1982

Assertion training: Its effectiveness with professional nurses

Timothy J. McIntyre
The University of Montana

ASSERTION TRAINING: ITS EFFECTIVENESS WITH PROFESSIONAL NURSES

BY

Timothy J. McIntyre

B.A., Wichita State University, 1978

Presented in partial fulfillment of the requirements for the degree of

Master of Arts

University of Montana
1982

Approved by:

D Balfour Jeffrey
Chairman, Board of Examiners

Dean of the Graduate School

6/7/82
Date

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

7-9-82

ABSTRACT

McIntyre, Timothy J., M.A., 1982 Psychology

Assertion Training: Its Effectiveness With Professional Nurses

Director: D. Balfour Jeffrey DBJ

This study evaluated the intercorrelation of scores on five assertion inventories as well as role playing with professional registered nurses. It also assessed the effectiveness of assertion training for treating subassertive nurses and evaluated the durability of changes produced.

Normative data was gathered and intercorrelations evaluated on five self-report measures: the Assertiveness Self-Statement Test, Rathus Assertiveness Schedule, Adult Self-Expression Scale, and two global Likert Scales. Role play was also employed and the results compared with these measures. A repeated measure split plot design was used to evaluate treatment effectiveness and durability. Twenty-six self-referred registered nurses were tested, randomly assigned to either a training or control group, retested at Post-training and again at a two-month Follow-up. Those receiving training participated in five weekly two-hour sessions of group assertion training following Lange and Jakubowski's (1976) cognitive-behavioral model. Control group members were placed on a waiting list and received training at a later time.

The psychometric results indicated: 1) all but one (A Likert Scale) of the self-report measures displayed substantial test-retest stability at both six and 14 weeks, 2) the self-report tests converged in their evaluation of the nurses' assertiveness, 3) the distribution of scores resembled those of female college students while stability estimates suggested greater test-retest stability than that found for college populations, and 4) correlations between self-report test scores and ratings of role play performance were moderately low at Pre-training, very low to negative at Post-training, and moderately high and signifigant at Follow-up. The treatment results indicated: 1) the nurses were indeed subassertive prior to training, 2) the self-report scores revealed highly significant gains in assertiveness as a result of training, 3) treatment gains were successfully maintained at the two-month Follow-up, 4) role play ratings paralleled and supported the self-report results, but not at significant levels (multiple comparisons using Scheffe's test revealed highly significant increases in assertion for the treatment group on role play ratings while the control group remained the same), 5) there was strong empirical support for the social validity of assertion training, and 6) Pre-Post questionnaire data indicated a high degree of credibility for the program.

The assessment results extend earlier-reported psychometric data on the assertion inventories. The pattern of correlations between test scores and role play ratings was explained as a product of interactions between the treatment design and insufficient time or opportunity to practice. It was hypothesized that this interaction might underlie the often-reported discrepancy between test scores and role play ratings in assertion research. Treatment results replicate the effectiveness of cognitive-behavioral group assertion training programs. They also support the applicability of such programs to registered nurses and to professional populations in general. Implications from the present study for future research were drawn.

ACKNOWLEDGEMENTS

This investigation has spanned two years from conception to completion and brought me into contact with many fine people who were kind enough to contribute their various talents, ideas, and encouragement so that I could accomplish this personal goal. I've tried to thank all of you along the way and I reiterate my deep appreciation here. However, a few individuals' contributions were exceptionally precious and those people warrant special acknowledgement in the opening pages of this final document.

I am profoundly indebted to my beloved wife, Sandra Lee McIntyre, whose selfless contributions flowed from her deep love for me. She supported me financially and emotionally, kept our household functioning, was my companion in celebrating successes, and the shoulder I cried on in those moments of despair that always seem to accompany any undertaking of this magnitude. In addition to these crucial contributions, she functioned as a typist, co-therapist, and consultant on the project.

I also am indebted to my thesis advisor, "Bal" Jeffreys, who over the course of this study provided valuable guidance and helped me both expand and polish my understanding of scientific research and it place in our profession. At a personal level, I've appreciated his treating me as a colleague and a friend.

Finally, I want to thank my lovely daughter, Rebecca, to whom this work is affectionately dedicated. Her sacrifice of countless hours of playtime with her "Daddy" will be forever, fondly remembered and deeply appreciated.

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Chapter I

INTRODUCTION

Prior to 1970, the psychological profession witnessed a modicum amount of research into assertiveness and assertion training (Lange and Jakubowski, 1976). After Andrew Salter's description of an early form of assertion training in Conditioned Reflex Therapy (1949), the topic remained largely dormant until Joseph Wolpe began investigating its potential as a therapeutic behavioral intervention (1958,1969). Within the last decade the amount of investigation has become a torrent permeating much of the professional literature and making assertion training a "stock-in-trade" of many mental health professionals (DeGiovanni and Epstein, 1978; Galassi and Galassi, 1976; Lange and Jakubowski, 1976).

This marked increase in professional interest and subsequent research boom likely resulted from several factors. First of all, the profession was probably responding to popular interests brought on by the cultural mileau of the Sixties and early Seventies. During this period, openness and honesty in personal relationships began to be more highly prized and the definitions of socially acceptable behavior broadened (Lange and Jakubowski, 1976). This resulted in a favorable and potentially lucrative

public medium in which the psychological profession could both investigate assertiveness and meet some pressing social/cultural needs. Besides cultural factors, Bordewick (note 1) suggests the research boom may have been partially due to several factors inherent in assertion training: One, it employed primarily behavioral techniques to treat a significant adult clinical problem. During the late Sixties and Seventies , there was a dramatic increase in the investigation of behavioral treatment programs and their efficacy; two, a variety of assessment instruments/tasks were developed for assertion research and besides improving evaluation of treatment effects, the instruments themselves provided another area to be researched, i.e. further reliability and validity data needed to be gathered (Galassi and Galassi, 1978; Hall, 1977; Rich and Schroeder, 1976); and three, the concept of assertiveness had been applied to a wide realm of interpersonal situations, behaviors, and training techniques. There was and still remains a need to empirically validate many of these applications (Bordewick, note 1; Heimberg, Montgomery, Madson, and Heimberg, 1977; Rich and Schroeder, 1975).

The review that follows examines the development of the concept of assertion and current thinking regarding the components of assertion. It also includes an inspection of some means for assessing assertiveness and closes with a

survey of some widely endorsed and commonly used assertion training procedures.

Definitions of Assertion

Systematic progress in the area of assertion training has been hampered by a lack of consensus as to what constitutes "assertive" behavior (Packman, Foy, Massey, Eisler, 1978). Probably the first attempt to describe assertive behavior and establish a training program was made by Andrew Salter. In his book, Conditioned Reflex Therapy (1949), he described assertion as "excitatory" behavior acquired by conditioning and subassertion as conditioned emotional inhibition. He suggested subassertive individuals could be reconditioned by practicing behavioral exercises such as I-statements and "feeling talk". Rimm and Masters (1974) list two shortcomings of Salter's definition: It describes assertion as a trait and fails to delineate assertion from aggression.

In 1958, Wolpe defined assertion as situationally-specific behavior but failed to distinguish it from aggression. It wasn't until the early Seventies that researchers started differentiating aggression from various types of assertion. Until then the concepts were seen as nearly synonymous and subassertive persons were often encouraged to be aggressive (Lazarus, 1966). Later authors

have attempted to clarify and operationalize the concepts of aggression, assertion , and subassertion.

Alberti and Emmons (1974) used the idea of "rights" to clarify the three in their popular book Your Perfect Right. They defined assertion as: "Behavior which enables a person to act in his or her own best interests, to stand up for herself or himself without undue anxiety, to express honest feelings comfortably, or to exercise personal rights without denying the rights of others." Aggression involved denying the rights of others while subassertion consisted of denying one's own rights.

After reviewing the literature, Rich and Schroeder (1975) concluded that current definitions of assertion were more hindrance than help to researchers evaluating assertion training. Consequently, they suggested that assertiveness be defined,

> ". . . as a group of partially independent, situation-specific response classes. Assertive behaviors may best be defined as skills that (a) are concerned with seeking, maintaining and enhancing reinforcements and (b) occur in interpersonal situations involving the risk of reinforcement loss or the possibility of punishment."

This definition has not been widely employed. Like Wolpe's early definition, it describes assertion as situation-specific but fails to adequately differentiate it from

aggression or subassertion.

Lange and Jakubowski (1976) carried Alberti and Emmons (1974) position one step further by defining assertion as ". . . standing up for personal rights and expressing thoughts, feelings, and beliefs in direct, honest , and appropriate ways which do not violate another person's rights." With this definition rights became central to the concept of assertion. Though widely accepted, the idea of tying assertion to interpersonal rights has been criticized because it places assertive behavior into an ethnocentric, moralistic framework (Heimberg, et. al., 1977). In an attempt to minimize the value judgements accrued by these definitions, DeGiovanni and Epstein (1978) suggested focusing on "the topography of the response": Aggression entails coercion to force another's compliance while assertion is self-expression without coercion. However, the concept of coercion is probably as culture-bound and morally determined as the concept of rights. If so, this suggestion does little to resolve the criticisms levied at the above definitions.

Perhaps the only real answer to these criticisms is recognition that assertion, like all "acceptable behavior", is defined by the cultural mileau (Galassi and Galassi, 1976). If assertion training is going to help people adapt

and function in that mileau it must not teach behaviors that are "asocial" and widely unaccepted. Furthermore, it may be best to present assertion training via concepts which the people are familiar with (i.e. rights) since this would seem to enhance assimilation. Despite the ambiguity that still exists regarding the precise definition of assertion (Galassi and Galassi, 1976; DeGiovanni and Epstein, 1978), there appears to be general agreement on many of the components of assertive responses.

Components of Assertive Responses

A variety of verbal and nonverbal components have been identified and generally upheld by research (Alberti and Emmons, 1974; Packman Foy, Massey, and Eisler, 1978; Rich and Schroeder, 1975; Wolpe and Lazarus, 1966). The most commonly mentioned verbal component is speech content which is often categorized by the type of assertion message being delivered: basic, empathic, escalating, confrontive, and positive/caring assertion (Lange and Jakubowski, 1976). Lists of nonverbal components usually include eye contact, body posture, gestures, facial expression, physical proximity, and paralinguistic speech characteristics such as rate, tone , intensity, duration, and affect (Alberti and Emmons, 1974; DeGiovanni and Epstein, 1978; Eisler, Miller, and Hersen, 1973; Lange and Jakubowski, 1976;

Phelps and Austin, 1975; Packman, et. al., 1978; Rich and Schroeder, 1975; Serber, 1972; Wolpe and Lazarus, 1966). Several authors have suggested the nonverbal components are more important than the verbal when delivering an assertive response (Alberti and Emmons, 1974; Lange and Jakubowski, 1976).

During the Seventies , cognitive mediating variables began to be examined as a third major subset of assertion components (Bordewick and Bornstein, 1980). Cognitive sets of perfectionism, self-criticism, unrealistic approval needs, and fear of criticism have been postulated as inhibiting assertion (Rich and Schroeder, 1975; Schwartz and Gottman, 1976). Further, certain cultural values were suggested to promote and sustain subassertion/ aggression: Such as, 1) Think of others first-- even if you are tired or hurting; 2) Be humble-- never brag or show pride; 3) Always listen and be understanding-- never complain (Clark, 1978; Cotter and Cotter, 1977; Herman, 1977; Lange and Jakubowski, 1976; Phelps and Austin, 1975). Research suggests that many early assertion training programs may have failed because they didn't deal with these cognitive variables (Rich and Schroeder, 1975). Consequently, later programs usually attempted to incorporate lectures, readings, and/or exercises that addressed the cognitive aspects of assertion (Alberti and Emmons, 1974; Lange and

Jakubowski, 1976; Phelps and Austin, 1975).

Adding cognitive variables to theoretical formulations of assertion has made them more comprehensive, but it has also made the difficult problem of assessing assertiveness even more difficult. Instead of simply evaluating whether or not a person has learned assertive behaviors during training or practices them in daily living, researchers must now also attempt to evaluate quantities such as beliefs about assertion, expectations of results, inhibitory cognitive sets, and conditioned anxiety (Eisler, Frederikson, and Peterson, 1978; Galassi and Galassi, 1976).

Assessment of Assertiveness

Until 1970, evaluation of assertion deficits and improvements consisted almost entirely of global clinical judgements (Galassi and Galassi, 1976; Hersen, Eisler, and Miller, 1973; Rich and Schroeder, 1975). Yet, during this same period there was marked uncertainty among therapists and/or researchers regarding the construct "assertion". Subsequently, evaluation of results across projects investigating assertion training's effectiveness on specified target behaviors was virtually impossible.

Since 1970, a number of new devices and approaches have been developed in an effort to improve assessment of assertiveness and assertion training (Hall, 1977; Galassi and Galassi, 1978; Rich and Schroeder, 1975). But as mentioned earlier, uncertainty about what constitutes assertion and how to differentiate it from aggression still plagues the field. The result has been confusion and confounding of the two response classes on many of the measures developed (DeGiovanni and Epstein, 1978). Nevertheless, several self-report and behavioral measures offer significant improvements over global clinical judgements, seem to have fairly good psychometric properties, and have been used widely in assertion research.

Self-Report Measures. McFall and Marston (1970) used the Goldfried and D'Zurilla (1969) empirical approach to inventory construction in developing the Conflict Resolution Inventory (C.R.I.). It was found to correlate with Pre- and Post-test behavioral role plays .69 and .63, respectively. Of the assertiveness inventories developed in recent years, Rich and Schroeder (1975) found the C.R.I. to be the only one with demonstrable validity and usefulness for screening and assessment purposes. It is limited, however, to college populations and refusal behavior.

Another widely used instrument intended for college populations is the College Self Expression Inventory (Galassi, Delo, Galassi, and Bastein, 1974). Designed to evaluate positive and negative expressions and self-denial, the College Self Expression Inventory displays high test-retest stability and concurrent validity (Galassi, et. al., 1974; Galassi,Hollandsworth, Radecki, Gay, and Evans, 1976). The Adult Self-Expression Scale was later developed from the College Self-Expression Inventory to be used with a broader adult population (Gay, Hollandsworth, and Galassi, 1975). As might be expected, it also showed high test-retest stability of .88 and .91 for two and five weeks, respectively. Concurrent validity was displayed in the tests' discrimination of subjects according to anxiety, seeking counseling, and self-concept.

The Assertiveness Self-Statement Test (ASST) is a 34-item questionnaire with 17 "positive" self-statments that should make it easier for a person to be assertive and 17 negative self-statments that should inhibit assertion (Schwartz and Gottman, 1976). These positive/negative self-statements were concensually validated on a sample of 37 college students and only those statements with 90% or more agreement regarding direction were kept. The ASST has been largely used to evaluate cognitive self-statements and their influence on assertive behavior.

The final inventory to be mentioned, the Rathus Assertiveness Schedule (RAS), was developed from several forerunners (Rathus, 1973). The 30 item RAS is perhaps the most heavily researched assertion inventory currently available. Rathus'(1973) study indicates adequate test-retest (eight weeks) stability and split-half reliability of .78 and .77, respectively. The means, standard deviations, and stability coefficients for the RAS were later replicated by Brown and Jeffrey (note 2) lending support to the notion that test results are consistent within college populations. However, Brown and Jeffrey (note 3) also found that subjects' scores on the RAS were readily influenced by experimental demands. Validity data has been obtained by comparing the RAS with two other assertion inventories. Besides displaying good psychometric properties, the RAS has normative data available based on a national sample of college students (Rathus and Nevid, 1978).

The scales outlined are a significant improvement over former means of assessing assertiveness and assertion training. However, they are limited in that they all were validated on college populations, have yet to be evaluated with the general public (Bordewick, note 1), and most assess only a few assertion response classes.

Behavioral Measures. Behavioral assessment has been used in attempts to evaluate assertion but it has yet to be thoroughly explored , validated, and correlated with other means of assessment. Researchers have employed direct observations, in both natural and contrived settings, as well as role playing in their efforts to determine behavior change and generalization resulting from assertion training (Heimberg, et. al., 1977; Rich and Schroeder, 1975). In a series of experiments, McFall and Twentyman (1973) provided an exemplary model of some of the problems encountered with behavioral assessments of assertiveness. They also showed how those problems can be resolved to obtain a sensitive, more representative, measure of the subjects actual extralaboratory behavior. Since one of their concerns was to demonstrate the "ecological validity" of treatment effects (McFall and Twentyman, 1973), they primarily employed in vivo telephone calls as Follow up assessments. Subjects were contacted and asked to volunteer their time to stuff envelopes , buy magazine subscriptions, or loan their class notes before an exam. In the first of four experiments, the measure failed because the request was either too easy or too difficult to refuse. Also, the authors were made aware of the demand characteristics, latent in their requests, which elicited altruism and other attitudes that justifiably inhibited refusal. By the fourth

experiment, the in vivo call had been refined to using a graded series of seven progressively unreasonable requests rather than a single all-or-nothing request. The result was a more sensitive measure that yielded evidence of a significant transfer of training (McFall and Twentyman, 1973).

In addition to problems like demand characteristics and choosing an appropriately difficult request, a number of other problems have been encountered in using behavioral measures. For example, such measures are often not unobtrusive and at times tap variables other than assertion (Galassi and Galassi, 1976; McFall and Twentyman, 1973). Observational measures are often confounded by subject bias if the subject knows or suspects he/she is being observed. Finally, a particular problem noted in role playing is the "staged" unnaturalness of it for most subjects (Rich and Schroeder, 1975).

Former studies that employed in vivo assessment rarely used more than one real life assessment situation or type of situation (i.e. refusal). Though McFall and Twentyman (1973) tried multiple in vivo assessments in a single analog study, they obtained mixed results and subsequently returned to a phone call measure. Given the research suggesting assertive behavior is highly situation-specific, this one

shot effort at in vivo assessment seems insufficient because it taps only one form of assertion under one set of conditions. In light of the problems mentioned, in vivo assessment has yet to be adequately explored. Using several carefully planned, unobtrusive in vivo assessments of assertion with the same subject might resolve these problems while providing additional "real life" data about generalization. Additionally, it would permit more extensive correlation of in vivo assessment with assertion inventories and role playing.

By providing better analysis of individual subject's assertiveness and the various components of assertion, improved assessment procedures have played an integral part in many assertion training programs. They have often been used to screen for appropriate subjects, to evaluate progress during training, and to assess behavior durability and generalization resulting from training (Lange and Jakubowski, 1976). Such use must continue and preferably increase if assertion is to grow beyond its present state: a vaguely articulated treatment orientation where assertion defines the target behavior rather than the training procedure (Galassi and Galassi, 1976; Lange and Jakubowski, 1976; McFall and Marston, 1970; McFall and Twentyman, 1973; Rich and Schroeder, 1975; Winship and Kelley, 1975).

Assertion Training Programs

Perhaps one of the factors contributing to the "vagueness" of assertion training as treatment is that it has generally consisted of a wide package of techniques chosen on face validity (Hersen and Bellack, 1977). Such packaged programs have included behavioral rehearsal, hierarchically presented stimulus situations, operant shaping, constructive criticism, coaching, role playing, role-reversal, cognitive restructuring, group discussions, bibliotherapy, audio- and/or videofeedback, homework assignments, modeling, nonverbal signals analysis, instruction, self-reinforcements, amd more (Galassi and Galassi, 1976; Rich and Schroeder, 1975). The variety of programs available and used in assertion training research has made comparisons and general conclusions difficult to derive. This problem has been further compounded by researchers using identical names for different techniques (Galassi and Galassi, 1976). Consequently, it seems further experimentation will be needed to empirically validate the effective, necessary components of assertion training for various populations.

A classic example of an attempt to isolate the effective, necessary components of assertion training for college populations was provided by McFall and Twentyman

(1973). In their research, students drawn from an Introductory Psychology course were given two sessions of training under experimental conditions which varied across and within the four experiments conducted. McFall and Twentyman (1973) found that covert/overt rehearsal and coaching both made significant, additive contributions to improved performance on both behavioral and self-report measures of assertion. Modeling , on the other hand, did not add to the effects of rehearsal alone or rehearsal plus coaching.

There is still an insufficient number of outcome studies validating the alleged effectiveness of assertion training and its' various components with a variety of populations. Nearly all the studies conducted thus far have used college students or hospitalized psychiatric patients as subjects (Hersen, Eisler, and Miller, 1973; Heimberg, et. al., 1977). Evidence suggests these two populations differ in their response to some components. If similar differences were found among other populations, then different assertion programs may be required for different groups (Heimberg, et. al., 1977).

Despite inconclusive research findings regarding the most effective combinations of techniques (Lange and Jakubowski, 1976), a review of assertion training programs

and research suggests some widely endorsed practices and commonly used training procedures. Perhaps the most common practice is to offer assertion training in groups of five to twelve rather than individually. However, Alberti and Emmons (1974) reflect current thinking in the field when they advocate individual assertion training for severely nonassertive persons and for individuals whose subassertion is part of other clinical pathology. For most people, group training is considered the treatment of choice because it affords more interaction with a greater number of people. It also provides a broader base for social modeling, more diverse perspectives, and greater social reinforcement (Alberti and Emmons, 1974; Lange and Jakubowski, 1976).

Another broadly endorsed practice, substantiated by research, is to limit the length of assertion training to between five and eight sessions. Alberti and Emmons (1974) feel little is gained by extending the program beyond eight weeks; conversely, significant material must often be sacrificed if the program is shorter than five weeks.

After an extensive review of the literature, Rich and Schroeder (1975) concluded that training procedures could be categorized by function into five areas: 1) Response-reproduction Operations, 2) Response Acquisition Operations, 3) Response-shaping and -strengthening

Operations, 4) Cognitive Restructuring Operations , and 5) Response Transfer Operations. Probably the most commonly used response-reproduction operation is role playing. In a series of experiments, McFall and Twentyman found that role playing (behavioral rehearsal) combined with coaching accounted for nearly all of the treatment variance between training and control groups. The effects of these two components were independent, additive, and primarily responsible for improvement. Behavioral rehearsal/ role playing has been conducted covertly and overtly but the research suggests the latter to be slightly more effective (Galassi and Galassi, 1976).

The two most commonly used response-acquisition operations are modeling and instructions/coaching (Rich and Schroeder, 1975). However, in the series of experiments already mentioned, McFall and Twentyman (1973) found that modeling did not significantly add to treatments effects achieved with a program of behavioral rehearsal and coaching. Whereas, coaching did add significantly to a program of behavioral rehearsal and modeling. Despite their evidence that modeling may have little value for most subjects, McFall and Twentyman suggested a prudent strategy of building some form of modeling into assertion training programs. Their suggestion probably reflects the current uncertainty about the value of modeling as a component of

assertion training. For example, contrary to McFall and Twentyman's results, Kazdin (1974, 1976) found covert modeling and modeling reinforcement significantly improved assertive behavior. However, unlike McFall and Twentyman, he didn't attempt to determine if modeling made a significant contribution to a program of coaching and behavioral rehearsal, or vice-versa. In most programs, the group trainers/leaders act as role models as they interact in the group processes.

Since initial attempts at assertion tend to be awkward and inefficient (Bandura, 1971), many programs use shaping procedures to refine the response. Audiovisual and/or group feedback are the more common shaping operations. As the response is refined it is strengthened by group encouragement and support. In addition, some programs use hierarchically arranged homework assignments designed to provide clients with initial success at assertion (Rich and Schroeder, 1975). The intent in using such assignments is to strengthen assertive responding and help the client transfer assertion to his/her daily life.

A fourth set of commonly employed training procedures focuses on cognitive restructuring with the goal of altering the client's perceptions of assertion "... from a socially undesirable behavior to a highly desirable, perhaps

essential, one." (Rich and Schroeder, 1975). Nearly all programs incorporate cognitive restructuring in one form or another. It may be simply the trainer's repeated affirmation of assertion's desirability or it might be a more elaborately designed series of discussions, lectures, and readings focused on changing the client's belief system (Alberti and Emmons, 1974; Lange and Jakubowski, 1976; Rich and Schroeder, 1975). In either case, recent research suggests focusing on cognitive restructuring may be crucial to the development and continued use of assertive behaviors (Derry and Stone, 1979; Fiedler and Beach, 1978; Schwartz and Gottman, 1976).

In this regard, Schwartz and Gottman (1976) found little difference in assertive and nonassertive individuals' knowledge of appropriate assertive behaviors. Fiedler and Beach (1978) discovered that both groups placed similar value on the consequences of assertion. In light of their's and Schwartz and Gottman's results, Fiedler and Beach concluded that perhaps the focus of training should be to change the client's cognitive expectations of assertion rather than focusing on values or specific behaviors. Other research suggests that greater gains in behavior change and generalization occured when cognitive restructuring was one of the primary focuses of assertion training (Derry and Stone, 1979)

Response transfer operations is the final area mentioned by Rich and Schroeder (1975). They found a noteworthy lack of such procedures in many programs and appropriately wondered if transfer from training to real-life could be achieved when provisions for such transfer weren't provided. Programs incorporating response transfer procedures usually use hierarchically arranged homework assignments and heartily encourage clients to practice being assertive (Alberti and Emmons, 1974; Rich and Schroeder, 1975). Clients are instructed to initially attempt assertion in situations likely to produce rewarding results. As they acquire more skill and finesse, and after they've begun to expect favorable consequences, they are encouraged to tackle progressively more difficult situations.

After conducting their extensive review, Rich and Schroeder (1975) concluded all programs should provide procedures for response acquisition, reproduction, shaping and strengthening, cognitive restructuring, and transfer. A good model of an assertion training program which does seem to provide for all of these areas is presented in Responsible Assertive Behavior by Arthur Lange and Patricia Jakubowski (1976). They initially outlined twelve "process goals" which they felt were critical to successful assertion training:

> We believe that the following process goals are critical considerations for successful assertion training: (1) identify specific situations and behaviors which will be the focus of training; (2) teach the participants how to ascertain if they have acted assertively rather than aggressively or nonassertively; (3) help individuals to accept their personal rights and the rights of others; (4) identify and modify the participants' irrational assumptions which produce excessive anxiety and anger and result in nonassertion and aggression; (5) provide opportunities for the participants to practice alternative assertive responses; (6) give specific feedback on how the members could improve their assertive behavior; (7)encourage the members to evaluate their own behavior; (8) positively reinforce successive improvements in assertive behavior; (9) model alternative assertive responses as needed; (10) structure the group procedures so that the members' involvement is widespread and supportive; (11) give considerable permission and encouragement for the participants to behave assertively within and outside of the group; and (12) display leadership behavior which is characterized by assertion rather than aggression or nonassertion. (Lange and Jakubowski, 1976, pp. 4-5)

They incorporated into their program a variety of suggestions, exercises, and discussions designed to fulfill these twelve goals. One of the by-products is that they also provide for the five areas upheld by Rich and Schroeder (1975).

Applications of Assertion Training Programs

Since the advent of assertion programs, they have been applied with varying success to a variety of college and clinical populations (Fiedler and Beach, 1978; Heimberg,

et. al., 1977; Hersen, Eisler, and Miller, 1973). Heimberg and his colleagues (1977) concluded that with all populations investigated to date, assertion has resulted in behavioral changes superior to any produced by no-treatment and placebo conditions. Clinical applications have included obsessive-compulsive disorders, chronic crying (Rimm, 1967), chronic alcoholism (Eisler, Hersen, and Miller, 1974), maladaptive interpersonal behaviors, marital and family crises (Eisler and Hersen, 1973), aggressive and explosive behaviors (Heimberg, et. al., 1977), impotence (Hersen, Eisler, and Miller, 1973), and others. Though at first glance it appears there is no underlying element common to these populations, Hersen, Eisler, and Miller (1973) suggest that in most cases the "...patients are characterized by moderate to severe interpersonal deficits." However, this summary appears to broad and overgeneralizing. A better summary of the underlying common element might be the following: Individuals/families suffering from the problems mentioned above are characterized by moderate to severely limited skills of self-expression which enhance or promote social problem-solving. These limitations are probably only apparent in certain contexts. However, assertion training is effective because it teaches improved self-expression skills and thereby enhances subsequent problem-solving.

Despite the application of assertion training to various clinical populations and college students and despite the research done to date, authors who have reviewed the literature point to several areas still needing further investigation (Hersen, Eisler, and Miller, 1973; Heimberg, et. al, 1977; Rich and Schroeder, 1975). They claim there is still an insufficient number of outcome studies validating the alleged effectiveness of assertion training with a variety of populations. It seems the vast majority of studies conducted thus far have used college students or hospitalized psychiatric patients as subjects. In regard to this, several sources (Clark, 1978; Herman 1977; Phelps and Austin, 1975) point directly to nurses as a potential population for further investigation since they seem particularly prone to cultural values that promote and sustain subassertion (i.e.,think of others first--even if you are tired or hurting; be humble-- never brag or show pride; always listen and be understanding-- never complain or confront). Another issue mentioned both by the above authors and earlier in this paper is the need for further validation of existing assessment devices/procedures.

