Follow-up study of an assertiveness-training program at Windsor Western Hospital.

Heather Jill. Doney
University of Windsor

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FOLLOW-UP STUDY OF AN
ASSERTIVENESS-TRAINING PROGRAM
AT WINDSOR WESTERN HOSPITAL

by
Heather Jill Doney

A Thesis
Submitted to the Faculty of Graduate Studies
Through the School of Social Work
In Partial Fulfillment of the
Requirements for the Degree
of Master of Social Work at
The University of Windsor

Windsor, Ontario, Canada
1979
ABSTRACT

This research project was proposed as an evaluation of an assertiveness training program which had been in operation for two years at a general hospital in Windsor, Ontario, for a population of psychiatric out-patients. There had been no previous consistent evaluation of the training program.

The research took the form of a program evaluation based on the objectives of the assertiveness training program which were to improve assertiveness through the training process in such a way and to such a degree that gains would be maintained over a significant period of time. It was believed that such achievement would be related to the type of persons enrolled in the program and therefore, an assessment of personality traits of participants was included.

Four specific objectives were identified. First, personality characteristics of participants were measured with the Personality Research Form-E. It was found that the personality traits were within the normal range although tending to be somewhat more than average dependent, depressed, impulsive, and passive or aggressive. Assertiveness training was judged an appropriate treatment modality.
The second objective was to measure the achievement of assertiveness during the course of the training program. It was first necessary to establish the reliability and validity of the instrument which the hospital had been using as an assertiveness inventory. For the purpose of comparison, the Rathus Assertiveness Schedule was introduced. Scores on inventories indicated a bipolar shift toward appropriate assertiveness, but the nature of the scales confounded the statistical findings. Therefore, the hypothesis that participants attained an increased level of assertiveness could not be demonstrated.

For the third objective, which was the measurement of maintenance of levels of assertiveness over time, the distribution of scores on inventories suggested some degree of maintenance. However, the hypothesis could not be statistically supported. Scores were obtained by mailing out inventories to ninety-five graduates of the training program of whom fifty responded.

The fourth research objective was to report on the subjective evaluation of the training program by persons who had completed the program from two to twenty-four months previous to receiving a mail-out questionnaire designed by the author. Responses to items on the questionnaire were correlated with scores on each of the
two assertiveness inventories yielding high $\eta$ and $\eta^2$ values. Although mean test scores indicate that for the most part clients were still functioning at somewhat low levels of assertiveness, the respondents themselves said the change was important and that the program was helpful and worthwhile.

It was recommended that the program be continued on the basis of the pattern of change in participants towards appropriate assertiveness. The author notes that the results of this research cannot be generalized to other patient populations or community groups. It is suggested that future research into assertiveness training as an intervention strategy with out-patients would benefit from a comparison of its effectiveness with a control group and with other training groups in the community.
ACKNOWLEDGEMENTS

The author wishes to thank the members of her committee, F.C. Hansen, M.S.W., M. Meyer, M.S.W. and A. Diemer, Ph.D., for their assistance in completing the thesis.

Dr. M. Morf of the Department of Psychology provided expert opinion on the use of the Personality Research Form and his help is gratefully acknowledged.

The research project could not have been completed without the consent and co-operation of Windsor Western Hospital. Special thanks are extended to Mr. M. Dhar, A.C.S.W., Chief Social Worker, for facilitating the research.

The author wishes to express her deep gratitude to Mr. Walter Clemens, M.S.W., one of the leaders of the Assertiveness Training Program at Windsor Western Hospital and her supervisor during field placement there. Mr. Clemens' enthusiasm and commitment significantly influenced the undertaking of this particular research project and its successful completion.

The author also wishes to thank her parents and those friends and colleagues who provided understanding and support.
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CHAPTER I

Purpose of the Study

The assertiveness training program at Windsor Western Hospital, I.O.D.E. Unit in Windsor, Ontario was known to the author through her field placement there as part of the MSW program in 1977-78. It was reported that although the hospital had received some positive comments from participants, there had not been any consistent evaluation of the outcome of the program during two years of operation.

