CLIENT ANXIETY LEVEL AND THE TREATMENT OF

THE UNASSERTIVE INDIVIDUAL

by

JEREMY DAVID SAFRAN

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Department of _____ Psychology _____

The University of British Columbia
2075 Wesbrook Place
Vancouver, Canada
V6T 1W5

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ABSTRACT

The present investigation was conducted to evaluate the hypo-
thesis that in the context of assertion training, client anxiety will
interact with treatment modality in such a fashion that high anxiety
individuals will benefit more from a cognitively oriented treatment
than traditional skills training procedures, whereas low anxiety
individuals will obtain equivalent therapeutic gain from the two
treatment approaches.

Twenty-eight male and female college undergraduates seeking
assertion training were dichotimized into low and high anxiety cate-
gories on the basis of the discomfort scale of Gambrill and Richey's
Assertion Inventory. Subjects within both categories were then ran-
domly assigned to two treatment conditions: behavioural skills
training (ST), and cognitive behaviour modification (CBM). The ST
condition included components of instruction, modelling, social feed-
back, and behavioural rehearsal. The CBM procedure was derived ori-
ginally from the self-instructional training procedure employed by
Meichenbaum in the treatment of test anxiety. It included components
of didactic presentation, training in the discrimination and systema-
tic observation of self-statements, training in the modification of
maladaptive cognitive processes, and the implementation of cognitive
coping strategies and task-relevant self-statements. Both treatment
conditions were run in a group format and consisted of six, two hour
sessions. All subjects were assessed prior to and after treatment on
self-report and behavioural measures of assertion and anxiety.

Experimental support was obtained for a modified version of the original hypothesis. While high anxiety subjects tended to benefit more from CBM than from ST in the phenomenal realm, this trend was reversed on the behavioural measures where ST was more effective. Results of the study are explained in terms of a theoretical analysis of the nature of anxiety, and implications for future treatment programmes are discussed.

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INTRODUCTION

Historical Review and Critique

Various forms of social anxiety have been recognized and treated clinically since the conception of contemporary psychotherapy (Finichel, 1945). Salter (1949), however, is credited by the current behavioural tradition with pioneering the field of assertion training with his publication of Conditioned Reflex Therapy (1949). It was here that he described the dynamics of and techniques for the clinical management of what he termed the "inhibitory personality", the individual who is characterized by a high level of anxiety and a correlated functional inadequacy in interpersonal situations.

Following Salter, Wolpe reasoned that functional inadequacy of this type is often the consequence of an upbringing by "parents who bound by convention and conformity, transmit stoic and ascetic habits of self-control to their children in the name of breeding, manners, good taste, and refinement." It was maintained that developmental experiences of this sort led to the suppression of inner feelings, a process which "may lead to a continuing inner turmoil, which may produce somatic symptoms and even pathological changes in predisposed organs-psychosomatic illnesses" (Wolpe, 1969).

This inhibitory response was contrasted by Salter with the excitatory response, wherein the individual's feelings are outwardly expressed. The excitatory response was renamed by Wolpe, assertion, a term he felt was more appropriate, since anxiety is also a form of excitation.

He reasoned that the direct, assertive expression of feelings was

a response antagonistic to the anxiety response, and as such would act as a reciprocally inhibiting agent. It was maintained furthermore, that the assertive response itself would be reinforced in an operant fashion as a result of the decrement in anxiety and increase in comfort experienced.

Although forms of assertion training have been employed clinically for the last two decades, systematic, controlled research in the area is a relatively recent development. McFall and Marston (1970), enumerated three primary factors responsible for retarding this development: (1) the complexity of clinical procedures and multiplicity of treatment components obscure an understanding of effective therapeutic components and militate against experimental replication; (2) the target population is heterogeneous; (3) there is difficulty obtaining valid and reliable behavioural measures in the area. While phobia studies yield the opportunity for behavioural avoidance tests, test anxiety presents the opportunity for simulated test taking situations, and the efficacy of speech anxiety treatment can be evaluated through simulated public addresses, it is far more difficult to faithfully replicate the stimulus situations problematic for the unassertive individual in the laboratory.

Despite these problems, in recent years a number of controlled investigations on assertion training have been conducted. In the following pages, a selective review of this research is presented primarily for purposes of highlighting certain salient methodological, assessment, and conceptual issues.

McFall and his colleagues are responsible for establishing a program of research which has done much to lay the groundwork for a systematic approach to assertion training. The research strategy adopted has been termed by them a "constructive strategy", in contrast to Lang's dismantling strategy (Lang, 1969). The decision was made to examine the therapeutic efficacy of therapeutic components in isolation, beginning with what they perceived to be the most basic component, and progressively augmenting it with additional components, while evaluating the extent to which therapeutic efficacy was incremented.

With this in mind, a decision was made in the initial study (McFall & Marston, 1970) to devise an analog procedure to examine the relative efficacy of basic behavioural rehearsal versus behavioural rehearsal with feedback. In the basic behavioural rehearsal condition, subjects responded to prerecorded situations requiring assertive responses. The rehearsal with feedback condition supplemented the first procedure by playing the subject's recorded response back to him.

The two treatment conditions yielded significantly better results than the control and attention placebo conditions for self-report, behavioural, and physiological measures (pulse rate). A follow-up measure, consisting of a persuasive sales pitch delivered over the telephone, demonstrated significantly better performance of the combined treatment groups on only one of a number of criteria rated. Thus the first study in the series tended to support the hypothesis that simple behavioural rehearsal is more effective than no treatment and an insight placebo in improving assertion, but failed to demonstrate that the addition of a feedback component has much incremental value.

In a second study (McFall & Lillesand, 1971), the behavioural rehearsal with feedback package was supplemented with two new components: therapist coaching and symbolic modeling. Two treatment conditions were contrasted with an assessment placebo control on self-report and behavioural measures: (1) covert rehearsal + therapist coaching + symbolic modeling and (2) overt rehearsal + feedback + therapist coaching + symbolic modeling.

Once again a significant difference in efficacy was demonstrated between the two treatment conditions and the control condition, but not between treatment conditions. There was, however, a trend for the covert rehearsal condition to be more effective than the overt modeling condition. This evidence, however, was confounded by the fact that the covert rehearsal omitted the feedback component present in the overt rehearsal condition. The authors reasoned that the overt rehearsal + feedback treatment may actually have had an inhibiting or debilitating effect upon subjects' performance. A telephone follow-up measure once again failed to convincingly demonstrate the superiority of either of the treatment procedures over the control condition.

The next four studies in the series (McFall & Twentyman, 1973) were conducted to clarify and further elaborate on the findings of the first two studies. Semi-automated tapes were once again employed to create standardized analog procedures. Among the findings yielded by this series of studies were: (1) behavioural rehearsal and coaching (therapist instruction) had additive and independent effects upon assertive behaviour; (2) symbolic modeling failed to significantly enhance treatment efficacy over behavioural rehearsal. This was true of both

purely audio modeling and audio-visual modeling. It was also true for

a variety of modeling conditions, including tactful vs. nontactful models,

and modeling with vicarious reinforcement vs. modeling without reinforce-

ment. This failure to demonstrate the value of modeling as a thera-

peutic procedure may be due to a number of factors which will be discussed

subsequently. (3) There was no difference in efficacy between covert

rehearsal and overt rehearsal once the feedback component was eliminated,

thus further substantiating the hypothesis that feedback may have a

detrimental effect upon performance; (4) despite a failure to convincingly

demonstrate transfer of training effects through telephone follow-ups

in the first three studies, some success was achieved through a more

sensitive follow-up measure employed in the fourth study.

Although various authors have spoken about the nonverbal behaviours

associated with assertion (Serber, 1972; Alberts & Emmons, 1974), none

of the studies reviewed to this point have actually paid explicit atten-

tion to the role of these component behaviours in assertion training or

employed them in an assessment context. Eisler, Miller, and Hersen (1973)

attempted to specify empirically in a psychiatric population, what com-

ponent behaviours are associated with assertive behaviour. Subjects were

instructed to role play responses to fourteen standard interpersonal

situations and were rated by trained judges on nine behavioural dimensions

presumed to be associated with assertion. They were also rated for

global overall assertion and dichotomized into low and high assertive

categories on this basis. High assertive subjects were discriminated

from low assertive subjects on seven rated dimensions. These were:

latency of response, loudness, duration of response, compliance, requests

for new behaviour, and affect.

An initial treatment study (Eisler, Hersen, and Miller, 1973) evaluated the effectiveness of a modeling procedure on eight components of assertive behaviour rated from videotaped responses to five interpersonal situations. Subjects in the treatment condition were exposed to videotaped assertive models for four sessions. These subjects were found to improve significantly more than subjects in a practice control condition, and a test-retest control condition on five of the eight dimensions rated: duration of reply, requests for new behaviour, affect, loudness, and overall assertion.

Hersen, Eisler, Johnson, and Pinkston (1973) evaluated the relative efficacy of modeling, instructions, and modeling plus instructions, in increasing assertive behaviour in an unassertive psychiatric population. Subjects were once again videotaped while responding to five standard interpersonal situations, and rated along seven behavioural dimensions: duration of looking, duration of reply, loudness of speech, compliance content, requests for new behaviour, affect, and overall assertiveness. Treatment consisted of four separate trials of responding to the standard interpersonal situations interspersed between the pretest and the posttest. The exact procedure and instructions were varied in accordance with the treatment condition.

In addition to the three treatment conditions, a practice control group was simply instructed "That's o.k., but try to do better next time", for each of the four trials, while a test-retest control group omitted the four trials.

Modeling plus instructions proved significantly more effective than

any other conditions on three of seven rated dimensions, equally effective to instruction alone on one, and equally effective to modeling alone on one. The two remaining dimensions, loudness and compliance, were most significantly affected by instructions alone and modeling alone, respectively.

Eisler, Hersen, Miller, and Blanchard (1975) reasoned that research studies as a rule neglect to consider important variables which affect assertion in real life, and incorporated three such variables as factors in the investigation: kind of assertion (negative or positive), sex of other, and familiarity of other. Employing a psychiatric population and the same basic assessment procedures used in previous studies, they discovered a complex pattern of interactions between these variables and assertion. They concluded that the clinician's treatment programme must be based upon a thorough assessment of the particular pattern of assertion weaknesses and strengths evidenced by clients.

The discrepancy between college and psychiatric patients populations with respect to the value of modeling may be attributable to more than one factor. One possibility is that subjects in a college population are less impaired prior to treatment. The appropriate assertive responses may already be available in the behavioural repetoire, and are readily enough elicited through coaching and established through behavioural rehearsal. If this is the case, the additional information conveyed through modeling procedures may be unnecessary. Evidence suggesting that in college populations cognitive inhibiting factors play a major role in unassertiveness will be discussed subsequently. If, however, modeling possesses disinhibiting properties as well as information

conveying functions (Bandura, 1969), this explanation would appear to be less than adequate.

A second possibility to be considered is the differences in assessment methodologies employed in the studies reviewed. While Eisler and colleagues evaluated changes in various global and component behavioural dimensions, the McFall investigations limited the behavioural assessment specifically to a measure of compliance. No stylistic or paralinguistic factors were considered. A logical examination of the difference between modeling and coaching as techniques for conveying information reveal that a major characteristic of modeling is its potential to convey more information to different sensory modalities simultaneously, relative to simple verbal instructions. Thus while one can to some extent describe the appropriate response content and convey some information about the fashion in which the response should be delivered through verbal instruction, modeling has the advantage of conveying precise information about both content and as many stylistic factors as the observer is capable of attending to and processing at one time. If, however, the only dimension evaluated by the assessment instrument is whether or not the subject complied, any additional information conveyed to the subject is superfluous. In such a case it would not be surprising to find that supplementing verbal instruction with modeling did not appear to improve performance.

The appropriate resolution of an assessment issue as fundamental as this is prerequisite for assertion training research to take a meaningful direction. Although evaluating subject responses exclusively along the dimension of compliance may simplify assessment procedures, the

clinical relevance of studies employing such procedures is questionable.

Development of appropriate behavioural assessment methodology in this context is dependent upon the prior specification in concrete terms of what constitutes assertive behaviour. There is a growing tendency in the literature, recognized by Heimberg, Montgomery, Madsen, and Heimber (1977) to reconceptualize assertive behaviour in terms of socially effective behaviour. Procedures for specifying and assessing socially effective or competent responses have been developed, and are relevant in this context (Goldfried & D'Zurilla, 1969).

A second issue warranting examination is the finding that response feedback apparently has no therapeutic value, and if anything , is detrimental in its effects. This finding has been corroborated by Melnick and Stocker (1977) who found that neither the addition of response recording playback or knowledge of recording proved to be significantly more effective than basic behavioural rehearsal in increasing assertion. An important consideration in interpreting these results is that the relevant studies have been analog in nature. The fact that subjects do not improve performance as a result of listening to audio playback of their own response cannot be extrapolated to infer that clients do not benefit from therapist feedback in a therapeutic context. There are a wealth of factors in a therapeutic situation which may serve to catalyze the effect of feedback procedures. These include therapist empathy, warmth, support, and perahps most important, specific feedback which serves to differentially reinforce appropriate and inappropriate response content. Thus, though admirable in terms of experimental rigour, the ecological validity of the studies in question is

dubious at best.

While the shortcomings inherent in therapy analog studies is certainly not a new revelation for psychologists (Bernstein & Paul, 1971), studies investigating the efficacy of assertion training for college students in a clinical context have been limited in number. This is particularly surprising in light of the current popularity of assertion training groups on college campuses.

Rathus (1972) compared assertion training to attention placebo and assessment control groups in the treatment of female college undergraduates. Exercises in the assertion training group were derived from Salter's "excitatory exercises". Findings were equivocal. Treated subjects demonstrated equivalent knowledge of appropriate response to attention placebo subjects, and significantly greater knowledge than assessment only subjects. Assertive behaviour itself was not evaluated. A second study (Rathus, 1973) incorporated the use of videotaped assertive models into the treatment condition. Subjects in the assertion training group reported significant increases in assertive behaviour, while self-report of non-treated subjects remained unchanged. Inadequate assessment methodology and ambiguous interpretation of results limits the value of these two studies.

Galassi, Galassi, and Litz (1974) evaluated the efficacy of an assertion training group using videotaped modeling and feedback, behavioural rehearsal, and group and therapist feedback. Following treatment subjects reported and demonstrated greater assertive behaviour than attention placebo subjects and maintained these gains at one year follow-up (Galassi, Kosta, & Galassi, 1975).

In general, investigations of assertion training in group settings have been characterized by inadequate assessment methodology, equivocal results, and insufficient specification of treatment procedures. Well structured treatment sessions, with explicit session by session therapist manuals, would provide a compromise between the clinically irrelevant analog study and the inadequately controlled clinical study.

Assertion Training: A Paradigm in Transition

Recently it has been suggested that cognitive behaviour modification techniques (CBM) may be useful in the treatment of unassertive individuals (Lange & Jakubowski, 1976; Schwartz & Gottman, 1976). This suggestion may be seen as reflecting the occurrence of a number of different events.

1. The last decade has witnessed a shift in the behavioural paradigm from a purely behavioural conceptualization of human functioning and change, where cognitive events were considered to lie outside of the domain of an empirical science, to an expanded conceptual framework which has attempted to reintegrate the investigation of cognitive concerns within its corpus. This shift is heralded historically by Homme's now classic paper where he coined the term coverants to refer to cognitive events, "the operants of the mind" (Homme, 1965).

2. A parallel shift is taking place in conception of the etiology of unassertiveness. Although the etiology and treatment dynamics for unassertiveness were originally conceptualized primarily in classical conditioning terms (Salter, 1949; Wolpe, 1969), over the years a number of different hypotheses have been advanced.

Curran (1977) lists the major etiological concepts as: (a) skills deficit, (b) conditioned anxiety, and (c) faulty cognitive evaluative appraisal. The skills deficit hypothesis maintains that the primary basis for unassertiveness lies in the absence of an appropriate behavioural repetoire and that the associated anxiety arises in reaction to this behavioural inadequacy. This behavioural inadequacy may take different forms. An individual may lack information about what constitutes the appropriate content for an assertive response. He may also lack information about stylistic factors which are involved in the delivery of an assertive response. The response may thus be marred by paralinguistic behaviours which are incongruous with an otherwise assertive verbal content (Goldfried & Davison, 1976; Serber, 1972).

The conditioned anxiety hypothesis maintains that social anxiety and resulting inhibition of assertive behaviour arise from the association of previously neutral social cues with the response of anxiety. An important corollary of this position is that anxiety can become a conditioned response to the cue of social interactions, regardless of the adequacy of the individual's behavioural repetoire.

The cognitive evaluative hypothesis states that cognitive evaluative factors are primarily responsible for unassertive behaviour. Various cognitive stylistic factors such as unrealistic expectations from oneself, negative self-evaluations, and insufficient self-reinforcement, result in the production of anxiety and the inhibition of assertive behaviour.

