whereby the therapist-client relationship actually affects the process and outcome. However, while the behavioral orientation provides us with many techniques of changing behavior, it

offers us few guidelines on procedures for building and maintaining the therapist-client relationship. For these procedures it is necessary to return once again to the Rogerian research findings. The theory and techniques of Carl Rogers seem appropriate to this building and maintenance of the therapist-client relationship through the therapist-offered core conditions, which foster a facilitative condition. The following literature explores the appropriateness of the Rogerian personality theory for the nonassertive person, and sets out the theoretical basis for inclusion of the therapist-client relationship enhancers in assertion training.

According to Rogers (1959), the basic motivation and source of development in the person is the inherent tendency of the organism to maintain, enhance, and actualize itself. Nevertheless, the person is subject to strong environmental influences, particularly from the social environment. For the infant, on the one hand, subjective experience is reality and those experiences which enhance the organism, for example, feeding, dry clothes, bodily contact with parents, are valued positively by the organism. On the other hand, as the child grows older, organismic valuing is replaced in part by learned "conditions of worth" which may parallel but may also conflict with the organismic valuing process. Concurrent with the child's increasing self awareness is a development

of the need for positive regard from significant others. This is a reciprocal process in which satisfaction of the other person's need for positive regard is a satisfaction of one's own need for positive regard. The need for positive regard may be so compelling as to eclipse the organismic valuing process as the basis of thought, feeling, and behavior. When this occurs, the person may deny feelings and signals from his organism and orient himself primarily toward achieving positive regard.

The achievement of positive regard depends on the specific behavior of the individual, with some behaviors being approved and bringing positive regard and other behaviors being disapproved and not providing positive regard. By acting in accord with what he perceives to be the guidelines for achieving positive regard, the individual seeks to maximize positive regard and self regard. Thus, he has developed his conditions of worth; he achieves positive regard and self regard when he acts certain ways.

Self experiences that are in agreement with the conditions of worth are processed and symbolized accurately in awareness. But what happens when the individual meets experiences that are not compatible with his conditions of worth? The incongruence of these experiences with the conditions of worth must be dealt with, since experiences that are contrary to the conditions of worth threaten the

achievement of positive regard. These incongruent experiences, then, are distorted or denied and are not accurately symbolized in awareness. This distortion and denial are examples of the selective perception that has been activated by the incongruence and threat. Such selective perception allows the conditions of worth and positive regard to remain unviolated. Should the incongruence become so strong as to enter awareness because the defenses are inadequate, then the individual becomes increasingly disorganized, vulnerable, and anxious, perhaps leading him to seek counseling.

The key emphasis in the process of counseling is to break down the conditions of worth which the person has developed and which have led him to falsify, distort, and deny his own experiences and feelings. This breakdown is achieved by the counselor who offers unconditional positive regard to the client. This is communicated in the context of empathic understanding from the counselor, in which he attempts to see and experience the world as if he were the client. This empathic understanding and unconditional regard dissolve the conditions of worth so that the client is free to perceive himself as an acceptable person independent of the approval of others. Hence, the client's feelings of self regard rise, his feelings of threat and anxiety decrease, and the need for defensiveness diminishes. Experiences that were previously incongruent with his conditions

of worth are now admitted into awareness without distortion or denial.

The personality characteristics reported by non-assertive subjects may be seen to fit into this Rogerian framework. Compared to the assertive person, nonassertive subjects tend to report more tension (Schwartz & Gottman, 1976), are more anxious (Orenstein, Orenstein & Carr, 1975), more externally controlled (Appelbaum, Tuma & Johnson, 1975), concerned with the approval of others (Hartsook, Olch & DeWolf, 1976), and low in self esteem (Tolor, Kelley & Stebbins, 1976). Lange and Jakubowski (1976) give a general characterization of the nonassertive person as violating his own rights by failing to express honestly and openly his feelings, thoughts, and beliefs, as acting on the socialized messages of others, with acceptance of the self contingent on acceptance from others, and with the source of nonassertive behavior being fear of loss of approval from others.

Thus, the nonassertive person has developed his conditions of worth determined by the approval of others. Behaviors which may bring negative feedback, i.e., rejection and loss of approval, are avoided as they threaten the conditions of worth. The nonassertive person monitors his own thoughts, feelings, and perceptions in accord with the conditions of worth. Defensiveness is activated so as

to control the emergence into awareness of the incongruence of the organismic needs and the conditions of worth. Thus, the person feels vulnerable, anxious, and threatened. When the incongruence becomes too strong, the individual may seek out counseling.

In order for counseling to be effective, the person must be first willing to discuss his concerns. Initially, however, this implies a risk on the person's part since he opens himself to possible ridicule, exploitation, insensitivity, and rejection from the counselor. Thus, as the receiver of communications, the counselor responds to the person in such a way as to minimize these feelings of vulnerability. The counselor reacts with accurate understanding, warmth, and acceptance of the other. As the person receives these from the therapist, he becomes more willing to deal with previously problematic experiences, he feels more accepting and confident of self, and becomes less defensive, threatened, tense, and anxious.

Review of Discussion Literature

It has been noted that group therapy has no exact analogue of the therapist-client relationship; instead, the relationship encompasses member feelings about the leader, other members, and the group as a whole (Lieberman, 1975; Yalom, 1970). Thus, group factors affect therapy

process and outcome. Prominent among these is cohesion, usually defined as "the resultant of all the forces acting on all the members to remain in the group" (Cartwright & Zander, 1960, p. 74). Several factors have been found to affect cohesion.

Communication between members is related to satisfaction with the group such that members who are positioned to send and receive more communications are more satisfied than those who are more peripheral to the communication flow or those who lack information (Leavitt, 1951; Shaw, 1954). Members of a group who participated in achieving group goals by cooperative discussion and reciprocal teaching tended to be more likely to try out group suggestions than members of a group who received a didactic presentation of the same suggestions (Lewin, 1958). Berkowitz (1954) found that conformity was greater in cohesive groups, due to communications from group members to bring deviant members into acceptable limits of behavior. Bales (1950) found that communication was higher among members of more cohesive groups. Discussion among group members preceding risk taking tended to increase risk taking in the group as compared to group members who did not discuss the action as a group but only thought it over individually beforehand (Wallach, Kogan & Bem, 1962).

A sense of identity with the group is also related to cohesion. When members of a group share similar

attitudes and abide by normative guidelines, group cohesion rises (Newcomb, 1956, 1961). Members of similar ability levels tend to increase solidarity, too (Zander & Havelin, 1960). Groups with a weak sense of identity, on the other hand, tend to be more vulnerable to outside influences which can disrupt the group process (Verba, 1961).

Attraction to the group basically revolves on the assessment of potential gains and losses to the person which accompany group membership (Thibaut & Kelley, 1959). One of the gains offered by a group is the reduction of ambiguous or threatening circumstances by provision of group evaluation of the situation and determination of appropriate action, thus lowering individual anxiety (Schachter, 1959). The incentive properties of the group also derive from the expectation of members that the group will satisfy individual needs (Ross & Zander, 1957). Thibaut and Kelley (1959) pointed out that the expectation of satisfaction with the group is affected by previous group experience, which either satisfied or did not satisfy the member's needs, thus affecting the amount of attraction toward the group.

The effects of cohesion are several (Cartwright, 1968), including increased likelihood of remaining in the group, increased susceptibility of the members to group influence, increased interaction among members, increased participation in group activities, and more acceptance,

trust, and confidence in the group. It has also been pointed out (Pepitone & Reichling, 1955) that more cohesive groups can provide a sense of security such that members will be more likely to express negative or hostile feelings.

Most of these cited studies have used work groups or social groups to explore the determinants and effects of cohesion. However, several studies have shown that group cohesion also affects process and outcome in a treatment oriented group.

Dickoff and Lakin (1963) found that patients who perceived their groups as more cohesive attended more sessions, experienced greater social interaction with other members, felt accepted by other members, perceived similarity between themselves and other members, and judged the groups as therapeutic. Kapp, Glaser, Brissenden, Emerson, Wingt, and Kashdan (1964) similarly concluded that self perceived personality change correlated significantly to member's assessment of group cohesion and feelings of personal involvement. Clark & Culbert (1965) correlated therapy outcome with intermember relationships and demonstrated that members who entered into the most interaction with fellow members improved the most. The perceived relationship with the leader did not affect outcome, such that member-to-member relationship was seen as the prime determinant in change. Yalom, Houts, Zimerberg, and Rand (1967) showed that positive outcome in group therapy was

related to individual member's attraction to the group (cohesion) and popularity of the member within the group. Thus, it seems documented that cohesion is related to outcome in therapy.

In therapy groups, individuals with high self disclosure reported higher attraction for their group than members who did not so self disclose (Query, 1964). Also, group members valued most those sessions in which they participated more than they customarily did. These sessions were seen as most helpful and relevant to their problems (Sechrest & Barger, 1961). Finally, Coons (1957) compared a discussion group with an insight oriented group and a no treatment control condition among hospitalized patients. A manipulation check showed that the discussion group had more intermember interaction than the insight group, and outcome measures showed 69% of the discussion group were judged improved and 43% of the insight group were similarly rated ($p < .04$).

Thus, it can clearly be seen that cohesion affects the outcome of both task oriented and therapy oriented groups. Cohesion, in turn, is related to numerous variables, among them the amount of interaction between group members.

Summary of the Literature Reviewed

From reviewing the various areas of literature several main trends emerge. In terms of assertion training, the interest has moved from a laymanlike definition of assertion to an emphasis upon techniques for training assertion, several of which have been found to be effective in instigating assertion. Modeling is effective when used alone or in combination with other procedures such as instructions, feedback, and coaching or roleplaying (Eisler, Hersen & Miller, 1973; Foy, Eisler & Pinkston, 1975; Friedman, 1971; Goldstein et al., 1973; Hersen, Eisler & Miller, 1974; Hersen, Eisler, Miller, Johnson & Pinkston, 1973; Young, Rimm & Kennedy, 1973), with covert modeling achieving comparable results to overt modeling (Kazdin, 1974, 1975, 1976a, 1976b; McFall & Lillesand, 1971; Nietzel et al., 1977; Rosenthal & Reese, 1976).

Behavioral rehearsal is effective both individually and when used in combination with modeling or instructions, feedback, and coaching (Aiduk & Karoly, 1975; Lazarus, 1966; McFall & Marston, 1970; Melnick & Stocker, 1977; Rimm et al., 1976; Turner & Adams, 1977). Covert behavioral rehearsal is as effective as overt procedures (McFall & Lillesand, 1971; McFall & Twentyman, 1973). Although simple instructions exhorting the subject to act as the most assertive person would have produced favorable outcomes

(Goldstein et al., 1973; Nietzel & Bernstein, 1976; Schwartz & Gottman, 1976), instruction is most useful when used in combination with other procedures like feedback (Edelstein & Eisler, 1976; Eisler, Hersen & Miller, 1974; Hersen & Bellack, 1976), modeling or behavioral rehearsal.

Systematic desensitization seems to be ineffective in training up the skill deficits of assertion but is useful in counterconditioning anxiety (Piaget & Lazarus, 1969; Wolpe & Lazarus, 1966; Wright, 1976). A more recent trend in training assertion has been the use of cognitive modification procedures, so far with promising results (Glass, Gottman & Shmurak, 1976; Ludwig & Lazarus, 1972; Schwartz & Gottman, 1976; Wolfe & Fodor, 1977).

Increasing attention is being paid to the generalization of skills across time (within the lab) or across situations outside the training lab (Eisler, Hersen & Miller, 1973; Galassi, Kostka & Galassi, 1975; Kazdin, 1974; McFall & Lillesand, 1971; McFall & Marston, 1970; McFall & Twentyman, 1973). Also, situation specificity has been of recent import in training; specific response classes of skill deficit are to be identified and accordingly treated (Frazier & Carver, 1975; Hersen, Eisler & Miller, 1973; Rich & Schroeder, 1976).

Turning to the therapist-client relationship literature, research à la Rogers has found the relationship to be

intimately connected to therapy process and outcome (Truax, 1961; Truax, 1966; Truax & Carkhuff, 1965a; Schauble & Pierce, 1974; Van Der Veen, 1961) with the amount of change related to client perceived as well as objectively rated levels of the core conditions (Bergin & Suinn, 1975; Rogers, 1965; Strong, 1968).

Within the behavioral literature, some attention has been paid to the therapist-client relationship as influential in outcome (Bent et al., 1976; Feldman & MacCullough, 1965; Gormally et al., 1975; Lieberman, 1968; Staples et al., 1976), but so far, the research lacks statistical support and theoretical integration with the Rogerian findings.

Theoretically, it has been pointed out that the therapist-client relationship is influential: (1) since the therapist acts as a counterconditioner of anxiety. (2) by increasing interpersonal attraction, and by (3) overcoming client resistance (Wilson & Evans, 1976; Wilson, Hannon & Evans, 1968). The therapist-client relationship can also affect the openness to persuasibility or suggestion, risk taking, and trust (Goldstein, 1975; Johnson & Matross, 1975).

By reviewing the Rogerian personality theory (Rogers, 1959), it can be seen that the therapist offered core conditions can specifically affect the conditions of worth, and symptomatic feelings of anxiety and tension reported by the

nonassertive person. Likewise, group discussion, by increasing the possibility of intermember interaction, liking, similarity, and cohesion can affect the therapy process and outcome (Clark & Culbert, 1965; Coons, 1957; Dickoff & Lakin, 1963; Kapp, Glaser, Brissenden, Emerson, Wingt & Kashdan, 1964; Query, 1964; Sechrest & Barger, 1961; Yalom, Houts, Zimberberg & Rand, 1967).

Theoretical Basis for Project

From the literature reviewed, there is good reason to believe that the independent variable, facilitative conditions, should affect the dependent variables. Also the discussion time should have effects on the dependent variables. The third independent variable, the standard assertive training package, should affect some of the dependent variables.

First, it is theoretically expected that the facilitative conditions should affect subjects' perceptions of leader attractiveness because leaders will be seen as a source of reinforcement, thus increasing the leaders' emotional value (Byrne, 1971; Staats, 1968). By feeling that the leaders have been able to truly perceive their deeper feelings, subjects' attraction for the leaders should increase (Goldstein, 1975).

Theoretically, subjects' perception of leaders' expertness should be increased by the facilitative conditions

because the subjects will see the leaders competently dealing with anxiety-laden and problematic material in a calm, accepting, and empathically understanding manner (Rogers, 1959; Wilson & Evans, 1976). Thus, the subjects will see the leaders as skillful and adept in their roles.

Theoretically, subjects' feeling of trust for the leaders will be increased by the facilitative conditions because leaders' attitude of empathic understanding, warmth, and acceptance in their roles as receivers of the subjects' communications minimizes subjects' fears of vulnerability, possible ridicule, and rejection, thus becoming less defensive and more trusting (Rogers, 1959).

Risk taking on the subjects' part should also theoretically be increased by the facilitative conditions because by responding to subjects' expression of anxiety-laden material, especially fears and feelings about being assertive, with warmth, acceptance, and empathic understanding, the leaders countercondition fears connected to expressing such material and becoming more assertive, thus feeling subjects to behave in more assertive ways (Johnson & Matross, 1975; Rogers, 1959; Wilson & Evans, 1976), which involve risk taking inside and outside the group.

Openness to suggestion theoretically should be increased by the facilitative conditions because, by responding

warmly and with acceptance and empathic understanding to the subjects' fears, the leaders overcome subjects' resistance to the change program (Johnson & Matross, 1975; Rogers, 1959; Wilson & Evans, 1976).

Theoretically, probability of responding assertively will be increased by the facilitative conditions because the increased trust, attraction, and perceived expertness of the leaders, combined with the overcoming of resistance and increased openness to persuasion, will enable the subjects to participate more fully in the assertion training program and thus increase skill levels resulting in more effective assertive behavior (Johnson & Matross, 1975; Wilson & Evans, 1976). Following this, discomfort in assertion should logically be expected to decrease because subjects feel more adequate in situations calling for assertive skills so that their self perception is more congruent with their behavior and their perceptions of self worth are less dependent upon the approval or conditions imposed by others (Rogers, 1959). Thus, conditions in which the subjects experience the facilitative conditions should result in subjects' perception of highest levels of leaders' attractiveness, trust, and expertness, and greatest subjects' openness to suggestion and risk taking. Consequently, this should accompany greatest increase in probability of responding assertively and greatest decrease in discomfort in assertion.

However, within a group setting it is recognized that group variables, such as self disclosure, possibility of interpersonal attraction, and cohesion, can likewise affect these dependent variables. Theoretically, subjects' ratings of leaders' attractiveness, expertness, and trustworthiness are not expected to be affected by the discussion treatment, because the leaders were instructed to respond in a neutral fashion, not encouraging expression of warmth or empathic understanding on the leaders' part towards the subjects.

The discussion should prompt an increase in the cohesion of the group by allowing subjects to interact more with each other, thus increasing self disclosure, find similarities and differences in attitudes and feelings, and increasing the possibility of liking and acceptance among members. Theoretically, more cohesive groups have been found to be more influential on their members' behavior, prompting greater participation by members, thus theoretically increasing subjects' openness to suggestion and risk taking which, in turn, will logically affect assertion probability and discomfort (Cartwright, 1968; Clark & Culbert, 1965; Coons, 1957; Dickoff & Lakin, 1963; Lewin, 1958; Newcomb, 1956, 1961; Query, 1964; Yalom et al., 1967).

The standard behavioral package theoretically should not affect subjects' perception of leaders' attractiveness, expertness, or trustworthiness because the subjects have

little opportunity to experience the leaders' warmth or empathic understanding; likewise, subjects' risk taking or openness to suggestion should not theoretically be increased by the behavioral package because little leader attention is directed toward reducing subject resistance to treatment procedures or working through and reducing fears related to assertion.

However, the behavioral treatment theoretically should increase subjects' probability of assertive responding by increasing assertive skill levels in the subjects. Consequently, discomfort in assertion should decrease because of the ability of the subjects to adequately meet assertive demands, thus decreasing anxiety about assertion.

Statement of Purpose and Theoretical Hypotheses

The purpose of this study was to test out the influence of the addition of facilitative conditions (emphasizing development of a therapist-client relationship) to a behaviorally oriented assertion training package on outcome. In order to more clearly delineate the effect of the facilitative conditions, group discussion was used to control for variables such as self disclosure, interpersonal attraction, and cohesion. A standard behavioral assertion training package group was the group against which comparisons were made. Thus, there were three groups, all of which

received the standard behavioral assertion training package, but two of these three groups received an additional experimental manipulation. One received a 15-minute (per session) facilitative interchange between members of the group and the leaders, while the other group participated in a 15-minute (per session) group discussion. Equivalency of time for treatment was maintained between the three groups.

Thus, these three independent variables, facilitative conditions (plus standard behavioral package), group discussion (plus standard behavioral package), and the standard behavioral package alone were investigated in relation to: (1) subjects' perception of leaders' attractiveness, (2) expertness, (3) trustworthiness, (4) subjects' openness to suggestion, and (5) risk taking, and (6) outcomes on assertion discomfort, and (7) probability of response. This was accomplished by testing the following null hypotheses:

1. There will be no statistically significant differences between the facilitative condition group and the other two treatment groups on the seven dependent variables.
2. There will be no statistically significant differences between the discussion group and the other two treatment groups on the four dependent variables of openness to suggestion, risk taking, assertion discomfort, and assertion probability of response.
3. There will be no statistically significant differences between the standard behavioral package group and the other two treatment groups on the two dependent variables of assertion discomfort and assertion probability of response.

CHAPTER II

METHOD

In this chapter, the setting, subjects, procedures, and instruments utilized to assess the experimental hypotheses are explained. Four sections are presented. First, the setting (location, staff utilized) is explained. Second, demographic characteristics of the sample and the treatment groups are presented. Third, procedures are described, including the design, groups, manipulation of the independent variable, manipulation checks, prescreening of subjects, and the follow-up meeting. Fourth, instruments for assessment are set forth, offering psychometric data and rationale for inclusion of said instruments.

Setting

The University of Ottawa Counselling Service was the setting for all procedures, i.e., prescreening interviews, all assertion training sessions, and follow-up meetings. The assertion training groups have been regularly offered each semester for the past three years as part of the services available to the university community. The students were informed of the group through several sources such as student services information sent out to new students, brochures passed out during registration, and information and application forms

printed in the student newspaper each semester. Registration for the group was based on self referrals gathered at the beginning of the fall and winter semesters of the 1977-1978 calendar school year. Interested students returned completed registration forms to the Counseling Service and were, in turn, contacted by phone by one of the assertion training leaders to arrange a prescreening interview.

It is the policy of the Counseling Service, being a service unit, not to videotape or tape-record actual treatment sessions. This policy is in accord with the fact that some students were concerned that information would be accessible to their professors. Recording of sessions, were it possible, would have improved the study in two ways. First, the measurement of the leaders and consequently measurement of the manipulation would have been refined. The actual data of interchanges would have been accessible to ratings. Second, the recording procedure would have permitted behavioral measure of assertion both at pretreatment and posttreatment, providing a behavioral measure of change in assertiveness over time.

Leaders. Each assertion training group had two leaders. A full-time professional staff member who had conducted the groups in the past was the leader of the group, assisted by a trainee staff member, master or

doctoral level interns who had received training by the professional staff prior to the school year. This training, which occurred during the summer of 1977, consisted of imparting information about assertion training as well as having the interns proceed as group members through a number of group sessions. Each group had a male and a female leader, providing a competent model of each sex, a factor deemed important since groups were mixed in regards to sex. Four of the six leaders involved were blind to the experimental hypotheses and rationale of the study. The other two were not.

There was no way of assessing if the leaders were imparting high levels of facilitative conditions. It was considered to have each leader trained to criterion on ability to instigate facilitative conditions. Alternatively, it was considered to assess, in the sessions, the leaders' attempts at instigating the facilitative conditions. Both considerations would have provided evidence as to the leaders' ability to promote a warm, supportive atmosphere. However, these assessment methods could not be accommodated due to the practical limitations of the Service Centre in which no video-audio tape-recording was possible.

Description of Sample

Forty-five subjects were trained in the assertion groups utilized in this study. Forty-one of the subjects

were self referred university students who had registered through the Counselling Service for the Anglophone assertion training groups. The other four subjects were non-students who were referred by their respective counselors from the University of Ottawa Guidance Centre, which provides psychological services to the general public. These nonstudents were in reply to a request by the experimenter for referrals from the Guidance Centre of clients who could benefit from assertion training. This was done in order to increase the number of participants in the research project. Consequently, all subjects were a clinical population specifically seeking assertion training. No subject was offered financial remuneration for his participation, nor were students offered any points or credits toward their academic courses.

The assertion training groups were run in both the fall and winter semesters of the 1977-1978 school year. Each semester included three assertion groups for a total of six groups over the school year. The three assertion groups, experimentally called facilitative, discussion, and control, consisted of the following numbers of subjects each semester: first semester facilitative, 7; discussion, 6; control 8; second semester facilitative, 10; discussion, 8; control 6; for year totals of facilitative, 17; discussion, 14; control, 14.

Mean age for the total sample ($N = 45$) was 24.4 years, ranging from 18 to 36 ($SD = 5.32$). There were 23

males and 22 females in the groups. The average number of years of schooling was 2.5 beyond high school (see Table 1, p. 70). A plurality of subjects ($n = 12$, 26.7%) were in first year university, while the lowest percent ($n = 4$, 8.8%) were the nonstudents. The levels of education ranged from high school graduate to graduate student. Seven different faculties were represented in the sample (see Table 2, p. 71). The majority of subjects ($n = 21$, 46.6%) were from the Arts faculty, while the next largest group of subjects ($n = 5$, 11.1%) was from the psychology and social sciences area. Statistically, the frequencies of faculties present in the sample are not representative of the distribution of students per faculty in the Anglophone university population (Lee, in press; Yates corrected $\chi^2(4) = 21.86$, $p < .001$; see Table 3, p. 72).