Given these research concerns, the purpose of this study was threefold: (1) to evaluate the convergence and/or divergence of scores on multiple assessment devices with a professional population which in this study was registered

nurses; (2) to guage the effectiveness of assertion training for registered nurses during treatment; and, (3) to assess the durability of changes produced by assertion training.

Chapter II

METHOD

Subjects

A power analysis was performed using data from previous research with the Rathus Assertiveness Schedule and it indicated that a total of 64 nurses were needed for ample statistical power. With alpha equal to .05 and the studentized differences between the means of the treatment/control groups equal to .7, the probability of rejecting the null hypothesis when false would have been .66 to .7. However, only 30 registered nurses responded to the direct mailing recruitment (see Appendix A for a copy of the advertising brochure). Of the 30, two nurses subsequently dropped out and two moved leaving 26 nurses who participated in the entire program. Despite the large discrepancy between the desired and actual number of nurses recruited, it was decided that the obtained sample be used and, if necessary, a second sample be acquired at a later time.

A pretraining questionnaire and interview with each of the participants revealed one nurse who had previously had assertion training and another who was currently participating in marital counseling. As a result of random assignment, the R.N. with previous exposure to assertion training was placed in the waiting-list control group. Her

prior experience had consisted of a two-day, six hour workshop. The R.N. who was currently receiving counseling was randomly assigned to the training group. Her counselor was consulted prior to commencing training and indicated strong approval of the R.N.'s choice to participate. It was unnecessary to exclude any of the individuals who enrolled in the program.

Persons participating were required to pay a twenty dollar ($20.00) registration fee at the first training session. When they completed the Post-training assessment, ten dollars were returned and they were awarded 12 continuing education units (Montana CEARP). These measures were employed as incentives to remain in the program and, thus, help reduce subject attrition. Approval for conducting the study was obtained from the Institutional Review Board for Use of Human Subjects in Research (see Appendix B).

Design

The design for this study was a 2 X 2 (treatment/control group X time of testing) split-plot repeated measures analysis of variance (Edwards, 1972) with subjects randomly assigned to groups. Two month Follow up data was collected on the treatment group and the remaining untrained control subjects. This data was analyzed using a

2 X 3 (treatment/control group X time of testing) split-plot repeated measures analysis of variance with unequal subjects across groups. A flow chart of the entire design and procedures can be found in Table 1.

Procedure

Pretraining individual assessment periods were arranged with nurses responding to the brochure. Upon arriving at the University of Montana Clinical Psychology Center, they were given a brief questionnaire to fill out (see Appendix C). The completed questionnaire was reviewed in their presence by the investigator who specifically discussed responses to the following items: Years nursing experience, club/social group membership, (question 4) difficult feelings to express, (7) goals in participating, (9) previous assertion training experience, (10) current counseling, (11) willingness to attend all sessions, (12) motivation, (13) confidence (see Appendix C).

After this conversation, they were given a synopsis of the program. In brief, they were told that an assertiveness training program had been specifically developed for improving registered nurses abilities to effectively express themselves in their personal and professional environments. Furthermore, because the program as a whole was being evaluated to determine its effectiveness and to improve

Table 1

Flow chart of Design and Procedures

Recruitment	Pre-training Assessment	Training Conditions	Training	Post-training Assessment	Two-Month Follow up
Direct Mailing of Brochure to all R.N.'s in Missoula and Ravalli Counties n = 751	Questionnaire Interview Role Play a. Five scenes ASST Likert Scales RAS ASES	Random Assignment to: Assertion Training	Week: (1) Introduction, Definitions, and Human Rights (2) RET, Cognitive Restructuring, and Positive Assertion (3) Socialization Myths, Nonverbal Components (4) I-language, Basic Empathic Assertion (5) Confrontive and Escalating Assertion Questionnaire	Interview Role Play a. Ten Scenes ASST Likert Scales RAS ASES	Interview Role Play a. Ten Scenes ASST Likert Scales RAS ASES
		Waiting-list Control	None	Interview Role Play a. Ten Scenes Likert Scales RAS ASES	Interview Role Play a. Ten Scenes Likert Scales RAS ASES

similar programs, they were told the cost was only twenty dollars payable at the first training session and ten dollars would be returned if they completed the program. After being informed of the length and times that meetings would be held and of the pending application for continuing education (CEARP) credits, the nurses were told that because of the response to the brochure, not everyone who enrolled would be able to take the training immediately. Rather, to be fair to all, a random selection procedure would be used to pick nurses to start immediately and the remainder would commence training in six to eight weeks. They were also told that the assignments hadn't been made yet but everyone would be notified as soon as they were.

Following this explanation, all individuals completed the Pre-training assessment battery. Role playing was the first measure in the test battery and involved the help of a male assistant whom the subject didn't know. After the assistant was introduced, the subject was given five 3 X 5 note cards each containing a scene requiring an assertive response on the subject's behalf. However, each scene needed a one sentence prompt by the assistant to complete it. The nurse was instructed to read the card, familiarize herself with the scene, and imagine how she would likely respond. When she indicated that she had completed these three tasks, the investigator turned on a tape recorder and

the assistant completed the scene with the one sentence prompt to which the subject responded. The tape recorder was then turned off. No second prompts were provided and further responses were not elicited. This routine was followed for all role play scenes during the Pre-/Post-training and Follow up assessments. After the role plays, the subject completed a battery of assertion inventories in the following order: 1) Assertiveness Self Statement Test (Schwartz and Gottman, 1976); 2) Two Likert scales (Bordewick, note 1); 3) Rathus Assertiveness Schedule (Rathus, 1973); and 4) Adult Self-Expression Scale (Gay, Hollandsworth, and Galassi, 1975). It took approximately one and a half hours for each subject to complete the Pre-training questionnaire, interview, and assessment battery.

Next, nurses were randomly assigned and notified, via telephone, of their assignment to five weeks of assertion training or a five week waiting period. Training followed an abbreviated version of the cognitive-behavioral model outlined by Lange and Jakubowski (1976). Refer to Appendix L for a detailed account of each session.

During the Post-training assessment session, the nurses were readministered the five pre-training role play scenes, five novel role play scenes, and the five assertion inventories. After two months, a Follow up assessment was

conducted using the same ten role play vignettes and the same inventories.

Dependent Measures

A variety of measures were used to evaluate the efficacy and durability of behavioral/cognitive changes.

Behavioral Role Play. A number of assertion vignettes were employed in assessment. Briefly, the vignettes were written descriptions of situations requiring an assertive response. The descriptions were read to the subject followed by a prompt which was the subject's cue to respond; for example, "You have just picked out four items at the grocery store. As you head for the checkout counter, a woman with an overloaded cart sees you coming and rushes to get in front of you. As she does so she bumps the front of your cart and mutters: (prompt) Mind if I cut in ahead of you?" The vignettes enhanced assessment by providing an opportunity to observe the person as she applied her assertion skills to a potential real-life situation. They thus permitted assessment of changes in the person's behavioral repetoire.

The vignettes used for the behavioral role play were taken from Bordewick (note 1) who gleaned them from previous assertion research (McDonald, note 5; McFall and Lillesand,

1972; McFall and Marston, 1970; Eisler, Herson, Miller, and Blanchard, 1975). Because many of these vignettes had been written for specific populations, Bordewick discarded some, reworded others, and created a few new ones. He then had graduate students in clinical psychology at the University of Montana rate the resulting 43 vignettes along three dimensions: 1) difficulty, 2) realism, 3) clarity. As with Bordewick's study, scenes which were clear and equated for difficulty and realism were used in the Pre-Post-Follow up tests. Two additional vignettes depicting typical nursing situations that require assertion were written by the investigator and an R.N.. These were also included in the ten assessment role plays (see Appendix D for a list of the vignettes). For training purposes, subjects were both encouraged and expected to bring work-related or personal situations that they would like to role play.

Following Bordewick's procedure, two graduate student assistants were given 12 hours of training in rating audiotapes of role played assertion responses. They rated responses on three assertive component behaviors: 1) noncompliant speech content; 2) requests for new behavior; and 3) affect (Bordewick and Bornstein, 1980; Packman, et. al., 1978). They also provided a fourth global rating of overall assertiveness. After the Follow up, each judge

rated one third of the responses independently and both rated the final third as a check on reliability (see Appendix E for rating criteria). Responses were randomized and judges remained "blind" with respect to whether the role plays were Pre-/Post-training or Follow up.

Assertiveness Self-Statement Test (ASST). Developed by Schwartz and Gottman (1976; see Appendix F), the ASST was designed to tap positive and negative self-statements which serve to promote or inhibit ability to refuse. The reported 34 test items were concensually validated on a sample of 37 college students. Only items with 90% or more agreement as to whether they promoted or inhibited refusal behavior were employed. The investigator obtained a copy of the ASST directly from Dr. Gottman. However, the copy sent had only 32 items. Bordewick (personal communication) reported a similar happenstance and, therefore, it was decided that the study be run using the test as forwarded by Dr. Gottman to both Bordewick and the current investigator.

Global Likert Scales. During Pre-/Post-testing and Follow up, the subjects were given two Likert scales (Bordewick, note 1; Appendix G). They were asked to rate themselves on general assertive behavior and ability to refuse requests.

Rathus Assertiveness Schedule (RAS). Developed as a broad range measure of assertion (Rathus, 1973; Appendix H), the RAS is probably the most heavily researched and widely used paper and pencil test of assertion. Norms and percentile rankings based on a national sampling of college students are available for both males and females (Rathus and Nevid, 1978). Rathus (1973) employed split-half reliability and test-retest stability checks on the test items and found an acceptable level of .78 for both. Two factor analytic studies revealed a minimum of eight principal components suggesting the RAS does indeed sample a wide range of assertive behavior (Law, Wilson, and Crassini, 1979; Nevid and Rathus, 1979).

Adult Self-Expression Scale (ASES). In developing the ASES, Gay, Hollandsworth, and Galassi's (1975) intent was to construct a standardized measure of assertion that was applicable to adults in general rather than strictly college populations (see Appendix I). Nevertheless, their standardization sample consisted of 464 subjects from a "large community college". Subjects ranged in age from 18 to 60 with an average age of 25.38 years. The 48 item ASES displayed a high test-retest stability of .88 and .91 over two and five weeks, respectively. A factor analysis produced 14 factors that accounted for 55.91% of the variance. Concurrent validity was displayed in the test's

discrimination of subjects according to anxiety, seeking counseling, and self-concept.

Therapists

Four doctoral students in clinical psychology were co-therapists for two groups. They were given explicit assertion training manuals, read and discussed pertinent sections of Responsible Assertive Behavior (Lange Jakubowski, 1976), and participated in three 2-hour training sessions prior to the first group meetings. Each group session was audiotaped to check both the proficiency of the therapists and adherence to the programmed procedures. Furthermore, each team of therapists met with the investigator and the other team for one hour per week to review tapes of the previous session. Subjects were asked on a Post-training questionnaire to rate therapists on warmth, confidence, enthusiasm, and competence (see Appendix J for Post-training questionnaire, Appendix K for trainer's manuals, and Appendix L for subject's manuals). Following the final session, the therapists completed a Post-training questionnaire consisting of 15 nine-point Likert scales. The therapists were asked to rate themselves on various therapist attributes, to rate aspects of the approach, and to provide impressions of the group experience for the nurses (see Appendix J).

Treatment Conditions

Subjects were randomly assigned to either a cognitive-behavioral assertion training group or a waiting list control group. This study did not include an attention placebo group since previous research indicates such groups have not matched gains made with behavioral packages (Galassi and Galassi, 1976).

The assertion training group followed a shortened (five vs. nine weeks), slightly modified version of the program outlined by Lange and Jakubowski (1976). In addition to providing for the five types of operations Rich and Schroeder advocate and fulfilling Lange and Jakubowski's 12 process goals for assertion training, the program included: a) teaching individuals Rational-Emotive Therapy (RET) techniques (Ellis, 1962), and b) training individuals in nonverbal and verbal behavioral assertion skills. The cognitive components of treatment included identifying and accepting human rights, analysing irrational beliefs and negative self-statements, and then using cognitive restructuring to alter those beliefs and statements. Assertion skills training involved role playing, coaching, modeling, group exercises, discussion, and positive reinforcement in focusing on both the nonverbal and verbal aspects of I-language, basic, empathic, confrontive, and

escalating assertion. Training manuals were provided (see Appendix L) and homework was assigned between sessions. Subjects met weekly at the Clinical Psychology Center for five 2 hour sessions. Table 2 summarizes the topics covered in each session (for a detailed presentation of each session see Appendix M and the trainer's manual, Appendix K).

The waiting list controls were given all Pre-training measures. They were later telephoned and informed that because of the number of nurses seeking training and as a result of random selection, they would have to wait approximately six to eight weeks before being able to participate. At the end of that time, they were contacted for an "updated" assessment, which consisted of the Post-training assessment measures, and offered training. Seven of the nurses in the control group opted to receive training at this time.

Two months after the Post-training assessment, all the nurses who had initially undergone training and those control subjects who had not yet been able to take training were recontacted and asked to retake the assessment measures for the final time. The control subjects were told that since two months had elapsed it was necessary to repeat the assessment measures a final time before they started training. This Follow up assessment was identical in form

Table 2

Topics covered within each Session

Session 1	Suggested Time
Introductions	15 min.
Brief Introductory Lecture	10 min.
Differentiating Assertion, Aggression, and Subassertion	30 min.
Break	10 min.
Cognitive Components I: Identifying and Accepting Human Rights	20 min.
Homework	10 min.
Extra time	25 min.
Total	120 min.

Session 2	Suggested Time
Homework and Session 1 Review	10 min.
Cognitive Components II: RET A-B-C Lecture Irrational Beliefs Negative Self-statements	30 min.
Break	10 min.
Rational Self Analysis Exercise	30 min.
Positive Assertion	5 min.
Giving and Receiving Compliments Exercise	15 min.
Homework	10 min.
Extra time	10 min.
Total	120 min.

Session 3	
Homework and Session 2 Review	15 min.
Cognitive Components III: Socialization Myths	10 min.
Inane Topics Exercise	15 min.
Break	10 min.
Nonverbal Components of Assertion	15 min.
Role Play Concentrating on Nonverbals	25 min.
Homework	10 min.
Extra time	20 min.
Total	120 min.

Session 4	
Homework and Session 3 Review	10 min.
Types of Assertion I: I-language, Basic, Empathic	20 min.
Making and Refusing Requests Exercise	30 min.
Break	10 min.
Role Play Concentrating on Nonverbals and above types	40 min.
Homework	5 min.
Extra time	5 min.
Total	120 min.

(Table 2 cont.)

Session 5	Suggested Time
Homework and Session 4 Review	10 min.
Types of Assertion II: Confronting, Escalating	30 min.
Break	10 min.
Role Play: Concentrating on above types and incorportating previous material on nonverbals, assertive types, and cognitive components	50 min.
Questionnaire Arrange assessment	20 min.
Extra time	0 min.
Total	120 min.

and content to the Post-training assessment. Following this assessment, the remaining six control subjects were given the training.

Chapter III

RESULTS

In order to clarify the presentation of the results, the data will be discussed in the following order: 1) Pre-training questionnaire; 2) Self-report inventories and global ratings (i.e., the ASST, two Likert scales, RAS, and ASES); 3) Role play ratings by trained judges; 4) Correlational analyses; and, finally, 5) Post-training questionnaires. Two sets of univariate analyses were performed on the self-report inventories and global ratings: 1) a split-plot repeated measures design: two groups (i.e., training, waiting-list control) X two levels (i.e., Pre-training, Post-training); and 2) a split-plot repeated measures design with unequal observations: two groups (i.e., training, waiting-list control) X three levels (i.e., Pre-training, Post-training, follow up).

Four univariate analyses and, where appropriate, chi square tests were conducted on the trained judges role play ratings at Pre-Post and Pre-Post-Follow up. Interrater reliability was calculated using Pearson's product-moment correlation coefficient with the Spearman-Brown adjustment. Pertinent correlations within and across measures are presented for the Pre- and Post-training questionnaires. Correlations across measures are presented for the

self-report inventories, global ratings, and trained judges ratings on role plays.

After the nurses were randomly assigned to the training and waiting-list control conditions, it was necessary due to work schedules to offer those in the training condition an afternoon or an evening group. Subsequently, group membership for the training conditions depended largely on the nurse's work schedules rather than random assignment. This could have potentially resulted in a systematic bias that would alter the composition of the two groups and render the assumption of homogeneity of variances not tenable. However, a test of the homogeneity of the two training groups' variances conducted on each of the self-report measures at Pre-, Post-, and Follow up indicated no significant differences, $p > .05$ (see Appendix N). Furthermore, t tests conducted between the two training group's means on each of the measures revealed only one significant difference at any point in time. The difference was on Likert 1, a global rating of assertiveness, at Follow up, $p<.05$.

Pretraining Questionnaire

The pretraining questions and ratings fell into four categories: Biographical information, problems and objectives, self-perceived assertiveness, and interest in

participating in the assertiveness training program. Twenty-six female registered nurses participated in the project and were randomly assigned to either the training or waiting-list control conditions. Table 3 displays the means and standard deviations for these two groups on biographical data collected. A *t* test conducted on each category indicated no significant differences in age, $t(24)=1.349$, $p>.05$, education, $t(24)=.945$, $p> .15$; nursing experience, $t(24)=.179$, $p> .4$; or, the number of persons living in their household, $t(24)=.250$, $p> .4$, between the two groups. In addition, the groups were also very similar in having approximately the same number of members above and below age 35, having exactly the same distribution of degree and diploma R.N.'s, and having almost the same number of hospital employed R.N.'s (Training=10, Control=9). On an additional question aimed at assessing social involvement, 10 of the 13 subjects assigned to training indicated being involved in one or more social or professional organizations while 8 of the 13 control subjects reported likewise.

Regarding problem definition and objectives, the R.N.'s were asked to indicate persons they had difficulty expressing their feelings with and particular feelings they have difficulty expressing. Combining data from both groups, the rank order of individuals with whom it was very difficult to openly express feelings (question 3,

Table 3

Means and Standard Deviations for biographical information provided by Training and Waiting-List Control groups.

	TRAINING		WAITING-LIST CONTROL	
	$\bar{X}$	StD	$\bar{X}$	StD
Age	38.15 (Over 35: 7)	12.07	38.92 (Over 35: 8)	9.79
Education	15.69 (Individuals with degrees: 5)	.86	16.08 (Individuals with degrees: 5)	1.26
Nursing Experience	9.46	7.30	10.15	7.83
Persons in Household	2.62	1.26	3.38	1.39

Pretraining Questionnaire, Appendix C) was as follows: employer/teacher (marked by 17 people), strangers (13), a family member (12), the opposite sex (9), casual acquaintances (8), friends (6), doctors/coworkers (5), nearly everyone (4), and one particular individual (0). The feeling most difficult to express (question 4) was anger (25) followed by hurt (21), fear (6), affection (4), sadness (2), positive compliments (1), and happiness (0).

The R.N.'s were also asked to indicate what they hoped to accomplish by participating in the assertive training program. A variety of objectives were given involving themes of: Increasing the ability to openly express themselves at work and at home in a constructive manner without losing control or hurting others; decreasing their guilt feelings following expression of their opinions, beliefs, thoughts, needs, or desires; increasing their self-confidence in coping with problems that involve others; becoming less concerned or fearful of others reactions; being able to remain firm on decisions; handling angry or upset people more effectively; and, increasing self-esteem. Clearly, the individuals who registered for the program presented a wide range of problems and objectives encompassing behavioral, cognitive, and emotional components.

To determine self-perceived assertiveness, the nurses were asked to rate themselves with respect to others on how assertive they usually are and where they stood in saying "No" to tasks they didn't want to do (Questions 1 and 5, respectively, Pretraining Questionnaire, Appendix C). They rated themselves on scales ranging from 0 to 100%. The rating was supposed to indicate the percentage of the population that the nurse felt more assertive than or more capable than in saying "No" to unwanted tasks. Hence, a rating of 0 percent would suggest the individual felt she was less assertive than everyone she knew; 50 would indicate she felt as assertive as half the people; and, 100 would denote feelings of being more assertive than virtually everyone. Across all subjects combined, the assertiveness rating was $\underline{M}$=50.38 (SD=13.71) and desired level of assertiveness was $\underline{M}$=85.19 (SD=10.05). The refusal ratings indicated ability to say "No" to unwanted tasks/requests was $\underline{M}$=52.31 (SD=19.45), and desired ability to refuse was $\underline{M}$=88.85 (SD=10.64). Therefore, based on self-rated placement with respect to others, the R.N.'s saw themselves as equal to approximately half the population in assertion but nonetheless they desired to be more assertive.

There were three ten-point rating scales which focused on evaluating the nurses interest in participating in the assertion training program (Questions 10, 11, and 12,

Pretraining Questionnaire, Appendix C). Results from these scales indicated there was very high willingness to attend all of the sessions, $\underline{M}$=9.62 (SD=.57); very strong motivation to become more assertive, $\underline{M}$=9.08 (SD=1.04); and high confidence that they could become more assertive, $\underline{M}$=7.69 (SD=1.87). No individual indicated less than moderate (rating of 5 or less) willingness to attend all sessions or a lower than moderate level of motivation.

Two final questions dealt with previous exposure to assertion training programs and current participation in counseling/psychotherapy (Questions 8 and 9, respectively, Pretraining Questionnaire, Appendix C). One R.N. responded affirmatively to the former and one to the latter question. It was mentioned earlier that, as a result of random assignment, the R.N. with previous exposure to assertion training was placed in the waiting-list control group. Her prior experience had consisted of a two-day, six hour, workshop. Also mentioned earlier was the fact that the R.N. who was currently receiving counseling was randomly assigned to the training group. Her counselor was consulted prior to commencing training and indicated strong approval of the R.N.'s choice to participate.

Self-Report Inventories and Global Ratings

Two sets of univariate analyses were conducted on the ASST, two Likert scales, RAS, and ASES: 1) a split-plot repeated measures design on Pre-Post-training data and 2) a split-plot repeated measures design with unequal observations on Pre-Post/Follow up data. Means and standard deviations for both training and waiting-list control groups are presented in Table 4. F ratios at Pre-Post-training and at Pre-Post-Follow up are also presented in Table 4 (see Appendix O for individual ANOVA summary tables of Pre-Post-training and Appendix P for similar tables of Pre-Post-Follow up). As Table 4 indicates, there was no significant between groups effect at Post-training on the ASST, $F(1,24)=.01$, $p>.05$; Likert 1, $F(1,24)=2.92$, $p>.05$; RAS, $F(1,24)=.72$, $p>.05$; or ASES, $F(1,24)=.04$, $p>.05$. There was a significant between groups effect, however, on Likert 2, $F(1,24)=5.8$, $p<.05$.

A probable reason for the lack of significant between groups effects becomes apparent when the Pre-Post mean scores in Table 4 are reviewed. The training group's average score, in contrast to the control group, was lower at Pre-training on the ASST, RAS, and ASES but higher at Post-training. The waiting-list control group's average remained fairly constant though there was a noteworthy

Table 4

Means, Standard Deviations, and F ratios for self-report measures

Variable	Training (n=13)		Control (n=13)		Pre-Post F ratio (2 X 2)		Pre-Post-FU F ratio (2 X 3)	
	$\bar{X}$	St.D.	$\bar{X}$	St.D.				
ASST								
Pre	86.62	12.29	93.46	9.88	Groups	.01 NS	Groups	.06 NS
Post	100.00	16.11	92.39	5.91	Pre-Post	8.58**	Pre-Post	8.90**
FU	98.90	19.07	94.83	5.91	Inter.	11.85**	Inter.	6.77**
	(n=10)		(n=6)					
Likert 1								
Pre	-.39	2.33	-.85	2.41	Groups	2.92 NS	Groups	2.81 NS
Post	1.92	1.61	-.23	2.24	Pre-Post	17.57***	Pre-Post	11.98***
FU	2.30	1.56	-.33	1.97	Inter.	5.50*	Inter.	4.28*
	(n=10)		(n=6)					
Likert 2								
Pre	-.08	2.69	-1.38	1.85	Groups	5.80*	Groups	4.05 NS
Post	1.69	1.65	-.39	2.06	Pre-Post	10.30**	Pre-Post	11.03***
FU	1.70	1.63	-.50	1.64	Inter.	1.26 NS	Inter.	2.62 NS
	(n=10)		(n=6)					
RAS								
Pre	-24.62	24.16	-20.32	21.85	Groups	.72 NS	Groups	.50 NS
Post	4.54	17.02	-12.69	22.45	Pre-Post	26.24***	Pre-Post	27.88***
FU	9.00	23.18	-3.17	9.02	Inter.	8.9*	Inter.	8.95**
	(n=10)		(n=6)					
ASES								
Pre	85.39	18.82	93.00	19.13	Groups	0.04 NS	Groups	.10 NS
Post	106.23	21.61	95.77	18.42	Pre-Post	24.42***	Pre-Post	26.57***
FU	109.80	25.30	99.83	6.01	Inter.	14.31***	Inter.	8.03**
	(n=10)		(n=6)					

NS = nonsignificant
* = $p<.05$
** = $p<.01$
*** = $p<.001$

change on the RAS. It was the higher, though subsequently constant, averages at Pre-training of the control group that obliterated the between groups effect. If the training and control groups would have been more equivalent at Pre-training, a significant between groups effect would probably have been manifest.

The lack of significance between groups on Likert 1 is probably best attributed to the positive gains exhibited by control subjects from Pre- to Post-training on this scale. These gains would make it dificult to detect significant differences between training and control groups.

Finally, the significant between groups effect on Likert 2 at Post-training is largely a result of a reversal from that which occurred on the ASST, RAS, and ASES. The training group averaged higher on Likert 2 at Pretraining, made substantial gains, and, concomitantly, a significant between groups effect was revealed.

A highly significant Pre-Post effect was shown on all measures at Post-training: ASST, $F(1,24)=8.58$, $p < .01$; Likert 1, $F(1,24)=17.57$, $p<.001$; Likert 2, $F(1,24)=10.30$, $p< .01$; RAS, $F(1,24)=26.24$, $p<.001$; ASES, $F(1,24)=24.42$, $p< .001$. A significant groups X Pre-Post interaction effect was also shown for all but one of the measures: ASST, $F(1,24)=11.85$, $p<.01$; Likert 1, $F(1,24)=5.50$, $p<.05$; RAS,

$F(1,24)=8.9$, $p < .05$; and ASES, $F(1,24)=14.31$, $p<.001$. The Likert 2 scale did not show a significant interaction effect, $F(1,24)=1.26$, $p>.05$, probably because both training and control groups showed substantial gains on this scale from Pre- to Post-training.

Univariate analyses conducted on Pre-Post-Follow up data were even more consistent and revealed the same pattern that emerged in the Pre-Post analyses. There was no significant between groups effect on any of the measures: ASST, $F(1,14)=.06$, $p>.05$; Likert 1, $F(1,14)=2.81$, $p>.05$; Likert 2, $F(1,14)=4.05$, $p>.05$; RAS, $F(1,14)=.497$, $p>.05$; and ASES, $F(1,14)=.1$, $p>.05$. The underlying explanation is probably the same as that offered earlier: The higher averages for the control group at Pre-training coupled with often increased average scores at Post-training and/or Follow up obliterated the between groups effect. As a result of random assignment, it seems highly unlikely the initial higher scores and subsequent gains that occurred would be due to any systematic intervention or influence other than repeated testing or practice.

There was a highly significant Pre-Post-Follow up effect on all measures: ASST, $F(2,28)=8.90$, $p<.01$; Likert 1, $F(2,28)=11.98$, $p<.001$; Likert 2, $F(2,28)=11.03$, $p < .001$; RAS, $F(2,28)=27.88$, $p < .001$; and ASES, $F(2,28)=26.57$, $p<$

.001. The finding for each measure was subjected to Scheffe's test for multiple comparisons and the results are presented in Table 5. On each measure there were highly significant differences between Pre-Post and Pre-Follow up, $p < .01$, but no significant differences between Post-Follow up, $p > .05$. Thus, significant changes occurred between Pre- and Post-training and were maintained from Post-training to Follow-up. A glance at the means in Table 4 indicates that the changes from Pre- to Post-training were positive, thus suggesting increased assertiveness.

There was a significant groups X Pre-Post-Follow up interaction effect on all but one of the measures: ASST, $F(2,28)=6.77$, $p<.01$; Likert 1, $F(2,28)=4.28$, $p<.05$; Likert 2, $F(2,28)=2.62$, $p>.05$; RAS, $F(2,28)=8.95$, $p<.01$; and, ASES, $F(2,28)=8.03$, $p<.01$. Scheffe's test for multiple comparisons was applied to these findings and the results are listed in Table 6. When coupled with the means listed in Table 4, the results reveal pronounced and stable patterns for both groups. The training group made highly significant gains in the "more assertive" direction across all measures from Pre- to Post-training, $p < .01$. Furthermore, the gains were maintained at Follow up as revealed by the lack of significant changes from Post-training to Follow up and by highly significant differences in the assertive direction between Pre-training

Table 5
Scheffe's Test for multiple comparisons conducted
on Pre-Post-Follow up effects.

