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THE RELATIONSHIP BETWEEN GOAL ATTAINMENT AND SELF
CONCEPT FOR ASSERTIVE TRAINING GROUPS

by

Lori Peterson

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

of

MASTER OF SCIENCE

in

Psychology

Approved:

UTAH STATE UNIVERSITY
Logan, Utah

1978

ACKNOWLEDGEMENTS

I wish to thank all those who assisted in the completion of this study.

This thesis is dedicated to Dr. Bill Dobson, my committee chairman, to whom I express appreciation for his suggestions, guidance, and continual support and care throughout my training and completion of this study.

I would also like to sincerely thank Dr. Keith Checketts for his willingness to contribute time and statistical knowledge to this research project.

To Dr. Elwin Nielsen, I express gratitude for the encouragement and support he has given throughout my training.

Finally, I would like to give special mention to my colleagues who helped make my graduate work especially enjoyable.

Lori Peterson

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	ii
LIST OF TABLES	v
LIST OF FIGURES	vi
ABSTRACT	vii
Chapter	
I. INTRODUCTION	1
Statement of the problem	1
Purpose	2
Objectives	4
Hypotheses	4
Definitions	5
II. REVIEW OF LITERATURE	8
The Development of Assertive Training.	8
Assertive Training Methods	11
Self-Concept and Assertive Training	15
Assertive Training and Goal Setting and Attainment	19
Summary of Review	20
III. METHODOLOGY	22
Subjects	22
Treatments	23
Instruments	24
Tennessee Self Concept Scale (TSCS)	24
Reliability and Validity of the TSCS	25
Goal Attainment Scaling (GAS)	26
Reliability and Validity of GAS	29
Behavioral Monitoring Progress Record	30
Procedures	30
AT Methods	34
Research Design	37
Statistical Analysis	38
IV. RESULTS	39

Hypothesis 1 - Correlation Between Pretest TSCS and GAS	39
Hypothesis 2 - Correlation Between Posttest TSCS and GAS	39
Hypothesis 3 - Test of Significance Between Correlation Coefficients	40
Hypothesis 4 - Differences in GAS for Each Group	42
Hypothesis 5 - TSCS Mean Comparisons	42
 V. DISCUSSION AND CONCLUSIONS	 44
Discussion of Results	44
Conclusions	47
Limitations	49
Recommendations	49
 REFERENCES	 50
 APPENDICES	 54
Appendix A. Informed Consent Form	56
Appendix B. Information for Assertive Training Study	58
Appendix C. Samples of Goal Attainment Follow-Up Guide and Behavioral Monitoring Progress Record59-61
Appendix D. Group Assertive Training Handout	63

LIST OF TABLES

Table	Page
1. Means, Standard Deviations and Correlation Coefficients for Pretest and Posttest TSCS and GAS	41
2. Summary Table for 2x3 Analysis of Variance	43
3. Pretest and Posttest TSCS Means for Each Group	46

LIST OF FIGURES

Figure	Page
1. Goal Attainment Follow-Up Guide	27-28
2. Behavioral Monitoring Progress Record	31
3. Mean Tennessee Self Concept Scale Scores of subjects at Pretest and Posttest	46

ABSTRACT

The Relationship Between Goal Attainment
and Self Concept for Assertive
Training Groups

by

Lori Peterson

Utah State University, 1978

Major Professor: Dr. William R. Dobson
Department: Psychology

The objective of this research was to investigate the relationship between self-concept and goal attainment for assertive training groups. To determine if self-concept is related to the extent to which one's goals are attained was of major interest. Another purpose was to determine if self-concept measures increase as a result of participation in group assertive training.

Subjects were 67 volunteers, students from Utah State University, and Cache Valley, Utah, community members.

Subjects were administered as pretests and posttests the Tennessee Self Concept Scale and the Goal Attainment Scaling procedures including the Behavioral Monitoring Progress Record.

Three groups were formed: 1) AT I, a self-directed assertive training group, 2) AT II, a directed, goal-oriented assertive training group, and 3) a no-treatment control group. Four assertive training sessions were conducted and posttesting was completed.

Two correlations were computed: 1) the pretest TSCS scores were correlated with the GAS scores, and 2) the posttest TSCS scores were

correlated with the GAS scores. A test of significance between correlation coefficients was applied to the two correlation coefficients obtained. The two correlations were not significantly different at the .05 significance level suggesting that the extent to which goals are attained is not related to self-concept for the two assertive training groups.

Increases from the TSCS pretest to posttest for each assertive training group were significant as indicated by the analysis of variance for repeated measures. The experience of participating in both assertive training groups was suggested as effecting positive changes in self-concept.

(65 pages)

CHAPTER I

INTRODUCTION

Assertive training, a relatively new therapeutic approach for the facilitation of more rewarding interpersonal interactions, is being implemented by many professionals and paraprofessionals across the country. Since the publication of Your Perfect Right (Alberti & Emmons, 1970, 1974) in 1970, there has been a rash of books, journal articles, seminars, symposia, and widespread media coverage dealing with assertive training. Although assertiveness is not considered a panacea, benefits have accrued to some passive and inhibited, as well as aggressive persons under the auspices of competent assertive trainers (or therapists) (Lange & Jakubowski, 1976).

In brief, assertive training involves the acquisition of skills such as expressing positive and negative feelings in a direct and honest manner, complimenting others and being able to accept compliments, initiating and maintaining conversation in social settings, expressing feelings and opinions in a way that will not result in retaliation, punishment and feelings of guilt, learning how to avoid being taken advantage of by others, achieving closer and more rewarding relationships, and acquiring a greater degree of self-confidence and control over one's life (Alberti & Emmons, 1974; Osborn & Harris, 1975).

Statement of the Problem

Vast research in the area of assertiveness has evolved around the effectiveness and evaluation of group and individual training techniques (McFall & Marston, 1970; Freidman, 1971; McFall & Twentyman, 1971, 1973;

Eisler, Hersen, & Miller, 1973; Hersen, Eisler & Miller, 1973; Eisler, et al., 1975; Galassi & Galassi, 1976); the development of measures of assertiveness (Rathus, 1972; Gay, 1975; Gambrell & Richey, 1975); and the component behaviors of assertiveness (Eisler, et al., 1973).

The goal of assertive training as a behavior therapy approach (Wolpe, 1958, 1969) is to facilitate assertive behaviors suppressed or lacking in the individual's response repertoire. Assertive training is goal-oriented in that it centers on determining the desired assertive behaviors and the goals or methods required to facilitate obtaining these behaviors.

Though theorists and practitioners purport that behaving assertively enhances one's self-concept (Alberti & Emmons, 1974; Osborn & Harris, 1975; Cotler & Guerra, 1976; Lange & Jakubowski, 1976), research supporting this assumption has been largely neglected. Extensive reviews of the literature (Fitts, 1972; Thompson, 1971) on the specific relationship between behavior change and self-concept have revealed little research. No significant studies have been conducted to determine how self-concept and assertiveness are related. Likewise, no evidence exists in the literature investigating the effectiveness of goal setting and attainment level on self-concept for assertive training group members. The necessity of using a behaviorally structured, goal-oriented method in assertive training is repeatedly emphasized (Cotler & Guerra, 1976).

Purpose of Study

The major purpose of this study was to investigate the relationship between measures of self-concept and the extent to which goals related

to assertiveness are achieved for directed and self-directed assertive training groups. The two assertive training experimental groups differed on their goal setting and approach procedures.

The procedures for the directed group (AT Group II) included an individual interview to specify goals in behavioral terms, delineation of goal outcome (GAS) levels, specification of step-wise approaches to each goal, and the establishment of weekly procedures for the acquisition of long-term goals. This method required each individual to meet weekly with a group leader at the end of each AT session to discuss attainment or performance of the week's goals. The goals for the following week were targeted for each individual. Group leaders encouraged individuals to work on identified goals in and out of the assertive training group sessions. During the time designated for role-playing personal/social encounters, this group was instructed to practice or work on their pre-determined goals.

The self-directed group (AT Group I) was characterized by the same goal identification interviews, behaviorally described goals, and delineation of probable or expected levels of goal outcome. Individuals independently selected goals for themselves during group sessions. Group leaders encouraged members to select goals to work on in and out of assertive training group sessions which they felt were personally relevant. No guidance for goal selection was provided, although attainment of personal goals was encouraged. The self-directed procedures were similar to the type of procedures typically implemented in assertive groups cited in the literature.