Two main discrepancies existed between the assertion training sample and the Anglophone university population at large: first, more Arts students were represented in the assertion groups (about 22.3% more) than was found in the university population and, second, the assertion groups consisted of proportionately fewer science students (about 25.8% less) than in the university population at large.

Experimental groups. The demographic characteristics of the experimental groups can be set out as well as describing the sample (see Table 4, p. 73). The group

Table 1
 Number and Percentage of Subjects in Each
 Year of University

Year	Group			Total
	Facilitative	Discussion	Control	
1	4 (23.5%)	4 (28.5%)	4 (28.5%)	12 (26.7%)
2	4 (23.5%)	1 (7.1%)	4 (28.5%)	9 (20.0%)
3	4 (23.5%)	3 (21.4%)	2 (14.3%)	9 (20.0%)
4	1 (5.8%)			1 (2.2%)
Graduate	4 (23.5%)	2 (14.3%)	4 (28.5%)	10 (22.2%)
Nonstudent		4 (28.5%)		4 (8.8%)
No. per group	17 (99.8%)*	14 (99.8%)*	14 (99.8%)*	45 (99.9%)*
Average no. of years in university	2.8	1.8	2.7	2.5

*Due to rounding error.

Table 2
Faculties Represented in the Total
Sample

Faculty	Number	Percentage
Arts	21	46.6
Psychology & Social Sciences	5	11.1
Business Administration	4	8.8
Science & Engineering	4	8.8
Education	3	6.7
Physical Education & Recreation	2	4.4
Law	2	4.4
Nonstudents	4	8.8
Total	45	99.6*

*Due to rounding error.

Table 3

Chi Square:-Comparing Faculty Representation of the Sample
to the Anglophone University Population (First Year
Registrations)

Categories	Assertion Sample	Anglophone Population
A	23 (56.1%)	231 (33.8%)
B	5 (12.2%)	26 (3.8%)
C	4 (9.8%)	243 (35.6%)
D	5 (12.2%)	117 (17.1%)
E	4 (9.8%)	66 (9.7%)
Total	**41(100.1%)***	683(100.0%)

$$\chi^2(4) = 21.81, p < .001$$

*A = Arts+Philosophy+Common Law+Civil Law

B = Psychology & Social Sciences

C = Science+Medicine+Nursing

D = Education & Recreation

E = Business Administration

**4 subjects were nonstudents

***Due to rounding error

Table 4

Analysis of Variance: Age and Sex Characteristics of the
Three Treatment Groups

Group	Number	Sex	Age
Facilitative (F)	17	Male: 9	\bar{X} 22.5
		Female: 8	<u>SD</u> 4.2
Discussion (D)	14	Male: 7	\bar{X} 28.3
		Female: 7	<u>SD</u> 5.7
Control (C)	14	Male: 6	\bar{X} 22.7
		Female: 8	<u>SD</u> 4.2
Totals	45	Male: 22 Female: 23	\bar{X} 24.4 <u>SD</u> 5.3

Significant differences $F(2, 42) = 6.98, p < .01; D > F, C.$

numbers were facilitative 17, discussion 14, and control 14. The male-female breakdown was facilitative 9:8; discussion 7:7, and control 6:8. These numbers reflect a balance within groups and consequently between groups on sex. A significant difference between groups was noted on age, as the discussion group was significantly older than the other two groups ($F(2, 42) = 6.98, p < .01$) which were equal to each other. This age difference seems to be primarily due to the four nonstudents in the discussion group (ages 35, 32, 36, and 28), as well as to three graduate students (ages 34, 33, and 35) in the same group. However, there are good reasons to believe that age is not a confounding factor in this study.

First, a Pearson correlation showed age to be correlated to pretreatment measures of assertion $-.167$ (on discomfort scale) and $.065$ (on response probability scale), and to posttreatment measures of assertion $.110$ (on discomfort scale) and $.252$ (on response probability scale, $p < .04$). Thus, the relationship of age and assertion accounted for only a small proportion of the total variance ($r^2 = 2.7\%, 0.4\%, 1.0\%,$ and 6.0% , respectively) so that an analysis of covariance did not seem warranted. Secondly, there is no evidence from the assertion literature indicating that age (past 18 years) is influential in the subject's ability to either grasp the concepts presented during the training or to develop assertion skills.

In terms of education (see Table 1, p. 70), the facilitative group averaged 2.8 years of university experience, while the discussion group had 1.8 years, and the control group 2.7 years. Once again, this difference was due to the four nonstudents in the discussion group and the relatively low representation ($n = 1$) of second-year students in the discussion group as compared to the other two groups. Although this reflected an imbalance between the groups, the assertion literature does not suggest education as a significant variable in affecting subjects' ability to benefit from the training. In terms of faculty representation, a plurality of the subjects in all three groups were enrolled in the Arts faculty (see Table 5, p. 76). The facilitative group had eight (47.1%) subjects from Arts, the discussion group had six (42.8%), and the control had seven (50.0%). The rest of the subjects were spread across several faculties, except for the discussion group which included the four nonstudents (28.5%).

Although the foregoing demographic information showed that the age and education levels were not randomly distributed throughout the three treatment groups, it did support the conclusion that the groups were comparable on some demographic factors.

Table 5
Faculty Representation in Treatment Groups

Faculty	Facilitative Discussion		Control
Arts	8 (47.1%)	6 (42.8%)	7 (50.0%)
Psychology & Social Sciences	3 (17.6%)		2 (14.3%)
Business Administration	2 (11.8%)	2 (14.3%)	
Science & Engineering	1 (5.9%)		3 (21.4%)
Education	1 (5.9%)	1 (7.1%)	1 (7.1%)
Physical Education & Recreation	1 (5.9%)		1 (7.1%)
Law	1 (5.9%)	1 (7.1%)	
Nonstudents		4 (28.5%)	
Total	17(100.1%)*	14 (99.8%)*	14 (99.9%)*

*Due to rounding error.

A between treatment groups (three) univariate design was the structure of this study. The three groups were facilitative, discussion, and control. Treatment, as the independent variable, consisted of the standard behaviorally oriented assertion training program with an additional manipulation in the facilitative and discussion groups. All groups were run once a week for eight weeks. The experimental manipulation occurred in the last 15 minutes of each session, for each of the eight meetings. 703

Assignment of subjects to experimental groups. The subjects were not randomly assigned to the treatment groups due to the fact that subjects chose group times in accordance with their class schedules. However, treatment conditions were randomly assigned to the groups by the experimenter.

Control treatment. In the control condition, the standard behavioral training program customarily used at the Counseling Service was administered. This treatment program included the behavioral procedures of modeling, imagination, and roleplaying with feedback and coaching. All these techniques were used within the same sessions so that the effects of any single procedure could not be separated. In addition, the program utilized not only standard problem situations but also individually tailored situations. Sessions were held once a week for two hours, and continued for eight weeks.

The facilitative and discussion groups included the same standard assertion training package as the control

group, but differed from the control in that the last 15 minutes of each session were devoted to a manipulation procedure. It can be seen that in this study, control condition refers to a no treatment condition in the sense that the last 15 minutes were utilized in a routine manner using the standard behavioral package. In the facilitative condition, the last 15 minutes consisted of a facilitative interchange between leaders and members, whereas in the discussion condition the last 15 minutes were devoted to a group discussion among members.

Facilitative treatment. The facilitative condition attempted to emphasize the therapist-client relationship as based in Rogerian theory. This treatment condition provided the subjects with a formal opportunity to express personal thoughts and feelings about themselves and their assertion problems and progress, as well as an opportunity to experience the concern of the leaders for each person as an individual. This was accomplished through a facilitative interchange in which the leaders interacted with each subject individually and responded to the subject with statements of understanding, acceptance, and warmth. The last 15 minutes were devoted to this interchange which the leaders introduced by saying: "Now we're going to spend a few minutes talking about our feelings and thoughts about our concerns ... You know ... the unassertive feelings and actions that brought us to this group."

After this, the leaders engaged each subject individually within the group setting, asking the subject about his personal feelings and reactions in a recent assertive or nonassertive situation or about his experience in the group that day. Some questions used by the leaders to initiate this interaction were, for example: "How did you feel in the roleplay today?" "What were you feeling when you watched 'so and so' dealing with that situation?" "How did you feel when you were assertive in that situation?" The leaders responded to the subjects' remarks in a facilitative manner, meaning that the expressions of the leaders were essentially interchangeable with those of the subject since they both expressed the same affect and meaning. The leaders' responses did not subtract any meaning or depth of affect from the subject's responses, although in some cases the leaders' responses may have added to the subject's response so as to express the feelings at a deeper level than the subject was able to express himself (Carkhuff, 1969a). The goal of this interaction was to make the subjects feel accurately understood and accepted by the leaders. Within these 15 minutes, subjects had few opportunities to talk or to question each other, so that subjects became acquainted with one another's ideas and feelings by hearing the leaders and individual members interact. Thus, within this time, there was little direct opportunity to develop or express ideas and feelings about each other.

After all the subjects had been so engaged, the leaders summarized the feelings expressed and closed the session. An interaction similar to this occurred in sessions 2 through 8, lasting approximately 15 minutes at the end of each session.

Discussion treatment. In the discussion group, the last 15 minutes of each session were devoted to a group discussion about the subjects' thoughts and feelings about their assertion problems and progress, or about their experiences in the meeting. The leaders here replied to subjects' responses in a neutral, nonempathic manner, and attempted to encourage further conversation among the group members. They did not reply directly to the content of the subjects' comments but asked, for example, whether other group members had similar experiences, had anything to add, any new topics, thoughts, etc. By engaging in this discussion, members had specific opportunities to develop and express feelings of friendliness or hostility, and agreement or disagreement, or support. Thus, members could directly assess their similarity of feelings, abilities, and attitudes to other group members (see Review of the Literature, pp. 52-56). The purpose of this treatment condition was to rule out self disclosure, intermember attraction and similarity, interaction per se, and dynamics as an explanation for the effectiveness of the facilitative group.

These three groups, control, facilitative, and discussion, constituted the independent variable treatment conditions. The manipulation was checked by inclusion of the Relationship Inventory (Barrett-Lennard, 1962) which was administered at the fifth session. This instrument was designed to measure the presence of the Rogerian facilitative conditions as perceived and reported by the subjects. It was expected that the facilitative group would report higher levels of leader caring, understanding, and empathy than the other two groups. This measure will be further explicated in the fourth section of this chapter, Instruments.

Prescreening. The prescreening procedure, besides providing a measurement point, also provided an opportunity to select appropriate group members and to prepare prospective members for the training program.

The measurement at prescreening occurred before any explanation of the group or discussion of the subject's need for the group was initiated. The first step at prescreening was to obtain any demographic information from the subject that was not already available on the subject's registration form such as age, faculty, or year in university. Next, the interviewer requested the subject to fill in two questionnaires for research purposes. The Gambrill Richey Assertion Inventory (1975, see Appendix 2) was

administered after it was ascertained that the subject correctly understood the directions. This provided the pretreatment measure of assertiveness. After this was completed, the subject was asked to fill out three Likert items measuring the need for, belief in effectiveness of, and expectations of help from the assertion training program (Carvell, 1978; see Appendix 3). These questions were included to investigate preliminary findings by the Counselling Service that these three variables showed some predictive ability on outcome measures of assertion (Carvell, 1978). Although these questions were not per se addressed in the present experimental hypotheses, this study did provide an additional data base on which to examine these variables. At this point, the measurement portion of the prescreening interview was concluded.

Next, the interviewer met with the subject to assess appropriateness of the group for the subject. Three basic criteria of selection were used. One, if the subject seemed too shy or timid to take an active part in the group it was proposed to the subject that he deal with such extreme timidity on an individual basis before taking part in the group. Two, since many foreign students enroll at the University of Ottawa it was necessary to check the person's language abilities. If the interviewer noted any difficulties in either expressing or understanding

ideas, the interviewer pressed further the subject's understanding of the nuances of words since assertion training is concerned partly with communication skills. Three, the subject's motivation in applying for assertion training was assessed principally by asking the subject why he selected to take part in such a group and what needs or expectations he held regarding the group and being assertive. At the same time that the interviewer could assess whether the group was appropriate for the person, the person could decide whether the group would meet his own needs and goals.

If these conditions were met, then the person was prepared for entrance into the group. This involved explaining how the groups were run, what was expected from the members as active participants, what to expect from the leaders, ground rules of the group, basic set up of a typical session, and presentation of the contract to the subject. The contract (see Appendix 1) stated the duties of leaders and members and requested a signature from both the leader and the subject. If the subject was hesitant about signing the contract, he was asked to take it home with him and to make another appointment to settle any further concerns since no one was permitted to take part in the groups without having first signed the contract. Finally, the subject was informed of the date of the first assertion training meeting.

These procedures marked the end of prescreening. Only one person was screened out at this interview and this was due to language difficulties.

Follow-up meeting. At the eighth session, the subjects were informed of a date for a follow-up meeting to be held four weeks after termination of training. There were two aims in this meeting. First, the Assertion Inventory was administered to assess the maintenance of assertion skills or any changes in assertion that may have occurred since termination of training. Second, after this testing, feedback was given to the subjects about their scores on the pre- and posttreatment measures of assertion, and the research project in general. This meeting lasted about 45 minutes and concluded all procedures for the research project.

Instruments

Seven dependent variables were measured: assertion (two indices: discomfort and probability of response), subjects' ratings of leaders' attractiveness, expertness, and trustworthiness, risk taking on the subjects' part, and subjects' openness to suggestion from the leaders (see Table 6, p. 85). Measurement of five of these variables occurred at prescreening, fourth session, fifth session, eighth session and at 1-month follow-up. Two variables, risk taking and openness

Table 6

List of Dependent Variables and Measurement
Instruments

Variable	Instrument
Assertion: Discomfort	Gambrill Richey Assertion Inventory
Assertion: Response probability	Gambrill Richey Assertion Inventory
Attractiveness	Counselor-Rating Form: Attractiveness scale
Expertness	Counselor Rating Form: Expertness scale
Trustworthiness	Counselor Rating Form: Trustworthiness scale
Risk taking	Roleplaying and Monitoring Cards
Openness to suggestion	Homeworks

to suggestion were measured as part of the ongoing group process. For example, risk taking was measured each session through use of monitoring cards, while openness to suggestion was measured by the subjects' return of homework assignments on four occasions (see Table 7, p. 87). The purpose of this section is to explain the way in which such measurement was accomplished within the sessions and at follow-up, and to explain in detail the psychometric properties of the scales and the rationale for their inclusion in the study.

Introduction of measurement into the sessions. As it was necessary to administer scales throughout the course of the 8-week training, the scales were introduced into the groups in the least disruptive manner and without giving the subjects hints as to the true purpose of the specific measures given.

In the prescreening meeting, subjects were informed that they would be asked to complete a number of questionnaires as part of the ongoing research conducted by the Counselling Service which would help the Counselling Service provide more effective service. Therefore, when subjects were asked to answer questionnaires, they were not surprised at the request nor distrustful of the leaders. All testing was done at the end of the session after the experimental manipulation, and was introduced by the leaders as follows:

Table 7

Flow Diagram of Measurement Times

	Assertion Inventory	Need Belief Expectation	CRF	Relation-ship Inventory	Role-plays	Monitoring Cards	Assigned Homework	Optional Homework
Prescreening	X	X						
Session 1								
2					X	X	X	
3					X	X	X	X
4			X		X	X		
5				X	X	X	X	X
6					X	X		X
7					X	X		
8	X		X					
Follow-up (4 weeks)	X							

We've handed out to you today a questionnaire that will assist us in our research here at Counselling Service. The instructions are at the top of the page. If you have any questions please ask them. Please put your student number and today's date at the top of the page. Answer every item; it should take about 20 minutes to complete the scale. Try to respond with your first impressions to the question. Answer as honestly as possible, your confidentiality will be respected. Thank you.

When the scales were completed, the subjects folded their tests, placed them in an envelope, and returned the envelope to the leaders.

A similar procedure was used in any session where testing took place.

The purpose of this section is to discuss the seven dependent measures used to assess the experimental hypotheses. Several measures have been researched and their psychometric data are presented here. Those measures which lack such data were used to provide more immediate, behavioral measures of the dependent variables and will also be explained in this section.

Gambrill Richey Assertion Inventory. The Gambrill Richey Assertion Inventory (Gambrill & Richey, 1975; Appendix 2) was used to measure the main dependent variable, assertion. The 40 items on this scale cover eight areas of assertion, including (1) turning down requests, (2) expressing personal limitations such as admitting ignorance in some area, (3) initiating social contacts, (4) expressing positive feelings, (5) handling criticism, (6) disagreeing

with another person, (7) assertion in service situations, and (8) giving negative feedback to others. Assertion involving acquaintances, strangers, friends, and family members was included in many of the items. Thus, a wide range of assertion problem areas are identified with this instrument. Altogether, the Assertion Inventory takes about 40 minutes to complete.

The scale yields three indices: the degree of discomfort, the probability of assertive responding, and enumeration of specific situations that the subject finds problematic. The scores of the discomfort and response probability scales are computed by adding the values that the subject assigns to each item. The degree of discomfort is measured on a 5-point scale (1, no discomfort; 5, very much discomfort) across the 40 items. The scores on this scale range from 40 to 200; the higher the score the more discomfort the subject reports feeling in situations calling for assertion. The response probability scale is measured on the same 40 items on a 5-point scale (1, always do it; 5, never do it), with a possible range of scores from 40 to 200. The higher the score the lower probability of responding assertively is indicated. The third index is the number of situations circled by the respondent indicating particular situations which the person would like to handle more assertively. This index ranges from 0 to 40.

By comparing a respondent's discomfort and response probability scores, it is possible to identify four types of asserters. A person may self report a high amount of discomfort (high score) and low response probability (high score), indicating the typical nonassertive person who feels much anxiety in a situation and does not act assertively. The typical assertive person is reflected in low discomfort (low score) and high probability of response (low score), such that the person does not feel much anxiety in situations demanding assertive responding and tends to act assertively. A third type of asserter, the anxious asserter, tends to reflect high discomfort (high score) and yet still reflects high response probability (low score). Finally, the last type of asserter is the nonanxious nonasserter reflected by a low discomfort (low score) matched with a low response probability (high score). This person seems not to feel anxious in situations but also tends not to respond assertively. These distinctions are helpful in interpreting the results of the Assertion Inventory.

Norms and other psychometric data have recently been compiled on the Assertion Inventory (Gambrill & Richey, 1975). However, the instrument is a new one such that data are still being gathered. A 5-week test-retest procedure was run on 49 subjects (16 males, 33 females), yielding coefficients of .87 for discomfort and .81 for response probability, indicating relatively stable scores across time.

Some sex differences were noted, principally along the lines of social expectations for each sex. Males, for example, reported higher probability of response to resisting sexual overtures, turning down requests for a date, or asking if they had offended another, whereas females reported higher probability of response to discussing someone's criticism of their work, or requesting a date from another. In spite of this sex bias, validity information is promising.

Comparisons were made between a clinical population ($N = 19$) and two undergraduate populations: a norming sample ($N = 313$) and a test-retest sample ($N = 49$) (Gambrill & Richey, 1975). The mean discomfort score for the clinical population before training (107.7) was significantly higher than the mean discomfort scores for the other two groups (95.6 and 96.0, no significance level reported). Also, following training, the clinical population's scores decreased significantly, while the scores of the reliability sample ($N = 49$) did not change. For example, the posttreatment mean discomfort score for the clinical population was 82.0, while the test-retest sample mean discomfort score was 95.2 ($t(66) = 2.27$, $p < .05$). The posttreatment mean for the clinical group on the response probability scale was 87.9, while the test-retest sample mean response probability score was 105.0, reflecting a significant difference between the groups ($t(66) = 3.67$, $p < .002$). Within the clinical population itself the

scores significantly decreased from pre- to posttreatment. The mean discomfort score decreased from 107.7 to 82.0 ($t_{(36)} = 3.67, p < .002$) and the mean response probability score decreased from 104.8 to 87.9 ($t_{(36)} = 2.39, p < .05$). The authors also reported a greater decrease in discomfort scores for a social interaction group (-22.50) than for an attention placebo group (-4.67) or a waiting list control group (-4.75). Further validity has been assessed by noting a significant correlation between changes in blind observers' ratings and changes in subjects' scores for discomfort (before versus after training for 15 females; $r = .465, p < .05$).

Some normative data have been collected on several populations (Gambrill & Richey, 1975). One sample ($N = 313$) had a mean discomfort score of 95.61 ($SD = 19.93$) and a mean response probability score of 104.3 ($SD = 15.70$). A second sample of males ($N = 137$) had a mean discomfort score of 90.28 ($SD = 22.06$) with a mean response probability score of 103.68 ($SD = 15.5$). A third sample of females ($N = 158$) collected at the same time as the above-mentioned male sample showed a mean discomfort score of 94.67 ($SD = 21.97$) and a mean response probability score of 102.68 ($SD = 17.5$).

After reviewing these data, two comments are in order. First, the mean response probability score tends to be higher than the mean discomfort scores in these samples.

Given that the 1 to 5 scales on each measure are equal, this can be interpreted to mean that the norming populations indicated lower discomfort compared to a higher probability of not responding assertively. Also, as Gambrill and Richey (1975) pointed out, the standard deviations are fairly large, indicating "a fairly wide range of scores in all undergraduate samples" used for norming purposes. Thus, the assertive responses in a population are varied and this instrument seems capable of addressing itself to these varied response categories.

In the present study, this instrument was used as a pre- posttreatment measure (8 weeks apart) and at follow-up (4 weeks after termination of training). The scale was chosen for a number of reasons besides its psychometric properties. The two indices of discomfort and response probability is one advantage of the scale; instead of just identifying levels of assertion, the subscales provide information that can be more meaningfully interpreted through the identification of the different types of asserters. Additionally, interpretation of the scale is straightforward since scale names directly label the areas of difficulty: discomfort or probability of response. Another advantage is that specific response categories can be measured by collating similar items within the scale. Thus, one can identify a particular area of assertion

difficulties and thereby attend to the situation-specificity aspect of assertion. The wide range of response categories represented (8) allows greater specificity of target behaviors and goals. Accordingly, a varied population reflecting different concerns can be assessed with this instrument. Finally, the scale has been used at the Counselling Service as part of ongoing data collection on the assertion groups. Thus, its use furthered accumulation of a data base.

Need, Belief, and Expectation Questions. These three questions (Carvell, 1978) were arranged on an 11-point Likert scale. The low value (1) on the scales reflected no need for assertion training, no belief in the effectiveness of the training, and no expectation of help from the training, while the higher value (11) reflected high need for, belief in, and expectations of help from the training (see Appendix 3). On each question, the subject would mark the items in accord with his own self perceived need, belief, and expectation of the training. The questions took about one minute to answer and were administered at the prescreening interview.