Variable	F' Pre-Post (2,45)	F' Post-Follow Up (2,45)	F' Follow Up-Pre (2,45)
ASST	14.98**	$.23^{NS}$	11.49**
Likert 1	16.37**	$.17^{NS}$	19.63**
Likert 2	18.65**	$.31^{NS}$	14.15**
RAS	33.44***	1.44^{NS}	48.77***
ASES	33.30***	$.58^{NS}$	42.66***

NS= nonsignificant
*= $p<.05$
**= $p<.01$
***= $p<.001$

Table 6

Scheffe's test for multiple comparisons conducted on groups' Pre-Post-Follow Up interaction effects.

Variable	F' Pre-Post		F' Post-Follow Up		F' Follow Up-Pre	
	Tr(2,18)	C(2,10)	Tr(2,18)	C(2,10)	Tr(2,18)	C(2,10)
ASST	27.68**	$.22^{NS}$	1.13^{NS}	$.35^{NS}$	17.61**	$.01^{NS}$
Likert 1	19.17**	$.82^{NS}$	$.77^{NS}$	$.20^{NS}$	27.61***	$.20^{NS}$
Likert 2	20.99**	1.29^{NS}	$.12^{NS}$	$.21^{NS}$	17.89**	$.47^{NS}$
RAS	50.05***	$.096^{NS}$	$.78^{NS}$	2.56^{NS}	54.09***	3.65^{NS}
ASES	44.68***	$.63^{NS}$	$.60^{NS}$	$.34^{NS}$	55.65***	1.90^{NS}

NS= nonsignificant
*= $p<.05$
**= $p<.01$
***= $p<.001$

and Follow up. The control group, on the other hand, displayed no significant changes across time on any of the measures, $p>.05$.

Role Play Ratings

Interrater Reliability. Two independent judges rated the audiotaped role played responses along four dimensions: 1) affect or firmness, 2) compliance, 3) requests for changed behavior, and 4) overall level of assertiveness. The Pearson product-moment correlation coefficient for the judges' interrater agreement on the four dimensions was .90, .80, .59, and .86, respectively, $p's < .001$. The Spearman-Brown formula was used to adjust these correlations since they were calculated using only a third of the role plays rated by the judges. The Spearman-Brown adjusted correlations yielded values of .96, .92, .81, and .95, respectively (Taplin and Reid, 1973). The high correlations between observers on three of the four dimensions reflects high interrater agreement (Johnson and Bolstad, 1973). The drop in agreement on the fourth dimension, "Request for changed behavior" ($r=.81$), was of some concern since it lowers the degree of confidence which can be given to analyses involving that rating. Inspection of the data suggested that there was an overall tendency for one judge to rate this and the other dimensions slightly higher than

the other judge. However, a t test conducted on the two judges' ratings showed no significant differences on any of the dimensions, $p>.05$. The explanation for the reduced agreement on this dimension is probably contained in the comments of each rater following completion of their rating session. Each judge independently commented that rating a response for whether it did or didn't contain a request for altered behavior was difficult. The difficulty involved determining what constituted a request. In light of these comments and the lower agreement relative to the other dimensions, less confidence should be placed in the data and analyses reported here with respect to this dimension. However, it should be noted that this is a conservative suggestion since the level of agreement displayed is still within acceptable levels for observational data (Johnson and Bolstad, 1973). A detailed account of the rating scales used by the judges is contained in Appendix E.

Group Comparisons. The judges' role play ratings on the "affect" and "assertiveness" dimensions were analyzed separately with univariate ANOVA's using a split-plot repeated measures design at Pre-Post and a similar design with unequal observations at Pre-Post-Follow up. Furthermore, it was found that previously administered role play items, when readministered at Post-training, did not correlate highly with novel items (average r=.5).

Correlations calculated on the two sets of items at Follow up further confirmed the need for separate analyses (average r=.47). Therefore, separate analyses were performed on the two sets of items at Pre-Post and at Pre-Post-Follow up. The individual ANOVA summary tables are in Appendices Q and R. A combination of two factors probably accounts for the low correspondance between ratings on the two sets of items: 1) practice effects and 2) the situational specificity of assertive behavior.

One possible effect of practice would be to reduce the amount of variability on the original five items from Pre- to Post-training assessment. Such a reduction would restrict the range of the five readministered items and result in a decreased correlation with the five novel items (Nunnally, 1978). Examination of the original five role play items revealed that there was a pronounced reduction in variance from Pre- to Post-training assessment. By itself this does not account for the reduced correlation since the variance and distribution on the novel items still might resemble the variance and distribution on the original items at Post-training. However, examination of the novel items' variance showed it to be higher than the original items at Post-training assessment but not quite as high as the original items at Pre-training. In summary, by restricting the range of variance on the original items at

Post-training, the effect of practice was a reduction in the correlation with the five novel role play items.

The second factor contributing to the reduced correlation between the two sets of items is the situational specificity of assertive behavior. Different individuals find being assertive in different situations more or less difficult for a variety of situational, behavioral, emotional, and cognitive reasons. As a result, there is a vast domain of situations that could potentially be used for role play. Given this wide domain of "all situations that require assertive behavior on the part of nurses", it is highly unlikely that two sets of only five items each are going to adequately sample that domain for different persons and, hence, display a large amount of overlap. As the degree of overlap goes down, so does the extent of correlation. Consequently, the small number of items employed, given the domain of items to be sampled, limits the degree of correlation between the original items readministered at the Post-training assessment and the novel items.

Because of the complexity of the role play analyses, they will be presented in the following order: 1) univariate ANOVA's performed on data from the original items at Pre-Post and Pre-Post-Follow up, 2) chi squares conducted

on the same data, 3) univariate ANOVA's performed on data from the novel items at Pre-Post and Pre-Post-Follow up, and 4) chi squares conducted on this data. Table 7 presents the means, F ratios, and chi square statistics for the role play ratings. A review of Table 7 with regard to the F ratios reported on data from the original five role play items suggests a pronounced Pre-Post effect but almost no between groups effect or groups X Pre-Post interaction. It would appear at first glance that there is a highly significant improvement over time and that improvement is not limited to either group. Indeed, a close look at the means of the two groups provided in Table 7 indicates that both do improve from Pre- to Post-training, but, the training group improved more. At Pre-training, the training group's average score was lower on both affect and assertiveness, but, at Post-training, they averaged considerably higher. The fact that the training group tested lower at Pre-training and higher at Post-training coupled with higher scores by the control group at Post-training, accounts for the lack of significant groups X Pre-Post interaction effects. However, there was a significant interaction effect on ratings of overall assertiveness, $p<.05$.

As mentioned, the F ratios calculated on the Follow up data display the same pattern as those at Post-training: A highly significant Pre-Post-Follow up effect but

Table 7

Means, F ratios, and Chi Square statistics for role play ratings by trained judges

Variable	Training (n=13)		Control (n=13)		X^2	Pre-Post F ratio (2 X 2)		Pre-Post-FU F ratio (2 X 3)	
Original Items	$\bar{X}$	St.D.	$\bar{X}$	St.D.					
Assertive									
Pre	3.29	.80	3.54	.74	---	Groups	.19^{NS}	Groups	1.38^{NS}
Post	4.29	.59	3.85	.80	---	Pre-Po	15.44**	Pre-Po	10.70**
FU	3.86	.69	3.87	.92	---	Inter.	4.31*	Inter.	1.23^{NS}
	(n=10)		(n=6)						
Affect									
Pre	3.55	1.03	3.57	.79	---	Groups	1.39^{NS}	Groups	.10^{NS}
Post	4.52	.43	3.94	.89	---	Pre-Po	14.20**	Pre-Po	29.82***
FU	4.34	.51	4.27	.75	---	Inter.	2.85^{NS}	Inter.	1.31^{NS}
	(n=10)		(n=6)						
Noncompliance									
Pre	.78	.19	.72	.16	.31^{NS}				
Post	.94	.13	.80	.24	4.33*				
FU	.92	.11	.90	.17	.01^{NS}				
	(n=10)		(n=6)						
Request									
Pre	.26	.27	.26	.23	.00^{NS}				
Post	.48	.26	.29	.21	3.93*				
FU	.56	.19	.53	.25	.00^{NS}				
	(n=10)		(n=6)						
Novel Items									
Assertive									
Pre	---	---	---	---	---	Groups	.06^{NS}	Groups	.15^{NS}
Post	4.34	.57	3.98	.88	---	Pre-Po	11.49**	Pre-Po	7.69**
FU	4.30	.63	3.63	.39	---	Inter.	1.88^{NS}	Inter.	7.19**
	(n=10)		(n=6)						
Affect									
Pre	---	---	---	---	---	Groups	.53^{NS}	Groups	.16^{NS}
Post	4.29	.57	3.92	.80	---	Pre-Po	7.19*	Pre-Po	2.84^{NS}
FU	4.24	.68	3.9	.59	---	Inter.	.89^{NS}	Inter.	2.61^{NS}
	(n=10)		(n=6)						
Noncompliance									
Pre	---	---	---	---	---^{NS}				
Post	.88	.16	.78	.23	.31^{NS}				
FU	.90	.15	.77	.24	1.37^{NS}				
	(n=10)		(n=6)						
Request									
Pre	---	---	---	---	---^{NS}				
Post	.31	.26	.29	.26	.00^{NS}				
FU	.40	.24	.43	.32	.00^{NS}				
	(n=10)		(n=6)						

NS = nonsignificant
* = $p<.05$
** = $p<.01$
*** = $p<.001$

nonsignificant groups and groups X Pre-Post-Follow up interaction. Again, a close examination of the means in Table 7 will help explain this result. The training group is rated slightly lower on the average at Pre-training. Both groups' ratings increase but the training group's increase more by Post-training. By Follow up, there have been further increases by the control group. Because of the steady progression by the control group and the "see-sawing" of the training group, the usually powerful analysis of variance is incapable of detecting a groups X Pre-Post-Follow up effect. However, given the highly significant Pre-Post-Follow up effect, it would be useful to conduct multiple comparisons to evaluate when the effect occurred and which, if either, of the two groups scores was most responsible for the effect. Therefore, multiple comparisons using Scheffe's test were performed on the Pre-Post-Follow up effect and groups X Pre-Post-Follow up interaction. The results are presented in Table 8. There was a highly significant change in scores from Pre- to Post-training on both assertiveness and affect ratings, $p < .01$. This change was not sustained at a significant level at Follow up for ratings of assertiveness but it was for affect, $p < .05$. Comparisons between the two groups on assertiveness indicate that only the training group changed significantly from Pre- to Post-training and this change was

Table 8

F' ratios for multiple comparisons using Scheffe's test on role play ratings at Follow Up.

Comparison	Original Items		Novel Items	
	Assertiveness	Affect	Assertiveness	Affect
Within Effects				
1)Pre-Post	12.30**	17.5**	12.57**	4.50
2)Post-FU	3.09	1.29	.11	0.0
3)Pre-FU	3.09	9.29*	10.34**	4.03
Between x Within Effects				
1)Treatment x Pre-Post	12.40**	17.91**	20.86**	8.85*
2)Treatment x Post-FU	1.53	1.11	.03	.08
3)Treatment x Pre-FU	5.21	10.08*	22.41**	7.21*
4)Control x Pre-Post	1.38	1.87	.01	.14
5)Control x Post-FU	1.60	.24	.56	.04
6)Control x Pre-FU	0.0	.77	.74	.04

*=p<.05

**=p<.01

maintained at a near significant level, $p<.1$, by Follow up. Similar results occurred with ratings of affect. Note, however, the change by the training group was still significant at Follow up, $p<.05$. In summary, it appears that ratings primarily changed from Pre- to Post-training, that the training group's ratings changed the most, were fairly stable, and were primarily responsible for the Pre-Post change; and, finally, insufficient change was maintained at Follow up for the ANOVA to depict a groups X Pre-Post-Follow up interaction effect.

Chi square statistics were calculated on the ratings of compliance and requests for altered behavior. These are shown in Table 7. Results were the same for both ratings. There were no significant differences between groups in compliance or requests for altered behavior at Pre-training or Follow up on the original five items. However, significant differences were displayed on both ratings at Post-training, $p < .05$. The training group's scores showed that they were significantly less compliant with unreasonable requests and made significantly more requests for altered behavior on the other's part. Apparently, however, the phenomena was short lived since the two groups were nearly indentical by Follow up.

Separate univariate ANOVA's were performed on ratings of the novel items at Post-training and these same items readministered at Follow up. Means, F ratios, and chi square statistics for these ratings can be found in Table 7. The F ratios for these items at Post-training depict a pattern similar to the readministered items at Post-training and Follow up: Significant Pre-Post effects but nonsignificant between groups effects or groups X Pre-Post interaction. Inspection of the group means in Table 7 suggests the explanation for these results is the same as well. On the Pre-training assessment, the training group's ratings were lower on both affect and assertiveness, but, on the Post-test they averaged higher. The fact that the training group tested lower at Pre-training and higher at Post-training probably accounts for the nonsignificant between groups effect. This, coupled with higher scores by the control group at Post-training, accounts for the lack of significant groups x Pre-Post interaction effects.

F ratios based on ratings of the role plays from Pre-Post-Follow up show an entirely different pattern. There were highly significant Pre-Post-Follow up and groups X Pre-Post-Follow up interaction effects, $p<.01$, on ratings of overall assertiveness but no significant main or interaction effects on ratings of affect/firmness. Multiple comparisons using Scheffe's test were performed and the

results are displayed in Table 8. On ratings of assertiveness, a highly significant change in ratings occurred between Pre- and Post-training, $p<.01$ and this change was maintained at Follow up, $p<.01$. There were no significant changes in the control group's mean scores over time; but, the training group's scores changed significantly from Pre-training to Post-training, $p<.01$, and these changes were maintained at Follow up, $p<.01$.

As one would expect from looking at the ANOVA F ratios, there were no significant changes over time on ratings of affect for both groups combined. However, when the contributions of the two groups are viewed separately, the training group's ratings increased significantly from Pre- to Post-training, $p<.05$, and were maintained at Follow up, $p<.05$. The control group's ratings did not change significantly over time.

Chi square statistics calculated on ratings of compliance and requests for altered behavior showed no significant differences between the two groups at Pre-training, Post-training, or Follow up. The implication is that individuals were not significantly less compliant and made no more requests on novel role play items as a result of training.

Correlational Analyses

Self-report measures. Pearson product-moment correlation coefficients were calculated for the ASST, Likerts 1 and 2, RAS, and ASES at Pre-training, Post-training, and Follow up. The results for the training group are presented in Table 9 (Control group correlations are in Appendix S). At Pre- and Post-training, scores on nearly all the measures appeared to be significantly related to each other. The only exception was the scores on the Likert 1 with ASES scores at Pre-training. Regarding Follow up scores, the RAS and ASES were significantly related to all other instruments.

The results in Table 9 also indicate that scores on the ASES and, to a lesser extent, on the RAS display a significant linear relationship both with scores on other instruments and themselves at different times. For example, Pre-training ASES scores show a significant correspondance to Post-training scores on Likert 1, ASES, and RAS. The Pre-training ASES scores also covary significantly with Follow up scores on all other instruments.

Table 10 contains the Pearson product-moment correlation coefficients for the self-report measures with total behavioral rating scores of assertiveness and affect at Pre-training, Post-training, and Follow up. Only Likert

Table 9

Self-report measures correlation matrix for the Training Group at Pre-training, Post-training, and Follow Up.

Pre-Training

		ASST	Likert 1	Likert 2	RAS	ASES
ASST	pre	----				
	post	.56*				
	follow up	.73**				
Likert 1	pre	.66**	----			
	post	.67**	.48*			
	follow up	.07	.37			
Likert 2	pre	.80***	.59*	----		
	post	.56*	.14	.37		
	follow up	.33	-.14	.51		
RAS	pre	.61*	.74**	.78***	----	
	post	.46	.32	.30	.45	
	follow up	.36	.39	.41	.77**	
ASES	pre	.66**	.43	.67**	.79***	----
	post	.56*	.09	.36	.37	.69**
	follow up	.52	.17	.40	.79**	.77**

*= p<.05

**= p<.01

***= p<.001

Table 9 cont.

Post-Training

		ASST	Likert 1	Likert 2	RAS	ASES
ASST	pre					
	post					
	follow up	.86***				
Likert 1	pre	.18				
	post	.76***	----			
	follow up	.11	.40			
Likert 2	pre	.14	.44			
	post	.70**	.81***	----		
	follow up	.40	.26	.43		
RAS	pre	.10	.53*	.29		
	post	.64**	.75**	.61*	----	
	follow up	.52	.70*	.62*	.81**	
ASES	pre	.38	.63*	.46	.64**	
	post	.70**	.75**	.77***	.85***	----
	follow up	.73**	.70*	.69*	.84***	.97***

*= p<.05
**= p<.01
***= p<.001

Table 9 cont.

Follow Up

		ASST	Likert 1	Likert 2	RAS	ASES
ASST	pre					
	post					
	follow up	----				
Likert 1	pre	.28				
	post	.81**				
	follow up	.25	----			
Likert 2	pre	.43	.30			
	post	.87***	.27			
	follow up	.54	.39	----		
RAS	pre	.35	.72**	.40		
	post	.65*	.68*	.37		
	follow up	.60*	.87***	.61*	----	
ASES	pre	.66*	.69*	.64*	.79**	
	post	.89***	.52	.67*	.79**	
	follow up	.87***	.57*	.71**	.81**	----

*= $p<.05$
**= $p<.01$
***= $p<.001$

Table 10

Correlations between self-report measures and role play ratings for the Training group at Pre-training, Post-training, and Follow up.

Original Items

		Pre		Post		Follow up	
		Affect	Assert.	Affect	Assert.	Affect	Assert.
	ASST	.23	.07	-.18	.09	.20	.50
	Likert 1	.57*	.53*	-.03	.02	.12	.49
Pre	Likert 2	.19	.01	-.30	.03	.02	.49
	RAS	.60*	.46	.12	.25	.22	.66*
	ASES	.46	.26	.18	.22	.59*	.68*
	ASST	-.06	-.29	.13	.14	.60*	.52*
	Likert 1	.14	.01	.11	.02	.66*	.58*
Post	Likert 2	-.03	-.22	-.12	-.07	.50	.41
	RAS	-.00	-.05	.22	.16	.80**	.82**
	ASES	-.05	-.17	.11	.30	.61*	.69*
	ASST	.12	-.07	.10	.45	.46	.45
	Likert 1	.42	.33	.50	.42	.36	.62*
FU	Likert 2	.05	-.30	.50	.62*	.24	.51
	RAS	.41	.22	.61*	.60*	.50	.78**
	ASES	.02	-.15	.36	.56*	.61*	.67*

*= $p < .05$

**= $p < .01$

(Table 10 cont.)

Novel Items

		Post		Follow Up	
		Affect	Assert.	Affect	Assert.
	ASST	.05	.07	.19	.20
	Likert 1	.19	.35	.35	.41
Pre	Likert 2	-.25	-.22	.35	.36
	RAS	.27	.32	.67*	.74**
	ASES	.42	.38	.56*	.53
	ASST	.32	.29	.17	.19
	Likert 1	.37	.40	.28	.34
Post	Likert 2	.19	.16	.17	.22
	RAS	.50*	.47	.59*	.57*
	ASES	.40	.31	.39	.41
	ASST	.39	.36	.17	.20
	Likert 1	.48	.53	.64*	.73**
FU	Likert 2	.07	-.08	.31	.36
	RAS	.63*	.62*	.68*	.78**
	ASES	.44	.38	.42	.44

*= $p<.05$

**= $p<.01$

scale 1 correlated significantly with both affect and assertiveness ratings at Pre-training. The only other significant correlation at Pre-training was RAS scores with affect ratings. Nevertheless, other correlations on the RAS and ASES were positive suggesting a degree of linear relationship.

There was virtually no correspondance between self-report scores at Post-training and ratings of affect and assertiveness on the original items. There was, however, a significant relationship between Post-training scores and ratings of affect and assertiveness at Follow up. Earlier, data presented in Table 9 indicated that individuals who scored high, medium, or low on one self-report measure at Post-training tended to score in the same way on all measures. The results ,overall, in Table 10 suggest no similar correspondance for behavioral ratings. Persons scoring high on the self-report measures may obtain high, medium, or low ratings on the role plays. However, two patterns in the data warrant mention. There was a drop in correlation between scores and ratings from Pre- to Post-training. By Follow up this had reversed so that correlations at Follow up were higher than both previous testings. The second pattern was a consistent linear relationship between Post-training scores on the self-report measures and Follow up ratings. This was very pronounced on

the readministered role plays but less so on the novel items. On ratings of the novel items, the RAS was the only measure that displayed a consistent, significant correspondance over time.

Post-training Questionnaires

Participant's Questionnaire. Participants were provided a questionnaire during the last half hour of the final session that contained 16 Likert scales (see Appendix J). The scales covered motivation, expectations, logic of the training approach, willingness to recommend the program to others, therapist attributes (4 scales), group cohesiveness, appropriateness of various program components (4 scales), personal improvement, and satisfaction with the program. Means and standard deviations for each scale are presented in Table 11. Scales ranged from one to nine with higher scores being more positive (i.e., very high, very reasonable, very willing, etc.). Without exception, average scores were in the high to very high range suggesting satisfaction with results from the program, specific components of the program, and the program in general. Regarding this last item, the R.N.'s were asked to comment on the program as the final question on the questionnaire. Every participant indicated she was personally highly satisfied with the program but had one complaint: It ended

Table 11

Means and Standard Deviations of the Post-Training Questionnaire.

Question	Mean	StD
1. Motivation to improve	8.15	.80
2. Expectation to improve	7.08	1.66
3. Reasonableness of rationale	8.31	1.11
4. Willingness to recommend	8.23	1.69
5a. Male therapist warmth	8.62	.51
5b. Female therapist warmth	7.62	1.76
6a. Confidence and knowledge of female	7.54	1.05
6b. Confidence and knowledge of male	8.23	.60
7. Group support/cohesion	9.00	.00
8. Appropriateness of role play	7.69	1.44
9. Appropriateness of assertive scenes	7.23	.83
10. Appropriateness of group discussion	8.23	.60
11. Appropriateness of group exercises	7.77	.73
12. Homework assignments	7.77	1.54
13. Overall satisfaction with program	8.31	1.03

too soon!

One question asked the nurses to list specific ways in which improvements occurred and a second focused on improvements "besides overt behavioral changes". The most frequently listed specific improvement was feeling comfortable and secure in saying "No" or expressing themselves. This was followed in frequency by knowledge of rights and assertive responses, awareness, and increased coping/communication skills. "Changed attitudes" was the most frequently listed response to improvements "besides overt behavioral changes". Also listed were: increased self-confidence, more expressive, more decisive, awareness, and less angry.

Therapist's Questionnaire. Therapist's individual ratings and the averages across therapists on the Therapist Post-training Questionnaire (see Appendix J) are presented in Table 12. In addition, therapists were asked to specify the most effective aspect of this approach and the least effective. All four therapists indicated role playing as the most effective aspect. Likewise, all four agreed that the A-B-C theory presentation was the least effective.

Table 12

Therapists ratings on Post-Training Questionnaire

	Therapist				
	I	II	III	IV	$\bar{X}$
1. Warmth	6	8	7	6	6.75
2. Rapport	7	8	7	6	7.00
3. Confidence	4	8	7	5	6.50
4. Outlined procedure	5	6	8	8	6.75
5. Group cohesiveness	6	6	8	8	7.00
6. Enthusiasm of members	7	6	7	7	6.75
9. Adequacy of homework	5	5	6	6	5.50
10. Effectiveness of role play	7	6	7	6	6.50
11. Effectiveness of group discussion	8	8	7	7	7.50
12. Expected effectiveness of approach	5	7	7	6	6.25
13. Overall effectiveness	5	6	7	7	6.25
14. Coordination of work	7	5	8	8	7.00
15. Treatment effectiveness	6	6	7	7	6.50

Chapter IV

DISCUSSION

The purpose of this study was threefold: (1) to evaluate the convergence and/or divergence of scores on multiple assessment devices with a professional population which in this study was registered nurses; (2) to guage the effectiveness of assertion training for registered nurses during treatment; and, (3) to assess the durability of changes produced by assertion training. Following a detailed discussion of these areas, a few broad implications will be cited and suggestions for further research offered.

Assessment

Five self-report instruments along with role playing served as the dependent measures for this study. Considering the individual measures, the Assertiveness Self-Statement Test was designed to tap cognitive components (i.e., self-statements, thoughts) that promote or inhibit assertive behavior (Schwartz and Gottman, 1976). Given that several authors suggest nurses seem prone to developing beliefs and values that promote subassertion (Clark, 1978; Herman , 1977), it was felt important to include a measure that attempted to tap this domain and also might reflect shifts in these components due to training. The Likert

scales were included to acquire a quantified self-evaluation of how the individual felt she compared with others in saying "No" to unreasonable requests and in overall assertiveness. The Rathus Assertiveness Schedule was chosen because of its widespread use, extensive, albeit college, norms, and proven ability to distinguish subassertive from assertive individuals. The final self-report measure comprising the battery was the Adult Self Expression Scale. In developing the Adult Self Expression Scale, Gay, Hollandsworth, and Galassi's (1975) intent was to construct a standardized measure of assertion applicable to adults in general rather than strictly college populations. Consequently, it seemed appropriate to include the Adult Self Expression Scale since: (1) the development of most other assertion measures was based heavily, if not exclusively, on college populations, and, (2) the nursing population would more likely resemble adults in general rather than a strictly college population. A final reason for incorporating each of the self-report measures was that all needed further validation on non-college populations. Role playing was used because it seemed to be a good indicator of changes in the person's behavioral repetoire.

Self-Report Measures. There were positive, signiificant correlations between scores on the Assertiveness Self-Statement Test at Pre-training and scores

at Post-training and Follow up for both the training and control groups. The data indicated test-retest stabilities of .79 and .73 at 6 and 14 weeks, respectively. Since Schwartz and Gottman (1976) didn't report stability estimates it's impossible to compare the current estimates with their previous research. However, the present test-retest stability estimates suggest adequate stability for use with registered nurses. With regard to normative data, the mean score for subassertive nurses, based on the combined scores of the training and control groups at Pre-training, was 90.04.

The Assertiveness Self-Statement Test also displayed positive, significant correlations with all other self-report measures at Pre-training and Post-training; and, with the Rathus Assertiveness Schedule and Adult Self Expression Scale at Follow up. Such a robust pattern clearly implies strong convergent validity for the Assertiveness Self-Statement Test. There was little correspondance between Assertiveness Self-Statement Test scores and role play ratings at Pre-training, Post-training, and Follow up. However, significant positive correlations existed between Post-training scores and Follow up ratings. In summary, the Assertiveness Self-Statement Test displayed adequate test-retest stability with nurses and showed strong convergent validity with other self-report measures but not

with role play ratings. However, with regard to role play ratings, it should be noted that the Assertiveness Self-Statement Test revealed the same pronounced pattern of correlations as three of the other self-report measures. This pattern will be discussed later.

Correlations on the Likert scales showed a less consistent pattern than correlations calculated on the more standardized instruments (i.e., Assertiveness Self-Statement Test, Rathus Assertiveness Schedule, and Adult Self Expression Scale). There were significant, positive correlations between scores on the Likert scales at Pre-training and scores at Post-training for the control groups. Correlations between Pre-training and Follow up scores were positive but not significant. The data from Likert scale 1 indicated test-retest stabilities of .84 and .37 at 6 and 14 weeks, respectively. Test-retest stability coeffecients on Likert 2 were .61 at 6 weeks and .51 at 14 weeks. It appears that Likert scale 1 scores are highly stable and Likert 2 scores probably adequate for periods up to 6 weeks, but both are psychometrically inadequate for assessing changes over a period of 14 weeks. The mean scores for subassertive nurses at Pre-training was -.62 on Likert scale 1 suggesting they viewed themselves as slightly less able to say "No" to unwanted tasks than others. The mean on Likert 2 was comparable, -.73, indicating the nurses

also viewed themselves as slightly less assertive than others.

Likert scale 1 was positively and significantly correlated with the Assertiveness Self-Statement Test, Likert scale 2, and the Rathus Assertiveness Schedule at Pre-training but not significantly with the Adult Self Expression Scale. At Post-training, Likert scale 1 was highly correlated with all the self-report measures; but, by Follow up, only correlations with the Rathus Assertiveness Schedule and Adult Self Expression Scale were significant. In contrast to the other self-report measures, Likert scale 1 was both positively and significantly correlated with role play ratings of affect and assertiveness at Pre-training. However, an explanation for these correlations and the subsequent lack of significance at Post-training and Follow up was not readily apparent in the data. As with the Assertiveness Self-Statement Test, significant, positive correlations were displayed between Post-training scores and Follow up ratings and this will be discussed later with the role play ratings. In summary, Likert scale 1 displayed good convergent validity with the other self-report measures, showed strong stability over 6 weeks, but was inadequately stable for periods of 14 weeks or more.