Goldfried and Davison (1976) discuss two additional etiological

factors: (a) unrealistic expectations and (b) moral and ethical concerns. In the first case the individual may have unrealistic expectations about the likely social consequences of assertive behaviour. Anxiety may thus be generated by the inaccurate anticipation of hurt, discomfort, or anger in other persons.

The variable of moral and ethical concerns refers to the individual who is raised to believe that it is wrong to assert oneself and stand up for one's rights in many social situations, and thus experiences anxiety engendered in anticipation of doing so.

3. This broadening in conceptualization of the dynamics of unassertiveness, although partially a function of a more general shift in orientation from a purely behavioural bias towards a more cognitively oriented psychology, may also reflect a shift in target population resulting from the demands of empirical research. Just as the tradition of small animal phobias research evolved partially to expedite the process of experimental evaluation (Bernstein & Paul, 1971), a target population of social anxious undergraduates in many circumstances has come to replace a truly clinical population with problems of greater severity as a subject of experimental concern. It may be that cognitively oriented interventions are more appropriate for the relatively verbal, intelligent college undergraduate for whom the absence of knowledge of appropriate assertive responses is a less important etiological component than it is for the client typically seen in private practice.

Some support for this conjecture is provided by Schwartz and Gottman (1976), who conducted a task analysis of unassertive behaviour in a college sample. They found that although low assertive subjects performed

less adequately than moderate and high assertive subjects in role plays of social situations, they evidenced no differences in heart rate, or knowledge of competent social response. They did, however, report greater self perceived tension, more negative self-statements, and fewer positive self-statements than moderate and high assertive subjects.

4. A fourth factor behind the increasing interest in the application of cognitively oriented techniques to unassertive populations reflects the rise in concern for the issue of generalization and maintenance of therapeutic gains. As previously noted, attempts to demonstrate transfer of training effects for assertion training have been less than impressive (McFall & Marston, 1970; McFall & Lillesand, 1971; McFall & Twnetyman, 1973).

Proponents of cognitively oriented behavioural techniques have repeatedly emphasized the utility of cognitive coping strategies for this purpose (Goldfried, 1973; Goldfried & Trier, 1974; Suinn & Richardson, 1971) and there is a growing body of evidence that interventions of this type promote greater maintenance and generalization than traditional behavioural techniques.

Meichenbaum and Cameron (1974) found that a stress innoculation treatment involving components of self-instructional training and relaxation training produced greater generalization of fear reduction in multiphobic patients to nondesensitized stimuli than did traditional desensitization. Glass, Gottman, and Shmurak (1976) evaluated the relative efficacy of self-statement modification versus coaching and rehearsal in the treatment of minimal dating males. They found that the cognitive technique produced greater transfer of training effects to untrained

role-playing situations than did the coaching and rehearsal.

Although failure to demonstrate transfer of training effects for

assertion training may result partially from assessment problems (i.e.,

designing meaningful and sensitive transfer of training measures),

concern for this issue is well warranted, especially considering the

evidence that deficits in assertive behaviour are situation specific

in nature (Eisler, Hersen, Miller, & Blanchard, 1975).

Cognitive Behaviour Modification

The last decade has witnessed an increasing acceptance of cogni-

tively oriented techniques by behaviour therapists. The impact of this

trend was well recognized in the first published issue of Behaviour

Therapy which contained three separate theoretical articles by Beck,

Ulman, and Bergin, all attempting to integrate this trend with the

behavioural tradition. In evaluation of the significance of this shift

Bergin stated:

> In general the descriptions of techniques, the
> theoretical interpretations of pathology, and the
> rationale for therapeutic procedures look pro-
> mising and interesting; however, considerably more
> substance must be provided before the message is
> persuasive.
> (Bergin, 1970).

Since that time a profusion of articles have been published outlining

and evaluating cognitively oriented therapeutic procedures for the

treatment of a variety of clinical problems. The two therapies which

have received the most experimental attention are rational emotive

therapy and self-instructional training.

The development of Ellis' rational emotive therapy (RET) historically

preceded the incorporation of cognitive concerns within the behavioural
tradition, and it has influenced the subsequent development of other
cognitive techniques. Ellis' central thesis is that people in the
final analysis become psychologically and emotionally disturbed not be-
cause of events occurring in their environment, but rather because of
the fashion in which they perceive them. The focus of RET then is upon
maladaptive cognitions. Ellis maintains that human beings have an in-
nate propensity to cognize in "irrational" terms which precipitate un-
happiness and psychological maladaptiveness. The function of the rational
emotive therapist is to educate the client to think in a more rational
fashion. This is accomplished by teaching him to recognize the irra-
tional beliefs which lie at the basis of his problem and to replace them
with more rational beliefs.

Ellis describes a number of commonly held irrational beliefs.
These include such premises as, "the idea that it is a dire necessity
for an adult to be loved by everyone for everything he does", and "the
idea that one should be thoroughly competent, intelligent, and achieving
in all possible respects". The approach is characterized by a rather
forceful attempt to convince the client that maladaptive emotions do
indeed arise from irrational premises, but as Meichenbaum (1976) notes,
we must distinguish here between essential components of this therapeutic
technique, and Ellis' own characteristic style.

Goldfried (Goldfried, Decenteceo, & Weinberg, 1974) has attempted
to conceptualize RET in terms of learning principles and to modify
some of the implementation procedures to render it more clinically viable.
Systematic Rational restructuring is conceptualized as a self-control

technique, "whereby anxiety provides the individual with the signal to
rationally reevaluate the reason for the upset" (Goldfried et al., 1974).
Dollard and Miller's (1950) conception of cue-producing responses is
invoked as a learning theory basis for Ellis' basic notion that emotional
responses result from a cognitive labelling of the situation, rather
than the situation itself. Goldfried deemphasizes the confrontative
nature of Ellis' approach and outlines procedures for evolving a common
conceptual framework with the client. Ellis' focus upon the rational
analysis of maladaptive beliefs is, however, retained and the presenta-
tion and subsequent discrediting of common unreasonable assumptions forms
an integral component of the therapy. It is to be noted, however, that
Goldfried advocates having the client generate his own arguments about
the unreasonableness of these assumptions in order to facilitate atti-
tide change. Rational reevaluation is taught to clients as an active
coping skill for dealing with anxiety.

The most extensively research variation within the general class
of cognitive restructuring techniques is Meichenbaum's self-instructional
training. Meichenbaum first became interested in the role of self-
instructions in cognition, following his observation that schizophrenics
could be trained to modify their behaviour by engaging in overt self-
statements modelled on cognitions verbalized by the experimenter
(Meichenbaum, 1976).

On a theoretical level, self-instructional training has been linked
to the work of Luria, who suggested the existence of three stages in
the development of internalized self control of behaviour. Initially,
a child's actions are controlled by the verbal instructions of external

agents. In the next developmental stage the child begins to control

his own performance by overtly verbalizing some of these instructions.

The final stage is one of internalization of self-instructions (Luria,

1964).

Self-instructions are thus seen as serving a guiding self-control

function. They are conceptualized as a form of internal dialogue which

typically operates at an automatic symbolic level to direct attention,

perception, and finally behaviour. More recently, Meichenbaum arti-

culated a three stage cognitive-behavioural system consisting of cog-

nitive structures, inner dialogue, and behaviour. The cognitive struc-

ture is considered to be a central executive processor which organizes

and determines the patterns of thought in which the individual engages.

The internal dialogue may in a sense be seen as arising in interaction

between cognitive structures and behaviours. The individual evaluates

environmental events and his own behaviours in context of existing

cognitive structures. This evaluation and resulting emotions and self

instructions appear to be what constitute the inner dialogue.

According to Meichenbaum if therapeutic change is to occur, the

central cognitive structure must inevitably be modified. This change,

he maintains, may be initiated at the level of either the cognitive

structure itself, the self-statements, or the behavioural level

(Meichenbaum, 1977). He suggests that a major distinction between RET

and self-instructional training is that RET focuses on the first level,

while self-instructional training focuses on the second.

A logical scrutiny of actual implementation procedures reveals a

strong parallel between the two. Both strategies focus upon the analysis

and alteration of dysfunctional thought patterns; both employ didactic instructions, graduated performance tasks, and modeling of appropriate covert processes. The primary difference appears to be one of focus. Whereas Ellis attempts to alter cognitions directly through rational confrontation, Meichenbaum provides the client with an alternative conceptual framework and a technique he can employ to modify his own cognitions (i.e., self-instructing in the appropriate fashion).

Subjects treated with therapies incorporating principles of RET and/or self-instructional training have consistently reported significantly less subjective anxiety than no treatment controls. This has been demonstrated in the treatment of speech anxiety (Karst & Trexler, 1970; Trexler & Karst, 1972; Meichenbaum, Gilmore, & Fedoravicius, 1971), test anxiety (Meichenbuam, 1973; Holroyd, 1976), and phobias (Meichenbaum & Cameron, 1974; Williamson & Brender, 1973; Weir, Nelson, & Odam, 1975).

Evidence of improvement in the behavioural realm has been less consistent. Thus, Meichenbaum (1971) and Karst and Trexler (1972) have demonstrated behavioural improvement in speech anxious clients. A study by Karst and Trexler (1970) failed in this respect.

Meichenbaum (1972) and Holroyd (1976) have both demonstrated improvement of grade point average in test anxious subjects treated with self-instructional training. Sarason (1973), using a modeling self-instructional approach, improved performance of high test anxious individuals on anagrams. These successes are congruent with the wealth of evidence implicating attentional factors and cognitive styles in test anxiety (Wine, 1970).

Findings regarding the reduction of avoidance behaviour in phobic

subjects have once again been mixed. Cognitive coping strategies involving the anticipation of the relevant stressor have been found to decrease avoidance behaviour in snake phobics (Williamson & Brender, 1973).

A cognitive restructuring strategy focusing exclusively on the reconceptualization of the problem behaviour in nonanxiety producing terms has been demonstrated to reduce avoidance behaviour in snake phobics (Weir, Nelson, & Odam, 1975), but not in individuals who are phobic of dead animals (D'Zurilla, Wilson, & Nelson, 1973). This discrepancy may be accounted for by the difference in clinical severity and degree of circumscription of the two phobia types. Meichenbaum's multi-component stress innoculation package involving components of self-instructional training, relaxation training, and graded behavioural assignments, successfully reduced avoidance behaviour in subjects phobic of rats and snakes. The success of this programme relative to the simplified cognitive restructuring procedure previously mentioned provides some evidence for the therapeutic utility of a more comprehensive coping skills oriented treatment (Goldfried, 1971).

Evidence for the efficacy of cognitive interventions on a physiological level is more limited. Trexler and Karst (1972) found no significant changes in finger sweat print indices of anxiety after RET, and Weir, Nelson, and Odam (1975) failed to demonstrate changes in heart rate in clients undergoing cognitive restructuring. Schwartz and Gottman (1976) found that heart rate did not differentiate between assertive and unassertive individuals, despite the fact that unassertive individuals perceived themselves as more tense than their assertive counterparts.

A number of studies have yielded favourable information on the
efficacy of cognitive interventions when the effects of therapeutic
non-specifics are controlled for. Holroyd (1976) has demonstrated self-
instructional training with test anxious subjects to be significantly
more effective than group mediation attention placebo control and a sys-
tematic desensitization group on self-report and behavioural measures.
Therapeutic gains were maintained at a one month follow-up.

Speech anxious subjects receiving self-instructional training have
evidenced greater improvement on self report and behavioural measures
than attention placebo subjects discussing neutral subjects, in both
self-report and behavioural realms at post assessment and a three month
follow-up (Meichenbaum, Glimore, & Fedoravicius, 1971).

Trexler and Karst (1972) report equivalent improvement from RET and
relaxation procedures with speech anxious clients.

In the treatment of phobics, Meichenbaum and Cameron
(1974) has found that multiphobic clients receiving stress innoculation
show greater benefit than clients receiving systematic desensitization
on self-report and behavioural measures. In addition they experience
greater generalization of treatment to nondesensitized phobic stimuli

Cognitive Behaviour Modification and Assertion Training

Two recent studies have specifically evaluated CBM procedures in
the treatment of unassertive individuals with encouraging results.
Wolfe and Fodor (1977) evaluated the relative efficacy of traditional
assertion skills training, skills training with rational emotive therapy,

and consciousness raising procedures in the treatment of unassertive women. While both skills training and skills training with rational emotive therapy conditions proved superior to consciousness raising and a no treatment control on behavioural measures of assertion, there were no significant differences between the first two conditions in this respect. Supplementing basic skills training with an RET component did however decrease self-report of anxiety during role playing situations. No treatment effects were found on self-reported assertion or on self-reported social anxiety.

Alden, Safran, and Weideman (1977) compared a CBM intervention combining components of both self-instructional training and rational emotive therapy to a more traditional skills training approach in the treatment of unassertive male and female college undergraduates. They found both treatments to be approximately equivalent in potency and significantly more effective than a no contact control group on self-report measures of anxiety, assertion, and irrational beliefs, and behavioural ratings of assertion, aggression, anxiety, and various component behaviours.

It is interesting to note that both of these studies failed to find significant differences between the two treatment approaches in many respects. While caution in   interpretation of results is warranted in the second study because of the omission of an attention placebo control, the first study did demonstrate therapeutic superiority for both cognitive and behavioural interventions over a consciousness raising group. One hypothesis advanced to explain this apparent therapeutic equivalence (Alden et al., 1977) is that both procedures produce therapeutic change

through the same effective mechanism.

Bandura's theory of self-efficacy, for example, specifies that therapeutic interventions which appear to be different in implementation may nevertheless facilitate change through a unitary mechanism which involves strengthening perceptions of personal effectiveness (Bandura, 1977). In the two studies cited, it may be the case that clients in both behavioural and cognitive treatment conditions were provided with coping skills (overt behavioural in one case and covert cognitive strategies in the second) to employ in social situations where they had previously seen themselves as inadequate or powerless).

A second and compatible hypothesis derives from Mandler's theory of anxiety (Mandler, 1966). He specifies that the subjective feeling of anxiety arises from the experience of helplessness and cognitive disorganization precipitated by the interruption of an organized response sequence. When the individual has a cognitive schema for anticipating the anxiety provoking situation and a plan of action for dealing with it, the response sequence remains uninterrupted, and the plan is carried through to completion. The individual can thus engage in purposeful behaviour and the experience of helplessness and anxiety is avoided. In the same vein, Meichenbaum contends that the coping strategies employed in stress innoculation training enable the individual to convert the experience of learned helplessness to one of learned helpfulness (Meichenabum, 1974).

In the assertion training context, it is thus possible that both skills training and CBM procedures provide the individual with coping strategies which allow the response sequence to be completed.

Another potential element responsible for these findings of thera-
peutic equivalence is the possibility that cognitive and behavioural
treatments were differentially effective for certain individuals and not
for others, and that these differences were obscured by the utilization
of aggregate data in the analyses. In other words, real and clinically
important differences between interventions may be disguised by the
imposition of a uniformity myth on the population of unassertive clients
(Colby, 1964; Keisler, 1966).

Anxiety Level as a Moderator Variable

To summarize some of the major points in the preceding pages:

1. Although assertion training techniques have been employed clinically

    for the last two decades, it is only within the last six or seven

    years that the field has been subjected to rigourous experimental

    evaluation.

2. While evidence for the effectiveness of assertion training has been

    accumulated, much of this evidence comes from analog studies, with

    limited clinical relevance.

3. Experimental progress will be facilitated by the development of

    meaningful assessment procedures and the employment of clearly

    specified treatment techniques in clinical studies.

4. For a variety of reasons, the treatment of unassertive individuals

    with cognitive behavioural modification techniques is becoming

    popular.

5. Preliminary evidence exists that cognitive techniques are effective

    in the treatment of unassertive individuals.

6. While there is some evidence that the supplementing skills training
   procedures with rational emotive therapy decreases situational
   anxiety (Wolfe & Fodor, 1977), no clear pattern of differential
   efficacy between the two procedures has emerged.

7. Some hypotheses have been advanced as to the mechanisms through
   which both cognitive and skills training procedures function in the
   treatment of unassertive individuals, but the precise nature of
   these "effective components" has not been clarified empirically.

There is a growing awareness among researchers (Keisler, 1966;
Strupp, 1968) that global research questions such as "Is systematic
desensitization effective?", or "Is cognitive restructuring useful?"
have been relatively unproductive from the standpoint of both the re-
searcher and the clinician. Research questions of this sort are subject
to the "uniformity myth" originally labelled by Colby (1964), that
"patients at the start of treatment are more alike than they are dif-
ferent". This mistaken assumption of client population homogeneity is
the same fallacy which retarded research on schizophrenia until the
strategy was adopted of searching for schizophrenic subcategories which
were homogeneous with respect to important characteristics (Herron, 1962).

The suggested strategy of grouping clients with respect to charac-
teristics presumed to be of importance has direct relevance to both the
research and the clinician. The clinician requires information regarding
what specific techniques to employ with clients of different characteristics,
or as Paul (1967) has articulated: "What treatment by whom is most
effective for this individual with what specific problem and under what
set of circumstances?"