It was of particular interest to determine if there were differences between pretest measures of self-concept and posttest measures of

self-concept for each group in order to investigate contentions that self-concept improves as a result of participation in assertive training.

Objectives

1. To determine the relationship between pretest measures of self-concept and measures of goal attainment.
2. To determine the relationship between posttest measures of self-concept and measures of goal attainment.
3. To ascertain the relationship between the correlation of self-concept pretest measures with goal attainment measures and the correlation of posttest self-concept measures with goal attainment measures.
4. To determine if there are differences between groups on level of goal attainment.
5. To ascertain if there are differences between groups on measures of self-concept following assertive training.

Hypotheses

Stated in the null form the following hypotheses have been tested:

1. There is no correlation between pretest measures of self-concept as measured by the Tennessee Self Concept Scale (Fitts, 1965), and measures of goal attainment, as measured by the Goal Attainment Scale (Kiresuk & Sherman, 1974).
2. There is no correlation between posttest measures of self-concept, as measured by the Tennessee Self Concept Scale, and measures of goal attainment as measured by the Goal Attainment Scale.
3. There is no difference between the correlation of the pretest self-concept measures with goal attainment measures (Hypothesis 1) and

the correlation of posttest self-concept measures with goal attainment measures (Hypothesis 2).

4. There is no difference between the Goal Attainment Scaling (GAS) scores for each group (conditional on obtaining significance with Hypothesis 3).

5. There is no difference between the pretest and posttest Tennessee Self Concept (TSCS) scores for each group.

Definitions

Assertion (assertive, assertiveness). The term "assertion" (used interchangeably with "assertive" or "assertiveness") in the present study refers to:

Behavior which enables a person to act in his own best interests, to stand up for himself without undue anxiety, to express his honest feelings comfortably, or to exercise his own rights without denying the rights of others (Alberti & Emmons, 1970, p. 2)

Assertiveness is a self-enhancing behavior involving an honest expression of feelings usually resulting in attainment of one's goals in contrast with inhibiting, self-denying behaviors and aggressive behaviors (Alberti & Emmons, 1970).

In addition, the definition of assertive behavior according to Cotler and Guerra (1976) will be employed:

Behaviorally speaking, an individual who is assertive can establish close interpersonal relationships; can protect himself from being taken advantage of by others; can make decisions and free choices in life; can recognize and acquire more of his interpersonal needs; and can verbally and nonverbally express a wide range of feelings and thoughts, both positive and negative (Cotler & Guerra, 1976, p. 3)

AT. An abbreviation for "assertive training" which is a behavior therapy training approach characterized by its emphasis on acquiring assertive skills or behavior using a self-directed or directed group approach.

AT therapist. An AT group leader or facilitator.

AT group member. Volunteers from Cache Valley, Utah and students from Utah State University, Logan, Utah, selected as subjects for AT. AT group members are often referred to as "group member", "client", "assertor", and "subject".

Directed group (AT Group II). An AT group in which each group member's goals are delineated and behaviorally described with steps to attain the goals prescribed in cooperation between the AT therapist and the AT group member (also referred to as the "goal-oriented" or "prescribed" group).

Self-directed group (AT Group I). An AT group in which group members are allowed to select and approach their own assertive goals without direction by the AT therapists.

TSCS. The Tennessee Self Concept Scale used as a measure of self-concept for AT group members and control group.

GAS. Goal Attainment Scaling, an approach using behavioral scales to demonstrate attainment relevant to specific goals within major problem areas.

Guide-to-goals. A programmed instruction manual (from the GAS model) which guides subjects through identification of concerns or areas in which attainment of assertive behavior is desired. These concerns are noted on a GAS follow-up guide.

GAS follow-up guide. A procedure for joint identification of concerns between the AT therapist and subject specifying predicted levels of goal attainment to be checked prior to and following intervention.

BMPR. Behavioral Monitoring Progress Record is a goal monitoring procedure in which weekly subgoals are set in collaboration with an AT therapist and AT Group II member. Goals are monitored to assess weekly GAS progress for AT Group II group members only.

CHAPTER II

REVIEW OF LITERATURE

The literature reviewed for this study was divided into four areas of concern: 1) The Development of Assertive Training, 2) Assertive Training Methods, 3) Self Concept and Assertive Training, and 4) Assertive Training and Goal Setting and Attainment.

The Development of Assertive Training

Salter's (1949) book entitled Conditioned Reflex Therapy perhaps dates back farthest in the literature of assertive training. Salter maintained that attainment of a "free, outflowing personality in which true emotions are expressed in speech and action" is a matter of reconditioning the faulty, inhibitory behaviors in the direction of excitation. In order to condition excitation, Salter (1949) prescribed six therapeutic response styles in terms of "feeling talk" (saying what you feel); "facial talk" (the corresponding nonverbal expression of feelings); the ability to make "contradict and attack" statements when in disagreement; the frequent use of "I" statements; the ability to accept praise and compliments; the ability to praise oneself; and the ability to live for the present and act spontaneously. These six behaviors termed "excitatory reflexes" by Salter, have been equated with assertive behavior. Many procedures currently implemented in assertive training can be found in Salter's publication.

Another individual who has made a major contribution to the area of assertion is Joseph Wolpe. In a number of his writings, Wolpe (1958, 1969, 1970) presented assertion training as one of the

major procedures by which an individual can reciprocally inhibit and, consequently, eliminate anxiety. Whereas Salter (1949) applied "excitatory reflexes" when describing behaviors, Wolpe preferred to label these behaviors "assertive" since anxiety is a form of excitation (Wolpe, 1958). Assertive responses, being incompatible with anxiety, are encouraged and reinforced and used to compete with the more anxiety-related maladaptive responses that occur in the course of interpersonal relationships (Wolpe, 1969).

To investigate Wolpe's contentions, Orenstein, Orenstein, and Carr (1975) studied the relationship between assertiveness and anxiety in college undergraduates using self-report measures. Three discrete groups were formed on the basis of the Rathus Assertiveness Schedule (Rathus, 1972) scores: high assertive, average assertive, and low assertive. Trait anxiety and fear schedules were administered to the 86 subjects. The results supported the hypothesis that assertiveness and anxiety are inversely related. There were significant differences between the three groups on all measures. Low assertive subjects showed elevations of both trait anxiety and interpersonal fears. These findings may have implications for the treatment of low assertive patients who suffer from generalized anxiety.

The relative efficacy of three treatment conditions (cognitive rational therapy, assertive training, and a combined treatment) on the production of assertive behavior and reduction of interpersonal anxiety was investigated by Tiegerman (1975). The subjects, 51 volunteer undergraduate students, were assigned to the three groups which met for twelve weekly sessions. Self-report measures of assertion, interpersonal anxiety and general emotional adjustment were

administered. The hypothesis predicting that the combined treatment condition would be most effective was not supported. Instead, the assertive training group evidenced the most consistent gains in promoting assertion and reducing interpersonal anxiety.

These findings clearly support Wolpe's (1969) contentions that assertive training is effective in inhibiting interpersonal anxiety for college undergraduates.

In addition to Salter's (1949) response inhibition theory for explaining the presence of inappropriate behaviors (consequently, the need for excitation) and Wolpe's (1958) anxiety hypothesis for the occurrence of nonassertive behaviors, there is another notable explanation. This third explanation assumes that the appropriate assertive behaviors are not in the individual's response repertoire from the beginning (Wolpe & Lazarus, 1966; Laws & Serber, 1971; Hersen, Eisler, & Miller, 1973). In Behavior Therapy Techniques (Wolpe & Lazarus, 1966), the authors indicated that not only do individuals have certain basic assertive "rights" which they are entitled to exercise, but that anxiety, and somatic symptoms can result if these "rights" are not acted upon. Anxiety may be only one of several negative consequences resulting from nonassertion or aggression. Also described in some detail by Wolpe & Lazarus (1966) are the treatment variables currently found in assertion training such as the use of behavior shaping techniques, behavioral rehearsal or role-playing, modeling the therapist's assertive behaviors, and homework assignments.