Likert scale 2 displayed positive, significant correlations with all other self-report measures at Pre- and Post-training but only with the Rathus Assertiveness Schedule and Adult Self Expression Scale at Follow up. Though correlations between Likert 2 and role play ratings were positive, they weren't significant. In summary, Likert scale 2, like Likert 1, revealed good convergent validity with the other self-report measures, showed adequate stability for 6 week periods, but was too unstable for periods of assessment spanning 14 weeks or more.

Of the five self-report instruments used in this study, the Rathus Assertiveness Schedule has had the most psychometric investigation and been used the widest. However, the psychometric investigations to date have primarily been conducted with college student samples. Data from the current study with a professional population of subassertive nurses showed positive, highly significant correlations between scores on the Rathus Assertiveness Schedule at Pre-training and Follow up. Furthermore, the control group revealed a highly significant correlation at Post-training as well. Data from the control group indicated test-retest stability coefficients of .83 and .77 at 6 and 14 weeks, respectively. The six week coefficient was stronger but comparable to the eight week stability of .78 for college students (Rathus, 1973). The fourteen week

stability was also comparable suggesting that scores on the Rathus Assertiveness Schedule are probably stable for longer periods with nurses.

Normative data from the control and training groups at Pre-training revealed an average score of -22.47. Comparing this with the mean for college females of 7.1 and standard deviation of 23.00 (Rathus and Nevid, 1978), the nurses scored on the average much lower, but, judging from standard deviations in Table 4, their distribution of scores was very similar. Since the normative data from this study is for self-referred nurses who were seeking training for subassertion, one would expect lower average scores. The data tends to confirm that, indeed, the nurses in this study were subassertive prior to training.

Turning to the issue of convergent validity, the Rathus Assertiveness Schedule displayed positive, significant correlations with all self-report measures at Pre-Post-Follow up. This augments previous reports of validity on the Rathus (Rathus and Nevid, 1978) and further confirms it as an instrument with strong convergent validity. The Rathus Assertiveness Schedule was one of the four instruments which displayed positive, but insignificant correlations at different assessment periods with role play ratings; but, a pronounced correspondance occurred between

Post-training scores on the Rathus and Follow up role play ratings of affect and assertiveness. This pattern will be addressed in the discussion of the role play findings. In summary, the present study confirms earlier reports of the test-retest stability of the Rathus Assertiveness Schedule and extends those earlier findings to professional nurses. Furthermore, the present results show the Rathus Assertiveness Schedule remained adequately stable for up to 14 weeks while earlier reports have only indicated 8 weeks. With regard to convergent validity, the Rathus displayed strong convergent validity with the other four self-report measures used and this both confirms and adds to earlier reports.

One of the reasons for including the Adult Self Expression Scale was because it was designed for "adults in general" rather than strictly college students (Gay, Hollandsworth, and Galassi, 1975). However, there was need of further psychometric data with the former since the original standardization sample was taken from a community college. The present sample of professional nurses falls in the class of "adults in general", albeit subassertive adults, and thereby should add to the base of psychometric data for the Adult Self Expression Scale. There were positive, highly significant correlations between scores on the Adult Self Expression Scale at Pre-training and scores

at Post-training and Follow up for both the training and control groups. Test-retest stabilities for the control group were .95 at 6 weeks and .77 at 14 weeks. The present findings support Gay, Hollandsworth, and Galassi's (1975) earlier reported coefficients of .81 at two weeks and .91 at five weeks. Furthermore, they extend those findings by suggesting the Adult Self Expression Scale is highly stable for 6 week periods and remains adequately stable for up to 14 weeks with nurses.

Normative data from the control and training groups at Pre-training revealed an average score of 89.20. Gay, Hollandsworth, and Galassi (1975) reported that the adult females' (mean age = 25.38) mean score was 114.78 with a standard deviation of 21.22. Like the Rathus Assertiveness Schedule, comparison of the results indicates a lower mean score between the groups but similar distributions. Again, the lower mean score is to be expected and further supports that the R.N.'s were subassertive prior to training.

Inspection of the correlation between the Adult Self Expression Scale and other instruments at Pre-Post-Follow up revealed highly significant, positive correlations in all but two instances. Likert Scale 1 at Pre-training was positively correlated but not significantly and at Follow up was significant but not highly significant. Nevertheless,

the Adult Self Expression Scale displayed many of the highest and most frequent correlations with the other instruments suggesting very strong convergent validity. With regard to the role play ratings, the Adult Self Expression Scale paralleled the pattern of correlations displayed by the Rathus Assertiveness Schedule, Assertiveness Self-Statement Test, and Likert Scale 1: generally, positive, insignificant correlations except between Post-training test scores and Follow up role play ratings. This pattern will be addressed in discussing the role play ratings. In summary, the Adult Self Expression Scale appears highly stable for 6 week periods and adequately stable over 14 weeks with professional nurses. This finding adds to original estimates of test-retest stability (Gay, Hollandsworth, and Galassi, 1975). Furthermore, the Adult Self Expression Scale shows strong convergent validity with other tests of assertiveness. Coupled with the information provided by Gay, Hollandsworth, and Galassi (1975) regarding discriminant validity, the present results enhance the construct validity of the Adult Self Expression Scale for assessing assertiveness.

The preceeding discussion and an inspection of Table 9 indicate that only the Rathus Assertiveness Schedule and Adult Self Expression Scale were significantly correlated with all other tests' scores at the two month Follow up. A

combination of at least two factors probably accounts for this phenomenon. First, of all five instruments, these two sample the widest number of situations. The wide variety of situations sampled would increase the likelihood of overlap between each of these two tests and the others. Second, the Adult Self Expression Scale and Rathus Assertiveness Schedule display strong test-retest stabilities and scores on them wouldn't seem to be as heavily influenced or altered by fluctuations in mood across test periods, the person's immediately preceeding performance on the role play, or gradual gains/losses in assertion skills. The nearly identical correlations of Post-training and Follow up scores on the Rathus and the Adult Self Expression Scale with Post-training scores on the other measures provides some support for this factor.

Additional results from the present study suggested a significant linear relationship over time in scores on the Adult Self Expression Scale and, to a lesser extent, the Rathus Assertiveness Schedule. Given such a relationship, it might be possible with this and similar populations to administer the Adult Self Expression Scale and the Rathus and then predict the approximate degree of increase in scores as a result of applying the current training program. If increased scores on these measures do actually represent increased assertiveness, then one would in essence be

predicting the approximate degree of improvement to be accrued through training with this program. At this point, however, caution should be exercised until the existence of this linear relationship is replicated preferably with a larger sample.

In summary, with regard to convergence or divergence of the assessment measures, the five self-report instruments displayed significant, positive intercorrelations over time and this was probably due to their tapping the common dimension "assertiveness" and to some extent, their sharing a common methodology. Of the five self-report instruments used, the Rathus Assertiveness Schedule and the Adult Self Expression Scale were the most stable and consistently showed the highest intercorrelations. They were also the only instruments which displayed significant linear relationships with themselves and with most of the other instruments at Pre-Post-Follow up. There was little linear correspondance between scores on the self-report measures and role play ratings of affect and assertiveness at Pre-Post-Follow up. The reduced correlations were probably due in part to the different assessment methodologies of role play ratings and paper-pencil tests. Nevertheless, a pronounced pattern of correlations occured between Post-training self-report scores and Follow up role play ratings. This pattern will be discussed with the role play

ratings. The significant, positive relationship displayed among all the self-report instruments at Pre-training and Post-training and by the Rathus and the Adult Self Expression Scale with all other measures at Follow up suggests strongly that the five tests can each be used with registered nurses to effectively tap the construct "assertiveness".

Treatment and Maintenance

Self-Report Measures. The second major purpose of this study was to guage the effectiveness of assertion training for registered nurses during treatment. Assessment procedures like those used in this study have previously been used to evaluate progress as a result of training (Lange and Jakubowski, 1976). Furthermore, since the assessment results discussed previously suggest the self-report measures converge in tapping the dimension "assertiveness" in registered nurses, it seems appropriate to discuss "improvement" in light of these measures.

Random assignment produced two groups of nurses (training and control) who were approximately equivalent in average age, education, nursing experience, and mean number of persons in their household. There were no significant differences between these two groups in test scores or role play ratings at Pre-training. There was, however, a

tendency for the training group to score lower, i.e., less assertive, than the waiting-list control group on all but one of the self-report measures. This tendency may have been largely responsible for the subsequent lack of groups effects. Both group's average scores were more than one standard deviation below the mean of existing norms on the Rathus Assertiveness Schedule and the Adult Self Expression Scale, thus clearly indicating that the nurses viewed themselves as subassertive.

Data taken from the same self-report measures readministered after the training group had completed five weeks of training, showed a dramatic change in the relationship of the two groups scores. Split-plot analyses of variance performed on the Pre-Post data revealed highly significant groups by time interactions on all self-report measures except Likert Scale 2. Whereas the waiting list control groups scores remained approximately the same, the training groups scores increased 1.10 standard deviations on the average across the five tests. Comparison between normative scores and the training group's Pre-Post mean scores on the Rathus Assertiveness Schedule revealed that prior to training the group was 1.38 standard deviations below the norm but after training they were only .11 standard deviations below. A similar comparison with the Adult Self Expression Scale found that at Pre-training the

training group was 1.39 standard deviations below the norm but after training they were only .40 standard deviations below. Data such as this implies social validation for the training program. Given that the five tests do indeed tap the general dimension "assertiveness", such a pronounced change would suggest the registered nurses who underwent assertion training significantly increased their assertiveness while those who did not undertake training remained the same. To summarize with regard to the second major purpose of this study, the combined data from the self-report measures support the conclusion that assertion training was highly effective at increasing registered nurses assertiveness during training.

The final major purpose of this project was to determine if changes produced during training were maintained. Consequently, the nurses were recontacted two months after training and readministered the battery of measures and the role play items. Again, a split-plot analysis of variance performed on the Pre-Post-Follow up data revealed there were no group effects on any of the measures owing largely to the control groups higher scores before training on most measures. However, a highly significant groups by time interaction was maintained with the training group's Follow up mean scores indicating even greater assertion. At Post-training, the training group had

been .11 standard deviations below the college norms for females on the Rathus Assertiveness Schedule. By Follow up, they were .08 standard deviations above the norm. Likewise, with the Adult Self Expression Scale, the training group was .40 standard deviations below the norm at Post-training. By Follow up, they were only .23 standard deviations below. Furthermore, multiple comparisons indicated major changes in the training groups scores on all measures occured from Pre- to Post-training and were maintained at Follow up. The waiting-list control group's mean scores on the other hand, remained approximately the same throughout the study.

Behavioral Role Play. The present investigation differed from most reported studies in that it was an actual training program (i.e., as opposed to an analog study) with professional nurses (i.e., as opposed to college students or psychiatric patients) that employed role playing as part of the Pre-/Post-training and Follow up assessments. Readministering the role plays at Follow up appeared to be an infrequent practice and it was hoped that such data would shed light on the often reported discrepancy between role play ratings and self-report tests.

Since the explanation of the role play ratings was closely tied to the design of the training program, it seemed appropriate to discuss all of the role play data

under training and maintenance. Focusing on correlations between the self-report instruments and role play ratings, the instruments varied in their degree of temporal correspondance with role play ratings of affect and assertiveness. However, two very interesting patterns were evident in the data. The first was a drop in the correlation between scores and ratings from Pre- to Post-training. This was followed by an increase in correlations at Follow up. The second pattern was a significant relationship between self-report scores at Post-training and role play ratings at Follow up. By Follow up, a high degree of correspondance had developed so that high, medium or low scorers at Post-training obtained respective ratings on Follow up role plays.

It seems that several factors and their interaction need to be considered in deriving a comprehensive explanation of these results. The first factor relates to the fact that individuals who scored medium to high on the Post-test self-report measures probably felt more comfortable with and had more positive expectations for assertive responses. Nevertheless, even after five weeks of training there had been insufficient time and opportunity for them to incorporate assertive behavior into their response repetoire. Consequently, there were no significant differences in performance between individuals who scored

high, medium, or low at Post-test and, therefore, little correlation between test scores and ratings. In fact, there were lower correlations than at Pre-training. However, because they would tend to be more comfortable with assertion, medium and high scorers would find it easier to practice the new assertive skills over the two months between Post-test and Follow up. Increased comfort and more positive expectations, resulting in a greater tendency to attempt and thereby practice assertion, would probably improve their performance or at least retard their loss of skills. Either of these consequences would in time, produce significant correlations at Follow up. This might also account for the few significant correlations between the self-report measures and ratings of affect and assertiveness on novel items.

If correct, this factor has ramifications for assertion training programs. The vital importance of practice (i.e., role playing and other activities that provide practice) in helping people to become more assertive is reverified. This supports McFall and Twentyman's (1973) earlier finding with regard to the contribution of role playing in training people to be more assertive. Furthermore, practice would appear to be as important in training professionals as it is in training college students (McFall and Twentyman, 1973) to be more assertive. Consequently, it would behoove program

designers and trainers to: 1) focus on those cognitive, emotional, and environmental variables that obstruct a person's willingness to practice either because they are uncomfortable or because of negative expectations, 2) spend ample in-training time practicing, and 3) provide extra-training assignments that stress practice. With regard to these last two points, some constructive suggestions gleaned from the present study can be offered.

Because of time constraints, the present assertion training program was limited to five weekly sessions with two hours per session. Though this was ample time to impart and discuss necessary concepts, it compromised the amount of time that could be devoted to practicing. Therefore, it would be beneficial to add two or three sessions for further practice and clarifying of concepts, difficulties, etc.

A suggestion that spans both the points of ample in-training practice time and extra-training assignments concerns the practice vignettes. Requiring participants to provide vignettes drawn from their own experiences rather than providing "canned" vignettes was a significant addition to the current program. It seemed to work particularly well with the groups in this study because they all shared the same occupation and sex. As a result, the vignettes brought in were often current or former problems common to all

participants. An additional benefit commented on by many of the R.N.'s was that having to search for potential vignettes positively heightened their awareness of their behavior, other's behavior, and their opportunities to be assertive.

A final suggestion relates to the point of providing homework assignments which stress practice. Though not instituted in this training program, it seems worthwhile for future programs to provide vignettes that group members practice at home with friends or family members playing the other part. Of course this should probably occur later in the program when the group member is comfortable and familiar with role playing and the rudiments of assertive behavior. This procedure conforms nicely to the goal of most homework assignments which is to help group members transfer their new skills to the extra-training environment (Alberti and Emmons, 1974; Rich and Schroeder, 1975).

Returning now to the discussion of factors that may have contributed to the pattern of correlations between self-report tests and role play ratings, a second factor was the design of the training program. Often the design of programs may foster different periods or potentially different rates of acquisition for cognitive versus behavioral changes. Most training programs, like the current one, necessarily commence with didactic material

about "assertiveness" and then advance from there to learning assertive behavior. Performance of assertive responses is often the last and least practiced information the person encounters before the Post-training test. Under such circumstances, the potential for discrepancies between role play ratings and self-report test scores would seem to be high. For example, it could be argued that scores on the self-report measures primarily reflect knowledge of the correct response and the nurse's prediction of how she might feel or respond in a hypothetical situation. In contrast, the judge's role play ratings of nurse's audiotaped responses reflect more heavily performance variables such as vocal intonation, duration, firmness, and verbal content. Given the design of the current program, the nurses would probably have developed an excellent knowledge of assertion but have had insufficient time and practice to build this into their behavioral repetoire by the Post-training assessment.

Referring back to the first factor, it was suggested that there was a direct relationship between the degree of comfort and positive expectations about assertive behavior and the extent of subsequent practice or employment. Those individuals that became more comfortable and developed more positive expectations about assertive behavior as a result of training would probably practice and employ assertion

more than those who were less comfortable/positive or those who had sought but not received training. Such a tendency would seem to slowly erode the discrepancy that existed between self-report and role play measures at Post-training. Thus, based on this explanation, one would expect a greater degree of correspondance between the two by the Follow up assessment.

Data from the current study revealed the same type of discrepancy often found by researchers between test scores and ratings at Post-training. However, current data also showed this discrepancy had eroded by Follow up. In light of these results and the suggested influential factors, it seems that further research needs to be conducted comparing self-report measures and role play assessment over protracted periods. Nevertheless, explanation of the present pattern of covariation between the self-report and role play assessment probably rests in the interaction between these two factors. Furthermore, the same explanation may underlie previously reported discrepancies as well.

Having discussed the pattern of correlations between role play ratings and self-report measures, the issues of changes wrought by training and maintenance of those changes can be discussed with respect to the role play assessment.

Findings for the self-report measures at Post-training were supported though not at significant levels by judges' ratings of affect and assertiveness on the role plays. There was a tendency for ratings of both the training and waiting-list control groups to increase over time so no significant group differences or group by time interactions were manifest. Nevertheless, the training group did show greater average increases and mean scores at Post-training.

Date from the role play ratings at Follow up also revealed a strong tendency to parallel the results on the self-report measures. This was not immediately apparent in the analyses of variance. Because of a small, steady increase in the control group's ratings and a slight "see-sawing" of the training group's scores, the analysis of variance was incapable of detecting a groups X Pre-Post-Follow up interaction effect but did reveal a highly significant Pre-Post-Follow up main effect.

Scheffe's test of multiple comparisons was used to further evaluate these findings. Based on the tests, it was found that the training group was responsible for the significant changes that occured over time. The control group displayed no significant changes at any point. Changes in ratings of the training group on both original and novel items occured from Pre- to Post-training and were

maintained at Follow up.

In summary, the role play ratings lent support though not at significant levels to earlier conclusions drawn from the self-report data. Results on the role play tended to support the conclusion that training did enhance the behavioral repetiore of the nurses with regard to being assertive and that this change was maintained at the two month Follow up. There was no attempt in this study to use the role play as a predictor of performance in the nurses natural environments. Rather, as implied in the above conclusion, the role play performance was felt to be a sample of the person's "assertive-behavior repetoire" and, therefore, could provide some indication of whether that repetoire changed as a result of training.

Participant's Post-training Questionnaire. During the last half-hour of training, the nurses were given a questionnaire and asked to anonymously rate various aspects of the program they had just completed. Without exception, the ratings indicated high to very high satisfaction with results from the training, with various components such as role playing, exercises, homework, and discussions, and high endorsement of the program in general. One question requested the nurses list specific way in which improvements occurred. The most frequently listed improvement was an

increased ability to say "No" to unwanted tasks at work and home. This was the same as the primary objective listed for participation, by the nurses, on the Pre-training questionnaire. Coupled with the nurses high ratings for "reasonableness of rationale", the above indicates a high degree of "credibility" for the training program as a means of treating subassertive behavior. Another question asked the R.N.'s to list improvements "besides overt behavioral changes". Again, the improvements listed duplicated many of the objectives listed at Pre-training: increased self-confidence, more decisive, less angry, and more expressive.

Ratings of various aspects of the program provided by the nurses offered a suggestion for potentially improving the quality and success of future assertion training programs. The most positively rated aspect of the present program was the group support/cohesion which seemed to be fostered by a shared profession and sex. The nurses consistently indicated on the Post-training questionnaires, when asked for comments, that sharing a common profession resulted in commonly experienced problems that held their interest within and across sessions. Furthermore, it seemed to encourage greater empathy, attention, and more active participation in discussions. Perhaps future assertion training programs could produce greater improvements and

suffer less attrition if they focused on training more homogeneous groups. For example, groups could be organized around a common profession (i.e., nurses, social workers, teachers), tailored to the needs of a specific age group (i.e., over 65, adolescents), or based on a combination of shared factors (i.e., adolescents males, paraplegic women).

Therapist's Post-training Questionnaire. Prior to discussing the therapist's evaluations of the training experience, the nurses' evaluations of the therapist's will be briefly considered. To accomodate the nurses' schedules, the training subjects were divided into an evening and an afternoon group. Each group had a male and female therapist throughout training. On their Post-training questionnaire, the nurses were asked to rate each therapist with regard to warmth and confidence/knowledge. For both groups individually and combined, the nurses rated the male therapists as both warmer and more confident/knowledgeable. The explanation for this result probably rests in the fact that both male therapists had had greater previous exposure to group therapy as well as cognitive-behavioral therapy techniques. Furthermore, on the therapist Post-training questionnaire, the male therapists generally ranked themselves higher on warmth, confidence, and rapport, than the females ranked themselves. This further suggests that the male therapist's probably felt more comfortable,

confident, and relaxed than the female therapists; and, consequently, were probably perceived as such by the nurses. In summary, the higher ratings given to the male therapists were probably a reflection of their greater comfort and experience with the approach rather than any sex-related characteristics or bias.

Turning to the therapist Post-training questionnaire, as a rule the therapists rated various aspects of the treatment approach lower than did the participants. They rated "group discussion" as one of the most effective aspects of the training program giving it a higher rating than any other component including role playing. Nevertheless, when asked to list the most effective aspect later in the questionnaire, each therapist listed role playing. It may be that the therapists listed the most effective aspect later while earlier rating just how effective they thought role playing had been with their group.

Despite the male therapists' increased knowledge, comfort, and previous experience with cognitive-behavioral approaches, all four therapists listed the "R.E.T." material as the least effective aspect of the training program. A careful review of the audiotapes of the first two sessions in each group and discussions with the therapists after the

sessions revealed a highly probable explanation for all four therapists listing the R.E.T. material as least effective. It seems to have been an artifact of the program design. The R.E.T. material is presented early in training prior to the development of good group processes, cohesion, and warmth. It also was more didactic than later material and thus probably appeared to further minimize group process and discussion. In reviewing the training program for the least effective aspect, the therapists had a less positive impression of the early sessions and attributed it to the R.E.T. material rather than to it being the early, formative stages of a new group.

To summarize the discussion of treatment and maintenance, data taken from self-report instruments indicated that registered nurses who underwent assertion training significantly increased their assertiveness while those who didn't receive training remained the same. This finding was supported, though not significantly, by judges role play ratings. On Post-training questionnaires, the nurses indicated high to very high satisfaction with the overall program and with various individual aspects. At the two month Follow up, the training group scored even higher on the self-report tests suggesting they had at least maintained their Post-training levels of assertion. The control group remained unchanged. Again, the behavioral

role play ratings paralleled and supported the self-report findings but not at significant levels. However, multiple comparisons using Scheffe's test showed that even on the role play ratings, only the training group made significant gains.

Summary and Recommendations

The present study's results can be applied to several concerns in the field of assertion training. Several authors (Heimberg, et.al., 1977; Hersen, Eisler, and Miller, 1973; Rich and Schroeder, 1975) have proclaimed a derth in the number of outcome studies validating assertion training's effectiveness with noncollege and nonclinical populations. The present study addresses this proclamation by providing empirical support for assertion training's effectiveness and durability with professional registered nurses.

Another general issue mentioned by the above authors is the need for further validation of existing assessment devices/ procedures. Evidence acquired through this research indicated that scores on five self-report measures designed and, in varying degrees, validated for tapping assertiveness covary significantly over time and in response to training. Furthermore, the present study contributes to the field by supplying needed stability and convergent

validity data (Galassi and Galassi, 1978; Hall, 1977; Rich and Schroeder, 1976). Support was also provided for the validity of using the instruments with registered nurses and potentially with other professional groups. With regard to role play assessment, a testable explanation was offered for the often reported low correspondance between test scores and role play ratings at Pre- and Post-training. If the explanation is accurate, then low correlations between test scores and role play ratings are to some extent an artifact of: 1) programs providing insufficient opportunity or time to practice; and, 2) the order in which most programs necessarily cover pertinent materials. The first factor would most likely occur with shorter training programs such as those frequently used in research. The present study lasted five weeks and was, consequently, as long or longer than most of the studies reported in the literature. Nevertheless, the therapists and participants suggested adding two or three sessions devoted solely to practice. It would behoove future training programs to incorporate this request and provide several sessions at the end of training exclusively for practice. Since the present five session program was an abbreviated version of Lange and Jakubowski's (1976) model, the current experience supports their suggested program of six to nine sessions.

Having reviewed some of the contributions of this study, it seems prudent to suggest areas for further research. The present study supplied evidence of convergent validity (Campbell and Fiske, 1967) for a professional population with the five self-report tests used. It would advance the psychometric standing of these instruments if future studies included other tests that would allow assessment of discriminant validity. Further, the strong empirical support provided by the present study for the specific assessment measures and assertion training's effectiveness with registered nurses does not preclude the need for further validation with professional populations and populations other than college students and hospitalized psychiatric patients.

Another set of very interesting and potentially heuristic findings were the highly significant linear relationships between: 1) the ASES and RAS, 2) the ASES and other scores, 3) the RAS and other test scores, and 4) Both test's scores over time. Further research should be devoted to evaluate these findings with similar and disparate populations. If such relationships are valid and fairly robust across time, populations, and training programs, use of these two tests as standard instruments in assertiveness assessment batteries could reap several benefits. They could potentially provide means for comparisons across

research projects and provide clinicians/ researchers with a way of roughly predicting the extent of improvement that can be expected following training. Until the present findings are replicated, however, they must remain tentative and possibly an artifact of the present study.

A third area of research stems from the hypothesis offered for the pattern of correspondance found between self-report test scores and role play ratings over time. Although the effects of practice on acquiring assertion skills has been investigated and reported (McFall and Twentyman, 1973), research has not been focused on either the lack or often late introduction of practice as a possible explanation for the discrepancy between test scores and role-play ratings. Further research work could also be devoted to the question of an optimal amount of practice as a means of improving the efficiency of training time.

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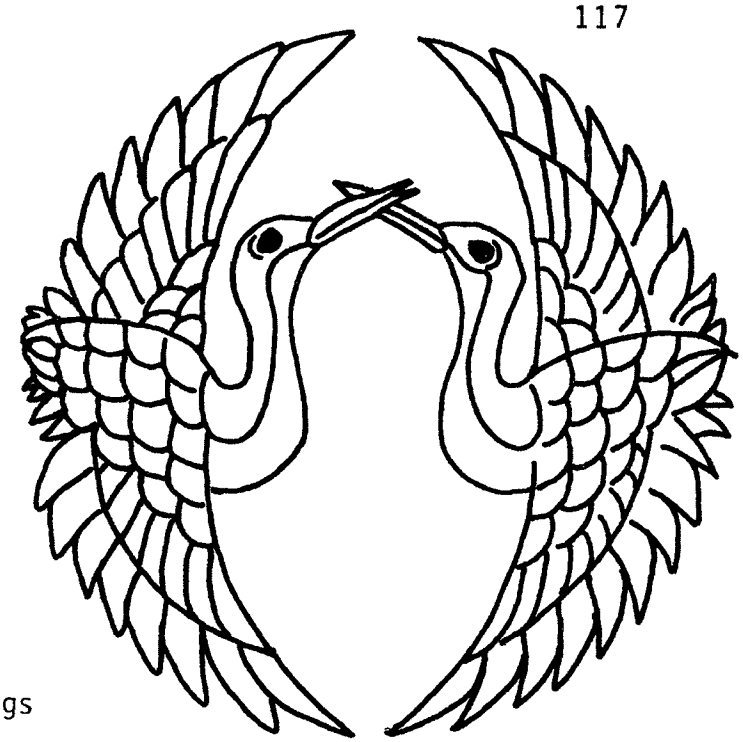
APPENDICES

Appendix A

Advertising Brochure

(See following page)



ASSERTION TRAINING

for REGISTERED NURSES

in PROFESSIONAL SETTINGS

Sponsored by

T. J. McIntyre & D. B. Jeffrey, Ph.D.
University of Montana
Department of Psychology

Have you ever felt like someone was taking advantage of you but you couldn't tell them? Or, when you did, they didn't seem to "hear you"?

Do you ever find yourself agreeing to do things you really don't want to do?

Do you find it difficult to talk in groups, to disagree with others, or to be forceful when the situation requires?

Being assertive involves being able to stand up for your personal rights or the rights of others and being able to express thoughts, feelings, or beliefs in direct,honest, and appropriate ways in which the rights of others aren't violated. It is not a "personality trait" but a skill, like passing medications or other Nursing skills, which is readily learned and very adaptive in today's society. Assertion enables you to correct unfair situations, increase your self-confidence, and enhance interpersonal communication. It also helps you avoid commitments to activities you aren't interested in or don't want to participate in.

The present program was designed with Registered Nurses in mind and is tailored to meet their special concerns as persons and professionals. It also is part of a larger project designed to evaluate and improve Assertion Training for Nurses.

The program involves meeting in groups of 8 to 12 on the University of Montana campus for six 1½ hour sessions: One session per week starting May 13. Convenient times for all work shifts have been arranged: 1 pm. and 7 pm. on Wednesday and Thursday.

There is a $20.00 registration fee but $10.00 will be refunded if the course is completed. Training manuals will be supplied which participants may keep and twelve (12) continuing education (CEARP) credits have been applied for.

We need and would greatly appreciate your participation. To register, call 542-2088, between 4 pm. and 9 pm.