The questions were included in this study on the basis of previous findings at the Counselling Service. Carvell's (1978) study used discriminant analysis and found that these three variables might be important factors in predicting the outcome of assertion training. It was

found that the belief in effectiveness of training question correlated $-.35$ ($p < .01$) with a posttreatment measure (Gambrill Richey Assertion Inventory) of discomfort in assertion and $-.43$ ($p < .01$) with probability of responding. This was interpreted to mean the higher the initial belief in effectiveness of training, then the lower would be the posttreatment anxiety (low discomfort score) with a greater probability of responding (low response probability score). This same question correlated with a change in discomfort score $.49$ ($p < .01$) and change in response probability score $.34$ ($p < .01$), again supporting the above interpretation.

The other two questions were less helpful in predicting outcome assertion measures. The expectation of benefit question correlated $-.29$ with the posttreatment discomfort score (approaching significance) and $-.45$ with response probability scores ($p < .01$). Thus, the greater the expectation of benefit, the lower was the discomfort (although not significantly lower) and the higher the probability of responding in an assertive manner. Finally, the need for training question did not correlate significantly with the posttreatment measures of assertion but did correlate significantly with change in discomfort score ($.49$, $p < .01$).

On the basis of these preliminary findings, it was decided to include these questions for the purpose of

verifying these initial results and because they seem to be potential predictors of success in assertion. These questions were not addressed in the experimental hypotheses although they may offer additional information about the way in which the subjects perceive the training program and the leaders..

Counselor Rating Form. The Counselor Rating Form (Barak & LaCrosse, 1975; Appendix 4) was used to tap the subjects' perceptions of leaders' attractiveness, expertness, and trustworthiness, the three indices of this scale. The directions on the test were altered to ask subjects to respond to the items as they perceived both leaders in the group. The scale is based on Strong's (1968) model of counseling as an interpersonal influence process. The three dimensions of attractiveness, expertness, and trustworthiness were supported by research as active forces in the counseling process (Kaul & Schmidt, 1971; Strong & Dixon, 1971; Strong & Schmidt, 1970). Thirty-six adjective pairs (12 pairs per subscale) are placed on a 7-point bipolar scale. The range of possible scores is 12 to 84 for each of the subscales. Split-half reliability is reported to be .87 for expertness, .85 for attractiveness, and .90 for trustworthiness (LaCrosse & Barak, 1976). Some evidence for concurrent validity is available (Barak & LaCrosse, 1977) based on nonsignificant differences of ratings on the three dimensions of the scale between

respective clients, counselors, and supervisors in 19 cases. The Counselor Rating Form was administered at two points in the group program (sessions 4 and 8) to note if differences in subject perception of the leaders existed between the groups early in training (fourth session) or later in the group process (eighth session).

Several advantages recommend the inclusion of this scale in this study. The bipolar nature of the items makes the scale a simple one to answer, and it took subjects only a short time (approximately 10 minutes) to fill it out. The scale measures important aspects of the therapist-client relationship, aspects that were predicted to be affected by the manipulation. Finally, the instrument was substantiated by sound psychometric properties which warranted its inclusion in the research.

Barrett-Lennard Relationship Inventory. The Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1962; see Appendix 5) was used in the present research as a measure of the effectiveness of the manipulation. The Relationship Inventory purports to measure subjects' perception of the therapist-offered Rogerian facilitative conditions. This 64-item scale is composed of a 6-point Likert scale running

from -3 to +3 and has four subscales: empathy, congruence, unconditional positive regard, and level of regard. The total score reflects ~~the~~ overall level of the core conditions such that the higher the score the more the conditions have been met. Each subscale score ranges from -48 to +48, while the total score ranges from -192 to +192. The wording of each item, instead of saying "he" or "she" indicating one leader, was reworded to say "they" indicating rating of both leaders together.

After five therapy sessions, Barrett-Lennard (1962) administered the Relationship Inventory to clients ($N = 42$) and the split-half Spearman Brown method was used to determine internal consistency. The resultant correlations ranged from a low of .82 for unconditional positive regard to a high of .93 for level of regard. Initially, content validity was established by judges for the items included in the scale. Statistical analysis on scores obtained after the fifth session showed that subjects who changed more in therapy scored significantly higher on level of regard ($p < .005$), empathy ($p < .005$), unconditional positive regard ($p < .01$), and total score ($p < .001$) than subjects who changed less in therapy as judged by therapists' ratings. Based on client scores at termination of therapy, the following three scores reached significance between the more and less changed clients: empathy ($p < .05$), congruence ($p < .005$), and total score ($p < .02$).

Thus, this quick (15 minutes) measure provided a reasonably psychometrically sound instrument to assess subjects' perception of the presence of the Rogerian conditions. The test is easy to administer and scoring is by an objective method, so that there was no need for professional raters. The important issue for this research is the subjects' perception of the facilitative conditions, since creation of this atmosphere was intended by the manipulation. Consequently, the total score would best reflect the presence of these facilitative conditions.

The remaining measures in this study, roleplaying, monitoring cards, and homeworks, were utilized as more immediate, behavioral measures of the dependent variables. Since there is no psychometric data to support their inclusion, interpretation would be cautious.

Roleplaying. The roleplaying measure was based on the number of people who took part in a roleplay situation within each session. Each time a roleplay opportunity was present within the session, the leaders would ask who would like to roleplay; even after obtaining the needed number of participants (usually two) the leaders would still inquire whether other members would like to play the situation. Thus, two indices were obtained, the number of people who wanted to roleplay (potential roleplays) and the number of people who actually roleplayed (actual roleplays). If

someone who was a potential roleplayer actually got the chance to roleplay, then the number of actual roleplays increased and the number of potential roleplays decreased accordingly. Occasionally it was necessary to force a subject to roleplay, but these occurrences were not counted as actual roleplays because they did not represent either actual or potential risk taking. Throughout each session, one of the leaders surreptitiously kept record of the roleplay numbers. It was not considered necessary to test interrater reliability since the numbers involved were small (i.e., 4 or so) and the leader could record occurrence at the time of volunteering. In data analysis, the roleplay totals were collapsed across the eight sessions so that group differences could be examined.

The roleplaying was used as a measure of risk taking within the session because roleplaying is a major part of assertion training and because past experience at the Counselling Service has shown volunteering for roleplaying to be difficult for the subjects.

Monitoring Cards. A second measure of risk taking to be used outside the group sessions was the monitoring cards (see Appendix 6). The use of the monitoring card was introduced in the first session by the leaders, who both explained its use and merits and gave to each subject a set of typed instructions and example card (see Appendix 6).

Each subject kept a record of situations that occurred throughout the week that demanded assertive behavior on his part as well as his response to these situations whether his response was assertive or nonassertive. In data analysis, the number of assertive and nonassertive responses were collapsed within each group so that analysis dealt with group scores, not individual subject responses.

This measure was felt to reflect behavioral attempts by the subjects to take risks outside the group; although open to reliability questions, the measure was nonetheless considered a valuable index of behavioral risk taking.

Homeworks. The homework assignments (see Appendices 7, 8, 9, 10, 11, and 12) were used to assess subjects' openness to suggestion and were culled from the homeworks used in previous Counselling Service assertion training groups. The homeworks were chosen to reflect the varied situations that call for assertive responding and were given to capitalize on assertion skills presented in group sessions (see, for example, discrimination abilities, Appendices 7 and 9, and DESC Scripting, Appendix 10, which were practiced within the group as well as given in homework).

Assigned homeworks were those which the subjects were asked to complete as an integral part of the training package. Optional homeworks were those that were presented

to the subjects as homeworks which they might choose to complete and were suggested by the leaders as helpful. The words "optional" or "assigned" did not appear on the homeworks, but the subjects were told whether the homeworks were assigned or optional by the manner in which the leaders presented them.

Each of the assigned and optional homeworks were tallied for each person, but in statistical analyses group scores were used. Completion of these tasks was considered a reflection of subject openness to suggestion. The assigned homeworks were considered to tap the variable of openness to suggestion in general, while the optional homeworks were considered to be more sensitive to the openness instigated by the experimental manipulation.

CHAPTER III

RESULTS

The purpose of this chapter is to explain the statistical procedures used to analyze the data collected. This information is presented in four parts. First, procedures were run to determine whether the treatment groups were initially equivalent on assertion, and then whether the groups changed in assertiveness as a result of the training program, regardless of the experimental manipulation. Second, statistical results addressed to the hypotheses are presented. Third, analyses used to test the effectiveness of the experimental manipulation are set out. Fourth, additional analyses follow which add interpretive information to the study.

In all computations, the alpha level was set at .05, and the sample sizes were: facilitative group, 17; discussion group, 14; and control group, 14. Homogeneity of variance was computed in all analyses because of the unequal cell sizes. Power analysis is reported to indicate the chances of finding significance if significance occurred.

Preliminary Analyses

Some preliminary analyses were computed prior to addressing the individual hypotheses. A one-way analysis

of variance (Nie, Hadlai Hull, Jenkins, Steinbrenner & Bent, 1970) was computed on each of the two scales of the Assertion Inventory to determine whether initial equivalency between the three groups existed. The data used in this equivalency test were gathered at the prescreening session. On the discomfort scale data no statistically significant difference between the three groups was found ($F(2, 42) = 1.228, p < .303$; see Table 8, p. 105) and homogeneity of variance existed between the three groups (Bartlett Box $F(2, 42) = .175, p < .83$). Thus, there were no significant differences in discomfort in situations calling for assertive responding across the three groups. However, comparison to a general population revealed some interesting facts. The present sample reported higher levels of discomfort ($\bar{X} = 111.111, SD = 25.76$) than a norming population ($\bar{X} = 95.61, SD = 19.93, N = 313$; Gambrill & Richey, 1975), suggesting that this clinical sample did, indeed, differ from the general public on the amount of discomfort associated with assertion. At the same time, this sample seemed to be comparable on discomfort to a reported (Gambrill & Richey, 1975) clinical sample of 19 females ($\bar{X} = 107.7, SD = 22.37$).

Thus, based on the first analyses, the three groups were equivalent on the initial discomfort measure of assertion. Although this sample reported a higher level of discomfort than a general population, the present sample's

Table 8

Analysis of Variance: Prescreening Assertion Discomfort Scores by Treatment Groups.

Source of Variation	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between groups	1613.500	2	806.750	1.228	n.s.
Within groups	27585.062	42	656.787		
Total	29198.562	44			

discomfort level was similar to other reported clinical samples.

On the other scale of the Assertion Inventory, the probability of response scale, no statistically significant difference between the three groups was found ($F(2, 42) = .578, p < .571$); see Table 9, p. 107). Again, homogeneity was met (Bartlett Box $F(2, 42) = 1.294, p < .27$). Thus, the three groups were not statistically different on the pre-treatment response probability dimension.

Comparing this sample's probability of response scores to a general population revealed the following. The grand mean of this clinical sample ($\bar{X} = 117.222, SD = 18.19$) reflected a lower probability of responding than the norming population ($\bar{X} = 104.3, SD = 15.7, N = 313$; Gambrill & Richey, 1975). Thus, the general population seemed more likely to respond to a situation by behaving assertively than did the present sample of subjects prior to training. Furthermore, this sample reported a lower probability of responding than an elsewhere reported (Gambrill & Richey, 1975) clinical sample of 19 females ($\bar{X} = 104.8, SD = 22.55$).

Thus, the three groups were not significantly different in initial probability of response measure of assertion. Additionally, this sample reported a lower probability of responding assertively than did a general population and another clinical sample.

Table 9

Analysis of Variance: Prescreening Assertion Probability
of Response Scores by Treatment Groups

Source of Variation	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between groups	389.687	2	194.843	.578	n.s.
Within groups	14170.187	42	337.385		
Total	14559.875	44			

Another preliminary investigation was undertaken to see if each of the three treatment groups changed on the dimension of assertion from the pretreatment to posttreatment regardless of the experimental manipulation. The control group improved in assertion as shown by significantly lower scores on the discomfort scale ($t(13) = 4.48, p < .001$; see Table 10, p. 109) and significantly lower response probability scores ($t(13) = 4.12, p < .001$; see Table 10). Thus, over the course of training, the control group became statistically significantly more likely to respond assertively and with less discomfort during assertion. It can also be noted that the observed means for both the post-treatment discomfort and response probability scales were similar to the means obtained on a general population (Gambrill & Richey, 1975). Thus, the behaviorally oriented assertion training package alone was sufficient to instigate significant changes in assertion.

Since the facilitative and discussion groups received the same basic assertion training package as the control group, as well as receiving the experimental manipulation, it was not surprising to find statistically significant improvement in assertion from pre- to posttreatment on both indices of assertion (discussion group: discomfort decrease $t(13) = 2.61, p < .022$; probability of response decrease $t(13) = 4.06, p < .001$; facilitative group: discomfort decrease

Table 10

t Tests: Within Groups Pre- to Posttreatment Measures of Assertion

Dependent Measure	Pretreatment		Posttreatment		n	t observed	p
	<u>X</u>	<u>SD</u>	<u>X</u>	<u>SD</u>			
Control							
Discomfort	119.50	23.22	94.14	25.46	14	4.48	.001
Response probability	119.92	14.87	98.92	23.67	14	4.12	.001
Discussion							
Discomfort	104.64	27.36	83.07	25.02	14	2.61	.022
Response probability	119.07	16.23	98.85	28.07	14	4.06	.001
Facilitative							
Discomfort	109.52	26.03	80.64	21.29	17	5.59	.0001
Response probability	113.47	22.17	92.23	22.61	17	5.35	.0001

$t(16) = 5.59, p < .0001$; probability of response decrease
 $t(16) = 5.35, p < .0001$). Again, the changes reflect significantly lower discomfort and significantly higher probability of responding assertively.

Tests of Hypotheses

In order to address the three null hypotheses, it was necessary to examine the effects of the three independent variables upon each of the seven dependent variables in separate analyses.

First, the assertion discomfort scores of the three groups were analyzed. A one-way analysis of variance was computed on the posttreatment assertion discomfort scores between the three treatment groups. The nonsignificant results between the groups ($F(2, 42) = 1.347, p < .270$; see Table 11, p. 111) suggested that none of the treatments was superior to the others in decreasing discomfort scores. Homogeneity of variance was present (Bartlett Box $F(2, 42) = .271, p < .76$). A meaningful covariate was sought but not found. A one-way analysis of variance showed that pretreatment assertion discomfort scores were not significantly different from each other ($F(2, 42) = 1.228, p < .303$). Since initially the groups were not statistically different, the pretreatment discomfort scores were not used as a covariate (see Table 8, p. 105). However, unqualified acceptance of

Table 11

Analysis of Variance: Posttreatment Assertion Discomfort
Scores by Treatment Groups

Source of Variation	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between groups	1528.250	2	764.125 ^a	1.347	n.s.
Within groups	23822.625	42	567.205		
Total	25350.875	44			

no difference between treatments is not in order. This is due to other considerations, to be explicated later, that the theory may not have been powerfully tested in this study. One reason for this stance was the low power present in these analyses. The power of the overall F was 35%, the power of the contrast between the control and facilitative groups was 30%, between the control and discussion groups 19%, and between the discussion and facilitative groups 6%. Based on these analyses, the groups reported similar levels of discomfort at posttreatment.

The second dependent variable analyzed was the probability of responding assertively. A one-way analysis of variance was computed on the posttreatment probability of response scores with nonsignificant results ($F(2, 42) = .383, p < .689$; see Table 12, p. 113). Homogeneity of variance was met (Bartlett Box $F(2, 42) = .360, p < .703$). Again, no difference between treatments was noted in ability to instigate increased probability of assertive responding. Since the groups were equivalent on pretreatment response probability scores ($F(2, 42) = .578, p < .571$; see Table 9, p. 107), it was not necessary to use these scores as a covariate. Again, other factors influenced the meaning of these results. The power for the overall F was 35%, while the power for the control and facilitative contrast was 12%; between discussion and control it was

Table 12

Analysis of Variance: Posttreatment Assertion Probability
of Response Scores by Treatment Groups

Source of Variation	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between groups	468.750	2	234.375	.383	n.s.
Within groups	25715.875	42	612.282		
Total	26184.625	44			

6%, and between facilitative and discussion was 10%. It was concluded from these analyses that similar levels of post-treatment probability of responding was evinced between the groups.

Analysis of the follow-up data, which were collected four weeks after termination of training, reflected similar nonsignificant results between the groups. These data were based on 42 subjects (control 12, discussion 14, and facilitative 16) and were analyzed in a one-way analysis of variance procedure. On the Assertion Inventory discomfort scale the three groups reported equivalent amounts of discomfort at follow-up ($F(2, 39) = 1.324, p < .277$). Homogeneity of variance was present (Bartlett Box $F(2, 39) = .833, p < .438$). The power of the overall F for the discomfort scale was 31%. Nonsignificance between the groups was also noted on the response probability follow-up measure ($F(2, 39) = 1.211, p < .309$). Homogeneity of variance was met (Bartlett Box $F(2, 39) = .220, p < .804$). The power of the overall F was 31%. Thus, the three groups were equal both at posttreatment and follow-up on both measures of assertion.

Correlated t tests within each of the treatment groups showed that assertive gains made from pre- to post-treatment were maintained at follow-up (see Table 13, p. 115, Figure 1, p. 116, and Figure 2, p. 117). For the control group, neither the amount of discomfort

Table 13

Mean Discomfort and Probability Scores and Standard Deviations
at Pretreatment, Posttreatment, and Follow-up

	Control		Discussion		Facilitative	
	\bar{X}	\underline{SD}	\bar{X}	\underline{SD}	\bar{X}	\underline{SD}
Pretreatment						
Discomfort	119.50	(23.22)	104.64	(27.36)	109.52	(26.03)
Response probability	119.92	(14.87)	119.07	(16.23)	113.47	(22.17)
Posttreatment						
Discomfort	94.14	(25.46)	83.07	(25.02)	80.64	(21.29)
Response probability	98.92	(23.67)	98.85	(28.07)	92.23	(22.61)
Follow-up						
Discomfort	90.25	(28.73)	75.78	(19.89)	78.87	(22.45)
Response probability	96.75	(25.89)	94.28	(21.30)	83.93	(23.64)

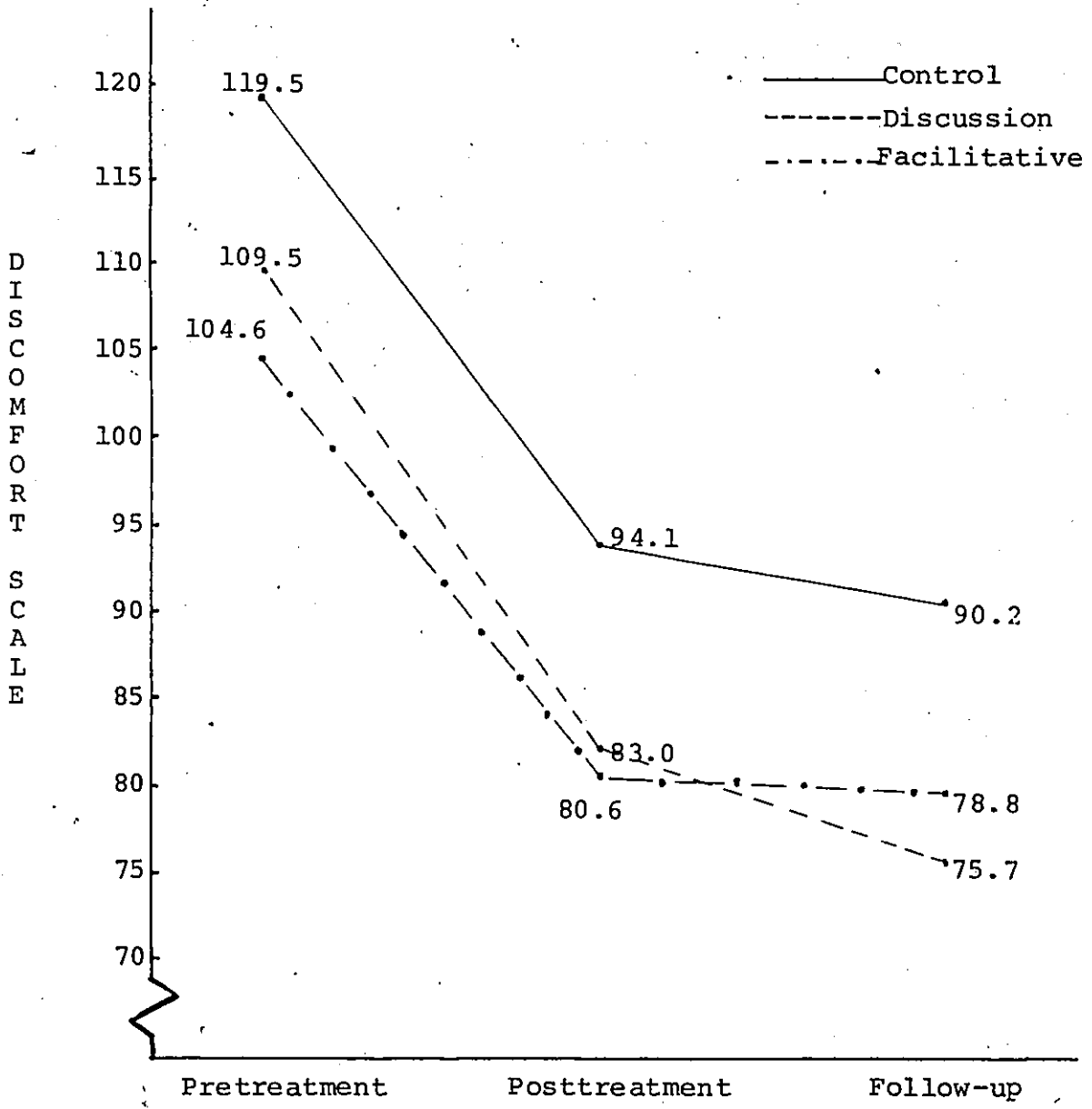


Figure 1. Mean Discomfort Scores of Treatment Groups at Pretreatment, Posttreatment, and Follow-up.