For the researcher, a failure to incorporate the awareness of client heterogeneity with respect to important characteristics into the experimental design can result in either misleading conclusions or the more innocuous situation where results are simply not illuminating.

There are both theoretical and empirical grounds to implicate anxiety level as a potential moderator variable in the treatment of the unassertive individual.

On a theoretical level, Lazarus and Averhill (1972) distinguish between fright and anxiety reactions. Fright emotions are relatively stimulus bound. In instrumental fear, a threat is perceived and so is the possibility of normal problem solving behaviour.

It can, however, be easily transformed into anxiety as the situation increases in complexity or becomes more immediate or less manageable. The experience of anxiety is characterized by a cognitive disorganization, an inability to construe the situation in meaningful and task relevant terms. Fright reactions, they contend, might well be reduced through desensitization or habituation. But as the degree of anxiety increases, reflecting a greater degree of cognitive disorganization, a more cognitively oriented cognitive reconstructive approach may be required. Thus it can be extrapolated that to the extent that a traditional skills training approach lacks a cognitive restructuring component, its benefits may be decreased with high anxiety clients.

Gambrill and Richey (1975) have marshalled evidence that in fact the dynamics of unassertive behaviour are not unitary in nature, and that unassertive clients are heterogeneous with respect to subjectively experienced anxiety level in interpersonal situations.

They report that subjects, on the basis of a self-report inventory where ratings were obtained for both degree of discomfort and response probability for a given assertive behaviour, fell into three distinct categories.

Some respondents consistently reported high discomfort ratings coupled with low probability of response ratings. These subjects were seen by them as constituting the population we normally conceived of as unassertive.

A second subcategory of subjects tended to report low ratings of discomfort in conjunction with high ratings of response probability. This constitutes the population we would normally consider assertive. A third category of subjects consistently reported high level of discomfort together with high probability of performance. These individuals are labelled anxious-performers.

Gambrill and Richey argue that the existence of these subcategories may have differential treatment implications. While traditional skills training approaches may be more effective for the high anxiety-low probability of performance category, it may well be the case that the anxious-performers may be more amenable to an approach focusing upon modification of coverants or mental operations rather than focusing upon the specific verbal and nonverbal components of assertion.

A fourth category of clients might conceivably exist who are characterized by low anxiety level, paired with low probability of assertive response. In a population of this sort it may well be that any attempt to deal with inhibitory mental processes is superfluous and that a specific behavioural skills training approach is most appropriate.

More evidence regarding the heterogeneity of unassertive individuals is provided by Alden and Safran (1977), who demonstrated that even within a sample of college undergraduates seeking help for assertion problems, the degree to which cognitive factors played a role was variable.

There is also some preliminary evidence on a treatment level to suggest that client anxiety level has therapeutic implications.

Pechacek (Meichenbaum, 1976),employing a CBM procedure (with components of relaxation, image rehearsal, and modification of self talk) in the treatment of smokers found an interaction between the treatment and client's initial level of anxiety.

Casas (1975) compared the efficacy of Goldfried's rational restructuring technique (1974) versus self-control desensitization in the treatment of speech anxious clients and found that the CBM technique led to minimal changes. A post hoc analysis, however, indicated that subjects who were high on anxiety level were the greatest beneficiaries of rational restructuring procedures. Similarly, Meichenbaum (1971) in his study of self-instructional training for speech anxiety, noted a relationship between anxiety level and efficacy of treatment.

Sarason (1973) divided one hundred and twenty female students into high and low anxiety groups on the basis of his Test Anxiety Scale (TAS). Subjects in both categories were randomly assigned to three conditions. In the performance only condition, the experimenter solved three problem anagrams while subjects watched. The experimenter in the performance-verbalization condition verbalized about his responses while solving the anagram (e.g., "I'll move the A in front of the N", "Maybe L will give me a start"). In the performance-verbalization-principles condition

the experimenter supplemented the manipulation of the letters with ver-
balizations of general problem solving principles employed as well as
task facilitative reflections about his performance (e.g., "I want to
be sure not to get stuck on just one approach to the letter combinations",
"At times it looks like a hopeless group of letters, but I'm sure I'll
hit on something").

Sarason found that low TAS subjects outperformed high TAS subjects
in the performance only, and performance-verbalization conditions.
There was, however, a significant anxiety x condition interaction with
high TAS subjects outperforming low TAS subjects in the verbalization of
principles condition.

A study by Sarason (1972) implicates anxiety level as a moderator
variable in an unexpected fashion. An experimental programme to teach
social skills to juvenile delinquents divided the boys into high test
anxious and low test anxious groups. Subjects were then administered
one of two experimental conditions: (a) subjects observed models who
coped effectively with interpersonal problems salient to the boys, and
then rehearsed the observed behaviours; (b) the same procedure was sup-
plemented with videotaping of the models and the boys.

It was found that the group which responded most poorly to treat-
ment was the high test anxious-modeling-videotape group. Subsequent
interviews with the boys indicated that high test anxious boys observing
the videotapes of themselves and the models confirmed their evaluation
of themselves as inadequate and, it might be inferred, this confirmation
of negative self statements inhibited performance.

Studies with socially anxious individuals have shown that they

are more sensitive to social feedback and more likely to perceive neutral feedback as being negative than nonanxious individuals (Smith, 1972; Smith & Sarason, 1975).

Taken together, these findings suggest the possibility that truly anxious clients with faulty cognitive evaluative processes taking the form of a systematic bias towards misperceiving their own behaviours as socially incompetent, may not be able to benefit from the new information obtained from behavioural changes. In other words, the cognitive structures they have developed regarding themselves in interpersonal situations may be resistant to change resulting from behavioural information.

The anxiety experienced results from an existing cognitive schema, in which any behaviours are taken as further confirmation of their own social ineffectiveness. Thus although behavioural interventions may be effective in modifying perception of self-efficacy in some individuals, there may be other individuals who require an intervention directed specifically at modifying the fashion in which information from social situations in construed.

The present study was designed to evaluate the hypothesis that there is a relationship between subjective experience of anxiety prior to treatment and the form of treatment (cognitive or skills training) which is most effective.

More specifically, it was hypothesized that a cognitive treatment strategy would be more effective than a skills training intervention in the treatment of highly anxious unassertive subjects. For the low anxiety subjects it was hypothesized that there would be no significant

differences in efficacy of the two treatments.

No hypotheses were formulated as to the relative efficacy of the two interventions, collapsing across levels of anxiety, or as to the degree of improvement of treated subjects relative to nontreated or minimally treated subjects, since both of these issues have been addressed in previous studies.

The hypotheses were thus exclusively of an interactional nature, and for this reason, assessment only and attention placebo control groups were not included in the study.

METHOD

Thirty-six male and female UBC undergraduates were recruited to participate in an assertion training programme. The programme was advertized through notices posted around the university campus and brief announcements made in classes. Potential subjects were told that the programme was offered for individuals who felt they they had difficulty in interpersonal situations and would like to learn to express their feelings and beliefs more comfortably. They were informed that the group would be offered free of charge in return for their co-operation in the evaluative procedure.

All subjects volunteering participated in an initial assessment procedure to screen out any individuals who were evaluated to be inappropriate for the research-treatment programme, either because of psychological instability or absence of characteristics which would make them appropriate candidates for assertion training.

A total of six subjects dropped out during the interval between the initial recruitment and the final post assessment. Four of these left prior to the commencement of the treatment programme because of scheduling conflicts and two dropped out after the commencement of treatment. (One of these sustained a back injury, while the other found that his schedule was busier than he had originally anticipated.)

Treatment Conditions

There were two treatment conditions. Each condition involved a total of six two hour sessions, and was held at weekly intervals.

Skills Training (ST). Subjects in this condition were taught verbal

and nonverbal behaviours believed to be important in assertion. It was

a structured treatment programme involving components of instruction,

modeling, social feedback, and behavioural rehearsal. Therapists were

provided with a manual which specified the procedure to be followed on

a session by session basis.

The first session began with a general introduction and orientation

to assertion training. It was emphasized that people are not born

assertive or unassertive and that assertive behaviour is a skill which

can be learned like any other skill. Following the orientation, clients

took turns discussing the problems which had brought them to the group.

They were then instructed to monitor problematic situations over the

next week and the session was adjourned.

The next four sessions were broken down into two portions. In

the first portion clients were taught stock responses to assertion situ-

ations and nonverbal behaviours associated with assertion (Lange &

Jakubowski, 1976; Serber, 1972). These techniques and nonverbal behaviours

were described and modelled by the therapists and clients were then

instructed to rehearse these skills. Feedback on performance was pro-

vided by both the therapists and the other clients. (Principles under-

lying the various techniques were explained to the clients, in the hope

that these skills would in time generalize and that the assertive

behaviour would not be confined to a simple reproduction of stock res-

ponses.)

The second portion of the sessions provided the clients with an

opportunity to rehearse alternative responses to social situations which

they had found problematic between sessions. Modeling, coaching, and feedback procedures were employed in this context as well.

In the sixth and final session, the skills and principles learned in the preceding sessions were summarized and clients were then asked to specify areas in which they felt they had improved, as well as areas which they felt warranted attention in the future.

Throughout the programme, the importance of practicing the skills between sessions was emphasized.

Cognitive Behaviour Modification (CBM). The roots of this treatment procedure were derived from the therapist manual employed by Meichenbaum in the treatment of test anxious college students (Meichenbaum, 1972). It involved components of didactic presentation, training in the discrimination and systematic observation of self-statements, training in the modification of maladaptive coverants, and the implementation of coping strategies and task-relevant self-statements. A session by session manual similar in form to that employed in the skills training condition was provided for the therapists.

The first session commenced with a general introduction and orientation to assertion training. Here it was emphasized that all individuals know how to behave assertively in social situations, but that the anxiety produced by maladaptive cognitions inhibits assertive behaviour. Following the didactic presentation and orienting rationale, clients were asked to speak about the particular problems which had prompted them to join the group. They were then asked to monitor problematic assertion situations between meetings and the session was adjourned.

During the next four sessions, clients were taught to become more

aware of the subjective feelings and cognitions experiences during prob-

lematic situations. Emphasis was placed upon employing subjective ex-

periences of anxiety and physiological symptoms associated with anxiety,

such as increased breathing and heart rate, and increased perspiration,

as cues that maladaptive cognitions or negative self-statements were

occurring. Once they were able to identify their own negative self-

statements, clients were taught to replace them with more adaptive self-

statements.

A standard procedure was modelled and rehearsed, whereby the sub-

jective experience of discomfort would cue the utilization of a cogni-

tive coping strategy. This involved:

1. Monitoring the subjective experience of anxiety.

2. Identifying the negative self-statements.

3. Self-instructing not to panic, but rather to breathe slowly, to

   relax, and not to feel compelled to act immediately. Clients were

   encouraged not to feel overwhelmed by problematic situations, but

   rather to think of them as opportunities to employ the coping skills

   they has rehearsed in the therapy sessions.

4. Implementing the adaptive self-statements modelled and rehearsed

   in therapy sessions. These included a number of strategies compiled

   for the programme:

   a. Task relevant. This strategy consisted of focusing upon be-

      havioural alternatives which might potentially be employed to

      deal with the immediate situation, instead of ruminating upon

      possible disasterous repercussions.

   b. Externally oriented. This cognitive strategy involved refocusing

attention from anxiety provoking self-referring ruminations to
the other people in the situation. Clients were trained to
become aware of the extent to which other people are experiencing
discomfort or confusion in a social situation, rather than to
automatically attribute confidence or critical intentions to
them. The underlying principle for the strategy comes from ob-
servations that anxious individuals are characterized by rumi-
native, self-referring critical thought (Wine, 1970) and obser-
vations in pilot work that socially anxious individuals tend to
underestimate their own social skills and to overestimate the
skills of others.

c. Challenging. The challenging strategy involved rationally ex-
amining the negative self-statements to evaluate the extent to
which they are realistic.

d. Positive. Positive self-statements were somewhat similar to
challenging statements, but were distinguished by the instruc-
tion to focus upon the positive characteristics which are possessed
by the individual, and to recall situations where social inter-
actions has been negotiated effectively.

e. Exaggerating negative self-statements. This was presented to
clients as a technique to aid them in seeing the invalidity of
some of the negative self-attributions and catastrophizing
cognitions, by exaggerating the negative self-statements to the
point where they become transparently absurd. It was also em-
ployed as a means of obtaining a greater awareness of maladaptive
cognitions which were not immediately obvious. For example: in

a situation where a client was not able to pinpoint a negative
self-statement when thinking of the situation in retrospect,
the therapist might instruct him: "Even if you're not aware of
a negative self-statement when thinking of the situation in retro-
spect, what is the most negative, anxiety producing thought a
person might be thinking in this situation?"

f. Reinforcing self-statements. Emphasis was placed here on the
importance of covertly rewarding oneself for any therapeutic
gains, no matter how small. The impetus for employing this pro-
cedure stems from the clinical observation that clients often
retard their own progress by failing to notice real, but small,
steps towards their objectives which are taking place. The
result can be a countertherapeutic perception of failure, where
in reality some progress has been made. A second origin of the
procedure is in the observation that depressed and socially
anxious individuals are often characterized by a low frequency
of self-reinforcement (Rehm, 1977).

These six cognitive strategies were presented to the clients as
examples of self-statements they might employ to modify their cognitions
in an adaptive fashion. It was emphasized that the strategy types had
been broken down into categories primarily to facilitate teaching and
recall, and that in fact, at any point in time they could employ one
of the strategies or any combination of them. They were further instructed
to become aware of and to record types of negative self-statements which
were particularly characteristic of them, as well as adaptive self-state-
ments which they found to be particularly effective.

Although various adaptive self-statements were modelled by therapists in the group, clients were encouraged to develop their own self-statements and to express them in words which were meaningful to them.

As in the skills training condition, the importance of practicing newly acquired skills in vivo between sessions was emphasized.

The final session, once again, was primarily devoted to summarizing the key principles which had emerged and to having clients identify progress which had been made, problem areas left to work on, and specific procedures for promoting maintenance and generalization of therapeutic gain.

Subject Assignment

The treatment groups were run in six sections: three ST sections and three CBM sections. This division into sections was designed to optimize the client to therapist ratio, as it was felt that having more than six members to a group would dilute treatment effects. After the initial assessment, subjects were categorized into high and low anxiety groups. The median score (101) on the discomfort scale from the Gambrill and Richey Assertion Inventory provided the criterion for dichotomization. Subjects within each anxiety group were then randomly assigned to either the ST or the CBM treatment condition. Subsequently, subjects within each treatment condition were randomly assigned to one of three sections, subject to the constraint of scheduling problems.

The final sample size after subject attrition was 30.

Therapists

Each section was led by two co-therapists. Therapists were six

psychology graduate students and two psychology honours students with clinical experience ranging from two months to one and one-half years. All therapists participated in a two month training workshop directed by a Ph.D. clinical psychologist. In addition, they were supervised on a session by session basis, using audio recordings of therapy sessions to provide a basis for clinical supervision and to ensure that sessions were proceeding as planned.

The author served as a therapist in one ST section and one CBM section in order to obtain first hand experience of any therapeutic or research-procedural problem encountered in actual therapy sessions, while the Ph.D. level psychologist served as a therapist in one of the CBM sections. An attempt was made to balance therapists between conditions with respect to levels of expertise. Differences in treatment efficacy due to individual therapists were assessed independently.

Assessment

A pre-therapy assessment session was held one to two weeks prior to the commencement of treatment, while post-therapy assessment was conducted one week after treatment had concluded.

Dependent Measures

Behavioural. All subjects role played nine interpersonal situations calling for assertive responses which were based upon items in the Gambrill and Richey Assertion Inventory and the McFall Conflict Resolution Inventory.

As Neitzel, Martorano, and Melnick (1977) have observed, a consistent shortcoming of assertion training programmes is a failure to train

clients to deal with noncompliant responses to their own assertion. A
specific concern in the present study was one of devising an assessment
instrument sensitive enough to differentiate between individuals with
well established assertive behaviour and individuals with response re-
petoires of a more fragile nature. Galassi and Galassi (1976) report
that variations in role playing procedures have important implications
for results obtained and that compliance rate in unassertive subjects
increases markedly when subjected to successive social demands rather
than a single request.

For these reasons, experimenters were instructed to follow subject
responses in each situation with a standard set of responses, prolonging
the interaction until either three assertive responses were obtained or
the subject complied. It was reasoned that an assessment procedure of
this type would provide a better simulation of real social situations
where responses are interactional in nature, rather than discrete.
These interactions were videotaped and subsequently rated by two psycho-
logy graduate students along seven dimensions: eye contact, voice
volume, body expression, anxiety, aggression, compliance, and global
assertion. The two raters participated in a training workshop and were
provided with a rating manual.