Between 1966 and 1970, the number of articles on assertion-related procedures began to increase dramatically. Various studies

were conducted comparing different treatment techniques (Cotler & Guerra, 1976). In 1970, the interest and research in assertion training began to proliferate when Alberti and Emmons (1970, 1974) published Your Perfect Right: A Guide to Assertive Behavior which is perhaps, one of the best reference books on assertion training since Salter's 1949 text. A distinction was made between assertive behavior, nonassertive and passive behaviors and aggressive behaviors. In changing the label of "patient" to "trainee" and that of "therapist" to "facilitator", Alberti and Emmons (1970) drew attention to the "training" aspects existing in assertion training. Alberti and Emmons also discussed assertion training done in groups (which has become the treatment of choice in recent years) since the nature of assertive training implies a social context (Fensterheim, 1972; Cotler & Guerra, 1976).

The bulk of the literature from 1970 to present centers around the relative efficacy of various training techniques or models as well as comparing assertive training to other therapeutic methods.

Assertive Training Methods

Behavioral training approaches to therapy are based on a response acquisition model of treatment. The therapeutic objective is to provide clients with direct training in precisely those skills lacking in their response repertoires. Little attention is given to eliminating existing maladaptive behaviors; instead, it is assumed that as skillful, adaptive responses are acquired, rehearsed, and reinforced, the previous maladaptive responses will be displaced and will disappear (McFall & Twentyman, 1973). Assertive training possesses these behavioral training characteristics.

Alberti and Emmons (1970) indicate that a group provides a "laboratory" of other people with whom to work. Because the group is typically understanding and supportive, the client is able, and encouraged to experiment with new behaviors. There is a broader base for social modeling and greater feedback in group than in individual assertive training (Alberti & Emmons, 1970).

Group training allows for the implementation of behavioral training methods for the treatment of nonassertive individuals. These methods are: 1) Behavioral rehearsal: the assertor practices responding assertively in the problem situation with the therapist and other participants role-playing others in the scene. The therapist and other participants may serve as assertive models for and coach the assertor. By actively role-playing or rehearsing those situations which the assertor has avoided or fears, the assertor is able to acquire additional verbal and nonverbal skills and is, hopefully, able to reduce anxiety in the process (Fensterheim, 1972; Lange & Jakubowski, 1976; Cotler & Guerra, 1976; Wolpe, 1969). 2) Modeling: the assertor observes the therapist, a coached actor, another participant, or an audio and/or video tape demonstrating assertive behavior and vicariously assertive behavior is learned (Lange & Jakubowski, 1976). 3) Coaching: The therapist and other participants offer the assertor descriptions or suggestions of what constitutes an appropriately assertive response (McFall & Twentyman, 1972; Lange & Jakubowski, 1976). Constant feedback, prompting, and positive reinforcement are given to the assertor (Cotler & Guerra, 1976).

Behavioral rehearsal modeling and coaching are the basic components of assertive training and are used frequently in groups cited

in the literature. These methods are typically implemented as follows.

In the behavioral rehearsal approach the assertor role-plays in a situation where interpersonal difficulties are encountered. The individual must respond with various behaviors that may have been avoided in the past. The situation is practiced until the appropriate skills have been acquired and until the anxiety is within tolerable limits. During this practice, the assertor is provided with a coach who assists, prompts, reinforces, and gives feedback to the assertor. In cases where anxiety is initially high, the assertor may vicariously experience the assertive interaction by observing a model role-play in a specific situation (Cotler & Guerra, 1976; Lange & Jakubowski, 1976; Wolpe, 1970).

Numerous studies have been conducted investigating the relative effectiveness of behavior rehearsal, modeling and coaching in combination, isolation, and in comparison to other training techniques.

McFall and Marston (1970) investigated the effectiveness of behavioral rehearsal therapy in assertive training with and without feedback as compared with that of two control conditions: placebo insight therapy and no therapy. Forty-two nonassertive college students were administered anxiety, fear, and assertive self-report inventories measures, as well as a behavioral role-playing test in which subjects were presented with tape recorded stimulus situations requiring assertive responses. Subjects in the feedback group received a playback of their responses to the behavioral test. The no-feedback subjects were instructed to reflect on their responses. The findings revealed that the two behavioral rehearsal procedures resulted

in significantly greater improvements in assertive performance than did the control conditions. There was a nonsignificant tendency for behavioral rehearsal coupled with performance feedback to show the strongest treatment effects.

A later study with college students by McFall and Lillesand (1971) tested the effectiveness of behavioral rehearsal with modeling and coaching. Subjects in an "overt" group practiced their assertive responses (refusing requests) aloud and heard a recorded replay of their behavior. A "covert" behavioral rehearsal group also received modeling and coaching, but the subjects spent time reflecting on their refusal responses and did not hear a recorded replay of their assertive behavior. Compared to a no-treatment control group, both treatment groups showed significant improvement on various measures with respect to refusing unreasonable requests. Although the learning had generalized to other untrained refusal situations, it did not generalize to other forms of assertive behaviors. Consequently, it may be important and necessary for the individual to have assertive training experience with each of the situations in which difficulties are experienced.

In a complex study, McFall and Twentyman (1973) attempted to evaluate the relative contribution that rehearsal, modeling, and coaching made to the assertion process. Each nonassertive college student was assigned to one of six treatment conditions: 1) rehearsal, modeling, and coaching; 2) rehearsal and modeling; 3) rehearsal and coaching; 4) rehearsal only; 5) modeling and coaching; and 6) assessment control (no rehearsal, coaching or modeling). The subjects were administered the Behavioral Role-Playing Assertion Test and self-report

assertiveness measures. Their results indicated that the training components of rehearsal and coaching both made significant additive contributions to improved performance on self-report and behavioral assertion measures; however, modeling added little to the effects of rehearsal alone or rehearsal plus coaching. Positive treatment effects generalized from trained to untrained situations. There was evidence that treatment effects transferred from the laboratory to real-life situations.

Other studies, using nonassertive college students as subjects, where the variables of modeling, rehearsal, and coaching were either evaluated and/or used as an integral part of the procedure include Hedquist and Weinhold (1970); Friedman (1971); Rathus (1972); and Galassi and Galassi (1976). In each of these studies, the variables of modeling, rehearsal, and coaching or combinations of these procedures proved superior to various groups that were used for comparison.

In addition to studies involving college students as the subject population, a number of other significant studies have been conducted more recently with hospitalized patients as the treatment population (Weinman et. al., 1972), psychotic patients (Eisler, Hersen & Miller, 1973) and schizophrenic patients (Hersen, et al., 1973). Assertive training was effectively implemented for these groups of individuals.

With respect to out-patient populations, assertive training has been used by itself or in conjunction with other behavioral procedures in both individual and group settings in order to treat a wide variety of presenting problems (Salter, 1929; Wolpe, 1969, 1970; Wolpe & Lazarus, 1966; Alberti & Emmons, 1970, 1974; Fensterheim, 1972).

Although research involving assertive training and its components is abundant, the effects of assertive training on personality variables other than anxiety have not been researched to a great degree. Investigations of the relationship between self-concept and assertive training are limited, while the assumptions that assertive training positively effects self-concept are ample.

Self-Concept and Assertive Training

The notion that "assertive people" are happier and more self-accepting is intriguing since most therapists hope their patients leave treatment with an enhanced self-concept (Percell, 1976). Carl Rogers (1961) is perhaps the most vocal proponent of the notion that a devalued sense of self-worth is often at the heart of client's problems. Rogers advocates a psychotherapy which provides a means of establishing feelings of self-acceptance, defined as the client's perception of self as worthy, independent, able to cope with problems and the subjective experience of liking oneself.

It is often implied by assertive training therapists and proponents that a reduction in anxiety and an increase in assertive behavior following assertive training is accompanied by an increase in positive self-feelings or an improved self-concept. Alberti and Emmons (1974) suggest that adequate assertive behavior gains more positive responses from others which, in turn, leads to an enhanced evaluation of self-worth. Their focus is on changing behavior patterns to facilitate improved interpersonal functioning and a greater valuing of oneself. Nonassertive individuals are described by Cotler and Guerra (1976) as "often depressed and having a poor self-concept" (p. 24). They describe assertive training as an elaborate set of procedures

aimed at teaching social skills and enhancing self-concept (Cotler & Guerra, 1976). Likewise, a major reason for participating in assertive training is to increase one's self-respect, resulting in greater self-confidence (Lange & Jakubowski, 1976). According to Lange and Jakubowski (1976), measures of self-concept are conceptually related to assertion and may be helpful to include as additional measures of assertion.

