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Assertion Training Groups: Therapist-Directed and Self-Directed Goal Orientation Methods

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ASSERTION TRAINING GROUPS: THERAPIST-DIRECTED AND

SELF-DIRECTED GOAL ORIENTATION METHODS

by

Lawrence George Jarvis

A dissertation submitted in partial fulfillment
of the requirements for the degree

of

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<div align="right">Lawrence George Jarvis</div>

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ABSTRACT

Assertion Training Groups: Therapist-Directed and

Self-Directed Goal Orientation Methods

by

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Utah State University, 1980

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The present study was designed to investigate the effectiveness

of two methods of goal specification in Assertion Training groups

as assessed by two self-report measures, the Goal Attainment Scaling

process and the Assertion Inventory. An Assertion Training group

method having specific behavioral steps for approaching individualized

goals was represented as the Therapist-Directed Assertion Training

group. The second Assertion Training group was a Self-Directed group

that allowed subjects to independently set and approach their own

goals without the assistance of therapists in setting goals. Sub-

jects were selected from among individuals who volunteered for the

Assertion Training group in response to solicitation in general

psychology classes, newspaper articles and circulars. Of the 76

subjects who filled out registration materials, 63 remained in the

study, with 21 each assigned to the two Treatment groups, and to a

Waiting List Control group. While the Waiting List Control group

participated in pre- and post-screening only, the Treatment groups

underwent four weeks of group assertion training. The Self-Directed
group was essentially encouraged to seek personally relevant goals,
whereas the Therapist-Directed group members, with the help of a
therapist, set up long- and short-range goals, which were monitored
weekly by use of the Behavior Monitoring Progress Record. The level
of assertion as assessed by the dependent measures appeared to be
significantly enhanced by providing the Therapist-Directed group
treatment or to a lesser extent by using the Self-Directed group
method. The rationale for the study as well as the analysis of
differences between groups are presented. Implications of the limita-
tions and results of the present study are related to recommendations
for future studies.

(165 pages)

CHAPTER I

INTRODUCTION

In the last decade, there has been an increasing amount of attention
in the literature to the area of Assertion Training (AT) (Alberti &
Emmons, 1974; Friedman, 1971b; Galassi & Galassi, 1977b; Lange &
Jakubowski, 1976). In the AT research literature it is suggested
that Assertion Training is typically conducted in a group setting and
includes methods such as instructions, general didactics, modeling,
behavior rehearsal, coaching, feedback and other AT program components
(Whiteley & Flowers, 1978). While AT research has emphasized exam-
ination of the effectiveness of complex treatment programs, investi-
gations also have been oriented toward examining the effectiveness
of various combinations of AT components that make up the more complex
Assertion Training packages.

The present investigator was unable to find any reported studies
which have investigated, specifically, the effect of an AT component
specifying individualized goals in a step-wise progression toward
increasing assertion and attaining target behavior(s). However,
Cotler and Guerra (1976) have underscored the importance of more
goal specification as an initial procedural AT component as yet un-
researched as a potential contributing factor in increasing the
effect of AT on assertive behaviors. The necessity and importance
of constructing AT treatment approaches that specify the goals of

each client is suggested and implied frequently in the literature
although no identified research deals with goal specification as a
viable component of AT (Alberti, 1977; Bellack & Hersen, 1979;
Cotler & Guerra, 1976; Whiteley & Flowers, 1978). Considering this
deficit in the literature and consistent with behavior therapy tech-
niques (Salter, 1949; Wolpe, 1958, 1969), Bellack and Hersen (1979)
and Meichenbaum (1978) emphasize the need for assessment of assertive
behavior deficits, thereby, deriving appropriate treatment interven-
tion specific to the needs and goals of the individual. The use of
goal specification derived from assessment procedures would link
assessment to treatment for the first time in the Assertive Training
literature as a viable and effective AT component.

In addition, AT literature has described a nebulous goal specifi-
cation process less frequently noted, although accepted and applied
widely in AT groups and workshops (Booraem & Flowers, 1978; Lange &
Jakubowski, 1976). This procedure allows clients the freedom to
select their own goals and assess their own deficits, thereby direct-
ing their individual AT treatment without specific, direct profes-
sional assistance in delineating and specifying goals. This self-
directed AT procedure assumes clients can assess their assertive be-
havior deficits and develop assertively in the directions and toward
goals they choose for themselves. Although in AT these individuals
are encouraged to seek solutions to assertive deficits and participate
in activities, no attempt is made by the professional(s) to aid in
delineating client's goals. Goals in the sense discussed here take a

purely subjective quality for each participant while the group therapist
functions as group facilitator and leader.

Statement of the Problem

Although the importance of goal setting in behavior therapy and
various methods of achieving this process are suggested in the liter-
ature, investigation of the effectiveness of goal specification and
step-wise approaches to setting goals for members of AT groups has
been largely neglected. The purpose of the present study, then, was
to compare the effectiveness of two methods of goal specification
in AT groups as assessed by two self-report measures. A goal specifi-
cation method using specific behavioral steps for approaching the
individualized goals was warranted as one AT group component. The
second AT group component was a self-directed group procedure that
allowed each client independently to set and approach their own goals
although using the structure of the group and assistance of the
therapists to reach for those goals.

Objectives of the Study

The question to which the present study was directed was: Will
Therapist-Directed as compared to Self-Directed goal setting and
attainment procedures have differing effects on the assessed level
of the subjects' assertive behavior as measured by scores on two
dimensions of the Assertion Inventory (the Degree of Discomfort;
the Response Probability), and scores from Goal Attainment Scaling

(GAS, a goal oriented process and program evaluation system)?

The two goal setting and approach procedures used for this AT group study were designated as Therapist-Directed and Self-Directed methods. The former is a goal setting procedure characterized by an interview to individualize and specify goals in behavior terms, a delineation of possible GAS goal outcome levels, and a specification of step-wise approaches to each goal, with weekly procedures toward acquisition of long-term goals. The Therapist-Directed method requires each subject to meet weekly with a group leader to discuss attainment or performance of the weeks goals and emphasize targeting of each individual's goals for the week to come. Direction to work on identified goals in and out of AT group according to individualized procedures with directions to attain and exceed these goals, if possible, is provided.

The Self-Directed goal setting method is characterized by the same goal identification interview and behaviorally described GAS with delineation of probable levels of goal outcome. Subjects characteristically proceed to approach goals they select independently for themselves during weekly AT sessions. Group AT leaders encourage participants to select goals in and out of AT group to work on. Subjects are encouraged to work on any goals they feel are important or personally relevant. No guidance in selection of personally relevant goals is provided. Subjects are encouraged to attain their personal goals and exceed them if possible.

Hypotheses

Stated in the Null form the following hypotheses were tested:

1. There is no difference in the mean Degree of Discomfort scores among the Therapist-Directed, Self-Directed and Control Waiting List groups.

2. There is no difference in the mean Degree of Discomfort scores for Pretest and Posttest within the two Treatment groups and control group.

3. There are no significant interaction effects between testings, AT treatment groups and the Control Waiting List group with Degree of Discomfort scores.

4. There is no difference in the mean Assertion Response Probability scores among the Therapist-Directed, Self-Directed and Control Waiting List groups.

5. There is no difference in the mean Assertion Response Probability scores for Pretest and Posttest within the two treatment groups and control group.

6. There are no significant interaction effects between testings, AT treatment groups and the Control Waiting List group with Probability of Response scores.

7. There is no difference in the mean GAS scores among the two treatment groups and the control group.

8. There is no difference in the mean GAS scores for Pretest and Posttest within the two treatment groups and the control group.

9. There are no significant interaction effects between testings, AT treatment groups and the Control Waiting List group with Goal Attainment Scale scores.

Definition of Terms

Assertion

The term assertion or assertiveness as used in the present study refers to a psychological construct mainly based on the statement of principles by Robert E. Alberti, and John P. Galassi (Alberti, 1977; Galassi & Galassi, 1977a). According to Alberti (1977), assertion or assertive behavior involves:

> that complex of behaviors emitted by a person in an interpersonal context which express that person's feelings, attitudes, wishes, opinions, or rights directly, firmly, and honestly, while respecting the feelings, attitudes, wishes, opinions, and rights of the other person(s). Such behavior may include the expression of such emotions as anger, fear, caring, hope, joy, despair, indignance, embarrassment but in any event is expressed in a manner which does not violate the rights of others. Assertive behavior is differentiated from aggressive behavior which, while expressive of one person's feelings, attitudes, wishes, opinion, or rights, does not respect those characteristics in others.
>   While this definition is intended to be comprehensive, it is recognized that any adequate definition of assertive behavior must consider several dimensions,
>   A. Intent: Behavior classified as assertive is not intended by its author to be hurtful of others.
>   B. Behavior: Behavior classified as assertive would be evaluated by an objective observer as itself honest, direct, expressive, and nondestructive of others.
>   C. Effects: Behavior classified as assertive has the effect upon the receiver of a direct and nondestructive message, by which a "reasonable person" would not be hurt.
>   D. Sociocultural Context: Behavior classified as assertive is appropriate to the environment and culture in which it is exhibited, and may not be considered assertive in a different sociocultural environment. (p. 367)

In addition, the present study uses the definition of assertion extended by Spencer Rathus (1978) to include, "the antithesis of inhibited behavior" (p. 49) implying an extension of assertive behavior beyond a purely interpersonal context, i.e., positive, productive self motivated behaviors.

AT (Assertion Training)

AT, an approach or method of behavior therapy characterized as either therapist-directed or self-directed.

AT Group

Assertion Training characterized by intervention in a group setting.

Therapist-Directed Group

An AT group wherein each group member's goals are delineated with behavioral steps to attain the goals prescribed in cooperation between the AT therapist and the AT client.

Self-Directed Group

An AT group wherein group members are allowed to select and approach their own goals without goal direction by the AT therapists.

AT Therapist

An AT group leader or facilitator.

Clients

Volunteers selected for AT as subjects after responding to a

request for volunteers who felt they needed AT. Also referred to
as subjects and patients.

AI (Assertion Inventory)

The self-report Assertion Inventory (Gambrill & Richey, 1975).

Degree of Discomfort. A score derived from the AI providing
a self-report index of anxiety relative to specified hypothetical
situations.

Probability of Response. A score derived from the AI providing
a self-report index of the judged probability of engaging in specific
behaviors in hypothetical situations.

GAS (Goal Attainment Scaling)

A systematic process or approach using behavioral methods (Guide
to Goals and GAS Follow-up Guide) to demonstrate attainment relevant
to specific goals within major problem areas, individual specific
and situation relevant (Kiresuk & Sherman, 1974).

Guide To Goals. An instruction manual guiding clients through
identification of areas of concern and development of a GAS Follow-
up Guide (Garwick, 1974a; Kiresuk & Sherman, 1974).

GAS Follow-up Guide. A procedure for identification of concerns
between AT therapist and client, specifying predicted levels of goal
attainment to be checked prior to and following intervention (Garwick,
1977).

Level of Assertion

A client's Goal Attainment Scale score, or AI scores.

BMPR

Behavioral Monitoring Progress Record, a goal monitoring proce-
dure setting weekly subgoals, reviewing, and revision if necessary,
with AT therapist and client in order to monitor GAS progress.

Limitations of the Study

Only individuals enrolled in Introductory Psychology at Utah
State University and/or residing in Cache County, Utah, were selected
as subjects. Although participants identified "home" as a wide
variety of in-state and out-of-state locations, results may have
limited generalizability beyond Cache County, Utah, Utah State
University or this College population. Since the AT groups participated
in an applied therapeutic study, control of content within the treat-
ment groups is problematic. The AT therapists followed procedural
steps presenting didactic and experiential materials in sequence for
each group, respectively. However, group process itself varied
depending upon variability of group discussions and individual inter-
ests. In addition, the AT therapists may have added or deleted
materials from one group session to the next although they rigidly
adhered to the procedures.

Initial group differences may to some extent be attributable to
the selection procedure. Six clients from the control group were
disturbed about not being included in the treatment groups. These
six control clients called numerous times during the study to question
the experimentor or acquire information concerning their own entry

into the AT group. It is interesting to note that other control group clients did not inquire and did not desire to attend the AT groups after termination of the present study, while some did participate.

Initial group differences may have been affected by mortality and resulting subject manipulation for statistical purposes. Each group began with 24 subjects. One subject dropped out of each experimental group and three out of the control. This left groups with 23, 23 and 21 subjects, respectively. In order to achieve the same number of subjects in each group for the intended statistical analysis, two subjects from each experimental group were randomly eliminated from the data analysis, leaving 21 subjects per group.

CHAPTER II

REVIEW OF LITERATURE

The present study follows the lead and recommendations of McFall

and Marston (1970) concerning strategies of research in the investi-

gation of psychotherapy techniques and Assertion Training (AT) in

particular:

> Alternatively, an investigator can follow a <u>constructive</u>
> strategy. In this case, he starts by isolating the most funda-
> mental, or theoretically significant, treatment component, and
> assesses its effects on behavior. Then, building on this base,
> new treatment components are systematically added to determine
> whether they systematically enhance the fundamental treatment
> effects; only the effective components are retained. This
> constructive strategy is most appropriate for studying complex,
> non-systematic techniques that are loosely organized around a
> central treatment mechanism, e.g., behavior rehearsal. One
> advantage of the constructive strategy is that it can lead to
> the development of an empirically based technique which is
> ultimately more powerful than the one initially giving rise
> to the research. (p. 302)

Relevant research related to the isolation of fundamental and signi-

ficant AT treatment components, and assessment of their effects on

behavior is presented in the following review of the literature. The

literature cited in this review has been separated into sections:

(a) the development of AT as a psychotherapeutic approach, (b) the

research investigation of AT component methods, (c) the importance

of goal specificity and approach in AT, and (d) the procedures used

in AT.

AT as a Psychotherapeutic Approach

In his book entitled Conditioned Reflex Therapy, Andrew Salter (1949) made the following statement: "To change the way a person feels and thinks about himself, we must change the way he acts toward others; and by constantly treating inhibition, we will be constantly getting at the roots of his problem" (p. 100). The elimination of inhibitory behaviors and conditioning of "excitatory reflexes" (Salter, 1949, p. 97), with its emphasis on emotional freedom and honesty, is regarded as the beginning of AT as a systematic therapy technique (Cotler, 1975, 1978).

Salter (1949) suggests a sequence of re-educative events in altering the individual's social interaction techniques by removing:

(1) Conditioned inhibitory emotional reflexes by practicing
(2) Deliberate excitatory emotional reactions which become
(3) Conditioned excitatory emotional reflexes. (p. 101)

In order to accomplish the sequence of re-education, he offers six methods to increase excitation: (a) "feeling talk," spontaneous utterance of felt emotions; (b) "facial talk," appropriate affect; (c) "contradict and attack," when you differ express it; (d) "deliberate use of the word I"; (e) "express agreement when you are praised," praise of self can be volunteered; and (f) "improvisation," be spontaneous, don't plan (Salter, 1949, p. 101).

Although Salter initiated the latter methods under the label expressive procedures (Salter, 1949, 1977), Joseph Wolpe subsequently referred to them as assertive (Wolpe, 1958). Salter (1977) takes Wolpe to task over lexicographal differences between expressive and

assertive. He (Salter, 1977) claims definitions of assertion do not include the expression positive emotions. While Wolpe (1969), on the other hand, extends his definition to include these positive expressions.

Semantic differences aside, primary credit for contemporary development of assertion training is generally attributed to Joseph Wolpe (1958) and Arnold A. Lazarus (1966). They regarded non-assertive behaviors as resultants of a history of maladaptive habit formation. From this position Wolpe (1958, 1969) hypothesized that assertive behavior could be initiated with reinforcement and overlearning, while fears and anxieties in normal social contexts and interactions would be inhibited. Assertive or relaxing responses are encouraged and used to compete with the more anxiety related maladaptive responses (Wolpe, 1969). If a response inhibitory to anxiety, i.e., pleasurable or non-aversive, can be made in the presence of the anxiety provoking stimuli, i.e., social contexts or interactions, it will weaken the bond between the stimuli and the anxiety response. Thus, allowing for the learning and production of the appropriate social interaction response, Wolpe's (1969) conceptualization of AT does not differ essentially from that of Salter (1949).

Kelley (1955), Wolpe (1958), and Lazarus (1965) proposed that subjects with deficiencies or inhibitions in their social or inter-personal behaviors be given direct training in more efficient and effective alternative behaviors. Assertive Training fulfills this training need and is considered to be the treatment of choice for

patients exhibiting response deficits in interpersonal relationships
(Wolpe & Lazarus, 1966). When utilizing AT to facilitate learning
of more appropriate response styles, the following diverse treatment
variables can be considered: reinforcement procedures, shaping,
constructive positive feedback, role playing, role reversal, video-
tape practice, homework assignments, verbal and nonverbal response
feedback and training, encouragement, modeling, relaxation and didactic
elements (Fensterheim, 1972; McFall & Marston, 1970; Rathus, 1973;
Wolpe & Lazarus, 1966). Indeed, AT has not developed to a single
crystalized methodology (Cotler, 1973, 1978; Cotler & Guerra, 1976).
At the present, AT remains a therapeutic methodology composed of compon-
ent procedures.

AT Component Methods

As a form of behavior therapy (Wolpe, 1973), AT provides for
the systematic delivery of specific component parts modifiable for
a wide range of individual problems and situations. Although these
components can be provided by therapists on an individual or group
basis, the present emphasis is upon components that can be used within
a group context. Lazarus (1968) gave one of the first descriptions
of group AT methodology. Indeed, investigation of AT components
within AT groups, has provided encouraging results in the literature
demonstrating their effectiveness, flexibility and advantages within
social group contexts (Cotler & Guerra, 1976; Fensterheim, 1972;
Flowers & Guerra, 1974; Lazarus, 1968).

Shoemaker and Satterfield (1977) broke down the multiplicity

of AT group components into four major categories: "1) Instruction,

2) Modeling, 3) Practice, 4) Feedback" (p. 57). These four categories

of AT components are considered in the following order: modeling,

practice, feedback and instruction.

Bandura (1969) used the term vicarious learning to describe the

modeling process. In an AT group, modeling occurs through client

observation of therapists and/or other clients engaged in role play-

ing or otherwise interacting to demonstrate assertive behaviors.

Exposure to modeling presents three different effects indicated by

Bandura (1977) as:

> First, an observer may acquire new patterns that did not
> previously exist in his behavioral repetoire.
> Second, observation of modeled actions and their conse-
> quences to the performer may strengthen or weaken inhibitory
> responses in observers.
> Third, the behavior of others often serves merely as
> discriminative stimuli for the observer in facilitating the
> occurrence of previously learned responses in the same general
> class. (p. 120)

Even with recognition of these three posited modeling effects,

it has been difficult to assess the contribution of modeling to the

AT group process. McFall and Twentyman (1973) indicated that modeling

included, not only modeling, but also accompanying introductions or

descriptions very similar to coaching or instructions. Lacks and

Jakubowski (1975) speculated that modeling to one researcher was

modeling plus additional components to another researcher, i.e.,

modeling plus reinforcement, modeling plus instructions, plus coach-

ing, etc.

Lange and Jakubowski (1976) pointed out modeling in AT groups, typically, was an informal unsystematic method with demonstration provided via a role playing sequence. They (Lange & Jakubowski, 1976) indicated formal use of structured audio and video sequences can provide a more systematic exposure to modeling.

Considering the complexity possible in utilizing modeling, it was suggested to be an effective procedure (Eisler, Hersen & Miller, 1973; Friedman, 1971a; Goldstein, Martins, Hubben, Van Belle, Schaaf, Wiersma & Goedhart, 1973; Hersen, Eisler, Miller, Johnson & Pinkston, 1973; Rathus, 1973). The Eisler, Hersen and Miller (1973) study assigned unassertive psychiatric patients to one of five conditions with 10 subjects in each group: (a) test-retest, (b) practice-control, (c) instructions, (d) modeling, and (e) modeling plus instructions. Subjects were videotaped (pre- and post-) while responding to five interpersonal situations requiring assertive responses. Judges independently rated all subjects on seven verbal and non-verbal components of assertiveness. The results indicated that observation of a videotaped model combined with focused instructions facilitated the acquisition of assertive responses to specific situations.

Rathus (1973) showed that an AT method using videotape mediated assertive models increased self-reported and observed overt assertive behavior significantly with a group of undergraduate college women. Women exposed to the modeling treatment reported less fear of social criticism and incompetence than did the placebo and no-treatment controls. In an earlier study by Green and Marlatt (1972), subjects

were provided instructional conditions: instructions to speak about a specific topic, instructions to talk about feelings in the same topic area, and a no-instructions control group. Half of the subjects listened to a model discussing his feelings in the specific topical areas, while the other half of the subjects received no modeling. Modeling increased significantly the frequency of content statements and feeling statements in the specific topical areas. The modeling influence was most pronounced, increasing the time subjects talked. Green and Marlatt (1972) assumed that the model serves in a generalized manner to structure responses for the subject allowing the subject's perceptions of the situation to determine target responses.

Schinke and Rose (1976) examined possible alternative and effective assertive behaviors using group modeling and other AT components as treatment conditions. The treatment conditions included group modeling, group behavior rehearsal, role playing of assigned behaviors, and group feedback. They (Schinke & Rose, 1976) found subjects receiving these treatments to be significantly more assertive in general in responding to audio-taped role-playing situations, than placebo control groups. However, Rathus (1978, p. 76) criticizes Schinke and Rose (1976) for their failure to use "group means", thus suggesting experimenter bias.

In general, it appears modeling has been effectively used alone and with additional components to effectively alter assertive behaviors. McFall and Lillesland (1971) utilized modeling with prerecorded explicit descriptions of what constituted appropriately assertive

responses in each training session. One half of the subjects received a rehearsal-modeling-coaching treatment procedure participating in overt response rehearsal. The other half engaged in covert rehearsal. The subjects receiving only 40 minutes of the rehearsal-modeling-coaching training improved significantly in assertive-refusal responses on both self-report and behavioral measures. Eldelstein and Eisler (1976) compared a modeling, and a modeling plus instructions and feedback procedure in the social skill training of a male schizo-phrenic patient. Modeling increased affect alone, while the combined modeling-instructions-feedback procedure increased eye-contact, gestures and affect. A similar study with a subject manifesting explosive rages suggested that focusing instructions on target be-haviors facilitated maintenance of assertive changes produced by modeling (Foy, Eisler & Pinkston, 1975). Modeling alone was followed by an increase in hostile and complaint statements nearing pre-treatment levels of aggressive behaviors.

As with the modeling component of AT, the category of practice has been equally difficult to investigate and discriminate effects on assertiveness. The practice category subsumes such activities as behavior rehearsal, role playing, role reversal and other action oriented methods to involve the client in experimenting with or trying-out new modes of behavior. A review of practice activities such as role playing follows.

Interestingly enough, until recently (Alberti, 1977; Alberti & Eoomons, 1974) psychodrama was the most common and widely known form

of role playing (Moreno, 1953). Psychodrama originally was created as a method to assist institutionalized delinquent girls in social skill development. Although not using psychodrama, Sarason (1968) utilized role playing drawn from psychodrama to augment development of appropriate social behaviors in delinquent youth. Role playing was accomplished in pairs with some audio or video recording and playback. Sarason's (Sarason, 1968) use of role playing and that of Prazak (1969) in teaching job interview skills are similar to the role playing used in AT.