Hospital staff expressed an interest in appraising the usefulness of an assertiveness inventory which was being used as pre-test and posttest of the training. Staff also suggested that an evaluation of the effects of training and of the long-term outcome of the program was needed. These "felt needs" were the original stimuli for preliminary investigation of this area as a worthwhile research project.

An initial review of the professional literature clarified some of the issues related to assertiveness training with a psychiatric out-patient population. While there has been significant work done on identifying those elements contributing to behaviour improvement,
there was clearly a need for therapeutic outcome studies with a variety of patient populations. Moreover, the question of transfer of training, generalization of assertive responding in different interpersonal situations has received little attention in the research literature but has serious implications for program design. The author was intrigued by another issue relevant to the assertiveness inventories: the so-called attitudinal lag on self-report measures as an explanation of why those measures may not coincide with rapid overt behavioural improvement.

During this initial review of literature, the author identified personally with the notion the individuals in the helping professions need to better express their positive thoughts and feelings. She anticipated that research in the area of assertiveness training would contribute significantly to both her professional and personal development.

The research took the form of a program evaluation based on the objectives of the assertiveness training programs which were to improve assertiveness through the training process in such a way and to such a degree that gains would be maintained over a significant period of time. It was believed that such achievement would be
related to the type of persons enrolled in the program and therefore, it was proposed to include an assessment of personality traits of participants.

The research objectives are further clarified in Chapters III - VI which include research design, methodology and analysis of findings. The following chapter provides a review of pertinent literature relating to assertiveness training in which the research issues are identified.
CHAPTER II

Assertiveness Training: Theory and Context

The proliferation of assertiveness training books and programs might lead one to wonder if such a "fad" can be a legitimate technique for therapy or personal development. The popular and professional growth of assertiveness training in the 1970's is reminiscent of the "sensitivity movement" of the 1960's and is spurred on by various social liberation doctrines, in particular, the women's movement, (Shoemaker & Satterfield, 1977, pp. 49-58).

The technology for behavior change includes a long list of processes, a wide range of applications, and varying population groups. The whole spectrum of assertiveness training has been conceptualized as an inverted pyramid with three levels: 1. technique, 2. the assertive interpersonal response system, and 3. an assertive lifestyle, (Shoemaker & Satterfield, 1977, p. 52). The purpose of this chapter is to describe the theory base of assertiveness training, to define its components, to relate it to the cultural context, and to define the social work role in the training.
The development of scientific behaviour therapy is a twentieth century phenomenon with most significant elaboration during the past twenty-five years (Alberti 1977, Wolpe & Lazarus 1966, pp. 1-11). The principles of learning which guide behaviour therapy, established by Pavlov, Skinner, and Thorndike, are in contrast to the traditional approach of descriptive psychiatry or the psychodynamic model, (Karoly 1975, p. 196). Social learning theory rests on the empirical relationships between behaviour and environment which have been found to hold over a wide range of animal species, behaviours and situations, (Gambrill 1977, p. 5). The principles of behaviour which describe the various relationships between behaviour and environment form the base for the re-arrangement of relationships between behaviour and environmental events so that desirable behaviours increase and undesirable behaviours decrease, (the intervention method known as contingency management), (Gambrill 1977, p. 5). The relationships can be observed in certain rates and patterns of behaviour.

"The behavioural model emphasizes the relationship between behaviour and the current antecedent and consequent events that effect behaviour", (Gambrill 1977, p.5). The past is considered to be reflected in the
present but the emphasis is on the identification of the events that occasion and maintain behaviour; these may be located inside a person or in the external environment. Practice in the field of behavioural modification emphasizes observable and countable responses, as opposed to thoughts and feelings.

Obtaining quantitative data regarding the effects of intervention has been a concern of those utilizing a behavioural model and the collection of data has been less problematic because of the above-mentioned emphasis on behaviour identified in observable, countable terms, (Gambrill, 1977, p. 9).