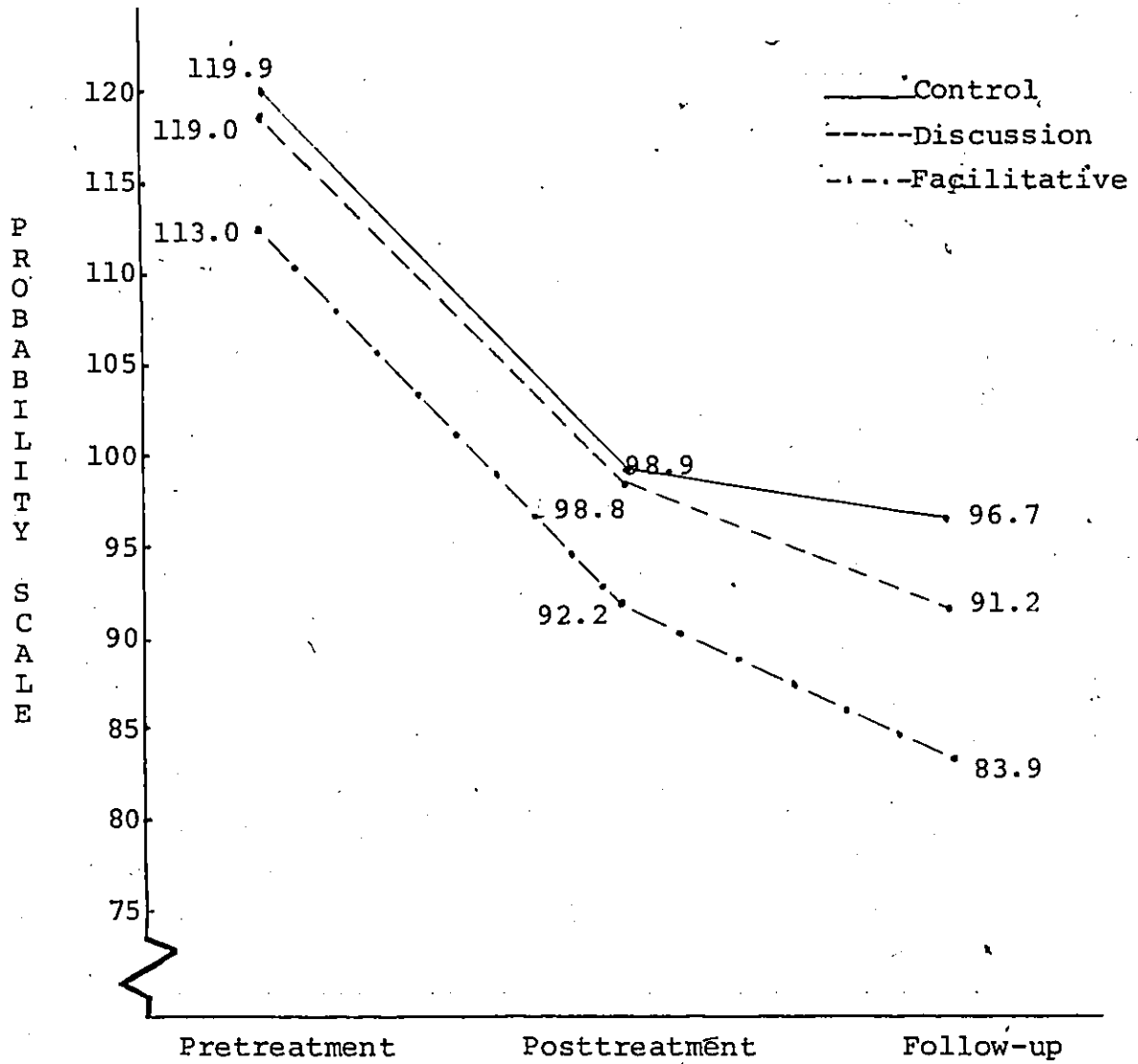


Figure 2. Mean Probability of Response Scores of Treatment Groups at Pretreatment, Posttreatment, and Follow-up.

($t(11) = .870, p < .401$) nor the probability of response ($t(11) = .270, p < .793$) changed significantly from post-treatment to follow-up. However, the discussion group showed a significant decrease from posttreatment to follow-up on the discomfort scale ($t(13) = 2.27, p < .041$), thus reporting lower self perceived discomfort. The probability scale for the discussion group ($t(13) = 1.04, p < .317$) remained unchanged. Finally, the facilitative group evinced nonsignificant changes from posttreatment to follow-up on the discomfort scale ($t(15) = .800, p < .436$) but did significantly decrease on the probability scale ($t(15) = 4.81, p < .0001$), signifying increased chances of responding assertively.

The posttreatment and follow-up sample means for the discomfort (post $\bar{X} = 85.60, SD = 24.00$; follow-up $\bar{X} = 81.09, SD = 23.82$) and response probability (post $\bar{X} = 96.37, SD = 24.39$; follow-up $\bar{X} = 91.04, SD = 23.69$) scales were similar to scores obtained by the general population (Gambrill & Richey, 1975; discomfort $\bar{X} = 95.61, SD = 19.93$; response probability $\bar{X} = 104.3, SD = 15.70; N = 313$). Thus, it was concluded that after treatment all three groups more closely resembled the general population than they did prior to treatment.

The third dependent measure analyzed was the Counselor Rating Form measure of attractiveness. The one-

way analysis of variance computed on posttreatment data evinced no significant difference between the groups ($F(2, 42) = 2.373, p < .104$; see Table 14, p. 120). Homogeneity of variance was met (Bartlett Box $F(2, 42) = .743, p < .480$). Thus, similar amounts of attraction toward the leaders were reported by all treatment groups. The power of the overall F ratio was 40%. The power of the individual comparisons was: between control and facilitative 40%, between control and discussion 38%, and between discussion and facilitative 6%.

Although not addressed in the hypotheses, the Counselor Rating Form was administered at the fourth session to more closely pinpoint the time needed for the experimental manipulation to take effect. However, the three groups did not differ in reported attraction toward the leaders at the fourth session ($F(2, 42) = 1.490, p < .237$; see Table 15, p. 121). The lack of significance at both measurement times may have several explanations including insufficiently strong independent variable manipulation, too short manipulation time, or inability of the measure to pick up subtle differences between the groups.

The fourth dependent measure analyzed was the Counselor Rating Form measure of expertness. Nonsignificance was evinced by the one-way analysis of variance ($F(2, 42) = 1.492, p < .235$; see Table 16, p. 122). Homogeneity of

Table 14

Analysis of Variance: Counselor Rating Form Attractiveness
Scale by Treatment Groups (Eighth Session)

Source of Variation	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between groups	124.125	2	62.062	2.373	n.s.
Within groups	1098.375	42	26.151		
Total	1222.500	44			

Table 15

Analysis of Variance: Counselor Rating Form Attractiveness
Scale by Treatment Groups (Fourth Session)

Source of Variation	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between groups	104.940	2	52.470	1.490	n.s.
Within groups	1479.511	42	35.226		
Total	1584.451	44			

Table 16

Analysis of Variance: Counselor Rating Form Expertness Scale
by Treatment Groups (Eighth Session)

Source of Variation	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between groups	85.625	2	42.812	1.492	n.s.
Within groups	1205.250	42	28.696		
Total	1290.875	44			

variance was present (Bartlett Box $F(2, 42) = .015, p < .97$). Thus, equal amounts of leader expertness were reported by the three treatment groups. The power of the overall F ratio was 29%. The power of the comparisons was: between control and facilitative 30%, between control and discussion 27%, and between discussion and facilitative 6%. Additionally, the three groups did not report significantly different levels of perceived leader expertness at the fourth session ($F(2, 42) = 1.043, p < .361$; see Table 17, p. 124). Again, several explanations are tenable given the nonsignificance at both measurement times: insufficiently strong manipulation of independent variable, too short manipulation time, or inability of the measure to pick up subtle differences between the groups.

The fifth dependent variable analyzed was the Counselor Rating Form measure of trustworthiness. The analysis of variance found nonsignificant differences between the groups ($F(2, 42) = 2.364, p < .104$; see Table 18, p. 125). Homogeneity of variance was met (Bartlett Box $F(2, 42) = .428, p < .658$). Thus, similar amounts of trust for the leaders were reported by the three groups. The power of the overall F ratio was 40%. Power of the comparisons was: between control and facilitative 47%, control and discussion 29%, and between discussion and facilitative 7%. Also, the three groups did not report significantly




Table 17

Analysis of Variance: Counselor Rating Form Expertness
Scale by Treatment Groups (Fourth Session)

Source of Variation	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between groups	80.581	2	40.290	1.043	n.s.
Within groups	1623.048	42	38.644		
Total	1703.630	44			

Table 18

Analysis of Variance: Counselor Rating Form Trustworthiness
Scale by Treatment Groups (Eighth Session)

Source of Variation	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between groups	125.375	2	62.687	2.364	n.s.
Within groups	1113.875	42	26.520		
Total	1239.250	44			

different levels of trust in the leaders at the fourth session ($F(2, 42) = 2.045, p < .142$; see Table 19, p. 127).

Tenable explanations for this nonsignificance at both measurements are the same as suggested for the attractiveness and expertness dependent variables.

The sixth dependent variable was risk taking, measured both within and outside the group. Risk taking within the group was assessed by roleplaying that occurred from sessions 2 to 8 inclusive. Placing the actual and potential numbers of people who roleplayed into a 2 X 3 chi square (roleplay numbers X treatments) showed nonsignificant differences between the three groups ($\chi^2(2) = 4.375$; see Table 20, p. 128). The power of this statistic was 10%. Thus, there was no statistical difference between the three groups based on the number of people who roleplayed. This is true for both indices, actual and potential roleplays. Therefore, it was concluded that the three groups were equivalent on risk taking within the group setting.

Risk taking outside the group was measured by monitored assertion demanding situations. Placing the number of assertive and nonassertive situations reported into an F_{\max} statistic resulted in significance indicating heterogeneity of variance (assertive $F_{\max}(13, 16) = 10.996$, nonassertive $F_{\max}(13, 16) = 2.55$; Tabled F

Table 19

Analysis of Variance: Counselor Rating Form Trustworthiness
Scale by Treatment Groups (Fourth Session)

Source of Variation	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between groups	121.869	2	60.934	2.045	n.s.
Within groups	1251.343	42	29.793		
Total	1373.212	44			

Table 20

Chi Square: Roleplays--Actual and Potential By Treatment Groups

	Control	Discussion	Facilitative	Total
Actual	37	46	51	134
Potential	16	8	11	35
Total	53	54	62	169

$\chi^2(2) = 4.375$ Tabled .05 $\chi^2(2) = 5.991$

(13, 16, $p < .05 = 2.51$). Thus, the option selected was to run a 2 X 3 chi square on the data. This computation resulted in nonsignificance ($X^2(2) = .015$; see Table 21, p. 130). The power on this chi square was 1%. Thus, the amount of risk taking outside the sessions, as measured by the monitored assertive and nonassertive situations, was equal between the three groups.

The seventh and last dependent variable analyzed was openness to suggestion. The homeworks, as a measure of subject openness to suggestion from the leaders, consisted of three assigned and three optional tasks. Entering the number of assigned homeworks returned and the number of optional homeworks returned into a 2 X 3 chi square (assigned and optional by treatment groups) resulted in nonsignificance ($X^2(2) = .749$; see Table 22, p. 131). The power of the chi square was 1%. The number of homeworks returned, whether one looks at the assigned or optional numbers was not different between the three groups. Therefore, openness to suggestion was represented equally across the three groups.

In conclusion, the three null hypotheses were not rejected. The different levels of treatment did not result in statistically significant differences on assertion, subject perception of leaders' attractiveness, trustworthiness and expertness, or subject risk taking and openness to suggestion. Some tenable explanations for the nonsignificant

Table 21

Chi Square: Monitoring Cards--Number of Assertive and Non-assertive Situations by Treatment Groups

	Control	Discussion	Facilitative	Total
Assertive	157	100	212	469
Nonassertive	91	59	122	272
Total	248	159	334	741

$\chi^2(2) = .015$; Tabled $.05 \chi^2(2) = 5.991$

Table 22

Chi Square: Homeworks Returned--Assigned and Optional by Treatment Groups.

	Control	Discussion	Facilitative	Total
Assigned	35	30	43	108
Optional	26	30	34	90
Total	61	60	77	198

$\chi^2(2) = .749$; Tabled $.05 \chi^2(2) = 5.991$

results such as insufficiently strong manipulation of the independent variable, low power of the statistics, too short a manipulation time, or inability of the measures to tap differences between the groups will be explicated in the discussion.

Manipulation Checks

To check whether different levels of the facilitative conditions in general, and empathy in particular, existed between the three treatment groups, the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1962) was administered.

The first analysis of variance was computed on the total score of the Relationship Inventory. Heterogeneity of variance existed (Bartlett Box $F(2, 42) = 5.198, p < .006$), so that the alpha level originally set at .05 was reduced by half to .025 for both the overall F ratio and for post hoc procedures. With this new alpha level, the result was significant for the overall F ratio ($F(2, 42) = 4.885, p < .012$; see Table 23, p. 133). A statistically significant difference existed between the three treatment groups on the total score of the Relationship Inventory such that different levels of the facilitative conditions were perceived by subjects in the three groups. Post hoc comparisons on these data reflected two relationships possible between the groups. When more powerful but less conservative post hoc procedures (as

Table 23

Analysis of Variance: Relationship Inventory Total Scores
by Treatment Groups

Source of Variation	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>
Between groups	15337.058	2	7668.527	4.885*
Within groups	65930.070	42	1569.763	
Total	81267.125	44		

* $p < .01$

compared to other post hoc procedures) were utilized, the results showed the control group subjects reporting statistically significantly lower total scores than either the discussion group or the facilitative group, which were equal to each other. This was true using the Least Significant Differences and the Student Newman-Keuls as post hocs. The Least Significant Differences is exact for unequal group sizes, as in the present study, while the Student Newman-Keuls is only approximate for unequal group sizes. However, utilizing less powerful but more conservative post hoc procedures (Tukey's Honestly Significant Differences and Scheffe's Test) showed the discussion group reporting higher total scores than either the control or facilitative groups which were equal to each other. The Tukey's Honestly Significant Differences is approximate for unequal group size, while the Scheffe Test is exact even for the unequal group size. Observation of group means (see Figure 3, p. 135) indicated both the discussion and facilitative subjects reported higher total scores than the control group, but the facilitative group mean was lower than the discussion group mean. The omega for this analysis of variance was .147, indicating that 14.7% of the variance in the Relationship Inventory total scores was accounted for by the treatment variable. Therefore, other factors besides the manipulation seemed to be operative in the differences of perceived core conditions.

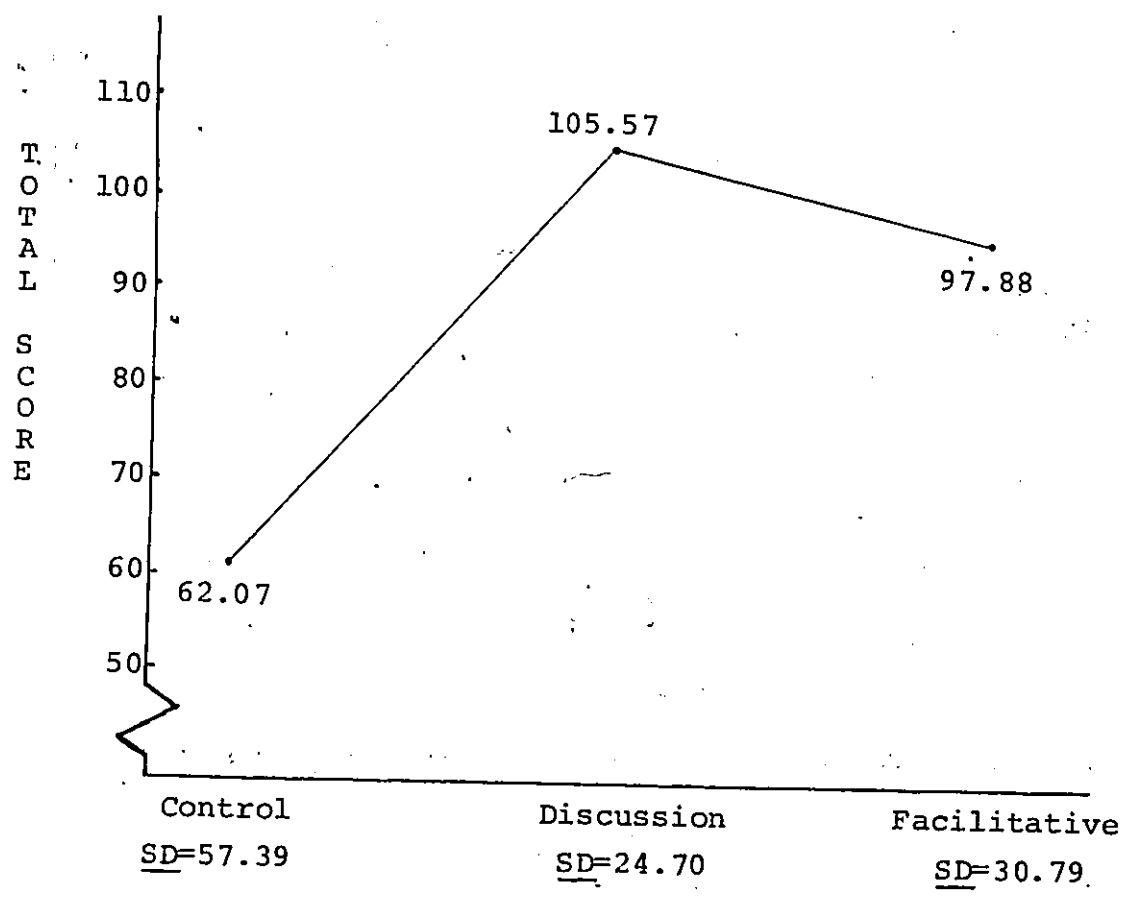


Figure 3. Mean Scores of Treatment Groups for the Relationship Inventory Total Scores.

Placing the Relationship Inventory subscale of empathy in an analysis of variance resulted in nonsignificant results ($F(2, 42) = 3.802, p < .030$; see Table 24, p. 137). Since heterogeneity of variance existed (Bartlett Box $F(2, 42) = 4.006, p < .018$), the alpha level was set at .025 so that the overall F ratio probability of .03 was not significant. Thus, the perceived amount of empathy present in the treatment groups was not significantly different. The power of the overall F ratio was 52%. The power of the individual comparisons was: 40% between the control and facilitative groups, 60% between the control and discussion groups, and 12% between the facilitative and discussion groups. This pattern of results seemed to indicate that the manipulation may not have been powerful enough to produce different levels of perceived empathy between the groups. The pattern of means for the empathy scores (see Figure 4, p. 138) is similar to the pattern noted for the total scores. That is, both the discussion and facilitative groups reported higher levels of empathy than the control group, but the discussion group was higher than the facilitative group. This calls into question the effectiveness of manipulation of the independent variable.

Table 24

Analysis of Variance: Relationship Inventory Empathy Scores
by Treatment Groups

Source of Variation	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>
Between groups	1294.521	2	647.260	3.802*
Within groups	7151.109	42	170.264	
Total	8445.628	44		

* $p < .03$; not significant due to heterogeneity of variance ($p < .025$)

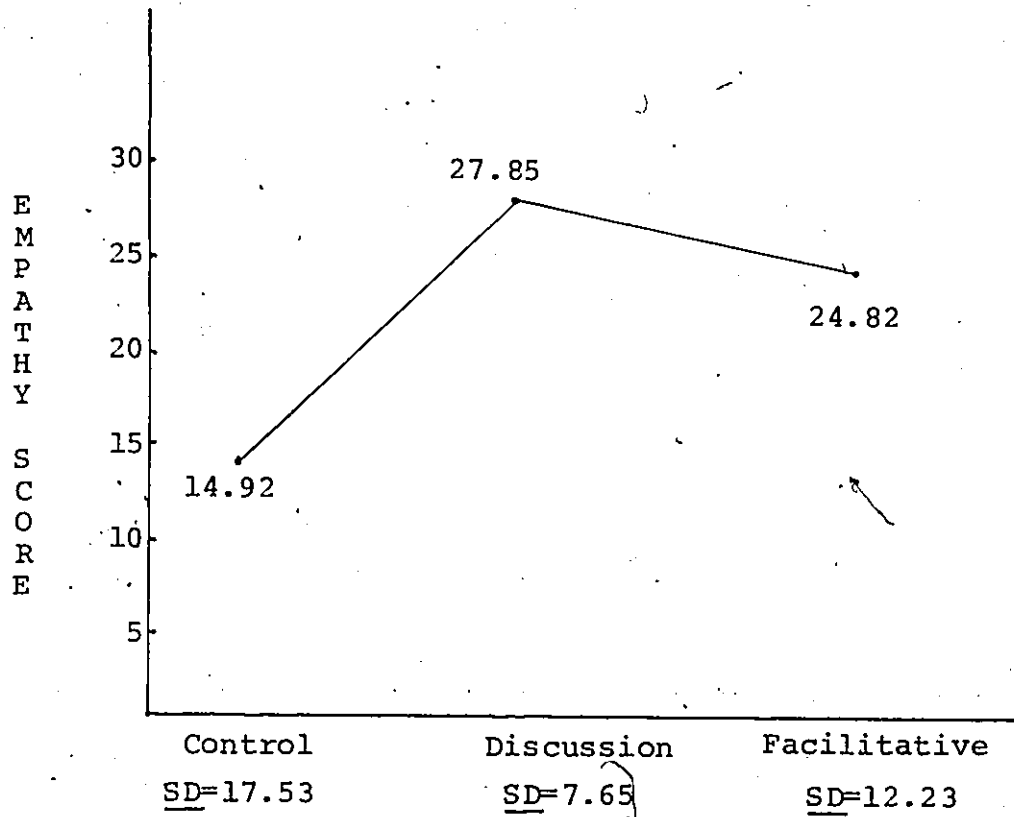


Figure 4. Mean Scores of Treatment Groups for the Relationship Inventory Empathy Subscale

This fourth and final section reports statistical analyses on four areas of data collection. These four areas were analyzed in anticipation that they would provide helpful information in interpretation of results. The four areas are: (1) the need, belief, expectation questions, (2) age as a factor, (3) sex as a factor, and (4) internal consistency of the dependent measures, Assertion Inventory, and Counselor Rating Form. Finally, perceived facilitative conditions were correlated with the dependent variable set irrespective of the group membership of the individual. This was done, as it was quite possible that facilitative conditions were present in groups other than the one specifically designated facilitative condition.

Need, Belief, and Expectation

The need, belief, and expectation questions were analyzed in three separate analyses of variance. The pretreatment levels of need, belief, and expectation were equivalent across the treatment groups (see Tables 25, 26, and 27, pp. 140, 141, and 142). Next, the need, belief, and expectation data were each correlated to the Assertion Inventory. The impetus for computing these correlations was to see if these questions would predict outcome, i.e., posttreatment levels of assertion (see Table 28, p. 143).

The need question did not correlate significantly with the posttreatment discomfort score (.075) nor the posttreatment probability of response score (-.080). However, it did correlate significantly with the pretreatment

Table 25

Analysis of Variance: Prescreening Need Question by Treatment Groups

Source of Variation	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between groups	11.623	2	5.811	1.821	n.s.
Within groups	134.020	42	3.191		
Total	145.644	44			

Table 26

Analysis of Variance: Prescreening Belief Question by Treatment Groups

Source of Variation	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between groups	16.039	2	8.019	2.095	n.s.
Within groups	160.760	42	3.827		
Total	176.799	44			

Table 27

Analysis of Variance: Prescreening Expectation Question by Treatment Groups

Source of Variation	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between groups	6.846	2	3.423	1.240	n.s.
Within groups	115.953	42	2.760		
Total	122.799	44			

Table 28
 Correlation Matrix of Need, Belief, and Expectation Questions
 with the Assertion Inventory Discomfort and Response
 Probability Scores (Pre- and Posttreatment)

	Need	Belief	Expectation
Pretreatment			
Discomfort	.444**	.239	.034
Response probability	.194	.107	-.159
Posttreatment			
Discomfort	.075	-.072	-.237
Response probability	-.080	-.056	-.256*

* $p < .045$

** $p < .001$

level of discomfort (.444, $p < .001$), but not with pretreatment probability of response (.194). The significant correlation indicated that the more discomfort in assertion the subject reported at pretreatment the more the subject reported a need for the assertion training. Thus, it appeared that self perceived discomfort was the criterion that subjects used to determine that they needed assertion training. However, the initial need level did not predict the outcome levels of assertion.

Turning to the belief question, no significant correlations were noted between pretreatment expression of belief in the effectiveness of the group and pretreatment assertion (discomfort $r = .239$, and probability of response $r = .107$) or posttreatment assertion (discomfort $r = -.072$, and probability of response $r = -.056$). Hence, belief was not related to assertion concerns at either pretreatment or posttreatment.

The reported level of the extent the subject expects to benefit from the assertion training did not correlate with pretreatment levels of assertion (discomfort $r = .034$, response probability $r = -.159$). However, the initial expectation did significantly correlate with the posttreatment probability of response ($r = -.256$, $p < .045$), but not with posttreatment discomfort ($r = -.237$, $p < .058$). That is, the more the subject expected to benefit from the

training the more he reported that he was responding assertively after training.