Prior to the Sarason (1968) and Prazak (1969) studies in role playing, Lazarus (1966) presented the first investigation of role playing in AT as an "objective clinical appraisal" of this behavior therapy procedure (p. 209). He (Lazarus, 1966) describes an account of a typical procedure for developing assertive behaviors as follows:

> In this method patient and therapist role-played various scenes which posed assertive problems for the patient . . . expressing disagreement with a friend's social arrangements, asking a favour, upbraiding a subordinate at work, contradicting a fellow employee, refusing to accede to an unreasonable request, complaining to his employer about the inferior office fixtures, requesting an increment in salary, criticizing his father's attire, questioning his father's values, and so forth. Commencing with the less demanding situations, each scene was systematically rehearsed until the most troublesome encounters had been enacted to the satisfaction of patient and therapist. The therapist usually role-played the significant persons in the patient's life according to descriptions provided by the latter. The patient's behavior was shaped by means of constructive criticism as well as modeling procedures in which the therapist assumed the patient's role and demonstrated the desirable responses. A situation was regarded as "satisfactorily covered" when (1) the patient was able to enact it without feeling anxious (if he became tense or anxious while rehearsing a scene, deep relaxation was applied until he felt calm again); (2) when his general demeanor, posture, facial expression, inflection in

tone, and the like, lent substance to his words (repeated play-
backs from a tape recorder helped to remove a querulous pitch
from his voice) and (3) when agreement was reached that his
words and actions would seem fair and fitting to an objective
onlooker. In order to expedite the transfer from consulting
room to actual life, the patient was initially encouraged to
apply his newly acquired assertive skills only when negative
consequences were highly improbable . . . He soon grew pro-
ficient at handling most situations that called for uninhibited
and forthright behaviour. (p. 209)

The study this quote is taken from (Lazarus, 1966) compared role

playing with direct advice and a non-directive therapy technique.

Thirty-minute sessions were provided to each subject on a one-to-one

basis with the therapist. If no evidence of change or learning within

one month was found the treatment was judged to have failed. Criterion

for change or learning was objective evidence of behavior adaptation

in the prior problem area. Of the 75 subjects completing the treat-

ment process (25 subjects per treatment), 23 from the role playing

group evidenced change or learning while only 8 and 11 subjects showed

change from the non-directive and advice groups, respectively.

Twenty-seven of the unchanged subjects were subsequently subjected

to the role playing treatment resulting in 22 of these subjects

adapting their behavior problems. Lazarus (1966) suggests that role

playing is significantly more effective in ameliorating specific

social and interpersonal problems than direct advice or non-directive

therapy.

In a 1970 study entitled "An experimental investigation of

behavior rehearsal in assertive training," McFall and Marston com-

pared the effectiveness of behavior rehearsal therapy in AT with and

without feedback to 42 nonassertive college students with two control
conditions, placebo insight therapy and no therapy. Subjects were
presented taped interpersonal stimulus encounters requiring assertive
responses. Subjects practiced or rehearsed responses to the stimuli
which were taped. Some subjects were allowed to listen to playbacks
of their practiced responses while others reflected verbally how
they might improve their responses with more practice. Behavioral,
self-report and physiological measures were taken to assess treatment
effects. None of the measures revealed significant differences be-
tween the two treatment rehearsal conditions. The feedback subjects
showed the highest changes in the behavioral measures of assertion.

In support of the McFall and Marston findings (1970), the Hersen,
Eisler, Miller, Johnson and Pinkston (1973) study, noted earlier in
the modeling section of this review of the literature, confirmed
that practice or role playing in the absence of other techniques
does not lead to change in assertive behavior on either the verbal
or non-verbal dimension. In fact, Flowers (1975) describes AT as a
role playing methodology essentially inseparable from instructions,
modeling, feedback, reinforcement, self-observation and self-evaluation.

In a comparison of six methods of changing the social behavior
of minimally dating males, Melnick (1973) used three groups (control,
traditional therapy, and modeling) employing no role playing and
three groups using modeling plus role playing, modeling plus role
playing plus self-observation, and modeling with role playing plus
self-observation with reinforcement, respectively. Subjects were

rated in response to videotape sequences and in simulated dating interactions. No significant changes were found for the traditional therapy, modeling, or modeling plus role playing groups. However, the modeling- role playing- self-observation group via videotape significantly changed their behaviors becoming more assertive. Therefore, role playing or role playing with modeling may not offer enough feedback and reinforcement alone to bring about change. A combination of methods again presents the most significant effects.

Other researchers have found similar results using behavioral rehearsal or role playing indicating their effectiveness as a component of AT when coupled with feedback, modeling and instructions McFall & Lillesland, 1971; Piaget & Lazarus, 1969). Eisler, Hersen and Miller (1973) found that role playing or practice in the absence of additional techniques in combination are not adequate to alter non-assertive behaviors (Friedman, 1971a, 1971b; Hersen, Eisler, Miller, Johnson & Pinkston, 1973). Flowers (1975) states,

> If one thinks of the therapeutic process as one that involves instructions, modeling, role playing, feedback, external reinforcement, self-observation, and self-reinforcement, role playing may simply be a behavior that increases the effects of instructions and modeling, and may be an event which provides an easily instituted opportunity for various types of feedback and reinforcement. (p. 173)

As with the role playing and modeling components, research into reinforcement effects in AT typically have been in combination with the other components. Reinforcement methods range from tokens, social rewards, video playback to coaching, all used as feedback- reinforcement strategies (Shoemaker & Satterfield, 1977). These

reinforcement methods can be found in the literature in combination with various role playing, modeling and instructional procedures (Flowers, 1975; Flowers & Guerra, 1974; Friedman, 1971a, 1971b; Hersen, Eisler, Miller, Johnson & Pinkston, 1973; McFall & Twentyman, 1973; Piaget & Lazarus, 1969).

The use of token feedback in group AT to increase discrimination between assertive, aggressive and non-assertive subjects' responses is described in a study by Shoemaker and Paulson (1973). White tokens were given for assertive responses, while red and blue tokens were given for aggressive and withdrawal statements, respectively. Group AT with token feedback was effectively used to increase group interaction and reinforce the assertive response style. Paulson (1974), and Flowers, Booraem, Brown and Harris (1974) also found effective token reinforcement of assertive therapeutic interactions in groups.

Another of the reinforcement methods, coaching, has been found to be effective in the AT process. McFall and Twentyman (1973) found role playing and coaching components to provide additive and independent effects to AT. In addition, Flowers and Guerra (1974) found coaching to be an important AT component. They (Flowers & Guerra, 1974) used coaching such as "pointing out errors, suggesting strategy, and actually supplying dialogue to the interactors" (p. 415) in role playing triads. The results of the Flowers and Guerra (1974) study suggest that nonprofessional coaching by a fellow client is superior to coaching by a professional. The Flowers and Guerra

(1974) study, then, concluded that peers coaching other group members provide an extremely helpful source of feedback. Coaching plus role playing or modeling in multiple combinations reveals significant treatment effects over controls (Friedman, 1971a; Hedquist & Weinhold, 1970; Rathus, 1972; Young, Rimm & Kennedy, 1973). Liberman (1970) indicated that the importance of social reinforcers in group treatment is well established and coaching appears to function as such a reinforcer.

The instructional component, too, provides evidence of combinational AT treatment effects. The instructional component may include didactic presentations, discussions, provision of educational materials and goal setting (Shoemaker & Satterfield, 1977). These have been combined in many ways with other component procedures such as modeling, role playing and reinforcement methods as indicated in prior studies described.

In the Green and Marlatt (1972) study discussed earlier instructional conditions were used separately and in combination with modeling. The findings of these authors (Green & Marlatt, 1972) suggest:

> that by imposing some structure and direction for an S, success in eliciting feeling and possibly other verbal responses which seem difficult for Ss to express may be greatly enhanced. As the specificity and explicitness of instructions are increased, the ability of an S to respond is likely to increase regardless of the nature of the particular verbal response class elicited. (p. 196)

An instruction component was used in the previously mentioned Eisler, Miller, Johnson and Pinkston (1973) study that compared five experimental conditions. Instructions and modeling plus instruction

groups served as the two experimental groups. In the instructions alone group, verbal encouragements were given directing the subjects toward longer verbalizations, speaking loudly, increasing eye contact and making sure the role playing opposite understood the verbalized content of the communication as well as the role to be played. The instructions plus modeling group was given a combination of the instructions plus directions to observe the model in order to improve assertiveness. The hypothesis that focused instructions and modeling in combination facilitates the attainment of assertive responses was supported. The Eisler, Hersen and Miller (1974) study provides additional emphasis that practice without modeling and instructions in combination will not lead to verbal or non-verbal changes in behavior.

The 1974 Eisler, Hersen and Miller investigation used instructions and immediate feedback in shaping target behaviors. The results of two single subject designs (multiple baseline techniques) reveal attainment of assertive behaviors. In addition, the authors drew the conclusions that delineating specific areas of deficiency, focusing on those deficiencies and providing training on the specific identified targets provided for the attainment of substantial gains in overall assertiveness. In addition, the relative promise of instructions with immediate feedback as promising techniques in focusing training and improving assertive outcome were emphasized. A study by Foy, Eisler and Pinkston (1975) supported these conclusions when they noted that focusing instructions on specific target behaviors facilitated and maintained changes initiated by modeling conditions.

Goal Specificity and Approach in AT

Another instructional method aside from direct verbal instruction is goal setting and delineation of approach procedures. Cotler and Guerra (1976) indicate that goal identification and approach procedures are extremely important. They (Cotler & Guerra, 1976) employ their own Assertive Training Diary, Assertive Goal Scale and Homework Diary to actively engage clients in seeking and monitoring their own goal approaches and behavior. Related to these record keeping procedures are the use of homework assignments frequently referred to in the AT literature (Alberti & Emmons, 1974; Fensterheim, 1972; Salter, 1949; Wolpe & Lazarus, 1966). Homework is typically assigned in graduated tasks or steps beginning with easier behaviors to perform, progressing to more difficult tasks (Fensterheim, 1972; Wolpe & Lazarus, 1966). Shelton (1977) suggests homework should contain one or more of the following items:

1. A do statement. "Read . . . practice . . . count . . . observe . . . say . . . some kind of thought, action, or emotion."
2. A quantity statement. "Talk three times about . . . spend thirty minutes on three occassions ask 'why' . . . write a list of at least ten."
3. A record statement. "Count and record the number of times you say 'yes' . . . each time he yells, mark your chart . . . whenever the thought comes to you, check your golf counter."
4. A bring statement. "Bring your list . . . the chart . . . your spouse . . . to the next appointment."
5. A contingency statement. "Call for your next appointment after you have done . . . for each time you say 'no' a dollar bill will be deducted . . . each minute you spend thinking about your rights will earn you . . ."

(p. 97)

Michael L. Emmons (1977) indicated a preference for allowing clients to select and pursue their own goals, problems, or homework employing essentially a non-directive method of goal orientation. This non-directive approach to the instructional method of goal setting is noted by Lange and Jakubowski (1976) in unstructured AT groups. These AT groups use role playing directed and focused entirely by the clients. Rich and Schroeder (1976) speculate:

> that improvised response practice may produce greater transfer than does directed response practice. To wit, greater transfer may result from greater responsibility by clients during therapy to devise their own solutions to assertion challenges. (p. 1088)

On the other hand, structured or semi-structured AT groups can be described by the instructional methodology and flexibility of the AT therapists. Lange and Jakubowski (1976), and Shoemaker (1977) present models for instructional methods describing varying therapist-client structured AT groups. These groups vary from and encompass rigid AT groups that are theme oriented with therapist defined content and process to AT groups oriented to client-therapist cooperation in specifying individual and group goals. The differential effectiveness of these groups was not investigated.

It appears that goal setting and approach methodology have not been given attention as a research issue in group AT, although goal setting and approach procedures are recommended (Cotler & Guerra, 1976; Lange & Jakubowski, 1976). Diaries (Cotler & Guerra, 1976; Hedquist & Weinhold, 1970), task gradients (Rich & Schroeder, 1976), and self-monitoring and homework assignments (Cotler & Guerra, 1976; Hedquist & Weinhold, 1970; Rathus 1978) provide generally

unorganized or indirect attention to the basic behavior therapy

procedure of behavioral goal description and task analysis. In

addition, AT research often focuses on one target behavior, response

inhibition, limiting for control purposes the target of AT and the

generalizability of results (Lehman-Olson, 1976). Lehman-Olson (1976)

identified another limitation of AT stating:

> Another criticism of the work done to date on assertiveness
> has been a lack of training using the relationship context
> (Eisler, 1973a; Shoemaker & Paulson, 1974 being the exceptions)
> [Eisler & Hersen, 1973; Shoemaker & Paulson, 1973] or relevant
> personal situations (the subject's own data). Most of the
> studies reported have used standardized training situations
> without regard to actual situations (or types of situations)
> that actually cause difficulties for the subjects. (p. 104)

Lawrence (1970), McFall and Lillesland (1971), and Rich and

Schroeder (1976) noted that AT restricted response classes do not

generalize to other behavior classes. For example, learning to

refuse unreasonable requests will not assist a client in returning

merchandise to a store or expressing his affection toward another.

As Rich and Schroeder (1976) conclude facilitation of behavior

change will occur when detailed target behaviors have been identified

with precision.

AT Assessment Procedures

Many therapists who utilize AT agree that the first step with a

client is to assess the needs of the client and determine his level

of assertiveness (Alberti, 1977; Cotler & Guerra, 1976; Fensterheim,

1972; Galassi & Galassi, 1977b; Jakubowski & Lacks, 1978; Lange &

Jakubowski, 1976). Rathus and others (1978) (Cotler & Guerra, 1976)

indicate that practicing therapists accomplish this assessment by clinical interview. Wolpe (1973) uses a set of five questions to determine the need for AT. If a person is unable to stand up for himself in the context of the questions, Wolpe (1973) recommends AT.

Although in a practical sense a clinical interview alone cannot maintain strict scientific rigor, AT group assessment can be accomplished (Galassi & Galassi, 1977a; Lange & Jakubowski, 1976; Wolpe, 1973). AT group assessment provides for determining a client's need for assertion, progress during AT, change and maintenance of behaviors upon completion of AT. Procedures for assessing progress and change are dealt with briefly in the following review.

Procedures for determining or monitoring progress during AT groups are sparsely reported in the literature. One way recommended to ascertain progress is for the therapist to note the type and difficulty of situations clients are role playing (Lange & Jakubowski, 1976). Hedquist and Weinhold (1970) required clients to maintain daily logs on behaviors previously specified as goal or target behaviors. This is not unlike the homework instructions described in the AT component section of the present paper requiring logs and diaries to monitor progress (Cotler & Guerra, 1976; Fensterheim, 1972; Galassi & Galassi, 1977a, 1977b; Lange & Jakubowski, 1976; Shelton, 1977; Wolpe & Lazarus, 1966).

Another progress monitoring method, the Behavioral Monitoring Progress Record (BMPR), was adapted by Hart (1976) from Austin, Liberman, King and DeRisi's Behavior Progress Record (1974). The

BMPR provides a procedure for deriving goals and monitoring the approaches to these goals weekly. The BMPR was adapted to increase movement toward specified criteria for each client-therapist delineated goal and behaviorally specified homework-type assignments. Each weekly goal set forth a method for attaining specified goals and for assessing the degree of progress toward that goal, i.e. the goals and progress were observable, definable and quantifiable.

Hart (1976) found that patients using the BMPR performed with significantly higher Goal Attainment Scale scores than patients in a treatment group not using the BMPR strategy. The BMPR procedural format provided information and feedback for client-therapist decisions, adjustments and outcome.

The next step from assessing progress during AT group is the assessment of behavioral change as a result of AT group. These procedures for assessing change are discussed in two-broad categories, behavioral measures and self-report measures.

Behavioral measures are created or simulated situations, e.g. audio or video-taped segments of modeled or role played stimuli (Eisler, Miller & Hersen, 1973), or rehearsed live simulations used as stimuli (Whiteley & Jakubowski, 1969), providing an opportunity for subjects to respond to the artificially developed situations. The point is to assess subjects elicited responses to the same set of sequenced situations before and after AT to assess changes (Lange & Jakubowski, 1976). Some simulated behavioral situations developed include those used by McFall and Marston (1970), McFall

and Lillesland (1971), Eisler, Miller and Hersen (1973), Galassi, Galassi and Litz (1974), and Galassi, Kostka and Galassi (1975). McFall and Lillesland (1971) and McFall and Marston (1970) developed a role playing situation test with 14 sequences simulating real life situations. The scenes with subjects' responses were videotaped using a role playing confederate presenting the situation. The tapes typically have been rated on a variety of assertive behavioral performance variables including response latency, loudness of speech, compliance content, request content, assertive affect, overall assertiveness, eye contact, facial expression, body expression, interpersonal space, and Subjective Units of Discomfort Scale (SUDS) ratings (Galassi, Hollandsworth, Radecki, Gay, Howe & Evans, 1976; Hersen, Eisler & Miller, 1973; Serber, 1972).

In assessing changes in level of assertion, ratings of the participants verbal responses have generally been accomplished by using various rating scales. Eisler, Hersen and Miller (1973) recorded pretest/posttest responses to simulated situations and required raters to ascertain whether the subjects' responses were assertive or not. Other ratings of assertive behaviors have had observers rate from 1 to 7 and 1 to 5, respectively, with the higher number being most assertive (McFall & Marston, 1970; Rimm, Hill, Brown & Stuart, 1974).

In addition, Bodner, Booraem and Flowers (1978) described having AT group members identify a collateral person to rate behaviors reported to have occurred outside the group setting. Hedquist and Weinhold (1970) reported utilizing a diary for subjects to report

and describe attempts at assertion. A validity check on 12 of their subjects by the experimenters contacting individuals who could verify the subject's reported behaviors confirmed all of the 12 situations and behaviors claimed. No deceit by the subjects was identified.

The behavioral performance format ultimately developed by Galassi et al. (1974) and Galassi et al. (1975) utilized 10 short live role playing scenes with either a male or female confederate. Five of these situations have been used in pretest measurement while the other five comparable scenes have been used in posttest measurement. This behavioral performance procedure used the following rating variables: (a) verbal assertive content, (b) percent of eye contact, (c) assertive affect, (d) overall assertiveness, and (e) mean SUDS scores.

Galassi et al. (1976) noted subjects identified by the College Self Expression Scale (CSES) as low in assertion could be differentiated from high scorers in assertion on the Behavioral Performance Test (BPT). Galassi et al. (1974) used the BPT and CSES as assessment devices. Subjects who received AT were found to be significantly more assertive than no-treatment controls. A 1-year follow-up (Galassi et al., 1975) with the BPT and CSES on the same samples continued to show experimental groups to be significantly more assertive than controls. Bellack, Hersen and Turner (1978) as well as Bellack and Hersen (1979) suggest role playing assessments consistently lack external validity as there appears to be little correspondence

between role playing assessment and in vivo behavior. Curran (1978)
indicates that role playing assessments use such brief format for
interaction that they fail to sample enough behaviors or situations.
In addition, Curran (1978) and Hersen, Bellack and Turner (1978)
both found role playing assessments of AT effects to place signifi-
cant amounts of stress on AT subjects reflecting elevated heart rate
and anxiety levels. Bellack and Hersen (1978, 1979) suggest that
physiological arousal may well interfere with social skill effective-
ness for some individuals. These authors all agree that role-play
assessment procedures appear to contain too little information to
clarify the situations adequately, place too much demand for instant
spontaneous responses, and unnecessary stress may create sufficient
anxiety to interfere with adequate responses. Bellack and Hersen
(1979) indicate the need for more indepth evaluation of behavioral
role playing assessments in AT before they should be relied upon
heavily.

Although behavioral measures are becoming more sophisticated,
behavioral assessment procedures are not as widely researched or
adhered to in AT practice as are self-reported measures. The primary
methods used to assess behavior change in group AT have been paper-
pencil measures (Rich & Schroeder, 1976). Galassi and Galassi (1976)
note 17 AT self-report inventories in different stages of construction
and use.

The abundance of self-report, paper-pencil AT inventories,
however, does not ensure the adequacy or quality of the instrumentation.

Rich and Schroeder (1976) indicated that the Conflict Resolution
Inventory (CRI) (McFall & Lillesland, 1971) and the Assertion Inven-
tory (AI) (Gambrill & Richey, 1975) are the only two instruments
developed recently to provide acceptable "validity and usefulness"
(p. 1091). They (Rich & Schroeder, 1976) discussed the acceptability
of the CRI and AI referring to the inadequacies of six other recent
inventories: the Wolpe-Lazaraus Assertiveness Questionnaire (Wolpe
& Lazarus, 1966); the Action-Situation Inventory (ASI) (Friedman,
1971a); Lawrence Assertive Inventory (LAI) (Lawrence, 1970); the
Constriction Scale (CS) (Bates & Zimmerman, 1971); Rathus Assertive-
ness Scale (RAS) (Rathus, 1973); and the College Self-Expression
Scale (CSES) (Galassi, DeLeo, Galassi & Bastien, 1974). These instru-
ments were criticized by Rich and Schroeder (1976) primarily for their
inability to demonstrate adequate validity with derivation of items
from the Wolpe-Lazarus Assertiveness Questionnaire presenting confusing
and vague stimulus referrants, no demonstration of a comparison in
their development with external behavioral measures, and in some
cases inadequate reliability coefficients.

Although Rich and Schroeder (1976) criticize the six assessment
instruments, they indicate two devices that do not possess the draw-
backs of the other six, the CRI (McFall & Lillesland, 1971) and the
AI (Gambrill & Richey, 1975). The former focuses upon one subclass
of behavior, refusing unreasonable requests. The CRI contains 35
items related to refusal behavior derived from sampling college stu-
dents, with the inventory being cross validated, and scoring and

content revised on three different samples. McFall and Lillesland

(1971) reported positive correlations with external behavioral mea-

sures (r = .69 and r = .63). Loo (1971) reported in a similar valida-

tion a high positive correlation (r = .82). The CRI satisfies Rich

and Schroeder (1976) as a valid and well-constructed assessment and

screening device. In addition, the CRI satisfies a 1968 review by

Mischel not only focusing on a homogeneous response class, i.e.,

refusing unreasonable requests, but providing the opportunity for

quantification of this assertive behavior.

Although not focusing on a restricted assertive behavior response

class, Gambrill and Richey (1975) developed the AI to sample a variety

of specific situations. This scale attempts to differentiate the

frequency of assertive behavior, the degree of discomfort experienced

in being assertive, and identify those items the client wishes assis-

tance with in becoming more assertive. Lange and Jakubowski (1976)

suggest this instrument lends itself to assessing problems and change.

Instead of one, eight response classes are dealt with: (a) handling

criticism; (b) differing with others; (c) giving negative feedback;

(d) expressing positive feelings; (e) assertion in service situations;

(f) turning down requests; (g) expressing personal limitations; and

(h) initiating social contacts (Gambrill & Richey, 1975). Test-retest

reliability was high (r = .87 and r = .81). Discomfort scores demon-

strated acceptable validity in discriminating unassertive students

and in demonstrating improvement following an AT program. Validity

for the Probability of Response score was not demonstrated. In

addition, Rich and Schroeder (1976) suggested that the scale has

limited validity until cross validation is accomplished between the

AI and a behavioral measure.

Although the AI and CRI are noted by Rich and Schroeder (1976)

as two instruments providing some evidence of adequate validity, they

pointed out the areas of need requiring development in assertion

instrumentation. Rich and Schroeder (1976) state that:

> Although behavior therapists have paid lip service to
> situational determinants of behavior, they have treated
> assertiveness as a trait. Research needs to recognize that
> different response classes and different situations need to be
> treated separately. Being able to say No to the boss appar-
> ently has little transfer to being able to ask him or her for
> a raise or the ability to compliment a friend. (p. 1094)

This statement essentially is supported by Dana Lehman-Olsen (1976)

when she states:

> One of the important limitations of past assertive training
> is that it has almost exclusively focused on one target
> behavior, i.e., social inhibition. (p. 104)

An additional comment by Rich and Schroeder (1976) emphasizes that

assertiveness instrumentation needs to be developed to assess all

response classes and be applicable to various populations.