Appendix B

Proposal for the use of Human Subjects

(See following pages)

Intra-campus MEMORANDUM

UNIVERSITY OF MONTANA

DATE: April 8, 1981

TO: Dr. William C. Shepherd, Chairman, Institutional Review Board for Use of Human Subjects in Research

FROM: Timothy J. McIntyre, graduate student in Clinical Psychology, and Dr. D. Balfour Jeffrey, Associate Professor , Department of Psychology

RE: Request for approval of project involving human subjects

In compliance with the policy statement for the use of human subjects in research, we are submitting the following proposal to the Institutional Review Board for their consideration. The ten points enumerated on pp. 4- 5 of the policy statement are listed and addressed as follows:

1. The intent of this project is to systematically evaluate the effectiveness of assertion training with professionals as opposed to college students or hospitalized psychiatric patients. Consequently, the subject population will be Registered Nurses employed in professional settings such as hospitals, community health settings, and Doctor's offices. Subjects will be obtained through a program of poster advertisements and direct mailing and then be assigned to either an Assertion Training or Waiting-list control group. All subjects will be interviewed and asked to complete an assertion battery which includes some role-playing. Besides providing data with which to evaluate the program, the interview and battery will permit screening of "high risk" subjects for whom assertion training is contradicted i.e. current or potential psychological difficulties.

Those subjects assigned to the Waiting-list control group will be asked to wait eight eight weeks for training due to the excessive number of Nurses that enrolled. At the end of eight weeks, they will be recontacted, reassesed, and then provided training.

Subjects placed in Assertion Training groups will receive six 1½ hour (one per week) sessions of assertion training. Training will follow the well-publicized, research-based program descirbed in Arthur Lange's and Patricia Jakubowski's book Responsible Assertive Behavior (1976). The program uses brief lectures, group exercises and discussion, role-playing, coaching, and modeling in an effort to help people think and act more assertively. Trainers for the groups will be graduate students in Clinical Psychology who themselves will have been given explicit instructions and training for conducting Assertion groups. Following training, the subjects will be reassessed by interview and the assertion battery. Approximately two months after this assessment, subjects will be recontacted and reassessed for the last time.

2. Being assertive often enables an individual to rectify unjust or inequitable situations, increase self-confidence and a sense of personal satisfaction, enhance interpersonal communication, and reduce interpersonal anxiety. Assertion training, by teaching people to be assertive helps them accrue many of these benefits. Consequently, subjects participating in

this study will most likely acquire these benefits as a result of learning through training to be assertive. However, the amount of benefit derived is directly related to the effectivness of assertion training with the population being trained. There have been few, if any, studies which have systematically evaluated the effectiveness of Assertion Training with professionals. Therefore, the present study will increase scientific knowledge in this area.

3. This point is covered under point one. Briefly, subjects will either be trained in assertion or, intially, assigned to a control group and then trained. All subjects "assertiveness" will be evaluated to assess changes over time.

4. Sixty-four Registered Nurses currently employed in professional settings will be used as subjects. Individuals who have previously participated in Assertion Training, who are currently in psychotherapy, or who display symptoms during assessment which contraindicate Assertion Training, will not be used. Furthermore, no minors will be involved in the study.

5. Other than the minor discomforts associated with mild self-examination and learning new behavior, subjects will not be exposed to other risks or discomforts.

6. Previous research with Assertion Training has shown that group support and feedback effectively minimize the already minor discomforts mentioned under point five. Furthermore, throughout training the position is made explicit that assertion in any situation is a matter of personal choice: Training simply provides the skills necessary to enact one's choice to be assertive.

7. Information, i.e. test data, questionaires, obtained from subjects will be assigned numbers and coded on a master sheet available only to the project supervisor. Once coded, all names will be obscured and all information reported in summary statistics.

8. See attachment.

9. Not applicable

10. Subjects will be informed during the initial assessment interview that they will be participating in a study which is in part designed to evaluate the effectiveness of Assertion Training with Registered Nurses in professional settings.

We hope our proposal meets with your approval. Should you require further information or clarification please feel free to contact us or leave a message at one of the following extensions -5664, -4521, -4523.

Sincerely,

Timothy J. McIntyre

D. Balfour Jeffrey, Ph.D.

a-campus MEMORANDUM

UNIVERSITY OF MONTANA

TE: April 15, 1981

TO: Timothy J. McIntyre and Dr. D. Balfour Jeffrey, Psychology

OM: University of Montana Institutional Review Board for Use of Human Subjects in Research

As a result of [x] administrative review ~~or [x] full board review~~ by the University of Montana Institutional Review Board your proposed research project, Evaluation of the Effectiveness of Assertion Training with Professionals

---

[x] has been approved and is considered

[x] a "no risk" project ~~not requiring the written informed consent of the participants~~

[ ] to involve sufficient risk to require the written informed consent of the participants as defined in the UM Policy Statement for the Use of Human Subjects in Research as amended in the memorandum of December 28, 1978, to your department.

[ ] has been conditionally approved and the conditions imposed by the Board are:

[ ] has not been approved in its present form. The Board suggests that you:

William C. Shepherd, Chairman

NOTE: It is mandatory that you report immediately to the IRB:

1. Changes in procedures,
2. Unanticipated problems,
3. ~~Ad~~Adverse reactions of, or effects on, subjects

Appendix C

Pretraining Questionnaire

Instructions:

The information you provide on this form will be kept strictly confidential. The purpose of the following questions is to provide us with a general idea of how you view your difficulties in assertiveness.

Name:_____ Age:_____ Sex:_____

Address:_____ Phone:_____

Marital status:_____ Years of school:_____

Number of persons in household:_____ Degree or Diploma R.N.:_____

Employment Status:_____ Years nursing experience:_____

Membership in clubs, social groups, or service organizations:_____

---

1. Compared with others, how assertive do you think you usually are? Answer by placing a check on the following scale:

/	/	/	/	/	/	/	/	/	/	/
0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

(more assertive than)

2. How assertive would you like to be and feel satisfied with yourself? Answer by placing a check on the following scale:

/	/	/	/	/	/	/	/	/	/	/
0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

(more assertive than)

3. Wich whom do you find it very difficult to openly express your feelings? Check any of the following that apply:

_____the opposite sex
_____friends
_____strangers
_____a family member
_____employer/teacher
_____casual acquaintances
_____one particular individual
_____nearly everyone
_____other,_____

Appendix C (cont.)

4. What feelings do you have the most difficulty expressing in an honest and straightforward manner? Check any of the following that apply:

_____Anger _____Affection _____Sadness _____Hurt _____Happiness

_____Fear _____Other,_____

5. Compared with others, where do you think you stand in saying "No" to something you really do not want to do?
Answer by placing a sheck on the following scale:

/ / / / / / / / / / /
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

(more able than)

6. Compared with others, where would you like to stand in saying "No" to something you do not want to do?
Answer by placing a check on the following scale:

/ / / / / / / / / / /
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

(more able than)

7. In a few words, what do you hope to accomplish by participating in this assertion training program?

8. Have you ever been in an assertion training group before?

Yes_____ No_____

9. Are you currently receiving counseling elsewhere?

Yes_____ No_____

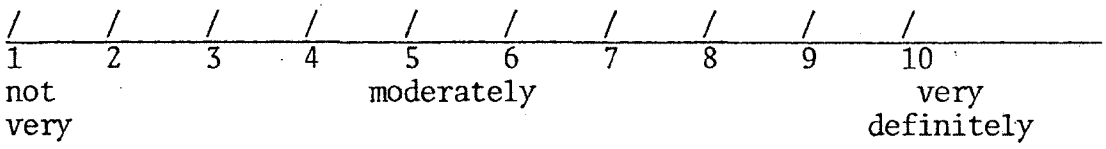
10. How willing and able are you to attend all of the assertion training group sessions? Answere by placing a check on the following scale:

/ / / / / / / / / /
1 2 3 4 5 6 7 8 9 10

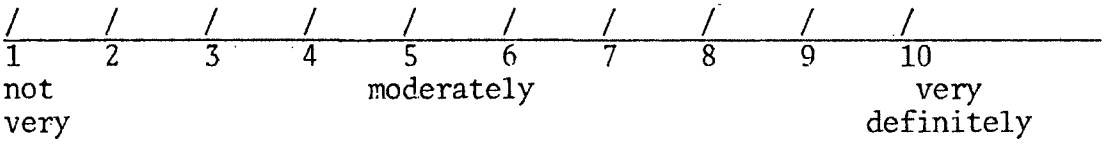
not very moderately very definately

Appendix C (cont.)

11. How motivated ate you to become more assertive? Answer by placing a check on the following scale.



12. How confident are you that you can become more assertive? Answer by placing a check on the following scale.



Appendix D

List of the Role Play Vignettes

A total of 43 vignettes was collected by Bordewick (see note 1) from previous research studies. To assess the items along the dimensions of clarity, difficulty, and realism, he collected ratings from 14 graduate students in clinical psychology at the University of Montana. Each vignette was rated on a five point scale for difficulty: 1 = little or no difficulty in responding assertively to the situation; 5 = very difficult, this situation would be very difficult to respond assertively to in "normal" life circumstances. They were also rated for realism: 1 = highly improbable, bears little or no relationship or reflection to the average person's experience, seems artificial, 5 = this is a common situation that most people confront, seems natural. Eight of the vignettes rated as clear (i.e., readily understood, easily envisioned) and used by Bordewick were incorporated for the role play assessment. Two additional vignettes (numbers 5 and 10) written by the investigator and an R.N. were also used. Average ratings of difficulty and realism on the original items, items 1 through 5, were 3.53 and 3.61, respectively. On the novel items, 6 through 10, difficulty and realism were rated 3.67 and 3.38, respectively.

(1) You are just getting ready to leave the Acapulco restaurant to join a friend who is waiting for you when someone you use to work with stops you and asks to buy you a drink. You explain that you don't want to keep the friend waiting and refuse, but, the person orders a drink for you, then turns and says:
(prompt)"Oh, you have time for one drink. How have you been?"

(2) You have just come home after a long hard day and are greeted by your spouse/roommate. He/she informs you that he/she has accepted an invitation for you to go out that evening. You would prefer to spend a quiet evening at home instead. He/she says:
(pormpt)"I knew you would want to go out tonight. Let's leave right after dinner."

(Appendix D cont.)

(3) It's a crisp October Saturday afternoon at the U of M football field. A Grizzly football game is about to begin. You are walking up to your seats with a friend. You both have reserved seats. The crowd is cheering as the game begins with the opening kickoff. As you approach your seats, you see someone sitting in yours. You show him your ticket. He looks up and says:
(prompt)"The game has already started. Why don't you find another seat?"

(4) You decide to call it a night and go to bed, but there is a loud party going on next door. The music is blaring and the windows are wide open. You go to your neighbor and knock. You are greeted by your neighbor who says:
(prompt)"Hey, why don't you join the fun?"

(5) You have just finished making out assignments and feel the unit will just be covered since you have two patients which require a lot of extra care. Just as you start report your supervisor calls to pull one of the R.N.'s to another floor for the second time this week. She says:
(prompt)"I need you to send one of the R.N.'s to four South since one of their R.N.'s just called in sick."

(6) Last week you bought an expensive tennis racket and resolved never to lend it out because it cost so much. A very good friend calls and says:
(prompt)"I'm going to play tennis tommorrow, but I don't want to buy a racket until I've played a few times. Could I use your racket?"

(7) You have taken a class at the university and sit in an assigned seat. For two weeks you have had the misfortune of sitting next to a chain smoker. He smokes one after the other apparently not concerned about

(Appendix D cont.)

where the smoke drifts. It usually floats over by you. It's really irritating. Finally, he turns and says to you:
(prompt)"You don't mind if I smoke, do you?"

(8) You loaned a friend 10 dollars with the understanding that she would pay you back the next day. It's been two months and she still hasn't returned the money. She never mentions it when she sees you. You're beginning to wonder if she intends to pay you back. You happen to see her one day at the Old Town Cafe and you think to yourself, "This is my chance to remind her." She says:
(prompt)"Here, have a seat next to me."

(9) You are shopping for a pair of dress shoes at a shoe store downtown. You have tried on several pair, but, have not found what you want. The salesman has been patient, but seems to be getting somewhat annoyed. You are aware of the time you have spent and that others are waiting to be helped. You still haven't found exactly what you want, but one pair is close. The salesman says:
(prompt)"This one is perfect. Shall I wrap it up?"

(10) A doctor approaches you to assist him just as you are heading down the hall with a stat pain medication for another patient. He says:
(prompt)"I'm ready to make rounds now and I need a suture set for Mrs. Smith."

Appendix E

Role Play Rating Criteria

1. Affect or firmness
   Using the following 5 point scale, rate the response for firmness:
   1 - flat affect, unemotional, unconvincing, very weak, or disregards an important aspect of the scene
   2 - less convincing than average
   3 - average level of emotion and firmness
   4 - more emotional and firm than average
   5 - extremely firm and convincing, very lively response

2. Compliance
   0 - Compliant, mixed
   1 - Noncompliant or offers a reasonable compromise

3. Request for change in unreasonable behavior
   0 - No request, mixed attempt
   1 - Request made or reasonable compromise offered

4. Overall Assertiveness
   Using the following categories, code the overall assertiveness of the response:
   1 - very subassertive or very aggressive
   2 - less assertive than average or aggressive
   3 - reasonably or about average in assertiveness
   4 - more assertive than average
   5 - very assertive

1. Affect or firmness

Top rating if firm and good intonation all the way through. Drop one rating if a minor part (e.g., start of a sentence) is bland, weak, or sounds hesitant. If thoroughly mixed between strong or weak affect, rate moderate if reasonably firm (e.g., finished firmly) and lower if it is so incongruous that it is disruptive (e.g. finished very unconvincingly). If only slight or no intonation or if the person disregards an important aspect of the scene as presented, then give lowest rating.

2. Compliance

As used here compliance means that a person agrees to another person's unreasonable demands or fails to mention that the person's behavior was unreasonable. A response must contain no ambiguity about willingness to go along with the other person; it has to clearly indicate one has not given into the demand of another to be rated as noncompliant (e.g., If asked about helping someone on a project, a response such as, "I have to see how much time I have available.", is noncompliant because it implies that the

person won't help unless certain conditions are in effect. The following response, "I'm not sure, I have a lot of things to do.", would be rated as compliant because there is no clear indication that the person is not agreeing or means to imply a conditional refusal. A conditional acceptance such as, "If you pay back the ten dollars you owe me, I'll loan you my car.", will be rated as noncompliant only if the conditions rectify the major objection to complying as stated in the role play scene.

3. Request for a change in behavior

A request for a change in behavior occurs only in situations where someone has made a demand or is acting in an unreasonable manner. There must be a clear statement of an alternative behavior that the person could ingage in (e.g., If someone was talking during a movie and being disruptive, "be quiet" and "shut up" are vague and not clear alternative behaviors. However, "talk in a whisper", and "please sit somewhere else if you must talk", are both clearly described requests for alternate behaviors and would be rated as requests for a change.

4. Overall Assertiveness

The top rating of overall assertion is based on content and delivery combined. It must indicate noncompliance and, in addition, it should be tackful. Strong consideration meeds to be given to whether the response expresses the person's true thoughts, feelings, or beliefs (as stated in the role play). "Solid" replies in which thoughts, feelings, and beliefs are not expressed should be given a slightly lower rating (i.e., 4). Unequivocal compliance is given the lowest rating of 1, while justified compliance is given a rating of 2 (e.g., "I wanted to spend the money on myself, but you really are a good friend and I know you will pay it back so I'll loan it to you.", is a 2). If delivery is good, compromising, but compliant (e.g., "I'll give you half the money") then it deserves a rating of 3. It it appears to be inappropriate to compromise, the rating whould be a 2 or 1 depending on the circumstances.

As was done with affect ratings, the scoring will be adjusted if part of a response is weaker than the remaining section.

1. Drop one rating if a minor part (e.g., unusually long pause, or apologetic response: "I'm sorry", "I hope you don't mind", or "I really shouldn't ask") is passive with the rest of the response being much better.

(Appendix E cont.)

2. If thoroughly mixed between strong and weak assertiveness, rate moderate if mostly assertive (a rating of 3) or less than average if ineffective or unconvincing (2).

3. If content is assertive but delivery is very poor, rate up to two ratings below what you would have judged it if the delivery was good. For example, if delivery sounds artificial, rate 1 or 2 points lower than you would if it was based on content alone. (Two points if it sounds so insincere that you are reasonably sure that it is not what the person would actually say. Don't go below a rating of 2 unless the person is compliant.

Appendix F

The Assertiveness Self-Statement Test

Directions

It is obvious that people think a variety of things when they are responding in different situations. These thoughts, along with feelings, determine what kind of responses a person will make.

Below is a list of things which you may have thought to yourself at some time while responding in the assertive situations. Read each item and decide how frequently you may have been thinking a similar thought during the assertive situations.

Circle a number from 1 to 5 for each item. The scale is interpreted as follows:

1=hardly ever had the thought

2=rarely had the thought

3=sometimes had the thought

4=often had the thought

5=very often had the thought

Please answer as honestly as possible.

1. I was thinking that it was not worth the hassle to refuse.

1	2	3	4	5
hardly ever	rarely	sometimes	often	very often

2. I was worried about what the other person would think about me if I refused.

1	2	3	4	5

3. I was thinking that I would probably feel guilty later if I refused to do the person a favor.

1	2	3	4	5

4. I was thinking that it is not my responsibility to help people I hardly know.

1	2	3	4	5

5. I was thinking that there didn't seem to be a good reason why I should say yes.

1	2	3	4	5

Appendix F (cont.)

6. I was thinking that it was my responsibility to help those who need me.

1	2	3	4	5
hardly ever	rarely	sometimes	often	very often

7. I was thinking that I just don't feel like saying yes.

1 2 3 4 5

8. I was worried that the person might become angry if I refused.

1 2 3 4 5

9. I was thinking that this request is an unreasonable one.

1 2 3 4 5

10. I was thinking that the person could ask someone else.

1 2 3 4 5

11. I was thinking that it is better to help others that to be self-centered.

1 2 3 4 5

12. I was thinking that I will be happy later if I don't commit myself to something I don't want to do.

1 2 3 4 5

13. I was thinking that I would get embarassed if I refused.

1 2 3 4 5

14. I was concerned that the person would think I was selfish if I refused.

1 2 3 4 5

15. I was thinking that this person really seems to need me.

1 2 3 4 5

16. I was thinking that I am perfectly free to say no.

1 2 3 4 5

17. I was thinking that if I don't say no now, I'll end up doing something I don't want to do.

1 2 3 4 5

Appendix F (cont.)

18. I was thinking that it is always good to be helpful to other people.

1	2	3	4	5
hardly ever	rarely	sometimes	often	very often

19. I was thinking that the person might be hurt or insulted if I refused.

1	2	3	4	5

20. I was thinking that this person should take care of his own business.

1	2	3	4	5

21. I was thinking that this request sounds pretty reasonable.

1	2	3	4	5

22. I was thinking that people will dislike me if I always refuse.

1	2	3	4	5

23. I was thinking that my own plans are too important.

1	2	3	4	5

24. I was thinking that I don't have to please this person by giving in to his/her request.

1	2	3	4	5

25. I was thinking that it is morally wrong to refuse someone who needs help.

1	2	3	4	5

26. I was thinking that if I commit myself, it will interfere with my plans.

1	2	3	4	5

27. I was thinking that a friendly person would not refuse in this situation.

1	2	3	4	5

28. I was thinking that I am too busy to say yes.

1	2	3	4	5

Appendix F (cont.)

29. I was afraid that there would be a scene if I said no.

1	2	3	4	5
hardly ever	rarely	sometimes	often	very often

30. I was thinking that since I hardly know the person, why should I go out of my way for him/her.

1	2	3	4	5

31. I was thinking that it doesn't matter what the person thinks of me.

1	2	3	4	5

32. I was thinking that this request is an imposition on me.

1	2	3	4	5

We would like to get some idea of the sequence of the thoughts that went through your mind during the situations you experienced. Please do the best job you can in summarizing the sequence of your thoughts by selecting one of the four choices below. Place an X to the left of the most appropriate choice.

_____a. First I thought that I wouldn't want to and wouldn't be able to respond correctly and then I thought that I would.

_____b. First I thought that I wouldn't want to or be able to respond correctly, and then I still thought that I wouldn't want to or be able to respond correctly.

_____c. First I thought that I would want to be able to respond correctly and then I still thought I would.

_____d. First I thought that I would want to or be able to respond correctly and then I thought that I wouldn't.

Appendix G

Global Likert Scales

COMPARED WITH OTHERS, HOW ASSERTIVE DO YOU THINK YOU USUALLY ARE?
Answer by placing a check on the following scale.

/	/	/	/	/	/	/	/	/	/	/
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
less than nearly everyone I know	less than most	much less	somewhat less	slightly less	no more assert. than others	slightly more	somewhat more	much more	more than most	more than nearly everyone i know

COMPARED WITH OTHERS, WHERE DO YOU THINK YOU STAND IN SAYING "NO"
TO SOMETHING YOU REALLY DO NOT WANT TO DO?
Answer by placing a check on the following scale.

/	/	/	/	/	/	/	/	/	/	/
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
less often than nearly everyone I know	much less than most	much less	somewhat less often	slightly less often	say no as often as others	slightly more often	somewhat more often	much more	much more than most	more often than nearly everyone I know

Appendix H

The Rathus Assertiveness Schedule

Directions: Indicate how characteristic or descriptive each of the following statements is of you by using the code given below.

+3 very characteristic of me, extremely descriptive
+2 rather characteristic of me, quite descriptive
+1 somewhat characteristic of me, slightly descriptive
-1 somewhat uncharacteristic of me, slightly nondescriptive
-2 rather uncharacteristic of me, quite nondescriptive
-3 very uncharacteristic of me, extremely nondescriptive

_____1. Most people seem to be more aggressive and assertive than I am.

_____2. I have hesitated to make or accept dates because of "shyness".

_____3. When the food served at a restaurant is not done to my satisfaction, I complain about it to the waiter or waitress.

_____4. I am careful to avoid hurting other people's feelings, even when I feel that I have been injured.

_____5. If a salesman has gone to considerable trouble to show me merchandise which is not quite suitable, I have a difficult time in saying, "No".

_____6. When I am asked to do something, I insist upon knowing why.

_____7. There are times when I look for a good, vigorous argument.

_____8. I strive to get ahead as well as most people in my position.

_____9. To be honest, people often take advantage of me.

_____10. I enjoy starting conversations with new acquaintances and strangers.

_____11. I often don't know what to say to attractive persons of the opposite sex.

_____12. I will hesitate to make phone calls to business establishments and institutions.

_____13. I would rather apply for a job or for admission to a college by writing letters than by going through with personal interviews.

_____14. I find it embarassing to return merchandise.

_____15. If a close and respected relative were annoying me, I would smother my feelings rather than express my annoyance.

Appendix H (cont.)

_____16. I have avoided asking questions for fear of sounding stupid.

_____17. During an argument I am sometimes afraid that I will get so upset that I will shake all over.

_____18. If a famed and respected lecturer makes a statement which I think is incorrect, I will have the audience hear my point of view as well.

_____19. I avoid arguing over prices with clerks and salesmen.

_____20. When I have done something important or worthwhile, I manage to let others know about it.

_____21. I am open and frank about my feelings.

_____22. If someone has been spreading false and bad stories about me, I see him/her as soon as possible to "have a talk" about it.

_____23. I often have a hard time saying "No".

_____24. I tend to bottle up my emotions rather than make a scene.

_____25. I complain about poor service in a restaurant and elsewhere.

_____26. When I am given a compliment, I sometimes just don't know what to say.

_____27. If a couple near me in a theatre or at a lecture were conversing rather loudly, I would ask them to be quiet or to take their conversation elsewhere.

_____28. Anyone attempting to push ahead of me in a line is in for a good battle.

_____29. I am quick to express an opinion.

_____30. There are times when I just can't say anything.

Appendix I

The Adult Self-Expression Scale

The following inventory is designed to provide information about the way in which you express yourself. Please answer the questions by filling in the appropriate number from 0 to 4 to the left of the question. Your answer should indicate how you generally express yourself in a variety of situations. If a particular situation does not apply to you, answer as you think you would respond in that situation. Your answer should not reflect how you feel you ought to act or how you would like to act. Do not deliberate over any individual question. Please work quickly. Your first response to the question is probably your most accurate one.

0	1	2	3	4
almost always or always	usually	sometimes	seldom	never or rarely

_____1. Do you ignore it when someone pushes in front of you in line?

_____2. Do you find it difficult to ask a friend to do a favor for you?

_____3. If your boss or supervisor makes what you consider to be an unreasonable request, do you have difficulty saying "no"?

_____4. Are you reluctant to speak to an attractive acquaintance of the opposite sex?

_____5. Is it difficult for you to refuse unreasonable requests from your parents?

_____6. Do you find it difficult to accept compliments form your boss or supervisor?

_____7. Do you express your negative feelings to others when it is appropriate?

_____8. Do you freely volunteer information or opinions in discussions with people whom you do not know very well?

_____9. If there was a public figure whom you greatly admired and respected at a large social gathering, would you make an effort to introduce yourself?

____10. How often do you openly express justified feelings of anger to your parents?

____11. If you have a friend of whom your parents do not approve, do you make an effort to help them get to know one another better?

____12. If you were watching a TV program in which you were very interested and a close relative was distrubing you, would you ask them to be quiet?

Appendix I (cont.)

____13. Do you play an important part in deciding how you and your close friends spend your leisure time together?

____14. If you are angry at your spouse/boyfriend or girlfriend, is it difficult for you to tell them?

____15. If a friend who is supposed to pick you up for an important engagement calls fifteen minutes before he/she is supposed to be there and says that they cannot make it, do you express your annoyance?

____16. If you approve of something your parents do, do you express your approval?

____17. If in a rush you stop by a supermarket to pick up a few items, would you ask to go before someone in the check-out line?

____18. Do you find it difficult to refuese the requests of others?

____19. If your boss or supervisor expresses opinions with which you strongly disagree, do you venture to state your own point of view?

____20. If you have a close friend whom your spouse/boyfriend or girlfriend dislikes and constantly criticizes, would you inform them that you disagree and tell them of your friend's assets?

____21. Do you find it difficult to ask favors of others?

____22. If food which is not to your satisfaction was served in a good restaurant, would you bring it to the waiter's attention?

____23. Do you tend to drag out your apologies?

____24. When necessary, do you find it difficult to ask favors of your parents?

____25. Do you insist that others do their fair share of the work?

____26. Do you have difficulty saying no to salesmen?

____27. Are you reluctant to speak up in a discussion with a small group of friends?

____28. Do you express anger or annoyance to your boss or supervisor when it is justified?

____29. Do you compliment and praise others?

____30. Do you have difficulty asking a close friend to do an important favor even though it will cause them some inconvenience?

____31. If a close relative makes what you consider to be an unreasonable request, do you have difficulty saying no?

Appendix I (cont.)

____32. If your boss or supervisor makes a statement that you consider untrue, do you question it aloud?

____33. If you find yourself becoming fond of a friend, do you have difficulty expressing these feelings to that person?

____34. Do you have difficulty exchanging a purchase when you are dissatisfied?

____35. If someone in authority interrupts you in the middle of an important conversation, do you request that the person wait until you have finished?

____36. If a person of the opposite sex whom you have been wanting to meet directs attention to you at a party, do you take the initiative in beginning the conversation?

____37. Do you hesitate to express resentment to a friend who has unjustifiably criticized you?

____38. If your parents wanted you to come home for a weekend visit and you had made important plans, would you change your plans?

____39. Are you reluctant to speak up in a discussion or debate?

____40. If a friend who has borrowed $5 from you seems to have forgotten about it, is it difficult for you to remind this person?

____41. If your boss or supervisor teases you to the point that it is no longer fun, do you have difficulty expressing your displeasure?

____42. If your spouse/boyfriend or girlfriend is blatantly unfair, do you find it difficult to say something about it to them?

____43. If a clerk in a store waits on someone who has come in after you when you are in a rush, do you call his attention to the matter?

____44. If you lived in an apartment and the landlord failed to make certain repairs after it had been brought to his attention, would you insist on it?

____45. Do you have difficulty verbally expressing love and affection to your spouse/boyfriend or girlfriend?

____46. Do you have difficulty asking your boss or supervisor to let you off early?

____47. Do you readily express your opinions to others?

____48. If a friend makes what you consider to be an unreasonable request, are you able to refuse?

Appendix J

PARTICIPANT POST-TRAINING QUESTIONNAIRE

NAME _____ GROUP (DAY/TIME) _____

THERAPISTS _____ DATE _____

_____

With regard to the five training sessions you have just completed, please rate the following items on the 9-point scales provided. For each item, simply circle the number on the scale that best reflects your answer.