Assertiveness training is not to be understood as operating from a basis of only classical learning theory because "human emotions and behaviour are enormously influenced by cognitions", (Ellis, 1973, p. 27). In Humanistic Psychotherapy (1973), Albert Ellis describes cognitive therapy (and rational-emotive therapy in particular) as among the most humanistic of psychological treatment procedures and presents some strong arguments for his case. Ellis maintains that a person's concepts and constructs strongly influence perceptions and emotions and that consequently a re-educative approach, dealing with beliefs, attitudes, and values rather than stimuli and response, is a powerful modifier of self-acceptance.
Rational-emotive therapy teaches people to be less suggestible, to think largely for themselves, and to decrease a strong need for approval and success, (Ellis, 1973, p. 10). It is a logico-empirical method of confronting not only the external world but also oneself and one's own functioning, (Ellis, 1973, p. 25).

The modification of cognition and the modification of behaviour share unifying themes in their orientation. Briefly, these principles are: 1) the client must be a knowledgeable partner in the process of change; behavioural approaches must not be imposed on clients; 2) behavioural change includes changing internal processes such as thoughts and feelings; 3) a comprehensive assessment of a client's total situation is essential to the development of an effective plan for intervention; and 4) the practitioner is accountable for the outcome of his or her intervention, (Gochros, 1978, p. 256).

It is this concept of behaviour therapy and assertiveness training specifically that motivates the author's interest in researching the methodology and effects of treatment within the framework of professional social work.

Cultural Context:

As described by Rose (1975 p. 33), a lack of social competence is a problem for a large portion of the population
and is often a part of other problems, e.g. alcoholism, sexual dilemmas, absenteeism, depression, aggression and loneliness. Lubbock (1978, p. 47) argues that our society is becoming peopled by victims or individuals with a fear-based personality who conduct their lives according to outside paradigms and not in accordance with more personal values and needs which then lead to satisfaction. This orientation probably reflects major social, economic, and political changes, particularly in North America.

However, the extent of cultural change and its manifestation in the social atmosphere is not properly the subject of this thesis.

Unassertiveness appears to exist on a wide scale if judged solely by the proliferation of printed material and of programs for the teaching of skills and revising of attitudes. There isn't much doubt that this is also, for the present at least, a middle-class phenomena with roots in the middle-class sensitivity movement and the feminist movement. Moreover, the public and professional attention being accorded assertiveness provides employment for the burgeoning ranks of mental health professionals, (social workers, psychologists, nurses, clergy and para-professionals) and concomitantly widens the availability of treatment or training.
When assertion deficiencies result in circumscription of an individual's behaviour, e.g. undue deference to authority figures, or in a pervasive style of unassertiveness and his/her tactics are avoidant or maladaptive, therapeutic intervention is appropriate. MacDonald (1975 p.60) identified three sources of such patterns of behaviour. They are: 1. genuine skill deficit, (not knowing how to be appropriately assertive), 2. inadequate stimulus discrimination, (not knowing the circumstances for which assertion is appropriate), and 3. fear of irrational or rational consequences of being assertive, (may be self-generated). Our culture's definition of a socially potent person would not include these characteristics.

In the early development of behaviour therapy, there was some controversy over whether unassertiveness was based in fear (neurotic fear) or skill deficit, (see Wolpe & Lazarus, 1966). However, this no longer seems to be an issue, (see Gambrill 1977), and treatment procedures address all three areas mentioned above within a culture (or subpopulation) where psychological treatment is a socially acceptable mode of dealing with interpersonal problems.

Relevant Concepts:

In order to further develop an understanding of
assertiveness training, it is necessary to relate the theoretical concepts and socio-cultural context to constructs of personality.

The construct of social dominance involves taking the lead and influencing or controlling one's interpersonal environment and thus relates to assertive behaviour, (Hollandsworth, Galassi & Gay, 1977b, p. 407). On the other hand, the construct of abasement involves expressing feelings of inferiority and being socially impotent and is inversely related to assertiveness (Hollandsworth et al., 1977b, p. 407). A consequence of assertiveness viewed as socially potent behaviour is that it is often confused with aggression or with abrasive, threatening, or punitive actions, (Alberti, 1977, pp. 19-32).