An instrumentation device that provides the kind of specificity

for targeting behaviors and the opportunity for assessing a wide

variety of behaviors or situational response classes of AT clients

is the Goal Attainment Scale (GAS) system (Kiresuk & Sherman, 1968).

GAS is an accepted and standardized goal specification process for

developing "personalized, multivariable, scaled descriptions: which

can be utilized in outcome research, goal-setting or goal-orientation"

(Kiresuk & Garwick, 1974, p. 3). Besides flexibility, the GAS

procedures include: (a) collection of information about the client;

(b) delineation of specific major areas wherein change is either

helpful or desirable; (c) development of behaviorally specific predic-

tions for outcome levels for each area identified; and (d) scoring

of outcome at the end of treatment segments. An integral part of the

GAS process is the use of the Guide-to-Goals and the GAS Follow-up

Guide for goal orientation. One or more goal or problem areas may be

identified and dealt with for each subject depending on the needs

of the individual. This procedure allows for assessment of change

in one or more response classes.

In considering GAS in terms of the Rich and Schroeder (1976)

review, not only goal flexibility and specificity is provided by GAS,

but acceptable reliability and validity data can be presented.

Sherman, Baxter and Audette (1974) found interrater reliability to

be r = .711 and r = .625 for intake interviewers and therapists,

respectively. Garwick (1974b) and Sherman et al. (1974) suggested

test-retest characteristics of the Minnesota Multiphasic Personality

Inventory (MMPI) and other psychometric personality instruments

compare favorably with the GAS.

Garwick (1974d) indicated the necessity for understanding the

construct validity of the GAS since no adequate criteria are available

for assessing concurrent validity. The original Kiresuk and Sherman

article in 1968 predicted GAS to have a low to moderate correlation

with other outcome measures. He indicated that GAS should differ

from global or change-oriented measures because the GAS is based on
an individualized measurement system and it is specifically goal-
oriented. Therefore, the GAS should not provide a high correlation
with non-individualized measures (Kiresuk & Sherman, 1968). Garwick
(1974d) found GAS correlations to the Taylor Manifest Anxiety Scale,
Self-Rating Symptom Scale and Brief Psychiatric Rating Scale to vary
from less than r = .20 and r = .50. This supports the original specu-
lation (Kiresuk & Sherman, 1968).

The GAS is a highly specific individualized assessment process
or methodology which provides strong positive reliability and accept-
able validity considering its individual specificity. Although it
has not been cited in AT literature to date, it could become a signi-
ficant tool for, not only orienting clients to goals, but also for
measuring outcome (Kiresuk & Sherman, 1968).

Summary of Review

The present review of literature follows the development of
Assertion Training as a psychotherapeutic approach from its origins
to the development of AT as a behavior therapy. Research associated
with the AT component methods of modeling, practice, feedback and
instruction is presented with supporting studies. The importance of
goal specificity and approach in AT is examined and the paucity of
investigations into goal specification procedures is noted. A dis-
cussion of assessment procedures points out the limitations of various
AT assessment instruments, providing support and demonstrating the need
for an instrument assessing change in a variety of behavior classes
which may be individual specific.

CHAPTER III

METHOD

Subjects

Community members from Cache County, Utah, and college students
of Utah State University (USU) were solicited to participate as
subjects for the present study, with the recruitment and selection
of subjects occurring during Fall Quarter 1977. Subjects were selected
from among individuals who volunteered for Assertion Training (AT)
in response to solicitation either in a General Psychology class by
the Experimenters, or in response to newspaper notices and postings
of circulars on the USU campus inviting participants for the free
Assertion Training group to be offered. Notices of the AT program
indicated that the AT group was for individuals who desired to be
more out-going, more assertive in various social situations, less
fearful of social encounters or confrontations, and for those who
would like to improve their interpersonal communication or social
interaction skills. Along with examples of assertive situations,
informational notices indicated that subjects were being sought only
from individuals who wished to work on personal problems with assertion.

Seventy-six subjects filled out registration materials and fol-
lowed through with pre-testing interviews. Four subjects dropped
out immediately after interviewing and before AT began. Each of the
remaining 72 subjects were assigned to their preferences for a parti-
cular meeting time, as follows: Monday 3:30-5:30 p.m., Wednesday

3:30-5:30 p.m. and a "waiting list." Subjects were asked to indicate their first, second, and third choices of a preferred meeting time (group) and as far as possible, individuals were accommodated as to their first preference for assignment to a group. Individuals assigned to the Control Waiting List group were told that after two groups were filled, those on the waiting list would be able to enter either the Monday or Wednesday group if an opening should arise or alternatively, they would be able to attend an AT group Winter Quarter, when a more convenient meeting time might be available.

Twenty-four subjects were assigned to each group. The Monday and Wednesday groups were assigned to different experimental conditions randomly by coin toss. The Monday group was assigned to the Self-Directed group conditions, with the Wednesday group assigned to the Therapist-Directed group conditions. Three subjects dropped out of the Control Waiting List group and one from each of the experimental groups. The vacancies in the experimental groups were not filled because of the loss of the three subjects from the Control Waiting List group. Of the remaining 67 subjects, 57 were female and 10 male.

Subjects were told that AT sessions and assessment data were confidential and would be treated in a secure manner. The subjects were encouraged to keep confidential any personal information from other group members they came in contact with during AT group sessions. In addition, AT subjects were told that they would never be forced to enter into any training activity in which they would not

wish to participate and that they could withdraw from the AT sessions at any time if they desired.

Subjects were also told they would be informed by follow-up letter, after completion of the training and research study, as to the research goals, results and general implications of the study. Finally, after all data had been collected for the study, members of the treatment groups were offered continued training by attending the AT sessions to be conducted for the former control group subjects.

Treatment

The present study utilized two experimental treatments with a single control. The treatments included a goal oriented or Therapist-Directed AT group and a non-directed or Self-Directed AT group. Both experimental treatment groups employed each of the four major AT component categories: Instruction, modeling, practice and feedback (Eisler et al., 1973; Melnick, 1973). These components were combined in live groups for optimum AT effect.

Both groups met for 2-hour sessions, once per week for weeks 3, 4, 5 and 6, with the group sessions following the same general format each of these weeks. During weeks 1, 2 and 7, group members passed through the pre- and post-screening procedures. The formats of the sessions included elements such as a warm-up introductory activity, discussion and feedback of the past week's experiences, theme oriented exercises, modeling demonstrations, general didactic presentations, role-playing periods, and homework assignments.

Individuals in one experimental group received AT with the verbal encouragement to work on any goals they chose, in role playing periods, homework assignments, and during weekly activities. This encouragement occurred during each weekly session, with therapists inviting group members to direct themselves in goal attainment.

In the other experimental AT group, group members cooperated individually with the AT therapists in building Behavior Monitoring Progress Records (BMPR) (Austin, Liberman, King & DeRisi, 1974; Hart, 1976). The BMPR's helped individuals specify weekly, as well as 4-week goals, with each goal graded in step-wise fashion of increasing difficulty toward the attainment of one's overall goal. Each weekly goal's importance was emphasized by specifying the method of attainment and criterion. Within each of the AT sessions, group members were encouraged to seek their agreed-upon goals during role playing periods, as well as to accomplish homework assignments and other weekly activities. Following AT sessions each group member was interviewed briefly to monitor and assess BMPR progress, and discuss any necessary step revisions in the BMPR. Each weekly interview ended with encouragement to seek attainment of goals and acquire behaviors cooperatively prescribed and specified by therapist and individual together.

The use of goal specification or directedness in the AT groups of the present study was based upon the origins of behavior therapy in requiring specification of goals and approach methods, as suggested by the writings of Salter (1949) and Wolpe (1958, 1969). It can be noted, however, that more contemporary uses of AT in groups typically

utilize a less-structured, self-directed goal orientation approach
than the directed approach used in the present study (Alberti, 1977;
Cotler & Guerra, 1976; Lange & Jakubowski, 1976; Whiteley & Flowers,
1978).

All AT sessions were held in the same room of the Student
Union Building at Utah State University, Logan, Utah. The room was
a relatively large, carpeted classroom equipped with moveable and
comfortable seating, with a wall-mounted blackboard.

Measures

The Assertion Inventory

The AT developed by Gambrill and Richey (1975), is a 40-item,
self-report inventory allowing for the assessment of assertion prob-
lems, measurement of change, and identification of specific areas
in which the client would like to behave more assertively. The unique
format of the inventory allows for the collection of these types of
information: (a) the degree of discomfort experienced in specific
assertion situations, (b) the rated probability the client will
actually engage assertively in specific behaviors, and (c) identifi-
cation of specific situations which the client desires to handle
more assertively. The inventory items fall into the following re-
sponse class categories: (a) turning down requests, (b) expressing
ignorance, (c) initiating social contacts, (d) expressing positive
feelings, (e) coping with criticism, (f) disagreement with others,
(g) assertion in service to others, and (h) giving negative or

constructive feedback (Gambrill & Richey, 1975; Lange & Jakubowski, 1976).

In assessing the "discomfort" portion of the AI, the respondent is asked to indicate his/her degree of discomfort or anxiety, using a scale from 1 (no discomfort or anxiety) to 5 (very much discomfort or anxiety). On the portion of the inventory assessing the respondent's expectation of a behavior actually occurring, the respondent is asked to rate the likelihood he/she will display a particular behavior. Here again, the respondent is asked to rate the probability factor on a 1 to 5 scale, with 1 indicating high probability (always do it) and 5 indicating low probability (never do it). It is assumed that appropriately assertive individuals will typically have low discomfort scores and high response probability scores. The total discomfort score appears to be an indicator of potential clinical candidacy, for the therapeutic intervention, delineating by client's report anxiety perceived in various situations. The total response probability score may also be helpful in determining areas where some form of therapeutic intervention would be desirable.

Test-retest reliability with a 5-week interval yielded correlation coefficients for Degree of Discomfort and Probability of Response of r = +.87 and r = +.81, respectively (Gambrill & Richey, 1975). A clinical sample reported by Gambrill and Richey (1975) showed a significant decrease in discomfort scores following Assertion Training, while no change occurred during a 5-week interval in a control-reliability sample. A significant correlation was found between

changes in observer audiotape ratings of discomfort and changes in inventory scores. Inventory scores also differentiated significantly between a "clinical" group and a "normal" population.

Rich and Schroeder (1976) point out that AT validity data demonstrates acceptable validity for the Degree of Discomfort scale, while leaving the Probability of Response scale suspect because of failure to attempt correlational procedures with behavioral measures. Bodner, Booraem and Flowers (1978) point out that the identification of areas of client concern compliments the instrument's applicability to multiple response classes and diverse populations. Lange and Jakubowski (1976) indicated that the AI's format lends itself both to identification of assertion problems as well as assessment of change.

Goal Attainment Scaling

Goal Attainment Scaling (GAS) was developed as an assessment approach for individual clients and most recently used as a goal specification procedure for assessing change in psychotherapy pre- and post- (Hart, 1976; Kiresuk & Sherman, 1968). The GAS model is a systematic goal setting and evaluation process which targets client selected interpersonal and intrapersonal problem areas and identifies or plots these concerns on a grid specified as the GAS Follow-up Guide. The GAS Follow-up Guide specifies behavioral goals and, thus, enables an interviewer to assess the level of a subject's behavioral functioning in each problem area and at any point in time, i.e., before, during and/or after treatment. Behavioral expectations set five levels of predicted goal attainment, from the most unfavorable

outcome considered likely to the most favorable outcome likely.
Essentially, the interviewer and client identify goals, set expecta-
tions for the client's attainment, assess behavioral functioning at
the time of the interview and eventually allow for assessment of
change after treatment. The computed GAS score, thus, provides a
qualitative and quantitative index as a measure of outcome or level
of goal attainment in terms of behavioral goals agreed upon in the
previous goal setting interview.

The GAS Follow-up Guide yields a single score (Goal Attainment
Scale score) based upon the equal weights of the scales (Kiresuk &
Sherman, 1974). A change score can then be derived from pre- and
post-assessment of a client's assessed levels of behavioral function-
ing and goal attainment. This score is used to reflect whether or
not therapy succeeds in accomplishing what it proposed to accomplish.

In the first reliability study with the GAS, Sherman et al.
(1974) used two independently constructed GAS Follow-up Guides for
each subject, yielding correlation coefficients of $r = +.70$ and
$r = +.63$ for therapists on two interviews. In a similar study com-
paring scoring by nurses versus social workers, a correlation of
$r = +.65$ was attained between the first and second interview (Sherman
et al., 1974). Garwick (1974b), using videotaped interviews and
multiple rater scorings, found a correlational coefficient of $r = +.71$,
which was similar to the reliability reported in the study by Sherman
et al. (1974), in which two interviews by intake workers produced
an $r = +.70$.

Construct validity studies have supported the basic construct underlying GAS, i.e., "outcome or attainment of expectations" (Garwick, 1974d, p. 5). In his 1974 study Garwick (1974d) found the GAS score not significantly related to age, sex, education, marital status or intelligence. Low to moderate correlations have been reported, however, between other outcome measures and the GAS. For example, Mauger, Audette, Somonini and Stoelberg (1974) found somewhat low to moderate correlational results ($\underline{r}$ = +.14 to $\underline{r}$ = +.32) between Minnesota Multiphasic Personality Inventory (MMPI) scores and GAS scores, thus, providing more supportive data for the construct validity of the GAS. GAS scores between pre- and post- showed improvement in 85% of the subjects. Concomittantly, the MMPI scores revealed alterations pre/post in the direction of increased psychological health as interpreted by Mauger et al. (1974).

Garwick (1974e) correlated the GAS with the Self-rating Symptom Scale, Brief Psychiatric Rating Scale and the Taylor Manifest Anxiety Scale, yielding low to moderate coefficients ranging from $\underline{r}$ = .20 to $\underline{r}$ = .52. Kiresuk and Sherman's (1968) observation that GAS scores should correlate from low to moderate levels with current outcome measures has been consistently corroborated. In fact, Hart (1976) and Kiresuk and Sherman (1968) concluded the GAS relationship to other measures on the basis of the following rationale:

> (a) Since the Goal Attainment Score is based on an individualized measurement system, it should not have a high correlation with non-individualized measures, and (b) since it is specific and goal-oriented, it should differ from global or change-oriented measures even when they are individualized. (Hart, 1976, p. 34)

Further, Hart (1976) found the validity of the client's self-
reports to be high and that a correlation between client and col-
lateral posttest GAS measures provides evidence of a positive relation-
ship between client and collateral observation (r = +.88). Seventy-
eight percent of the variance was explained by the client GAS scores.
This is consistent with Hedquist and Weinhold's (1970) collateral
validation in their AT study whereby a perfect relationship existed
between client self-report and collateral observations of behavior.

Behavior Monitoring Progress Record

Austin et al. (1974) developed a goal-oriented behavioral progress
record (Behavior Monitoring Progress Record, BMPR) at Oxnard Day
Treatment Center in California. In examining the weekly goals set
for their mental health clinic patients, they (Austin et al., 1974)
found these goals did not correspond to the long-range goals or the
Goal Attainment Scale Follow-up Guide goals. In order to facilitate
monitoring and coordination of short- and long-range goals, short-
term goals presenting successive approximations to intermediate and
subsequent long-range goals were developed.

Austin et al. (1974) eliminated the use of GAS scoring and
prediction with the development of a Monthly Behavioral Progress
Record (MBPR). Each MBPR was designed to use for a 4-week period,
with long-range goals determined in advance and noted at the top
of the form. Four-week goals noted on the MBPR represented a clinical
judgment as to desired behavior by the end of the 4-week period.
With the 4-week goals set in a column fashion above the weekly goals,

behavioral specificity was applied and maintained in both sets of goals. As weekly goals represented successive approximations to 4-week goals, check marks made by clinical staff in weekly goal boxes on the MBPR indicated goal attainment by the patients. In addition, a space for method of goal was provided. Austin et al. (1974) reported that use of the MBPR was successful in linking short- and long-range behavioral goals of patients. A better understanding of goals by patients and staff was also achieved through use of the MBPR, with a corresponding increase in accuracy and ease of record keeping. Seventy-five percent of client goals were reported as attained during the period of time the MBPR was in use.

Success with the systematic procedure noted above (use of the MBPR) prompted the development of an educational workshop which was behaviorally based and structured by therapists to assist clients in acquiring skills needed to return to the community (Austin et al., 1974). Topics covered in the workshop included personal grooming skills, personal finances, current events, ethnic exchange, family relationships, and interpersonal skills. Austin et al. (1974) indicated that the therapists structured, operated, monitored and systematically evaluated the workshop and client progress using built-in performance criteria and the MBPR procedures. In effect, this format, with behavioral goal-orientation and record keeping, presented a new treatment approach for day care and educational skills workshops.

Hart (1976) adapted the BMPR from Austin et al. (1974) for the purpose of weekly monitoring of patient's behavior in a mental health

center. He also re-designed the BMPR as a treatment instrument as a possible means of increasing movement of the patient and the therapeutic process toward specified treatment goals. In this way, the BMPR was used as a goal setting procedure for shaping and monitoring patient movement toward therapeutic goals.

Hart's BMPR (Hart, 1976) is similar to the Austin et al. MBPR (see Figure 1, p. 51). However, Hart (1976) provided for the determination of patient goals in collaboration with patients, while the procedure used by Austin et al. (1974) had the patients' treatment goals, both short- and long-range, specified by the therapist or staff member unilaterally. In addition, Hart delineated 4-week goals that were observable, definable and measureable, as well as collaborative specification of methods that were step-wise and obtainable for patients. Therapists also met with patients weekly to discuss and monitor patient progress in terms of the BMPR (Hart, 1976).

The results of Hart's study showed that individualizing, behavioralizing, and monitoring patient progress toward specified goals provides measureable outcome indices (Goal Attainment Scale scores, GAS scores) that are sensitive to the uniqueness of each patient and his or her problems. In addition, behaviors considered not relevant to treatment or collaboration may be excluded temporarily or ruled out altogether as far as any need for measurement. According to Hart (1976) some implications for use of the BMPR and GAS as an intrinsic part of treatment are that they are:

(a) as a means for initial as well as ongoing collection of information; (b) an aid in organizing and recording the process

BEHAVIORAL MONITORING PROGRESS RECORD

NAME _____ THERAPIST _____ DATE OF 1ST SESSION _____

SEE SCALE HEADINGS ON FOLLOW-UP GUIDE	Unhappy with present employer	: Feels "dishonest, phony, playing games, can't be self	Doesn't stand up for rights	Avoids interpersonal relationships

MAJOR PROBLEMS &/OR COMPLAINTS

4-WEEK GOALS

PROJECT FROM CLIENT STATUS AT INTAKE	Find new employment that is stimulating and has career opportunities	To begin to feel it's safe to say what you feel with some people	Be assertive at least once a week	To be involved in one or two friendships or confidences

BE SPECIFIC, OBSERVABLE &/OR TASK-ORIENTED   **WEEKLY GOALS:**

Week of 3-1	Goal:	Investigate job market	Express concern of living at home with father	To assert self	Socialize with girls at church
	Method:	Two job interviews	Communication - time and place	Return wrong size dress	Go on outing
Week of 3-2	Goal:	Investigate job market	Discuss and identify two problems living at home	To assert self	Become acquainted with Marge
	Method:	Two or more job interviews	Communication - Bring father in	Collect $30 loan from Sheryl	Call Marge for lunch date
Week of 3-15	Goal:	Review list of questions with Mrs. J.	Express anger openly - say & do what you feel	To assert self	Say what you feel - speak honestly
	Method:	Set up appointment	"Let it out"	Request $600 in salary from Mrs. J	Communication
Week of 3-22	Goal:	Choose between two attractive job offers	Same as above	To assert self	Go out on double-date with Marge and friends
	Method:	Therapy - Rank, prioritize and weight - make decision	" " "	Name 3 major incidents last week in which you asserted self on own.	Call Marge for O.K. on double date

NOTES _____

Figure 1.   The Behavioral Monitoring Progress Record (Hart, 1976, p. 44).

of therapy; (c) a design for treatment that is adaptable to
various types of outpatients; (d) a feedback device for the
patient in determining strengths and weaknesses; (e) an outcome
effectiveness measure; (f) a monitoring device for ongoing
evaluation of treatment progress or the lack of it; and
(g) an assessment device to help determine what the patient's
behavioral deficits or excesses are, which provides new data
for realistic goal-setting. (1976, p. 63)

In keeping with the recommendations of Hart (1976), the present
study utilized the BMPR as determined by therapist-client collabora-
tion. An additional space for noting the "criterion" was added in
the lefthand column immediately below the "method" of goal attain-
ment in order to further clarify, more specifically, what the client
was to do to meet the expected criterion behavior. For example,
a weekly goal might be detailed on the BMPR as follows: (a) problem--
passivity; (b) weekly goal--assert self twice this week; (c) method--
say "no" to an unreasonable request and talk to one person you have
never met; (d) criterion--account for these incidents in diary, make
a verbal report to therapist giving name of person and description
of both interactions, and report the interview to group (Hart, 1976)
(see Figure 2).

Guide to Goals

The Guide to Goals, format I, is a programmed instruction manual
designed by Geoffrey Garwick (1974a, 1977) as a method for directing
patients through construction of their GAS Follow-up Guides. This
step-by-step procedure saves clinical time and allows the client to
assume responsibility in setting his/her own goals.

Garwick (1974c) indicates that patients in a day care mental
health facility showed significant gains in meeting their goals through

BEHAVIORAL MONITORING PROGRESS RECORD

Name _____ Interviewer _____ Date _____ Code No. _____

MAJOR PROBLEMS &/OR COMPLAINTS

SEE SCALE HEADINGS ON FOLLOW-UP GUIDE				

4-WEEK GOALS

PROJECT FROM CLIENT STATUS AT INTAKE				

BE SPECIFIC, OBSERVABLE &/OR TASK-ORIENTED

WEEKLY GOALS

	Goal:				
Week of	Method:				
	Criterion:				
	Goal:				
Week of	Method:				
	Criterion:				
	Goal:				
Week of	Method:				
	Criterion:				
	Goal:				
Week of	Method:				
	Criterion:				

Figure 2.   The Behavior Monitoring Progress Record, Adapted.

use of the Guide to Goals format as compared to a group of control
subjects ($\underline{N}$ = 80) who did not use the programmed guide. Ninety-five
percent of all Follow-up Guides written by patients had to be negoti-
ated with a therapist or interviewer (Stelmachers, 1974) as a means
of maintaining quality assurance for the GAS in follow-up. Stel-
machers (1974) reported that negotiations were typically short and
reflected the quality and ability of patients to develop relatively
good Follow-up Guides. Similarly, Jones and Garwick (1976) found
in their study that although the mental health patients appeared
very pessimistic about outcome, the use of patient constructed
Follow-up Guides from the Guide to Goals format contributed to im-
proved consumer satisfaction and higher Goal Attainment Scale scores.

The purpose of using the Guide to Goals in the present study
was to orient clients to setting and specifying goals, and involve
them more fully in the goal construction process. All clients read
the Guide to Goals and Goal Attainment Scale Follow-up Guides prior
to meeting with the AT therapists for collaboration, negotiation
and specification of individual goals.