Self-report.

a. Fear thermometer. After each role playing situation, subjects were
instructed to rate on a ten point scale, the degree of anxiety
experienced during that interaction.

b. Social Avoidance and Distress Scale. This instrument provides a
single index of distress in social situations (Watson & Friend, 1969).

c. The Assertion Inventory (Gambrill & Richey, 1975). This inventory
includes a self-report index of both response probability and degree
of discomfort for forty assertion situations.

d. Tennessee Self Concept Scale (Fitts, 1965). This instrument has
been standardized on a general population sample of 626 individuals,
and provides a multidimensional assessment of self concept. It in-
cludes a total P score of overall self-esteem, and eight subscales
which were established initially on the basis of face validity of
items of which they are composed. The eight subscores are:
identity, self-satisfaction, behaviour, physical self, moral-ethical
self, personal self, family self, and social self.

e. A group satisfaction questionnaire was administered at post-assess-
ment only. This contained five items relating to perceived warmth,
empathy, and competence of therapists. It was administered to
evaluate the extent to which differential demand characteristics
were operating between conditions, as well as to evaluate the pre-
sence of therapist x treatment interactions.

RESULTS

Descriptive Data

On the Assertion Inventory prior to treatment, the mean score on
discomfort for all subjects combined was 105.25 and the standard devi-
ation was 18.33. The mean score and standard deviation on response
probability were 113.04 and 14.80, respectively. Table 1 provides com-
parisons with the scores of 313 males and females sampled from a Cali-
fornia general college population and a sample of 19 California women
who were assessed prior to participation in a six week assertion training
programme (Gambrill & Richey, 1975). The average subject in the current
study tended to report greater discomfort than his counterpart in the
general sample (95.61) and approximately equivalent discomfort to the
average subject seeking assertion training (107.7). Probability of
assertive response tended to be less than it was for both subjects
from the general college population (104.3) and the average subject
seeking assertion training (104.8).

Table 2 divides the subjects into four categories both prior to
and following assertion training. These were established by Gambrill and
Richey (1975) on the basis of the norms for the general college popula-
tion and are constituted by four different combinations of discomfort
and response probability: (1) high discomfort-low response probability
(labelled unassertive), (2) high discomfort-high response probability
(labelled anxious performer), (3) low discomfort-low response probability
(labelled doesn't care), (4) low discomfort-high response probability
(labelled assertive).

Table 1

Means and Standard Deviations of Discomfort and Response

Probability Scores on the Assertion Inventory

	$\underline{N}$	Mean Discomfort	S.D.	Mean Response Probability[1]	S.D.
Current Sample	28	105.25	18.33	113.04	14.79
General College Sample*	313	95.61	19.93	104.30	15.70
Clinical Sample*	19	107.7	22.37	104.8	22.55

*from Gambrill and Richey (1975)

[1]Response probability is an inverted scale, with 1 indicating high response probability and 5 indicating low response probability.

Table 2

General Clinical Sample (Gambrill & Richey, 1975)

Response Probability

Discomfort	Low (105+)	High (104-)	Totals
High (96+)	unassertive 111 (35%)	anxious-performer 35 (11%)	146 (46%)
Low (95-)	doesn't care 55 (18%)	assertive 112 (36%)	167 (54%)
Totals	166 (53%)	147 (47%)	

Table 2 continued

Comparison of Current Sample and Clinical Sample

(Gambrill & Richey, 1975)

	Before Current Sample			Before Clinical Sample (Gambrill & Richey, 1975)		
	Response Probability			Response Probability		
Discomfort	Low (105+)	High (104-)	Totals	Low (105+)	High (104-)	Totals
High (96+)	18(64%)	3(11%)	21(75%)	9(47%)	5(26%)	14(23%)
Low (95-)	5(18%)	2(7%)	7(25%)	0	5(26%)	5(26%)
Totals	23(82%)	5(18%)		9(47%)	10(53%	
	After			After		
High (96+)	7(25%)	2(7%)	9(32%)	2(11%)	3(16%)	5(27%)
Low (95-)	3(11%)	16(57%)	19(58%)	1(5%)	13(38%)	14(73%)
Totals	10(36%)	18(64%)		3(16%)	16(84%)	

In the present study, prior to treatment, a greater proportion of the subjects (64%) fell into the unassertive category than did in the general sample (35%). Furthermore, they exceeded the proportion of subjects falling into the unassertive category prior to treatment in the clinical sample (47%). After treatment, this proportion was reduced to 25% in the current study and to 11% in the Gambrill and Richey study (an approximately equivalent reduction).

The proportion of subjects falling into the assertive category in the general population was 36%. Prior to treatment, the proportion of subjects falling into this category was 18% in the current study and 53% in the clinical sample. Following treatment, the proportion of subjects in this category was increased to 64% in the current study and 84% in Gambrill and Richey's clinical sample, thus both exceeding the proportion of "assertive" subjects in the general sample.

Prior to treatment, 11% of the current sample were what Gambrill and Richey label "anxious performers." (i.e., high response probability paired with high discomfort). This is equivalent to the proportion of "anxious performers" found in the general population, but less than that found in the clinical sample prior to treatment. The discrepancy here between the two clinical populations may be accounted for by the fact that Gambrill and Richey's clinical sample is composed entirely of women. In this culture, assertive behaviour may traditionally be less acceptable for women than for men and thus associated with more discomfort for females. Following treatment, this proportion was reduced to 7% in the current sample and 16% in the female clinical sample.

Finally, the proportion of subjects prior to treatment in the

"doesn't care" category was 18% in the present study and 0% in Gambrill

and Richey's sample. This compares with 18% found in the general popu-

lation. Following treatment, the proportion was reduced to 11% in the

present study and remained virtually the same, at 1% in Gambrill and

Richey's sample. It is likely that the reduction in this proportion

resulted from an increase in probability of response.

The fact that the proportion of "doesn't care" subjects seeking

treatment in the present study equalled the proportion in the general

population sample is noteworthy. It suggests the possibility that some

subjects sought assertion training as much out of interest's sake than

real discomfort in social situations.

Reliability and Validity of Behavioural Ratings

A randomly selected subset of videotaped situations were rated

independently by both raters to provide the basis for a reliability assess-

ment. Pearson r correlations were computed and reliability coefficients

for the seven behavioural dimensions were: eye contact, $r = .88$; body

expression, $r = .90$; voice volume, $r = .90$; anxiety, $r = .83$; aggression,

$r = .79$; assertion, $r = .93$; and compliance, $r = 1.00$.

The behavioural dimensions employed in the current study were

selected on the basis of empirical findings regarding behaviours associated

with assertion in psychiatric patients (Eisler, Miller, & Hersen, 1973),

as well as from suggestions in the literature regarding appropriate

behavioural targets for assertion training (Alberti & Emmons, 1974;

Bower & Bower, 1976). To date, however, there has been minimal success

in empirically establishing behavioural dimensions which will distinguish

between socially skilled and socially unskilled individuals in a non-psychiatric population (Glasgow & Arkowitz, 1975).

In order to establish the validity of the current behavioural measures, subjects were categorized into low and high assertive groups, on the basis of behavioural ratings of assertion prior to treatment. The median (2.65) was used as a cutting point. These groups were subsequently contrasted, using one-way ANOVAs on the six remaining behavioural measures. The two groups were found to be significantly different on four of the six behavioural measures: compliance, $F(1,26) = 7.87$, $p < .01$; eye contact, $F(1,26) = 26.05$; body expression, $F(1,26) = 20.04$; $p < .001$; and anxiety, $F(1,26) = 22.65$, $p < .001$. Voice volume and aggression did not distinguish between the two groups (see Table 3).

In addition, subjects were divided into high and low anxiety groups on the basis of extreme scores on subjective ratings of discomfort during role playing situations prior to treatment. These two groups were contrasted with one way ANOVAs and were found to be significantly different on the following behavioural measures : eye contact, $F(1,19) = 11.67$, $p < .01$; body expression, $F(1,19) = 6.20$, $p < .05$; anxiety, $F(1,19) = 8.20$, $p < .01$; and assertion, $F(1,19) = 8.44$, $p < .01$. Compliance, voice volume, and aggression failed to distinguish between the two self-report anxiety groups (see Table 4).

Table 5 contains the correlation matrix for the seven behavioural measures. The correlations between global assertion and both voice volume and aggression are conspicuously low (.17 and .30, respectively). In contrast, the correlations of the remaining behavioural measures with

Table 3

Means and Standard Deviations for Low and High Anxiety Behavioural

Assertion Categories on Behavioural Measures

Variable	Low Assertion		High Assertion		
	Mean	S.D.	Mean	S.D.	$\underline{F}$
Assertion	2.06	0.39	3.06	0.34	51.46*****
Compliance	2.47	0.45	2.86	0.25	7.87**
Anxiety	2.11	0.53	2.95	0.38	22.65*****
Aggression	3.29	0.50	3.50	0.43	1.47
Eye Contact	2.14	0.41	2.81	0.26	26.06*****
Body Expression	2.02	0.49	2.78	0.41	20.04*****
Voice Volume	2.53	0.44	2.78	0.35	2.74

*$\underline{p}$ < .05

**$\underline{p}$ < .01

***$\underline{p}$ < .005

****$\underline{p}$ < .001

*****$\underline{p}$ < .0001

Table 4

Means and Standard Deviations for Low and High Self-Perceived

Anxiety During Role Play Categories on Behavioural Measures

Variable	Low Anxiety		High Anxiety		
	Mean	S.D.	Mean	S.D.	F
Assertion	2.95	0.53	2.19	0.66	8.44****
Compliance	2.87	0.22	2.60	0.14	2.67
Anxiety	2.98	0.39	2.23	0.74	8.20**
Aggression	3.47	0.39	3.19	0.57	1.67
Eye Contact	2.81	0.21	2.18	0.55	11.67***
Body Expression	2.77	0.36	2.14	0.73	6.20*
Voice Volume	2.82	0.37	2.66	0.43	0.80

*$p < .05$

**$p < .01$

***$p < .005$

****$p < .001$

*****$p < .0001$

Table 5

Correlation Matrix for Behavioural Measures

	Compliance	Eye Contact	Body Expression	Voice Volume	Anxiety	Aggression	Assertion
Compliance		.59	.44	.18	.53	.16	.63
Eye Contact			.83	.05	.84	.17	.84
Body Expression				.14	.94	.04	.86
Voice Volume					.26	-.27	.17
Anxiety						-.10	.86
Aggression							.30
Assertion							

N = 28

global assertion are quite high (ranging from .63 to .86). Both

voice volume and aggression correlate poorly with the remaining

behavioural measures as well (voice volume ranges from .05 to .26,

while aggression ranged from .04 to .27).

The above analyses provide some support for the construct

validity of the behavioural measures.

The fact that voice volume consistently failed to distinguish

between groups despite its success in this respect with a psychiatric

population (Eisler, Miller, & Hersen, 1973), suggests that its value

as a dependent measure may be limited to a more highly impaired

population.

The importance of distinguishing between assertion and aggres-

sion has been consistently emphasized in the literature (Hollandsworth,

1977; Alberti, 1977). The current investigation,however, has failed

to distinguish between individuals who are rated as low and high

assertives in this respect. This failure may reflect the insensitivity

or inappropriateness of the guidelines employed to evaluate aggression

(Appendix V) in the present study, or the fact that the current sample

was not characterized by much variance in aggressive behaviour. The

observations of group leaders that few group members tended to behave

very aggressively is compatible with the latter hypothesis.

An important qualification in interpretation of the above findings

is that all of the subjects were seeking assertion training and the

resulting distribution of criterion scores employed for categoriza-

tion is consequently skewed towards the unassertive end. It is worth

noting, however, that even within this truncated distribution, the

behavioural measures possessed some discriminating utility.

Nonspecific Factors

During postassessment a five item group satisfaction question-
naire was administered to provide some evaluation for the presence
of differential therapeutic nonspecific factors within cognitive and
skills training groups. Subjects responded to the following questions
on a five point scale, anchored on one end with "not very" and the
other end with "extremely":

1. How skilled were your co-leaders as therapists?

2. How warm do you feel your leaders were towards group members?

3. How understanding were your leaders of group members' problems
   and feelings?

4. How satisfied were you with your group?

5. How likely is it that you will use the techniques you have
   learned?

One way ANOVAs were employed to contrast cognitive and skills
training treatment conditions on the basis of responses to the five
questions. There were no significant differences between the two
treatment conditions on questions 1, 4, and 5. Thus subjects in
cognitive and skills training conditions perceived their therapists
as equally skillful, were equally satisfied with their groups, and
had equal intentions of using the techniques they had learned.

Subjects in skills training groups saw their therapists as
significantly warmer, $F(1,24) = 5.25$, $p < .05$, and more understanding,
$F(1,24) = 5.65$, $p < .05$, than did subjects in the cognitive condition.

Since therapists were not crossed with treatment conditions, it is difficult to evaluate the relative influences on this discrepancy of individual therapist differences versus characteristics inherent in the treatment modalities. The subjective experiences of the group leaders themselves suggested a tendency to feel more comfortable and confident implementing skills training rather than cognitive procedures, which they perceived to be less structured or procedurally less clear-cut. This factor may have resulted in increased confidence and hence increased demonstration of warmth and empathy.

A second possible factor is that the format of the skills training condition provided more opportunity for direct therapist feedback to clients on specific behaviours; whereas the cognitive therapists, for methodological reasons, were not allowed to provide specific behavioural feedback and coaching. It was not uncommon in supervision sessions for therapists to report that a client had appeared to become frustrated when such feedback was not forthcoming.

Table 6 contains the correlation matrix for the five items on the group satisfaction questionnaire. All items are significantly positively correlated with the exception of the final item which correlates significantly with general satisfaction. The item which correlates highest with general satisfaction is perception of therapist competence, while the item which correlates highest with intention to use the techniques is general satisfaction.

Factorial Analysis of Variance

Two subjects were randomly dropped from the high anxiety x skills

Table 6

Correlation Matrix for Group Satisfaction Items

	Therapist Skill	Therapist Warmth	Therapist Understanding	General Satisfaction	Intention to Use Techniques	Total 1	Total 2
Therapist Skill		.58	.34	.54	.19	.66	.78
Therapist Warmth			.73	.38	.00	.48	.81
Therapist Understanding				.33	.04	.54	.73
General Satisfaction					.35	.73	.79
Intention to Use Techniques						.54	.22
Total 1							.80
Total 2							

Total 1 = total score with question 5 included

Total 2 = total score with question 5 excluded

55

training treatment condition prior to analysis in order to approach proportionality of cells for factorial ANOVA (Weiner, 1970). The final $\underline{N}$ was thus 28, with an $\underline{n}$ of 7 subjects per cell. Adequacy of initial random assignment of subjects was assessed via 2 x 2 (treatment x anxiety) ANOVAs on the pre assessment scores. These analyses revealed that prior to treatment there were no significant main effects for treatment condition, and no significant treatment condition x anxiety level interactions.

Since adequacy of initial random assignment had been confirmed statistically, all subsequent analyses were conducted on post assessment scores, once again employing 2 x 2 AVOVAs.

Analysis of Post Scores

a. Self-report measures. There were no significant main effects for treatment conditions on any of the self-report measures. Treatment x anxiety interactions approached significance on self concept, $\underline{F}(1,24) = 3.12$, $\underline{p} < .10$.

b. Behavioural measures. None of the behavioural dimensions rates yielded significant treatment main effects. The treatment x anxiety interaction was significant for body expression, $\underline{F}(1,24) = 4.03$, $\underline{p} < .05$, and approached significance for global anxiety, $\underline{F}(1,24) = 3.21$, $\underline{p} < .10$.

Analysis of Simple Effects (Statistical)

Since a priori hypotheses were formulated as to the nature of the interactions, analyses of simple effects on post assessment scores were conducted via a series of two-tailed planned orthogonal contrasts

between cognitive and skills training treatment conditions for (1) low anxiety subjects and (2) high anxiety subjects (see Table 7).

1.   There were no significant differences for low anxiety subjects between the two treatment conditions on any of the dependent measures.

2.   For high anxiety subjects, the following pattern of results was found.

a.   Self-report measures.   Superior efficacy of cognitive over skills training interventions approached significance on the following self-report measures: Social Avoidance and Distress, $t(24) = 1.86$, $p < .10$, and Tennessee Self Concept total score, $t(24) = 1.84$, $p < .10$.

b.   Behavioural measures.   On three of the seven behavioural measures employed, high anxiety subjects benefitted more from the skills training procedure than the cognitive procedure.   This difference was significant for global anxiety, $t(24) = 2.26$, $p < .05$, body expression, $t(24) = 2.74$, $p < .01$, and approached significance for eye contact, $t(24) = 2.14$, $p < .10$.

Analysis of Simple Effects (Graphic)

Due to the constraints of orthogonality imposed by the planned contrasts procedure, statistical comparison of cell means was limited to two contrasts: low anxiety-skills versus low anxiety-cognitive and high anxiety-skills versus high anxiety-cognitive.   This set of contrasts was considered to be most directly relevant to the original hypothesis.   Further clarification of the nature of the interactions, however, can be obtained by visual inspection of the graphed interactions.