Age

Since significant differences on age were noted between the groups (see Table 4, p. 73), correlations were computed between age and assertion scores to determine whether it was necessary to covary out the age effects. Pearson correlations showed age to be correlated with pretreatment discomfort $-.167$ ($p < .136$), with pretreatment probability of response $.065$ ($p < .334$), with posttreatment discomfort $.110$ ($p < .235$), and with posttreatment probability of response $.252$ ($p < .047$). This last correlation was the only significant one, and although significant, was quite low, accounting for only 6.3% of the variance. Thus, age was not entered into further analyses, nor was it considered to significantly affect the results.

Sex

Sex as a factor was investigated to ascertain if it was influential in the measurement results. A t test between sexes (male = 23, female = 22) was computed on the pretreatment discomfort score ($t(43) = -.34$, $p < .736$) resulting in nonsignificance. A similar t test on pretreatment probability of response scores was nonsignificant

($t(43) = .68, p < .499$). The power for each t test, respectively, was 6% and 10%. Therefore, both sexes reported equivalent initial levels of assertion (see Table 29, p. 147). Similarly, t tests were computed between sexes on the posttreatment assertion data. Again, results were nonsignificant for discomfort ($t(43) = .31, p < .758$), and for probability of response ($t(43) = .22, p < .826$). The power on these respective comparisons was 6% for both. Hence, males and females reported equal changes in assertion following treatment (see Table 29, p. 147). Therefore sex was not found to influence the assertion results.

Based on posttreatment data, sex was not seen as influential in the subject reported perception of the leaders in terms of the three scales of the Counselor Rating Form: attractiveness ($t(43) = -.53, p < .599$), expertness ($t(43) = -1.40, p < .169$), and trustworthiness ($t(43) = -.75, p < .458$). Thus, no difference was evinced between sexes on the Counselor Rating Form perceptions of the leaders.

Sex as a factor in the Relationship Inventory (manipulation check) was also investigated. Nonsignificance was observed for both the total scores ($t(43) = -.61, p < .543$) and the empathy subscale score ($t(43) = -.59, p < .555$). The power of each t test was 9%. Thus,

Table 29

Means and Standard Deviations of Pre- and Posttreatment
Levels of Assertion by Sex

	Males (n=23)		Females (n=22)	
	\bar{X}	SD	\bar{X}	SD
Pretreatment				
Discomfort	109.82	(25.61)	112.45	(26.43)
Response probability	119.04	(16.29)	115.31	(20.19)
Posttreatment				
Discomfort	86.69	(20.96)	84.45	(27.27)
Response probability	97.17	(22.59)	95.54	(26.66)

no difference was evinced between sexes on the Relationship Inventory ratings of the leaders.

Sex as a factor was investigated on the Relationship Inventory and the Counselor Rating Form in response to Slaney (1977) who reported sex differences on counselor perceived expertness and female preference for a facilitative counselor (as opposed to a behaviorally oriented one).

The final additional analyses computed were internal consistency coefficients for the Assertion Inventory and Counselor Rating Form (both dependent measures). The Pearson correlations were calculated between the split halves which were then corrected for the reduced number of items by the Spearman Brown formula. It must be remembered that such a procedure results in inflated estimates as opposed to a test-retest procedure.

Four internal consistency coefficients were calculated, one each for the discomfort and probability scales and for both times the two scales were administered, pre-treatment and posttreatment. Since the Assertion Inventory measures eight different categories, the split was random within the eight categories, therefore not biasing the split toward any one category. The resultant coefficients were fairly high, all being above .91 (see Table 30, p. 149). Thus, it seemed evident that these scales of the Assertion Inventory were internally consistent.

Table 30

Internal Consistency: Split Half with Spearman Brown
Correction on Assertion Inventory Discomfort and
Response Probability Scales (Pre- and Post-
treatment)

	Discomfort	Response Probability
Pretreatment	.958	.917
Posttreatment	.963	.947

The three Counselor Rating Form scales of attractiveness, expertness, and trustworthiness were split by the odd-even procedure. Since the form was administered at the fourth and eighth sessions, six coefficients were computed. The coefficients ran from a low of .735 (attractiveness - eighth session) to a high of .93 (trustworthiness - fourth session). See Table 31, p. 151. Thus, internal consistency for the three subscales of the Counselor Rating Form seemed adequate.

The following section reports the results of correlating the Barrett-Lennard Relationship Inventory total score with the outcome variable set. This was computed on all subjects regardless of treatment or group membership. Given the suggestion from the literature that clients may more appropriately perceive the therapist and the session from a general viewpoint, instead of a singular (i.e., only empathic, or only congruence, etc.) viewpoint, the total score on the Inventory was used in analyses. Correlations were computed between the total score and each dependent variable except the roleplay data (number of roleplays within a group) since this data was not available per subject.

The total score of the Relationship Inventory correlated significantly with the posttreatment assertion discomfort score ($r = -.30$, $p < .02$, see Table 32, p. 151a). The higher the subject's perceived relationship score the

lower the self reported assertion discomfort score (less discomfort) at posttreatment. However, the posttreatment assertion response probability score did not significantly correlate with the Relationship Inventory total score ($r = -.17$, $p < .12$, see Table 32, p. 151a).

Correlating the total score with the Counselor Rating Form at posttreatment resulted in significant correlations for the subscales of attractiveness ($r = .53$, $p < .001$, see Table 32, p. 151a), expertness ($r = .45$, $p < .001$, see Table 32, p. 151a), and trustworthiness ($r = .53$, $p < .001$, see Table 32, p. 151a). The higher a subject's total score (perceived relationship) the more the leader was perceived as attractive, expert, and trustworthy.

A Spearman rank order correlation coefficient (ρ) was used to ascertain the correlation between the Relationship Inventory total score with the number of self monitored situations outside the group sessions. The ρ coefficient was used since the self monitoring data was frequency data and there existed few ties in the observations of the data. The correlation coefficient was not significant ($r_s = -.07$, $p < .32$, see Table 32, p. 151a). There is little relationship between the perceived facilitative conditions and the variable of reported risk taking outside the group. This was also true either when one looked at only the assertive monitored

situations ($r_s = -.15, p < .15$) or whether one looked at the nonassertive monitored situations ($r_s = -.12, p < .09$).

Turning to the homework data, as a measure of openness to suggestion from the leader, the Kendall's τ (τ) correlation coefficient was used since there were many ties in the data. The Relationship Inventory total score did not correlate significantly with the number of homeworks returned ($\tau = .05, p < .32$, see Table 32, p. 151a). There seems to be little relationship between reported openness to suggestion and the perceived facilitative conditions. This was the case when one looked at assigned homeworks returned ($\tau = -.02, p < .41$) and optional homeworks returned ($\tau = .07, p < .25$).

Additional analyses were carried out on the assertion scores. A score of 4 or 5 on the individual items in the Assertion Inventory discomfort scale indicated situations in which the subject experienced "much" or "very much" discomfort; similarly, a score of 4 or 5 on the individual items in the Assertion Inventory response probability scale indicated situations in which the subject responded assertively "rarely" or "never." The number of situations (items) given a score of 4 and/or 5 were counted for each subject on the two areas--discomfort and response probability, at both pretreatment and posttreatment. Thus, each subject had four scores. Each score was the total number of 4 and/or 5 responses for: (1) pretreatment discomfort, (2) pretreatment response probability, (3) posttreatment discomfort, and

(4) posttreatment response probability. The change in occurrences of 4 and/or 5 responses from pre- to post-treatment was considered an estimate of a behavioral measure of assertive behavior. Since responses of 4 and 5 indicate situations in which one is not assertive and/or feels discomfort, analyzing these particular items (problematic situations) could provide evidence of change in assertion, which may have otherwise been clouded by a total score.

Comparing the number of 4 and 5 scores reported by all subjects on the discomfort scale resulted in a statistically significant difference from pretreatment to posttreatment ($z = -5.22, p < .0001$). The Wilcoxon matched pairs signed ranks test was used since the data were frequency tallies for correlated groups. The z statistic is reported due to a large sample. The change was a significant decrease in the number of self reported situations given a score of 4 and/or 5. A similar statistically significant decrease was noted for the subjects on the response probability scale from pretreatment to posttreatment ($z = -4.71, p < .0001$). Thus, the subject's scores decreased significantly on the number of problematic situations.

The next four analyses used the Mann-Whitney U Rank Sum test since they involved uncorrelated nonparametric comparisons. All subjects were ranked on the Barrett-Lennard Relationship Inventory total score. The subjects were then

split on low versus high scores (low versus high perception of the facilitative conditions) to see if differential perception resulted in different measures on self reported behavior change. Since there were 45 subjects, an equal split was not possible. Therefore, the split involved the top 22 subjects (high scores) as compared to the lower 22 subjects (low scores). These two groups were compared on the change of occurrences of 4 and 5 responses from pre-treatment discomfort to posttreatment discomfort. The resultant z value of $-.89$ (large sample) was not significant ($p < .18$). This indicates that the decrease in problematic situations was not statistically significantly different for the subjects who perceived more versus less facilitative conditions. This was also true using the probability of response change scores ($z = -.25, p < .40$).

However, taking the upper third of subjects ($n = 15$) on the Relationship Inventory total score (high perceivers) and comparing them to the lower one-third of subjects ($n = 15$), low perceivers) resulted in statistical significance ($z = -1.80, p < .03$) for the discomfort scale. That is, comparing the decrease of problematic situations on the discomfort scale for the high perceivers of facilitative conditions versus low perceivers of facilitative conditions resulted in a statistically significant difference. The high perceivers reported a larger decrease in

the number of problematic situations relative to low perceivers. Yet, this difference was not supported when using the change in numbers of problematic situations on the response probability scale ($z = -.22, p < .41$).

A general overview from the entire statistical analyses is possible. First, it was not possible to reject any of the three null hypotheses. Also, the results of the Relationship Inventory manipulation check analyses called into question the strength of the manipulation. Some issues to be discussed are weak manipulation of the independent variable, too short a time for manipulation, small sample size, and low power of comparisons. These are addressed in the next chapter.

Table 31

Internal Consistency: Split Half with Spearman Brown
Correction on Counselor Rating Form Attractiveness,
Expertness, and Trustworthiness Scales (Fourth
and Eighth Sessions)

	Attractiveness	Expertness	Trustworthiness
Fourth session	.787	.763	.930
Eighth session	.735	.777	.838

Table 32

Correlations of the Barrett-Lennard Relationship Inventory
with the Outcome Variable Set for All Subjects (N=45) *

	Barrett-Lennard Relationship Inventory Total Score
Post Assertion Inventory	
Discomfort	-.30**
Response probability	-.17
Post Counselor Rating Form	
Attractiveness	.53***
Expertness	.45***
Trustworthiness	.53***
Self Monitoring	-.07
Homework returned	.05

*Roleplay data not available per subject.

** $p < .02$

*** $p < .001$

CHAPTER IV

DISCUSSION

Several conclusions can be drawn from this study despite the inability to reject the null hypotheses. In this portion of the thesis, the significant effects of the training program on assertion are set out as well as possible explanations for the ineffectiveness of the experimental manipulations. In this regard the strength of the manipulation and the power of the statistics are examined to point out weaknesses in the present study. Also, given the practical limitations at the service setting, it was difficult to draw firm conclusions on the basis of the data gathered. Nonetheless, some tentative interpretations and preliminary conclusions are derived. In addition, suggestions for further research are derived from this exploratory study.

Significance of Change from Pre- to Posttreatment

In the present study, the subjects who applied for assertion training reported more discomfort in assertive situations and a lower probability of responding assertively than did persons of a similar age but who did not consider assertion to be a problem area (Gambrill & Richey, 1975). However, as statistical evidence in this study shows, all three treatment groups changed significantly from pre-treatment to posttreatment in the direction of becoming less anxious and uncomfortable and more likely to respond in an

assertive manner. In fact, after the assertion training, the sample's discomfort and response probability scores were comparable to those reported by the general population (Gambrill & Richey, 1975). Furthermore, the assertive gains made through training were maintained at a 4-week follow-up and in two instances (discussion group discomfort and empathy group response probability) increased assertion was noted. In this respect, the training goals of increased assertion were met.

In this study, although all three groups received the same basic assertion package, the control condition most clearly resembled a pure behavioral training package. The present control condition, composed of modeling, roleplaying, and rehearsal with feedback and coaching, was effective in increasing assertive responding and decreasing discomfort in assertion. These significant changes were consistent with those reported in the assertion training literature, which point to the effectiveness of a behaviorally oriented assertion training program in instigating assertion (for example, Friedman, 1971; Goldstein et al., 1973; Gutride et al., 1973; Hersen, Eisler & Miller, 1973; Hersen, Eisler & Miller, 1974; Hersen, Eisler, Miller, Johnson & Pinkston, 1973; Lazarus, 1966; McFall & Lillesand, 1971; McFall & Marston, 1970; McFall & Twentyman, 1973; Turner & Adams, 1977; Young, Rimm & Kennedy, 1973), even though the effects of the particular procedures could not be delineated.

Since two of the six leaders involved were aware of the hypotheses, it was necessary to determine that their knowledge did not bias subjects' responses to the dependent measures. A t test was run between the informed leaders' groups and the uninformed leaders' groups. Results showed no significant differences between the groups on six of the seven dependent variables at posttreatment: assertion discomfort ($t(43) = .41, p < .685$), response probability ($t(43) = .70, p < .490$), attractiveness ($t(43) = .82, p < .416$), expertness ($t(43) = 1.15, p < .255$), trustworthiness ($t(43) = 1.58, p < .122$), openness to suggestion (optional and assigned homeworks $\chi^2(1) = .089$, Tabled .05 $\chi^2(1) = 3.841$). On the seventh dependent variable, risk taking, the groups were equivalent on risk taking within the group (roleplaying: $\chi^2(1) = 2.00$, Tabled .05 $\chi^2(1) = 3.841$), but the informed group showed significantly less risk taking outside the sessions than the uninformed group (monitoring cards: $\chi^2(1) = 4.15, p < .05$; Tabled .05 $\chi^2(1) = 3.841$). Thus it was concluded that the informed leaders did not bias outcome measures.

This nonsignificance between the informed and uninformed groups was also apparent on the follow-up data (discomfort scale: $t(40) = .05, p < .961$; response probability: $t(40) = .23, p < .818$), and on the manipulation check (Relationship Inventory total score: $t(43) = 1.17, p < .248$; empathy subscale $t(43) = 1.65, p < .106$).

This sample included both Arts and Science students. Besides including both groups of students, their representation was "non-comparable," (i.e., there were more Arts students, and fewer Science students compared to the large university population). The Science program, with its practical emphasis on grades, and many courses with labs, which require extra time, may be composed of students who are different than the Arts students. The difference, epitomized by the push for grades to enter graduate school and more "pure" Science courses for the Science students, may suggest different life experiences for these students and as such they may be different from the Arts students. Consequently, this sample pool can be considered heterogeneous as to experience and possibly as to expectations and needs. Thus, this study's findings are probably not as clear as they could have been were the project undertaken with a more homogeneous sample pool.

Discussion of Nonsignificant Results

The conclusion must be made that the experimental manipulation, of providing particular opportunities for the subjects to experience leaders' acceptance, warmth, and empathic understanding, did not have a significant effect on the dependent measures. That is, the subjects in the empathy treatment condition did not perceive their leaders as more attractive, expert, and trustworthy than the leaders of the discussion and control conditions. The facilitative condition subjects were not more willing to take risks either within or outside the group setting and did not show higher openness to suggestion than the other two groups. Lastly, the facilitative group did not show greater gains in assertion than the other two groups. Given these results, it was not possible to reject the null hypotheses; however, there are serious reasons to believe that the hypotheses were not fully tested.

First, it must be questioned whether the experimental manipulation was sufficiently strong to affect the treatment package. At least three lines of evidence support this conjecture.

1. Because all three groups changed significantly on assertion and because all three groups were treated with a behaviorally oriented package, it is probable that the observed changes were the result of the skill building and

practice of the modeling, roleplaying, coaching, and feedback procedures. This is especially credible since none of the three groups differed in terms of risk taking, openness to suggestion, or perceptions of attraction, trust, and expertness of the leaders. In effect, the manipulation appears to have been overwhelmed by the strong behavioral package. This suggestion gained support from the fact that the relationship of the facilitative conditions (as represented in the Relationship Inventory total score) and the posttreatment assertion measures explained only a small proportion of the total variance (discomfort $r^2 = 9.2\%$; probability $r^2 = 3.1\%$). This suggested that factors other than the manipulated aspects of the therapist-client relationship were responsible for instigating gains in assertion. What contribution the relationship had seems limited based on these coefficients of determination. This result was consistent with previous research (Bergin & Suinn, 1975; Esse & Wilkins, 1978; Slaney, 1977) in which the therapist-client relationship was seen as an enhancer of the therapy process, and not as a sufficient base for change.

2. It is also possible that the effect of the manipulation in which 15 minutes per session were set aside for experiencing the leaders' warmth, concern, and empathic understanding, was overshadowed by the uncontrolled presence of these same leader-offered characteristics. For example, by virtue of the training process of becoming a therapist,

the leader may be constantly striving to be empathic, understanding, and accepting of the client in professional interactions, such that these characteristics are constantly given out by the leader despite attempts to minimize them. By the very way the leaders greeted the group members, listened to members delineate their assertive problem situations, coached the subjects in their roleplays, they conveyed an interest in and commitment to the subjects. Thus, within each of the three groups, the leaders may have expressed or subjects may have perceived leader empathy, understanding, and acceptance that were not instigated by the experimental manipulation. In fact, these overall uncontrolled facilitative conditions may have been strong enough to eclipse the effect of the manipulation. This seemed likely since all leaders were seen to be equally attractive, expert, and trustworthy, and since subjects responded to all leaders with equal levels of openness to suggestion and risk taking.

3. What had been expected in this study was that the manipulation would provide additional experience of the facilitative conditions above and beyond what the leader normally gives in his professional interactions. However, did the manipulation really have this effect? The Relationship Inventory was used as a check of this question. Although the overall F ratio on the total score of the Relationship

Inventory was significant (between groups), post hoc procedures were not consistent in separating the three groups.

While it was expected that the facilitative group would report the highest levels of facilitative conditions, and the discussion and control groups lower levels, the most powerful, least conservative of the post hoc procedures showed the discussion and empathy groups reporting equal levels of the facilitative conditions and the control group to have significantly lower levels. But, the less powerful and more conservative of the post hocs showed the discussion group reporting significantly higher levels of facilitative conditions than the facilitative and control groups which were equal to each other. The three groups showed no significant differences in perception of empathy from their respective leaders (based on the Relationship Inventory empathy subscale). Thus, it seems that the facilitative condition was perceived as generally lower on the facilitative conditions than the discussion group, although both these groups had higher levels of facilitative conditions in most instances than the control group. This was contrary to prediction and some explanation of this finding is in order.

While it may be true that the discussion group reported a higher level of facilitative conditions, this result may be due, not so much to the leaders' behavior in the group, but to the fact that the leaders provided an opportunity for the development of self disclosure,

intermember attraction, finding similarity of attitudes, feelings, or abilities, and group cohesion by allowing time for members to talk to and question the other group members, experience the concern of the other members, and realize that the other members had fears and were willing to share these fears with each other. It seems possible that subjects were more anxious about risk taking and performance in front of their peers than in front of the leaders. In part, this may be due to a stereotypic expectation by the group members of the leaders as accepting, expert, respectful, and confidential. Hence, the discussion may have allowed subjects in the discussion group to have more positive feelings toward their peers, feelings which they also related to the leaders. It has been noted (Lieberman, 1975; Yalom, 1970) that group therapy has no exact analogue of the therapist-client relationship; instead, the relationship encompasses the members' feelings toward the leader, the other members, and the group as a whole. This global feeling about the group may be reflected in the Relationship Inventory scores, such that more positive feelings about peers may have raised the scores of the perception of the leaders.

However, it must be remembered that even though the discussion group reported higher levels of facilitative conditions, they did not differ from the other groups on

the dependent measures. Thus, it still must be concluded that the manipulation was either not long enough temporally or not strong enough to affect the dependent measures.

The second major reason for the nonsignificance of the results is the power of the statistics. Basically, the power of the statistics denotes the probability of finding the significant event should such an event occur. When power is high, say 80% or 90%, this designates that 8 or 9 times out of 10 the significant event, if it occurs, will be detected by the statistics. However, power in the main analyses was generally low in this study, ranging from a high of 60% to a low of 1%. Thus, even if significance were present, chances of finding it were poor. The low power seemed to be due to two principal factors: small sample size and poor reliability of the measures, resulting in small effect size.

In general, the power of the statistical contrasts increases as the sample size increases. For example, on the posttreatment Assertion Inventory discomfort and probability of response scores, the power for both analyses of variances was 35% on the sample of 45 subjects. On the other hand, in order to achieve a power of 90%, it would be necessary to have 48 subjects per treatment group. This would at least require tripling the size of the present sample (i.e., $3 \times 48 = 144$).

The reliability of the measures used also affects the power of the contrasts such that the lower the reliability of the measures the lower the power may be. This is due to the fact that when reliability is high, the measure contains little error variance. When error variance (mean square within) is small, the separation of the means brought about by the treatment need not be so large to obtain statistical significance as when the error variance is large. When the error variance is large, the separation of the means by the treatment must be greater so as to achieve significant results. Thus, when reliability is low, the measures used are not capable of detecting subtle differences between the groups.

The reported reliability for the Assertion Inventory is adequate; test-retest (5 weeks) coefficients were .87 on the discomfort scale and .81 on the response probability scale (Gambrill & Richey, 1975). In the present sample, internal consistency was high: .96 for the discomfort scale and .94 for the response probability scale, although it must be remembered that these coefficients are artificially very much inflated since they were computed by the split half method corrected by the Spearman Brown formula. However, the standard deviations, reflecting the amount of variance of scores within groups were also high. For example, on the posttreatment discomfort scores the standard deviation was 24.0 for all three groups combined. On this

scale, individual scores ranged from 51 to 142. On the posttreatment response probability scale, the standard deviation was 24.39 for the combined groups with individual scores ranging from 54 to 153. These standard deviations are representative of all standard deviations on the Assertion Inventory found in this study and are consistent with the standard deviations reported in Gambrill and Richey's (1975) article. With such large variance in the scores of the groups, separation of group means by the treatment procedure was not sufficient to produce statistically significant results. Consequently, the effect size, as an index of the separation between the means in standard deviation units was low. Combining this low effect size with small sample size led to low power.

The additional statistical results, based on the correlations of the dependent variable set with the total Relationship Inventory scores (see Table 32, p. 151a) and the difference between high versus low perceivers merit further comments. The Relationship Inventory's total score was utilized in correlations as it was considered more appropriately sensitive to what the subjects were perceiving about the leaders in the sessions. A general facilitative condition may have been perceived.

The significant correlation coefficients of the total score to posttreatment discomfort suggests that the

more the subject perceived a facilitative, supportive atmosphere the less discomfort in assertion was felt at the end of the eight weeks of training. Thus, a facilitative supportive atmosphere may be influential in allowing a subject to feel less threatened, anxious, or uncomfortable in situations calling for assertive responding. Possibly a sort of in vivo desensitization during the eight weeks of training may have occurred. Yet, similar findings were not found for the posttreatment probability scale. Although a supportive atmosphere may be a factor in the subject's reported feeling of less discomfort, the same support may not be as influential in behavior change as, for example, roleplaying or modeling might be.