Procedures

Initial Screening, Pretest

During week 1 of this study, subjects were invited to register
for AT by filling out a packet of screening materials provided by
the secretary in the Psychology Department Counseling Lab at Utah
State University (USU). Each subject was assigned a registration

number. Subjects were asked to fill out demographic information

forms, read and sign an understanding of the research and an agreement

to participate. In addition, they were asked to complete the demo-

graphic materials and the Assertion Inventory (AI) prior to leaving

the registration session. The last item in the packet was the Guide

to Goals which they were asked to fill out following the orientation

instructions and to bring it with them the following week for their

initial interview (See AT group procedure schedule, p. 57).

Interviews with the AT therapists were assigned by appointment,

which were made through the secretary of the Psychology Department

Counseling Lab. Individual interviews were scheduled between 8 a.m.

and 9 p.m., Tuesday through Saturday.

Interviews were held in regular counseling rooms of the USU

Psychology Department counseling facilities. The initial portion

of the interview reviewed for each subject the process and content

of the AT group, including discussion of role playing, modeling,

instructions, readings, activities and didactic presentations. This

orientation to AT group was followed by a review of the self-constructed

Goal Attainment Scale Follow-up Guide. AT therapists negotiated

goals and levels of expectation with each subject, specifying behavi-

oral goals, quantifying and making provision for realistic attainment

of each subject's goal(s) by the end of the 4-week AT group. AT

therapists filled out an intake status form which reproduced the

Follow-up Guide in miniature to allow for recording of the status

of the subject on a separate record form from the GAS Follow-up Guide

(see Appendix B, Status at Intake Form).

Determination of the particular group that subjects would attend was accomplished after completion of the GAS phase for each client. All clients had been assigned to a group based upon ability to attend at specified group times. A coin toss determined which group was to be identified with which experimental conditions. Group members' names were looked up on a list specifying their group. Clients falling into the Self-Directed group were allowed to leave, while subjects identified as belonging to the Therapist-Directed AT group remained to construct a personal BMPR. The subjects identified as members of the Therapist-Directed group, then, negotiated and constructed BMPR's, specifying realistic and attainable goals, methods, and criterion of attainment. As each weekly goal was set, clients were repeatedly asked to be sure the goals, methods, and criterion specified could be attained within the week. Therefore, with the assistance of the therapist, clients determined what weekly steps toward long-range goals they individually would seek, with emphasis placed upon attainability. The Therapist-Directed subjects were told to work on their weekly goals with the intent to attain or exceed each of their specified 4-week goals. They were also instructed to meet with the AT therapists following each AT group session to discuss and review their progress.

Essentially both Therapist-Directed and Self-Directed groups proceeded through the same initial screening, with the differences being that the Therapist-Directed group constructed a BMPR, actually specified goals in writing along with projected weekly successive

approximations of those goals, and were instructed by the therapists
to achieve or exceed these expectations. On the other hand, the
Self-Directed group was instructed only to work on any personally-
relevant assertion goals they chose (see AT Group Schedule and Pro-
cedure).

Two graduate students in psychology, one male and one female,
conducted the interviews, GAS Follow-up Guide construction, and
BMPR construction. Both graduate students were familiar with GAS
procedures and Follow-up Guide construction, as well as use of the
intake status forms used to record level of functioning at intake.
The graduate students were kept naive as to the AT group assignment
of subjects until after the GAS Follow-up Guide had been constructed.

AT Group Schedule and
Procedure

I. The initial screening of clients occurred during session I,
week 1.

    A. Clients registered with the secretary and received a screen-
       ing packet containing consent forms, screening material,
       instructions and registration number.

    B. Clients completed and turned the Assertion Inventory (AI)
       and information forms in to the secretary prior to leaving
       the Counseling Lab.

    C. Clients signed up for scheduled appointments with an AT
       therapist for a screening interview.

D. Clients filled out the Guide to Goals in the interim, in order to develop the Follow-up Guide themselves prior to the screening interview.

E. AT therapists examined the clients' AI's and demographic information forms prior to their interviews, so as to identify concerns of the respective subjects, and to be aware and familiar with each subject's background, concerns and goals, as a basis for maximizing the benefit of the therapist-subject interviews.

II. Clients were seen for the screening interviews during session II, week 2.

A. Each client's individual interview began with an orientation to assertion, the AT group, and also to the planned procedures of role playing, modeling, coaching and therapist encouragement to practice assignments.

B. Each subject and therapist jointly examined the subject-constructed GAS Follow-up Guide.

C. Therapists' collaborated with subjects in the construction of individual GAS Follow-up Guides using the subject-constructed Follow-up Guide and items identified by the subject as areas where he/she would like to become more assertive.

D. The AT therapist observed the status of problems or concerns on the intake record form.

E. The therapist and client developed specific predictions for

a series of outcome levels for each major problem area on
the Goal Attainment Scale Follow-up Guide.

F. Subjects were each assigned at this phase of the interview
to either the Therapist-Directed or Self-Directed AT group
and were informed of the AT group meeting time and place
to which they had been assigned.

1. Individuals who had been assigned at this phase of the
interview to the Self-Directed AT group were excused
from the screening interview.

2. Individuals who had been assigned to the Therapist-
Directed AT group remained in the interview for more
specific goal direction.

a. Individuals included in the Therapist-Directed AT
group were assisted by a therapist in translating
the 4-week goals from client problems on the GAS
Follow-up Guide to the BMPR, establishing weekly
goals, methods, and criteria for each client.

b. Therapist-Directed AT group subjects retained a
copy of their completed BMPR.

c. Therapist-Directed AT group subjects, then, were
instructed to attain or exceed, not only their weekly
BMPR goals, but also their agreed-upon 4-week goals.

AT Group Methods

Prior to each AT group session, subjects were randomly assigned to either the male or female therapist for subgroup activities. This assignment was made by random selection of subject enrollment numbers assigned to them previously when they first registered for the group. Both subgroups met in the same room, and the AT therapists assisted each other in large group discussions, demonstrations, and general didactic presentations. However, each therapist was responsible for assisting his/her assigned subgroup in the subgroup and individual activities. Each AT group session lasted approximately 2 hours, with four such sessions per treatment group over a period of 4 weeks. Subjects who could not attend a particular session during the 4-week period were offered a time for a make-up session. Subjects who missed sessions were contacted the same day to ensure regular attendance and to guard against a high incidence of subject drop-out during the study.

All sessions were followed by a 30-minute relaxation exercise session administered by the AT therapists for interested subjects. Relaxation procedures were used as an anxiety reducing and inhibiting method as often noted in the literature (Cotler & Guerra, 1976; Lange & Jakubowski, 1976). Six Therapist-Directed AT group members attended three of the relaxation sessions, while two Self-Directed AT group members attended one relaxation session.

I. Clients attended the first AT group session during session 3, week 3.

A. Both AT groups were provided with different goal orienta-
    tions during initial stages of their groups.

    1. The Therapist-Directed AT group subjects were directed
        by the therapists to work on their BMPR goals and to
        work toward either attaining or exceeding them.

    2. The Self-Directed AT group subjects were instructed
        to work on any personally relevant goals they chose
        and to work toward attaining or exceeding them.

B. Confidentiality was discussed with each AT group, emphasiz-
    ing the importance of keeping information about personal
    and group activities within the AT group.

C. All AT group members were told they did not have to parti-
    cipate in any activities they did not want to and could
    withdraw at any time.

D. In each group, subjects participated in a get-acquainted
    activity as a warm-up exercise, with group members at least
    exchanging names.

E. All AT group members were given a didactic presentation by
    AT therapists which included a definition of assertion,
    information on the passivity-assertion-aggression continuum,
    reasons for acting assertively, reasons why people act non-
    assertively or aggressively, the consequences of non-assertion
    or aggression and the Ten Assertive Human Rights (Smith,
    1975), followed by a discussion.

F. The AT group therapists also provided both AT groups with a discussion of AT group techniques, such as explicit instructions, role playing, modeling, and homework practice assignments.

G. The AT therapists discussed and modeled nonverbal dimensions of behavior including the following: eye contact, voice volume and tone, posture of body and head, facial expressions, gestures, and use of space.

H. The AT therapists instructed group members to use and practice a group role playing activity using multiple triads (observer, identified subject, target person) and personally relevant material.

I. The therapists provided time for practice of personally relevant social interactions in the role playing triads, with therapist observation and assistance.

  1. The Therapist-Directed AT group members were directed to work toward attaining or exceeding BMPR goals during the role playing period.

  2. The Self-Directed AT group members were directed to work toward achieving or exceeding any of their goals which were personally relevant.

J. The AT therapists gave all group members a homework assignment to read from handout material on assertion, to practice outside of group, and to be aware of the verbal and nonverbal dimensions of assertion (see Appendix E).

1. The AT therapists encouraged both AT groups to practice
   and be aware of eye contact and other nonverbal behaviors
   in the interim week.

2. In addition, the AT therapists instructed subjects to
   be assertive during the coming week.

   a. The AT therapists instructed Self-Directed AT group
      members to work on personal goals during the week
      and to work toward attaining or exceeding those
      assertion goals.

   b. The AT therapists met individually with Therapist-
      Directed AT group members to instruct them to work
      on their BMPR goals and to work toward attaining
      or exceeding their 4-week goals.

II. The AT therapists and each group of subjects participated in AT
group during session 4, week 4.

   A. Each AT group differed in the type goal orientation pro-
      vided during the initial portion of session 4.

      1. In the Therapist-Directed AT group, subjects were in-
         structed to work on their BMPR goals and to work toward
         attaining or exceeding them.

      2. In the Self-Directed AT group, subjects were instructed
         to work on any personally relevant goals they chose
         and to work toward attaining or exceeding them.

   B. Each AT group participated in an opening warm-up exercise,
      a listening skill activity, with participants paired back

to back during the initial part of the communication activity and subsequently, face to face, with eye contact, visual cues and touching (hand, arm, leg, etc. was used to experience effect on communication).

C. Each AT group was provided with a discussion of the past week's experiences with the verbal and nonverbal dimensions, an opportunity to give feedback about eye contact homework assignments, and an opportunity for group brainstorming to generate alternative ideas to assist clients with their experiences, providing an opportunity to receive and give verbal praise for successful assertive attempts or approaches.

D. Both AT groups participated in self-disclosure and listening skills exercises, with feedback on the verbal and nonverbal dimensions, emphasizing congruity, giving information, identifying and using free information, and reflecting and questioning (how, what, why).

E. Both AT groups were exposed to modeling exercises by the therapists, demonstrating assertive, non-assertive, aggressive, and passive-aggressive interaction styles.

F. Both AT groups were given by the therapists a discussion on giving/receiving compliments, affect messages, positive feedback, and constructive feedback.

G. Both AT groups participated in an activity which emphasized giving and receiving compliments.

H. Both AT groups practiced personally relevant social encounters
    or interactions in role playing triads.

    1. During the role playing segment, Therapist-Directed
        AT group members were instructed by the therapists
        to work toward attaining or exceeding BMPR goals.

    2. During the role playing segment, Self-Directed AT
        group members were instructed by the therapists to
        achieve or exceed any personally relevant goals they
        chose.

I. Both AT groups were given by the therapists a homework
    assignment to read handout materials on assertion (see
    Appendix F), practice giving and receiving compliments,
    affection messages, positive feedback, and self-disclosure
    and listening skills.

    1. Both AT groups were encouraged to practice any additional
        skills they discussed or role played in the AT group
        beyond the homework assignment.

    2. Both AT groups were instructed to be assertive during
        the next week.

        a. The Self-Directed AT group was instructed to work
            on personally relevant goals during the week and to
            work toward attaining or exceeding their assertive
            goals.

        b. The Therapist-Directed AT group members met indivi-
            dually with an AT therapist to monitor progress and

instruct each subject to work toward attaining or
exceeding their weekly BMPR goals.

III. The AT therapists and each group of subjects participated in
AT group during session 5, week 5.

   A. Each AT group differed in the type of goal orientation
      provided during the initial portion of session 5.

      1. In the Therapist-Directed AT group subjects were instructed
         to work on their BMPR goals and to work toward attaining
         or exceeding them.

      2. In the Self-Directed AT group, subjects were instructed
         to work on any personally relevant goals they chose and
         to work toward attaining or exceeding them.

   B. Each AT group participated in an opening warm-up exercise,
      with clients in triads attempting to communicate feelings
      or moods with each other using nonverbal cues exclusively.

   C. In each AT group, therapists led a discussion of group
      member's experiences and homework assignments in the last
      week, accompanied by verbal reinforcement for accomplish-
      ments and group brain storming on problems members had
      encountered.

   D. Each AT group was provided by the therapists with a dis-
      cussion and modeled example of three of Manuel Smith's
      (1975) systematic assertion skills and a discussion of the
      care which needs to be takn in applying these skills sensi-
      tively in interaction with others.

1. Each AT group was presented a discussion by the therapists of Smith's (1975) broken record technique and a modeled sequence, with one therapist attempting to borrow the other therapists car, followed by a role playing period to practice the technique in triads.

2. Each AT group was provided with a discussion and demonstration by the therapists of the fogging technique (Smith, 1975), followed by triad role playing of this technique by all group members.

3. Each AT group was provided by the therapists with a discussion and modeled demonstration of the negative inquiry technique (Smith, 1975), typically used in response to criticism, followed by triad role playing of this technique by all group members.

E. Each AT group was given by therapists a discussion of "I" messages versus accussatory "you" messages, followed by therapist-modeled examples and role playing in triads, emphasizing acceptance of responsibility through use of "I".

F. Both AT groups practiced personally relevant social encounters or interactions in role playing triads.

1. During the role playing segment, Therapist-Directed AT group members were instructed by the therapists to work toward attaining or exceeding BMPR goals.

2. During the role playing segment, Self-Directed AT group members were instructed by the therapists to achieve or exceed any personally relevant goals they chose.

G. Both AT groups were given by the therapists a homework assignment to read handout material on assertion (see Appendix G) and practice using the broken record, fogging and negative inquiry assertive skills, with caring and "I" messages, where appropriate.

    1. Both AT groups were encouraged by the therapists to practice in the coming week those assertive skills discussed and role played in AT group.

    2. Subjects were instructed to be assertive in the coming week.

        a. The Self-Directed AT group was instructed to work on personally relevant goals during the forthcoming week and to work toward attaining or exceeding their assertive goals.

        b. The Therapist-Directed AT group members met individually with an AT therapist to monitor progress and instruct each subject to work toward attaining or exceeding their weekly BMPR goals.

IV. The AT therapists and each group of subjects participated in AT group during session 6, week 6.

    A. Each AT group differed in the type of goal orientation provided during the initial portion of session 6.

        1. In the Therapist-Directed AT group, subjects were instructed to work on their BMPR goals and to work toward attaining or exceeding them.

2. In the Self-Directed AT group, subjects were instructed to work on any personally relevant goals they chose and to work toward attaining or exceeding them.

B. Each AT group participated in an opening warm-up exercise, using a positive strength bombardment activity to emphasize identifying and accepting complimented strengths.

C. In each AT group, therapists led a discussion of group members' experiences and homework assignments in the last week, accompanied by verbal reinforcement and group brain storming on problems members had encountered.

D. In each AT group, the therapists presented a discussion of two of Smith's (1975) assertion techniques, negative assertion and workable compromise, and Galassi and Galassi's (1977a) information on making and refusing requests, with therapist modeled demonstrations, followed by a role playing period.

E. In each AT group, the therapists presented a positive self-statement activity, providing an opportunity for subjects to accept responsibility for their strengths, skills and abilities, with these positive self-statements condoned and accepted by other group members.

F. In each AT group, members were given a period of time to role play in triads avoiding attempts by others to manipulate them with supposedly unreasonable requests.

G. Both AT groups practiced personally relevant social encounters or interactions in role playing triads.

1. During the role playing segment, Therapist-Directed
   AT group members were instructed by the therapists to
   exceed their BMPR goals.

2. During the role playing segment, Self-Directed AT
   group members were instructed by the therapists to
   achieve or exceed any personally relevant goals they
   chose.

H. Both AT groups were given a termination, AT group and asser-
tion summary emphasizing the need to continue striving to
be assertive, plus the final set of reading material (see
Appendix H).

1. The Self-Directed AT group was instructed by the
   therapist to continue striving for their personal goals
   and to work toward being assertive.

2. The Therapist-Directed AT group was instructed by the
   therapists to continue striving to attain or exceed
   their BMPR goals, preceded by monitoring the BMPR
   progress to goals.

I. Both AT groups were reminded by the therapist of the post-
screening session and interview.

V. The AT therapist and each group of subjects participated in the
AT group post-screening session and interview procedure, during
session 7, week 7.

A. Both AT groups completed post-test measures (AI, and a
consumer satisfaction questionnaire) in a group setting in

the University Lounge, Utah State University, where tables
and comfortable seating was provided.

B. Immediately after completing the AI, each AT group member
    in cooperation with an interviewer participated in a follow-
    up interview to attain subjects' impressions, a critique and
    self-assessment of assertion level.

    1. As AT subjects completed AI post-screening, the inter-
        viewers alternated or took turns interviewing subjects.

    2. Each interviewer was naive as to the object or experi-
        mental procedures of the Assertion Training and as to
        which subjects were from the experimental or control
        groups.

    3. Each interviewer was familiar with the GAS Follow-up
        Guide, how ratings were derived and what the five levels
        represented.

    4. Each interviewer was familiar with how to determine
        present level of functioning on the Follow-up Guide.

    5. Each interviewer was familiar with what and how to
        record their status at post-screening forms and how to
        follow the interview outline.

        a. Interviewers followed a list of steps and questions
            (see Appendix C for post-screening and interview
            format), and recorded from AT subjects the informa-
            tion on a record sheet and status at follow-up
            post-screening form.

b.   Interviewers terminated the interview with AT sub-
jects by offering a consumer satisfaction and critique
form to fill out, if clients chose to.

c.   While one interviewer was assessing status of AT
subjects at follow-up (item 4 on the interviewers
format), simultaneously the second interviewer was
making the same follow-up assessment using the GAS
Follow-up Guide and answers to the format questions.

C.   AT subjects were contacted by telephone within 2 weeks fol-
lowing post-screening and solicited to purchase a magazine
subscription.

1.   The solicitor of the magazine judged each AT subject's
response to be assertive, non-assertive or aggressive
based upon refusal or reaction to sales pitch.

2.   The magazine solicitor immediately notified each subject
following the sales pitch and response that the telephone
call was part of the research study to assess post-test
generalization to a live situation.

Independent Variables

Goal Orientation

Two AT groups were conducted for a 4-week AT program, with AT
therapeutic components, such as role playing, modeling, coaching, etc.
Each AT group, initially comprised of 24 subjects in each group,
was exposed to the same male and female AT therapists, both of whom
followed strict adherence to the AT group format. The two experimental

groups were designated either Therapist-Directed or Self-Directed according to goal orientation.

Following the screening interview, each member of one group of subjects was verbally directed to work toward assertive goals they chose for themselves and to either reach or exceed their goals. During AT these subjects were told to work on any situations, they found personally relevant or felt they needed to work on. Verbal instructions to select situations in which they wished to improve or become more assertive were given to these subjects prior to initiating weekly AT group meetings, during AT sessions, and prior to initiating the role playing segment of the AT groups. At the termination of each weekly session, subjects were verbally instructed to work on improving and increasing their level of assertion during the coming week by working on personally relevant problems in assertiveness. Essentially, subjects were encouraged verbally to select their own goals and tasks to work on in terms of becoming more assertive.

The second group of subjects were directed by the AT therapist toward attainment of mutually-agreed-upon goals, methods and criterion for attainment of the goals. These AT group members filled out a Behavior Monitoring Progress Record (BMPR) in collaboration and cooperation with one of the AT therapists following the screening interview. Subjects' specified goals on their AT Goal Attainment Scale Follow-up Guide, indicating problems or complaints, were transferred to the BMPR and the expected levels of outcomes were delineated as 4-week goals, subjects and their therapist negotiated successive weekly approximations of the projected goals, specific methods for

attaining the short- and long-range goals, and the criterion for assessing goal attainment. Here again, subjects were instructed to work on their goals and to strive to obtain or exceed their weekly goals on the BMPR.

AT group subjects were verbally directed to work toward, reach or exceed their assertive goals, not only prior to initiating the weekly sessions, but also during the AT group sessions. Following AT sessions, subjects were verbally instructed to improve or increase their level of assertion by accomplishing or working toward their weekly goals. In addition, the subjects' progress was monitored in relation to their individual BMPR goals, methods, and criteria. Individuals, who had difficulty in reaching any weekly goals, were assisted by the therapists in reworking these goals to make them more easily attainable. Prior to leaving each AT session, verbal reinforcement and encouragement to continue to seek their BMPR weekly goals was provided.

A third group of subjects served as a control group. These individuals were maintained on a waiting list (Control Waiting List group) expecting to be accepted into an AT group when space (an open slot) became available. Control Waiting List group subjects participated in pre- and post-screening procedures without AT intervention in the interim. However, they were told upon individual inquiry that working on goals was their choice, and any sort of goal seeking was left entirely to their own initiative.

As detailed above, the independent variable of goal specification

or orientation was represented on three levels: Self-Directed, Therapist-Directed, and Control Waiting List.

Statistical Analysis

The data were analyzed using a 2 x 3 analysis of variance on three separate pre- and post-test dependent variables: Goal Attainment Scale scores, Degree of Discomfort socres (AI), and Response Probability scores (AI). The independent variables manipulated for the study were the two experimental AT group treatments (Therapist-Directed and Self-Directed) and the control group (Waiting List). A 2 x 3 ANOVA using pre- and post-Goal Attainment Scale scores was analyzed in terms of the three goal orientation or goal specification modalities to which the subjects of the study were assigned, i.e. Therapist-Directed AT, Self-Directed AT and no AT (control group). The ANOVA analysis was also used to compare each of the three treatment modalities with pre- and post-scores of subjects on their respective measures of Degree of Discomfort and Response Probability. The analyses were performed by hand using ANOVA computational procedures outlined by Winer (1971) in Statistical Principles in Experimental Design.

Inter-rater reliability between alternative raters, on both the post-test Goal Attainment Scale scores and on the AI test-retest reliability at a 6-week interval after post-screening was accomplished via Pearson Product-Moment Correlations. Two inter-rater reliabilities were computed for each interviewer-rater combination. The two individuals doing the rating and interviewing alternated between the

interviewer position and the rater position with each change in client. As interview one was completed, the interviewer became the rater for the next client and the rater became the interviewer, thus, alternating duties and positions.

The resulting inter-rater reliability was r = +.97 for one combination of interviewer and rater and r = +.99 for the other combination. The raters were asked to rate their confidence in GAS, scoring 0 for minimum, 1 for moderate, and 2 for high confidence. Of the 245 ratings made, the raters scored the high confidence category on 230 occasions, moderate on 14 and minimum on 1 occasion.

The test-retest reliability was r = +.63 (N = 63) for the Degree of Discomfort (AI) and r = +.71 (N = 63) for the Response Probability (AI).

In responding to the question of validity, Kiresuk and Sherman (1968) predicted that Goal Attainment Scale scores should have a low to moderate correlation with already existing measures. Since GAS scores are based on an individualized program of measurement, there should not be a very high correlation with more non-individualized measures. GAS scoring is goal-specific and goal-oriented which Kiresuk and Sherman (1968) say should differ from global assessments or measures monitoring change. Confirming the predictions of Kiresuk and Sherman (1968), this study yielded cross validational computations between Assertion Inventory (AI) Degree of Discomfort scores and Goal Attainment Scale scores (GAS), r = -0.57. The correlation between AI Response Probability scores and GAS scores yielded a coefficient of correlation of r = -0.46.