Table 7

Planned Orthogonal Contrasts

| | Low Anxiety | | | | | High Anxiety | | | | |
| | Skills | | Cognitive | | | Skills | | Cognitive | | |
Variable	M	SD	M	SD	t	M	SD	M	SD	t
Self-Report										
Gambrill										
Discomfort	69.71	11.76	82.14	18.83	1.33	102.00	22.44	92.57	14.79	1.01
Frequency	84.14	20.55	92.57	15.05	.96	108.14	12.74	101.86	15.77	.72
Fear Thermometer	34.86	10.49	37.86	10.25	.53	34.57	8.16	43.57	13.07	1.58
Social Anxiety	8.86	9.62	6.57	3.78	.65	12.57	7.28	6.00	3.79	1.86*
Self Concept	351.14	22.95	341.71	33.73	.66	319.71	30.85	346.14	16.43	1.84*
Global Behaviour Ratings										
Compliance	2.79	.29	2.83	.37	.22	2.86	.38	2.69	.41	.87
Assertion	2.86	.66	2.84	.58	.04	3.16	.43	2.66	.77	1.50
Aggression	3.73	.27	3.56	.42	.66	3.76	.35	3.43	.77	1.26
Anxiety	2.86	.61	2.93	.43	.27	3.16	.46	2.58	.42	2.26**

Table 7 continued

| | Low Anxiety | | | | | High Anxiety | | | | |
| | Skills | | Cognitive | | | Skills | | Cognitive | | |
Variable	M	SD	M	SD	t	M	SD	M	SD	t
Component Behaviour Ratings										
Eye Contact	2.50	.48	2.69	.71	.57	2.93	.10	2.57	.43	2.14*
Body Expression	2.56	.66	2.59	.43	.10	3.09	.43	2.33	.52	2.74***
Voice Volume	2.21	.55	2.61	.47	1.46	2.81	.38	2.87	.27	.33

*p < .10

**p < .05

***p < .01

On the self-report measures: Social Anxiety and Distress, and Self Concept, self-report remains approximately constant in the cognitive condition across both levels of anxiety. In the skills condition, however, high anxiety subjects tend to report greater discomfort associated with assertion, greater social anxiety, and lower self concept than low anxiety subjects (see Figure 1).

Inspection of Figure 2 reveals a different interaction pattern for the behavioural measures. On measures of eye contact, the superior efficacy of skills training for high anxiety subjects cannot be attributed to decreased performance in cognitive subjects, since eye contact in this treatment condition remains constant across both levels of anxiety. The contributing factor here is an actual improvement in performance of skills training subjects when anxiety level is high. Similarly on both body expression and global anxiety, although low anxiety subjects do tend to benefit more than high anxiety subjects from the cognitive treatment, a major contributor to the interaction is this same increment in performance of skills training subjects when anxiety level is high.
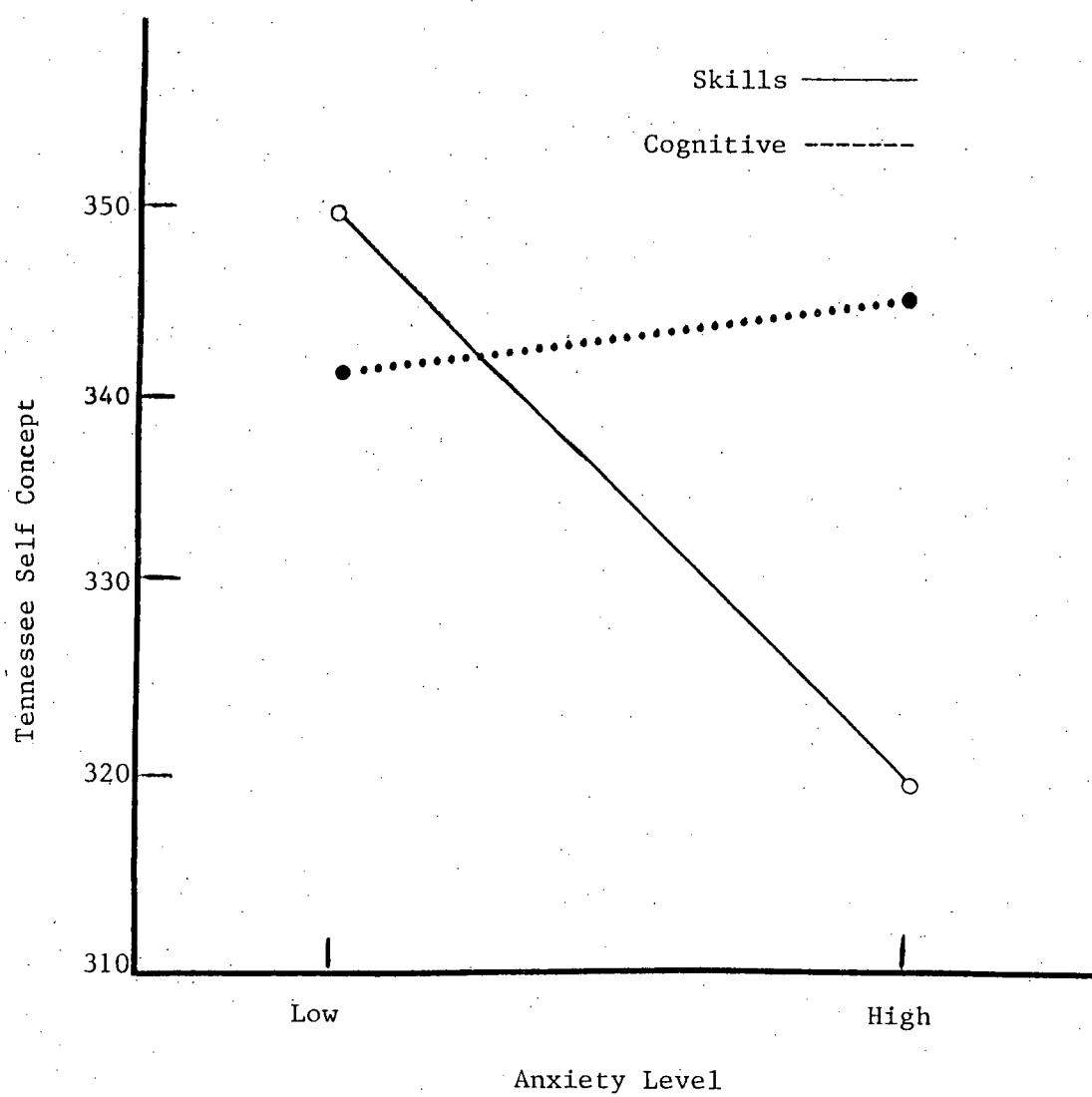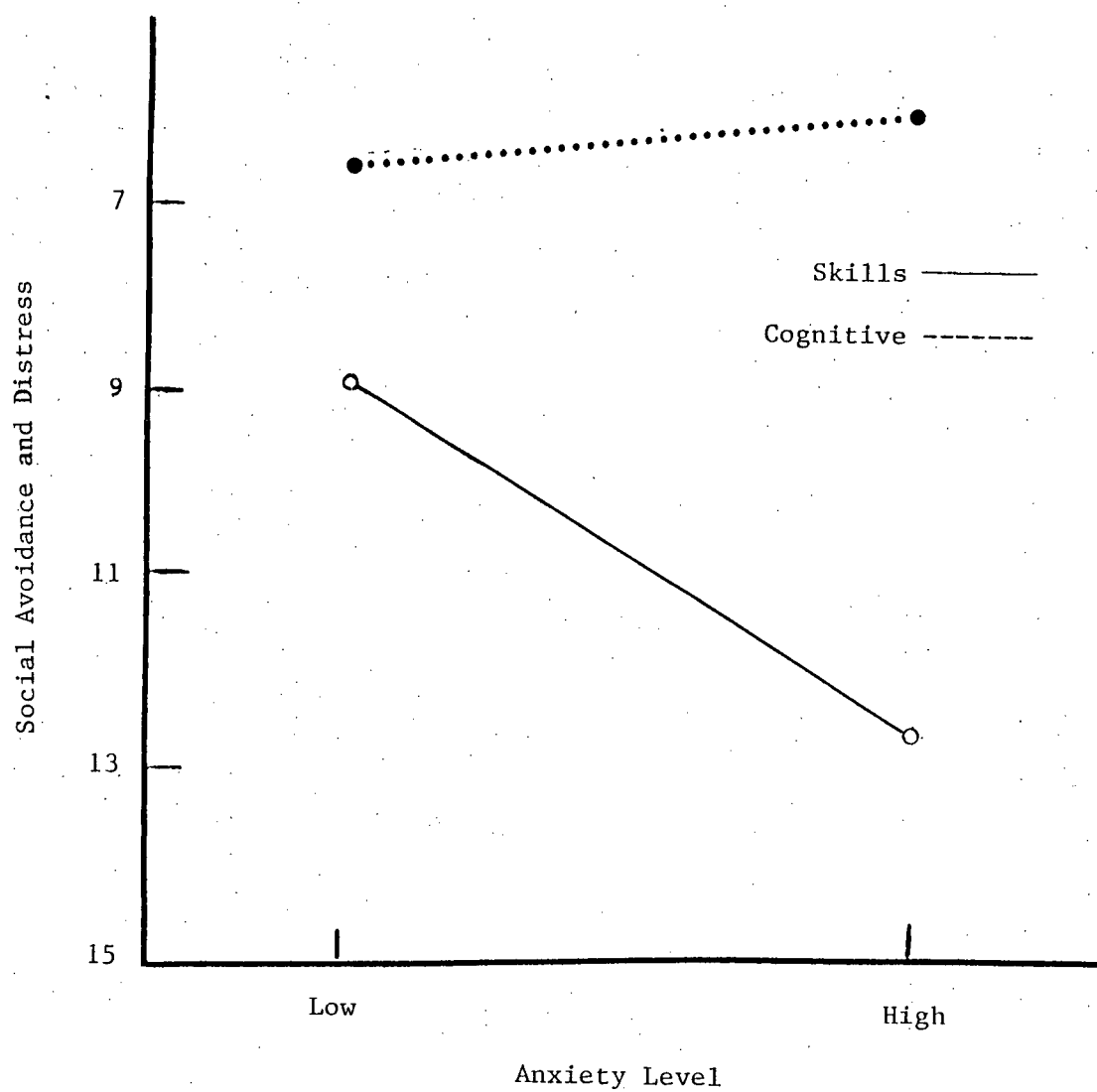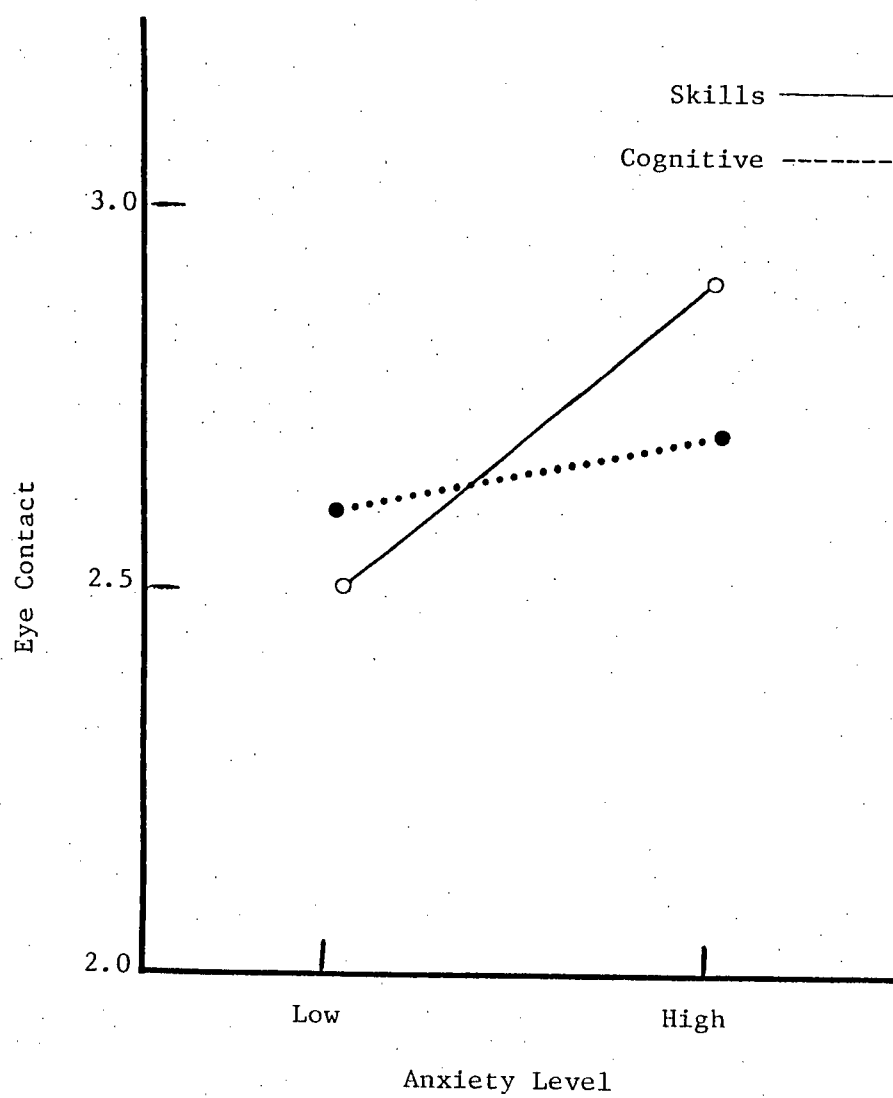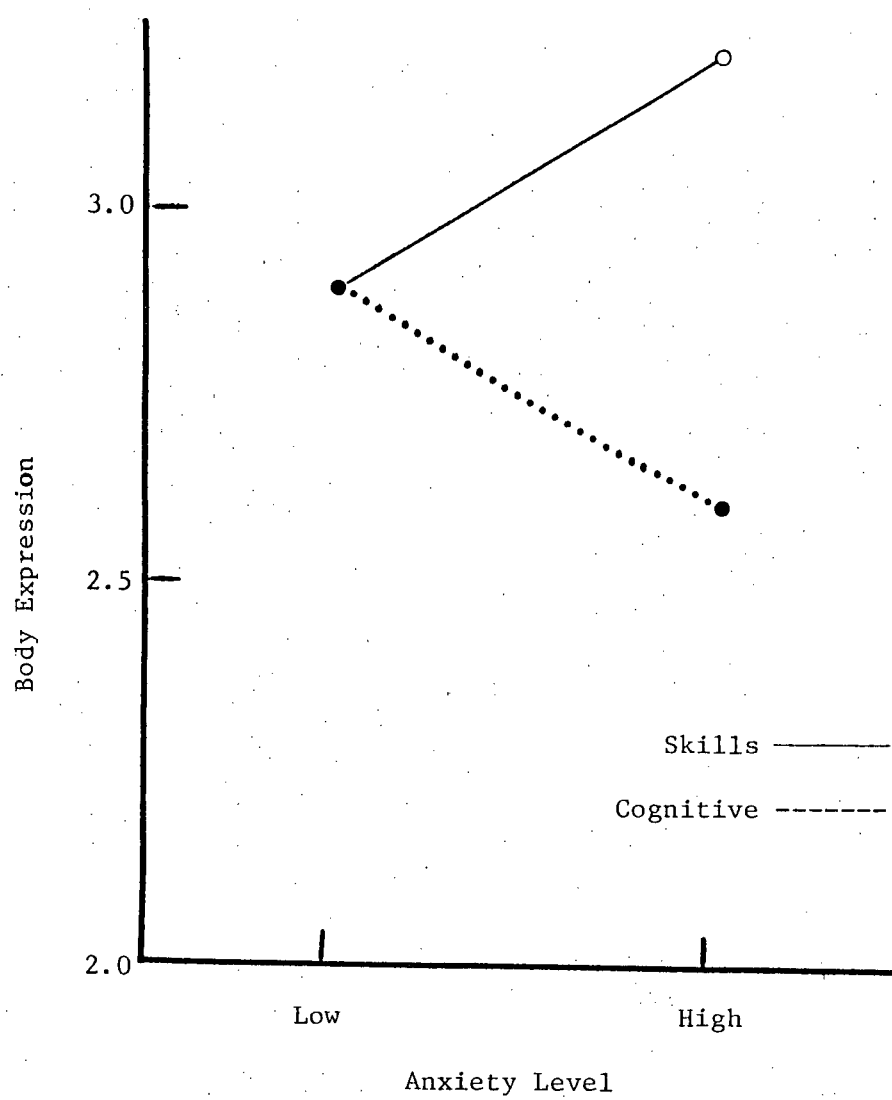
Figure 1a.

Figure 2

Figure 2a.