All three Counselor Rating Form scales (attractiveness, expertness, and trustworthiness) were significantly correlated with the total Relationship Inventory score. That is, the perceptions of the leaders by the subjects were congruent across the two instruments. As the leader was seen in a more facilitative, supportive role he was also perceived as more attractive, expert, and trustworthy. Since these therapist variables are factors in treatment, then steps to ensure that the therapist is viewed as high on these dimensions warrants attention. For assertion training, the facilitative, supportive leader may increase his ability to help the client.

The homeworks returned and self monitoring data were not significantly correlated with the total Relationship Inventory score. Thus, these behaviors were not found to be related to perceived facilitative conditions.

From the correlation coefficients one may glean the suggestion that striving to approximate facilitative conditions, being warm, supportive, accepting, etc., is influential in behavioral assertive training. Yet, providing a supportive atmosphere is by no means tantamount to instigating change in client behavior. However, it does seem to play an influential role, especially in setting the stage for behavioral change. That is, the client may be more willing to attempt successive approximations of change in behavior within the confines of a supportive atmosphere.

The analyses on problematic situations (i.e., scores of 4 and/or 5) corroborate the previous findings that for the overall score the subjects significantly changed from pre- to posttreatment. That is, the number of self reported problematic situations decreased significantly. Additionally, the subsequent significant analyses on the subjects high on perceived facilitative conditions (upper one-third) versus subjects low on perceived facilitative conditions (lower one-third) suggested that higher perceivers showed greater decreases in problematic situations. This is based on the discomfort dimension, which as stated earlier, seems to be

influenced by the supportive atmosphere. However, this was not noted for the probability of response scale. The higher perceivers did not report a greater decrease in problematic situations on the probability of response as compared with low perceivers. The supportive atmosphere may deal more with felt discomfort than with actual behavior change. Thus, a tentative conclusion suggests client's perception of a supportive atmosphere may be related to self reported change and, consequently, future research should investigate if fostering of high facilitative conditions (as measured in the sessions) by a leader, as opposed to low fostering, would influence outcome behavior change.

In general terms, the inability to reject the null hypotheses need not imply the theoretical ideas of this study are not logical ones. Rather, from the research literature, a good rationale exists to suggest that facilitative conditions, through effecting intermediate steps of perception of therapist qualities and by increasing openness to suggestion and risk taking, should affect assertion training outcome.

It might be concluded that the pure behavioral program is sufficient to produce significant increases in assertion. However, the question still remains as to whether an emphasis upon the therapist-client relationship might add to and enhance upon the behavioral program.

The present study did not accept the null hypotheses. Due to its exploratory nature and commitment to in-vivo testing of the hypotheses, the study suffered from several limitations that led to the adoption of the conclusion that the theory was not fully tested in the present study. However, future research projects might garner several suggestions from this study.

One contribution of this study is to point out the need for an extremely powerful manipulation in future studies. This is necessary both to statistically adjust for the sometimes low reliability of the measures and the large variance within groups, as well as to overcome naturally occurring and uncontrolled levels of leader-offered facilitative conditions. This might be done in part by allowing longer time periods for the experimental manipulation and insuring that non- or minimally facilitative leaders are used in the comparison treatment. Since the subjects who perceived high facilitative conditions also showed significant change, studies should attempt to more cleanly manipulate the presence of the facilitative conditions. That is, a comparison group involving a classroom setting or lecture, or a video tape presentation may more effectively provide a minimally facilitative comparison group.

Secondly, future studies should attempt to utilize large sample sizes so as to achieve more adequate power of.

the statistics, thus improving chances of finding significance if it is present. Unfortunately, such large sample sizes are often difficult to handle in an in vivo study, since a large sample size necessitates a high demand for assertion training, several available leaders for such groups, and longer time periods to conduct training groups for such large numbers of subjects. Alternatively, analogue studies, which more clearly control the facilitative conditions by preplanned taped scenes or written transcripts, and at the same time allow the experimenter to utilize large numbers of subjects, could be proposed. It must be remembered, however, that subjects in the present sample and other reported clinical populations (Gambrill & Richey, 1975) differ significantly in assertion from the general population. Thus, such analogue studies might have limited generalizability to a clinical population. One way to improve generalizability in an analogue study would be to prescreen the subjects on an assertion measure and to use only those subjects who score in a highly non-assertive direction. At least, then, the analogue sample would approach a clinical sample on the assertion dimension.

Third, the present methods of measuring the assertion dimension leads to large amounts of within group variance. A scale could be developed to overcome this drawback by first assessing the general lifestyle of the

subject to delineate response class deficits. This could be done through a scale similar to the Assertion Inventory. After this, a separate scale, delineating situations within the response class, could be used to derive scores on assertion in this area; changes in assertion as a result of training would be measured on this response class only. Using such a two-part assessment method would contribute to increasing the power of the statistical contrasts. More reliable measures could also be obtained by using behavioral ratings of pretreatment and posttreatment performance, although such measures require more extensive outlays of time, experienced objective raters, and more elaborate audiovisual equipment than may be possible to employ in service-oriented research sites.

On the Assertion Inventory, selection of the items scored 4 and/or 5 (problematic situations) may prove to be a more sensitive index of behavioral change than the overall score. This needs to be further investigated. This would be especially the case were specific content factors studied independently, as opposed to a total Assertion Inventory change score.

Suggestions for the treatment of assertion can also be made. The higher rating on presence of facilitative conditions by the discussion group suggests that in some manner this condition allowed the subjects to feel and

report more understanding, acceptance, and warmth from the leaders. Although the exact cause of this perception of high facilitative conditions is not known, it may, given adequate research, result in significant in-group and outcome behavior changes, perhaps by increasing group cohesion. Thus, this variable, group discussion, may be a viable avenue to investigate in further research of group assertion training.

Regarding the need, belief, and expectation questions administered at prescreening, the significant correlations of self reported need to pretreatment assertion discomfort scores ($r = .444$, $p < .001$) and expectation to posttreatment assertion probability of response scores ($r = .256$, $p < .045$) suggest that further research efforts be directed toward understanding the contribution of these variables. One probable mechanism for the predictive capability of these questions is the self fulfilling prophecy phenomenon; if the subject has invested his belief, need for, or expectations of help in the assertion training, it may be that he will "live up to" his investment. For the clinician offering assertion training, it would seem useful to survey these variables prior to treatment, since they may provide potential indications of ability of the client to benefit from assertion training.

SUMMARY AND CONCLUSIONS

The results of the present study showed that the three experimental groups did not differ significantly on outcome measures of assertion, on their perception of the leaders as attractive, trustworthy, and expert, nor in their willingness to undertake risks within or outside the group, or in their openness to suggestion from the leaders.

However, the inability to reject the null hypotheses was not accepted to mean that the theory or experimental predictions were unjustified. On the contrary, in the view of practical constraints it was difficult to draw firm conclusions from the data gathered. It was suggested that the manipulation was probably not strong enough to affect subjects' perception of leaders, perhaps due to the short time periods relied upon in the manipulation (15 minutes per session), or the strength of naturally occurring levels of facilitative conditions in all treatment groups. Secondly, the statistics lacked sufficient power to detect the occurrence of significance, and this low power was found to be related to small sample size, large amounts of variance within the treatment groups, and effect size, calling into question the reliability of the measures. Nevertheless, on the basis of additional analyses, a tentative conclusion

suggests client's perception of a supportive atmosphere may be related to self reported change, and consequently, future research should investigate if fostering of high facilitative conditions (as measured in the sessions) by a leader, as opposed to low fostering, would influence outcome behavior change.

Several other suggestions for future research were put forth so as to overcome the present limitations and more adequately test the theory. These included use of assessment scales that more closely attended to situationally specific response class deficits (with adequate reliability), the inclusion of behavioral measures, planning studies which utilized larger sample sizes, and studies which utilized a stronger experimental manipulation. Analogue studies were suggested as one way to overcome the limitations of this study, but it was also pointed out that such studies would be of questionable (or at least limited) generalizability to a clinical population.

REFERENCES

- Aiduk, R., & Karoly, P. Self regulatory techniques in the modification of nonassertive behavior. Psychological Reports, 1975, 36, 895-905.
- Alberti, R. E., & Emmons, M. L. Your perfect right. California: Impact Press, 1974.
- Appelbaum, A. S., Tuma, J., & Johnson, J. Internal-external control and assertiveness of subjects high and low in social desirability. Psychological Reports, 1975, 37, 319-322.
- Arkowitz, H., Lichtenstein, E., McGovern, K., & Hines, P. The behavioral assessment of social competence in males. Behavior Therapy, 1975, 6, 3-13.
- Ascher, L. M., & Phillips, D. Guided behavior rehearsal. Journal of Behavior Therapy and Experimental Psychiatry, 1975, 6, 215-218.
- Baer, D., Wolf, M., & Risley, T. Some current dimensions of applied behavior analysis. Journal of Applied Behavior Analysis, 1968, 1, 91-97.
- Bales, R. F. Interaction process analysis: A method for the study of small groups. Reading, Mass.: Addison-Wesley, 1950.
- Bandura, A. Principles of behavior modification. New York: Holt, Rinehart & Winston, 1969.
- Barak, A., & LaCrosse, M. B. Multidimensional perception of counselor behavior. Journal of Counseling Psychology, 1975, 22(6), 471-476.
- Barak, A., & LaCrosse, M. B. Comparative perceptions of practicum counselor behavior. Counselor Education and Supervision, 1977, 16(3), 202-208.
- Barrett-Lennard, G. T. Dimensions of therapist response as causal factors in therapeutic change. Psychological Monographs, 1962, 76(43, Whole No. 562).
- Bates, L. M., & Zimmerman, S. Toward the development of a screening scale for assertive training. Psychological Reports, 1971, 28, 99-107.

- Bent, R. N., Putman, D. G., Kiesler, D. J., & Nowicki, S. Correlates of successful and unsuccessful psychotherapy. Journal of Consulting and Clinical Psychology, 1976, 44(1), 149.
- Bergin, A. E., & Strupp, H. H. Changing frontiers in the science of psychotherapy. Chicago: Adline-Atherton, 1972.
- Bergin, A. E., & Suinn, R. M. Individual psychotherapy and behavior therapy. Annual Review of Psychology, 1975, 26, 509-556.
- Berkowitz, L. Group standards, cohesiveness, and productivity. Human Relations, 1954, 7, 509-519.
- Borgatta, E. The structure of personality characteristics. Behavioral Science, 1964, 9, 8-17.
- Bower, S. A., & Bower, G. H. Asserting yourself: A practical guide for positive change. Reading, Mass.: Addison-Wesley, 1976.
- Byrne, D. The attraction paradigm. New York: Academic Press, 1971.
- Carkhuff, R. R. Helping and human relations: A primer for lay and professional helpers (Vol. 1). New York: Holt, Rinehart & Winston, 1969. (a)
- Carkhuff, R. R. Helping and human relations: A primer for lay and professional helpers (Vol. 2). New York: Holt, Rinehart & Winston, 1969. (b)
- Carlson, N., & Johnson, D. Sexuality assertiveness training: A workshop for women. The Counseling Psychologist, 1975, 5(4), 53-59.
- Cartwright, D. The nature of group cohesiveness. In D. Cartwright and A. Zander (Eds.), Group dynamics, research and theory (3rd ed.). New York: Harper & Row, 1968.
- Cartwright, D., & Zander, A. Group dynamics, research and theory (2nd ed.). Evanston, Ill.: Row, Peterson, 1960.
- Carvell, C. Assertiveness changes following assertive training as a function of some personality characteristics. Unpublished Master's thesis, University of Ottawa, 1978.

- Clark, J. B., & Culbert, S. Mutually therapeutic perception and self awareness in a T-group. Journal of Applied Behavioral Science, 1965, 1, 180-194.
- Colson, W. N. Self disclosure as a function of social approval. Unpublished Master's thesis, Howard University, 1968. In F. H. Kanfer and A. P. Goldstein (Eds.), Helping people change. New York: Pergamon, 1975.
- Colter, S. B., & Guerra, J. J. Assertion training: A humanistic behavioral guide to self dignity. Champaign, Ill.: Research Press, 1976.
- Coons, W. H. Interaction and insight in group psychotherapy. Canadian Journal of Psychology, 1957, 11, 1-8.
- Corby, N. Assertion training with aged population. The Counseling Psychologist, 1975, 5(4), 69-74.
- Deutsch, M. Cooperation and trust: Some theoretical notes. In M. R. Jones (Ed.), Nebraska symposium on motivation. Lincoln, Neb.: University of Nebraska Press, 1962.
- Dickoff, H., & Lakin, M. Patients' view of group psychotherapy: Retrospections and interpretations. International Journal of Group Psychotherapy, 1963, 13, 61-73.
- Edelstein, B. A., & Eisler, R. M. Effects of modeling and modeling with instruction and feedback on the behavioral components of social skills. Behavior Therapy, 1976, 7(3), 382-389.
- Edwards, N. Case conference: Assertive training in a case of homosexual pedophilia. Journal of Behavior Therapy and Experimental Psychiatry, 1972, 3, 55-63.
- Eisler, R. M., Hersen, M., Agras, W. S. Videotape: A method for the controlled observation of nonverbal interpersonal behavior. Behavior Therapy, 1973, 4, 420-425.
- Eisler, R. M., Hersen, M., & Miller, P. M. Effects of modeling on components of assertive behavior. Journal of Behavior Therapy and Experimental Psychiatry, 1973, 4, 1-6.

- Eisler, R. M., Hersen, M., & Miller, P. M. Shaping components of assertive behavior with instruction and feedback. American Journal of Psychiatry, 1974, 13(12), 1344-1347.
- Eisler, R. M., Hersen, M., Miller, P. M., & Blanchard, E. Situational determinants of assertive behavior. Journal of Consulting and Clinical Psychology, 1975, 43(3), 330-340.
- Eisler, R. M., Miller, P. M., & Hersen, M. Components of assertive behavior. Journal of Clinical Psychology, 1973, 29(3), 295-299.
- Eisler, R. M., Miller, P. M., Hersen, M., & Alford, H. Effects of assertion training in marital interaction. Archives of General Psychiatry, 1974, 30, 643-649.
- Ellis, A. Reason and emotion in psychotherapy. New York: Lyle Stuart Press, 1962.
- Esse, J. T., & Wilkins, W. Empathy and imagery in avoidance behavior reduction. Journal of Consulting and Clinical Psychology, 1978, 46(1), 202-203.
- Eysenck, H. J. Learning theory and behaviour therapy. In H. J. Eysenck (Ed.), Behaviour therapy and the neuroses. New York: Pergamon Press, 1960.
- Feather, B. W., & Rhoads, J. M. Psychodynamic behavior therapy: I. Theory and rationale; II. Clinical aspects. Archives of General Psychiatry, 1972, 26, 496-511.
- Feldman, M. P., & MacCullough, M. J. The application of anticipatory avoidance learning to the treatment of homosexuality. I. Theory, technique, and preliminary results. Behaviour Research and Therapy, 1965, 2, 165-183.
- Fensterheim, H. Assertive methods and marital problems. In R. D. Rubin, H. Fensterheim, J. D. Henderson, and L. P. Ullman (Eds.), Advances in behavior therapy. New York: Academic Press, 1972.
- Flowers, J. V., & Goldman, R. D. Assertion training for mental health paraprofessionals. Journal of Counseling Psychology, 1976, 23(2), 147-150.

- Foy, D., Eisler, R. M., & Pinkston, S. Modeled assertion in a case of explosive rage. Journal of Behavior Therapy and Experimental Psychiatry, 1975, 6, 135-137.
- Frazier, J., & Carver, J. Some comments on the problem of defining assertive training. Comprehensive Psychiatry, 1975, 16(4), 369-373.
- Freud, S. The interpretation of dreams (A. A. Brill, Tr.). New York: Macmillan, 1913.
- Friedlander, F. The primacy of trust as a facilitator of further group accomplishment. Journal of Applied Behavioral Science, 1970, 6, 387-400.
- Friedman, P. H. The effects of modeling and roleplaying on assertive behavior. In R. D. Rubin, H. Fensterheim, A. Lazarus, and C.M. Franks (Eds.), Advances in behavior therapy. New York: Academic Press, 1971.
- Galassi, J. P., DeLo, J., Galassi, M. D., & Bastien, S. The college self expression scale: A measure of assertiveness. Behavior Therapy, 1974, 5(2), 165-171.
- Galassi, M. D., & Galassi, J. P. The effects of roleplaying variations on the assessment of assertive behavior. Behavior Therapy, 1976, 7(3), 343-347.
- Galassi, M. D., & Galassi, J. P. Assert yourself. How to be your own person. New York: Human Science Press, 1977.
- Galassi, J. P., Galassi, M. D., & Litz, M. C. Assertive training in groups using video feedback. Journal of Counseling Psychology, 1974, 21(5), 390-394.
- Galassi, J. P., Kostka, M., & Galassi, M. D. Assertive training: A one-year follow-up. Journal of Counseling Psychology, 1975, 22(5), 451-452.
- Gambrill, E. D., & Richey, C. A. An assertion inventory for use in assessment and research. Behavior Therapy, 1975, 6, 550-561.
- Gay, M., Hollandsworth, J., & Galassi, J. P. An assertiveness inventory for adults. Journal of Counseling Psychology, 1975, 22(4), 340-344.

- Gibb, J. R. Climate for trust formation. In L. P. Bradford, J. R. Gibb, and K. D. Benne (Eds.), T-Group theory and laboratory method. New York: Wiley, 1964.
- Glass, C. R., Gottman, J. M., & Shmurak, S. H. Response acquisition and cognitive self statement modification approaches to dating skills training. Journal of Counseling Psychology, 1976, 23(6), 520-526.
- Goldstein, A. P. Relationship-enhancement methods. In F. Kanfer and A. Goldstein (Eds.), Helping people change. New York: Pergamon Press, 1975.
- Goldstein, A. P., Martens, J., Hubben, J., VonBelle, H. A., Schaaf, W., Wiersma, H., & Goedhart, A. The use of modeling to increase independent behavior. Behaviour Research and Therapy, 1973, 11, 31-42.
- Gormally, J. Personal communication. November 29, 1976.
- Gormally, J., Hill, C., Otis, M., & Rainey, L. A micro-training approach to assertiveness training. Journal of Counseling Psychology, 1975, 22(4), 299-303.
- Gutride, M. E., Goldstein, F., & Hunter, G. F. The use of modeling and roleplaying to increase social interaction among asocial psychiatric patients. Journal of Consulting and Clinical Psychology, 1973, 40(3), 408-415.
- Hartsook, J. E., Olch, D. R., & deWolf, V. A. Personality characteristics of women's assertiveness training group participants. Journal of Counseling Psychology, 1976, 23(4), 322-326.
- Hedquist, F. J., & Weinhold, B. K. Behavioral group counseling with socially anxious and unassertive college students. Journal of Counseling Psychology, 1970, 17(3), 237-242.
- Hersen, M., & Bellack, A. S. A multiple baseline analysis of social skills training in chronic schizophrenics. Journal of Applied Behavioral Analysis, 1976, 9(3), 239-245.
- Hersen, M., Eisler, R.M., & Miller, P.M. Development of assertive responses: Clinical measurement and research considerations. Behaviour Research and Therapy, 1973, 11, 505-521.

- Hersen, M., Eisler, R. M., & Miller, P. M. An experimental analysis of generalization in assertive training. Behaviour Research and Therapy, 1974, 12, 295-310.
- Hersen, M., Eisler, R. M., Miller, P. M., Johnson, M. B., & Pinkston, S. G. Effects of practice, instruction, and modeling on components of assertive behavior. Behaviour Research and Therapy, 1973, 11, 443-451.
- Hollandsworth, J. G., & Wall, K. E. Sex differences in assertive behavior: An empirical investigation. Journal of Counseling Psychology, 1977, 24(3), 217-222.
- Jakubowski-Spector, P. Facilitating the growth of women through assertive training. The Counseling Psychologist, 1973, 4(1), 75-86.
- Johnson, D. W. The effects of the order of expressing warmth and anger upon the actor and the listener. Journal of Counseling Psychology, 1971, 18, 571-578.
- Johnson, D. W., & Matross, R. P. Attitude modification methods. In F. H. Kanfer and A. P. Goldstein (Eds.), Helping people change. New York: Pergamon Press, 1975.
- Johnson, D. W., & Noonan, M. P. The effects of acceptance and reciprocation of self-disclosure on the development of trust. Journal of Counseling Psychology, 1972, 19, 411-416.
- Kanfer, F. H., & Goldstein, A. P. Helping people change. New York: Pergamon Press, 1975.
- Kanfer, F. H., & Phillips, J. S. Behavior therapy: A panacea for all ills or a passing fancy? Archives of General Psychiatry, 1966, 15, 114-128.
- Kapp, F., Glaser, C., Brissenden, A., Emerson, R., Wingt, J., Kashdan, B. Group participation and self-perceived personality change. Journal of Nervous and Mental Disease, 1964, 139(3), 255-265.
- Kaul, T. J., & Schmidt, L. D. Dimensions of trustworthiness. Journal of Counseling Psychology, 1971, 18(6), 542-548.

- Kazdin, A. E. Effects of covert modeling and modeling reinforcement in assertive behavior. Journal of Abnormal Psychology, 1974, 83(3), 240-252.
- Kazdin, A. E. Covert modeling, imagery assessment, and assertive behavior. Journal of Consulting and Clinical Psychology, 1975, 43(5), 716-724.
- Kazdin, A. E. Assessment of imagery during covert modeling of assertive behavior. Journal of Behavior Therapy and Experimental Psychiatry, 1976, 7(3), 213-219. (a)
- Kazdin, A. E. Effects of covert modeling, multiple models, and model reinforcement in assertive behavior. Behavior Therapy, 1976, 7(2), 211-222. (b)
- Kirschner, N. M. Generalization of behaviorally oriented assertive training. Psychological Record, 1976, 26, 117-125.
- LaCrosse, M. B., & Barak, A. Differential perception of counselor behavior. Journal of Counseling Psychology, 1976, 23(2), 170-172.
- Lange, A. J., & Jakubowski, P. Responsible assertive behavior. Champaign, Ill.: Research Press, 1976.
- Lawrence, P. S. The assessment and modification of assertive behavior. Dissertation Abstracts International, 1970, 31(1-B), 396.
- Lazarus, A. A. Behavior rehearsal versus nondirective therapy versus advice in effecting behavior change. Behaviour Research and Therapy, 1966, 4, 209-212.
- Lazarus, A. A. Behavior therapy and beyond. New York: McGraw-Hill, 1971.
- Lazarus, A. A. On assertive behavior: A brief note. Behavior Therapy, 1973, 4, 697-699.
- Lazarus, A. A. Multimodal behavior therapy. New York: Springer, 1976.
- Leavitt, H. J. Some effects of certain communication patterns on group performance. Journal of Abnormal and Social Psychology, 1951, 46, 38-50.