CHAPTER IV

RESULTS

The intent of the present research was to investigate, by
comparison, the effectiveness of goal setting, generally, as well
as a more specific, step-wise approach to goal setting by subjects
in Assertion Training (AT) groups. Two different approaches for
setting goals in Assertion Training groups were assessed by use of
two self-report measures. One AT group utilized a goal directed
method, with specified behavioral steps for approaching individualized
goals. A second AT group used a self-directed goal procedure, with
clients independently setting and approaching their own goals. A
third group of subjects, who were "wait listed" for AT when available,
served as a control group.

The specifics of the various statistical analyses are presented
in order of the study's previously stated hypotheses. The working
hypotheses of the present study have been stated in the null form to
conform with statistical procedures.

Mean Degree of Discomfort Scores

In testing Degree of Discomfort, the first three null hypotheses
(differences in statistical analysis of Degree of Discomfort scores
between the treatment groups, differences between the pre/post test-
ings, and the nature of the interaction effects) are presented in
Table 1. The 2 x 3 analysis of variance data of Table 1 utilized

Table 1

2 x 3 Analysis of Variance Data for Testing Differences in
Mean Degree of Discomfort Scores of Therapist-Directed,
Self-Directed and Waiting List AT Groups

Source	df	MS	F
Between Subjects	62	43	0.056
A (between groups)	2	764.51	
Subjects within groups	60		
Within Subjects	63		
B (pre vs. post)	1	11,314.6	58.19*
AB	2	1,843.4	9.48*
B x Subjects within groups	60	194.44	

*Significant at .05 level.

the Assertion Inventory mean Degree of Discomfort scores obtained

from the three treatment groups, Therapist-Directed group, Self-Directed

group and a Control Waiting List group.

Hypothesis 1

There are no differences in the mean Degree of Discomfort scores

among the Therapist-Directed, Self-Directed and Control Waiting List

groups.

Hypothesis 2

There are no differences in the mean Degree of Discomfort scores

for pretest and posttest within the two AT treatment groups and the

Control Waiting List group.

Hypothesis 3

There are no significant interaction effects between testings,
AT treatment groups and the Control Waiting List group.

To test these hypotheses a 2 x 3 analysis of variance (see
Table 1)(Glass & Stanley, 1970) was used.

Between groups the F ratio of 0.056 with 2 and 60 degrees of
freedom is not significant at the .05 level. Therefore, the null
form of Hypothesis 1 was not rejected.

Within groups the F ratio of 58.19 with 1 and 60 degrees of
freedom is significant at the .05 level. The null form of Hypothesis
2 was, therefore, rejected at the .05 level.

The interaction between testings, AT treatment groups and the
Control Waiting List group yielded an F ratio of 9.48 with 2 and 60
degrees of freedom which is significant at the .05 level. The null
form of Hypothesis 3 was rejected at the .05 level.

Figure 3 graphically represents the mean Degree of Discomfort
scores at pretest, posttest interactions. These mean Degree of Dis-
comfort scores at pretest and posttest, Figure 3, depict the differ-
ences between testings and treatment groups. Control group pretest
and posttest scores appear relatively static. Treatment group scores
are demonstrated in Figure 3 to decline noticeably between pretest
and posttest for both the Therapist-Directed group and the Self-
Directed group.
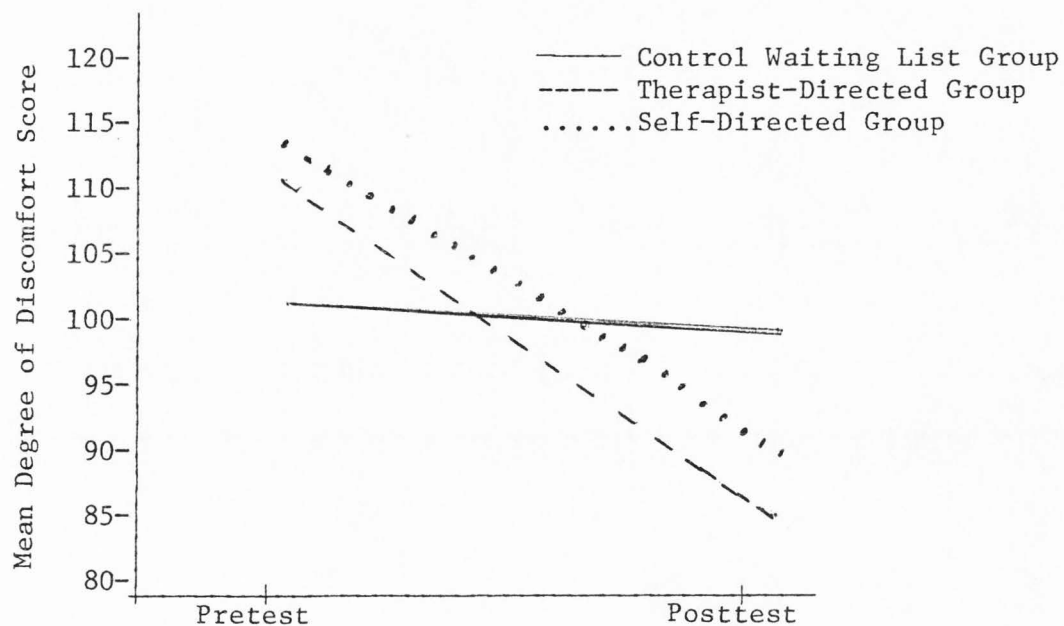
Figure 3. Mean degree of discomfort scores of AT groups at pretest and posttest.

Mean Probability of Response Scores

In testing Null Hypotheses 4, 5 and 6, the statistical analysis presented in Table 2, concerning mean Probability of Response scores, yields data pertaining to differences between the treatment groups and differences between the pre/post testings, as well as the nature of the interaction effects. The 2 x 3 analysis of variance data of Table 2 utilized the Assertion Inventory mean Probability of Response scores obtained from the two treatment groups, Therapist-Directed group, Self-Directed group and Control Waiting List group.

Hypothesis 4

There are no differences in the mean assertion Probability of Response scores among the Therapist-Directed, Self-Directed and Control Waiting List AT groups.

Table 2

2 x 3 Analysis of Variance Data for Testing Differences in
Mean Probability of Response Scores of Therapist-
Directed, Self-Directed and
Waiting List AT Groups

Source	df	MS	F
Between Subjects	62		
A (Between groups)	2	33.63	0.03
Ss within groups	60	525.42	
Within Subjects	63		
B (Pre vs. Post)	1	6,400.03	65.11*
AB	2	1,535.92	15.63*
B x Ss within groups	60	98.29	

*Significant at .05 level.

Hypothesis 5

There are no differences in the mean assertion Probability of
Response scores for pretest and posttest within the two AT treatment
groups and the Control Waiting List group.

Hypothesis 6

There are no significant interaction effects between testings,
AT treatment groups and the Control Waiting List group.

To test these hypotheses a 2 x 3 analysis of variance (see
Table 2 (Glass & Stanley, 1970) was used.

Between groups the $\underline{F}$ ratio of 0.03 with 2 and 60 degrees of
freedom is not significant at the .05 level. The null form of Hypo-
thesis 4 is not rejected. Within groups the $\underline{F}$ ratio of 65.11 with 1
and 60 degrees of freedom is significant at the .05 level. Null

Hypothesis 5 was rejected at the .05 level.

The interaction between testings, AT treatment groups and the Control Waiting List group yielded an F ratio of 15.63 with 2 and 60 degrees of freedom which is significant at the .05 level. Null Hypothesis 6 was rejected at the .05 level.

Figure 4 represents in graphic form mean Probability of Response scores at pretest, posttest interactions. These mean Probability of Response scores at pretest and posttest, Figure 4, delineate the differences between testings and treatment groups and the Control Waiting List group.

AT group scores are exhibited in Figure 4 to decline noticeably between testings for both the Therapist-Directed group and the Self-Directed group while Control Waiting List group scores appear relatively static. The Therapist-Directed group depicted reveals more of a drop in mean Probability of Response scores between testings than the Self-Directed group (Figure 4).

Mean Goal Attainment Scale Scores

In testing null hypotheses 7, 8 and 9, statistical analysis revealed differences in Goal Attainment Scale scores between the treatment groups and between pre/post testings as well as revealing the nature of the interaction effects. The statistical analysis testing hypotheses 7, 8 and 9 is presented in Table 3 as a 2 x 3 analysis of variance which utilized the mean Goal Attainment Scale scores obtained from the two treatment groups and Control Waiting List group.
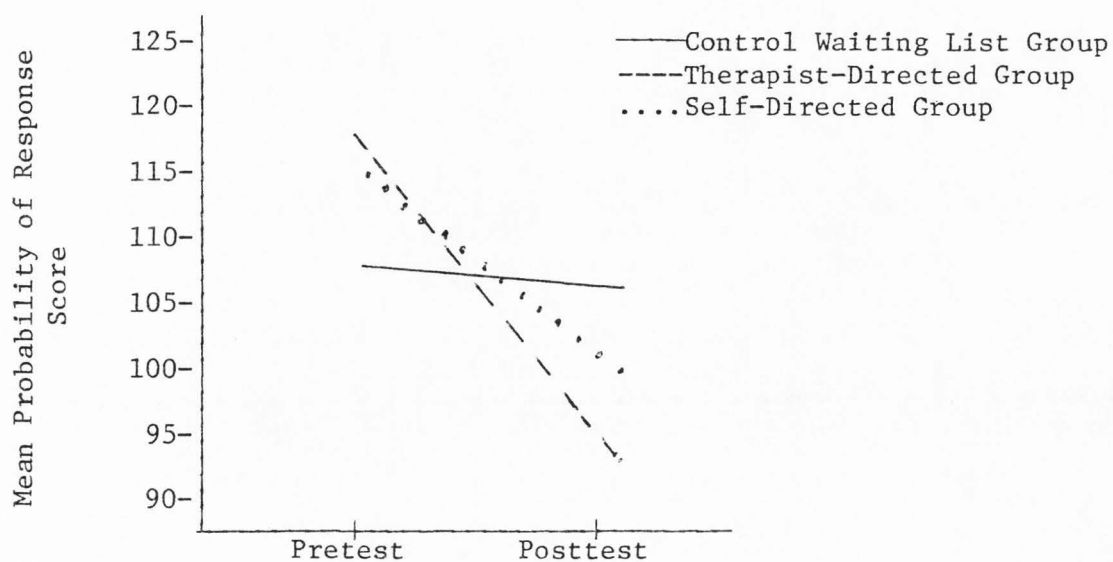
Figure 4. Mean probability of response scores of AT groups at pre-
test and posttest.

Table 3

2 x 3 Analysis of Variance Data for Testing Differences in
Mean Goal Attainment Scale Scores of Therapist-Directed,
Self-Directed and Control Waiting List Groups

Source	df	MS	F
Between Subjects	62		
A (Groups)	2	2,197.5	27.24*
Ss within groups	60	80.67	
Within Subjects	63		
B (pre vs. post)	1	14,178.99	392.12*
AB	2	2,378.26	65.77*
B x Ss within groups	60	36.16	

*Significant at .05 level.

Hypothesis 7

There are no differences in the mean Goal Attainment Scale scores among the Therapist-Directed, Self-Directed groups and the Control Waiting List group.

Hypothesis 8

There are no differences in the mean Goal Attainment Scale scores for pretest and posttest within the two AT treatment groups and the Control Waiting List group.

Hypothesis 9

There are no significant interaction effects between testings and the AT treatment groups as well as the Control Waiting List group.

Between groups the F ratio of 27.24 with 2 and 60 degrees of freedom is significant at the .05 level. The null form of Hypothesis 7 was rejected.

Within groups the F ratio of 392.12 with 1 and 60 degrees of freedom is significant at the .05 level. Null Hypothesis 8, therefore, was rejected.

The interaction between testings, AT treatment groups and the Control Waiting List group yielded an F ratio of 65.77 with 2 and 60 degrees of freedom which is significant at the .05 level. Therefore, the null form of Hypothesis 9 is rejected.

Figure 5 graphically represents changes in mean Goal Attainment Scale scores between pretest and posttest. The mean Goal Attainment Scale (GAS) scores presented depict the differences between testings and treatment groups.
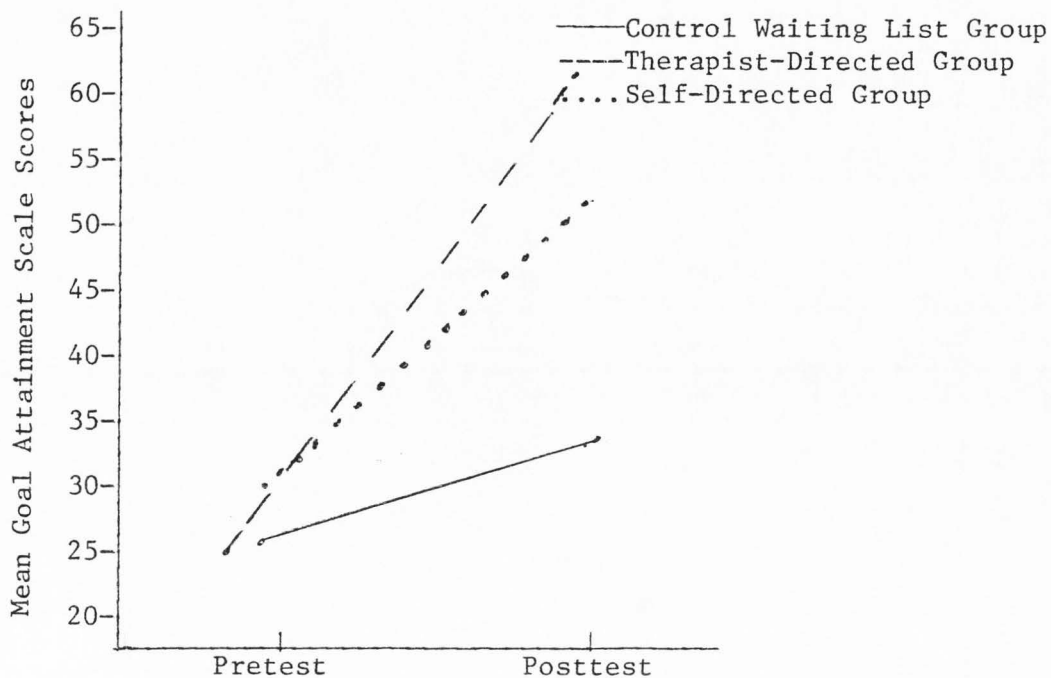
Figure 5. Mean goal attainment scale scores of AT groups at pretest
and posttest.

Figure 5 demonstrates a prominent elevation in AT group mean
GAS scores between testings for the Therapist-Directed group and the
Self-Directed group. The Control Waiting List group scores on Figure 5
also appear to increase between testings although much less dramati-
cally than the two treatment group scores. In addition, the Therapist-
Directed group mean GAS scores (Figure 5) depict a greater rise
between testings than the Self-Directed group mean scores.

Consumer Satisfaction

Consumer satisfaction forms (see Appendix D) which were filled
out on a voluntary basis yielded subjective information for further
evaluation of this AT study.

All 63 participants stated the voluntary nature of their enroll-
ment in this study.

When asked about level of satisfaction (Table 4), information
was reported as follows:

1. The Control Waiting List group reported "indifferent" for
all participants.

2. The Therapist-Directed AT group reported 13 "very satisfied"
and 8 "satisfied" participants.

3. The Self-Directed AT group reported 7 "very satisfied" and
14 "satisfied" participants.

4. The three groups reported no "dissatisfied" participants.

When asked on the consumer form about continuing in AT, 15 Self-
Directed respondents wished to continue in AT, as compared with only
10 respondents of the Therapist-Directed group wishing to continue
AT. In addition, 15 and 12 respondents of Self-Directed and Therapist-
Directed groups, respectively, indicated a desire to enter the AT
group in the following winter quarter of school.

In identifying reasons for changes on the consumer forms, 19
of 21 members of the Therapist-Directed AT group attributed changes
in assertion mostly to the AT they received, while the 2 remaining
indicated a partial attribution to AT. Of the Self-Directed AT group
members, 9 specified attribution of changes in assertion mostly to
group AT, 9 attributed change partially to AT, and 3 indicated that,
for the most part, no change could be attributed to the AT group.
Nineteen Control Waiting List group members indicated no changes

Table 4

Consumer Satisfaction Survey   ~

	Groups		
	Therapist-Directed	Self-Directed	Control
Voluntary	21	21	21
Required	--	--	--
Satisfaction	13	7	
Very Satisfied	8	14	--
Satisfied	--	--	--
Indifferent	--	--	21
Dissatisfied	--	--	--
Very Dissatisfied	--	--	--
Continue in AT			
Yes	10	15	--
No	7	3	--
Begin Winter AT Group			
Yes	12	15	14
No	4	3	7
Changes or Lack of Changes Attributed to AT			
Yes, mostly	19	9	
Yes, partly	2	3	
Not for the most part	--	3	
Not at all	--	--	19

attributed to AT, with two subjects in this group not responding to this item.

Group members were also asked on the Consumer Satisfaction Survey (Table 5) if their enrollment in the AT group was in order to deal with real life concerns and if these concerns had been dealt with as intended. The data for the Therapist-Directed and Self-Directed groups shown in Table 5 are summarized as follows: "Real life concerns," 21; "Interested" in AT, 8; "No reason," 5; and AT group members not responding, 8. Seventeen AT group participants from both the Therapist-Directed and Self-Directed groups intended to work on real life concerns, but had not done so. Apparently, 11 Therapist-Directed group members indicated that they had worked on real life concerns as intended.

Table 5

Consumer Satisfaction Survey Offered to Therapist-Directed and Self-Directed Group Participants

| | AT Groups | |
	Therapist-Directed	Self-Directed
Enrollment for Real Life Concerns		
Yes	11	10
Interested	3	5
No	2	3
Intended Real Life Concerns Dealt With		
Yes	11	7
No	6	11

Post Screening Telephone Solicitation

Finally, as can be observed in Table 6, only 14 of the Self-Directed group members were contacted via telephone for the live assessment of assertion level while 16 and 20 subjects responded from the Therapist-Directed AT group and Control Waiting List group, respectively. Though the AT group members were difficult to contact by phone, the trend appears to show differences in assertion comparable in terms of non-assertion (6 versus 7) and assertive responses (10 versus 5) for Therapist-Directed versus Self-Directed groups, respectively. The Self-Directed group was observed to have two individuals who responded in an aggressive manner to the solicitation. The Control Waiting List group appears evenly divided with 10 subjects each responding assertively and non-assertively.

Table 6

Response to Post Screening Telephone Solicitation
of a Magazine Subscription

AT Groups	Responses		
	Non-Assertive	Assertive	Aggressive
Therapist-Directed	6	10	--
Self-Directed	7	5	2
Control Waiting List	10	10	--

CHAPTER V

SUMMARY AND CONCLUSIONS

Summary

The primary aim of the present study was to assess the relative effects of Therapist-Directed versus Self-Directed goal setting procedures as compared with a "waiting list" control procedure on assessed levels of assertion as measured by three dependent variables (Degree of Discomfort, Probability of Response, and Goal Attainment Scaling). Specifically, it was intended to compare the levels of assertion and the measured effects of Therapist-Directed versus Self-Directed procedures for setting and attaining goals in assertion training groups. The two experimental groups were also compared against a control group comprised of subjects who were assigned to a "waiting list" during the period of the study.

This applied study examines two variations of goal setting procedures as components of group Assertive Training (AT). In the Therapist-Directed AT group an interviewer assisted in setting goals and developing a weekly Behavior Monitoring Progress Record (BMPR) which was specific to each individual's assertion needs, in order to determine the merits of the step-wise approach for achieving personal goals during the AT sessions.

The Progress Record was also used for monitoring each subject's progress toward goals and to provide feedback. The Self-Directed AT

group members were allowed to determine their own level of assertion functioning in specific areas and were not provided with assistance in developing weekly goals or in monitoring their progress or change.

This study accomplished the basic objective for which the study was designed, and as presented in the introductory section of Chapter 1. The objective was to determine how Therapist-Directed versus Self-Directed AT groups and a Control Waiting List group would differ in pre- and post-levels of assessed assertion with homogeneous groups of volunteers, and also to determine the relative effects of the two treatment methods for helping subjects set and attain individual goals through AT.

A 2 x 3 analysis of variance design on the three dependent variables, pretest and posttest, was used with three groups ($\underline{N}$ = 21 for each group) of volunteers from Utah State University and Cache County, Utah. Subjects were assigned into groups which were randomly designated to treatment conditions. One treatment group was assigned to use the BMPR to set goals and monitor progress during AT sessions, and the other treatment group had no set goals or monitoring process although group members were encouraged simply to strive for individual goals. The control group was also established, with subjects selected for this group being placed on a "waiting list" for AT "when available."

Conclusions

Results demonstrated a significant change in Goal Attainment Scale (GAS) scores from pretest to posttest for both Therapist-Directed

and Self-Directed AT groups. The change in GAS scores depicted the improvement or movement toward assertion goals. This was accomplished by comparing an AT group member's GAS score for status at the intake interview with the follow-up GAS score. Change in level of assertion was measured from the time of initial interview to the time of the follow-up interview, involving four 2-hour AT group sessions over a period of 7 weeks.

The significant changes noted in the mean Goal Attainment Scale scores from pretest intake to posttest, indicated that positive changes occurred in both experimental groups during group assertion training. Self-Directed and Therapist-Directed assertion training groups were shown to have a positive impact on changed levels of assertion.

The significant difference of the mean GAS scores between the treatment groups and control group suggests a higher beneficial change in AT group member goal attainment in the Therapist-Directed AT group. The Therapist-Directed AT group showed the greatest amount of change, although similar, but lesser change was also made by the Self-Directed AT group. Both experimental groups evidenced significantly greater change than did the Control Waiting List group.

A significant interaction effect between treatment groups and the Waiting List Control across testings was found with each of the dependent variables. The Probability of Response and Degree of Discomfort scores both showed trends indicating increased assertion for both treatment groups while the control group showed little change.

The Goal Attainment Scale scores also suggest increased levels of assertion and goal attainment between testings while the control group showed a lesser degree of change.

The level of assertion appears to be enhanced by providing Therapist-Directed AT group treatment or to a lesser extent by using Self-Directed AT group methods. In addition, the Control Waiting List group was relatively static between testings.

Considering the conclusions indicating that AT group treatment enhances level of assertion of group members, the comparison of GAS scores with each of the other two dependent variables yields moderate negative correlations (GAS and Degree of Discomfort, $r = -0.57$; GAS and Probability of Response, $r = -0.46$). As might be expected, the correlation coefficient $r = -0.57$ indicates a tendency for Degree of Discomfort scores (an index of anxiety) to diminish as GAS scores (a measure used to assess level of assertion) increase. These results also suggest that individuals high in level of assertion tend to score low in anxiety or Degree of Discomfort.

In addition, the correlation $r = 0.46$ suggests a similar tendency. High GAS scorers tend to have low Probability of Response scores. Low Probability of Response scores suggest an AT group member would be likely to respond assertively.

The more assertive an individual, then, the tendency is for less discomfort subjectively experienced and greater subjective intent to respond assertively.

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APPENDICES

Appendix A

The Assertion Inventory

THE ASSERTION INVENTORY

Code No._____

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 mark 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

Note: 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 paper over your discomfort ratings while responding to the situations a second time for response probability.

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 date with a person	
	18.	Your initial request for a meeting is turned down and you ask the person again at a later time	
	19.	Admit confusion about a point under discussion; 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 demands	
	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	
	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 B

Goal Attainment Scaling Forms

Goal Attainment Scaling Forms--Adapted from Russell R. Hart, <u>The Therapeutic Effectiveness of Goal</u> <u>Attainment Scaling</u>, 1976.