Figure 2b.
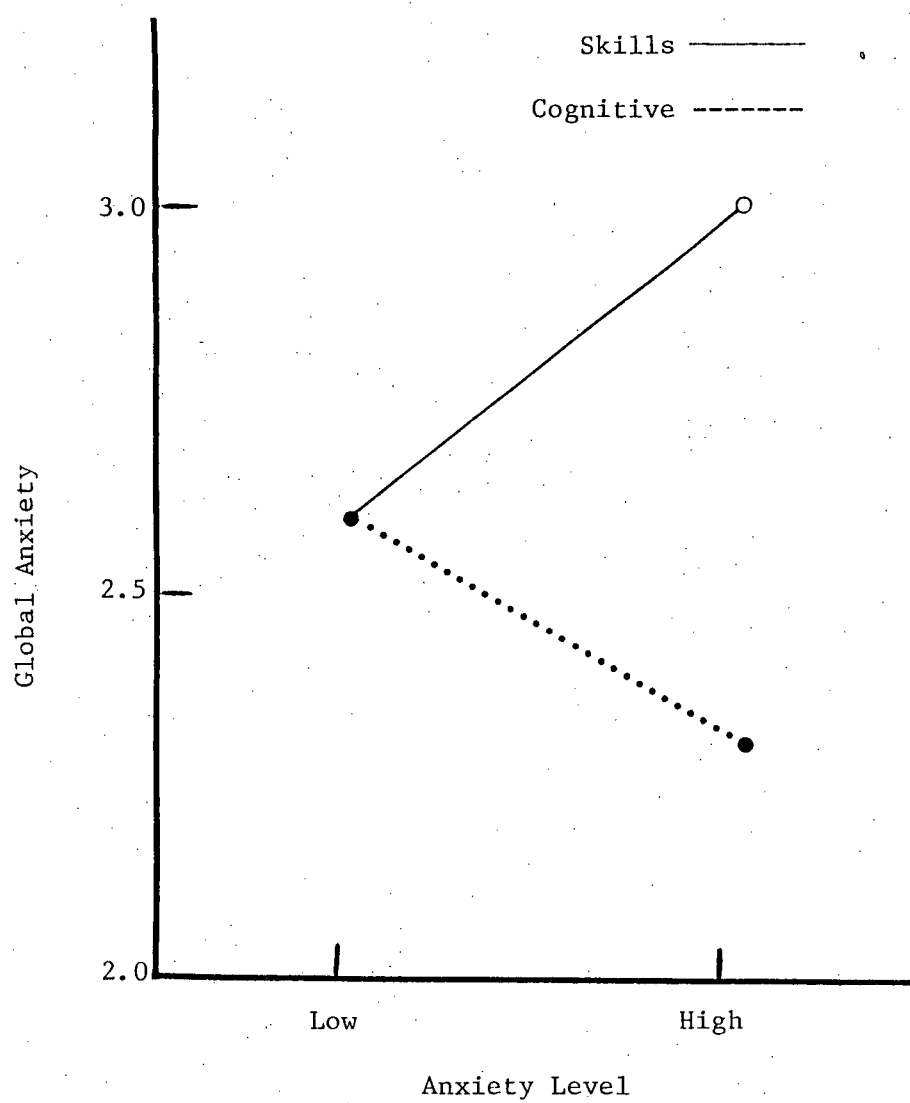
Figure 2c.

DISCUSSION

A brief summary of the experimental results is as follows. Col-
lapsing across high and low anxiety conditions, no significant differences
in efficacy were found between skills training and cognitive treatments.
When, however, low and high anxiety subjects were considered indepen-
dently, some interesting differences emerged. For low anxiety subjects,
skills training and cognitive interventions were found to be equivalent
in therapeutic efficacy. Differences in this respect, however, emerged
for high anxiety subjects.

These individuals reported a greater reduction in social anxiety
and a greater improvement in self concept when treated with cognitive
procedures than they did when treated with traditional skills training
procedures. This pattern, however, was reversed on the behavioural
measures, where skills training procedures were significantly more ef-
fective than the cognitive treatment in reducing behavioural ratings of
global anxiety, body expression, and eye contact, for high anxiety
subjects.

There is, however, evidence for a modified version of this hypo-
thesis. Client anxiety level does appear to function as a moderator
with consequent implications for the treatment of unassertive individuals.

The results of the present study suggest that with low or moderate
anxiety clients there is a consistency between modification in pheno-
menal and behavioural realms. This consistency, however, breaks down
for high anxiety clients for whom behavioural changes are not neces-
sarily accompanied by changes in self concept or subjective anxiety.

This lack of consistency may partially be accounted for in terms of a faulty cognitive-evaluative model of unassertiveness (Curran, 1977). For such clients, self-evaluational processes may distort social reality in a self-critical fashion (Smith & Sarason, 1975) and the existing cognitive structure may not accomodate to new evidence regarding personal competence from the behavioural realm. For these clients it may be essential for purposes of facilitating perceptual change, to intervene directly at the cognitive level. Behavioural change in the absence of preparatory cognitive modification may prove to be insufficient to substantially alter cognitive structures.

What emerges as particularly interesting in the current study is the finding that the presence of a high anxiety level appears to have functioned as a two edged blade, decreasing the efficacy of skills training procedures in the phenomenal realm, yet at the same time increasing the benefits obtained from skills training behaviourally.

The relative superiority of skills training in the behavioural realm for high anxiety subjects can be conceptualized in two ways. On one hand, the cognitive treatment may be seen as lacking in vital components existing in the skills treatment which are prerequisite for behavioural change. In this sense the value of coaching, modeling, and behavioural rehearsal for producing specific behavioural change has once again been reaffirmed.

On the other hand, the tendency for high anxiety subjects to benefit more than low anxiety subjects from skills training on behavioural measures of global anxiety, eye contact, and body expression suggests ironically that high anxiety actually functioned as a facilitating

variable in the skills training treatment. This fact, although contrary to initial expectations, is not inconsistent with evidence from other studies that under certain conditions high anxiety subjects may actually outperform low anxiety subjects (Wine, 1970; Sarason, 1976) and becomes more intelligible in light of both theoretical and empirical evidence that anxiety, or more accurately, high arousal, may function in both debilitating and facilitating ways (Alpert & Haber, 1960). The experience of anxiety is not in and of itself debilitating. It is rather the "worrying" component of anxiety, or the inward direction of attention in a task irrelevant, ruminative, self-critical fashion, which impairs performance (Wine, 1970).

Easterbrook (1959) has demonstrated that anxiety arousal affects attention by narrowing the range of cue utilization. As long as attention is directed inwards in a self critical and evaluative fashion, the effective utilization of important task relevant cues is precluded. If, however, attention can be redirected outward in a task relevant fashion, the intensified attentional focus characteristic of this state can facilitate a more effective utilization of appropriate cues.

In the present study, the cognitive treatment was partially designed to deal with precisely this component of anxiety arousal. Thus subjects were instructed specifically (see Appendix III) to redirect attention in a task relevant fashion and were taught various cognitive strategies for this purpose.

Why then was the skills training treatment more effective in this context? One hypothesis is that the emphasis upon specific verbal and nonverbal behaviours provided subjects with a very tangible attentional

focus. The cognitive procedures for attentional redirection, although
theoretically appropriate, were simply not characterized by the same
tangeability   as the concrete behavioural procedures.

Regardless of this fact, the cognitive treatment did appear to
be more effective in improving self-report for high anxiety subjects. A
number of possibilities may account for this. Firstly, improved be-
havioural performance, for reasons already described, does not neces-
sarily guarantee a change in subjective experience. The fact that no
significant treatment x anxiety interaction emerged on the self-report
of anxiety during role playing stiuations seems to support this suppo-
sition. Subjects may perform quite competently by objective standards
and still perceive themselves as ineffective.

Secondly, the potential reactivity of the self-report measures for
subjects in the cognitive treatment must be considered. It is possible
that the cognitive treatment which focused intensively upon the role of
self-critical cognitions in the inhibition of assertive behaviour may
have intensified demand characteristics to respond positively on self-
report instruments dealing with this very issue.

This hypothesis, however, appears less convincing in light of the
fact that for low anxiety subjects, no differences were found on self-
report measures between skills and cognitive groups.

Another important issue warranting consideration is that of main-
tenance of therapeutic gains. As Heimberg, Montgomery, Madsen, and
Heimberg (1977) have pointed out, assertion training studies have a
poor track record insofar as the implementation of follow-up assessments
is concerned.

The present hypotheses regarding the relationship between anxiety
level and treatment modality efficacy are all inferred on the basis of
a postassessment conducted at one time point, scheduled very soon after
the termination of treatment.

If we conceive of phenomenal and behavioural realms as inter-
dependent and exerting reciprocal influence through the dimension of time,
any conclusions drawn on the basis of one time point are premature, and
at best, incomplete. The possibility that high anxiety subjects re-
ceiving skills training will in time modify their cognitions in response
to perceptions of changed behaviour and modifications in social reactions
to that change, and that these same subjects receiving cognitive behavioural
modification will in time modify their behaviours in accordance with
their new self concepts cannot be ruled out, and indeed, warrants serious
consideration.

A study designed to specifically assess the pattern of inter-
relationships between cognitive and behavioural changes over
time analysis would be valuable in this respect.

Caution in overinterpretation of the current study is warranted for
a number of additional reasons. The limited sample size necessitated
the assignment of subjects to high and low categories on the basis of a
median split, rather than extremes of the distribution. This qualifies
the extent to which subjects can be considered truly "high" and "low"
anxiety clients. In addition, limited sample size resulted in attenua-
tion of statistical power. On one hand it can be argued that this limi-
tation increased the probability of beta type error and that the current
pattern of results would have been more convincingly demonstrated with an

increased sample size. The possibility, however, that results incompatible with the current conclusions were obscured by this factor cannot be ruled out.

Because of the absence of control groups, it cannot be conclusively inferred that therapeutic gain in the current study resulted from treatment interventions. The therapeutic efficacy of both skills training and cognitive procedures have, however, been demonstrated repeatedly, and the general question of therapeutic gain is not directly germaine to the specific interactional questions addressed in the current investigation.

Comparison of subject scores on the Assertion Inventory with normative data collected on general and clinical populations indicates that on a self-report basis, prior to treatment subjects in the current investigation clearly fell towards the unassertive end of the continuum. The proportional reduction in "unassertive" individuals resulting from treatment was approximately equivalent to that found in Gambrill and Richey's clinical sample, while the proportional increase in "assertive" individuals was higher (Gambrill and Richey, 1975).

In summary, the results of the present study suggest that client anxiety level has important implications for the treatment of the unassertive individual. Although high anxiety clients do benefit from basic skills training procedures, it is advisable to supplement such techniques with interventions aimed specifically at modifying cognitive evaluative styles, in order to ensure therapeutic gain at the phenomenal level.

It has been suggested by Wolpe (1969), that desensitization procedures should be employed prior to assertion training, when clients are

characterized by an inordinate amount of social anxiety. This suggestion reflects an underlying assumption that in the context of assertion training, anxiety is in some sense a "cognitive excess", which should be "done away with" in order to facilitate acquisition of assertive behaviour. The current findings suggest that it may prove valuable to reconceptualize anxiety as a subjective experience reflecting a maladaptive cognitive style.

Therapeutic interventions should thus be geared not only towards "decreasing the quantity" of anxiety, but perhaps more importantly, towards helping the client to reinterpret his experience of social reality. An integrated therapeutic approach, which trains unassertive clients to employ behavioural strategies as coping skills in context of a stress innoculation format (Meichenbaum, 1977) would capitalize upon the utility of behavioural tasks for attentional redirection, and subsequent redirection of anxiety.

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APPENDIX I

*SKILLS GROUPS

SESSION I.

You will need: sentences for the EXERCISE on assertion/nonassertion/aggression.

1. Introduction of co-leaders. Introduction of group members.

2. Brief discussion of goals of group. (Two or three sentences stating that the goal of this group is to learn and practice assertion skills.)

3. Brief Discussion of confidentiality. ("We generally find that everyone would prefer to keep anything discussed in our sessions confidential. That way we all can feel free to discuss anything. Is this acceptable to everyone?")

4. Mention of taping of sessions. (This should sound routine and matter-of-fact.) ("We will be taping the sessions. We do this so we don't have to take notes. Also, our supervisor may listen to some tapes. This is a routine procedure.) If anyone asks, tapes are erased after you listen to them.

5. Discussion of deposit, reason for, etc.

(As we mentioned to you earlier, we are asking everyone to give a deposit pledging that they will attend all 6 group sessions. WE have found in the past that if someone drops out in the middle of the group, it disrupts the group for others. What is your reaction to this.? .... Of course this deposit is returned after the last session.)

6. Rationale for skills training. (See rationale sheet).

7. EXERCISE DEFINING TERMS.
   a. Begin with reason for exercise. (...so we all recognize what responses are assertive, which are unassertive, and which are aggressive.)
   b. define assertive, unassertive, and aggressive.
   c. EXERCISE_ read sentences in book and have group members discuss whether the statement is assertive, unassertive, or aggressive.

   Have them state what about the statement makes it what it is.
   (eg. tone of voice, content, is putting someone down, is apologetic etc).

   We have found that unassertive people often view assertive statements as aggressive. You must use your authority to point out incorrect answers to the group and to discuss why statements are assertive, not aggressive.

8. GO ROUND the group. Have each member tell what brings him to the group, his goals.
   a. Have them identify the situations with which they have problems.
   (who, when, where, what is going on.)

b. Have them talk about what they do in these situations now. Have
them specify what they want to do in these situations.
(If they can . Some unassertive people just don't know what to do, so the
answer in global, vague terms.)

c. You should be making notes about the situations they want to work on.

d. This is the time to foster group solidarity and discussion. Your
goal is to get group members to talk and to feel comfortable with
each other.

When someone brings up a problem, get the group to respond   to him .
Such statements as "Does anyone else have a similar difficulty.?"
and "Who else wants to work on assertion with professors?"
are useful.

The biggest mistake a young therapist can make here is to talk too
much. If you talk, the group won't. Your job is to get them to
talk. Don't be made anxious by some pauses, learn to accept pauses
quietly .

Point out commonalities and differences in their problems.
Be alert to nonverbal cues (eg. shifting in chairs, facial experssions)
that indicate that someone wants to chime in. Encourage this.

If some don't talk, call on them by name or look at them and get them
involved in the discussion.

e. Reward self-disclosure or even attempts at same. Say such things as
"good", you've identified on situation to work on. That's the first
step".

f. This is very threatening to some people. Be supportive, acknowledge that it
is difficult (if anyone mentions it), but push a little for self-disclosure.
If they don't talk now, they may remain quiet the whole group.

9. If you have time, again go over rationale.

10. FINAL GO-ROUND.
We end all our groups by going around and having everyone tell the group what
he is thinking and feeling. One co-leader should begin this and the other
end it. The first leader should model giving positive and negative comments
about the group (keep it basically positive however). The last leader
should terminate the session and remind of time for next session.

11. Homework: for this session, keep track of assertion situations encountered
between now and next session. Mention how important it is to have situations
to discuss next time.

*author: L.E. Alden

SESSION II.

Need: At least six stock situations (situations calling for assertiveness) that can be appropriately handled by empathic assertion.

1. Repeat rationale briefly.

2. Present Empathic assertion.
    a. define term.
    b. role-play two stock situations using empathic assertion.
    c. Have group split into pairs (be sure no one is left out) and practice using empathic assertion in the problem situation you just modeled. Co-leaders should rotate around dyads and give feedback on use of the technique. Give another stock situation.
    d. come back into group and discuss how this felt, problems etc.

3. Present Repeated assertion.

    a. define term
    b. role-play two stock situations using repeated assertion.
    c. HAVE group split into pairs and practice using repeated assertion in the last situation you modeled.
       Have pairs practice another stock situation.
    d. Come back into group and discuss how this felt and problems etc.

4. GO-Round for situations that have occurred for clients during the week.
    a. When client comes up with situation that has been problemmatic, have him and another client role-play the situation, using (if possible) empathic or repeated assertion. Go over situation.

    b. Have group give feedback on role-playing and make suggestions.
    c. Practice until client feels satisfied.
    d. Go to every group member.

5. Homework: Practice using empathic and repeated assertion this week if possible.

6. Final go-round to discuss feelings about the group.

SESSION III.

Need: 6 stock situations appropriate for basic assertion and non-verbal feedback.

1. Present the non-verbal cues that convey unassertiveness. Express how important these nonverbals are.
       (Research has shown that over 50% of the message received by a listener comes from the nonverbal aspects of your behavior.)

2. Nonverbals to be covered.
    a. eye contact- look listener directly in the eye . (Not a frozen glare, look away occasionally, just not too much.)
    b. voice volume- keep voice loud and firm.
    c. body expression- don't fidget.
    d. facial expression- keep pleasant, relaxed look on face. (If possible bring in mirror, so clients can see face.)

e.   voice tone- pleasant, matter-of-fact. (Matter-of-fact aspect is quite important. If client is anxious, he will make the other person anxious. Practice smooth, non-anxious style.)

3.   Co-leaders act out unassertive and assertive styles.

4.   Have group divide into dyads. Give them a stock situation to use. Have them role-play. Then have other member of dyad or co-leader give feed-back on non-verbals.