- Lee, D. Some characteristics of freshmen entering the University of Ottawa, September 1977. Ottawa: University of Ottawa Press (in press).
- Lewin, K. Group decision and social change. In E. Maccoby, T. Newcomb, and E. Hartley (Eds.), Readings in social psychology. New York: Holt, Rinehart & Winston, 1958.
- Lieberman, M. A. Group methods. In F. Kanfer and A. Goldstein (Eds.), Helping people change. New York: Pergamon Press, 1975.
- Lieberman, R. Aversive conditioning of drug addicts: A pilot study. Behaviour Research and Therapy, 1968, 6, 229-231.
- Liss-Levinson, N., Coleman, E., & Brown, L. A program of sexual assertiveness training for women. The Counseling Psychologist, 1975, 5(4), 74-78.
- Ludwig, L., & Lazarus, A. A cognitive and behavioral approach to the treatment of social inhibition. Psychotherapy: Theory, Research, and Practice, 1972, 9(3), 204-206.
- MacDonald, M. L. Teaching assertion: A paradigm for therapeutic intervention. Psychotherapy: Theory, Research, and Practice, 1975, 12(1), 60-67.
- MacPherson, E. L. Selective operant conditioning and deconditioning of assertive modes of behavior. Journal of Behavior Therapy and Experimental Psychiatry, 1972, 3, 99-102.
- McFall, R. M., & Lillesand, D. B. Behavioral rehearsal with modeling and coaching in assertive training. Journal of Abnormal Psychology, 1971, 77(3), 313-323.
- McFall, R. M., & Marston, A. R. An experimental investigation of behavior rehearsal in assertive training. Journal of Abnormal Psychology, 1970, 76(2), 295-303.
- McFall, R. M., & Twentyman, C. T. Four experiments on the relative contributions of rehearsal, modeling, and coaching to assertion training. Journal of Abnormal Psychology, 1973, 81(3), 199-218.

- Meichenbaum, D. H. Cognitive modification of test anxious college students. Journal of Consulting and Clinical Psychology, 1972, 39, 370-380.
- Meichenbaum, D. H., & Cameron, R. Training schizophrenics to talk to themselves: A means of developing attentional controls. Behavior Therapy, 1973, 4, 515-534.
- Meichenbaum, D. H., Gilmore, J. B., & Fedoravicius, A. Group insight vs. group desensitization in treating speech anxiety. Journal of Consulting and Clinical Psychology, 1971, 36, 410-421.
- Melnick, J., & Stocker, R. An experimental analysis of the behavioral rehearsal with feedback technique in assertiveness training. Behavior Therapy, 1977, 8, 222-228.
- Mills, D. H., & Zytowski, D. G. Helping relationship: A structural analysis. Journal of Counseling Psychology, 1967, 14(3), 193-197.
- Mintz, J., Luborsky, L., & Auerbach, A. Dimensions of psychotherapy: A factor-analytic study of ratings of psychotherapy sessions. Journal of Consulting and Clinical Psychology, 1971, 36(1), 106-120.
- Morris, R. J., & Suckerman, K. R. The importance of the therapeutic relationship in systematic desensitization. Journal of Consulting and Clinical Psychology, 1974, 42, 148. (a)
- Morris, R. J., & Suckerman, K. R. Therapist warmth as a factor in automated systematic desensitization. Journal of Consulting and Clinical Psychology, 1974, 42(2), 244-250. (b)
- Muehlberg, N., Pierce, R., & Drasgow, J. A factor analysis of therapeutically facilitative conditions. Journal of Clinical Psychology, 1969, 25(1), 93-95.
- Newcomb, T. M. The prediction of interpersonal attraction. American Psychologist, 1956, 11, 575-586.
- Newcomb, T. M. The acquaintance process. New York: Holt, Rinehart & Winston, 1961.

- Nie, N., Hadlai Hull, C., Jenkins, J., Steinbrenner, K., & Bent, D. Statistical package for the social sciences (2nd ed.). New York: McGraw-Hill, 1975.
- Nietzel, M. T., & Bernstein, D. A. Effects of mediated demand on the behavioral assessment of assertiveness. Journal of Consulting and Clinical Psychology, 1976, 44(3), 500.
- Nietzel, M. T., Mortorano, R. D., & Melnick, J. The effects of covert modeling with and without reply training on the development and generalization of assertive responses. Behavior Therapy, 1977, 8, 183-192.

- Orenstein, H., Orenstein, E., & Carr, J. E. Assertiveness and anxiety: A correlational study. Journal of Behavior Therapy and Experimental Psychiatry, 1975, 6(3), 203-207.
- Patterson, R. L. Time out and assertive training for a dependent child. Behavior Therapy, 1972, 3, 466-468.
- Pepitone, A., & Reichling, G. Group cohesiveness and the expression of hostility. Human Relations, 1955, 8, 327-337.
- Piaget, G., & Lazarus, A. A. The use of rehearsal desensitization. Psychotherapy: Theory, Research, and Practice, 1969, 6(4), 264-266.
- Query, W. T. Self-disclosure as a variable in group psychotherapy. International Journal of Group Psychotherapy, 1964, 14, 107-115.
- Rachman, S. J. Observational learning and therapeutic modeling. In M. P. Feldman and A. Broadhurst (Eds.), Theoretical and experimental bases of the behavioral therapies. New York: Wiley, 1976.
- Rathus, S. A. A 30-item schedule for assessing assertive behavior. Behavior Therapy, 1973, 4, 398-406. (a)
- Rathus, S. A. Instigation of assertive behavior through videotape-mediated assertive models and direct practice. Behaviour Research and Therapy, 1973, 11, 57-65. (b)
- Rathus, S. A., & Ruppert, C. A. Assertive training in the secondary school and the college. Adolescence, 1973, 8(3), 257-264.
- Rich, A. R., & Schroeder, H. E. Research issues in assertiveness training. Psychological Bulletin, 1976, 83(6), 1081-1096.
- Rimm, D. C. Assertive therapy used in treatment of chronic crying spells. Behaviour Research and Therapy, 1967, 5, 373-374.
- Rimm, D. C., Hill, G. A., Brown, N. N., & Stuart, J. E. Group assertive training in treatment of expression of inappropriate anger. Psychological Reports, 1974, 34, 791-798.

- Rimm, D. C., Snyder, J. J., Depue, R. A., Haanstad, M. J., & Armstrong, D. P. Assertive training versus rehearsal and the importance of making an assertive response. Behaviour Research and Therapy, 1976, 14(5), 315-321.
- Rogers, C. R. The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 1957, 21, 95-103.
- Rogers, C. R. A theory of therapy, personality, and interpersonal relationships as developed in the client-centered framework. In Sigmund Koch (Ed.), Psychology: A study of a science, 1959, 3, 184-256.
- Rogers, C. R. The process equation of psychotherapy. American Journal of Psychotherapy, 1961, 15, 27-45.
- Rogers, C. R. The therapeutic relationship: Recent theory and research. Australian Journal of Psychology, 1965, 17(2), 95-108.
- Rogers, C. R. Client-centered therapy. In S. Arieti (Ed.), American handbook of psychiatry, 1966, 3, 183-200.
- Rogers, C. R. Empathic: An unappreciated way of being. The Counseling Psychologist, 1975, 5(2), 2-10.
- Rogers, C. R. Gendlin, G. T., Kiesler, D. J., & Truax, C. B. The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics. Madison: University of Wisconsin Press, 1967.
- Rosenthal, T. L., & Reese, S. L. The effect of covert and overt modeling in assertive behavior. Behaviour Research and Therapy, 1976, 14(6), 463-469.
- Ross, I., & Zander, A. Need satisfaction and employee turnover. Personnel Psychology, 1957, 10, 327-338.
- Russell, A., & Winkler, A. Evaluation of assertive training and homosexual guidance service groups designed to improve homosexual functioning. Journal of Consulting and Clinical Psychology, 1977, 45(1), 1-13.
- Ryan, V. L., & Gizynski, M. N. Behavior therapy in retrospect: Patient's feelings about their behavior therapies. Journal of Consulting and Clinical Psychology, 1971, 37(1), 1-9.

- Sabatasso, A., & Jacobson, L. I. Case report: Use of behavioral therapy in the reinstatement of verbal behavior in a mute psychotic with chronic brain syndrome. Journal of Abnormal Psychology, 1970, 76(2), 322-324.
- Salter, A. Conditioned reflex therapy. New York: Capricorn, 1949.
- Schachter, S. The psychology of affiliation. Stanford: Stanford University Press, 1959.
- Schauble, P. G., & Pierce, R. M. Client in-therapy behavior: A therapist guide to process. Psychotherapy: Theory, research, and practice, 1974, 11(3), 229-234.
- Schwartz, R. M., & Gottman, J. M. Toward a task analysis of assertive behavior. Journal of Consulting and Clinical Psychology, 1976, 44(6), 910-920.
- Sechrest, L., & Barger, B. Verbal participation and perceived benefit from group psychotherapy. International Journal of Group Psychotherapy, 1961, 11, 49-59.
- Serber, M. Teaching the nonverbal components of assertive training. Journal of Behavior Therapy and Experimental Psychiatry, 1972, 3, 179-183.
- Shaw, M. E. Some effects of unequal distribution of information upon group performance in various communication nets. Journal of Abnormal and Social Psychology, 1954, 49, 547-553.
- Slaney, R. B. Perceptions of alternative roles for the facilitative conditions. Journal of Counseling Psychology, 1977, 24(2), 169-172.
- Sloane, R. B., Staples, F. R., Cristol, A. H., Yorkston, N. J., & Whipple, K. Psychotherapy versus behavior therapy. Massachusetts: Harvard University Press, 1975.
- Staats, A. W. Social behaviorism and human motivation: Principles of the A-R-D system. In A. G. Greenwald, T. C. Rock, and T. M. Ostrom (Eds.), Psychological foundations of attitudes. New York: Academic Press, 1968.

- Staples, F. R., Sloane, R. B., Whipple, K., Cristol, A. H., & Yorkston, N. J. Process and outcome in psychotherapy and behavior therapy. Journal of Consulting and Clinical Psychology, 1976, 44(3), 340-350.
- Stevenson, I., & Wolpe, J. Recovery from sexual deviations through overcoming nonsexual responses. American Journal of Psychiatry, 1960, 116, 737-742.
- Strong, S. R. Counseling: An interpersonal influence process. Journal of Counseling Psychology, 1968, 15(3), 215-224.
- Strong, S. R., & Dixon, D. N. Expertness, attractiveness, and influence in counseling. Journal of Counseling Psychology, 1971, 18(6), 562-570.
- Strong, S. R., & Schmidt, L. D. Expertness and influence in counseling. Journal of Counseling Psychology, 1970, 17(1), 81-87.
- Taylor, D. A., Altman, I., & Sorrentino, R. Interpersonal exchange as a function of rewards and costs and situational factors: Expectancy confirmation-disconfirmation. Journal of Experimental Social Psychology, 1969, 5, 324-339.
- Thibaut, J., & Kelley, H. The social psychology of groups. New York: Wiley, 1959.
- Tolor, A., Kelley, B. R., & Stebbins, C. A. Assertiveness, sex role stereotyping and self concept. The Journal of Psychology, 1976, 93(first half), 157-164.
- Truax, C. B. The process of group psychotherapy: Relationships between hypothesized therapeutic conditions and intrapersonal exploration. Psychological Monographs, 1961, 75(7, Whole No. 511).
- Truax, C. B. Reinforcement and nonreinforcement in Rogerian psychotherapy. Journal of Abnormal Psychology, 1966, 71(1), 1-9.
- Truax, C. B., & Carkhuff, R. R. Experimental manipulation of therapeutic conditions. Journal of Consulting Psychology, 1965, 29(2), 119-124. (a)

- Truax, C. B., & Carkhuff, R. R. Personality change in hospitalized mental patients during group psychotherapy as a function of the use of alternate sessions and vicarious therapy pretraining. Journal of Clinical Psychology, 1965, 21, 225-228. (b)
- Truax, C. B., & Mitchell, K. M. Research on certain therapist interpersonal skills in relation to process and outcome. In A. E. Bergin and S. L. Garfield (Eds.), Handbook of psychotherapy and behavior change: An empirical analysis. New York: Wiley, 1971.
- Turner, S. M., & Adams, H. E. Effects of assertive training on the dimension of assertiveness. Behaviour Research and Therapy, 1977, 15(6), 475-483.
- Van Der Veen, F. Client perception of therapist conditions as a factor in psychotherapy. Wisconsin Psychiatric Bulletin, 1961, 1(10e). In J. T. Hart and T. M. Tomlinson (Eds.), New directions in client centered therapy. New York: Houghton-Mifflin, 1970.
- Verba, S. Small groups and political behavior: A study of leadership. Princeton, N.J.: Princeton University Press, 1961.
- Wallach, M., Kogan, N., & Bem, D. Group influence on individual risktaking. Journal of Abnormal and Social Psychology, 1962, 65, 75-86.
- Walton, R. W., & McKersie, R. B. Attitude change in intergroup relations. Institute for research in the behavioral, economic, and management sciences. Paper No. 86, Purdue University. Reported in F. H. Kanfer and A. P. Goldstein, Helping people change. New York: Pergamon, 1975.
- Weinman, B., Gelbart, P., Wallace, M., & Post, M. Inducing assertive behavior in chronic schizophrenics: A comparison of socioenvironmental, desensitization, and relaxation therapies. Journal of Consulting and Clinical Psychology, 1972, 39(2), 246-252.
- Wilson, G. T., & Evans, I. M. Adult behavior therapy and the therapist-client relationship. In C. W. Franks, G. T. Wilson (Eds.), Annual review of behavior therapy, theory, and practice. New York: Brunner/Mazel, 1976.

- Wilson, G. T., Hannon, A. E., & Evans, W. Behavior therapy and the therapist-patient relationship. Journal of Consulting and Clinical Psychology, 1968, 32(2), 103-109.
- Winship, B. J., & Kelley, J. D. A verbal response model of assertiveness. Journal of Counseling Psychology, 1976, 23(3), 215-220.
- Wolfe, J. L., & Fodor, I. G. Modifying assertive behavior in women: A comparison of three approaches. Behavior Therapy, 1977, 8, 567-574.
- Wolpe, J. Isolation of a conditioning procedure as the crucial psychotherapeutic factor: A case study. Journal of Nervous and Mental Disease, 1962, 134, 316-329.
- Wolpe, J. The practice of behavior therapy. New York: Pergamon, 1969.
- Wolpe, J. The instigation of assertive behavior: Transcripts from two cases. Journal of Behavior Therapy and Experimental Psychiatry, 1970, 1, 145-151.
- Wolpe, J., & Lazarus, A. A. Behavior therapy techniques. New York: Pergamon, 1966.
- Wolpe, J., Salter, A., & Reyna, L. The conditioning therapies. New York: Holt, Rinehart & Winston, 1964.
- Woody, R. H. Toward a rationale for psychobehavioral therapy. Archives of General Psychiatry, 1968, 19, 197-204.
- Wright, J. C. A comparison of systematic desensitization and social skill acquisition in the modification of a social fear. Behavior Therapy, 1976, 7(2), 205-210.
- Yalom, I. D. The theory and practice of group psychotherapy. New York: Basic Books, 1970.
- Yalom, I. D., Houts, P. S., Zimerberg, S. M., & Rand, K. H. Prediction of improvement in group therapy. Archives of General Psychiatry, 1967, 17, 159-168.

Young, E. R., Rimm, D. C., & Kennedy, T. D. An experimental investigation of modeling and verbal reinforcement in the modification of assertive behavior. Behaviour Research and Therapy, 1973, 11, 317-319.

Zander, A. & Havelin, A. Social comparison and interpersonal attraction. Human Relations, 1960, 13, 21-32.

APPENDIX 1

ASSERTION TRAINING CONTRACT

APPENDIX 1

ASSERTION TRAINING CONTRACT

I, _____ (participant), hereby declare my interest in learning to become a more assertive person. In order to achieve this goal, I agree to attend all scheduled sessions (barring unforeseen emergencies), to arrive on time for the meetings and, to the best of my ability, be an active member of the group. To do this involves:

- contributing to discussions
- roleplaying situations
- providing feedback to other group members
- completing assigned homework
- performing one or more specified behaviors outside the group and reporting back to the group on the outcome

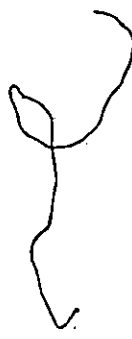
Lastly, in order that this program continue to be an effective one, I accept to participate in any effort to evaluate it.

We, _____ (group leaders), agree, to the best of our abilities, to provide the group members with the resources for them to learn to become more assertive people. This involves such things as a meeting place and time, commitment to the program, appropriate handouts and teaching materials, and a warm and supportive group atmosphere.

Signed (participant) _____

Date _____

Signed (leaders) _____



APPENDIX 2

ASSERTION INVENTORY



APPENDIX 2

ASSERTION INVENTORY

Code Number _____

Many people experience difficulty in handling interpersonal situations requiring them to assert themselves in some way, for example, turning down a request, asking a favor, giving someone a compliment, expressing disapproval or approval, etc. Please indicate your degree of discomfort or anxiety in the space provided before each situation listed below. Utilize the following scale to indicate degree of discomfort:

- 1 - none
- 2 - a little
- 3 - a fair amount
- 4 - much
- 5 - very much

Then go over the list a second time and indicate after each item the probability or likelihood of your displaying the behavior if actually presented with the situation.* For example, if you rarely apologize when you are at fault, you would make a "4" after that item. Utilize the following scale to indicate response probability:

- 1 - always do it
- 2 - usually do it
- 3 - do it about half the time
- 4 - rarely do it
- 5 - never do it

*It is important to cover your discomfort ratings (located in front of the items) while indicating response probability. Otherwise, one rating may contaminate the other and a realistic assessment of your behavior is unlikely. To correct for this, place a piece of paper over your discomfort ratings while responding to the situations a second time for response probability.

Name _____

Degree of discomfort	Situation	Response probability
_____	1. Turn down a request to borrow your car.	_____
_____	2. Compliment a friend.	_____
_____	3. Ask a favor of someone.	_____
_____	4. Resist sales pressure.	_____
_____	5. Apologize when you are at fault.	_____
_____	6. Turn down a request for a meeting or date.	_____
_____	7. Admit fear and request consideration.	_____
_____	8. Tell a person you are intimately involved with when he/she says or does something that bothers you.	_____
_____	9. Ask for a raise.	_____
_____	10. Admit ignorance in some area.	_____
_____	11. Turn down a request to borrow money.	_____
_____	12. Ask personal questions.	_____
_____	13. Turn off a talkative friend.	_____
_____	14. Ask for constructive criticism.	_____
_____	15. Initiate a conversation with a stranger.	_____
_____	16. Compliment a person you are romantically involved with or interested in.	_____
_____	17. Request a meeting or a date with a person.	_____
_____	18. Your initial request for a meeting is turned down and you ask the person again at a later time.	_____

Degree of discomfort	Situation	Response probability
_____	19. Admit confusion about a point under discussion and ask for clarification.	_____
_____	20. Apply for a job.	_____
_____	21. Ask whether you have offended someone.	_____
_____	22. Tell someone that you like them.	_____
_____	23. Request expected service when such is not forthcoming, e.g., in a restaurant.	_____
_____	24. Discuss openly with the person his/her criticism of your behavior.	_____
_____	25. Return defective items, e.g., store or restaurant.	_____
_____	26. Express an opinion that differs from that of the person you are talking to.	_____
_____	27. Resist sexual overtures when you are not interested.	_____
_____	28. Tell the person when you feel he/she has done something that is unfair to you.	_____
_____	29. Accept a date.	_____
_____	30. Tell someone good news about yourself.	_____
_____	31. Resist pressure to drink.	_____
_____	32. Resist a significant person's unfair demand.	_____
_____	33. Quit a job.	_____
_____	34. Resist pressure to "turn on."	_____
_____	35. Discuss openly with the person his/her criticism of your work.	_____
_____	36. Request the return of borrowed items.	_____

Degree of discomfort	Situation	Response probability
-------------------------	-----------	-------------------------

- | | | |
|-------|--|-------|
| _____ | 37. Receive compliments. | _____ |
| _____ | 38. Continue to converse with someone who disagrees with you. | _____ |
| _____ | 39. Tell a friend or someone with whom you work when he/she says or does something that bothers you. | _____ |
| _____ | 40. Ask a person who is annoying you in a public situation to stop. | _____ |

Lastly, please indicate the situations you would like to handle more assertively by placing a circle around the item number.

APPENDIX 3

NEED, BELIEF, EXPECTATION QUESTIONS

APPENDIX 3

NEED, BELIEF, EXPECTATION QUESTIONS

Student No. _____

Please place an "X" on the scale below to indicate the extent to which you believe or do not believe in the effectiveness of Assertion Training.

DO NOT BELIEVE
AT ALL

BELIEVE
STRONGLY

Please place an "X" on the scale below to indicate the extent to which you expect to benefit from this assertion training experience.

DO NOT EXPECT TO
BENEFIT AT ALL

EXPECT TO
BENEFIT
GREATLY

Please place an "X" on the scale below to indicate the amount to which you feel that you need this group experience.

DO NOT NEED
IT AT ALL

NEED IT
VERY MUCH

2

APPENDIX 4

COUNSELOR RATING FORM

1

APPENDIX 4

COUNSELOR RATING FORM

Code No. _____

Listed below are several scales which contain word pairs at either end of the scale and seven spaces between the pairs. Please rate your group leaders on each of the scales.

If you feel that the leaders very closely resemble the word at one end of the scale, place a check mark as follows:

fair ___:___:___:___:___:___: X unfair

OR

fair X:___:___:___:___:___:___ unfair

If you think that one end of the scale quite closely describes the leaders, then make your check mark as follows:

rough ___: X :___:___:___:___:___ smooth

OR

rough ___:___:___:___:___: X :___ smooth

If you feel that one end of the scale only slightly describes the leaders, then check the scale as follows:

active ___:___: X :___:___:___:___ passive

OR

active ___:___:___:___: X :___:___ passive

If both sides of the scale seem equally associated with your impression of the leaders or if the scale is irrelevant, then place a check mark in the middle space:

hard ___:___:___: X :___:___:___ soft

Your first impression is the best answer.

PLEASE NOTE: PLACE CHECK MARKS IN THE MIDDLE OF THE SPACES.

[Copyright, M. B. LaCrosse and A. Barak, 1974, 1975. Not to be reproduced without permission.]

agreeable	___:___:___:___:___:___:___	disagreeable
unalert	___:___:___:___:___:___:___	alert
analytic	___:___:___:___:___:___:___	diffuse
unappreciative	___:___:___:___:___:___:___	appreciative
attractive	___:___:___:___:___:___:___	unattractive
casual	___:___:___:___:___:___:___	formal
cheerful	___:___:___:___:___:___:___	depressed
vague	___:___:___:___:___:___:___	clear
distant	___:___:___:___:___:___:___	close
compatible	___:___:___:___:___:___:___	incompatible
unsure	___:___:___:___:___:___:___	confident
suspicious	___:___:___:___:___:___:___	believable
undependable	___:___:___:___:___:___:___	dependable
indifferent	___:___:___:___:___:___:___	enthusiastic
inexperienced	___:___:___:___:___:___:___	experienced
inexpert	___:___:___:___:___:___:___	expert
unfriendly	___:___:___:___:___:___:___	friendly
honest	___:___:___:___:___:___:___	dishonest

informed	___:___:___:___:___:___:___	ignorant
insightful	___:___:___:___:___:___:___	insightless
stupid	___:___:___:___:___:___:___	intelligent
unlikeable	___:___:___:___:___:___:___	likeable
logical	___:___:___:___:___:___:___	illogical
open	___:___:___:___:___:___:___	closed
prepared	___:___:___:___:___:___:___	unprepared
unreliable	___:___:___:___:___:___:___	reliable
disrespectful	___:___:___:___:___:___:___	respectful
irresponsible	___:___:___:___:___:___:___	responsible
selfless	___:___:___:___:___:___:___	selfish
sincere	___:___:___:___:___:___:___	insincere
skillful	___:___:___:___:___:___:___	unskillful
sociable	___:___:___:___:___:___:___	unsociable
deceitful	___:___:___:___:___:___:___	straightforward
trustworthy	___:___:___:___:___:___:___	untrustworthy
genuine	___:___:___:___:___:___:___	phony
warm	___:___:___:___:___:___:___	cold

APPENDIX 5

RELATIONSHIP INVENTORY

APPENDIX 5

RELATIONSHIP INVENTORY

Code No. _____

Instructions

Listed on the accompanying questionnaire are a variety of ways that people may feel or behave in relation to others. Please consider each statement with reference to your present relationship with your leaders.