While many theorists and practitioners have readily stated that exposure to assertive training effects positive changes in various aspects of self-concept, the research investigating these contentions is limited. Two pertinent studies were found in the literature.

To determine whether people who are assertive are also more self-accepting and less anxious, Percell, Berwick & Biegel (1974) administered both an assertiveness self-report inventory and a self-acceptance questionnaire to 100 psychiatric patients in treatment at a community mental health center. Patients were randomly assigned to either an assertive training group or a relationship-control group for eight sessions. Assertive behavior scores were correlated with measures of self-acceptance and anxiety. A positive relationship was found between assertive behavior scores and self-acceptance scores for both men and women, while a negative correlation resulted between the assertive behavior scores and anxiety scores for women only. The training group showed significant increases in assertiveness and self-acceptance, and significant decreases in anxiety, relative to controls. It appears that as a result of participation in assertive training groups, self-concept improves for men and women, while level of anxiety decreases for women exclusively.

Discrepant results were found by Williams (1977) who investigated whether cognitive variables (self-concept, self-confidence, self-acceptance, locus of control and anxiety) covaried with changes in behavior following group assertive training. To measure the cognitive variables, self-report inventories were administered as pre and posttests to 32 college students. Subjects were assigned to either an assertiveness training group or a placebo-discussion group. The assertive training group scored consistently higher on the self-report measures than the control group, although the differences were not significant. The results did not support the popular assumption that assertive training positively effects cognitive variables such as self-concept and self-acceptance.

From the behavioristic position, self-concept is one way of describing the way a person acts, indicating that self-concept is related to observable behavior (Strellich, 1976). Marston (1965) considers self-concept as a "construct that is essentially the sum total of self-directed verbalizations. This type of self-directed speech can be viewed as a link between self-concept and overt behavior" (p. 1). It is implied then that a person with a negative self-concept gives himself few positive verbal evaluations and little verbal reinforcement.

This contention appears to have merit especially when viewed in the interpersonal context. Results of a study with the FIRO-B (Schutz, 1967) show that subjects with healthy self-concepts are more active in behaviors which involve expressing affection, inclusion and control. Two reasons that patients have interpersonal problems, as postulated by Fitts (1970), are that they have not learned effective

interpersonal behaviors and do not have an appropriate behavioral repertoire for eliciting the desired responses from others. Secondly, they are highly variable in their behavior and tend to fluctuate between complete denial of their own needs (passive or nonassertive behavior) and unrestricted demands on others (aggressive behavior). It appears that through the facilitation of effective interpersonal behaviors and the proper social skills, that self-concept can be enhanced.

Assertive Training and Goal Setting and Attainment

Behavior therapy groups are organized on the basis that a common modification technique is applicable to all members. The groups are structured and goal-oriented with their primary aim being to modify specific target behaviors which in turn will ameliorate the problem situation. Assertive training tends to possess these characteristics (Fensterheim, 1972).

Although assertive training is not as standardized as other behavior therapy procedures, it remains task-oriented, emphasizing the acquisition of specific behavioral skills to deal with real life situations. In assertive training, assertive goals are informally set by each individual to attain these desired behavioral skills throughout the course of training. No record of the goals is made and no procedures are conducted to assess goal attainment.

The need to identify specific situations in which clients have difficulty acting assertively and to provide methods for clients to approach their goals has received limited recognition. Cotler and Guerra (1976) suggest clients determine assertive goals through the use of their Assertive Training Diary and Assertive Goal Scale (AGS).

The AGS requests information on what the goal is; how long it will take to achieve the goal; the stress anticipated in dealing with the problem; and the worst possible outcome (Cotler & Guerra, 1976). Goal identification, delineation and mastery procedures are left up to the individual. By becoming an active and contributing participant in the data collection process, the client need not see himself as being a helpless and dependent person who must totally rely on the trainer's responses in order to give direction and evaluate improvement (Cotler & Guerra, 1976).

Although many assertive training proponents suggest behavioral goal setting as an important therapy approach (Fensterheim, 1972; Hersen, Eisler, Miller, 1973; Cotler & Guerra, 1976; Lange & Jakubowski, 1976) there has been no systematic use of goals in group assertive training cited in the literature. Furthermore, no study was found to include goal identification or goal approach procedures in a behavioral sense or otherwise. Consequently, there are no studies examining the relationship between behavioral goal-oriented assertive training with self-concept. A goal-oriented approach seems a significant and necessary step in examining the effectiveness of group procedures.

Summary of Review

The present review of literature follows the development of assertive training from its origins to the progression of assertive training as a behavior therapy. The various methods employed in assertive training; behavioral rehearsal, modeling, and coaching, are covered and supported by research. The importance of investigating the relationship between assertive training and self-concept is

discussed as well as the dearth of evidence supporting the assumption that assertive training positively effects self-concept is noted. Finally, the need for researched goal-oriented assertive training procedures is discussed.

CHAPTER III

METHODOLOGY

Subjects

Participants for the study were Cache County, Utah community members and college students attending Utah State University during Fall Quarter 1977. Subjects were randomly selected from individuals who volunteered in response to notices in the student newspaper, posters on campus, and solicitation in psychology classes by the researcher. The subjects from general Psychology classes were allowed to participate as a term project for credit. Assertive training was advertised and explained as a group training for individuals who desire to become more assertive in social situations, more self-expressive, and for those who would like to improve their interpersonal communication skills. Subjects were told that only those volunteers who wished to learn to be assertive or to work on personal problems with assertion were desired for AT.

Seventy-six subjects completed registration materials, consent forms and pre-testing interviews. Immediately after interviewing, four subjects dropped out of the study. The remaining 72 subjects were assigned to one of three scheduled groups according to their preferences: Monday group, 3:30 pm - 5:30 pm, Wednesday group, 3:30 pm - 5:30 pm and Waiting List group. Subjects ordered their preferences as first choice - #1, second choice - #2 and third choice - #3. Where possible, individuals were included in the group they indicated as their first choice. Subjects assigned to the Waiting List group were

informed that if an opening arose in the Monday or Wednesday group they would be eligible to enter that group or attend a Winter Quarter AT group at a more convenient time.

The experimental conditions of the Monday and Wednesday group were assigned randomly by coin toss. Each group contained 24 subjects. Three subjects dropped out of the Waiting List group, and one from each of the experimental groups. Sixty-seven subjects (57 female, 10 male) remained throughout the completion of the study.

The confidentiality of all assessment data and training sessions was stressed. Subjects were told that they would not be forced to participate in any training activity they did not wish to and they could withdraw from training whenever they desired.

Subjects were told that upon their request when training and research were completed they would be informed by letter as to the purpose, results, and implications of the study. No subject requested a formal report of the findings.

Treatment

The present study included two experimental groups and one control group. The treatments included a directed or goal-oriented AT group and a non-directed or self-oriented AT group. Each group met for two-hour sessions once a week for four weeks. AT was held in a large, comfortable room on the third floor of the Student Union Building at Utah State University, Logan, Utah. Each week assertive training maintained a format including elements such as: a warm up activity, discussion of past weeks experiences, a didactic presentation, modeling demonstrations, role-playing periods, and homework assignments.

The directed or goal-oriented group members on Monday were

encouraged to work on weekly goals which were specified in cooperation between the individual and an AT therapist prior to training. The group members were invited to seek their pre-determined goals during the role-playing periods, and during the week between sessions. On Wednesday, the self-directed group members were encouraged to work on any goals they chose to during role playing periods and during the week between sessions. No emphasis was placed upon seeking pre-determined collaborated goals.

Instruments

All subjects received as pre- and post-measures, the Tennessee Self Concept Scale (Fitts, 1965) and the Goal Attainment Scale (Kiresuk & Sherman, 1968).

The Behavioral Monitoring Progress Record was used by the AT Group II goal-oriented group exclusively to monitor their weekly attainment.

Tennessee Self Concept Scale (TSCS). In developing the Tennessee Self Concept Scale (Fitts, 1965) a large pool of self-descriptive items, derived from other self-concept measures and from written self-descriptions of patients and non-patients, was compiled. These items attempt to reflect the way a person perceives himself, operating on the assumption that a person tends to behave in accordance with the way he views himself (Fitts, 1965).