5.   Do another situation.

6.   If an hour is not up, present Basic assertion .
     If the first hour is up, go on to Homework and present basic assertion in session 4.

     Follow-same steps as for session 2 in presenting technique.

7.   Homework discussion- go around and find out what assertion situations arose for clients during the week. Discover how they handled them. Role-play problemmatic situations.

8.   Homework: assign clients to pay attention to their nonverbals this week.

9.   Final go-round.

SESSION IV.
   (If you didn't finish Basic assertion last week, do it this week and I lang. next).
Need: situations appropriate for "I language".

1.   Define I language. (See enclosed sheet).
2.   Model 2 situations using I language.
3.   Break into dyads and role-play 2 situations.
4.   Come back into group and discuss how it went.
     (reassure that it gets easier with practice).

5.   Homework discussion- discuss assertion situations that arose for clients during the week. Role-play problemmatic situations.

6.   Homework assignment: assign practicing I language during the week.

7.   Final go-round.

Session V.
Need: Stock situations for escalating assertion.
1. Define escalating assertion.
2. Model escalating assertion.
3. Break into dyads and role-play situations.
4. Discuss how this went.
5. Homework discussion. - How did homework go? What assertion situations
     arose during the week?
6. Final go round.

Session VI.

Need: Situations for HELP ME technique.
1. Define HELP ME technique.
2. Model HELP ME technique
3. Break into dyads and role-play situations.
4. Discuss how this went.
5. Brief review of the techniques presented in the group.

6. Homework discussion. How did the week go?

7. What things have you learned in this group? What situations are you
     still concerned with? Discuss and role-play. What behaviors will
     you keep working on?

8. Final go-round

Remind about post assessment.

SKILLS RATIONALE

The goal of these groups are for each of us to learn how to behave in a more assertive manner. We are using the term "assertion" to mean "expressing one's feelings and opinions in a direct and appropriate fashion".

Assertion can be contrasted with unassertiveness, or "inhibiting one's opinions, or expressing them in a vague, apologetic manner". Assertion can also be contrasted with aggressiveness, or "expressing oneself in an angry, sarcastic manner without regard for the opinions and feelings of others."

All of us want to express ourselves directly. However, when we are involved in a situation calling for direct expression, we become tense, anxious; we feel uncomfortable. This discomfort results from not knowing exactly what to say or what to do. We desperately search for the appropriate words and behaviors. DOES THIS SOUND FAMILIAR? (Get feedback from group.)

We believe that assertiveness is a learned skill. You learn how to behave in an assertive manner. No one is born assertive or unassertive. Learning how to be assertive is like learning how to read. First, you learn the words, then you practice using them until you are comfortable using them.

In our group, we will first learn what assertive behavior is. We will examine techniques for handling situations assertively. Then, we will practice using these techniques in situations where we want to express ourselves.

Clinicians have drawn up a list of techniques for handling situations directly. We will be presenting and practicing these techniques.

ANY DISCUSSION ABOUT THIS? ((get group feedback))

When you first use these assertion techniques you may feel uncomfortable or tense. This discomfort comes from the unfamiliarity of the new behaviors. They don't "feel right". As we practice these techniques in our group and as you use the techniques outside the group, they will grow increasingly familiar and you will feel more comfortable using them.

This brings us to the importance of trying out these skills in between our sessions here. You have to practice these skills repeatedly so they become autonomatic and you feel comfortable with them. If you don't try out these techniques between sessions, you will soon forget them. We will be asking you to try out these techniques and to report back to us on how things went outside the group. This is essential.

HOW DO YOU FEEL ABOUT THIS? ((Get reactions))

You probably should write down what occurs during the week and bring your notes into sessions to discuss. Here are some little notebooks for you to use to record assertion situations you encounter during the week. We have found that people have difficulty remembering exactly what heppened in these situations if they don't write it down soon after it occurs.

HOW DO YOU FEEL ABOUT RECORDING NOTES BETWEEN GROUP SESSIONS?

APPENDIX II: ASSERTION TECHNIQUES

1. EMPATHETIC ASSERTION

Empathetic assertion conveys some sensitivity to the other person as well as one's feelings or needs. Empathetic 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.

For example: When two people are talking while a meeting is going on:

> "You may not realize it, but your talking is starting to make it difficult for me to hear. Would you keep it down."

When having some deliveries made:

> "I realize it's hard to say exactly when the truck will come, but I'd like some estimate of the time."

2. BROKEN RECORD (Repeated Assertion)

Broken record involves repeating the same message in a calm fashion. This technique is useful when someone won't take no for an answer and keeps pressuring you.

For example: When someone pressures you to have a second helping:

> "No thank you, I don't want another helping."
>   (Oh, come on. It's good.)
> "Yes, it's quite good, but I don't want another serving."
>   "Don't you like it?)
> "Yes, I really like it, but I don't want another serving."

3. ESCALATING ASSERTION

Escalating assertion is employed when someone becomes progressively more demanding and hostile when making demands on you. Escalating assertion involves starting with a basic assertive response. When the other person fails to respond, you should gradually become more firm (though not aggressive) in your response.

For example: When two women are in a bar and a man repeatedly pesters them:

> "That's nice of you to offer a drink, but we came here to talk."
>   (Oh, come on, have a drink.)
> "No thank you. We want to talk to each other."
>   (Hey come on.)
> "This is the third and last time I am going to tell you that we don't want your company. Please leave."

4. <u>CONTENT-PROCESS SHIFT</u>

....is an effective way of dealing with situations wherein
somebody directs an insulting remark at you, or becomes ex-
cessively angry without apparent reason. Respond by comment-
ing on what the person is doing rather than defending yourself.

For example: "Well it looks as if you made a mess of things
               again."

               <u>ANSWER</u>:

               "You really seem irritable today. Is something
               bothering you?"

5. <u>I - LANGUAGE</u>

-consists of stating the effect that a person's behavior has upon
you (and how it makes you feel) instead of "you-language" which
blames other people and makes them feel defensive.

For example: Somebody interrupts you and you say:

    "When you do that it makes me feel as if I'm not being
    heard, and that's frustrating."

For example: Somebody insults you and you say:

    "When you insult me like that it makes me think that
    you disrespect me, and that hurts."

APPENDIX III

MANUAL FOR SELF-INSTRUCTIONAL TRAINING

Session I.

1) Co-leaders introduce themselves
2) have clients introduce themselves
3) structure session: eg.

    "Today we're going to start off by discussing some procedural
    details. Then we'll talk a little bit about what assertive behaviour
    is and what our goals for the group are. Then we'll go around and
    give everybody a chance to talk about what problems bring you here,
    what concerns you have, and what you're interested in working on".

4) Discuss confidentiality
5) Mention taping
6) Discussion of Deposit
7) Define Assertion, Non-assertion, and Aggression. Use examples if
    necessary. Pause to see if group is with you. Finish off with
    some statement like:

    "In this group we're going to examine why it is difficult to
    be assertive all the time, what prevents us from expressing
    our feelings honestly and directly when we want to? Why is
    it that we have difficulty standing up for our rights?... and
    we'll learn various ways of handling these problems....ways
    of becoming more honest and comfortable with other people
    and with outselves".

8) Do assertion exercise:

    "Since we're going to be using the terms assertion, agression
    and nonassertion a lot, it;s important that we all share a
    common understanding of what it is exactly we're talking
    about ....".

    Use this exercise to

    a) evolve common framework
    b) modify any shared irrational beliefs which appear to be
        shared by group members.
    c) diagnose in your own minds any specific problems that group
        members have.

    Finish by turning it over to group. "Is there anything unclear, etc?".

9) Go around group to discuss specific presenting problems.

    Objectives:

        a) obtain information
        b) encouraging discussion and group solidarity
        c) eliciting statements about expectations, beliefs, negative
            self-statements, ruminations, self-concepts, etc.

    Encourage specificity, i.e., deal with specific situations. Use state-
    ments such as, "how does it make you feel when that happens"; "what
    do you think he/she thinks of you"; "how anxious do you feel"; "what
    makes you feel most anxious"; "what makes you feel better"; "why do
    you feel angry". Avoid drawing conclusions and lecturing at this

point. Encourage group discussion. Be sensitive to non-verbals. Use questions such as, "who has the same problems"; "who has the same feelings in situations like this"; "who has the same sort of worries".

- Encourage and reward self disclosure.
- Establish an atmosphere immediately where this type of behavior is acceptable.
- If a group member is not talkative or has difficulty, be supportive and acknowledge that it might be difficult at first.
- Use clinical judgment. This may be a time to get into the feelings that make it difficult to talk or make him/her self-conscious.
- Shape the discussion. Plant the seeds for the self-instruction rationale. Underscore key phrases, e.g., "so you feel incompetent. You feel they're laughing at you".

10) Begin to convey cognitive rationale (following Michenbaum's procedure) I.

11) Assignment
    a) Record assertion situations + self statements "Listen with 3rd ear" to self-statements. Write down what makes it easier and what makes it more difficult to become aware of self-statements.
    b) Hand out monitoring sheets
  * c) Emphasize importance of doing work between sessions. <u>Get feedback from group</u>. (it's important to resolve this issue as soon as possible).

12) Go-around. Where is everybody at. Therapists model.

Session II.

1) Welcome group
2) Is there any unfinished business from last time.
3) Convey: Expectation beliefs ---- feelings ---- behaviour self-statements.

Rationale. II (from Goldfield).
4) Discussion of last week's exercixe.
  (Deal here with the process of self-monitoring rather than the specifics).
  e.g. "How did things go over the week. What was it like for you listening to self-statements with a third ear?"
    a) Discuss what sorts of things seemed to facilitate monitoring.
    b)
    c) It may be appropriate here to use "learning to drive car" analogy to convey notion of automaticity of self-statements. III
    d) Convey the notion of using physiological signs, and feelings as cues to examine negative self-statements. (This is conveyed as a technique to use, but it is also the beginning of the cognitive relabelling process where cues with negative connotations are relabelled as facilitative.
5) Go around group. Discuss specifics of homework.
    a) encourage specificity.
    b) use either covert imagery or role playing to elicit negative self-statements.
    c) reward clients for verbalizing negative self-statements.

6) Ask group to reiterate some of the neg. s-s which arose, or which they're aware of in their own experience. (Write these down).

7) Homework:
   a) continue monitoring faithfully.
   b) become aware of breathing and other physiological signs in problematic situations.
   c) Label anxiety level from 1-10 at beginning of incidents and record at intervals. When does anxiety increase? decrease?

8) Final go around

Session III.

1) unfinished business.
2) Go-around discuss week's experiences with specific reference to
   a) success of monitoring efforts
   b) awareness of physiological signs
   c) labelling of anxiety level

   Elicit statements about changes in experience as a result of self-monitoring and changes in recorded anxiety level.
   d) hand out negative s-s from last week.

3) <u>Decision point</u>. If group is still having trouble becoming aware of negative s-s, spend more time on this process. If not - proceed.
4) Begin introduction of coping strategies. (see IV).
   Hopefully clients will have mentioned that recorded anxiety level sometimes dropped after they began examining s-s. (Psychological Heisenberg uncertainty principle). Use this to illustrate that they're not helpless victims of circumstances and that the very act of looking at their own mental processes begins to modify them. If clients report an elevation in anxiety level, employ a utilization technique, i.e., "good, you've noticed that the way in which you employ your attentional capacities can really change your experiences. Now we're going to find out which ways are most profitable for you".
5) Go-around. Do homework. Use role playing and covert imagery techniques.

   a) for each individual, after neg. s-s have been elicited, begin eliciting incompatible self-statements from individual and from group. Modify any statements which you think are inappropriate. Supplement statements offered with coping and task-relevant statements.
   b) Have group members "try on" coping skills overtly in role playing situations. Then fade to covert usage. Use covert coping imagery.

6) Finish off with discussion. Have group members generate coping statements (both ones which have been used in group and additions. (These are to be written down and presented to group under appropriate modifications next week). If group members can't generate necessary coping s-s, give them coping and taks-relevant s-s-.
7) Discuss reinforcing self-statements
8) Homework:
   a) continue monitoring
   b) label anxiety
   c) use coping skills
   d) note and record which statements are most effective in which situations.

Session IV

1) Unfinished business
2) Hand out list of self-statements.   Reiterate coping and task-relevant
   statements.
3) Describe externally oriented statements (see V).
4) Go around. Do homework. See if there are any problems.
   * be prepared for people to report lack of success. This is cue
   to explain to clients that they should not be discouraged. Rather
   they should set an objective of developing a greater awareness of
   slight changes in experience instead of expecting overnight success.
   To the extent that they are able to see small changes in their
   experience, the experiment is a success.
5) Continue using covert imagery and role playing to elicit negative s-s.
   Have clients "try on" coping, task relevant, and externally oriented
   s-s when appropriate.
6) NOTE: Some people may report an inability to change negative s-s.
   "I'm aware of the negative things I say, but they're all true".
   For these people assign as homework the task of exaggerating
   negative s-s. They are not to use positive s-s over the week.
   Rather, exaggerate, observe and record results. Encourage an
   experimental attitude.
7) Homework:
   a) continue monitoring
   b) practice using coping, task relevant, and externally
       oriented s-s.
   c) monitor which s-s are most effective, when?
   d) Important to write down any idiosymeratic + s-s which are
       particularly effective.
   e) encourage experimental attitude.
8) Final Go-around.

Session V.

1) unfinished business
2) deal with any problems which emerged in homework.
3) Review techniques which have been used
4) Describe challenging positive s-s. (It's quite probable that these
   have already emerged spontaneously).
5) Go-around. Deal with situations that arose thru the week.
   Use the various techniques.
6) If there's time have clients split into pairs, role play trying
   various self-statements covertly.
7) Homework:
   a) continue monitoring
   b) continue employing techniques
8) Final go-around.

Session VI.

1) Unfinished business
2) more cognitive restructuring
3) have clients discuss their experiences and where they see
   themselves going in future.

I.   Initial Cognitive Rationale.

(Note: It's important to pause and break this up by going to group
for feedback. Don't lecture. This is only an example. Modify,
abbreviate and tailor it for the group).

"As I listen to you talk about your problems, I'm aware of some
differences, but I also hear a lot of common themes.

   1). It seems common to experience situations where you know
        what you'd like to say or do, but you find it difficult,
        because you feel anxious, tense or angry. (Discuss with
        group if appropriate).

   2). A lot of us have had the experience of somebody saying or
        doing something which bothers us, or calls for a response,
        but we find that we get so tense, anxious, or angry, that
        we just blank out. Oftentimes we know exactly what we
        should have said afterwards and kick ourselves because then
        it's too late (pause for recognition of experience).

This is the first thing we'd like to focus on. Unassertive behaviour
doesn't arise in a vacuum. We find it difficult to be assertive because
we feel tense, or uncomfortable, or anxious. Our feelings affect the
way we behave.

    The other common thread I become aware of is that a lot of us
speak about the thoughts that go on in our heads in these situations.
(Use examples from group, e.g., "Benjamin, you're telling yourself
that people will think you're foolish". "Ethel, you're saying, I'm
so nervous it must show". "Clyde, you're saying, what if he thinks I'm
some kind of a fool". [Note: by phrasing cognitions in terms of
"you're telling yourself", "you're saying", you're anticipating the
self-instruction, self-verbalization rationale]). These thoughts which
go on inside our heads, (what you might call negative self-statements),
seem to accompany feelings of anxiety and discomfort, and this makes
it difficult for us to be ourselves and behave assertively. (Go to
group if appropriate).

    Now sometimes we're more aware of how we're feeling, and what's
going on inside our heads, than we are at other times. (Possibly refer
back to examples from group).

    Our first goal in this group is to develop our skills to become
aware of what we're feeling, and what sorts of things are going on inside
our heads when we have problems being assertive. To become aware of
when we're telling ourselves things like "I'll never be able to do it",
"What if I look like a fool", etc.

II. Expectations

  beliefs - feelings - behaviour -

     Last time we ended by talking a little bit about the way in which
the things we tell ourselves, our negative self-statements, inhibit
assertive behaviour. We find that our beliefs and expectation affect
the way we behave. Let me give you an example. Two people are going
to the same party. Now neither of them really knows what to expect but,
one person believes that he's going to have a miserable time. He's not
really looking forward to going, because he assumes that he probably
won't know anybody there, and that he'll probably feel uncomfortable
and kind of awkward, and end up spending most of the evening by himself.
The second person is optimistic. He tells himself that he may run into
some old friends, but that even if he doesn;t he'll have the opportunity
to meet some interesting people and possibly make some new friends. Now
let's examine what happens when these 2 attend the party. Our friend
with the negative expectations arrives and finds that he's right. He
doesn't know many people there. He expects to feel awkward and uncomfort-
able - assumes that people may not like him, and so he ends up being
tense and withdrawn and his behaviour makes people avoid him. The second
person on the other hand, because he has positive expectations is more
friendly and open. He ends up meeting people and enjoying himself.

     So we have two people going to the same party and both have shaped
what experiences they have there in different ways by the expectations
and beliefs they have.