Hollandsworth (1977a) contributes to clarification of the two constructs, assertion and aggression, by distinguishing between coercion and legitimate power as two forms of social power. Legitimate power is based on group or social norms and thus involves the socially defined rights of the individual, (Hollandsworth, 1977a, p. 350). Assertiveness training focusses on this legitimate power in its emphasis on the appropriate expression of the individuals' opinions and feelings within his/her social context, (Cf. Alberti 1977, pp. 111-147).
Definition of Assertive Behaviour:

The theoretical basis of assertiveness training has been discussed and what follows is a succinct statement describing assertive behaviour, the broad goal of training.

Assertive behaviour is:

that complex of behaviours emitted by a person in an interpersonal context which express that person's feelings, attitudes, wishes, opinions, or rights directly, firmly, and honestly, while respecting the feelings, attitudes, wishes, opinions and rights of the other person(s). Such behaviour may include the expression of such emotions as anger, fear, caring, hope, joy, despair, indignance, embarrassment, but in any event is expressed in a manner which does not violate the rights of others. Assertive behaviour is differentiated from aggressive behaviour which, while expressive of one person's feelings, attitudes, wishes, opinions, or rights, does not respect those characteristics in others, (Galassi & Galassi 1977, p. 233).

Such a definition includes the dimensions of intent, behaviour and, effects. It is understood to take into account the socio-cultural context.

Treatment Procedures:

The clinical potential of assertiveness training has been tested both with individuals, (Eisler, Miller, Hersen & Alford, 1974, Medelman, 1976), and with groups (Brown, 1976, Hersen, Eisler & Miller, 1973). The assigning of an individual to either of these options
must consider three factors: 1. the severity of the problem, 2. available staff resources and programs, and 3. professional commitment to principles of group treatment. (In a private agency, ability to pay would also be a consideration). Since the issue is one of social functioning or interpersonal relationships, peer support in a group setting could contribute to the effectiveness of training, (Rose 1975, p. 33). Obviously also, it is efficient to have others immediately at hand with whom to practice and from whom to receive feedback.

An exhaustive description of the treatment procedures of assertiveness training is beyond the scope of this research project. There are many handbooks available on the subject, both popular and professional, (Alberti & Emmons 1970, Fensterheim & Baer 1975, Galassi & Galassi 1977, Gambrill 1977, Rathus and Nevid 1977, Wolpe & Lazarus 1966). Nevertheless, some reference to technique could amplify understanding of the training.

Rose (1975, p. 35) listed the following treatment procedures in assertiveness training: 1) modeling or demonstrating a set of desirable responses to a problem situation, (by the trainer or by group members who are competent in the target behaviour); 2) coaching or explicitly describing what constitutes an appropriate response in the given situation; 3) behaviour rehearsal
or role-playing of the social skills each client is trying to learn; 4) covert rehearsal or acting out the given situation in one's imagination; and 5) contingency contracts or "homework" agreements between trainer and client, between or among clients, or between clients and friends and family. Hopefully, the professional trainer has the skill and flexibility to judge appropriately what individuals and groups most need. Some groups, for example, may need to spend significant amounts of time exploring the issue of self-concept which involves, among other things, the cognitive recognition that persons do indeed have a right to their own feelings and are entitled to express them.

The popular image of assertiveness training seems to be one of small-group, time-limited program extending over six to eight weeks, (Galassi & Galassi, 1977). However, the length of the training experience varies widely from a one-shot half-hour to three-hour individual or group sessions, or two to three hours weekly for six to twelve weeks, or weekly sessions over several months. This probably reflects the degree of skill deficit or psychopathy present in the patient and is likely one of the factors which distinguishes "therapy" from "training". It may be either treatment or training depending upon the setting, the clients, and the attitude of the trainer.
Clinical Use of Assertiveness Training:

"Although assertiveness training represents one of the earliest forms of behaviour therapy, systematic investigation of its potential clinical uses is fairly recent", (Quillin, Besing & Dinning, 1977, p. 418). Moreover, this research has largely been conducted by psychologists, (Hersen, Eisler & Miller 1974, McFall & Lillesand, 1971, Rathus, 1973, Lewison n.d.), and published in the professional psychology journals. A search of the psychological abstracts and social work abstracts has not found any reference to research articles by social workers using assertiveness training. A significant exception is E. Gambrill, a professor of social work and the author of a monumental twelve hundred page handbook of behaviour therapy, (Gambrill 1977).