The TSCS is a self-administering scale which consists of 100 self-descriptive statements to which the subject responds on a five-point Likert scale ranging from "completely false" to "completely true". Ten of the test items came from the L-scale of the Minnesota Multiphasic

Personality Inventory (1951) and constitute the Self-Criticism Score. Ninety of the items, equally divided as to positive and negative statements, make up the eight subscales of the test, which when combined, define the Total Self-Concept Score (TP). The TP score reflects the overall level of self-esteem. According to Fitts (1965) persons with high scores tend to like themselves, feel that they are persons of value and worth, have confidence in themselves, and act accordingly. Those who score low are doubtful about their own worth; see themselves as undesirable; often feel anxious, depressed, and unhappy; and have little confidence in themselves (Fitts, 1965). The clinical and research form of the test was administered and the TP score was used for analysis in this study.

Reliability and validity of the TSCS. Test-retest reliability, while varying for different scores, is in the high .80's (Buros, 1972). As reported in the Tennessee Self Concept Manual (Fitts, 1965), test-retest reliabilities for the sub-scales on 60 college students over a two week period range from .80 to .92. Moore (1972) analyzed test-retest reliability using Hoyt analysis of variance and reported coefficients of .80 to .90. Fitts, Adams, et al., (1971) report an internal consistency reliability coefficient of .91 using the Kuder-Richardson split-halves technique.

Concurrent validity of the TSCS has been fairly well established. According to Buros (1972) the Total Positive Score is negatively correlated, $-.70$, with the Taylor Manifest Anxiety Scale (Taylor, 1953). Content validity was established by submitting all items to seven clinical psychologists who served as judges to assess item appropriateness. Only items unanimously agreed upon were retained

(Fitts, 1965). Gable, et al., (1973) administered the scale to 125 college freshmen. Utilizing factor analysis, evidence to support construct validity in the correlations with selected personality measures was reported.

Many psychometric qualities of the TSCS meet the usual test construction standards that should exist in an instrument that hopes to receive wide usage (Buros, 1972).

Goal Attainment Scaling (GAS). GAS was originally developed as an assessment approach for individual patients in a community mental health center and has since been applied to goal setting for both individuals across the whole spectrum of human services.

The GAS methodology provides a goal setting format for an explicit specification of behavioral goals to be attained and the desired level of outcome following treatment. GAS is a systematic approach for targeting problem areas or concerns one desires to deal with in therapy. Each problem area is noted on a GAS Follow-Up Guide of grid-like design (see Figure 1).

In essence, the interviewer and the client identify goals in each area, set expectations for attainment, assess behavioral functioning at the time of the intake interview, and eventually allow for assessment of change after treatment.

The Follow-up Guide specifies behavioral goals for each problem area and allows for an interviewer to assess the individual's level of functioning on the grid in each area at the outset. Behavioral expectations or goals are set in five levels of predicted attainment, ranging from the most unfavorable outcome to the most favorable outcome considered likely. The Guide to Goals is a programmed instruction

GOAL ATTAINMENT FOLLOW-UP GUIDE					
SCALE ATTAINMENT LEVELS	Scale Headings and Scale Weights				
	SCALE 1/Drinking (w ₁ =)	SCALE 2/Temper & Destructive Be- havior (w ₂ =)	SCALE 3/Emotional upset and Dyspho- ria (w ₃ =)	SCALE 4/Tremor (w ₄ =)	SCALE 5/ (w ₅ =)
a. most unfavor- able treatment outcome thought likely	Reports drinking more than 10 beers or drinks every night.	Reports he has become so violent he has actually hurt someone bad- ly enough that the victim needs medical atten- tion.	Patient does something self- destructive; suicide attempt or actual suicide		
b. less than expected success with treatment	Reports drinking 8-10 beers per night; or equiva- lent number of drinks, every night.	Reports he be- comes uncontrol- lably violent at times, e.g., throws people down or over- turns furniture.	Reports he is still upset and feels that every- thing is "down", "in a rut" &/or can't concentrate on work.	Observer can note pronounced tremor of hands.	
c. expected level of treatment success	Reports that he drinks every night but re- duced to 6-7 beers or drinks.	Reports that he loses his temper, but does not be- come physically violent--fre- quency about once every two weeks.	Reports that he is upset less than once a week, but still has some of symptoms described at the "less than expected" level.	Hands can be observed to tremble only occasionally.	

Figure 1. Goal Attainment Follow-Up Guide

GOAL ATTAINMENT FOLLOW-UP GUIDE

SCALE ATTAINMENT LEVELS	Scale Headings and Scale Weights				
	SCALE 1/Drinking (w ₁ =)	SCALE 2/Temper & Destructive Be- havior (w ₂ =)	SCALE 3/Emotional upset and Dyspho- ria (w ₃ =)	SCALE 4/Tremor (w ₄ =)	SCALE 5/ (w ₅ =)
d. more than expected success with treatment	Reports that he drinks every night but 5 or fewer beers/ drinks.	Reports that he loses temper &/or becomes violent less than once every two weeks.			
e. best anticipated success with treatment	Reports he drinks only socially.	Reports that he now does not lose his temper at all, but is able to recog- nize & deal with anger other ways	Reports he now feels happy and satisfied, no longer upset and hopeless.	Hands cannot be seen to tremble at all by the observer.	

Figure 1 (continued)

manual designed to direct the client through the construction of the GAS Follow-Up Guide without previous instruction in GAS. A GAS score is computed yielding data summarizing the outcome or level of goal attainment of behavioral expectation. Comparing the level of functioning at the intake interview (pretest) with the level of functioning at the follow-up interview (posttest) on the Follow-Up Guide provides an estimate of behavior change following treatment.

Reliability and validity of GAS. Reliability studies (Garwick, 1974, Sherman, et al., 1974) found that GAS has a reliability that is comparable to test-retest coefficients characteristic of the MMPI (1951) and other self-report inventories (Hart, 1977). The correlation coefficients between first and second interviews range from .65 to .71.

Construct validity studies have supported the basic construct underlying GAS which is "outcome or attainment of expectations" (Garwick, 1974).

In a study of the construct validity of Goal Attainment Scaling (Mauger, Audett, Simonini, & Stollberg, 1974) both the MMPI data and the Goal Attainment Scaling data indicated that therapeutic changes occurred during treatment. All MMPI changes were in the direction of increased psychological health. The average Goal Attainment change scores were also highly positive, with about 84% of the subjects showing some positive change. Mauger indicates that the results suggest that intake interviewers can set goals for therapy or a treatment with expected levels of success which are appropriately scaled for each client. The reaching of these goals is not strongly influenced by "differential degrees of chronic psychopathology." Therapeutic

intervention can be shown to have an impact on client behavior even though a "cure" may not have been effected.

Utilizing the Behavioral Monitoring Progress Record (see Figure 2) Austin, et al. (1974) found that a behavioral goal-oriented approach to an educational program yielded a higher level of attainment of goals than a program using a more self-directed approach.

The purpose of the BMPR is to monitor goal attainment behavior on a weekly basis. Problems or concerns from the GAS Follow-Up Guide are identified, weekly goals for each problem area or column are determined, and method of attainment is specified. Essentially, for each problem area, a goal predicted to be attained within four weeks is determined. Four weekly goals, one goal per week, represent successive approximations to the four-week goal. In addition to specifying behavior, the GAS method provided both client and therapist the opportunity to assess the degree of attainment of each goal.

Hart (1977) suggests that the client and therapist collaborate in determining weekly goals, as was incorporated in this study. Joint client-therapist setting of goals which were observable, definable, and measurable was emphasized. Each individual's BMPR goals were monitored weekly by the therapist in AT group II, the goal-oriented group.