Code No._____

GOAL ATTAINMENT FOLLOW-UP GUIDE

Scale Headings					
Levels of Predicted Attainments	Scale 1:	Scale 2:	Scale 3:	Scale 4:	Scale 5:
Most unfavorable outcome thought likely -2					
Less than expected success -1					
Expected level of success 0					
More than ex- pected success +1					
Most favorable outcome thought likely +2					

GOAL ATTAINMENT FOLLOW-UP GUIDE

Scale Headings

Levels of Predicted Attainments	Scale 1: Procrastination	Scale 2: Meeting people	Scale 3: Complimenting close family and friends	Scale 4: Requesting	Scale 5 Refusing Requests
Most unfavorable outcome thought likely -2	Plans and accomp-* lishes no tasks on time without rushing and be- ing unprepared	Talk to no new people beyond formality	2 or less per week	Makes no requests with inquiry for clarification	1 or less per week
Less than expected success -1	Accomplish 1 planned task per week on time	Speak to 1 new* person reporting discomfort beyond formalities	Compliment* 3-7 times per week	1-3 times per* week	2 times per* week
Expected level of success 0	Plan and accomp- lish 2-4 tasks on time per week	Speak to 1 new person in or out of class--report feelings of com- fort in doing so	Compliment family & friends 7-10 times per week without feeling superficial	Requesting favors or services 4-6 times/wk.with an inquiry to deter- mine if others understood	Refusing re- quests in a caring and understanding way-3 times per week
More than ex- pected success +1	Plan and accomp- lish 5-7 tasks per week	2	11-16 times per week	7-8 times per week	4 times per week
Most favorable outcome thought likely +2	8 or more per week	3 or more	17 or more times per week	9 or more times per week	5 or more times per week

An * refers to level of functioning at time of assessment, pre or post.

GOAL ATTAINMENT FOLLOW-UP GUIDE

Scale Headings

Levels of Predicted Attainments	Scale 1: Meeting people in group	Scale 2: Communication of feelings	Scale 3: Refuse favors	Scale 4: Disagreeing with authority figures	Scale 5:
Most unfavorable outcome thought likely -2	Initiate no con-* versations in a group setting	Hold feelings in without express-ing them	Say yes to all requests even unwanted	Reports feeling* uncomfortable al-ways when disagree-ing with authority figures	
Less than expected success -1	1-3 times per week	Expresses feel-* ings honestly on all occasions except, 1 per day with regret	Says yes to two* unwanted requests per week	Feel uncomfortable disagreeing with authority figure in 1-2 minutes	
Expected level of success 0	Initiates conver-sation in group setting at least 4 times per week	Expresses feel-ings honestly each day al-though reporting regret half/time	Says yes to 1 unwanted re-quest per week	Feel comfortable disagreeing with authority figures in first 3 minutes	
More than expected success +1	5-6 times per week	Regret 1/4 time		3-6 minutes	
Most favorable outcome thought likely +2	Initiates conver-sation spontane-ously more than 6 times per week	Expresses feel-ings honestly & spontaneously daily, no re-grets	Says no to any unwanted request	Feels comfortable disagreeing with authority figures always	

GOAL ATTAINMENT FOLLOW-UP GUIDE

Scale Headings

Levels of Predicted Attainments	Scale 1: Ending conversations	Scale 2: Responsibility	Scale 3: Communication with mother	Scale 4: Friends refuse requests	Scale 5: Requesting favors
Most unfavorable outcome thought likely -2	Talk with others* 4-5 times per day	Do 7 unrequested* favors per week	Always uncomfort-* able talking with mother when alone	Do all requests	Fail to make* any request for favors
Less than expected success -1	3 times per day	4-6 unrequested favors per week	Feel comfortable 1-2 minutes talk-ing with mother	Say no to 1 un-* wanted request per week	1-3 per week
Expected level of success 0	Talk with others 2 times per day when busy	Do 3 unrequested favors and 1 re-quested favor per week	Feel comfortable talking with mo-ther 3-4 minutes	Say no to 2 un-wanted requests per week from friends	Make 4-5 re-quests of others per week
More than expected success +1	Talk with others 1 day per week when busy	Do 1-2 unrequest-ed, 2-4 requested favors per week	5-8 minutes	Say no to 3-4 un-wanted requests per week	6-7 per week
Most favorable outcome thought likely +2	Never talk with others when busy	Do favors only when asked	9-10 minutes	Say no to all unwanted re-quests	Make all rea-sonable re-quests

Code No._____

Name _____Interviewer_____

SCALE ATTAINMENT LEVELS

PATIENT STATUS AT INTAKE FORM

What is the Patient Status in Intake Form and how is it used?

For each scale on the Goal Attainment Follow-up Guide, the interviewer should indicate, on the Patient Status at Intake Form enclosed with each Follow-up Guide, the patient's status (condition or behavior) at the time of the intake interview. This form should always accompany the Goal Attainment Follow-up Guide.

The prime researcher is responsible for collecting this form, along with the Follow-up Guide after the interview session has elapsed.

To facilitate the retention of the "level at intake" data, please complete this form for each subject, using the following format.

Indicate the "level at the time of intake" with an asterisk in the appropriate cell for each scale completed. Any additional comments concerning the client's "level at intake" should be indicated on the reverse side of this form.

Thank you.

Scale 1	Scale 2	Scale 3	Scale 4	Scale 5
Much less than expected	Much less than expected	Much less than expected	Much less than expected	Much less than expected
Less than expected	Less than expected	Less than expected	Less than expected	Less than expected
Expected	Expected	Expected	Expected	Expected
More than expected	More than expected	More than expected	More than expected	More than expected
Much more than expected	Much more than expected	Much more than expected	Much more than expected	Much more than expected

Code No._____

Name_____Interviewer_____

SCALE ATTAINMENT LEVELS

PATIENT STATUS AT POST-TEST FORM

What is the Patient Status at Post-Test Form and how is it used?

For each scale on the Goal Attainment Follow-up Guide, the Scaler
should indicate, on the Patient Status at Post-Test Form enclosed
with each Follow-up Guide, the patient's status (condition or behavior)
at the time of the Post-Test interview. This form should always
accompany the Goal Attainment Follow-up Guide.

To facilitate the retention of the "Post-Test Level" data, please com-
plete this form for each client, using the following format.

Indicate the level at the time of "Post-Test" with an asterisk in
the appropriate cell for each scale completed. Any additional comments
concerning the client's "level at intake" should be indicated on
the reverse side of this form.

Thank you.

Scale 1	Scale 2	Scale 3	Scale 4	Scale 5
Much less than expected	Much less than expected	Much less than expected	Much less than expected	Much less than expected
Less than expected	Less than expected	Less than expected	Less than expected	Less than expected
Expected	Expected	Expected	Expected	Expected
More than expected	More than expected	More than expected	More than expected	More than expected
Much more than expected	Much more than expected	Much more than expected	Much more than expected	Much more than expected

Appendix C

Assertion Registration Forms

Assertion Registration Forms--Adapted from Russell R. Hart, The
Therapeutic Effectiveness of Goal Attainment Scaling, 1976.

Assertiveness Training, Fall 1977

Because of research interests surrounding the effectiveness of
assertive training these classes are offered free of charge. Since
research is involved, a reasonable commitment to participate by way
of attendance and on pre- and post-assessment interviews required
for research purposes is stressed.

The assertiveness classes will alst 7 weeks and consist of
approximately 14 hours of closely supervised instruction. Two of
these hours will be scheduled as a one hour pre-group interview and a
one hour post-group interview for assessment purposes. The remaining
hours will be scheduled as Section 1, Mondays 3:30-5:30 PM weekly and
Section 2, Wednesdays 3:30-5:30 PM weekly.

The assertive training group is for individuals who desire to be
more outgoing, more assertive in various social situations, and less
fearful of social encounters or confrontations, and for those who would
like to improve their interpersonal communication or social interaction
skills.

The assertion training sessions will consist of presentations of
information, modeling, role-playing, discussion of real-life situations,
and time set aside for working exclusively on personally selected situations.

If you cannot attend one of the two groups indicated, either
because the groups are full or because the time specified for the
sessions is not convenient for you, you will be signed up to a waiting
list group. If you are placed on a waiting list group and attend both
the pre- and post-group assessment interviews, you will be guaranteed
entry into a Winter Quarter Assertive Training group. The pre-group
session will be during the first week (one hour) and the post-group
(1 hour) session during the last week of training.

Name _____ Phone No. _____

Code No. _____

Section Requested: Mondays 3:30-5:30 _____   (1 = #1 choice
                     Wednesdays 3:30-5:30 _____   2 = #2 choice
                     Waiting List   _____   3 = #3 choice)

I understand that at the end of training I will be informed as to the
goals and results of this research project.

_____
                    Signed

INFORMATION FOR <u>GAS</u> STUDY

Code #_____

NAME_____

ADDRESS_____ CITY_____

TELEPHONE_____WORK_____HOME_____

DATE_____

AGE _____SEX_____MARITAL STATUS_____

GAS STUDY CLIENT CONSENT

DATE:_____

    I agree to participate in the GAS Assertion Study which is now
in progress. I understand that this is a scientifically structured
study undertaken to determine the effectiveness of GAS and Assertion
Training. Because of this, I agree to permit a follow-up interviewer
to contact me later on to find out if I have benefited from the
training.

_____
Signed

_____
Signed

Name and address of a relative, friend, agency, etc., through which
you can be reached in the next year.

NAME_____

ADDRESS_____

INFORMED CONSENT FORM
GAS ASSERTION TRAINING
RESEARCH PROJECT

I understand that any information acquired in the course of this research project (psychological tests, the assertion inventory, data forms, and assertion training process) will be held by the researcher in strictest confidence. In addition, I realize that I may refuse to participate in any assertion training activities that I do not desire to take part in and may withdraw from the program at any time.

_____   Date_____
Client's Signature

_____
Researcher's Signature

Appendix D

Consumer Satisfaction Forms

Consumer Satisfaction forms--Adapted from Russell R. Hart, <u>The</u>
<u>Therapeutic Effectiveness of Goal Attainment Scaling</u>, 1976

    Interviewer_____Code #_____

1. Was your decision to seek assertion training a voluntary one or
    was it required:

                           Voluntary_____
                           Required_____

2. How satisfied were you with the assertive training?

                           Very dissatisfied_____
                           Dissatisfied_____
                           Indifferent_____
                           Satisfied_____
                           Very satisfied_____

    If dissatisfied, note any reasons given.

3. Do you wish to (a) continue in the assertion training group and/or
    (b) begin with a group in the winter?

                           (a) yes_____._____
                                  no_____
                           (b) yes_____
                                  no_____

4. Ascertain the scale level at which the client is functioning at
    present by discussing each identified concern or problem area
    scaled previously during pre-testing. Refrain from divulging the
    material on the Follow-up Guide to the client except in a very
    general sense if necessary. (See follow-up post-test form).

5. Do you attribute any change(s) or lack of change to the assertion
    training you received?

                           yes, mostly_____
                           yes, partly_____
                           Not for the most part_____
                           Not at all_____

    If not mostly or partly, to what is change or lack of it attributed?

6. Indicate your level of confidence in the scoring you did for each
    scale by rating 0 for the minimum confidence, 1 for moderate con-
    fidence, and 2 for high confidence.

    Scale 1_____
    Scale 2_____
    Scale 3_____
    Scale 4_____
    Scale 5_____

NO NAMES PLEASE

Code #_____

List any suggestions for improving the assertion training.

Did you have any real-life concerns motivating or prompting you to enroll for assertion training?

Yes_____
No_____
Interested_____
Other_____

Do you have any real-life concerns you intended to deal with in assertion training, but have not yet approached or begun to deal with?

Yes_____

No_____

If yes, please list the concerns and be assured they will be held in confidence.

Appendix E

Training Session I, Assertion Training

Didactic Material

NOTE: The Assertion Training Didactic Material, which appears in this and the following Appendices (i.e. Appendices E, F, G. and H) are adapted from Assert Yourself (Galassi & Galassi, 1977a) with permission of the publisher, Human Sciences Press.

ASSERTIVE BEHAVIOR

1. Assertive behavior is often confused with aggressive behavior; however, assertion does not involve hurting the other person physically or emotionally.

2. Assertive behavior aims at equalizing the balance of power, not in "winning the battle" by putting down the other person or rendering him/her helpless.

3. Assertive behavior involves expressing your legitimate rights as an individual. You have a right to express your own wants, needs, feelings and ideas.

4. Expressing your own wants, needs, feelings and ideas in an assertive manner leads to an enhanced feeling of self importance and self esteem.

5. Remember other individuals have a right to respond to your assertiveness with their own wants, needs, feelings and ideas.

6. An assertive encounter with another individual may involve negotiating an agreeable compromise.

7. By behaving assertively, you open the way for honest and more intimate relationships with others.

8. Assertive behavior not only is concerned with what you say but how you say it.

9. Assertive words accompanied by appropriate "body language" (non-verbal cues) makes your message more clear and impactful.

10. Assertive body language includes the following:
    a. maintaining direct eye contact
    b. maintaining an erect posture
    c. speaking clearly and audibly
    d. making sure you do not have a whiney quality in your voice
    e. using facial expression and gestures to add emphasis to your words

Assertive behavior is a skill that can be learned and maintained by frequent <u>practice</u>.

*When you act assertively:
    You feel confident
    You feel self-respecting at the time and later
    You choose for yourself
    You may achieve your goal

*Assertive behavior:
    -direct, honest, and appropriate expression of one's feelings,
        opinions, and beliefs
    -self-enhancing
    -expressive
    -feel good about self
    -no one is hurt

*Aggressive behavior:
    -violation of other's rights
    -self-enhancing at expense of another
    -expressive
    -depreciates others
    -chooses for others
    -goal is achieved by hurting others
    -punishes others (humiliation)

*Nonassertive behavior (passive)
    -violation of one's own rights
    -permission for others to infringe on one's rights
    -self-denying
    -inhibited
    -hurt, anxious
    -others choose for him/her
    -doesn't achieve desired goal
    -self-punishing (guilt)

*Indirectly aggressive (passive-aggressive)
    -indirect, sneaky way to get what one wants
    -appears to be passive, but is achieving goal aggressively,
        sneakily.

ASSERTIVE TRAINING HINTS

Use "I" -- it's an assertive word

look the other person in the eye when communicating

don't act apologetic

don't smile or giggle if you're expressing something serious

let your feelings show -- if you're angry, let it appear on your face and in your posture

use names in talking to others -- it's less easy to be ignored

1. Assertive talk. Do not let others take advantage of you. Demand your rights. Insist upon being treated with fairness and justice. Examples: "I was here first," "I'd like more coffee, please," "Excuse me, but I have another appointment," "Please turn down the radio." "This place is a pigsty," "You have kept me waiting here for half an hour," "This steak is well-done and I ordered it medium-rare."

2. Feeling talk. Express your likes and dislikes spontaneously. Be open and frank about your feelings. Do not bottle up emotions. Answer questions honestly. Examples: "What a marvelous shirt!" "I am so sick of that man" "How great you look!" "I hate this cold," "I'm tired as hell," "Since you ask, I much prefer you in another type of outfit."

3. Greeting talk. Be outgoing and friendly with people whom you would like to know better. Do not avoid people because of shyness, because you do not know what to say. Smile brightly at people. Look and sound pleased to see them. Examples: "Hi, how are you?" "How do you like working at _____?" "Taking any good courses?" "What's been happening with so and so?"

4. Disagreeing passively and actively. When you disagree with someone, do not feign agreement for the sake of "keeping the peace" by smiling, nodding or paying close attention. Change the topic. Look away. Disagree actively and emotionally when you are sure of your ground.

5. Asking why. When you are asked to do something that does not sound reasonable or enjoyable by a person in power or authority, ask why you should do it. You are an adult and should not accept authority alone. Insist upon explanations from teachers, relatives and other authority figures that are convincing. Have it understood that you will live up to voluntary commitments and be open to reasonable suggestions, but that you are not to be ordered about at anyone's whim.

6. Talking about oneself. When you have done something worthwhile or interesting, let others know about it. Let people know how you feel about things. Relate your experiences, do not monopolize conversations, but do not be afraid to bring them around to yourself when it is appropriate.

7. Agreeing with compliments. Do not depreciate yourself or become
    flustered when someone compliments you with sincerity. At the
    very least, offer an equally sincere "Thank you." Or reward
    the complimenter by saying, "That's an awfully nice thing to say.
    I appreciate it." In other words, reward rather than punish
    others for complimenting you. When appropriate, extend compli-
    ments. For example, if someone says, "What a beautiful sweater!"
    respond "Isn't it a lovely color? I had a hard time finding it."

8. Avoiding trying to justify opinions. Be reasonable in discus-
    sions, but when someone goes out of his way to dominate a social
    interaction by taking issue with any comments you offer, say
    something like, "Are you always so disagreeable?" or "I have no
    time to waste arguing with you," or "You seem to have a great
    deal invested in being right regardless of what you say, don't
    you?"

9. Looking people in the eye. Do not avoid the gaze of others.
    When you argue, express opinion, or greet a person, look him
    directly in the eye.

Non-verbal behavior to watch for when role-playing:

1. Loudness of voice
2. Fluency of spoken word
3. Eye contact
4. Facial expression
5. Body expression
6. Distance from person with whom one is interacting

The one major rule of Assertive Training:

Never instigate an assertive act that is likely to have
punishing consequences.

Assertive Behavior defined:

The proper expression of any emotion other than anxiety,
towards another person.

Assert Yourself (Galassi & Galassi, 1977a)
Definition of Assertive Behavior:

Assertive behavior, or assertion, involves direct expression of
one's feelings, preferences, needs, or opinions in a manner that is
neither threatening nor punishing toward another person. In addition,
assertion does not involve an undue or excessive amount of anxiety
or fear. Contrary to popular opinion, assertion is not primarily

a way to get what one wants, nor is it a way of controlling or subtly manipulating others. Assertion is the direct communication of one's needs, wants, and opinions without punishing, threatening, or putting down the other person. It also involves standing up for one's legitimate rights without violating the rights of others and without being unduly fearful in the process. As such, assertion does not constitute a panacea nor a simple solution for the world's ills but simply is a means of direct and honest communication between individuals. The emphasis is placed on your ability to express your feelings and opinions appropriately.

Assertive behavior should be viewed as a behavior that is both learned and situationally specific. By this we mean that assertion is not something you are born with nor is it something that people either possess—like blue eyes—or do not possess. It is a skill or a way of behavior that one learns; therefore, it can be taught. Also, it is not necessarily a general way of behaving. People are not assertive in all situations. Rather, one learns different types of behavior in different situations. One individual may have difficulty in expressing disagreement with his/her parents but have no difficulty expressing disagreement to friends.

> Recognizing Nonassertive,
> Agressive, and
> Assertive Behavior

In order to behave assertively in a situation, you first need to understand what constitutes assertive behavior. An effective way to develop this understanding is by contrasting assertive behavior with aggressive and non-aggressive ways of responding. This procedure was suggested by R. E. Alberti and M. L. Emmons, <u>Your Perfect Right: A Guide to Assertive Behavior</u>.

Nonassertive Behavior

When a person behaves nonassertively in a situation, he/she may fail to express his/her feelings, needs, opinions, or preferences, or he/she may express them in an indirect or implicit manner. For example, verbally agreeing to activities one really is not interested in or failing to ask a favor even though one is needed represent the denial of one's opinion and needs. Accompanying the verbal denial may be such nonassertive nonverbal behaviors as avoidance of eye contact, hesitant speech pattern, low voice level, tense body posture, and nervous or inappropriate body movements.

Statements such as "I suppose we could go to the movies" or "I wish I knew someone who could teach me to jack up my car" represent indirect or implicit verbal communications in which the other party must infer what the needs or opinions of the speaker really are. One difficulty with indirect, incomplete, or implicit communication is

that mixed messages are being delivered. In some cases, the person's verbal and nonverbal behaviors are inconsistent or contradictory in the message. The person verbalizes that he/she would be delighted to do this favor but is frowning at the same time.

Aggressive Behavior

Indirect verbal aggressive behavior includes sarcastic remarks, catty comments, and malicious gossip. Indirect nonverbal aggressive behaviors include physical gestures performed while the person's attention is directed elsewhere, or physical acts directed toward other persons or objects. The following are examples of indirect aggression.

Sarcasm. A colleague has given you the final draft of his/her half of the report that you've both been working on for some time now. You read it and feel it needs a lot more work. Rather than tell him/her directly, you sarcastically say, "Hey Joe/Jane, you know that report you gave me? Not bad for a rough draft."

Malicious Gossip. You're quite annoyed at your neighbor because you told him/her about a month ago you were planning to have a party on the Fourth of July. After all your plans were made except for the invitations, you received an invitation from him/her for the same night. Instead of confronting him/her, you begin telling neighbors that he/she stole your ideas; that they shouldn't go to his/her party since he/she will just exploit them; that you can't trust him/her; that he/she is having this party since he/she and his/her spouse are having difficulties and he/she wants to impress the spouse.

The major characteristic of aggressive behavior is the achievement of one's goals in a situation with little regard for and at the expense of the other individual(s). Aggressive behavior often is regarded as pushy behavior, since one attempts to achieve goals at any expense, pushing aside people and other obstacles in the process.

Aggressive behavior often results in unfavorable consequences for both the aggressor and the object of the aggression. The unfavorable effects of aggressive behavior on the recipient are obvious. His/her rights have been denied. He/she may feel humiliated, embarrassed, or abused. In addition, the recipient may feel resentful or angry and seek revenge through direct or indirect means.

Although the person who behaves aggressively in a situation may achieve desired goals, he/she may experience unfavorable consequences both immediately and in the future. Aggressive behavior often results

in immediate and more forceful direct counteraggression in the form of physical or verbal abuse. Aggression may also lead to indirect counteraggression in the form of a softly delivered sarcastic retort or a defiant glance. Long-range consequences may include strain in the interpersonal relationship with the other person or avoidance of further contact by the other person. After behaving aggressively, the individual may suffer feelings of guilt and remorse for his/her behavior. However, since he/she has achieved desired goals (been reinforced) through aggressive behavior, it is likely that he/she will continue to behave aggressively in that situation in the future and simply tolerate the subsequent guilt feelings that may arise, unless the latter are exceedingly strong.

Assertive Behavior

Assertive behavior involves the direct expression of one's feelings, needs, legitimate rights, or opinions without being punishing or threatening to others and without infringing upon their rights. In addition, assertive behavior does not involve an excessive or undue amount of fear or anxiety. One's nonverbal behavior, such as eye contact, facial expression, body posture, and tone and loudness of voice, are also quite important and may add or detract from the verbal behavior. These behaviors need to be harmonious with the verbal content of the assertive message. For instance, when one is expressing feelings of affection, the tone and loudness of voice are quite different from when one expresses annoyance or displeasure. A further discussion of these nonverbal behaviors is presented in Discussion Module 3 (Galassi & Galassi, 1977a).

In contrast to nonassertive behavior, assertive behavior involves expressing one's feelings and opinions honestly and directly rather than hoping that the other person will read one's mind. For instance, rather than nonassertively saying to your neighbor, "Do you have any eggs in the house?" you might say, "Do you have two eggs I could borrow for the cake I'm planning to make tonight?" In the nonassertive remark, your neighbor does not know you want to borrow two eggs. In fact, he/she may think you have extra eggs you want to give him/her. In the assertive statement, you clearly state that you would like to borrow two eggs. It would be unlikely that your neighbor could misinterpret this direct request. It is important to stress that whether your neighbor has two eggs or one thousand eggs, he/she is under no obligation to let you borrow the eggs regardless of the manner in which you make your request. Your only responsibility is to ask in an assertive fashion so that your request is clear, and to respect the other person's reply. Depending on your neighbor's reply, you may or may not need to repeat your request. If your neighbor gives you a definitive reply, such as, "Sure Sam/Sue, here are two eggs," or "Sorry, Sam/Sue, I can't spare the two eggs tonight," then you need to respect his/her wishes. However, if your

neighbor replies, "Well, how many do you need?" or "Do you have to
have them tonight?" you need to answer his/her question and repeat
your request if necessary. Multiple requests seem appropriate if a
clear answer is not received. Judgments need to be made continuously
concerning what is appropriate and assertive for a particular situation.