1. MY OWN MOTIVATION TO IMPROVE.

1 2 3 4 5 6 7 8 9
very low moderate very high

2. MY OWN EXPECTATION TO IMPROVE.

1 2 3 4 5 6 7 8 9
very low moderate very high

3. WHEN THE ASSERTIVENESS TRAINING TECHNIQUE WAS EXPLAINED TO ME, I FELT THAT IT WAS A REASONABLE, LOGICAL APPROACH TO THE PROBLEM OF SUB-ASSERTIVENESS.

1 2 3 4 5 6 7 8 9
unreasonable very reasonable

4. HOW WILLING WOULD I BE TO RECOMMEND THIS ASSERTIVE TRAINING PROCEDURE TO OTHERS?

1 2 3 4 5 6 7 8 9
not very moderately very willing

5. a) THE MALE THERAPIST'S WARMTH AND GENUINENESS

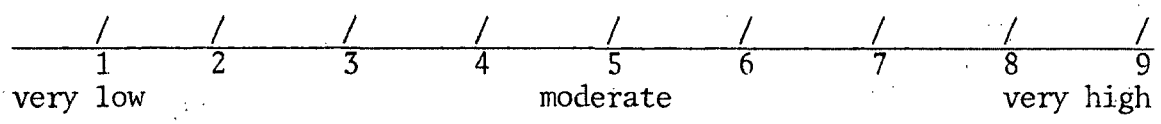
1 2 3 4 5 6 7 8 9
very low moderate very high

b) THE FEMALE THERAPIST'S WARMTH AND GENUINENESS

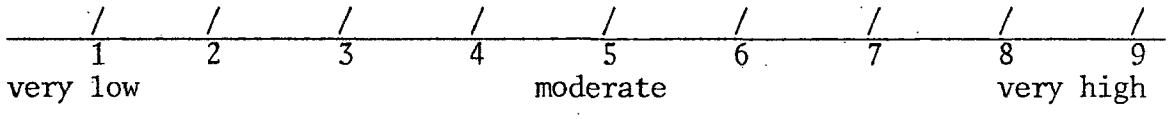
1 2 3 4 5 6 7 8 9
very low moderate very high

Appendix J (cont.)

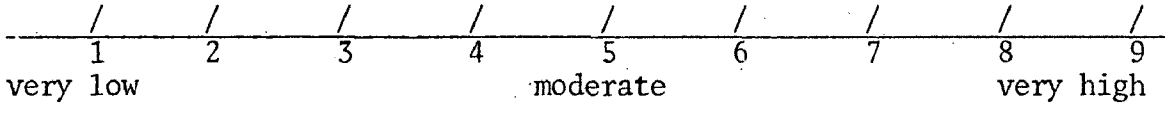
6. a)THE FEMALE THERAPIST'S CONFIDENCE AND APPARENT KNOWLEDGEABILITY.



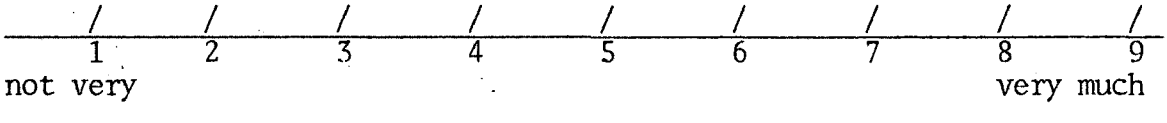
b)THE MALE THERAPIST'S CONFIDENCE AND APPARENT KNOWLEDGEABILITY.



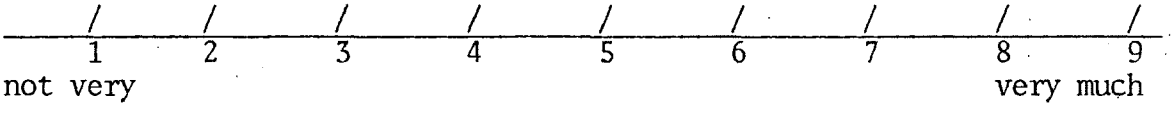
7. SUPPORTIVENESS OF OTHER GROUP MEMBERS (GROUP COHESIVENESS)



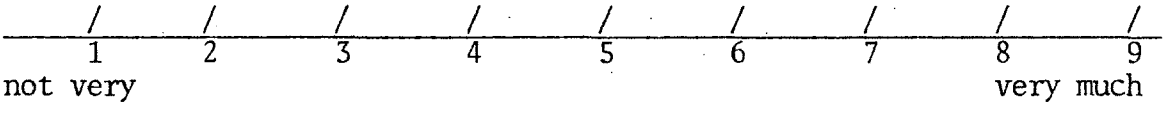
8. APPROPRIATENESS OF ROLE-PLAYING PROCEDURE



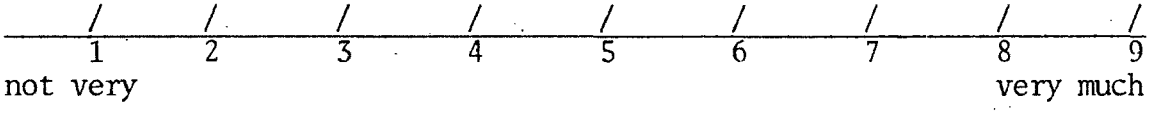
9. APPROPRIATENESS OF ASSERTIVE SCENES EMPLOYED



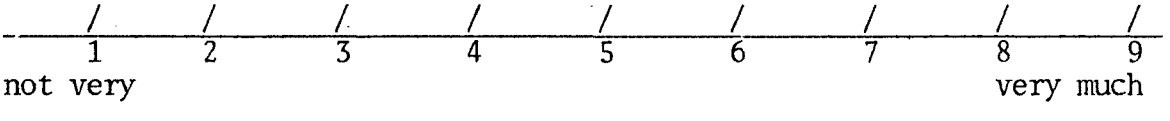
10. APPROPRIATENESS OF GROUP DISCUSSION



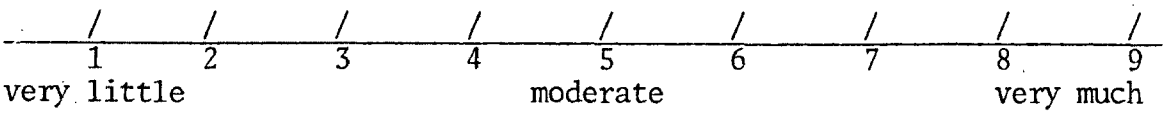
11. APPROPRIATENESS OF GROUP EXERCISES



12. APPRIATENESS OF HOMEWORK ASSIGNMENTS



13. EXTENT OF MY OWN IMPROVEMENT IN ASSERTIVENESS



Appendix J (cont.)

14. SPECIFIC WAYS IN WHICH THESE IMPROVEMENTS OCCURED. (LIST BELOW)

_____

_____

_____

_____

15. DID YOU NOTICE ANY OTHER IMPROVEMENTS IN ASSERTIVENESS BESIDES OVERT BEHAVIORAL CHANGES? (LIST BELOW)

_____

_____

_____

16. MY OVERALL SATISFACTION WITH THE PROGRAM

/	/	/	/	/	/	/	/	/
1	2	3	4	5	6	7	8	9

very low moderate very high

17. COMMENTS (IN GENERAL, LIKES/DISLIKES, SUGGESTED AREAS OF IMPROVEMENTS):

Appendix J (cont.)

THERAPIST POST-TRAINING QUESTIONNAIRE

NAME_____ DATE_____

GROUP_____

With regard to all four sessions, please rate the following items on the 9-point scales provided. For each item, simply circle the number on the scale that best reflects your answer.

1. YOUR WARMTH AS A THERAPIST

1 2 3 4 5 6 7 8 9
very low very high

2. YOUR RAPPORT WITH GROUP MEMBERS

1 2 3 4 5 6 7 8 9
very low very high

3. CONFIDENCE IN USING THIS APPROACH

1 2 3 4 5 6 7 8 9
very low very high

4. HOW CLOSELY YOU FOLLOWED THE OUTLINED PROCEDURES

1 2 3 4 5 6 7 8 9
not very very much

5. GROUP COHESIVENESS

1 2 3 4 5 6 7 8 9
very low very high

6. ENTHUSIASM OF GROUP MEMBERS

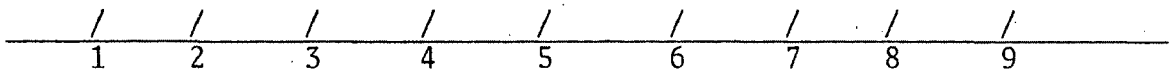
1 2 3 4 5 6 7 8 9
very low very high

7. MOST EFFECTIVE ASPECT OF THIS APPROACH:_____

8. LEAST EFFECTIVE ASPECT OF THIS APPROACH:_____

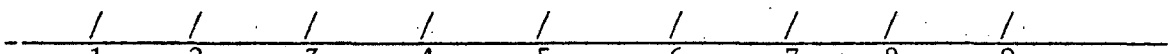
Appendix J (cont.)

9. ADEQUACY OF HOMEWORK ASSIGNED



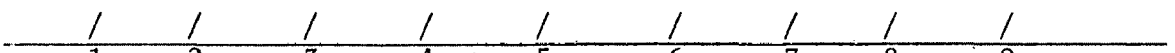
very low very high

10. EFFECTIVENESS OF ROLE PLAYING



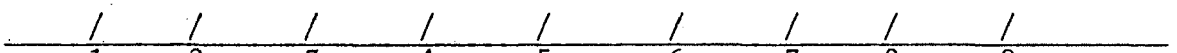
not very very effective

11. EFFECTIVENESS OF GROUP DISCUSSION



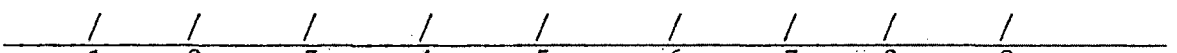
not very very effective

12. EXPECTED EFFECTIVENESS OF THIS APPROACH



very low very high

13. OVERALL EFFECTIVENESS



very low very high

14. COORDINATION OF WORK WITH YOUR CO-THERAPIST

not very very effective

Appendix K

Trainer's Manual

(see following pages)

Trainer's Manual for a Cognitive-Behavioral Assertion Training Program

This assertion training program will follow a shortened, slightly modified version of the agenda outlined in Lange and Jakubowski's Responsible Assertive Behavior (1976). Using this program will fulfill the twelve process goals for assertion training outlined by Lange and Jakubowski (1976):

> We believe that the following process goals are critical considerations for successful assertion training: (1) identify specific situations and behaviors which will be the focus of training; (2) teach the participants how to ascertain if they have acted assertively rather than aggressively or nonassertively; (3) help individuals to accept their personal rights and the rights of others; (4) identify and modify the participants' irrational assumptions which produce excessive anxiety and anger and result in nonassertion and aggression; (5) provide opportunities for the participants to practice alternative assertive responses; (6) give specific feedback on how the members could improve their assertive behavior; (7) encourage the members to evaluate their own behavior; (8) positively reinforce successive improvements in assertive behavior; (9) model alternative assertive responses as needed; (10) structure the group procedures so that the members' involvement is widespread and supportive; (11) give considerable permission and encouragement for the participants to behave assertively within and outside of the group; and (12) display leadership behavior which is characterized by assertion rather than aggression or nonassertion. (Lange and Jakubowski, 1976).

The program focuses on two areas: 1) teaching individuals Rational-Emotive Therapy techniques (Ellis, 1962) for recognizing and altering cognitions that may prevent or disrupt assertion, and 2) teaching individuals non-verbal and verbal assertion skills. The cognitive components of treatment will include identifying and accepting human rights; analysing irrational beliefs, negative self-statements, and socialization myths; and then using cognitive restructuring to alter those beliefs and statements.

Assertion skills-training will include the following techniques: role-playing, coaching, modeling, group exercises, discussions, and positive reinforcement. The focus will be the non-verbal and verbal aspects of I-language, basic, empathic, confrontive, escalating, and soft/tender assertions. Homework will be assigned to be completed between meetings. Subjects will meet weekly at the Clinical Psychology Center for five 2-hour sessions. Though a teaching format will be maintained throughout, the didactic orientation will taper off as the emphasis shifts to skills-training and practice during the latter part of the program. What follows is a <u>suggested</u> verbatim account of each session. While it is important to cover all major topics in the prescribed order, feel free to deviate from or modify the suggested verbal account in order to achieve a

style of presentation that is comfortable for you, yet helpful to the participants.

SESSION ONE

INTRODUCTION TO GROUP (Paraphrase, don't read)

Good evening. We would like to welcome you all here tonight. My name is _____ and this is my co-leader, _____. Both of us are graduate students in clinical psychology and we will be meeting with you for five weeks. (Switch Leaders)

In order for all of us to get to know each other better, I would like everyone to pair up with someone you don't know. I want you to introduce yourself, and spend the next several minutes getting to know each other. Just for fun, during the course of your chat I want each of you to tell your partner what medical instrument you would be and why if you had to be one for a day. Then, when we reform as a group, I would like you to introduce each other. For example, if I had been meeting with (co-therapist)_____, I might say, this is (name) who is from (hometown). He/she is presently a graduate student and one of his/her major goals is _____. If he/she had to be a medical instrument, he/she would be a stethoscope, N-G tube, or whatever, and why. In your introductions, identify the unit, floor, or location where the other person works and explain why they chose to join the group. Remember, we just want to meet everyone so don't feel concerned about what to say. Just relax and get

to know the other person. Okay, let's divide up. (Circulate among the pairs introducing yourself. After five minutes have people introduce each other. Be friendly and help anyone who is having trouble with the introduction). (Switch Leaders)

AN OVERVIEW AND STATEMENT OF GOALS

Now that we have all had a chance to learn a little bit about each other and what we hope to accomplish, we want to tell you more about what we will be doing in this group. As you all probably know, we will be meeting every _____ night for five weeks including tonight. We will get together for two hours and will have a lot to do in that time, so it is very important that we start on time and that everyone make it to all the meetings. We will be covering a number of areas which will be helpful in increasing your assertiveness. For example, we'll practice giving and receiving compliments, dealing with conflict situations (especially with people close to you), responding in difficult situations, and practicing specific situations where you can identify the personal rights you have and how you might act on them assertively as opposed to nonassertively or aggressively. You will also have a chance to discover how your thoughts and beliefs affect your feelings and behavior.

We expect that after you've completed the group, you will be better able to handle a number of situations more assertively. You will be less anxious in those situations; you will have a wider repertoire of responses available to use in tough situations; you will be able to identify your personal rights and be more inclined to act on them; and, you will have learned some ways to work by yourself on new situations which initially you might avoid or not handle as assertively as you'd like. (Switch Leaders)

Before we proceed this evening, I'd like to define assertiveness so that we all have a more accurate sense of what we are working toward. Assertiveness is being able to communicate your opinions, thought, needs, and feelings in a direct, honest, and appropriate manner. When I am non-assertive, I am communicating less than I'd like to express and I am denying my own interpersonal rights. When I'm aggressive, I'm standing up for my own rights but in such a way that the rights of others are violated. (Switch Leaders about here.)

Briefly, it may be helpful to think of an assertive response as one in which you are fair to yourself as well as fair to others. It expresses what you want to say, or what you are feeling in a way that does not take advantage of another person, such as by insults and threats. At the same

time, assertive replies do not apologize or deny your personal opinions, feelings, or needs.

All of us find times when we don't say something that we really think or feel. Many times this is appropriate such as when you need to be polite or the person you address would not respect your rights and may become hostile. However, if you find yourself angry, upset, or dissatisfied about not saying what you wanted to or not standing up for yourself, chances are you were not being assertive in that situation. (Switch Leaders about here.)

Many of us have beliefs which prompt feelings that we don't have the right to stand-up for ourselves, to ask something of others, or to tell them what we believe or want. In other words, we believe certain things and because we believe that way we don't act assertively. We will be looking at some of those beliefs, some of the negative things we tell ourselves, and some of our personal rights in more detail later. (Switch Leaders about here.)

A final fact we want to mention in this overview is that you can improve your assertive behavior by becoming clear on what is an appropriate response as well as by practicing specific skills that are used in open, straightforward communication. We will do this by practicing and role playing situations you've observed and

brought to the group. Between each meeting there will be homework assignments and it is very important that you work on them. Do you have any questions?

DIFFERENTIATING ASSERTION, AGGRESSION, AND SUBMISSION

In Section I of the training manuals you've been provided, you will find a page called "Criteria of Aggressive, Assertive, and Nonassertive Behavior". Please turn to that page.

Everyone has wondered at some time or another if they have put things too strongly, or not strongly enough. To help you identify appropriate assertive responding, let's take a close look at this section. (Go around the group having members reading the odd numbered points out loud. Switch Leaders)

PERSONAL RIGHTS

Now that we've begun to distinguish assertion, aggression, and submission, let's talk about personal rights and how our beliefs about them affect whether we are assertive, aggressive or submissive. Often times you may fail to acknowledge some rights and consequently feel as though it would be inappropriate to be assertive. On the other hand, I feel I have the right to be respected by others. By recognizing this right, I can feel good about

asserting myself when someone makes an unreasonable request.

Working together, let's identify some rights individuals in different groups have; (Divide blackboard into three sections. Write at the top of one section "Doctors", at the top of another "Women/Nurses", and at the top of the third "Patients". Try to get everyone to contribute something. Write suggested "rights" on the board. Areas in which rights can be listed include property, behavior, expression, working conditions, demands on time, etc.)

OK, we have come up with some fine examples and I'm sure we could come up with a lot more. (Have the group members compare and identify rights that cut across the groups, i.e., "I see here where we've said that Patients have the right to exercise some independence. But that doesn't appear on the Nurses' list. Do R.N.s have the right to exercise some independence on the job?) The point here is that we as a group have really been talking about human rights and since we're all human, we each are entitled to the rights we've identified. How does everyone feel about that? Are there any of these rights you have difficulty accepting? (Switch Leaders)

DISCUSSION AND HOMEWORK

Are there any questions over the things we covered tonight? Well, we covered a lot of ground. It is important that you review the criteria of aggression, assertion, and submission as well as the other material in Section I of your manuals so that you are familiar with it next week. In addition, on the page in your manual entitled Human Rights, I would like everyone to write down some human rights and at the bottom of the page jot down two personal rights that you have difficulty accepting. Bring your manuals and your lists next week so we can discuss them.

SESSION TWO

GENERAL DISCUSSION

We will start out tonight by discussing last week's assignments. First of all, what questions did you have after you reviewed the manual? (Try to elicit anything that was confusing to them.) What things seemed particularly relevant to you? (Pause) OK, I'd like everyone to share the personal rights that you find most difficult to accept or believe in. (Go around the group having members tell the rights they recorded. Switch Leaders)

IRRATIONAL BELIEFS AND THE ABC THEORY

Tonight we will explore how denying your personal rights and how certain beliefs or thoughts may inhibit assertive responding (Refer them to Section II in their manuals). Along with failure to adhere to personal rights, often times people openly or automatically, assume major beliefs which are unreasonable. In fact, believing you don't have the personal rights we've considered can be termed unreasonable or incorrect. We call these unreasonable or irrational beliefs. A number of commonly held irrational beliefs are listed in your manual. In a short while we will show you how such unreasonable thinking often blocks assertive behavior. First, let's focus on the

irrational beliefs themselves and see how they can be challenged (Either have the therapist cover each belief or have the group members read through the beliefs and challenges aloud. Be prepared to discuss any of the beliefs or challenges on which questions are raised. For example, 4 can be illustrated using Ellis's ABC theory.).

Some of the irrational beliefs may have been familiar to you. Many times we assume these beliefs and respond without actually noting or thinking about them. However, even though we don't literally think of them at the time, they still influence us and can easily make us feel anxious, afraid, or upset. If we held more reasonable beliefs, we would not get nearly as upset in the same situations and we would be able to function more effectively. For example, suppose something unfortunate happens to us and we feel anxious or depressed. Why do we become depressed? Because we convince ourselves that it is not only unfortunate and inconvenient, but that it is terrible and catastrophic. We've all seen or experienced this when we fail at a major task or are rejected by a significant person. Another example is when we feel hostile because we believe that others who act unfairly <u>absolutely should not act the way they do.</u>

A position held by many mental health professionals is that there are no legitimate reasons for people to make themselves hysterical, severely depressed, or overly agitated. They do support the expression of strong, appropriate feelings like sorrow, regret, displeasure, or annoyance. But they feel that experiencing self-defeating emotions like guilt, depression, rage, or worthlessness adds a magical hypothesis that things would be better if they were different. Another way to look at irrational beliefs is to use the ABC theory. (Switch leaders about here. The following presentation is facilitated by placing Figure 1 on the blackboard.)

The "A" stands for the antecedant. That is, the situation, including the person and/or event, you are faced with. For example, suppose your spouse or close friend yells unfairly at you. This would be the "A". Now "B" stands for the belief, thought, or assumption you have about the situation and it can either be reasonable or unreasonable. Say you believe it is horrible that you were screamed at by this person unfairly, which we will label "iB" for irrational belief. How do you think you would feel and respond? You might feel defensive, enraged, or possibly greatly hurt. It is also likely you would have a very difficult time constructively handling the situation. The product of an antecedent - irrational belief sequence we

call "iC", for irrational consequence. In this example, "iC" represents how you would behave towards the other person when enraged, defensive, or hurt. Do you see that because of your unreasonable belief you've responded unreasonably?

Now suppose that from point "A" you go to "rB", the "rational belief" that it is annoying but not terrible for this person to scream at me. Here you might feel angry or irritated; however, you are much less likely to become so emotionally upset by the incident that you are unable to respond in a sensible manner. Thus, you end up at "rC", which might be assertively telling your friend that you dislike being yelled at and that you feel he or she is being unfair. (Leave the schema on the board. If time permits run through another example such as fear of failure, i.e., irrational belief number 8; following this discussion take a ten minute break and switch Leaders following the break).

The rational self-analysis exercise is designed to help you learn to identify and challenge unreasonable beliefs and alter the negative things you tell yourself which cause you to feel extremely anxious, angry, depressed, or hopeless about acting assertively in a particular situation. This exercise first involves your describing a specific situation in which you'd like to act assertively but have been unable

to because fear or other strong emotions stopped you. The situation you choose to work on should be a specific one, as the following example illustrates: At meetings where people are being very competitive, and everyone is trying to outdo everyone else, I become totally quiet and fearful of speaking up even when I have a relevant comment to make. Here's another situation which is not sufficiently specific: Feeling anxious and scared; want to run away and let somebody else take care of the problem for me. (Instruct the group to write a specific situation in which they'd like to be more assertive but their emotions cause them to act aggressively or nonassertively. After a sufficiently specific, detailed situation is listed proceed with the following). The next step in this method is to write down the negative thoughts that come to mind as you think about acting assertively in the situation. Each of these thoughts will usually contain an irrational, often catastrophizing, sentence in it. Remember that these thoughts will be ones which produce negative feelings in you, and make it difficult to be assertive. For example: 1) People will think what I have to say isn't very bright or that I don't really understand the situation. They'll think I'm stupid; or 2) People will expect me to explain my views and I won't be able to. I'll be a complete failure. Are the following examples of self-defeating irrational thoughts? 1) I feel

guilty that I don't write to my parents more often; 2) My boss is awful. She had no right to criticize me. She should have liked my work; 3) I'm going to fail a test and that makes me a failure. (In the group discussion that follows, note that the first statement does not describe thoughts; it simply describes a feeling. The last two statements are thoughts which are likely to produce negative feelings. Next have the group members write some of their own typical self-defeating irrational thoughts. Afterwards, instruct the members in how to challenge and thus change their internal messages. You can introduce this segment of the exercise by making the following statements). The next step is to develop challenges to these thoughts. Look at each of the thoughts you've written. They'll be challenged in two ways. (Switch Leaders here.)

The first challenge is to identify the flaw in the self-message: Asking yourself, "Is this 100 percent true?" "Is the consequence I fear definitely going to happen?" "What do I know about myself or other people that says this may not happen?" Questioning negative thoughts will often reveal flaws in the thought. For example, take the statement: "People will think what I have to say isn't very bright or that I don't really understand the situation and that means I must be stupid." First of all is this true? Is it definitely a fact that people will think this? Is there

a possibility that they will think something else? Here's what a challenge would sound like: "It is possible that they will think what I have to say is bright. In the past, when I've said something, people have sometimes responded favorably. Some people may even like what I say. Generally it's only one or two people who are likely to respond negatively. The rest of the people may have a neutral reaction." The second type of challenge involves asking yourself two questions: (1) Even if this bad event happened, would it be a catastrophy? Could I handle it? and, (2) What implication does this bad event have for me? Does it make me a bad or worthless person? Does it make the other person bad? If not, what does it realistically make me or the other person? Here's how the second challenge would sound: "Even if people think that what I have to say isn't very bright, everyone is entitled to make a mistake. It's inconvenient and disappointing if they don't all think my thoughts are brilliant, but it's not the end of the world. I won't fall apart even though I don't like it and may feel uncomfortable. Just because I say something that isn't bright according to their standards doesn't automatically make me stupid. I don't have to say something bright 100 percent of the time in order to be bright. Better to offer my ideas than say nothing. If I never said anything, then they'd have real reason to believe that I

have nothing to offer."

Effective challenges do not include unrealistic pep talks like "Everything will turn out perfectly OK, cheer up" or "should" statements like "I should just relax and not be chicken". They also don't involve rationalizations like "I don't really care what they think of me". Rational challenges accurately assess a situation and reasonably recognize the possible outcomes. (Switch Leaders here)

SOFT, TENDER ASSERTIONS

The last topic we want to bring up is one many of you may have already considered. So far in training, most of our discussions and examples have involved expressing ourselves in requests, confrontations, refusals, violations, and disagreements. But, recall that we defined assertion as honestly expressing one's thoughts, feelings or beliefs in such a manner as not to violate another's rights. This definition applies equally to the "soft", honest feelings of good will, appreciation, admiration, caring, and love.

Some researchers suggest that these "soft assertions" are harder to convey than the others. There are a number of reasons why expressions of warmth are inhibited and most can be traced to unreasonable beliefs, negative self-statments, and denial of personal rights (Refer them to the list of

irrational ideas). For example, the superiority of reason over emotion, fear of rejection or ridicule, and fear of embarassment are all common excuses for inhibiting expressions of warmth, caring, and love. We would encourage you to bring some warmth into your life and other's by honestly and assertively expressing your tender feelings. (Switch Leaders here)

For a moment, consider how people are likely to respond to such assertions (Have group list ways like: 1) denying shyly, "Who me? No"; 2) Shifting the focus, "Oh, I like yours too."; and, 3) Rejecting, "You like this?! It's nothing."). Before we demonstrate how to assertively give and receive praise, compliments, or other expressions of warmth, I want to mention some common ways that people try to send warm messages:

(1) Self-depreciating: "I'm not good at this but you're great!"

(2) Sarcastic

(3) Crooked: "Most people don't like you but I do."

The problem with these attempts is they involve a double-message which hides the warm intent so that it gets lost or goes unnoticed. Let's look at an assertive way to deliver and receive a compliment (Demonstrate assertive

delivery and reception with co-therapist). Any questions? (Note: If someone fears appearing conceited, then distinguish between healthy self-pride and egotistical boasting that implies one-upmanship. Tie these ideas back into ABC schema. Switch Leaders here)

Now let's go around the group giving and receiving compliments. I'll start and the person I address will assertively receive the compliment. She will in turn give a compliment to someone who hasn't received one and so on. (Go around the group once; make sure everyone receives and gives a compliment.)

DISCUSSION AND HOMEWORK

Does anyone have any questions about the material covered tonight? (Pause) Alright, for next week I want you to review Section II in your manuals and on the blank page entitled "Irrational Beliefs" write down three irrational beliefs and appropriate challenges which you feel pertain to inhibition of your assertiveness. You can take them from the handout or develop them on your own. Also for homework, on the page entitled "ABC Restructuring", write in detail a situation you or someone you know encounters this week in which they were or could have been assertive. Write the underlying beliefs and the consequences.

SESSION THREE

GENERAL DISCUSSION

Does anyone have any questions about last weeks session or the material in Section II of the manual? Who would like to discuss one of the irrational beliefs that gives you problems? (Go through the ABC theory with the belief. Try to elicit several people's irrational beliefs.) Let's look at some of the situations people recorded (Again apply the ABC theory and some challenges, if appropriate, to one or two exemplary situations. Switch Leaders here).

SOCIALIZATION MESSAGES

We already have covered a variety of areas which can promote or inhibit being assertive: personal rights, negative self-statements, and irrational beliefs. We hope that the group discussion and homework has given you an opportunity to evaluate how your beliefs and thoughts effect your assertiveness. We want to encourage you to continue to think about these areas, to question your beliefs and thoughts if they prevent your assertion and to challenge them with more reasonable ideas. We will look at these further in specific situations later on but now we are going to look at different social messages you may have learned in growing up which adversely affect assertiveness. These

messages are taken from the work of Lange and Jakubowski (1976) who have written an excellent book on assertiveness. (Refer them to Section III, "Socialization Messages", in their manuals) Let's look at each message in detail. Does anyone find the first message familiar? (Either read the message or have someone else read it) Notice how it effects personal rights and assertive behavior. (Try to elicit comments as you go through the messages. Draw particular attention to the healthy message. Switch Leaders here).