Procedures

A female therapist (the researcher) and male therapist, a doctoral student in psychology, conducted each AT group session together. AT Group I received the self-directed goal-oriented treatment approach. AT Group II received the behavioral-prescriptive goal-oriented treatment approach. Both assertive training groups began with registration, completed a pretest measure and interview, participated in four two-hour assertive training sessions, and completed a posttest measure and

BEHAVIORAL MONITORING PROGRESS RECORD					
Name _____ Therapist _____ Date of 1st Session _____					
MAJOR PROBLEMS &/OR COMPLAINTS					
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 inter-personal relationships	
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 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
	Goal:	Investigate job market	Discuss and identify two problems living at home	To assert self	Become acquainted with Marge
	Method:	Two or more interviews	Communication--Bring father in	Collect \$30 loan from Sheryl	Call Marge for lunch date
Week 2	Goal:	Review list of questions with Mrs. J.	Express anger openly--say and do what you feel	To assert self	Say what you feel--speak honestly
	Method:	Set up appointment	"Let it out"	Request \$600.00 in salary from Mrs. J.	Communication
Week 3	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
Week 4					

Figure 2. Behavioral Monitoring Progress Record

follow-up interview.

The procedures followed will be presented in outline form:

Session 1, Week 1:

For all subjects:

- A. Registration was conducted at the Counseling Laboratory at Utah State University. Each subject received a packet of screening materials and a registration number. Demographic information forms and consent forms were completed. Subjects were asked to read the Guide to Goals and complete the Goal Attainment Follow-Up Guide in preparation for their individual interviews the following week.
- B. Subjects signed up for interviews, by appointment.

Session 2, Week 2:

- A. Interviews were conducted for all subjects at the Counseling Lab by two graduate students (male and female) in psychology familiar with GAS procedures. The interviews involved an orientation to Group AT and a review of the guide to goals. Major behavioral problem areas where change would be feasible and helpful were specified by the client and interviewer. Goals to obtain desirable assertive behaviors throughout the course of assertive training were set. Developing observable, definable, and measurable goals was emphasized. The Goal Attainment Scaling (Kiresuk & Sherman, 1974) Follow-Up Guide was used to record the assertive problem areas and the respective desired behavior or goals. A Goal Attainment Scaling (GAS) score was computed yielding data summarizing the outcome or level of attainment of goals comparing the level of functioning at the initial interview with the level of functioning at follow-up interview providing an estimate of change during treatment.

B. At this phase of the interview, subjects were assigned to AT Group I (self-directed) or AT Group II (goal-oriented) and given the group time and meeting place.

1. AT Group I:

Following the initial interview, AT Group I members received no further therapist direction or encouragement to achieve goals specified on GAS. Group members were self-directed and responsible for reaching their goals if they so desired. No further mention of GAS goals was made throughout the training sessions.

2. AT Group II:

In addition to the interview procedures mentioned, the goal-oriented AT Group II members each constructed a BMPR, setting successive weekly goals in collaboration with the interviewer in order to attain their desired terminal GAS goals. The goals determined on the BMPR's were monitored weekly by a therapist in a brief individual interview at the close of each assertive training session to determine how each individual progressed toward desired goal attainment. Throughout training, encouragement was given to achieve these individual goals. During the time reserved for role-playing personal social interactions, the group members were encouraged to rehearse those situations which facilitated their goal achievement.

3. Control Group:

The control group members received no treatment and were not contacted again until post-assessment was conducted. They

were informed that AT would be offered the following winter quarter for them.

- C. The Tennessee Self Concept Scale was administered to all subjects as a pretest assessment of self-concept.

AT Methods

The two assertive training groups were conducted for four weeks. Subjects who could not attend a session were offered make-up sessions. Subjects who missed sessions were contacted the same day to guard against mortality.

Session 3, Week 2:

AT Group

- A. Warm-up activity: Introductions, get acquainted
- B. Didactic Presentation
 1. What assertion is and is not
 2. Passivity-assertion-aggression differentiated
 3. Reasons for acting assertively
 4. Why people act passively and aggressively
- C. Discussion of assertive training group techniques to be used: role-playing, modeling, positive feedback, and homework.
- D. Discussion of nonverbal components: eye contact, voice, posture, tone of voice, facial expression, and use of hands.
- E. Opportunity to practice (role-play) personal social interactions in triads (observer, asserter, and target person)
- F. Assignment: Read handout materials on assertion, practice homework assignment, eye contact, nonverbal behaviors; encouraged to be assertive in social interactions during week. (Members of AT Group II had individual interviews to discuss their progress with goals.)

Session 4, Week 2:

AT Group

- A. Warm-up activity: communicate nonverbally
- B. Discussion of past week's experiences, practice of homework assignments.
- C. Modeling of self-disclosure and listening skills.
- D. Exercises in self-disclosure and listening to therapists
- E. Modeling of assertive, nonassertive and aggressive and passive-aggressive interaction styles by therapists
- F. Exercises in giving compliments, affection messages, and positive feedback.
- G. Opportunity to practice personal social interactions in triads
- H. Assignment: Read handouts on "broken-record", "fogging" and "negative assertion" techniques; practice self-disclosure and listening skills. (Members of AT Group II had individual interviews to discuss progress with their goals).

Session 5, Week 3:

AT Group

- A. Warm-up activity: practice different modes of interaction
- B. Discussion of past week's experiences and homework reading material
- C. "Broken-record", "fogging", and "negative assertion" each modelled by therapists
- D. Didactic presentation of "I" messages vs. accusative "you" messages
- E. Role-play "I" messages in triads

- F. Opportunity to role-play personal social encounters using "broken-record", "fogging", and "negative assertion"
- G. Assignment: Read handouts on "negative inquiry", "workable compromise", and "making and refusing requests". Practice assertion techniques were applicable. (Members of AT Group II had interviews to discuss progress with their goals).

Session 6, Week 4:

AT Group

- A. Warm-up activity: positive strength bombardment--making positive self statements, receiving compliments
- B. Discussion of past week's experiences and homework reading material.
- C. "Negative inquiry", "workable compromise", and "making and refusing requests" modelled by therapists
- D. Role-play avoidance of manipulation of self by others
- E. Opportunity to role-play personal social encounters in triads
- F. Summary and termination (Members of AT Group II discussed progress with their goals).

Session 7:

Posttesting and interviewing were conducted for all subjects in the University Lounge at Utah State University.

- A. The Tennessee Self Concept Scale was completed
- B. A follow-up interview was conducted to determine levels of goal attainment or progress made. Each subject's present reported behavior was compared to the behavior recorded on the GAS Follow-Up Guide (Kiresuk & Sherman, 1974) completed at the initial interview in order to obtain a GAS change score.

At the close of each interview, individuals were given the opportunity to express their criticisms and impressions of AT.

The two interviewers were male psychology graduate students naive as to the purpose of the study or experimental procedures of the AT and as to which subjects were from the experimental or control groups. Prior to interviewing, the interviewers were familiarized with GAS procedures, how to determine present level of functioning, and how to use the GAS Follow-Up Guide to determine level of goal attainment. The interviewers alternated subjects, scoring the Follow-Up Guide of every other subject. While one interviewer was assessing a subject's status at follow-up, the second interviewer, who was nearby, was making the same follow-up assessment silently and independent of the first interviewer. Both interviewers rated each subject's status at follow-up simultaneously although they alternated in doing the interviewing.

Research Design

A three-group pretest-posttest control group design was used for this study. The three groups were given pretests of the dependent variables, the experimental treatment was initiated and completed for the two experimental groups and all three groups were given posttests of the dependent variables. The treatment groups consisted of AT Group I and AT Group II, with both groups receiving the identical assertive training procedures with the exception that AT Group II was directed and goal-oriented.

The control group received no treatment and members were placed on a waiting list to receive AT the following Winter quarter. All three groups received the Tennessee Self Concept Scale and the Goal Attainment Scale interview as pre and post measures.

Statistical Analysis

For Hypotheses 1 and 2, the data were analyzed using a Pearson product moment correlation. For the three groups, the pretest scores of the TSCS were correlated with the GAS score to test Hypothesis 1. The posttest scores of the TSCS were correlated with the GAS scores to test Hypothesis 2.

To test Hypothesis 3, the two correlations obtained in testing Hypotheses 1 and 2 were compared to determine if they were significantly different at the .01 level.

An analysis of variance was used to test Hypothesis 4. A test of significance was to be employed to determine if any differences existed between groups or measures of goal attainment at the .01 level.

In testing Hypothesis 5, to determine if any differences existed between pretest and posttest TSCS scores for each group, the data were analyzed using a 2x3 analysis of variance with repeated measures. The dependent variables were Tennessee Self Concept Scale pre-and posttest scores for each group. The independent variables included three groups: AT Group I (self-directed), AT Group II (goal-oriented), and the control group (waiting list). The analyses were performed by hand using ANOVA computational procedures outlined by Winer (1971). The obtained F's were then tested for statistical significance at the .05 level.