     It's important for this reason to become aware of the beliefs, expect-
ations, and self-statements which affect our feelings and guide our behavior.

III. Automatic Nature of Self-statements
     It may be difficult at first to always be aware of our negative self-
statements. This is because our expectations and the things we tell
ourselves about situations are built up over a long period of time. Thus
it gets to the point where they become automatic. How many of you have
had the experience of learning how to drive a standard transmission
(or skiing, or whatever) - (pause for recognition of experience).
Remember what it was like at first? You were aware of every movement you made.
You had to keep track of the clutch, the brakes, the steering wheel, the
accelerator, and the cars in front of you and behind you all at the same
time. Remember how complicated it seemed? How much of that complicated
process are you aware of now?.......etc.......... If you wanted to become
aware of all these things now, you'd have to make a conscious effort. It's
precisely the same way with our negative self-statements.

IV. Introduction to Coping Strategies

     O.K. We've all reached the point now where we're developing some
skill at becoming aware of our feelings, mental processes, and self-
statements, and interestingly enough, some of you noted (draw on examples
from group if possible) that the simple act of becoming aware of what you're
telling yourself and what's interferring with assertive behaviour, makes it
a little easier to act assertively. This, you see, is really the first step.

It's one of stepping back and gaining some perspective on what's going on.

Normally we're so busy ruminating about all of the horrible, catastrophic things that might happen, that we're not aware of a lot of the things which are going on around us. We're not aware that the person we're talking to may be just as nervous as we are, or that maybe he/she is just as busy worrying about whether we like him, as we are about him. By beginning to take a step back and look at your negative s-s objectively, you break the automatic process, and gain some freedom from this strain.

When you feel anxious or uncomfortable, instead of panicing and being overwhelmed, start looking at these feelings as a cue, a cue that you're telling yourself certain things. Say to yourself something like – O.K., I'm feeling uncomfortable and anxious. What should I do? Alright. There's no reason to panic. I can handle this. I'm prepared. This is exactly the sort of thing we spoke about in the group. This feeling is a cue – a cue to use my coping skills. Label my anxiety and watch it change. O.K. Now step back and take a deep breath. There, I feel better already. It's working.

V. Eternally oriented S-S

We've spent some time now developing our skills to become aware of the things going on inside of us, the internal dialogues which make it difficult to behave assertively. We've all practiced using various techniques to handle these situations. Something which has come up repeatedly (hopefully it has if you've taken care to elicit it and underscore it) is that when we're preoccupied with what's going on inside our heads, it's impossible to really see, hear, understand, and be receptive to what's going on outside. We've all had the experience of being so nervous or apprehensive that we don't really hear or understand what the other person is saying. Or have any of you ever had the experience of travelling in a foreign country, or trying to learn another language. When you're really straining to understand, it's extremely difficult, but when you sit back and relax, you can make out the words. One of the things we're going to focus on today is ....

1) Coping statements

a. OK. I'm feeling uncomfortable and anxious. What should I do? Allright,
    there's no reason to panick. I can handle this. I'm prepared. This
    is exactly the sort of thing we spoke about in the group. This feeling
    is a cue - a cue to use my loping skills. Label my anxiety and watch
    it change. OK now stop back and take a deep breath. There I feel
    better already. It's working.

2) Task relevant

    Now what is it I have to do? What does the situation call for?
    No reason to get anxious. No need to worry. What do I really want to
    say in this situation? What am I really feeling? That's better.
    Now I'm in touch with what I want. No reason to feel small or over-
    whelmed.

3) Externally oriented

    There. Wait a minute. Slow down. I'm getting so worked up - so
    overwhelmed by my own negative self talk that I'm not really paying
    attention to him/her. Let's look at this rationally. /He's probably
    feeling just as uncomfortable as I am./ He's probably insecure. /He
    thinks I don't respect him. /He thinks I'm not listening/. What can
    I do to make it easier for both of us?/. etc.

4) Challenging

    Now let's look at this rationally. I know I'm feeling uncomfortable.
    or insecure right now, but I'm getting carried away. /I'm not totally
    incompetent/. I'm not that unattractive/. Nobody's even looking at me./
    It doesn't matter if I don't do this perfectly. Nobody will hold it
    against me. What would be so terrible if I ...

5) Positive

    I'm being too hard on myself. I may not be the most attractive/competent/
    intelligent person in the world but I'm OK ... Remember the time ...

6) Exaggerating Negative self statements

    When you find yourself using negative self statements and you find it
    difficult to change them, try exaggerating the negative self-statements.
    Keep doing that until you can see 1) the effect it has on you and
    2) how unrealistic they are.

7) Reinforcing self-statements

    When you've used a coping skill, it's important to reinforce yourself
    for doing it. Even if it hasn't been completely successful, it's
    important to realize that you've developing the ability to react
    differently to these situations and that every small step is important.

e.g.

It's working. I can control how I feel. Wait until I tell my group about this. I am in control. I made more out of my fear than it's worth. My dam ideas, that's the problem. When I control them I control my fear. It's getting better each time I use the procedure. I did it.

1)   Conveying rationales

        - familiarity with rationales
        - importance of engaging in dialogues.
          Be careful not to lecture

2)   Conducting initial discussion in first session with the aim of
     eliciting statements which anticipate the self-instructional training
     rationale techniques:
                              a) underscoring
                              b) empathic reflection
                              c) rephrasing feelings in terms of self-statements

3)   General techniques for eliciting negative self-statements:

     a. covert imagery
     b. role playing
     c. having client play role of others
     d. general ration of moving from specific situation to feelings to
        negative self-statements

4)   Familiarity with various incompatiable self-statements

        a. coping
        b. task-relevant
        c. externally oriented
        d. challenging
        e. positive
        f. exaggeration technique
        g. self-reinforcing

5)   Techniques for implementing incompatible self-statements

        a. moving from overt to covert usage
        b. using coping imagery

1) Client says "I don't talk to myself"
   - denies using negative self statements.

2) Client reports an inability to modify negative self-statements.

3) Clients fail to do homework.

4) Clients report failure experiences.

5) Client cries.

6) Client criticizes therapist or challenges authority.

7) Client is very untalkative. Feels nervous and uncomfortable in groups.

8) Group engages in nervous laughter.

9) Client speaks very quickly and tangentally - seems to sidestep real issue

10) Client asks if S-I approach is like the "power of positive thinking".

11) Client says: "OK, so I'm aware of the negative things I say to myself. So what?"

12) Client says: "I've always found that spending a lot of time introspecting makes things worse."

13) When using technique of having client imagine what the other says, client responds "I've always found that putting myself in other people's heads just gets me in trouble.

14) 2 clients start arguing with one another.

15) Clients give specific skills feedback.

Adaptive Self-Statements

The following statements are examples of the types of things you can say to yourself in order to combat the negative self-statements (the cognitive processes) which inhibit assertive behaviour. These statements are only guidelines. It is important to experiment and use statements phrased in your own language; statements which are especially effective for you. It's also extremely important to use these statements with feeling, rather than to just parrot them or say them mechanically. Although it may seem at first as if it would take too long to use this type of self-statement when you are actually in a problem situation, remember that it takes a lot less time to say something internally or to <u>think</u> it than to read it or to say it out loud. Also, one of the most common mistakes that people make is to believe that they don't have time to think about the situation before they respond; <u>to let themselves feel pressured</u>. There's <u>always</u> time to step back and gain some perspective on what's going on. Practice these self-statement techniques at first in less threatening situations, and work your way up to more problematic ones. Remember that it's less important to be completely satisfied with the way you deal with problem situations first time around, that it is to become aware of the small changes in experience that occur as a result of the techniques you'll be using. Don't talk yourself into believing that you're failing, by setting unreasonable objectives for yourself. This is just another kind of negative self-statement. Reward yourself for making small steps.

You can use the extra space provided to write down any special adaptive self-statements you've found, which are particularly effective for you.

1) <u>Coping statements</u>

   OK I'm feeling uncomfortable and anxious. What should I do? Allright, there's no reason to panic. I can handle this. I'm prepared. This is exactly the sort of thing we spoke about in the group. This feeling is a cue - a cue to use my coping skills. Label my anxiety and watch it change. OK now step back and take a deep breath. There I feel better already. It's working.

2) <u>Task relevant</u>

   Now what is it I have do do? What does the situation call for? No reason to get anxious. No need to worry. What do I really want to say in this situation? What am I really feeling? That's better. Now I'm in touch with what I want. No reason to feel small or overwhelmed.

3) <u>Focusing on the other</u>

   There. Wait a minute. Slow down. I'm getting so worked up - so overwhelmed by my own negative self talk that I'm not really paying attention to him/her. Let's look at this rationally. /He's probably feeling just as uncomfortable as I am. /He's probably insecure. /He thinks I don't respect him. /He thinks I'm not listening/. What can I do to make it easier for both of us?/. etc.

Adaptive Self-Statements (cont'd)

4) Challenging

Now let's look at this rationally. I know I'm feeling uncomfortable or insecure right now, but I'm getting carried away. /I'm not totally incompetent/. I'm not that unattractive/. Nobody's even looking at me./ It doesn't matter if I don't do this perfectly. Nobody will hold it against me. What would be so terrible if I.......

5) Positive

I'm being too hard on myself. I may not be the most attractive/competent/ intelligent person in the world but I'm OK.....Remember the time....(recall past successes).

6) Exaggerating Negative self statements

When you find yourself using negative self statements and you find it difficult to change them, try exaggerating the negative self-statements. Keep doing that until you can see 1) the effect it has on you and 2) how unrealistic they are.

7) Reinforcing self-statements

When you've used a coping skill, it's important to reinforce yourself for doing it. Even if it hasn't been completely successful, it's important to realize that you're developing the ability to react differently to these situations and that every small step is important.

e.g. It's working. I can control how I feel. Wait until I tell my group about this. I am in control. I made more out of my fear than it's worth. My damn ideas, that's the problem. When I control them I control my fear. It's getting better each time I use the procedure. I did it.

Basic Distinction Between Verbal Content and Nonverbal Components of Communication

Verbal content refers to what the individual says. Thus, for example, if someone asks an individual if he can borrow his car for the evening, the response: "No, you can't, I need it tonight", might be the verbal content of the communication. The way in which this is said, on the other hand, is the nonverbal portion of the communication. These nonverbals may include such components as eye contact, body expression, voice volume, voice tone, facial expression and verbal fluency. They strongly influence what the individual actually conveys to the listener and the fashion in which his response is interpreted.

General Description of Scales

1. Compliance

This scale is assessed solely on the basis of the verbal content of the subject's communication. If he has not expressed his feelings or turned down what he considers to be an unreasonable request he is rated as a 1 on the scale.

If he does so only partially or indirectly, or if he offers an excuse instead of expressing his feelings, he is scored 2 on the scale.

If the subject directly and honestly expresses his feelings, he is scored 3. The fashion in which he does this is irrelevant. Thus it is permissable to appear angry or nervous, and still be scored a 3.

2. Eye Contact

Eye contact is an important component of nonverbal communication. To communicate assertively and effectively it is essential to be able to maintain eye contact. Oftentimes, people who are feeling nervous, anxious or unsure of themselves, will look down or away when they are talking. This detracts from the effectiveness of their communication, and makes them appear to lack confidence in what they are saying.

To score 1 on the scale, the subject must be looking down or away over half the time.

If the subject makes eye contact, but looks away at times, score 2.

Score 3 if the subject makes direct, appropriate eye contact. It is permissable to look away briefly and occasionally. People normally shift their eyes around to some extent.

3. Body Expression

There are basically 3 things to look for here:
(a) tenseness or rigidity, e.g., hands clasped tightly, arms of chair clutched, shoulders hunched forward, or held tightly erect in an awkward fashion.
(b) fidgeting or nervous gestures, e.g., legs swinging, jerky or excessive hand movements, excessive head nodding, squirming or wriggling in chair, twitching of fingers.
(c) face distortions, raising eyebrows, etc.

To score 1, subject must appear extremely tense or rigid, or consistently make nervous movements which are quite noticeable.

To score 2, subjects is somewhat tense or rigid, or makes periodic, small nervous gestures. Mya look somewhat awkward.

To score 3, subject must appear generally natural and relaxed, with few nervous gestures.

To score 4, subject is very relaxed without any nervous or detracting gestures.

(NOTE: It is not uncommon to find both rigidity and nervous movements in the same subject).

4. Voice Volume

The important criterion here is audibility. There is a good range of variability in normal voice volume, thus it is important not to compare the subject to other subjects, but rather to an absolute criterion.

If the voice is generally low and actually inaudible at times, score 1.

Score 2 if voice tended to soft, but audible.

Score 3 if voice is audible, appropriate and well modulated.

The next three scales (5, 6 and 7) are global ratings and should be evaluated by combining verbal and nonverbal components to obtain a general impression.

5. Anxiety

Score 1 if subject appears to be quite uncomfortable. Cues: a conspicuous lack of verbal fluency, excessive squirming, shifting in chair, poor eye contact, quavering of voice, nervous laughter, giggling, excessive fidgetting, hand wringing, tenseness, nervous pauses, hesitation, twitching of face, eyebrows raising, facial distortions.

Score 2 if subject displays some discomfort. Any of the cues mentioned above may be present here in a less pronounced and exaggerated sense. Thus, subject may be somewhat tense, fidgetty, disfluent, etc.

Score 3 if subject is generally comfortable and relaxed.

Score 4 if subject is very relaxed and in control of the situation.

6. Irritability and Brusqueness

We are referring here to a general style which makes the subject appear somewhat arrogant, brusque, sarcastic or irritable.

Score 1 if the subject demonstrated irritability or anger in voice, or makes sarcastic comments, or tilts head backwards and talks down nose in an arrogant fashion, or speaks in an abrupt, clipped fashion.

Score 2 if there is some indication of arrogance in voice tone, response content, or general manner.

Score 3 if subject has slight edge in voice tone.

Score 4 if subject is calm, matter of fact and pleasant.

7. Assertion

This is the last scale to be rated and should combine all of the dimensions previously mentioned to form a general impression.

A rating of 4 on this scale indicates that the subject was able to turn down a request or express his feelings in a direct, honest and appropriate fashion. He demonstrated respect for himself and his own feelings, but at the same time, demonstrated respect for the other. It is important for this reason that the response is reasonably calm and nonaggressive. Content and nonverbals should indicate a minimal amount of anxiety, hesitation, anger, irritation or brusqueness. It should appear to be an effective response.

To score 3, content should be basically direct and assertive, but may be flawed by somewhat anxious nonverbals, a lack of smoothness, some irritation, etc.

To score 2, subject makes an attempt at assertion, but falls short because of his indirectness, hesitance, anxiety, aggression or apologetic fashion.

To score 1, subject must fail to express his feelings, or turn down an unreasonable request.

APPENDIX VI

Behavioural Ratings

1. Compliance

1	2	3
complete compliance: does not turn down request or express feelings	only partially or indirectly turns down request or expressed feelings or justifies with excuse	turns down request or expresses feelings (Aggression is permissable

2. Eye Contact

1	2	3
conspicuously avoids eyes of experimenter over half the time	makes eye contact, but unassertive glances away	appropriate, direct eye contact

3. Body Expression

1	2	3	4
body extremely tense or rigid or continuous fidgetting or nervous gestures with hands or head. Quite noticeable movements.	body somewhat tense, rigid or periodic nervous gestures, small movements	appropriate, natural and relaxed	very relaxed, without any nervous or detracting gestures

4. Voice Volume

1	2	3
low and inaudible at times	audible but soft	voice appropriate, audible and well modulated

5. Anxiety

1	2	3	4
displays a good deal of discomfort in content and/ or nonverbals	some discomfort displayed in content and non-verbals	nonanxious, relaxed, comfortable, matter of fact	very relaxed, and in control of the situation

6. Irritability and Brusqueness

1	2	3	4
irritable voice tone snotty head movements (talking down nose, head back, clipped statements, brusque	some edge on voice somewhat brusque slightly arrogant	slight edge in voice tone	calm, matter of fact and pleasant

7. Assertion

1	2	3	4
non assertive compliant or does not express feelings	attempts at assertions but not smooth. Hesitant. Vague or apologetic or excessively aggressive. Aggressive or nervous nonverbals	content assertive, but flawed by slightly anxious or aggressice nonverbals	smooth, firm effective assertion, expresses feelings in a direct, honest, approprate fashion

APPENDIX VII

Group Satisfaction Questionnaire

Please answer the following questions by circling either 1, 2, 3, 4, or 5.

1. How skilled were your co-leaders as therapists?

    1   2   3   4   5
    not very   average   extremely

2. How warm do you feel your leaders were towards group members?

    1   2   3   4   5
    not very   average   extremely

3. How understanding were your leaders of group members' problems and
    feelings?

    1   2   3   4   5
    not very   average   extremely

4. How satisfied were you with your group?

    1   2   3   4   5
    not very   average   extremely

5. How likely is is that you'll use the skills/techniques that you
    learnt in the group?

    1   2   3   4   5
    not very   somewhat   extremely