An aggressive approach to the egg-borrowing situation might
involve a demand for the two eggs or repeated demands after a defini-
tive answer has been given. In addition, the demand for the eggs
may be coupled with sarcastic or derogatory comments and hostile
gestures. For example:

Person 1: Hey, give me two of your eggs. I'm baking a
          cake tonight.
Person 2: Well, I'm really running low on them and I
          need them for some baking that I'm doing. I
          really can't spare them.
Person 1: Look, don't be so difficult. Just give me the
          two crummy eggs.

In this situation, it appears that Person 1 is attempting to force
or to make Person 2 responsible for the satisfaction of his/her needs.
The behavior displayed by Person 1 is an attempt to deny the rights
of Person 2 in this situation.

Assertive behavior is not designed primarily to enable an indivi-
dual to obtain what he/she wants. Rather, its purpose is the clear,
direct, and inoffensive communication of one's needs, opinions, and
so on. To the extent that this is accomplished, the probability
of achieving one's goals without denying the rights of others is
increased.

Assertive behavior is expressed with consideration of rights,
responsibilities, and consequences. The person expressing himself/
herself in a situation needs to consider what his/her rights are
in that situation and what the rights are of the others involved.
The individual also needs to be cognizant of his/her responsibilities
of that situation and the consequences resulting from the expression
of his/her feelings. For instance, if a friend has both failed to
meet you for an arranged meeting and failed to call to break the
engagement, you have a right to express how you feel, but you also
need to determine if there are extenuating circumstances. You have
a responsibility to listen to your friend's response in case the
situation was unavoidable (someone suddenly got sick, the car broke
down in an out-of-the-way area, or so on). You will want to express
how you feel, keeping in mind the consequences of your statements.
For instance, if your friend just forgot or decided to go elsewhere,
you need to consider the consequences of expressing your annoyance.
In the short run, your friend will feel slightly upset, but in the

long run he/she will be less likely to repeat this behavior, thereby increasing the likelihood of a more satisfactory relationship between the two of you.

Does assertive behavior in a situation result in the absence of conflict between two parties? The total absence of conflict between two parties is an impossibility. There are certain situations in which assertive behavior is appropriate and desirable but may cause some annoyance to the other person. For example, returning a defective piece of merchandise to a hurried store clerk in an assertive-or perhaps in any other manner may not be welcomed warmly. Similarly, expressing justified annoyance or legitimate criticism in an appropriate manner may bring an initial unfavorable reaction. Weighing the short-term and long-term consequences for both parties is what is important. It seems to us that assertive behavior results in maximizing favorable consequences and minimizing unfavorable consequences for individuals over the long run.

Assertive behavior in a situation generally results in favorable consequences to the parties that are involved. The person who has asserted himself/herself may or may not accomplish his/her objectives, but he/she generally feels better about having been able to state his/her opinions. The clear statement of one's position is likely to enhance the probability that the other person will respect that position and then behave accordingly. Thus, people who behave assertively in a situation express their rights, make their own choices and decisions, and accept responsibility for their behavior.

Favorable consequences also are likely to occur for the person who is the object of assertive behavior in a situation. This person receives a clear and nonmanipulative communication, in contrast to the unstated or implied communication that is transmitted in non-assertive behavior. In addition, he/she receives a request for new behavior or a statement of the other person's position rather than the demand for new behavior that is characteristic of aggression. As a result, there are few chances for misinterpretation. Although the other person may not agree, accept, or like what the assertive behavior relates (I love you; I like your dress; I'm annoyed that you forgot to call me as you said you would; I prefer not to let you drive my car), the manner in which it is delivered does not deny his/her rights, does not put him/her down, and does not force him/her to make another's decision or to take responsibility for someone else's behavior.

What happens when both parties behave assertively in a situation? This is probably a very desirable state of affairs. If the positions or opinions of the two parties are compatible, then both will be satisfied by the interaction. If the positions are incompatible, then both parties can clearly recognize this and attempt to compromise

or negotiate if they so choose or simply respect each other's right to disagree and not attempt to impose demands on each other. In the latter case, each can feel satisfied that he/she has expressed himself/ herself while recognizing and accepting that his/her goal may not have been achieved.

Initiating and
Maintaining Conversations

You have the right to initiate conversations with other people. Most people enjoy meeting others and usually respond favorably to people who attempt to initiate contact with them. On occasion, some people will not welcome such interactions. In these instances, you have the responsibility not to force yourself on them. Unfortunately, it is not immediately clear whether an individual is unwilling to engage in a conversation or whether he/she is initially shy or distrustful. After a few comments, such a differentiation often can be made. Unwillingness to engage in social interactions is sometimes indicated by: lack of smiles, hostile looks or comments, unresponsive nonverbal behavior, curt responses, and failure to ask the initiator questions in return. Conversely, willingness to engage in social interaction is indicated by: frequent smiles and gestures which indicate nonverbal responsiveness, verbal responses which disclose personal information, and/or questions directed to the initiator.

Many people report difficulty in knowing when to initiate a conversation and how to do it. It usually is easier to begin a conversation if you have the other person's attention and if you are not more than a few feet away so that you can be heard easily. Once you catch the other person's eye, you can smile and say whatever it is that you would like to say. In most initial conversations, people search for a topic of common interest to break the ice, for example, "I notice you are reading _____. Are you in Dr. Frederick's English class?" or "Hi I'm Bill Smith and I work in production. I've seen you around here lately, and I was wondering in which department you work."

Once a common topic has been established, there are several ways to maintaining and expanding the conversation. One way is to make a statement and then ask the other person for his/her views on the matter. Another way is to disclose personally relevant information such as likes, dislikes, attitudes, and so on. It is important that what you disclose be relevant to the topic and not be so personal that it seems out of place. Most people do not divulge their deepest secrets to total strangers. The idea is to make your comments gradually a little more personal so that the conversation becomes more meaningful. Another procedure is not to answer questions with a simple yes or no, but to give your answer and perhaps explain your views, so that the other person has something to which he/she can

respond. Also, asking questions which require more than a simple yes or no answer is helpful. Instead of asking, "Do you like Smith, the guy running for mayor?" you can say, "What do you think of Smith's views?" The second question encourages more participation in the conversation than the first question.

We suggest that you do not rely solely on one of these procedures to the exclusion of the others, since this can result in a mechanical or stilted conversation (like conversations in which you only ask the other person a series of questions). Rather, your goal is to integrate these procedures so that the conversation flows smoothly. At first, you may find that you are self-conscious, but this feeling will be reduced over time as you practice your skills.

Listed below are some of the common counterproductive attitudes that block attempts to initiate social interaction. We have provided internal dialogues for disputing them, and we refer you to Discussion Module 3 (Galassi & Galassi, 1977a) for additional procedures for disputing such attitudes.

Counterproductive beliefs about rights and responsibilities

I don't have the right to impose on or bother other people. What evidence do I have that initiating a conversation and trying to be friendly is equivalent to imposing on or bothering other people? Most people enjoy meeting others. If they feel that I am bothering them, they will probably indicate this to me in one way or another. Besides, am I afraid of bothering them or of being rejected by them? If I want to start a conversation with someone, I should be able to do so.

But he/she is so important that someone like me can't just go up and start a conversation. It's not right.

Here is another belief that does not help me to feel the way I want to feel. He/she puts on his/her slacks the same way I do and has the same needs that I have. Who knows, perhaps the fact that he/she is so important intimidates people and makes it unlikely that he/she has very many friendly conversations with other people. Maybe I'm doing him/her a favor by beginning a friendly conversation.

Counterproductive beliefs about how I should behave or appear to others.

I don't know what to say. If I don't say something brilliant, the other person will think that I'm an idiot, and I should be a brilliant conversationalist.

Well, this belief certainly doesn't help me to feel the way I want to feel. It prevents me from meeting new people. When I think

about the topics of most conversations, I realize that they are not
about such profound issues. People talk about the weather, TV shows,
class, other people, and so on. I can discuss those issues, too.
Perhaps what I say is not as important as is clearly indicating my
interest in making contact with the other person. If the other
person thinks that I'm an idiot, that's his/her problem. At least
I'm brave enough to try to meet someone new.

Eye Contact

The impact of your message is affected by the amount of eye con-
tact you maintain with the person to whom you are speaking. When
people are anxious, they often tend to look up, down, around, and
away from the other person. When you have little or no eye contact
with the other person, you appear to be unsure of yourself, and the
other person tends not to take your comments seriously. On the other
hand, when you look at the person to whom you are speaking, you are
generally perceived as more favorable and confident. People tend
to look at the person with whom they are conversing more when they
are in the listening role than when they are in the speaking role.
When you are speaking, it is normal to look away now and then to
gather your thoughts and ideas. Research has shown that individuals
look at the other person in a conversation about 70 percent of the time.

However, maintaining fairly constant eye contact is quite differ-
ent than staring at a person. Try not to engage in penetrating stares
or hostile glares. Look at the other person to show that you are
not only interested in what you are saying but in his/her comments
as well. Finally, there are cultures in which maintaining fairly
constant eye contact is not effective behavior but instead implies
disrespect. The latter is an exception, but if you are a member of
one of these cultures you need to adjust this criterion when inter-
acting with members of that culture.

Relaxed posture

Try to maintain a relaxed body stance while asserting yourself.
A very rigid and tense appearance or a slouched, almost asleep,
position detracts from your message. The rigid or tense body posture
often inhibits you from freely expressing yourself, whereas the
slouched posture often communicates disinterest to others. Practice
finding both comfortable sitting and standing postures that facilitate
delivering your message assertively.

Nervous laughter or joking

Nervous laughter or joking does not refer to laughing at appropri-
ate times or telling humorous stories. It refers to those situations
in which individuals find themselves laughing or making jokes be-
cause they are nervous, embarrassed, or don't know what else to say.

Nervous laughter or joking may help you get through some of those situations in which you feel uncomfortable or don't know what to say, but the laughter or joking doesn't help you to express your feelings, ideas, or opinions and can detract from your message. When you begin to joke or laugh nervously, concentrate on saying what you feel rather than the experience of discomfort. One way to accomplish this is by stating that you feel uncomfortable in the situation and that you would appreciate it if the other person would be patient with you.

Excessive or unrelated head, hand, and body movements.

    Anxiety may be communicated by some individuals through excessive or unrelated head, hand and body movements. For other individuals, these movements may be due simply to habit, not to feelings of anxiety.

    Excessive movements often divert attention from the verbal message. This does not mean that you shouldn't use your hands, head, or body for emphasis while expressing yourself. Rather, it means that it is important to check whether your nonverbal behavior is adding or detracting from your comments. This can be accomplished by asking a friend or looking in a mirror.

    Unrelated movements tend to confuse the other person(s) in the conversation because they contradict the verbal message. If you find yourself frowning when expressing positive feelings or smiling when expressing annoyance, then you need to develop more consistency between your verbal and nonverbal behavior. Practice making a simple statement, such as "I like you," and then smiling; or practice saying, "I am annoyed with you," and then frowning.

Evaluate Your Verbal Content

Say what you really want to say

    Your first consideration in evaluating your verbal behavior is to ask yourself whether you said what you really wanted to say. Often people do not say exactly what they want to say, and as a result they feel frustrated and unable to reach their objectives. For instance, telling your neighbor that you are annoyed at him/her for cutting some of the flowers in your garden by saying, "I'm annoyed that you cut my flowers. I don't want that to happen again," is preferable to saying, "My garden really looks barren with all those flowers missing." In the latter comment, you didn't say what you wanted to say.

Make comments concise and to the point

    If your comments are concise, to the point, and appropriate to the situation, your message is more likely to be listened to and understood. There is no reason to beat around the bush when you have something to say. State it directly.

When you make a request of a friend, there is no need to engage in a lengthy discourse such as this one: "Sam/Sue, you know the children get out of school early today. What are your children doing this afternoon? Well, maybe mine could do that, too. Would you mind....well, I have an appointment and I don't want the kids with me if possible....could my children play with yours and...well, could you keep an eye on them?"

Instead, be concise and get to the point: "Sue/Sam, I have an appointment at 1:00. Would you watch my children for me until I get home?" When your statements are concise, there is less room for misinterpretation.

Make comments definitive, specific, and firm.

If your comments are definitive, specific, and firm, they also are more likely to be understood. Be precise in your speech. Give an example, if necessary, to clarify the meaning of your comments.

How do you know when you are acting on misconceptions or counter-productive attitudes? There are a number of cues that suggest that this might be occurring. First, if you are rehearsing a particular situation and you do not feel more comfortable after successive rehearsals, then you need to step back and determine what is occurring. Are you becoming more anxious because you are attempting to engage in behaviors which are in opposition to your values or beliefs? If so, are those values and beliefs erroneous or counterproductive?

Perhaps you are rehearsing a situation and you know what you would like to say, but your speech is hesitant and faltering. This is another cue for you to examine your beliefs to determine whether you are erroneous or counterproductive.

In another situation, you find yourself becoming increasingly aggressive or hostile. Once again, this is a signal that you need to think about what your beliefs are in the situation that may be influencing you to act in this aggressive manner.

Finally, you encounter one of the situations in the exercise modules or in your daily interactions, and your immediate response is, "I can't cope with this situation, even though I know it is appropriate to act assertively." This is another cue to examine your beliefs and attitudes.

As we have said previously, people develop a variety of beliefs and attitudes throughout their lives. Some of these are beneficial and adaptive, while some are not. Other beliefs were appropriate at one point, but have outlived their usefulness. We are not suggesting that you attempt profound modification of your beliefs system. Rather, we are suggesting that you examine your beliefs and attitudes

in those specific situations in which you are having difficulty asserting yourself. Are some of those beliefs erroneous or based on misconceptions? If so, should they be changed?

Since no two individuals subscribe to exactly the same beliefs, there is probably an extremely large and varied set of erroneous or counterproductive beliefs and attitudes which are relevant to assertion training. These counterproductive attitudes and erroneous beliefs can be organized into three categories: beliefs about rights and responsibilities; beliefs about how one should behave or appear to others; and beliefs about probable consequences of behavior. Listed below are several examples from each category. A detailed presentation of counterproductive attitudes and erroneous beliefs and how to cope with them can be found in Discussion Modules 5-18 (Assert Yourself, Galassi & Galassi, 1977a).

Some examples of erroneous and/or counterproductive beliefs about rights and responsibilities include:

I do not have the right to say no to my friend's request.
I have the responsibility to provide other people with a
    consistent justification for my behavior at all times
    and in all situations.
I do not have the right to ask others to do things that might
    inconvenience them.
I do not have the right to disagree with others, especially
    elders.
I do not have the right to question authority.
I do not have the right to be angry with others, especially
    not with friends.

The following are examples of counterproductive beliefs about how one should behave or appear to others:

I should be loved, liked, or at least admired by practically
    everyone.
I should be perfect, or at least pretty close, and should not
    make mistakes.
If I can't say anything nice to a person, I shouldn't say
    anything at all.

Appendix F

Training Session II, Assertion Training

Didactic Material

Adapted from <u>Assert Yourself</u> (Galassi & Galassi, 1977a) by permission of the publisher, Human Sciences Press.

Giving and Receiving Compliments

Being able to give compliments and express appreciation in an assertive manner is an important skill. We feel that people have the right to provide positive feedback to others about specific aspects of behavior, dress, and so on, which they appreciate. For example, "Mary, it was very kind of you to run that errand for me when you realized that I was going to be late." If you feel warm and complimentary toward someone or about something, you have the right to express that feeling regardless of whether others share your feelings. It is rare indeed when a compliment hurts another person.

There undoubtedly are many reasons why it is important to give compliments and to express appreciation when it is justified. Among them are the following:

1. Other people enjoy hearing sincere, positive expressions about how you feel about them.
2. Expressing compliments results in deepening and strengthening the relationship between two people.
3. When people are complimented, it is less likely that they will feel unappreciated or taken for granted.
4. Those instances in which you have to express negative feelings or stand up for legitimate rights with an individual are less likely to result in a high pitched, emotional confrontation if they occur in a relationship in which you previously have complimented the individual about other aspects of his/her behavior. In other words, negative feedback is received more favorably and is less likely to be threatening if a generally positive climate exists between the people involved.

Often when people have difficulty giving compliments, it is because they hold certain misconceptions or counterproductive attitudes that interfere with their behavior. As we have mentioned before, these attitudes often are idiosyncratic, but they must be disputed when they are encountered, and they must be replaced with more productive attitudes.

Listed below are some of the common counterproductive attitudes that we have encountered that prevent people from giving compliments when they are merited. Each of the counterproductive attitudes is followed by an internal dialogue that can be used for disputing the attitude and for arriving at a more productive view. In exploring your own beliefs and in reading the beliefs listed below, you may find it helpful to refer to Discussion Module 3 to review the methods

for changing misconceptions and counterproductive beliefs (<u>Assert Yourself</u>, Galassi & Galassi, 1977a).

Counterproductive beliefs about how I should behave and appear to others:

<u>I shouldn't have to compliment others. They should know how I feel from the way I act. Besides, I feel funny complimenting them.</u>

What is the evidence for this? What basis do I have for believing that other people are mind readers and that they know how I feel about them? They could interpret (misinterpret) my actions in more than one way. A sincere compliment would let them know how I feel and would be less likely to be subject to misunderstanding. Sure, I feel funny about complimenting others. It's something I rarely do, so of course I'll feel funny for a while. No, I shouldn't be required to give compliments, but, if I want to, I will. It will make the other person feel good to hear the compliment, and it will make me feel good to give it, if that's what I want to do.

<u>Why should I compliment him/her? He/she is getting paid for the work.</u>

Does this belief help me to achieve my goals and to do so without hurting others? I guess it doesn't really hurt the other person that much if I don't compliment him/her. But, I know that people respond well to a sincere expression of satisfaction, and if I feel that he/she merits a compliment, then I ought to be able to give one if I want to.

How do I feel when I'm getting paid for something? I guess everyone appreciates a kind word now and then. Money isn't the only reward for me.

Counterproductive beliefs about the probable consequences of behavior:

<u>If I go around complimenting people and telling them how much I appreciate them, they will think that I want something from them. Also, they may think that I am insincere.</u>

Why is this true? I'm only talking about giving compliments when I feel they are warranted, not giving them ad nauseum. I suppose that I really give too few compliments. When was the last time that someone acted suspicious about a compliment? Don't people usually enjoy hearing compliments? Maybe I ought to ask someone how they would feel if I gave compliments more frequently?

<u>I don't compliment other people because most people don't know how to take a compliment gracefully; they get all flustered or embarrassed.</u>

This belief doesn't help me to feel the way I want to feel,
does it? I want to be able to give compliments and to feel comfortable
doing so. Why do I think that I am responsible for the other person's
behavior? I can't control the other person's reactions. Besides,
if he/she becomes embarrassed, I can say, "I just wanted you to know
that this is the way I feel." I cannot and should not force the
other person to accept the compliment or to give me one in return.
All I can do is give the compliment, and that's that.

Receiving Compliments

Receiving a compliment is similar to giving a compliment in that
the manner in which it is handled influences both individuals in the
interchange. It is important to accept a compliment gracefully. A
compliment is a subjective evaluation by another person. If you do
not accept the compliment or you make it difficult for the other
person to give it, you are either questioning the validity of that
judgment or the honesty of the person giving the compliment. For
example, assume that a person compliments you on a suit that you are
wearing. Your response is, "This old thing?" or "You don't really
mean that." What your response communicates is either that the person
giving the compliment has poor taste in clothing or that he/she is
an insincere flatterer. Of course, there are situations in which a
compliment is undeserved, and you assert yourself and indicate that
you appreciate the compliment but that it is not warranted, (for
example, Sally/Joe did the report for which you are being complimented).

Accepting a compliment involves at a minimum acknowledging it
with a simple thank you, a smile, or a sentence such as, "I appreciate
hearing that." In addition, if you agree with the compliment, you
may wish to comment briefly on it: "I'm glad you like my suit. It
is my favorite." "I'm pleased that you like the report. I worked
very hard on it, and I was pleased with the results."

Once again, people often subscribe to counterproductive attitudes
that make it difficult for them to accept compliments. A few of these
attitudes, followed by internal dialogues which may be used to dispute
them, are listed below.

Counterproductive beliefs about rights and responsibilities:

People <u>really</u> <u>shouldn't</u> <u>compliment</u> me <u>because</u> I <u>usually</u> <u>don't</u>
<u>deserve</u> <u>it</u>.

Why is this so? Why do I think I'm so undeserving? After all,
if that's the other person's opinion, then he/she is entitled to it.
Isn't it rather impolite to dispute it? If he/she really feels that
way, it probably makes him/her feel good to say it. I guess I ought
to take it seriously and enjoy it if he/she is sincere about the
feeling.

If someone says something nice about me, then I have to say something nice back.

Who says that this is my responsibility? Why is it? If it is a compliment, then it doesn't have any strings attached, and the only thing that I will want to do is to acknowledge it. Suppose the other person also holds the belief that compliments must be returned? Then he/she would feel obligated to give me a compliment when I returned his/her compliment with one of my own. At that point, I would have to return his/her compliment and then he/she would have to return mine. This business could go on forever. Neither of us would feel the way we wanted. We probably would feel frustrated with each other, rather than complimentary toward each other. Also if I struggle to formulate a compliment in return, what does that communicate to the other person?

You have the right to express in an appropriate manner feelings of love, liking, or affection to those for whom you have such feelings. For most people, hearing or receiving such sincere expressions constitutes a most pleasant and meaningful interaction and one which often strengthens and deepens the relationship between the parties. In many cases, failure to express these feelings can result in friction or disruption of close personal relationships. Such an omission can lead the other person to feel taken for granted or unappreciated and weaken the relationship. Obviously, the appropriateness of the time and the place of expression are important factors in asserting very personal feelings.

It is important to respect the other person's reactions to your feelings. He/she may not reciprocate your feelings, now or in the future, and may not experience these feelings to the extent that you do. You can control only what you feel and say, not what the other person feels or says.

Some misconception and counterproductive attitudes which prevent the expression of these feelings as well as internal dialogues for disputing them are presented below. Discussion Module 3 (Assert Yourself, Galassi & Galassi, 1977a) contains additional suggestions about how to change misconceptions and counterproductive beliefs.

Counterproductive beliefs about how I should behave or appear to others:

It's too emotional (unmasculine) to express these feelings, and besides I feel silly doing so.

Why is this so? Such feelings are legitimate and healthy. Who says that I'm not supposed to express these feelings? What does masculinity have to do with feeling and expressing love and affection to someone? If I have these feelings and I want to express them, then I can feel free to express them in an appropriate manner.

He/she <u>should</u> know how I <u>feel</u> by now. Why <u>do</u> I <u>have to</u> say <u>it</u>?

    What evidence do I have for this belief? Since when have other people become mind readers? I know that a direct expression is subject to less misinterpretation than no expression. People feel unappreciated and taken for granted if they don't hear sincere expressions of how others feel toward them from time to time. If I have these feelings, it's best to express them.