CHAPTER IV

RESULTS

The results of this study will be reported in terms of each of the hypotheses stated in Chapter 1.

Hypothesis 1 - Correlation Between
Pretest TSCS and GAS

There is no correlation between pretest measures of self-concept as measured by the Tennessee Self Concept Scale (TSCS) and measures of goal attainment, as measured by the Goal Attainment Scale (GAS).

A Pearson product-moment correlation was computed for the pretest Total Positive (TP) scores of the TSCS and the GAS change scores. The scores of the 67 subjects for all three groups combined were utilized.

A correlation coefficient of .058 was obtained which is not significant at the .05 significance level for a two-tailed test. Therefore, the null hypothesis that there would be no significant correlation between the pretest measures of self-concept and the GAS change scores was retained. With a sample size of 67, with 65 degrees of freedom, a correlation of .24 is necessary to produce a significant correlation.

Hypothesis 2 - Correlation Between
Posttest TSCS and GAS

There is no correlation between posttest measures of self-concept, as measured by the TSCS and measures of goal attainment, as measured by GAS.

A Pearson produce-moment correlation was computed for the posttest Total Positive (TP) scores of the TSCS and the GAS change scores. The scores of the 67 subjects for all three groups combined were utilized.

A correlation coefficient of .21 was obtained which is not significant at the .05 significance level for a two-tailed test. Therefore, the null hypothesis that there would be no significant correlation between the posttest measures of self-concept and the GAS change scores was retained. With a sample size equalling 67, with 65 degrees of freedom, a correlation of .24 is necessary to produce a significant correlation.

Hypothesis 4 - Differences in GAS for Each Group

There is no difference between the correlation of pretest self-concept measures with goal attainment measures and the correlation of posttest self-concept measures with a goal attainment measures.

A test of the significance between .058, the correlation coefficient obtained between pretest self-concept measures and goal attainment measures, and .21, the correlation obtained between self-concept posttest measures and goal attainment measures was employed.

Transforming both correlation coefficients into values of Z and utilizing the proper formula, a Z value of .89 was derived. For a two-tailed test, using the table of the standard normal distribution, a Z value 1.96 is required for significance at the .05 significance level. Consequently, the Z of .89 obtained in this

test was not significant at the .05 significance level. Therefore, the null hypothesis that there would be no difference between the correlation of pretest self-concept measures with goal attainment measures and the correlation of posttest self-concept measures with goal attainment measures was retained (see Table 1).

Table 1

Means, Standard Deviations and Correlation Coefficients
For Pretest and Posttest TSCS and GAS

	Pretest TSCS	Posttest TSCS	GAS
Mean	331.55	342.15	21.26
Standard Deviation	36.46	34.98	14.69
Correlation with GAS	.058	.213	-----

Test of significance between .058 and .213

$$Z = .89$$

Hypothesis 4 - Differences in GAS for Each Group

Hypothesis 4, with no difference between the Goal Attainment Scaling scores for each group, will not be tested since it was conditional on obtaining significance with Hypothesis 3. Since Hypothesis 3 was retained, there being no significant difference between the correlation of pretest self-concept measures with goal attainment measures and the correlation of posttest self-concept measures with goal attainment, the GAS scores for each group will not be investigated.

Hypothesis 5 - TSCS Mean Comparisons

There is no difference between the pretest and posttest Tennessee Self Concept (TSCS) mean scores for each group. The analysis of variance with repeated measures was computed.

From the mean square for the between subjects variance and the subjects within group variance, the main effect of treatments was determined. The obtained F value, 5.34, was significant at the .05 level, indicating that the different treatment groups have significantly affected self-concept.

The main effect of pretesting to posttesting was estimated from the mean square for the within subjects variance and the subjects within group variance. The obtained F value, 15.19, was significant at the .01 level indicating that significant positive changes occurred in the mean TSCS scores from pretest to posttest.

The interaction between testings and the treatment groups was determined using the mean square for interaction and the subjects within group variance. The obtained F value, 7.59, was significant at the .05 level. This finding indicated that the three treatment groups

had changed differentially from pretest to posttest on the TSCS.

The null hypothesis of no differences between pretest and posttest scores for each group was rejected. Table 2 gives the supporting ANOVA findings.

Table 2
Summary Table for 2x3 Analysis of Variance

Source of Variation	df	MS	F
Between Subjects	68		
A (Treatment vs. control)	2	10,518.57	
Subjects within groups	66	1,969.46	5.34*
Within Subjects	69		
B (pre. vs. post.)	1	3,662.19	15.19**
AB	2	1,831.10	7.59
BX subjects within groups	66	241.13	

*significant at .05 level

**significant at .01 level

CHAPTER V

DISCUSSION AND CONCLUSIONS

The primary aim of this study was to investigate the relationship between TSCS scores and the extent to which assertiveness related goals are attained for self-directed and prescriptive goal-oriented assertive training groups. TSCS pretest TP scores were correlated with GAS change scores to obtain r_1 . TSCS posttest scores were correlated with GAS change scores to obtain r_2 . A test of significance between the two correlation coefficients obtained, r_1 and r_2 , was employed and the results reported. Since no significant difference was found between r_1 and r_2 , the goal attainment measures for each group were not investigated. Of major interest were the pretest and posttest self-concept measure differences for each group. The differences between TSCS pretest and posttest means for each group were reported. The objectives of this study, as outlined previously, were successfully accomplished.

This section is devoted to discussing and drawing conclusions and implications about the data reported in the previous chapter.

Discussion of Results

The correlation between pretest TSCS scores and GAS scores was not significantly different from the correlation between posttest TSCS scores and GAS scores. This finding indicates that the relationship between a self-concept pretest and goal attainment and the relationship between a self-concept posttest and goal attainment is not significantly different. With goal attainment measures remaining constant, for these

correlations pretest and posttest self-concept measures did not vary significantly. Exploration of the relationships between GAS scores for each group was not necessary since the correlations between pretest self-concept measures and goal attainment and posttest self-concept measures and goal attainment were not significant.

These results are indicative that an objective measure of self-concept is not significantly related to the extent to which one's assertive goals are achieved. Goal attainment apparently did not significantly effect positive changes in self-concept as postulated by various theorists and practitioners.

For Hypothesis 5, it was stated that there would be no differences between pretest and posttest measures of self-concept for each group.

Computation of the analysis of variance for repeated measures produced significant F values for between subjects (treatments) within subjects (pretest to posttest), and interaction.

Significant changes in the mean TSCS and scores between the treatment groups indicated that, overall, the treatment groups effected positive changes in self-concept. The main effect of treatment on self-concept was significant.

Significant changes in the mean TSCS scores from pretest to posttest for all groups indicated that positive changes occurred during treatment.

Significant interaction between testings and treatment groups indicated that measures of self-concept from pretest to posttest improved differentially for the treatment groups. The assertive training groups, AT Group I and AT Group II, received significantly greater positive changes in self-concept as compared to the control

group. Table 3 gives the TSCS mean scores for each group on pre-and post-testing.

Table 3
Pretest and Posttest TSCS Means for Each Group

	Control	AT I	AT II
Pretest	342.3	312.0	341.3
Posttest	341.6	328.1	356.8

Figure 3 graphically presents the TSCS pretest and posttest means for each group.