Mark each statement in the left margin, according to how strongly you feel that it is true or not true, in this relationship. Please mark every one. Write +3, +2, +1, or -1, -2, -3, to stand for the following answers

- +3: Yes, I strongly feel that it is true.
- +2: Yes, I feel it is true.
- +1: Yes, I feel that it is probably true, or more true than untrue.
- 1: No, I feel that it is probably untrue, or more untrue than true.
- 2: No, I feel it is not true.
- 3: No, I strongly feel that it is not true.

Code No. _____

Date _____

- ___ 1. They respect me as a person.
- ___ 2. They want to understand how I see things.
- ___ 3. Their interest in me depends on the things I say or do.
- ___ 4. They are comfortable and at ease in our relationship.
- ___ 5. They feel a true liking for me.
- ___ 6. They may understand my words but they do not see the way I feel.
- ___ 7. Whether I am feeling happy or unhappy with myself makes no real difference to the way they feel about me.
- ___ 8. I feel that they put on a role or front with me.
- ___ 9. They are impatient with me.
- ___ 10. They nearly always know exactly what I mean.
- ___ 11. Depending on my behavior, they have a better opinion of me sometimes than they have at other times.
- ___ 12. I feel that they are real and genuine with me.
- ___ 13. I feel appreciated by them.
- ___ 14. They look at what I do from their own point of view.
- ___ 15. Their feeling toward me does not depend on how I feel toward them.
- ___ 16. It makes them uneasy when I ask or talk about certain things.
- ___ 17. They are indifferent to me.
- ___ 18. They usually sense or realize what I am feeling.
- ___ 19. They want me to be a particular kind of person.
- ___ 20. I nearly always feel that what they say expresses exactly what they are feeling and thinking as they say it.

- ___ 21. They find me rather dull and uninteresting.
- ___ 22. Their own attitudes toward some of the things I do or say prevent them from understanding me
- ___ 23. I can (or could) be openly critical or appreciative of them without really making them feel any differently about me.
- ___ 24. They want me to think that they like me or understand me more than they really do.
- ___ 25. They care for me.
- ___ 26. Sometimes they think that I feel a certain way, because that is the way they feel.
- ___ 27. They like certain things about me, and there are other things they do not like.
- ___ 28. They do not avoid anything that is important for our relationship.
- ___ 29. I feel that they disapprove of me.
- ___ 30. They realize what I mean even when I have difficulty in saying it.
- ___ 31. Their attitude toward me stays the same: they are not pleased with me sometimes and critical or disappointed at other times.
- ___ 32. Sometimes they are not at all comfortable but we go on, outwardly ignoring it.
- ___ 33. They just tolerate me.
- ___ 34. They usually understand the whole of what I mean.
- ___ 35. If I show that I am angry with them they become hurt or angry with me, too.
- ___ 36. They express their true impressions and feelings with me.
- ___ 37. They are friendly and warm with me.
- ___ 38. They just take no notice of some things that I think or feel.

- ___ 39. How much they like or dislike me is not altered by anything that I tell them about myself.
- ___ 40. At times I sense that they are not aware of what they're really feeling with me.
- ___ 41. I feel that they really value me.
- ___ 42. They appreciate exactly how the things I experience feel to me.
- ___ 43. They approve of some things I do and plainly disapprove of others.
- ___ 44. They are willing to express whatever is actually in their minds with me, including any feelings about themselves or about me.
- ___ 45. They do not like me for myself.
- ___ 46. At times they think that I feel a lot more strongly about a particular thing than I really do.
- ___ 47. Whether I am in good spirits or feeling upset does not make them feel any more or less appreciative of me.
- ___ 48. They are openly themselves in our relationship.
- ___ 49. I seem to irritate and bother them.
- ___ 50. They do not realize how sensitive I am about some of the things we discuss.
- ___ 51. Whether the ideas and feelings I express are "good" or "bad" seems to make no difference to their feeling toward me.
- ___ 52. There are times when I feel that their outward response to me is quite different from the way they feel underneath.
- ___ 53. At times they feel contempt for me.
- ___ 54. They understand me.
- ___ 55. Sometimes I am more worthwhile in their eyes than I am at other times.

- ___ 56. I have not felt that they try to hide anything from themselves that they feel with me.
- ___ 57. They are truly interested in me.
- ___ 58. Their response to me is usually so fixed and automatic that I really do not get through to them.
- ___ 59. I do not think that anything I say or do really changes the way they feel toward me.
- ___ 60. What they say to me often gives a wrong impression of their whole thought or feeling at the time.
- ___ 61. They feel deep affection for me.
- ___ 62. When I am hurt or upset they can recognize my feelings exactly, without becoming upset themselves.
- ___ 63. What other people think of me does (or would, if they knew) affect the way they feel toward me.
- ___ 64. I believe that they have feelings they do not tell me about that are causing difficulty in our relationship.

APPENDIX 6

INSTRUCTIONS FOR USE OF MONITORING CARDS

INSTRUCTIONS FOR USE OF MONITORING CARDS

The purpose of the monitoring card is to keep an individual record of all situations which you encounter and which call for assertive behavior on your part. This has been found effective in increasing awareness of when and how a person is assertive, nonassertive, or aggressive.

All situations encountered, no matter how small and unimportant they seem, should be registered on the card. The events need not be special, important, or new situations--they are the everyday type problems.

Several types of information will be registered on the card, as shown in the example below:

1. Student number or name
2. Day of recording
3. Situation: a very short description of incident
4. Response: your response to the situation, whether your response is nonassertive, assertive, or aggressive.

NOTE: Monitoring cards are to be filled out and handed in; they will be returned to you so that you can keep track of your own progress as the weeks go by. Remember, your card may contain assertive, nonassertive, and aggressive responses all within the same day or week.

EXAMPLE:

Student No. 000001

<u>Day</u>	<u>Situation</u>	<u>Response</u>
2/2/78	several people at bus stop - I didn't know them	spoke to them (hi, weather) (assertive)
2/2/78	fellow students complimented me on my research project	I blushed--said it was OK, not really much (nonassertive)
3/2/78	fellow student asked to borrow notes--I didn't want to lend them	I said I was using them--didn't come right out and say no (nonassertive)
4/2/78	roommate fixed a special dinner - I felt good about this	I thanked my roommate for the special work (assertive)

7

APPENDIX 7

DISCRIMINATING ASSERTIVE, NONASSERTIVE, AGGRESSIVE
BEHAVIOR

[Assigned Homework]

2



APPENDIX 7

DISCRIMINATING, ASSERTIVE, NONASSERTIVE, AGGRESSIVE
 BEHAVIOR
 [Assigned Homework]

Code No. _____

Date _____

A number of situations are described below. For each situation, three different responses follow. You are to mark each response as nonassertive, aggressive, or assertive. Write your answer on the blank line following each response.

1. Your friend has just arrived one hour late for dinner. He/she did not call to let you know that he/she would be detained. You are annoyed about his/her lateness. You say:
 - (a) Come on in. Dinner is on the table. _____
 - (b) I've been waiting for an hour. I would have appreciated your calling to let me know you would be late. _____
 - (c) You've got a lot of nerve coming late. That's the last time I'll invite you. _____

2. Your parents have just criticized your spouse/boyfriend/girlfriend. You feel the criticism is unjustified. You say:
 - (a) Shut up. You're both so stupid and prejudiced. _____
 - (b) Well, I see what you mean. _____
 - (c) I feel your criticism is unfair. He/she is not like that at all. _____

3. A friend has just complimented you on your new suit. It's the first time you've worn it and you really like it. You say:
 - (a) Thank you _____
 - (b) This? It's nothing special. _____
 - (c) Well ... I picked it up at a sale ... well ... _____

4. You're out with a group of friends. You're all deciding which movie to see. One person has just mentioned a movie you don't want to see. You say:
 - (a) You always pick movies I don't like. You only think about yourself. You're very selfish. _____

- (b) I don't want to see that one. How about a movie over at the Plaza Theatre? _____
- (c) Well, I don't know much about that movie. But, I guess, if you want to, we can see it. _____
5. You are returning a faulty item to the department store. You bought a shirt/blouse. When you took it home, you found a misweave in it. You do not want the item as it is. The clerk has just said no one will ever notice it. You say:
- (a) Well, I'd still like to return it or exchange it. I do not want this one. _____
- (b) Look, give me the money. I don't have all day for you to waste my time. _____
- (c) Well, are you sure no one will notice it? _____
6. You love your spouse/boyfriend/girlfriend very much and want to express this feeling to him/her. You've just finished a quiet dinner in your home and are sitting alone. You say:
- (a) I enjoyed the dinner. Oh...well... how do you feel? _____
- (b) Dear, I really love you. You're great. _____
- (c) Well, what's new? _____
7. Your parents have just called and they are coming to visit tonight. You already have plans for the evening that you do not want to break. You say:
- (a) Mom, I've seen you twice this week. Enough is enough. You are always bugging me. You're a pain. _____
- (b) Sure, I'd be glad to see you tonight, but couldn't you come tomorrow? _____
- (c) Mom, not tonight. I already have plans for the evening. _____
8. You'd like your child to go down the block and pick up a package at your friend's house. You say:
- (a) Billy, I'd like it if you would go over to Mrs. Smith's and pick up a package for me. I'd appreciate it if you could do it by 3 o'clock. _____
- (b) If you aren't too busy, well ... will you be going by Mrs. Smith's today? _____
- (c) Hey, it's about time you did something worthwhile. Go down to Mrs. Smith's and pick up a package for me. No back talk. Stop being such a lazy thing. Go on. _____

9. A co-worker keeps giving you all of his/her work to do. You've decided to put an end to this. Your co-worker has just asked you to do some more of his/her work. You say:
- (a) I'm kind of busy. But if you can't get it done, I guess I can help you. _____
 - (b) Forget it. It's about time you do it. You treat me like your slave. You're an inconsiderate S.O.B.
 - (c) No, Sue/Tom, I'm not going to do anymore of your work. I'm tired of doing both my work and your work. _____
10. A new person/family has just moved in next door. You really want to meet him/her/them.
- (a) You smile as your neighbor(s) walk by, but say nothing. _____
 - (b) You go next door and say, "Hi, I'm Sue/Tom. I live next door. Welcome to the neighborhood. I'm glad to meet you." _____
 - (c) You watch your neighbor(s) through your window. _____

APPENDIX 8

DEVELOPING ASSERTIVE RESPONSES
[Assigned Homework]

APPENDIX 8

DEVELOPING ASSERTIVE RESPONSES
[Assigned Homework]

Code No. _____

Date _____

Below are 10 situations which call for assertive responses. After each description of the situation, write your assertive response.

1. A good friend calls and tells you she desperately needs you to canvass the street for a charity. You don't want to do it and say:

2. You are at a meeting of seven men and one woman. (Assume you are the woman.) At the beginning of the meeting, the chairman asks you to be the secretary. You respond:

3. You are team teaching but you are doing all the planning, teaching, interacting, and evaluating students. You say:

4. The bus is crowded with high school students who are talking to their friends. You want to get off but no one pays attention when you say, "Out, please." Finally, you say:

5. A student comes late to class for the third time. The teacher responds:

6. The local library calls and asks you to return a book which you never checked out. You respond:

7. You are in a line at the store. Someone behind you has one item and asks to get in front of you. You say:

8. Your roommate habitually leaves the room a mess. You say:

9. A loud stereo upstairs is disturbing you. You telephone and say:

10. A friend often borrows small amounts of money and does not return it until asked. He/she again asks for a small loan which you'd rather not give. You say:

APPENDIX 9

DISCRIMINATION TEST ON ASSERTIVE, AGGRESSIVE, AND NON-
ASSERTIVE BEHAVIOR
[Optional Homework]

DISCRIMINATION TEST ON ASSERTIVE, AGGRESSIVE, AND NON-ASSERTIVE BEHAVIOR
[Optional Homework]

Code No. _____
The following self-check Discrimination Test Consists of 22 interpersonal situations. The responses to these situations are aggressive, assertive, or nonassertive. Read each situation and classify each response, as either assertive (+), aggressive (-), or nonassertive (N).

<u>Situation</u>	<u>Response</u>	+, -, or N
1. Husband gets silent, instead of saying what's on his mind. You say:	I guess you are uncomfortable talking about what's bothering you. I think we can work it out if you tell me what's irritating you.	_____
2. A friend has asked you for the second time in a week to babysit for her child while she runs errands. You have no children of your own, and respond:	You're taking advantage of me and I won't stand for it! It's your responsibility to look after your own child.	_____
3. An attendant at a gas station you frequently stop at for gas neglected to replace your gas cap. You notice this and return to inquire about it and you say:	One of you guys here forgot to put my gas cap back on! I want it found now or you'll buy me a new one.	_____
4. You'd like a raise, and say:	Do you think that, ah, you could see your way clear to giving me a raise?	_____

+, -,
OR N

Response

Situation

I am pressed for time today and can take you to a convenient bus stop, but I won't be able to take you home.

5. Someone asks for a ride home and it is inconvenient because you're late, have a few errands, and the drive will take you out of your way. You say:

You make the material interesting. I like the way you teach the class.

6. Student enjoyed the teacher's class and says:

I thought we agreed last Tuesday that you would have a talk with Barb about her behavior at school. So far, there's been no action on your part. I still think you should talk to her soon. I'd prefer sometime tonight.

7. Your husband promised you that he would talk to your daughter about her behavior at school. The promise has not been carried out. You say:

Well, I guess it's OK. I'm not going to be able to attend very much but it fits everyone else's schedule.

8. A committee meeting is being established. The time is convenient for other people but not for you. The times are set when it will be next to impossible for you to attend regularly. When asked about the time, you say:

Fairness and equality.

9. In a conversation, a man suddenly says, "What do you women libbers want anyway?" The woman responds:

I'm terribly sorry but my supper's burning, and I have to get off the phone. I hope you don't mind.

10. You've been talking for a while with a friend on the telephone. You would like to end the conversation, and you say:

I like our relationship the way it is. I wouldn't feel comfortable with any kind of dating relationship--and that includes lunch.

11. A married man persists in asking you out for a date, saying, "Come on, honey, what harm can it do to go to lunch with me just this once?" You respond:

Situation

Response

+, -,
or N

12. At a meeting, one person often interrupts you when you're speaking. You say:

Excuse me. I would like to finish my statement.

13. You are in a hard-sell camera store, and you have been pressured to purchase an item. You say:

Well, OK. I guess that's pretty much what I was looking for. Yes. I suppose I'll get it.

14. A blind person approaches and asks you to purchase some materials. You respond:

You people think that just because you're blind, people have to buy stuff from you. Well, I'm certainly not going to.

15. Teenager is asked to do laundry. As the child puts laundry in the washer, parent says:

Don't forget to balance the load. Make sure you push the right buttons. You just never do things right!

16. You have been pestered several times this week by a caller who has repeatedly tried to sell you magazines. The caller contacts you again with the same magazine proposition. You say:

This is the third time I've been disturbed and each time I've told you that I'm not interested in subscribing to any magazine. If you call again, I'll simply have to report this to the Better Business Bureau.

17. Kids upstairs are making a lot of noise. You bang on the ceiling and yell:

Hey you! Knock off the noise!

18. An acquaintance has asked to borrow your car for the evening. You say:

I don't know... Well, its not worth getting into a fuss about it. You can borrow it, but I should warn you that I've been having trouble with the brakes.

+, -,
or N

Situation

- 19. Wife tells husband she'd like to return to school. He doesn't want her to do this, and says:
- 20. An employee makes a lot of mistakes in his work. You say:
- 21. Husband expects dinner on table when he arrives home from work and gets angry when it is not there immediately. You say:
- 22. You've taken a suit to the cleaners that you plan to wear for a coming special occasion. When you go to pick it up, you find that there's a hole in it. You say:

Response

- Why would you want to do that? You know you're not capable enough to handle the extra work load.
- You're a lazy and sloppy worker.
- I know you are tired and hungry and would like to have dinner immediately, but I have been doing some sculpting which is important to me. I will have dinner ready soon.
- I planned to wear that tonight. Aren't you people responsible enough to do something about it?

APPENDIX 10

ASSERTIVE EXERCISE
[Assigned Homework]

APPENDIX 10

ASSERTIVE EXERCISE
[Assigned Homework]

Code No. _____

Date _____

Use DESC Scripting

Situation: A salesman has rung your doorbell to sell you brushes (or whatever). He is very persistent. How do you say no assertively?

Your
response:

Situation: You're a woman sitting with a girlfriend at a nightclub while waiting for the show to begin. Two uninvited men come to your table and sit down with you. Thinking you want to be picked up, they impose themselves obnoxiously. You and your friend want them to leave you alone. What assertive message can you deliver?

Your
response:

Situation: At a movie theater, the mother behind you has a 4-year old child with a persistent noisy cough. The child's coughing is disturbing you, although his mother seems unperturbed by his commotion. What can you do?

Your
response:

Situation: You are waiting in your car for another car to pull out of a parking space you want to take. You have to move a bit forward to let the other car out of the space. As he exits, a third car flashes in behind you, taking the parking space you've been waiting for. What do you do?

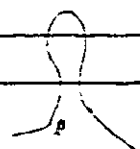
Your response: _____

Situation: Your small child falls while playing and hits her forehead, causing it to swell painfully. Fearing a skull fracture, you race to the emergency room of the local hospital. While you hold a bleeding, unconscious child, scared out of your wits, a very slow receiving clerk checks in the patient ahead of you. Then, turning to your case, she starts asking you a long series of questions to fill out her insurance form. Exasperated by her questions while you fear for your child's life, what do you say?

Your response: _____

Situation: You have waited in a movie line for 20 minutes only to learn at the door that you are in the wrong line, one for people who have already purchased tickets and are just waiting to go in. You are told to go to the end of the other line to buy a ticket. You know you'll never get in if you do that. What do you say and to whom?

Your response: _____



Situation: Your insurance agent calls you at dinner time and you are annoyed at being pestered in the middle of your meal.

Your
response:

Situation: You are waiting at a drive-up bank window while a slow cashier gets some traveler's cheques which you requested. The person in the car behind embarrasses you by honking his horn repeatedly. What can you do?

Your
response:

APPENDIX 11

PRACTICING ASSERTIVE RESPONSES
[Optional Homework]

APPENDIX 11

PRACTICING ASSERTIVE RESPONSES
[Optional Homework]

Code No. _____

Date _____

Please write your assertive response to the following situations:

1. A new boy/girl has just moved onto your floor in the dorm. You are interested in getting to know him/her.

2. You are attending a sporting event this evening with a few friends. You've been looking forward to this evening for some time. As you are leaving your house, your dad/mom says, "I'll see you right after the game." However, you hadn't planned on coming home immediately.

3. You are expecting a very important phone call between 7 and 10 p.m. tonight. You also have a class from 7 to 8:30 p.m. You know your roommate is planning to remain in the dorm tonight. You want to ask him/her to listen for the phone and take a message if the call comes before you get back.

4. You co-workers/friends always seem to be teasing you about one thing or another--your clothes, what you're planning to do, and so on. You're tired of being teased. You have decided the next time it occurs to express your annoyance and request that it does not occur again.

5. Your roommate has been quite helpful. He/she ran many errands for you when you were sick. He/she didn't have to do this for you and you want to express your appreciation.

6. You are up to your ears in work studying for final exams. You cannot take on any new tasks at this point. One of your classmates is approaching you now to ask for assistance with his/her studies.

7. Your friend is in the habit of borrowing your notes just before the exams. This is because he/she is often absent from class because he/she likes to play tennis at that time. He/she has done this repeatedly and you want to put a stop to it. He/she is approaching you now.

8. You are in a grocery store and the cashier is ringing up the prices for your items. You notice that she has overcharged you for a sale item. You want to point this out to the cashier, who seems very busy and irritable.

9. You are leaving in a few days for a 2-week trip and want to ask your neighbor to water your plants, collect your mail, and keep an eye on your apartment while you are away.

10. Your physician has just given you a prescription to get filled for the stomach discomfort you've been having. You want to know what the prescription is and what the potential side effects might be. Your doctor is generally quite vague on these issues.

APPENDIX 12

RESPONDING TO INSISTENT DEMANDS
[Optional Homework]



APPENDIX 12

RESPONDING TO INSISTENT DEMANDS
[Optional Homework]

Code No. _____

Date _____

1. You have been dieting for weeks and have managed to take off a few pounds. You go to a friend's house for dinner and he/she absolutely insists that you try some of everything and have doubles.

Friend: Have some of this.

You : _____

Friend: Oh, diets don't count on Saturday night.

You : _____

Friend: But you've lost so much weight, a little nibble won't hurt.

You : _____

Friend: This cheese cake is my specialty. It takes twelve eggs and two hours to make, not to mention one pound of cream cheese.

You : _____

Friend: Just try the homemade bread. It's worth every calorie.

You : _____

Friend: I guess you are pretty serious about your diet. I am glad that you did come tonight, even if you can't partake of it all.

2. A very persistent magazine salesman has come to your door. He is asking you to help him "gain some points" and if he gets enough points, he will be able to go to university for a semester. The young salesman gains his points, obviously, by selling magazines, but his pitch is aimed in large part at "people like you who are helping me work my way through university." You are not at all interested in buying a subscription to a magazine.

Salesman: Good afternoon. I'm working my way through university with the help of many kind people like yourself. I need to have 500 points by tonight to go to school for a semester, and right now I have 470. Could I talk to you about how you could help me get the points I need?

You : _____

Salesman: I have a number of fine magazines here, and I'm sure you'll find some you'd like to have.

You : _____

Salesman: Even if you don't want any personally, magazine subscriptions make excellent gifts for your family and friends, or you could send a subscription to a veterans' hospital. Just last month I gave a friend a subscription to Time for his birthday. I only need two more subscriptions to go to university this fall.

You : _____

3. A friend is raving about a movie he/she just saw. You have seen it, too, but thought it was unnecessarily violent and in bad taste. You want to express your point of view.

Friend : That movie was great. It seemed to really typify society today.

You : _____

Friend : I can't believe you did not like it.

You : _____

Friend : You must have missed the whole point of it.

You : _____

Friend : Oh, well, you can't please everybody.

4. You were assigned to work on a project with another person in your class about a month ago. You have been doing all the work by yourself. The project must be ready in five days, and you need his/her help if the project is to be completed by then. You decide to go and speak to this person.

You : _____

Co-worker: You've been doing an excellent job.

You : _____

Co-worker: I'm really very busy.

You : _____

Co-worker: I know you can handle it.

You : _____

Co-worker: You know, I guess I haven't been very helpful.
Are you free after lunch today to get together?

5. You have a term paper due in three days and really want to work on it this evening. You have purposely gone to the library so you wouldn't be interrupted. You have just started writing when your friend comes up and asks you to join him/her for a movie. You know you want to work on your paper.

Friend : Hi, Tom/Sue, how about going to a good movie with me now?

You : _____

Friend : Is it due tomorrow?

You : _____

Friend : Then come on. You have plenty of time to do it.

You : _____

Friend : This is the last night the movie will be showing.

You : _____

Friend : Okay, then.