Much of the published research has focussed on the impact of specific treatment modalities and on the development of a standardized instrument capable of accurately measuring assertive behaviours, (Gambrill & Richey 1975, Hollandsworth, Galassi & Gay 1977, Lange & Jakubowski 1976, Rathus 1973). Moreover, the subjects have for the most part been college students, (Galassi, Kostka & Galassi, Hollandsworth, Galassi & Gay 1977, Rathus 1973, MacDonald 1975), or long-term psychiatric in-patients, (Hersen, Eisler, Miller 1973, Goldsmith &
Assertiveness training has proved effective in the clinical treatment of depression, (Lewisohn n.d., Zeiss n.d.). Research suggests that the reduction of depression and/or the loss of fear is related to an alteration in the level and strength of self-efficacy, (Bandura quoted in Zeiss 1978, p.24) and that this type of change is the purpose of any form of psychological procedure. Mastery experiences, whether self-directed or part of group training, reinforce a sense of personal efficacy or restore morale. In this regard, it has not been shown that one treatment approach is more effective than another: all seem effective (Frank quoted in Zeiss, 1978, p.25). Therefore, the object of treatment, is to increase the number of positive experiences in the patients' daily lives. Clinically useful approaches should provide treatment alternatives which are readily available and less expensive than individual therapy.

Interpersonal skills training, or assertiveness training, is an effective treatment if it meets the following criteria: 1) provides a structure which guides the patient to the belief that she/he can control her behaviour; 2) provides training in skills which the patient can utilize to feel more effective in handling
her/his daily life, (in keeping with the rationale in 1.);
3) emphasizes the independent use of these skills out-
side of the therapy session and provides enough structure
so that the attainment of independent skill is possible;
4) encourages the patient's attributing improvement
in mood to her/his own increased skillfulness not to
the therapist's skillfulness, (Zeiss 1977).

Such a framework could be effective with patients
who manifest aggression as well as with the often pas-
sive depressed patient. Recent research by Foy, Eisler
and Pinkston (1975) and Rimm, Brown and Stuart (1974)
supports assertiveness training as an effective mode
of treatment for extremely aggressive patients.

With regard to the second major focus of research,
that is, the development of an instrument, there are at
least two standardized measures of assertiveness, the
Rathus Assertiveness Schedule, RAS (Rathus 1973) and the
Adult Self-Expression Scale, ASES, (Hollandsworth,
Galassi & Gay 1977). These have been widely discussed
in the professional journals and monographs (Ciminero,
Calhoun & Adams 1977, Gay, Hollandsworth & Galassi 1975,
Quillan et al. 1977, Vestrewig & Moss 1976, Weisman 1975),
and are based in the early self-report inventories of
Wolpe and Lazarus (1966). There seems to be an accept-
able tradition in psychology of building upon or refining
earlier instruments. The validity and reliability of such inventories has been established and they relate to a broad variety of situations. However, very little research addressed to the temporal stability of achieved social skills or to the cross-situational generalizability of assertiveness has been published. Follow-up studies seem not to have received very much professional attention perhaps due in part to the expense of conducting in vivo research, i.e., assessing the patients' live response, (verbal and nonverbal behaviour), to a test situation, (a known problem area or a new situation). Another alternative is pencil and paper tests for which a common difficulty is contacting and eliciting the cooperation of persons who have been discharged from institutions or therapy situations and who are then no longer in contact with a training program. A combination of inventory and behaviour performance test was used by Galassi, Kostka and Galassi (1975) in a one-year follow-up study. The subjects in this experiment attained significantly higher scores on an inventory and reported significantly lower levels of anxiety than a control group. The long-term effectiveness of assertiveness training was strongly supported.