Counterproductive or erroneous beliefs about probable consequences:

    <u>Expressing love, liking, and affection is risky since the other person may not feel the same way. If he/she doesn't feel the same way, where does that leave me</u>?

    This belief certainly does not help me to feel the way I want to feel. If I expect this relationship to become closer, someone will have to take some risks. If the other person doesn't feel the same way, at least I'll know. Wouldn't I rather express how I feel and take my chances than leave the other person and myself in doubt? If the other person doesn't feel the same way, then we can either work on the relationship or develop other more satisfying relationships.

    <u>If I tell the other person how I feel, then he/she should tell me how he/she feels</u>...(<u>or else</u>).

    Does this belief allow me to achieve my goals and to do so without hurting others? No, it doesn't. All I can do is to tell the other person my feelings and ask about his/hers. I can't force the other person to tell me how he/she feels. If I try to do so, I'm certainly violating his/her rights, and I'm probably working against my own best interest.

Appendix G

Training Session III, Assertion Training

Didactic Material

EXPRESSING PERSONAL OPINIONS

You have the right to express your personal opinions assertively. However, you do not have the right to force other people to accept those opinions or even to listen to them. The personal opinion category is rather broad, and in some ways expressing personal opinions is fundamental to all of the assertive behavior categories. Expressing personal opinions is concerned with volunteering a personal preference or taking a stand on an issue. It also includes being able to express an opinion which is in disagreement or potential disagreement with that of another person. Some examples of situations which call for you to express your personal opinions include: deciding how to spend an evening; choosing the color of a new car; expressing your opinions about friends; discussing a political issue; and expressing disagreement with another person's point of view. Each of these situations could involve one or more people and might require you to initiate the conversation, to volunteer an opinion, or to respond to a preceding question or point of view. . All of the situations offer you an opportunity to express your opinions.

Of course, we hope that you will choose freely to express or withhold your opinions in accordance with your evaluation of what is appropriate in that situation. We are concerned that you are able to express your opinions if you want to and that you do not feel pressured to adopt, to agree with, or to voice your opinion which runs counter to your own. We believe that people generally feel better about themselves if they are able to say what they think rather than being excessively concerned or preoccupied by anxiety about expressing themselves.

When you express your opinions, it is important to state them definitively and firmly. However, it is a violation of other people's rights if you badger or force them to accept or listen to your opinions when they clearly indicate that they are not interested.

Of course, there are potential risks that are involved in stating one's opinions, and you should be aware of them when you decide whether to express yourself in a given situation. One of the most common risks is that some people won't agree with your opinions. Others, of course, will. It is perhaps not as important that people agree with your opinions as it is to be able to express those opinions appropriately and to feel good about being able to do so. It is possible that some people might become angry or penalize you in some way for your opinions. Such occurrences probably are more infrequent than we fear; however, they do occur. If risk is realistic in a given situation, then it should be taken into account when you decide

whether to assert yourself or not. We believe that people worry
excessively about the possibility of reprisals for expressing their
opinions. As a result they are inclined to use their excessive
concern as an excuse or justification for not expressing their opin-
ions. Remember, when you are trying hard not to express your opinions,
you are still communicating something to your listener.

Some of the common counterproductive beliefs about expressing
personal opinions and internal dialogues to dispute these beliefs
are presented below. Discussion Module 3 contains additional sug-
gestions for changing counterproductive beliefs and misconceptions
(Assert Yourself, Galassi & Galassi, 1977a).

Counterproductive beliefs about rights and responsibilities:

I'm not smart enough, attractive enough, young enough, experi-
enced enough, etc., to be entitled to express an opinion on that
subject.

Is it true that I need to have special group membership in order
to be entitled to express an opinion? Of course not. Everyone is
entitled to his/her opinions. It is possible that special group
membership could give me more experience or knowledge about the sub-
ject. Nevertheless, I am still entitled to my opinion, and I have
the right to express it in an assertive manner.

Counterproductive beliefs about how I should behave or appear to
others:

If I voice my opinion and I am wrong, then how will I look?

I don't have to look any particular way to other people. What's
so awful about being wrong? I can't always be right. No one is.
If I am wrong, at least I'll know it, and I'll be able to rethink
my opinion. Besides, most opinions are subjective and are not nec-
essarily right or wrong. I'd rather be able to express my opinion
than to sit there like a bump on a log and feel inhibited.

Counterproductive or erroneous beliefs about probable consequences:

If the other person disagrees with my opinions, he/she won't
like me, and then we'll get into an argument.

What evidence do I have that supports this belief? People can
often disagree with each other on matters without disliking each
other. No two people and no group of people can always agree on
everything. If the other person doesn't like me for my views, that's
up to him/her, have a right to express them as long as I do it asser-
tively. Why does a disagreement have to result in an argument? All
I plan to do is to assert my position and listen to what the other
person has to say. If I feel that he/she is becoming aggressive,
I can always break off communication by saying something such as,

"Well, I understand your point of view, but I am still going to stand by my own views. Perhaps we could discuss it further at another time," or "I prefer that we do not discuss this any further since it seems we have reached an impasse on this matter."

EXPRESSING JUSTIFIED ANNOYANCE AND DISPLEASURE

There are a number of situations in which you are justifiably annoyed or displeased by the behavior of another person; a close relative constantly teases you about your new boyfriend/girlfriend; your secretary continues to make the same mistakes over and over after you have asked him/her repeatedly to correct it; someone violates your rights after you have indicated your position on the matter; your spouse comments on your weight problem when he/she knows how hard you are trying to stick to your diet; a subordinate continues to come to work late each morning; a friend or roommate borrows some jewelry without your permission. In all of these situations, you may feel justifiably annoyed or displeased, and if so, you have the right to express these feelings in an assertive manner. You also have the responsibility not to humiliate or demean the other person in the process. We trust that it is not your objective, when you express these feelings, to have the other person beg for your eternal forgiveness or throw himself/herself at your feet and plead for mercy.

What you are trying to accomplish is direct, nonaggressive communication of your feelings. Such an expression may or may not result in a change in the circumstances which originally caused your annoyance or displeasure. Sometimes it is too late to change the situation. However, by expressing your feelings you get these feelings off your mind so that you don't have to stew about them. In general, the purpose of expressing negative feelings is simply to relieve you of them as well as to make the other person aware of them so he/she doesn't repeat the same behavior again. We believe that, in most circumstances, it is better for you to express your justified annoyance and displeasure on the spot and hopefully resolve the matter than to carry these unpleasant feelings around with you.

As we mentioned earlier, expressing justified annoyance and displeasure assertively can be complicated by the fact that others may not respond favorably to such expressions. Such reactions probably can be minimized if a few general guidelines are observed when you formulate your verbal responses.

1. Keep your expression of annoyance and displeasure brief. Say exactly what you want to say initially. Once the other person has received the message, do not belabor or repeat it. That runs the risk of rubbing it in as well as the risk of escalating a mild annoyance into a full-scale war.

2. Don't make accusations or direct or indirect aggressive statements such as, "You are an inconsiderate so-and-so to have done that," or "Only people with very poor up-bringing would do such a thing. By the way where did you say you were raised?"

3. Incorporate "I" statements and "feeling talk" into the following three-part message:

   I (feel), when/because (<u>behavior that caused the feel-ing</u>). Next time, I would prefer that you (<u>request for new behavior</u>).

   You indicate in your message that you feel a certain way due to a specific behavior on the part of the other person. You also may wish to indicate to the other person how you would like him/her to behave to you in the future. The following statement is an example of how the general communi-cation can be used.

   I am really <u>annoyed</u>, because you <u>didn't consider my opinion when you made that decision</u>. Next time I would like you to <u>include me when you make a decision that affects both of us</u>.

   Such a message keeps the discussion on a more objective, less emotionally charged level.

4. If the other person wants to discuss or clarify the situa-tion, then he/she has a right to be heard, but without be-laboring the matter and without entering into an argument.

5. Use differential relaxation (Exercise Module 4, <u>Assert Yourself</u>, Galassi & Galassi, 1977a) as a way of helping you cope with excessive anxiety that you feel before, during, or after the situation.

In the same manner that we do not encourage you to run around asking others to grant all sorts of unnecessary favors for the thrill of it (see Discussion Module 6, <u>Assert Yourself</u>, Galassi & Galassi, 1977a), we also don't encourage you to spend your waking hours deter-mining every little thing that annoys and displeases you in order to express annoyance simply for the principle of it. Being able to express justified annoyance and displeasure is a valuable skill; however, we advise you to use it appropriately.

Listed below are some common counterproductive beliefs about expressing justified annoyance and displeasure and internal dialogues for disputing them. You may want to refer to Discussion Module 3 for additional suggestions about changing counterproductive beliefs (<u>Assert Yourself</u>, Galassi & Galassi, 1977a).

Counterproductive beliefs about rights and responsibilities:

   <u>If I'm really his/her friend, I don't have any right to be annoyed.
Real friends understand each other and don't get annoyed at each other.</u>

   What evidence do I have for this belief? Do I know anybody
who has such a relationship? Of course not. The people who are
really close are the ones who can get annoyed at each other from time
to time and still remain friends. I guess in some ways being able
to get annoyed at someone and then resolve it brings about a better
understanding between two people. Friendship involves a mutual give
and take. If I am justifiably annoyed or displeased, I have the
right to express it.

Counterproductive beliefs about how I should behave or appear to
others:

   <u>If I can't say something nice to someone, then I shouldn't say
anything at all.</u>

   Does this belief help me to feel the way I want to feel or to
avoid significant unpleasantness? It certainly seems rather difficult
to do. When I'm annoyed at someone, it's hard for me to remain happy,
cheerful, and pleasant. Usually I become less patient with them,
and sometimes I even avoid them. I guess that I'm kidding myself
if I think that by not telling them I'm annoyed that I'm concealing
my feelings toward them. My feelings will leak out in other ways
and may be subject to a great deal of misinterpretation. The other
person may not understand what is happening with me and may think
that the issue is a bigger deal than it really is. I can't expect
that ignoring my annoyance will make it go away or will hide it from
other people. It's better to express my annoyance. I hope that
will clear the air.

Counterproductive or erroneous beliefs about probable consequences:

   <u>If I express my displeasure, the outcome will be disastrous.</u>

   Is this belief true? I know that, when I assert myself, things
don't always work out exactly the way I hope they will, but a disaster
is unlikely. What am I afraid will happen? The other person will
be angry at me? I might be wrong. The other person won't like me?
Everyone can't like me. I'd rather express my annoyance and take the
chance that someone won't like me or will be angry at me. I can cope
with those possibilities better than walking around feeling annoyed
for a long time. If I'm wrong, then I will apologize. I don't know
of any magical formula that will allow me to determine beyond a
shadow of a doubt whether my annoyance is appropriate in a particular
situation. However, if I feel annoyed, then I have a right to express

it in an assertive manner. If the other person thinks that my annoy-
ance is misdirected or unjustified, he/she will tell me so, and then
we can discuss it. If my intentions are sincere, the other person
will probably understand how I feel and not hold it against me.

If I show my annoyance, the other person will use this annoyance
against me, and try to get me more annoyed.

What evidence do I have for this belief? Most people are rea-
sonable and will try to respect my feelings. If I meet someone who
gets pleasure out of annoying me, I can either ignore the other
person's childish attempts to provoke me or discontinue the relation-
ship. At least, I have control over my behavior.

EXPRESSING JUSTIFIED ANGER

You have the right to express justified anger in an assertive
manner to other people. You have the responsibility not to demean,
humiliate, or abuse them in the process. We trust that your objec-
tive is not to force the other person to beg for forgiveness.

Many people have been taught that they should not feel anger
or, at least, that they should not let other people know that they
feel it, and above all, that they should not express it. It probably
is impossible not to feel anger at some time, and we believe that
it often is undesirable and even damaging to an individual or a
relationship not to express justified anger when it is felt.

A major reason why people are taught not to express anger is
because they are likely to become aggressive during such expressions.
However, expressions of anger need not involve aggressive behavior.
It is possible to raise one's voice, scowl, be very intense, and
clearly indicate one's anger without threatening the other person,
without insulting the other person, or being punitive or sarcastic.
By using "I" statements and the three-part message described in
Discussion Module 12 (Assert Yourself, Galassi & Galassi, 1977a),
you will reduce the likelihood that aggressive content will creep
into your verbal behavior. Differential relaxation and changing
counterproductive beliefs also will help reduce the aggressive content
in both your verbal and nonverbal behavior.

We feel that it is important to be able to express justified
anger in an assertive manner when it occurs. Anger is a volatile,
potent emotional experience. It is difficult to bottle up and can
lead to the development of psychological and psychosomatic complaints
if it is frequently felt but seldom expressed. In addition, people
usually communicate their angry feelings in one way or another.
Many ways of expressing anger are not constructive. Some of these
include: revenge, impatience with the person who caused the anger
or with other people, avoidance of the person who caused the anger,

blowing up at the person over a trivial or minor incident, and so on. We believe that you usually will feel better if you express your anger in an assertive manner when it occurs, and that such expressions ordinarily will clear the air between you and the other person(s). We refer you to Discussion Module 12 for tips on how to express your anger in a constructive manner. In summary, they are:

1. Be brief. Once you've made your point, don't belabor it.
2. Avoid making accusations.
3. Use "I" statements and the three-part communication.
4. Be willing to listen to the other person's point of view. End the conversation if it appears that it may result in an argument.

Some of the common misconceptions and counterproductive beliefs about expressing anger and internal dialogues for disputing those beliefs are discussed below. Discussion Modules 3 and 12 also contain helpful information.

Counterproductive beliefs about rights and responsibilities:

There is something basically bad about people who make me angry. . Bad people ought to pay for their behavior, and since no one else seems to be punishing them for it, I guess I will have to do so.

Why is this true? Who says that people who make me angry are necessarily bad? In most cases, they probably don't do it deliberately. Who says they should be punished, and even if they should who gave me the right to mete out justice? Besides, it doesn't help me to attain my goals without hurting others in the process.

Counterproductive beliefs about how I should behave or appear to others:

If people see me get angry, they will think that I am uptight, irrational, crazy, or ill-tempered.

This belief certainly doesn't help me to feel the way I want to feel. It gives me a choice between two unpleasant feelings; remaining angry if I don't express my feelings, or feeling embarrassed if I express my feelings and someone witnesses the spectacle. I cannot control what others think. If they look down on me for expressing my anger, that's their right. At least, I won't have to carry that anger with me, and they may respect me for being able to express my anger without becoming aggressive.

Counterproductive or erroneous beliefs about probable consequences:

If I express my anger, the other person will fall apart.

Is this true, and does it help me to avoid significant unpleasantness without denying my rights? First, most people do not fall apart when others are angry at them. In some cases, they get upset for a short period of time, but that's about it. If I am dealing with a person who is very sensitive to anger or criticism, I can choose my words accordingly if necessary. However, I shouldn't use that as an excuse not to express how I feel, particularly if I'm going to feel worse as a result. Most people can cope with anger, and if I express it assertively then it's less of a problem for them.

Appendix H

Training Session IV, Assertion Training

Didactic Material

REFUSING REQUESTS

You have the right to say no to requests that are unreasonable and to requests which, although reasonable, you do not care to grant. Being able to say no when you mean no is important for a variety of reasons. First, it helps you to avoid becoming involved in situations which you think you will regret being involved in at a later time. It also helps to prevent the development of circumstances in which you will feel as though you have been taken advantage of, abused, or manipulated into doing something which you did not care to do. Finally, it allows you, rather than the other person, to make your decisions and to direct your life in that situation.

There are several points that are important to be aware of in situations in which requests are made of you. First, when someone makes a request, they are asking you to do something for them. It is their perfect right to make such a request. However, a request is something which you are perfectly free to grant or reject. It is not a social or moral obligation with emotional strings attached to it. Therefore, there is no reason to feel guilty or devoid of humanitarian spirit if you do not grant the request. Any attempt by the other person to manipulate you into granting it by making you feel uncomfortable is inappropriate and needs to be resisted. You may want to consult Discussion Module 6, Making Requests, for additional comments on this point and on related issues (Assert Yourself, Galassi & Galassi, 1977a).

Be sure you completely understand the request before you make your decision. If you don't understand it, ask for clarification and, if necessary, repeated clarification until you do understand it. Often it is those vague, small, or innocent requests which turn out to have those hidden, objectionable commitments or fine print buried in them. You have the right to understand what is being asked of you before you make your decision. Moreover, some people will attempt to capitalize on your fear of appearing unintelligent if you have to ask for clarification. The result is that you are pushed into making decisions that may not be in your best interests.

You also have the right to postpone making a decision. If you are not sure about how you feel about a decision, it is appropriate and even desirable to postpone a decision on the matter. In postponing the decision, you need not feel compelled to give a time or date by which you will make the decision. Our intent is not to encourage you to postpone making a decision because you are afraid that you will have to say no to someone. Rather, we are concerned with those situations in which you feel pressured to make a hasty

and premature decision. For example, a common principle of selling is to get the customer to make a decision on an article of merchandise while he/she is with the salesperson before he/she has an opportunity to do some comparison shopping or to evaluate the decision carefully and change his/her mind.

When you have decided to refuse a request, say no definitively and, if necessary, repeatedly. If you give excuses or long-winded explanations for your behavior, the other person may point out the lack of logic and the weaknesses in your arguments, thereby disarming you and resulting in your feeling bad. You need not feel responsible for justifying your refusal. If you feel pushed in the situation, you can always say something such as, "I just don't want to do it, so I would appreciate it if you wouldn't ask me again. My answer will remain the same." When your answers aren't definitive, you communicate to the other person that he/she has not convinced you yet and thereby reinforce his/her repeating the request. Once you have given a definitive response, further requests by the other person would seem pushy and inappropriate and can be ignored.

Listed below are some common counterproductive attitudes about refusing requests as well as internal dialogues to dispute them. You may want to refer to Discussion Module 3 for additional suggestions about changing counterproductive attitudes.

Counterproductive beliefs about rights and responsibilities:

It's such a worthy cause (reasonable request). It's not right to refuse.

Why is this so? Can I support all the worthy causes and grant all the reasonable requests with which I am confronted? Of course not. It's up to me to decide for myself what causes I'll support and what requests I'll grant. Just because it is reasonable or worthy is not sufficient. I have the right to say no if that's the way I feel. I don't have to justify my decision or to refute the other person's rationale.

Counterproductive beliefs about how I should behave or appear to others:

After he/she has shown me so many of these items, it would be cruel and insensitive to him/her not to buy at least one.

Why is this so? I came in with the idea of buying something if there was something I liked. I didn't come in to give this salesperson a hard time. Besides, he/she is getting paid and should realize that he/she can't make every sale. There is no reason for me to feel guilty, because I haven't done anything that is unfair or insensitive. If I appreciate his/her service, then I can say so. However, I am free to refuse to buy any items if they are not what I want.

<u>If I really am a friend, I should grant that request</u>.

Why is this so? Does friendship mean that I have to grant requests each and every time they are made? Does it mean having someone else make my decisions for me? Of course not. Certainly, I feel more inclined to do a favor for a friend than for a stranger, but my friendship shouldn't hinge on that. If this other person is really my friend, he/she will understand and respect my decision not to grant this request.

Counterproductive or erroneous beliefs about probable consequences:

<u>It is easier to grant this person's request than to face how he/she will feel if I don't grant it</u>.

This belief certainly doesn't help me to feel the way I want to feel or to avoid significant unpleasantness. This person just keeps asking and asking, and it's unpleasant each time it happens. Maybe I'm just encouraging him/her to ask me since he/she knows that I won't refuse. Right now I'm avoiding what I think will be an unpleasant experience if I say no, but as a result I have to endure a lot of unpleasant feelings each time I say yes. I have the right to say no. Perhaps if I say it in a definitive, assertive way, he/she won't bother me about it again. I'm not really sure that he/she will be upset if I say no. It's not my responsibility to sacrifice myself for his/her requests. It is my right to refuse if I want to refuse.

MAKING REQUESTS

This category, making requests, includes asking for favors, asking for help or assistance, and asking another person to change his/her behavior. We believe that you have both the right to make requests of other people and the responsibility to respect their definitive replies to your requests. People are not self-sufficient. They often require assistance from each other in a variety of daily interactions. As a result, we believe that it is natural and acceptable to make requests of other people (for example to perform certain tasks, to borrow money or possessions, and so on) with the understanding that they are free to comply with the request, refuse the request, or to postpone a decision on the request with no strings or emotional entanglements involved.

Lest we be misunderstood at this point, we want to state emphatically that we are not suggesting that you indiscriminately make requests of other people. We also suggest that you do not postpone performing tasks until it is no longer possible for you to complete them and then ask someone else to take on your responsibilities. You make a nuisance out of yourself by constantly asking others for

unnecessary favors. Such behavior is pushy and shows little concern for the rights of others. However, we do believe that it is quite acceptable to make requests when they are needed.

You have the responsibility to respect a definitive no. Often when we make a request of another person, the other person either does not fully understand the nature of our request, or has not decided whether he/she wants to comply with it. As a result, his/her responses are sometimes unclear or not definitive. In such instances, it seems appropriate to restate or clarify the request one or more times. However, at some point, a definitive response usually is forthcoming. If this response is negative, further requests would seem to be inappropriate. They would appear pushy or aggressive and would display little or no concern for the other person. In such a situation, a single request for the other person to reconsider his/her position may be in order, but no more. Appeals to the other person's sense of fair play, begging, threats, insults, or resorting to statements about the responsibilities of true friends seems manipulative and objectionable.

Some common counterproductive beliefs as well as internal dialogues for disputing them are presented below. Discussion Module 3 contains other suggestions about changing misconceptions and counterproductive attitudes.

Counterproductive beliefs about rights and responsibilities:

If I ask for a favor, I am imposing on someone.

What is the evidence for this belief? How am I imposing on someone by asking? I am only imposing if I do not believe that the individual has the freedom to reject my request or if I do not allow him/her to do so. I'm also imposing if I believe the request constitutes an unforgivable inconvenience. If I placed myself in the other person's position, would I consider the request to be an unforgivable inconvenience? Or, is it really quite reasonable? As long as I believe that the other person has the right to say no and as long as I don't make a nuisance of myself, I have the right to ask for favors.

Counterproductive or erroneous beliefs about probable consequences:

If I make a request, the other person won't be able to say no even if he/she wants to refuse.

What evidence do I have that most people cannot act in their own best interest? If I am not sure that someone really wants to grant my request, I can always ask him/her if he/she prefers that I ask someone else. If I expect to behave assertively in the area of making requests, I need to assume that people can refuse my requests if they want to do so.

<u>If I ask help or assistance, the other person should realize</u>
<u>that I really need it and should help me out</u>...(or else).

Does this belief enable me to achieve my goals and to do so
without hurting others? Of course, it doesn't. People are free to
grant or refuse my requests. They are not obligated to me. If I
believe that they are obligated, it only leads me to try to impose
my will on them. Such behavior is aggressive and hurts others. All
I can do is ask and indicate why I need and would appreciate their
help. Then it's up to them. At most, I can indicate my disappoint-
ment with them for not helping, but I can't and should not attempt
to force them to do my bidding.

<u>If I ask for and receive a favor, then I will be obligated to</u>
<u>the other person. I will be expected to do a favor of equal or</u>
<u>greater size in the future, and I don't want this obligation.</u>

Why is this so? A favor is a favor is a favor. It is granted
or refused freely. Any sense of obligation I feel is self-imposed.
If I feel obligated, it probably is because I believe I should be;
because I feel that I was not deserving; or because I think of favors
as social requirements which are not given freely. Yes, I may feel
grateful to someone who has done a favor for me, and I may be more
inclined to do a favor in return for him/her. However, in most
instances, obligation was not written into the favor when it was
granted.

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