NONVERBAL COMPONENTS OF ASSERTION

For the rest of this evening, we want to turn our attention to the nonverbal components of assertion, the body-language of being assertive. Have any of you ever said to yourself "If only I would of said such-and-such!" or "I can always think of the right things to say after the fact!" Well, tonight we want to let you in on a well-researched fact: The manner in which you express a message, particularly an assertive one, is a good deal more important than what you say because the vast majority of our communication is carried out nonverbally. One of the important implications this has for assertion is that an otherwise verbal assertive statement can become nonassertive or aggressive depending on the nonverbals you display (Switch Leaders here).

Before we explore the nonverbal components of assertion, let's try an exercise (Divide the group into triads and give each triad three slips of paper with one inane topic on each: bedpan, paper clip, lint. Instruct them that each member of the triad is to talk about her topic for one minute while the other two members note the nonverbal behaviors she uses. After all three have spoken on their topic, regroup, and discuss the nonverbals used. If a member reports feeling silly, ask them if they can give themselves permission to be silly, i.e., isn't it OK to be silly once in awhile?) Following this discussion take a ten minute break).

Nonverbal assertive behavior includes many nonverbals like the ones you've mentioned. It involves sustained eye contact, firm but calm facial expressions, strong stance and posture, appropriate accentuating hand gestures, and an appropriately loud voice that is smoothe, calm, and not too rapid. You will find a list of the nonverbal aspects of assertion in your manual. Turn to that page while _____(co-therapist) and I practice a scene using nonverbals associated with assertion, aggression, and subassertion. (Model the different nonverbals associated with assertion, aggression, and subassertion using the following example: One therapist is a dissatisfied customer who wishes to return a defective copy of Everything You Always Wanted to

Know About Assertiveness, But Were Too Timid to Ask to the bookstore; the other therapist is the clerk. Use the following words each time "I bought this book here last week, and discovered 20 pages are missing. I'd like a good copy or my money back.", the customer- therapist should display the nonverbals associated with assertion, aggression, and subassertion. These may need to be exaggerated for effect. Switch Leaders here.)

ROLE PLAY

Now in the time remaining we are going to start practicing and we will concentrate primarily on the nonverbal components. We will use the scenes you brought in as part of your homework and as we do, we want everyone to place yourself in the situation mentally. Pay attention to what irrational beliefs and negative self-statements you or the other person might be experiencing. Before you respond during the role play I want you to mention any irrational belief or negative self-statement that you think of in the context of the situation and then challenge that thinking. I'll then supply the prompt again and you can respond. Don't worry about what you say just concentrate on how you say it. Everyone will get a chance to practice. Who would like to be first? (As you go through the scenes be sure to concentrate on nonverbal behaviors. Alternate in leading

the role plays).

DISCUSSION AND HOMEWORK

Before we conclude, is anyone having problems challenging any of the negative self-statements or unreasonable beliefs we covered last week? Tonight's homework is intended to sensitize you to the crucial part that nonverbals play in communication. In Section III of your manual is a worksheet entitled "Nonverbal Communication". During the next week, I want you to record with some detail an assertive, aggressive, or subassertive situation you observed and the nonverbals that took place. Also, review Section III before next week. Any questions?

SESSION FOUR

GENERAL DISCUSSION

Let's start out the group by seeing if anyone has any comments or questions about anything we have done so far. How do things seem to be going? Have you been noticing and using the things we work on here? Let's share some of the situations and nonverbals that were discovered during the week (Briefly review nonverbal assertive behaviors if necessary).

Before we proceed with tonights material, we want to say a crucial word about practice. Being assertive is a skill you learn like any other skill whether it's riding a bike, giving good injections, etc. To learn it well and maintain it, you have to practice! You have to keep your skills current. Also like any other skill, if you don't use it, you lose it. So during the rest of the course, we will encourage you to gradually increase the amount and difficulty of situations you tackle assertively. In a very large way, the benefit you get out of this course will depend on your willingness to practice what you're learning. So by all means PRACTICE!!! (Switch Leaders here)

VERBAL COMPONENTS: I-LANGUAGE, BASIC, AND EMPATHIC ASSERTION

Last week we focused on and practiced being nonverbally assertive. Tonight we turn our attention to being verbally assertive as well. By being both, we won't be sending mixed messages that confuse other people or make them feel we aren't adament. There are five types of verbal assertive messages. These can be arranged hierarchically and then be used to deal with increasingly difficult situations. You will find these in Section IV of your manual and they are: I-language, Basic assertion, Empathic assertion, Confrontive assertion, and Escalating assertion. This evening we want to explore and practice the first three.

An "I" statement is simply taking ownership for your feelings and preferences by starting out the statement with the word "I". Notice the difference in this example: "You make me angry by not listening to me" vs. "I get angry when you don't listen to me." Did you notice that the first statement sounded as if it blamed the other person while the second stuck simply to the facts. Here is another example, "You should not get so upset when we discuss this." vs. "I would prefer that you did not get so upset when we discuss this." In the first statement, it is implied that there is some sort of universal decree about what the person should

do; however, no one can justifiably question the truth of the second remark. After all, who can argue with what you feel?

The second type of assertion we will cover tonight is Basic assertion. Basic assertion refers to a simple expression of standing up for personal rights, beliefs, feelings, or opinions. It doesn't involve other social skills such as empathy, confrontation, or persuasion. Examples of basic assertions are:

(1) When being interrupted: "Let me finish what I'm saying."

(2) When being asked an important question for which you aren't prepared: "Let me have a few minutes to think that over."

(3) When returning an item to a store: "I'd like my money back on this item."

(4) When refusing a request: "No, this is not a good time for me to visit with you."

Any questions regarding these two forms of verbal assertion? (Switch Leaders here)

Often people want to do more than simply express their feelings or needs, they may also want to convey some empathy with the other person. When this is the goal, the empathic assertion can be used. This type of assertion involves making a statement that conveys recognition of the other person's situation or feelings and is followed by another statement which stands up for the speaker's rights. Examples of empathic assertions are:

(1) When two people are talking loudly at a meeting: "You may not realize it, but when you're talking, I find it difficult to hear and concentrate on the meeting."

(2) At a union negotiation meeting: "I realize that the hospital has a limited budget, but I feel the hospital ought to show greater recognition that it's employees have families to provide for."

(3) When having a package delivered: "I know it's hard to say exactly when the truck will come, but I'd like a ball park estimate of the arrival time."

There is considerable personal power in the empathic assertion because other people more readily comply with assertion when they have been recognized first. Another important advantage of the empathic assertion is that it causes you to take a moment to try to understand the other

person's feelings before reacting. This can improve your perspective on the situation. Any questions about empathic assertion? (Switch Leaders here)

MAKING AND REFUSING REQUESTS

Making and refusing requests effectively is one area where you can be assertive. However, nonassertive persons often avoid making reasonable requests of others. When they do make requests, they seem to be apologetic or do not expect them to be accepted. On the other hand, some nonassertive persons have trouble saying "No" to requests and instead give excuses for not being able to comply when the real issue is that they do not want to comply. In contrast, aggressive persons can sound demanding, coercive, and hostile in refusing. Before the break this evening, we're going to practice making and refusing requests. To start, I'll make a request and no matter what it is or how reasonable it seems, the person I address is to refuse simply by saying "No". I'll then repeat my request and the person is to use an I-statement or Basic assertion to refuse. The person who refused is then to make a request of someone else in the group whom they don't know really well and so on. Any questions? (Watch non-verbals/verbal messages and shape them if necessary. After everyone has participated take a short break)

ROLE PLAY

During tonights practice, let's incorporate nonverbal, assertive behavior and one of these three types of verbal assertions. Using the situations you observed last week, who would like to begin? (Have each person try each type of response once. Attend to nonverbal behavior and shape the response. Alternate Leaders.)

HOMEWORK AND DISCUSSION

For next week, we want you to attempt being assertive in at least two situations, preferably one at home and one at work, and be prepared to practice the situations at our next meeting. If you have difficulty, analyze the situation and be prepared to tell us what gave you problems: unreasonable beliefs, negative expectations/thoughts, etc. Finally, review Section IV in your manual.

SESSION FIVE

GENERAL DISCUSSION

Welcome to our last meeting! How did the homework assignments go? What sort of experiences did you have? Is anyone experiencing any difficulties with the various techniques we have covered? (Try to elicit feedback about the "group experience" as well as suggested improvements. Switch Leaders here.)

VERBAL COMPONENTS: CONFRONTIVE, AND ESCALATING ASSERTION

Tonight we want to add confrontive, and escalating assertion to the skills you've already acquired. First, we'll briefly explain and demonstrate what they are. You will find these listed and defined in Section IV of your manual.

Let's look at confrontive assertion. Confrontive assertion is used when the other person's words contradict his deeds. This type of assertion involves objectively describing what the other person said would be done, then describing what he/she actually did do, and finally you express what you want. The entire assertive response is said in a matter-of-fact, non-evaluative way. For example, "I thought we'd agreed that you were going to be more considerate towards patients. Yet I noticed today that when

two patients asked for some information you said that you were busy and had better things to do. As we discussed earlier, I see showing more consideration as an important part of your job. I'd like to figure out what seems to be the problem." (Trainers may want to elicit situations from the group and construct a confrontive response. Mention that confrontive assertions will often require prior preparation. Switch Leaders here.)

Finally before beginning tonight's practice session, we want to explain Escalating assertion. Escalating assertion involves starting with a "minimal" assertive response that can usually accomplish the speaker's goal with a minimum of effort or anxiety and a small possibility of negative consequences. When the other person fails to respond to the minimal assertion and continues to violate one's rights, the speaker gradually escalates the assertion and becomes increasingly firm. An example will help illustrate this form of assertion: Suppose you were in a bar with a woman friend and a man repeatedly offers to buy you a drink. The escalating assertion might proceed like this,

(1) "That's very nice of you to offer but we came here to catch up on some news. Thanks anyway."

(2) "No, thank-you. We would rather just visit alone."

(3) "This is the last time I'm going to tell you that we don't want your company. Please leave us alone!"

Another work-related example might be dealing with a patient who refuses to follow his Dr.'s orders:

(1) "I understand that you're trying to be helpful, however, the Dr. has ordered complete bedrest with your leg elevated. Therefore, you can not get up to go to the bathroom."

(2) "No, you can not get up. Please use the bedpan."

(3) "I have explained your Dr.'s order and reminded you twice. Each time you have apologized and acknowledged you understood the order. If I find you have gotten up again, I will have to call your Dr."

Are there any questions regarding escalating assertion? Let's take a short break and then we'll practice these skills.

ROLE PLAY

Now let's practice some situations while incorporating these new messages. In our practice this evening, we want group members to play both parts. One will be very

persistant and force the other to respond progressively more assertively. (Proceed with role-play; Alternate Leaders).

DISCUSSION

Before we finish tonight, there is a questionnaire for everyone to fill out and we also would like to schedule the Post-test. But before we get to that, we want to give you some time to share any thoughts you have about the assertion training group you just completed. Does anyone have anything you would like to say? (Use this time to reinforce gains and build confidence. Explain the importance of continuing to practice and use the skills that they learned. Feel free to share any feedback that you would like to provide the group; Switch Leaders here).

QUESTIONNAIRE

(Pass out the questionnaire) To help evaluate the program, we would like everyone to complete the questionnaire. It is important that you give us your own evaluation of the program and for that reason please fill out the questions without discussing your answers until everyone is through. Here is a large envelope to place your completed questionnaire into. (Set the envelope where it is readily accessible to everyone). The coordinator will be the only one to see the questionnaires and he urges that

everyone be as candid as possible in your answers. When you finish, check with us to schedule a time for the Post-test. Any questions?

Thank you.

Appendix L

Subject's Manual

(See following pages)

ASSERTION TRAINING FOR REGISTERED NURSES IN A PROFESSIONAL SETTING

by

Timothy J. McIntyre*

University of Montana

*This program was designed by the author based on material from Responsible Assertive Behavior by Arthur Lange and Patricia Jakubowski (1976), an unpublished dissertation by Mark Bordewick, and Your Perfect Right by Robert Alberti and Michael Emmons (1974).

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AN OVERVIEW OF ASSERTION TRAINING

Assertion training involves a number of procedures designed to enhance a person's ability to express her feelings in an honest and straightforward manner and to assert her rights without dehying the rights of others. When a person responds assertively, he/she is expressing positive or negative feelings in an open but not hostile manner that alienates others. Consequently, assertiveness is more adaptive and often achieves better results than extreme inhibition and aggressive overreaction. In addition, assertive behavior often enables an individual to rectify unjust situations, increase self-confidence and a sense of personal satisfaction, enhance communication between herself and others, and reduce interpersonal anxiety.

The goal of assertion training then is to foster and promote assertive behavior. In assertion training groups, participants are first helped to locate sources of interpersonal anziety or discomfort which inhibit assertive responses. Also, those situations in which being assertive is difficult are examined. For example, one important problem for many people involves discrimination between reasonable and unreasonable actions, requests, or behavior of others; that is, knowing when you need to express your feelings in a straightforward manner or assert your rights. There are certainly no absolute rules in this regard that apply to every person in every situation. The primary focus of training will be aimed at teaching assertive skills that participants can use in situations in which they know that assertive responses are required. Once a person learns how to respond more assertively, he/she can choose when and where to respond in such a manner. The core of assertion training, then, involves learning effective assertive skills by means of repeated practice, exercises, brief lectures, and discussion. Such training takes on many forms depending on the particular needs of groupmembers. In general, assertion training groups provide a safe and supportive atmosphere in which new, more appropriate, and satisfying responses can be learned and practiced.

However, assertion training is different from open-ended encounter groups or other forms of group therapy because it involves more of a structured means of learning and practicing the skills of assertion. Still, the supportive group experience is generally found to be quite rewarding and satisfying for most participants. Another important aspect of assertion training is referred to as "role-playing". In this procedure, specific situations or "scenes" involving assertive responses are rehearsed by group members in an attempt to learn and practice being assertive. Most of the scenes used for this purpose are standard ones found to be troublesome by a majority of people. It will be assumed during training that assertive responses are desired under circumstances presented in the scene. Any questions or doubts in this area will certainly be discussed. At the beginning and end of training, role-played scenes are often audiotaped (and remain strictly confidential) to assess progress made during training. Participants usually become quickly adjusted to the taping procedure and this assessment procedure will be used in the current program.

The assertion training groups in which your are participating will focus on three important aspects of assertiveness: (1) the ability to request changes in thoughtless or unreasonable behavior or others, (2) the ability to refuse or say "no" to unreasonble requests, and (3) the ability to express positive and negative feelings to others.

In summary, what assertion training concerns itself with are those situations in which participants definitely want to behave more assertively but for some reason do not do so. The crucial aspect of training is to learn sound assertive skills.

S E C T I O N I

Criteria of Aggressive, Assertive, and Nonassertive Behavior

The social effectiveness of behavior is a function of the specific set of circumstances surrounding it. In situations where an assertive response is appropriate, a person's behavior may fall anywhere on a continuum of aggressive to assertive to nonassertive. At times, it is a difficult task to decide where a given response falls on that continuum, as people's opinions often vary on these issues. To resolve some of the confusion a number of writers in the field of assertion training (Alberti & Emmons, 1974; Hollandsworth, 1977; Lange & Jakubowski, 1976; MacDonald, 1978) have specified explicit guidelines by which a response may be judged for its appropriateness. Hence, the determination of the assertiveness/aggressiveness/nonassertiveness of a response may be reasonably consistent when the following guidelines are used (condensed from the writings of the cited authors).

Criteria of Aggressive Responses:

1. Behavior that may be self-enhancing and expressive of one's feelings, but usually hurts others by minimizing their value as a person, or by not letting them make their own choices.

2. Any response which delivers either verbally or nonverbally, noxious stimlation to another individual.

3. The use of threats and punishment to gain compliance, where a threat may be a statement of pending punishment, and punishment is a form of noxious stimulation: depriving expected gains or social punishment, such as, negative evaluation and social rejection.

4. Behavior that is a put down of the recipient; it may involve belittling, or overpowering other people so that they are less able to express and defend their needs, beliefs, and rights.

5. Behavior that does not indicate that another person has the right to ask for a favor, or to express themself.

6. The hostile expression of preference (by words or actions) in a manner coercing others to give in the these preferences.

Criteria of Assertive Behavior:

1. Behavior which involves standing up for rights and expressing thoughts, feelings, and beliefs in direct, honest, and appropriate ways which do not violate another person's rights.

2. Giving another person feedback in a non-threatening, non-punitive manner which may modify their behavior.

3. Behavior suggesting self-respect, in addition to, respect of another person's right to express themself.

4. A compromise that allows each party's needs to be met, without sacrificing either party's personal integrity.

5. Behavior that is self-enhancing, suggestive that the person has chosen for himself/herself, and is an honest expression of one's feelings.

6. The open expression of preferences (by words or actions) in a manner causing others to take them into account.

Criteria of Nonassertive Behavior:

1. Failure to express honest feelings, thoughts, and beliefs in situations where one's rights or interests are likely to be overlooked by others.

2. Behavior that is self-denying, indicates an inhibition of actual feelings, and often is accompanied by feelings of hurt or anger as a result of the inadequate response.

3. A response that is self-effacing, appeasing, or overly apologetic, as if one is avoiding conflicts at any cost.

4. Behavior that may either suggest a lack of self-respect, such as acting as though one is reprehensible for refusing a request, or a subtle lack of respect for another person's ability to handle disappointment.

5. Allowing others to choose for oneself.

6. The act of yeilding humbly to another person's preferences.

CRITERIA FOR ASSERTIVE BEHAVIOR

General Considerations

1. Assertive responses are firm and direct, but not aggressive.

2. Feelings of hurt, anger and disappointment can be openly expressed without hurting others, leading to fights or alienating others.

3. The ultimate sucess or failure of assertive responses is not as important as the attempt itself.

4. The expression of any feeling can be easily facilitated by simply beginning your response with the word "I". Such an assertive response is called an I-message.

5. When asserting your rights in an appropriate manner, lenghthy justifications are not necessary.

6. When requesting changes in unreasonable and thoughtless behavior or when refusing to comply with unreasonable requests, provide alternatives that might please both you and the other person.

7. Positive feelings such as affection should be expressed as openly as negative feelings such as anger. Assertive behavior involves the appropriate and straightforward expression of both positive and negative feelings.

8. The verbatim content of assertive responses depends upon the characteristics of the situation and persons involved.

9. Two important aspects of assertive behavior are: (1) refusing to comply with unreasonable requests and (2) requesting changes in thoughtless or unreasonable behavior.

Assertive behavior

When making an assertive response, remember the following points:

1. Maintain eye contact with the other person.

2. Speak loud enough to be clearly heard.

3. Make your response long enough to get your point across.

4. Be clear and distinct. Do not mumble.

5. Express yourself in clear and precise terms. Do not "beat around the bush."

6. Be firm and direct, showing sufficient emotional involvement without becoming aggressive or hostile.

7. Avoid unnecessary hesitiations. Try not to stumble over words.

8. Focus on the other person's behavior. Do not attack him/her personally by name-calling.

Further Helpful Hints

1. Reveal as much of your personal self as is appropriate to the situation and the relationship.

2. Strive to express all feelings, whether angry or tender.

3. Act in ways that increase your liking and respect for yourself.

4. Examine your own behavior and determine areas where you would like to become more assertive. Pay attention to what you can do

5. Do not confuse aggression with assertion. Aggressiveness is an act against others. Assertion is appropriate standing up for yourself.

6. Realize you may be unassertive in one area like business and assertive in another area, like marriage. Apply the techniques you use successfully in one area to the other.

7. Do not confuse glib, manipulatory behavior with true assertion. The aim of Assertion Training is to deepen the experience and expression of your humanness, not to turn you into a con artist.

8. Do! You can always find fifty reasons for not doing things, so that over time you become very skilled at creating an empty life As your actions change, often your feelings will.

9. Understand that assertion is not a permanent state. As you change, life situations change, and you face new challenges and need new skills.

HUMAN RIGHTS

Our beliefs about personal rights and what we should do when those rights are violated affect whether we are assertive, aggressive or submissive. For example, if I believe it is absolutely terrible when someone violates my rights or someone else's rights then I am likely to overreact and behave aggressively in my effort to defend those rights. On the other hand,if I fail to acknowledge my rights to myself, i.e. I don't believe I have a particular right, or I make excuses for those who violate my rights then I'll likely behave submissively, i.e. look the other way or "let it pass". However, if I believe in my rights and believe it is only fair that others respect my rights as I do theirs then I will speak up and feel good about doing so. For example, I believe I have the right to be respected by others. By recognizing this belief, I can feel good about asserting myself when someone makes an unreasonable request.

Record some human rights

What are 2 personal rights that you have difficulty accepting and upholding?

S E C T I O N I I

IRRATIONAL BELIEFS AND THE ABC THEORY

Along with failure to adhere to personal rights, often times people openly or automatically assume major beliefs which are unreasonable. In fact, believing you don't have the personal rights we've considered can be termed unreasonable or incorrect. We call these unreasonable or irrational beliefs. A number of commonly held irrational beliefs are listed on the following pages. Many times we assume these beliefs without even noting or thinking about them. However, they still influence us and can easily make us feel upset emotionally. If we held rational beliefs instead, we would not get nearly as upset in the same situations and be able to function more efficiently For example, we feel anxious or depressed because we convince ourselves that it is not just unfortunate and inconvenient, but that it is terrible and catastrophic when we fail at a major task or are rejected by a significant person. We also may feel hostile because we believe that others who act unfairly absolutely should not act the way they do.

We want to suggest that there are very few really legitimate reasons for people to make themselves hysterical or overly agitated. However, there are alot of reasons for people to express and experience strong feelings like sorrow, regret, displeasure, or annoyance. Another way to look at irrational beliefs and their affect is to use the ABC theory.

The "A" stands for the anticedant. That is, the situation or person or event you are faced with. For example, suppose your spouse or close friend yells unfairly at you. This would be the "A". Now at point "B" (see diagram below) you have a belief, thought, or assumption about the situation and it can either be rational or irrational. Say you believe or tell yourself that it was absolutely horrible , totally unfair, and uncalled for that this person screamed at you. We label this iB for irrational belief. Thinking or believing this way would very likely make you feel defensive, enraged, or deeply hurt. It is also likely you would have a very difficult time constructively handling the situation. The feelings and actions spawned by the irrational beliefs we call irrational consequences, "iC".

Now suppose that from point "A" you go to "rB", the belief that it is annoying to have this person scream at me. Here you might feel angry, or irritated; however, you are much less likely to become so emotionally engaged by the incident that you are unable to respond in a sensible manner. Thus, you end up at "rC", which is assertively telling your friend that you dislike being yelled at and that you feel he or she is being unfair.

Irrational Beliefs and Challenges

1. "It is a necessity to be loved by everyone for everything I do."
-instead of concentrating on one's own self-respect, winning approval for practical purposes, and loving rather than being loved.

2. "Certain acts are awful or wicked, and people who perform such acts should be severely punished."
-instead of the idea that certain acts are inappropriate and people who perform them are behaving ignorantly and would better be helped to change.

3. "It is horrible when things are not the way one would like them to be!"
-instead of trying to change or control conditions to make them more satisfying or temporarily accepting them if immediate solutions are not possible at present.

4. "Human misery is externally caused and is forced on one by outside people and events."
-instead of the idea that emotional disturbance is a result of the view one takes of such conditions.

5. "If something is or may be dangerous or fearsome, one should be terribly upset about it."
-instead of facing it or accepting the inevitable.

6. "It is easier to avoid than to face life's difficulties and self-responsibilities."
-instead of the idea that the easy way is often harder and less effective in the long run.

7. "One needs something other or stronger or greater than oneself on which to rely."
-instead of the idea that the risk of thinking and acting independently is more adaptive.

8. "One should be thoroughly competent, intelligent and achieving in all respects."
-instead of accepting oneself as imperfect with limitation.

9. "Because something once strongly affected one's life, it should indefinitely affect it."
-instead of learning from one's experiences.

10. "One must have certain and perfect control over things."
-instead of the idea that the world is full of uncertainty and probability.

11. "Human happiness can be achieved by inertia and inaction."
-instead of absorbing oneself in creative pursuits and devoting oneself to projects and people outside oneself.

12. "One has virtually no control over one's emotions and one cannot help feeling certain things."
-instead of the idea that one does have such control.

SELF-STATEMENTS THAT IMPEDE EFFECTIVE ASSERTION

I. Self-statements that lead to underassertive responses*

A. I must be loved and approved by every significant person in my life; and if I'm not, it's awful.

Challenges:

1. Why would it be terrible if the other person thought I was a bitch, or rejected me? How does that make me a worthless, hopeless human being?
2. What do I really have to lose by telling my boyfriend or husband that I don't like the way he behaves toward me? If worst comes to worst and he leaves me, how would that make me a failure? And what's the evidence that I couldn't find another guy who will treat me better?

B. It would be awful if I "hurt" the other person.

Challenges:

1. How can I really "hurt" another human being, simply by making my own well-being and comfort as important as theirs?

II. Self-statements that lead to hostile or overly aggressive responses*

A. It's awful when other people behave badly; and they should be punished or put down for it.

Challenges:

1. People are going to act the way they want, not the way I want.
2. Why should the other person roast in hell for behaving badly? Just because he/she is acting badly, doesn't mean he's a totally condemnible human being.
3. How can I express my displeasure to this person without calling them names or putting them down?

B. The world should be fair and just.

Challenges:

1. Why should the world be fair? It would be nice if it were, but it often isn't.
2. How can I determinedly try to change what I can change, and lump (or leave) the rest?

*from Wolfe

III. Common Self-defeating Self-statements

1. I don't want to unfairly antagonize the other person.
2. I don't want to make a fool out of myself.
3. If I say anything, the other person wouldn't like me.
4. It would be unfair and selfish of me to say anything.
5. I'm too upset to say anything.
6. I don't have a right to say anything.
7. I will offend the other person if I refuse.
8. I'm afraid of what others will think.
9. It would just be easier not to say anything.
10. I'll accept the unreasonable request as a friend.
11. I don't want to cause any trouble.
12. I'm not sure what to tell him.
13. I'm not sure if I have a right to say anything or not.
14. It won't do any good.
15. His behavior is not all that bad.
16. I don't want to appear angry.
17. I can take it.
18. I'll wait and say something next time.
19. I don't want to seem pushy.
20. Maybe, he's not in the wrong.
21. I'm too nervous to say anything.
22. It would be unkind to refuse.

IRRATIONAL BELIEFS

Write down three irrational beliefs and challenges which you feel pertain to inhibition of your assertiveness. You can take them from previous pages or develop your own.

ABC RESTRUCTURING

Describe in detail a situation you or someone you know encounters this week in which they were or could have been assertive. Write the underlying beliefs and the consequences.

S E C T I O N I I I

HOW SOCIALIZATION MESSAGES MAY NEGATIVELY EFFECT ASSERTION*

Socialization Message	Effects on Rights	Effects on Assertive Behavior	Healthy Message
Think of others first; give to others even if your're hurting yourself.	I have no right to place my needs above those of other people's	When I have a conflict with someone else, I will give in and satisfy the other person's needs and forget about my own.	To be selfish means that a person places his desires before practically everyone else's desires. This is undesirable human behavior. However, all healthy people have needs and strive to fulfill these as much as possible. Your needs are as important as other people's. When there is a conflict over need satisfaction, compromise is often a useful way to handle the conflict.
Be modest and humble. Don't act superior to other people.	I have no right to do anything which would imply that I am better than other people	I will discontinue my accomplishments and any compliments I receive. When I'm in a meeting, I will encourage other people's contrubutions and keep silent about my own. When I have an opinion which is different from someone else's, I won't express it; who am I to say that my opinion is better than theirs?	It is undesirable to build yourself up at the expense of another person. However, you have as much right as other people to show your abilities and take pride in yourself. It is healthy to enjoy one's accomplishments.
Be understanding and overlook trivial irritations. Don't be a bitch and complain.	I have no right to feel angry or to express my anger.	When I'm in a line and someone cuts in front of me, I will say nothing. I will not tell my girlfriend that I don't like her constantly interrupting me when I speak.	It is undersirable to deliberately nitpick. However, life is made up of trivial incidents and it is normal to be occasionally irritated by seemingly small events. You have a right to your angry feelings, and if you express them at the time they occur, your feelings won't

			build up and explode. It is importnat, however, to express your feeling assertively rather than aggressively.
Help other people. Don't be demanding.	I have no right to make requests of other people	I will not ask my girlfriend to reciprocate babysitting favors. I will not ask for a pay increase from my employer.	It is undesirable to incessantly make demands on others. You have a right to ask other people to change their behavior if their behavior affects your life in a concrete way. A request is not the same as a demand. However, if your rights are being violated and your requests for a change are being ignored, you have a right to make demands.
Be sensitive to other people's feelings. Don't hurt other people.	I have no right to do anything which might hurt someone else's feelings or deflate someone else's ego.	I will not say what I really think or feel because that might hurt someone else. I will inhibit my spontaneity so that I don't impulsively say something that would accidentally hurt someone else.	It is undesirable to deliberately try to hurt others. However, it is impossible as well as undesirable to try to govern your life so as to never hurt anyone. You have a right to express your thoughts and feelings even if someone else's feelings get occasionally hurt. To do otherwise would result in your being phoney and in denying other people an opportunity to learn how to handle their own feelings. Remember that some people get hurt because they're unreasonably sensitive and others use their hurt to manipulate you. If you accidentally hurt someone else, you can generally repair the damage.