The clinical effectiveness of assertiveness training
needs to be supported with follow-up studies with extended time frameworks in order to contribute to theories of maladaptive behaviour and psychopathology, to expand knowledge of effective treatment, and to justify public expenditure on assertiveness training programs.

**Social Work and Assertiveness Training:**

The spectrum of assertiveness training procedures, as described above, is within the range of appropriate skills for social workers and relates to acceptable professional objectives.

Kanfer and Goldstein (1975, p. 7) identify five goals of helping relationship: 1) change of a particular problem behaviour, such as poor interpersonal skills; 2) insight, or a clear rational and emotional understanding of one's problems; 3) change in a person's subjective emotional comfort; 4) change in a person's self-perceptions, including goals, self-confidence, and sense of adequacy, and 5) change in a person's lifestyle or "personality restructuring". For persons whose discomforts, psychological disabilities, and social inefficiencies have been of sufficient concern that the assistance of a trained outsider is deemed necessary, the professional
helper can serve as both a consultant and an expert teacher, (Kanfer & Goldstein, 1975, p. 1). The methods available to help people change do not properly belong to any one group of professional helpers. However, one might assume that assertiveness training which focusses on the broad spectrum of social functioning is a particularly attractive modality for social workers who traditionally are concerned with the individual in his social environment. Schools of social work haven't usually offered intensive training in specialized techniques, e.g. behaviour modification, Gestalt, bioenergetics, although they do provide the theory base in some cases.

Manuals such as Assert Yourself, (Galassi & Galassi 1977), provide guidelines for trainers as well as self-help users. However, they insist that ethical practice requires the trainer to have extensive and specific education and experience. As training may be available in treatment settings, and as professionals are personally motivated to achieve assertiveness, social workers can become qualified to lead assertiveness training programs in the community, (as has happened in Windsor at a general hospital, a family service agency, the "Y", and a community college).

This chapter provided an overview of assertiveness
training with reference to the behavioural model as the theoretical base and to the definition of components of the training. The cultural context of a widespread lack of social competence was described and the social work role in assertiveness training was defined.
CHAPTER III

Research Objective and Analysis:

Personality Characteristics of Participants

Recent developments in the field of assertiveness training have focused on the clinical potential of various treatment methods with different populations. This study provided further evidence of the effects of training on psychiatric out-patients and described the characteristics of such a population.

There has been a lack of follow-up studies, and consequently, one of the purposes of this research project was to acquire information about the temporal stability of changes in levels of assertive behaviour. It was also thought worthwhile to make known the opinions of participants as they reflect on the training experience and as they evaluate themselves after training.

The following chapters delineate four research objectives which are presented in Table One. In addition, this chapter provides a discussion of the classification of the research project, the population, and the research samples.

The Setting:

The research project was carried out at Windsor
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<td>Describe Personality characteristics of trainees</td>
<td>Personality Profile Profile PRF-E</td>
<td>Volunteers in training groups January-April 1978, n=23 Hospital RAS</td>
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<td>IV</td>
<td>Measure change in levels of assertiveness</td>
<td>Two assertiveness inventories: Hospital &amp; RAS</td>
<td>Pre-test 39 Posttest 27 Time period: Feb.77 - Apr. 78</td>
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<td>V</td>
<td>Measure maintenance of gains in assertiveness</td>
<td>Two assertiveness inventories: Hospital &amp; RAS</td>
<td>Posttest 27 Follow-up 50 Time period: Oct.76 - Apr. 78</td>
</tr>
<tr>
<td>VI</td>
<td>Evaluate effectiveness of assertiveness training program</td>
<td>Two assertiveness inventories: Hospital &amp; RAS</td>
<td>Follow-up 50 Questionnaire n=50 Mail-out: April 1978</td>
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</table>

RAS = Rathus Assertiveness Schedule

* There is some overlap of persons in the sample groups. For only eight persons are there complete sets of data, (the two inventories at three points in time), excluding the personality profile.