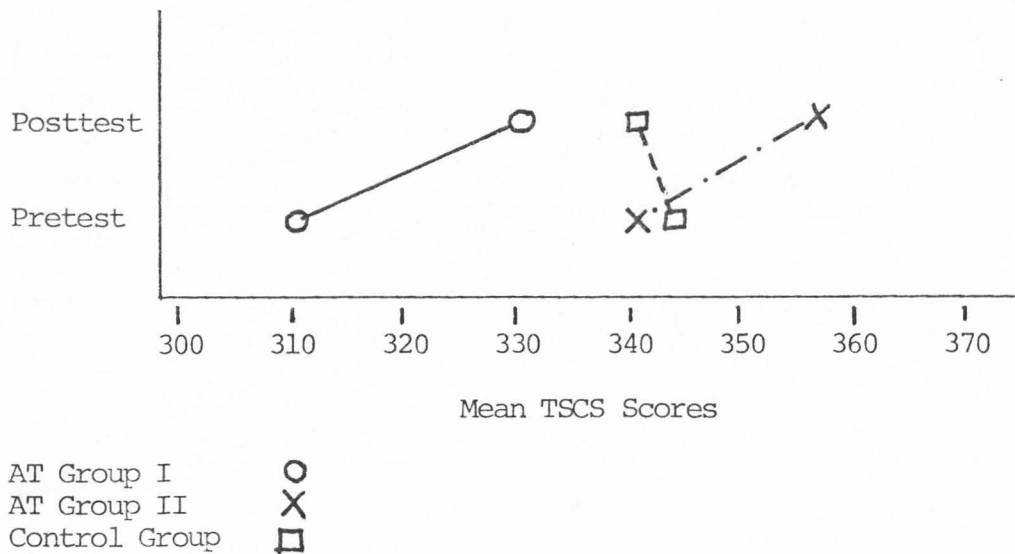


Figure 3. Mean Tennessee Self Concept Scale Scores of Subjects at Pretest and Posttest

Both experimental groups, AT Group I (self-directed) and AT Group II (goal-oriented) showed concomitant positive changes in self-concept measures while the control group showed nearly no change in self-concept from pretest to posttest.

The TSCS mean for AT Group I increased 16.1 points from pretest to posttest. For AT Group II the TSCS mean increased 15.5 points. Both treatments produced nearly equal changes in self-concept scores. The TSCS mean of the no-treatment control group decreased .7 points from pretest to posttest. The control group received no treatment or contact from pretest to posttest.

Alberti (1977) indicated that broad sweeping personality or value changes as a result of participation in time limited AT groups are unsupported by current research. In this study, in which assertive training was conducted for only four weeks, the personality trait of self-concept changed significantly from pretest to posttest. Regardless of participating in either a self-directed assertive training group or a goal-oriented, directed assertive training group, self-concept measures increased. The introduction of the element of goal attainment in assertive training had no differential effect on self-concept for the treatment groups. It appears that the experience of participating in an assertive training group of either type effects significant increases in self-concept. The subjects in the control group (waiting list) apparently interested in participating in assertive training did not experience commensurate changes in self-concept.

Conclusions

The insignificant difference between the two tested correlations,
1) the correlation between pretest self-concept measures with goal

attainment measures and, 2) the correlation between posttest self-concept measures with goal attainment, indicates that goal attainment measures, or the extent to which one's goals are achieved, are not related to self-concept measures.

The analysis of variance results indicated that goal-oriented and self-directed assertive trainings effect positive changes in self-concept, a finding which supports the theories espoused by contemporary assertive training proponents. Both experimental groups, AT Group I and AT Group II, experienced equivalent positive changes in self-concept while the control group showed a minute change.

The writer suggests that the mere experience of participating in an assertive training group effects positive changes in self-concept as compared to a control group receiving no contact with assertive training. Perhaps the nature of the assertive training group environment has an enhancing effect on self-concept. Theoretically the group members have common problems with assertion which unify the group. Alberti and Emmons (1974) noted that because the group members are typically understanding and supportive, the client is able, and encouraged to experiment with new assertive behaviors in an accepting social atmosphere. The improved self-concept score on the TSCS, as interpreted by Fitts (1965), indicates that persons tend to like themselves, feel they are persons of value and worth, have confidence in themselves, and act accordingly. Assertive training theorists and practitioners believe these same personality traits are characteristic of persons who have participated in assertive training groups. The findings in this study indicate that self-concept does increase

significantly as a result of participation prescriptive, goal-oriented and regular self-directed assertive training groups. This area of study is incomplete, since various research methods are yet to be applied and numerous variables to be investigated.

Limitations of the Study

1. The assertive training sessions were only four weeks in duration.
2. College students made up the major part of the subjects for the study limiting result generalizability.
3. Subjects were volunteers limiting the generalizability of findings.
4. Subjects were not randomly assigned to experimental and control groups. Groups assignments were chosen to fit individual's schedules.

Recommendations

For further study of assertive training as it relates to self-concept and goal attainment, it is recommended that:

1. The number of assertive training sessions be increased to facilitate positive changes in self-concept as related to goal attainment.
2. Other measures of self-concept be administered, including a self-report questionnaire or inventory.
3. The differences between self-concept for males and females participating in AT be investigated.

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APPENDICES

APPENDIX A

INFORMED CONSENT FORM
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 the 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.

Client's Signature

Date

Researcher's Signature

APPENDIX B

INFORMATION FOR ASSERTIVE TRAINING STUDY

DATE _____ CODE # _____
 NAME _____
 ADDRESS _____ CITY _____
 HOME TELEPHONE # _____ WORK # _____
 AGE _____ SEX _____ MARITAL STATUS _____

ASSERTIVE TRAINING STUDY CLIENT CONSENT

DATE _____

I agree to participate in the Assertion Study which is now in progress. I understand that this is a scientifically structured study undertaken to determine the effectiveness of Assertion Training.

 Client's Signature

 Researcher's Signature

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

APPENDIX C

Samples of Goal Attainment Follow-Up Guide and
Behavioral Monitoring Progress Record

Murray-Jordan-Tooele Mental Hygiene Centro-Gas Study
GOAL ATTAINMENT FOLLOW-UP GUIDE

Based on 8-Therapy Sessions	SCALE HEADINGS AND SCALE WEIGHTS				
Scale Attainment Levels	Scale 1: (w ₁ =)	Scale 2: (w ₂ =)	Scale 3: (w ₃ =)	Scale 4: (w ₄ =)	Scale 5: (w ₅ =)
most unfavorable treatment outcome thought likely					
less than expected success with treatment					
expected level of treatment success					
more than expected success with treatment					
best anticipated success with treatment					

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

week of	Goal:				
	Method:				
	Criterion:				
week of	Goal:				
	Method:				
	Criterion:				
week of	Goal:				
	Method:				
	Criterion:				
week of	Goal:				
	Method:				
	Criterion:				

APPENDIX D

Group Assertive Training Handout

GLOSSARY OF SYSTEMATIC ASSERTIVE SKILLS

Broken Record:

A skill that by calm repetition--saying what you want over and over again--teaches persistence without your having to rehearse arguments or angry feelings beforehand, in order to be "up" for dealing with others.

Clinical effect after practice: Allows you to feel comfortable in ignoring manipulative verbal side traps, argumentative baiting, irrelevant logic, while sticking to your desired point.

Fogging:

A skill that teaches acceptance of manipulative criticism by calmly acknowledging to your critic the probability that there may be some truth in what he says, yet allows you to remain your own judge of what you do.

Clinical effect after practice: Allows you to receive criticism comfortably without becoming anxious or defensive, while giving no reward to those using manipulative criticism.

Free Information:

A skill that teaches the recognition of simple cues given by a social partner in everyday conversation to indicate what is interesting or important to that person.

Clinical effect after practice: Allows you to feel less shy in entering into conversation while at the same time, prompting social partners to talk more easily about themselves.

Negative Assertion:

A skill that teaches acceptance of your errors and faults

(without having to apologize) by strongly and sympathetically agreeing with hostile or constructive criticism of your negative qualities.

Clinical effect after practice: Allows you to look more comfortably at negatives in your own behavior or personality without feeling defensive and anxious, or resorting to denial of real error, while at the same time reducing your critic's anger or hostility.

Negative Inquiry:

A skill that teaches the active prompting of criticism in order to use the information (if helpful) or exhaust it (if manipulative) while prompting your critic to be more assertive, less dependent on manipulative ploys.

Clinical effect after practice: Allows you more comfortably to seek out criticism about yourself in close relationships while prompting the other person to express honest negative feelings and improve communication.

Self-Disclosure:

A skill that teaches the acceptance and initiation of discussion of both the positive and negative aspects of your personality, behavior, lifestyle, intelligence, to enhance social communication and reduce manipulation.

Clinical effect after practice: Allows you comfortably to disclose aspects of yourself and your life that previously caused feelings of ignorance, anxiety, or guilt.

Workable Compromise:

In using your verbal assertive skills, it is practical, whenever you feel that your self-respect is not in question, to offer a workable compromise to the other person. You can always bargain for

your material goals unless the compromise affects your personal feelings of self-respect. If the end goal involves a matter of your self-worth, however, there can be no compromise.