*Taken from: Lange, A. J., & Jakubowski, P. Responsible Assertive Behavior, 1976.

NOTES ON THE NONVERBAL COMPONENTS OF ASSERTION*

The manner in which you express an assertive message is a good deal more important than the exact words you use. . . We are primarily concerned with encouraging honesty and directness, and much of that message is communicated nonverbally.

Eye contact: a relaxed and steady gaze at the other,looking away occasionally as it is comfortable, helps to make conversation more personal, to show interest in and respect for the other person, and to enhance the directness of your messages.

Body posture: A significant increase in personalizing the conversation occurs from a slight turn of the torso- say 30 to 45 degrees- toward the other person. Relative power in an encounter may emphasized by standing or sitting. In a situation in which you are called upon to stand up you rourself, it may be useful to do just that -- Stand up. An active and erect posture facing the other person directly, lends additional assertiveness to your message. A slumped, passive stance gives the other person an immediate advantage, as does any tendency on your part to lean back or move away.

Distance: Distance from the other person does have a considerable effect upon communication. Standing or sitting very closely, or touching, suggests a quality of intimacy in a relationship, unless the people happen to be in a crowd or very cramped quarters. "Coming to close" may offend the other person, make her/him defensive, or open the door to greater intimacy.

Gestures: Accentuating your message with appropriate gestures can add emphasis, openness, and warmth.

Facial Expressions: Effective assertions require an expression that agrees with the message, i.e. don't smile when expressing anger.

Voice Tone, Inflection, Volume: A level, well modulated conversational statement is convincing without intimidating. A whispered monotone will seldom convince antoher person that you mean business, while a shouted epthet will bring defenses into the path of communication. Consider the folowing dimensions of your voice: tone (is it raspy, whiny, seductively soft, angry?); inflection (do you emphasize syllables, as in a question, or speak in a monotone, or with a sing-song effect?): volume (do you try to gain attention with a whisper, or to overpower others with loudness, or is it very difficult for you to shout even when you want to?)

Fluency: A smooth, steady flow of speech is a valuable asset in getting your point across.

Timing: In general, we advocate spontaneity of expression as a goal. . . spontaneous assertion will help keep your life clear, and will help you to focus accurately on the feelings you have at the time. Remember too, that it is never too late to be assertive! Even though the ideal moment has passed, you will find it worthwhile to go to the person at a later time and express your feelings

Listening: Assertive listening involves tuning in to the other person attending to her/his message, and actively attempting to understand it before responding. If we are to be faithful to our commitment that assertiveness includes respect for the rights and feeling of others, our conception must be expanded to include assertive receiving--sensitivity to others— as well as assertive sending!

* the preceeding material was taken from: Alberti, R. & Emmons, M. Your Perfect Right, 1974.

NONVERBAL COMMUNICATION

Record with some detail an assertive, aggressive, or subassertive situation you observe and the nonverbals that took place.

S E C T I O N I V

VERBAL ASSERTIVE MESSAGES

I-language: An "I" statement is simply taking ownership for your feeling and preference by starting our the statement with the word "I". Notice the difference in this example: "You make me angry by not listening to me" vs."I get angry when you don't listen to me." The first example sounds blaming and accusatory while the second stuck smiply to the facts. Here is another example, "You should not get so upset when we discuss this." vs. "I would prefer that you did not get so upset when we discuss this." In the first statement, it is implied that there is some sort of universal decree about what the other person whould do, while no one can question the truth of the second remark. After all,you know what you prefer or feel.

Basic Assertion: Basic assertion refers to a simple expression of standing up for personal rights, beliefs, feelings, or opinions. It doesn't involve other social skills such as empathy, confrontation, or persuasion. Examples of basic assertions are:

1) When being interrupted: Excuse me, I'd like to finish what I'm saying.
2) When returning an item to the store: I'd like my money back on this item.
3) When refusing a request: No, this in not a good time for me to visit with you.

Empathic Assertion: This type of assertion involves making a statement that conveys recognition of the other person's situation or feelings and is followed by another statement which stands up for the speaker's rights. Examples of empathic assertions are:

1) When two people are talking loudly at a meeting: You may not realize it, but your talking is making it difficult for me to hear and concentrate on the meeting.
2) At a union negotiation meeting: I realize that the hospital has a limited budget, but the hospital must realize that it's employees have families to provide for.

Confrontive Assertion: This type of message involves objectively describing what the other person said would be done, what the other actually did do, after which the speaker expresses what he wants. It is most appropriate when the other person's deeds contradict his deeds. The entire response is said in a matter-of-fact, non-evaluative way. For example, "I thought we'd agreed that you were going to be more considerate towards patients. Yet i noticed today that when two patients asked for some information you said that you were busy and had better things to do. As we discussed earlier, I see showing more consideration as an important part of your job. I'd like to figure out what seems to be the problem.

Escalating Assertion: Escalating assertion involves starting with a "Minimal" assertive response like Empathic assertion or an "I" statement that can usually accomplish the speaker's goal with a minimum of of effort and anxiety, and a small possibility of negative consequences. When the other person fails to respond to the minimal assertion and continues to violate one's rights, the speaker gradually

escalates to basic assertion and finally confrontive assertive with each successive assertion becoming more firm.

*the preceeding material was taken from: Lange, A. J., & Jakubowski, P. Responsible Assertive Behavior, 1976.

S E C T I O N V

SOFT, TENDER ASSERTIONS

Throughout training most of our discussions and role-plays have involved expressing ourselves in requests, confrontations, refusals, violations, and disagreements. But, recall that we defined assertion as honestly expressing one's thoughts, feelings or beliefs in such a manner as not to violate another's rights. This definition applies equally well to the "soft", honest feelings of good will, appreciation, admiration, caring, and love.

Some researchers suggest that these "soft assertions" are harder to convey than the others. There are a number of reasons why expressions of warmth are inhibited and most can be traced to unreasonable beliefs, negative self-statements, and denial pf personal rights. For example, the superiority of reason over emotion, fear of rejection or ridicule, and embarassment are all common excuses for inhibiting expressions of warmth, caring, and love.

We would encourage you to bring some warmth into your life and other's by honestly and assertively expressing your tender feelings. However, be prepared for the following likely response to such assertions:

1) denying shyly: "Who me? No"
2) Shifting the focus: "Oh, I like yours too."
3) Rejecting: "You like this? It's nothing!"

By assertively expressing your warm feelings, you avoid the confusion that occurs with many common ways of expression. Some common ways that people try to send warm messages are:

1) Self-depreciating: "I'm not good at this but your great!"
2) Sarcastic
3) Crooked: "Most people don't like you but I do."

The problem with these attempts is they involve a double-message which hides the warm intent so that it gets lost or goes unnoticed. With assertion the message is delivered clearly and honestly. "I" statements lend themselves well to clear expressions of soft, tender assertions.

A CRUCIAL WORD ON PRACTICE!!!

Being assertive is a skill you learn like any other skill whether it's riding a bike, giving injections, etc. To learn it well and maintain it, YOU HAVE TO PRACTICE! You have to keep your skills current. Also, like any other skill, if you don't use it, you lose it. So during the rest of your life, we encourage you to gradually increase the amount and difficulty of situations you tackle assertively. In a large way the benefit you get out of this course will depend on your willingness to practice and use what you've learned. So by all means PRACTICE!

Appendix M

Outline of the Weekly Sessions

Week One

In the opening minutes of the first session, the nurses were divided into dyads, got to know their partners, and then introduced them to the groups. Following the introductions a brief overview of the program including a statement of goals and treatment rationale was presented (see Appendix K, Trainer's manual). Next, the groups covered material in their training manuals on differentiating assertive, aggressive, and subassertive behavior. They also listened to audiotaped illustrations of all three types of responses. The session closed with identification and discussion of some human rights and how beliefs about those rights affect how people behave. Homework was assigned to be completed by the next session and included: Reviewing Section 1 in the training manual (see Appendix L), recording some human rights, and noting two personal rights that they have difficulty accepting.

Week Two

The second session opened with a review of the homework and material covered previously. The nurses were then referred to Section 2 of their manuals which included material on irrational beliefs, challenges to such beliefs, and a short explanation of Ellis' A-B-C system for analyzing and modifying irrational beliefs. Subjects followed along as this material was explained and illustrated by the therapists. After a short break, the therapists lead the group in the rational self-analysis exercise designed to help subjects identify and change irrational self-messages that prevent assertive behavior (see Appendix K, Trainer's manual). Following this exercise, the therapists lead a group discussion of positive/soft assertions

(Appendix M cont.)

and conducted an exercise on giving and receiving compliments. Homework assignments for this week included recording three irrational beliefs that pertained to their own inhibition of assertive behavior, listing appropriate challenges for these beliefs, and, finally, using the A-B-C system, they were to analyze a situation(s) they observed during the week that could have been or was handled assertively.

Week Three

After reviewing the homework and answering questions over the previous week's material, the third session delved into socialization messages that promote aggression or subassertion (Lange and Jakubowski, 1976). Subjects received a brief lecture and were referred to Section 3 of their manuals where a number of socialization messages are illustrated. Section 3 also contains pertinent material on the nonverbal components of assertive behavior which was the topic that followed socialization messages in this session. The nurses were "sensitized" to nonverbal communication via a group exercise called "Inane Topics" (Lange and Jakubowski, 1976; See Appendix K, Trainer's manual). After a brief lecture and therapist's modeling of the nonverbal behaviors associated with aggressive, assertive, and subassertive behavior, group members started role playing using the situations brought in as part of the second session's homework. The group concentrated on the nonverbal aspects of each role play. Homework consisted of reviewing Section 3 in their manual and recording with detail an assertive, aggressive, or subassertive situation which they observed or in which they were involved. Specific attention was to be given to the nonverbals that were exhibited.

(Appendix M cont.)

Week Four

Session four began with general discussion, comments, and questions about material covered in the group so far. Specifically, the therapists sought feedback on how the group was progressing and the extent to which members used what they were learning. A lecture encouraging practice and explaining I-language, basic, and empathic assertion was presented and followed by role playing. Subjects were referred to Section 4 of their manuals where the types of verbal assertion are described. Using the situations brought in this week, group members role played assertive non-verbal behaviors along with "I" statements, basic, and empathic assertions. Prior to the role playing, there was an exercise on practicing making and refusing requests (Lange and Jakubowski, 1976; see Appendix M, Trainer's manual) and a short break. For homework, the nurses were assigned the task of attempting assertion in at least two situations (preferably one at home and one at work) and being prepared to role play the situations at the next session. For those who had trouble being assertive, they were to analyze the situation and be prepared to explain why they had trouble, i.e., unreasonable beliefs, negative expectations, realistic dangers.

Week Five

In the final session, the group began by discussing the homework, any difficulties they had with any of the techniques, and any comments the members wished to make about the group. Following the discussion, the therapists described and modeled confrontive and escalating assertions. After a break, role play ensued with the group divided into two units; using the situations brought in, group members worked on previously covered assertive skills, cognitions, and cognitive restructuring. The nurses

(Appendix M cont.)

then completed a post-training questionnaire and were scheduled for the post-training assessment.

Appendix N

Tests of Homogeneity of Variances for the Training Groups and *t* Tests of their Means on all Self-report Measures

Variable	Pre-training	Post-training	Follow up
ASST	s_1^2 = 95.47	s_1^2 = 134.25	s_1^2 = 127.60
	s_2^2 = 169.06	s_2^2 = 326.02	s_2^2 = 478.96
	$F(6,5) = 1.77$, $p > .05$	$F(6,5) = 2.43$, $p > .05$	$F(4,4) = 3.75$, $p > .05$
Likert 1	s_1^2 = 3.14	s_1^2 = 1.47	s_1^2 1.84
	s_2^2 = 6.53	s_2^2 = 3.06	s_2^2 = 1.04
	$F(6,5) = 2.08$, $p > .05$	$F(6,5) = 2.08$, $p > .05$	$F(4,4) = 1.77$, $p > .05$
Likert 2	s_1^2 = 7.14	s_1^2 = 1.14	s_1^2 = 2.16
	s_2^2 = 6.29	s_2^2 = 3.35	s_2^2 = 1.04
	$F(6,5) = 1.14$, $p > .05$	$F(6,5) = 2.94$, $p > .05$	$F(4,4) = 2.08$, $p > .05$
RAS	s_1^2 = 316.67	s_1^2 = 251.00	s_1^2 = 379.76
	s_2^2 = 682.86	s_2^2 = 277.55	s_2^2 = 411.84
	$F(6,5) = 2.16$, $p > .05$	$F(6,5) = 1.11$, $p > .05$	$F(4,4) = 1.08$, $p > .05$
ASES	s_1^2 = 227.47	s_1^2 = 310.73	s_1^2 = 222.20
	s_2^2 = 285.82	s_2^2 = 527.43	s_2^2 = 602.44
	$F(6,5) = 1.26$, $p > .05$	$F(6,5) = 1.70$, $p > .05$	$F(4,4) = 2.71$, $p > .05$

$n_1 = 6$

$n_2 = 7$

Appendix N (cont)

Variable	Pre-training	Post-training	Follow up
ASST	$\bar{X}_1$ = 88.83	$\bar{X}_1$ = 101.50	$\bar{X}_1$ = 94.00
	$\bar{X}_2$ = 84.71	$\bar{X}_2$ = 98.71	$\bar{X}_2$ = 103.80
	s = 7.02	s = 9.32	s = 10.82
	$t(11) = .59$, $p > .05$	$t(11) = ,30$, $p > .05$	$t(8) = .91$, $p > .05$
Likert 1	$\bar{X}_1$ = -.17	$\bar{X}_1$ = 2.17	$\bar{X}_1$ = 1.40
	$\bar{X}_2$ = -.57	$\bar{X}_2$ = 1.71	$\bar{X}_2$ = 3.20
	s = 1.34	s = .92	s = .76
	$t(11) = .30$, $p > .05$	$t(11) = .50$, $p > .05$	$t(8) = -2.37$, $p < .05$
Likert 2	$\bar{X}_1$ = -.17	$\bar{X}_1$ = 2.17	$\bar{X}_1$ = .80
	$\bar{X}_2$ = 0.00	$\bar{X}_2$ = 1.29	$\bar{X}_2$ = 2.60
	s = 1.56	s = .92	s = .79
	$t(11) = -.11$, $p > .05$	$t(11) = .96$, $p > .05$	$t(8) = -2.28$, $p > .05$
RAS	$\bar{X}_1$ = -30.00	$\bar{X}_1$ = 3.00	$\bar{X}_1$ = -5.20
	$\bar{X}_2$ = -20.00	$\bar{X}_2$ = 5.86	$\bar{X}_2$ = 18.60
	s = 13.70	s = 9.84	s = 12.36
	$t(11) = .73$, $p > .05$	$t(11) = -.29$, $p > .05$	$t(8) = -1.29$, $p > .05$
ASES	$\bar{X}_1$ = 79.83	$\bar{X}_1$ = 104.17	$\bar{X}_1$ = 97.00
	$\bar{X}_2$ = 90.57	$\bar{X}_2$ = 108.00	$\bar{X}_2$ = 122.60
	s = 9.72	s = 12.49	s = 12.62
	$t(11) = -1.1$, $p > .05$	$t(11) = .31$, $p > .05$	$t(8) = -2.03$, $p > .05$
	$n_1 = 6$		
	$n_2 = 7$		

Appendix O

ANOVA summary tables for self-report measures at Pre-Post

Assertiveness Self-Statement Test

Source	SS	df	MS	F
Rows	5140.31	25	------	
Trtmt/Control	1.92	1	1.92	.01^{NS}
S(Trtmt/Control)	5138.39	24	214.10	
Columns	492.31	1	-----	
Pre-Post	492.31	1	492.31	8.58**
Rows X Columns	2056.69	25	------	
Trtmt/Control X Pre-Post	679.69	1	679.69	11.85**
S(Trtmt/Control X Pre-Po)	1377.00	24	57.38	
Total	7689.31	51		

Likert 1

Source	SS	df	MS	F
Rows	211.30	24	------	
Trtmt/Control	22.92	1	22.92	2.92^{NS}
S(Trtmt/Control)	188.38	24	7.85	
Columns	27.77	1	------	
Pre-Post	27.77	1	27.77	17.57***
Rows X Columns	46.24	25	------	
Trtmt/Control X Pre-Post	8.62	1	8.62	5.50*
S(Trtmt/Control X Pre-Po)	37.62	24	1.58	
Total	285.31	51		

NS = nonsignificant
* = p<.05
** = p<.01
***= p<.001

(Appendix O cont.)

Likert 2

Source	SS	df	MS	F
Rows	190.92	25	-------	
Trtmt/Control	37.23	1	37.23	5.8*
S(Trtmt/Control)	153.69	24	6.4	
Columns	24.92	1	-------	
Pre-Post	24.92	1	24.92	10.30**
Rows X Columns	60.08	25	-------	
Trtmt/Control X Pre-Post	1.93	1	1.93	1.26^{NS}
S(Trtmt/Control X Pre-Po)	58.15	24	2.42	
Total	275.92	51		

Rathus Assertiveness Schedule

Source	SS	df	MS	F
Rows	18769.17	25	-------	
Trtmt/Control	549.25	1	549.25	$.72^{NS}$
S(Trtmt/Control)	18219.92	24	759.16	
Columns	4412.32	1	-------	
Pre-Post	4412.32	1	4412.32	26.24***
Rows X Columns	5533.18	25	-------	
Trtmt/Control X Pre-Post	1496.95	1	1496.95	8.90**
S(Trtmt/Control X Pre-Po)	4036.23	24	168.18	
Total	28714.67	51		

NS = nonsignificant
* = $p < .05$
** = $p < .01$
*** = $p < .001$

(Appendix O cont.)

Adult Self Expression Scale

Source	SS	df	MS	F
Rows	16567.02	25	-------	
Trtmt/Control	26.33	1	26.33	.04^{NS}
S(Trtmt/Control)	16540.69	24	689.20	
Columns	1812.48	1	-------	
Pre-Post	1812.48	1	1812.48	24.42***
Rows X Columns	2843.02	25	-------	
Trtmt/Control X Pre-Post	1062.02	1	1062.02	14.31***
S(Trtmt/Control X Pre-Po)	1780.99	24	74.21	
Total	21222.52	51		

NS = nonsignificant
* = $p<.05$
** = $p<.01$
***= $p<.001$

Appendix P

ANOVA summary tables for self-report measures at Pre-Post-Follow up

Assertiveness Self-Statement Test

Source	SS	df	MS	F
Rows	7113.98	15	-------	
Trtmt/Control	30.01	1	30.01	.06^{NS}
S(Trtmt/Control)	7083.97	14	506.00	
Columns	962.54	2	-------	
Pre-Post-Follow up	962.54	2	481.27	8.90**
Rows X Columns	2245.46	30	-------	
Trtmt/Control X Pre-Post-FU	731.73	2	365.87	6.77**
S(Trtmt/Control X Pre-Post-FU)	1513.73	28	54.06	
Total	10321.98	47		

Likert 1

Source	SS	df	MS	F
Rows	161.00	15	-------	
Trtmt/Control	24.20	1	24.20	2.81^{NS}
S(Trtmt/Control)	120.47	14	8.61	
Columns	39.04	2	-------	
Pre-Post-Follow up	39.04	2	19.52	11.98***
Rows X Columns	59.63	30	-------	
Trtmt/Control X Pre-Post-FU	13.96	2	6.98	4.28*
S(Trtmt/Control X Pre-Post-FU)	45.67	28	1.63	
Total	259.67	47		

NS = nonsignificant
* = $p<.05$
** = $p<.01$
***= $p<.001$

(Appendix P cont.)

Likert 2

Source	SS	df	MS	F
Rows	116.15	15	-------	
Trtmt/Control	26.07	1	26.07	4.05^{NS}
S(Trtmt/Control)	90.08	14	6.43	
Columns	35.54	2	-------	
Pre-Post-Follow up	35.54	2	17.77	11.03***
Rows X Columns	53.79	30	-------	
Trtmt/Control X Pre-Post-FU	8.44	2	4.22	2.62^{NS}
S(Trtmt/Control X Pre-Post-FU)	45.35	28	1.61	
Total	205.48			

Rathus Assertiveness Schedule

Source	SS	df	MS	F
Rows	12578.31	15	-------	
Trtmt/Control	430.90	1	430.90	.50^{NS}
S(Trtmt/Control)	12147.41	14	867.67	
Columns	6981.17	2	-------	
Pre-Post-Follow up	6981.17	2	3490.58	27.88***
Rows X Columns	5747.50	30	-------	
Trtmt/Control X Pre-Post-FU	2242.48	2	1121.24	8.95**
S(Trtmt/Control X Pre-Post-FU)	3505.02	28	125.18	
Total	25306.02	47		

NS = nonsignificant
* = $p<.05$
** = $p<.01$
***= $p<.001$

(Appendix P cont.)

Adult Self Expression Scale

Source	SS	df	MS	F
Rows	13007.25	15	-------	
Trtmt/Control	92.45	1	92.45	.10^{NS}
S(Trtmt/Control)	12914.80	14	922.49	
Columns	3716.79	2	-------	
Pre-Post-Follow up	3716.79	2	1858.40	26.57***
Rows X Columns	3081.88	30	-------	
Trtmt/Control X Pre-Post-FU	1123.61	2	561.81	8.03**
S(Trtmt/Control X Pre-Post-FU)	1958.27	28	69.94	
Total	19805.92			

NS = nonsignificant
* = $p < .05$
** = $p < .01$
*** = $p < .001$

Appendix Q

ANOVA summary tables for role play ratings of Affect and Assertiveness at Post-training

Original Five Items (Pre-training Readministered)

(1) Affect

Source	SS	df	MS	F
Rows	19.14	25	-----	
Trtmt/Control	1.05	1	1.05	1.39^{NS}
S(Trtmt/Control)	18.09	24	.75	
Columns	5.82	1	-----	
Pre-Post	5.82	1	5.82	14.20**
Rows X Columns	11.08	25	-----	
Trtmt/Control X Pre-Post	1.17	1	1.17	2.85^{NS}
S(Trtmt/Control X Pre-Po)	9.91	24	.41	
Total	36.04	51		

(3) Assertiveness

Source	SS	df	MS	F
Rows	17.01	25	-----	
Trtmt/Control	.13	1	.13	.19^{NS}
S(Trtmt/Control)	16.88	24	.70	
Columns	5.56	1	-----	
Pre-Post	5.56	1	5.56	15.44**
Rows X Columns	10.09	25	-----	
Trtmt/Control X Pre-Post	1.55	1	1.55	4.31*
S(Trtmt/Control X Pre-Po)	8.54	24	.36	
Total	33.47	51		

NS = nonsignificant
* = $p<.05$
** = $p<.01$
***= $p<.001$

(Appendix Q cont.)

Novel Five Items

(2) Affect

Source	SS	df	MS	F
Rows	18.87	25	-----	
Trtmt/Control	.41	1	.41	.53^{NS}
S(Trtmt/Control)	18.46	24	.77	
Columns	3.88	1	-----	
Pre-Post	3.88	1	3.88	7.19*
Rows X Columns	13.46	25	-----	
Trtmt/Control X Pre-Post	.48	1	.48	.89^{NS}
S(Trtmt/Control X Pre-Po)	12.98	24	.54	
Total	36.21			

(4) Assertiveness

Source	SS	df	MS	F
Rows	15.93	25	-----	
Trtmt/Control	.04	1	.04	.06^{NS}
S(Trtmt/Control)	15.89	24	.66	
Columns	7.24	1	-----	
Pre-Post	7.24	1	7.24	11.49**
Rows X Columns	16.22	25	-----	
Trtmt/Control X Pre-Post	1.18	1	1.18	1.88^{NS}
S(Trtmt/Control X Pre-Po)	15.04	24	.63	
Total	39.39			

NS = nonsignificant
* = $p < .05$
** = $p < .01$
***= $p < .001$

Appendix R

ANOVA summary tables for role play ratings of Affect and Assertiveness at Follow up

Original Five Items (Pre-training Readministered)

(5) Affect

Source	SS	df	MS	F
Rows	7.30	15	-----	
Trtmt/Control	.05	1	.05	.10^{NS}
S(Trtmt/Control)	7.25	14	.52	
Columns	6.55	2	-----	
Pre-Post-Follow up	6.55	2	3.28	29.82***
Rows X Columns	10.73	30	-----	
Trtmt/Control X Pre-Post-FU	.92	2	.46	1.31^{NS}
S(Trtmt/Control X Pre-Post-FU)	9.81	28	.35	
Total	24.58	47		

(7) Assertiveness

Source	SS	df	MS	F
Rows	10.57	15	-----	
Trtmt/Control	.95	1	.95	1.38^{NS}
S(Trtmt/Control)	9.62	14	.69	
Columns	5.78	2	-----	
Pre-Post-Follow up	5.78	2	2.89	10.70**
Rows X Columns	14.22	30	-----	
Trtmt/Control X Pre-Post-FU	1.16	2	.58	1.23^{NS}
S(Trtmt/Control X Pre-Post-FU)	13.06	28	.47	
Total	30.57	47		

NS = nonsignificant
* = $p<.05$
** = $p<.01$
*** = $p<.001$

(Appendix R cont.)

Novel Five Items (Readministered)

(6) Affect

Source	SS	df	MS	F
Rows	14.37	15	-----	
Trtmt/Control	.16	1	.16	.16^{NS}
S(Trtmt/Control)	14.21	14	1.01	
Columns	2.17	2	-----	
Pre-Post-Follow up	2.17	2	1.08	2.84^{NS}
Rows X Columns	12.64	30	-----	
Trtmt/Control X Pre-Post-FU	1.98	2	.99	2.61^{NS}
S(Trtmt/Control X Pre-Post-FU)	10.66	28	.38	
Total	29.17	47		

(8) Assertiveness

Source	SS	df	MS	F
Rows	12.08	15	-----	
Trtmt/Control	.13	1	.13	.15^{NS}
S(Trtmt/Control)	11.95	14	.85	
Columns	4.45	2	-----	
Pre-Post-Follow up	4.45	2	2.23	7.69**
Rows X Columns	12.38	30	-----	
Trtmt/Control X Pre-Post-FU	4.17	2	2.09	7.19**
S(Trtmt/Control X Pre-Post-FU)	8.21	28	.29	
Total	28.91	47		

NS = nonsignificant
* = $p<.05$
** = $p<.01$
***= $p<.001$

Appendix S

Self Report Measures Correlation
Matrix for the Control Group @
Pre-training, Post training, and Follow up

	Pre-training				
Pre-training	ASST	Likert 1	Likert 2	RAS	ASES
ASST	-				
Likert 1	.08	-			
Likert 2	.64**	.74**	-		
RAS	.38	.33	.60*	-	
ASES	.49*	.33	.59*	.92***	-
Post-training (6 weeks)					
ASST	.79***	.55**	.76***	.50*	.66**
Likert 1	.26	.84***	.76***	.45	.44
Likert 2	.14	.67**	.61*	.37	.40
RAS	.38	.62*	.63*	.83***	.87
ASES	.48*	.45	.72**	.86***	.95***
Follow up (2 months)					
ASST	.73**	.28	.43	.35	.66*
Likert 1	.07	.37	.30	.72**	.63*
Likert 2	.33	-.14	.51	.40	.64*
RAS	.36	.39	.41	.77**	.79**
ASES	.52	.17	.40	.44	.77**

* = $p < .05$
** = $p < .01$
*** = $p < .001$

Appendix S (Cont.)

	Post-training				
Post-training	ASST	Likert 1	Likert 2	RAS	ASES
ASST	-				
Likert 1	.52*	-			
Likert 2	.63*	.79***	-		
RAS	.67**	.69**	.62*	-	
ASES	.73**	.52*	.53*	.85***	-
Follow up (8 weeks)					
ASST	.86***	.81**	.87***	.65*	.89***
Likert 1	.11	.40	.27	.67*	.52
Likert 2	.40	.26	.43	.37	.67*
RAS	.52	.70*	.62*	.81**	.79**
ASES	.73**	.70*	.69*	.84**	.97***

	Follow up				
Follow up					
ASST	-				
Likert 1	.25	-			
Likert 2	.54	.39	-		
RAS	.60*	.87***	.61*	-	
ASES	.87***	.57*	.71**	.81*	-

* = $p < .05$
** = $p < .01$
*** = $p < .001$