** Time period differs because of introduction of modified instrument in February 1977.
Western Hospital, I.O.D.E. Unit which is a public general hospital and includes a psychiatric unit offering services to both in-patients and out-patients through the Psychiatry Department and, as such, is financed by the Ontario Health Insurance Plan.

This hospital is one of four active-treatment hospitals serving the City of Windsor and a large part of Essex County.

Windsor is a medium sized city, (approximately 200,000 population), whose economic base is primarily industrial and whose labour force is relatively young. The proximity of Metropolitan Detroit undoubtedly exerts a strong cultural influence.

The Population:

The study focussed on those persons who had completed the assertiveness training program in the previous two years and, on those who were involved in the program between January and May 1978. This population included both men and women who were, by definition, registered as patients at the hospital and referred to the program by a physician or counsellor, but who were not necessarily receiving any other form of psychotherapy. Therefore, while some portion of this population might not consider themselves as psychiatric
patients, this is nevertheless a psychiatric population. This study did not examine the psychiatric history of the subjects, the implication of the mix of subjects, nor the significance of the setting.

Classification of Research Design:

The goals of the research define the study as a program evaluation within the class of quantitative descriptive studies, (as opposed to experimental or exploratory studies). This is a class of empirical research investigations which have as their major purpose the delineation or assessment of characteristics of phenomena, program evaluation, or the isolation of key variables (Tripodi, Fellin & Meyer 1969, p. 38).

The study cannot be classified as experimental because it did not involve a control group or manipulation of variables. It does, however, focus on measurable variables such as levels of assertiveness as self-reported on inventories, components of personality measured by a reliable test, and levels of achievement and satisfaction as self-reported on a follow-up questionnaire.

The study satisfies the third requirement of the quantitative-descriptive classification in that it proposes to accurately describe quantitative relations
among selected variables. Some of the relationships which were of interest were those between scores on inventories and self-perception of assertiveness, between elapsed time and maintenance of assertive behaviour, and between self-confidence and scores on inventories.

Within the framework of a descriptive study, this is more specifically a program evaluation and as such the research questions arise as much from the stated goals of the training program as from a theoretical base. However, this research is limited to an assessment of the outcome of the program and does not examine other approaches such as content, process, structure, or impact. "Concentration on outcome posits that the ultimate criterion to be used in judging social work services should be the net alteration or change in the individual recipient" (Polansky 1975, p. 186).

Assumptions:

Several assumptions have been made which relate to the formulation of hypotheses and to the choice of methodology. These assumptions are:

1. That assertiveness training focuses participants' attention on personal issues of non-assertiveness.
2. That persons are capable of changing their behaviour and can use training to facilitate change.
3. That persons in training can identify which aspects of the program were most helpful for them in achieving change.

4. That persons are able to recall the quality of their experience after the passage of time.

5. That the self-report inventory and questionnaire are valuable research tools for recording an individual's level of assertiveness and for investigating the long-term effects of the training.

Definition of Terms:

The following operational definitions are provided to clarify the hypotheses and research questions:

assertiveness: The direct communication of one's needs, wants, and opinions without threatening or punishing the other person, (for discussion see Chapter II): also, as measured by a reliable instrument.

assertiveness training: A program of education and/or treatment led by mental health professionals for nonassertive individuals, usually in a small group format which may include behaviour modification, rational-emotive therapy, or social skills training. In this study it
means the six-week, twenty-six hour program at Windsor Western Hospital.

assertiveness inventory: A self-report instrument for the measurement of assertiveness.

personality characteristic: Items of individual personality states or traits susceptible to psychological measurement as measured by standardized tests.

Research Objective:

The first objective of the research was to describe the demographic and personality traits of typical participants in order to understand the type of person referred to assertiveness training.

Hypotheses:

There were research questions which could be addressed in a general way and specific hypotheses to be tested. Thus, with this first objective, some general statements can be made about age, sex, and marital status and the relationship of these features to scores on assertiveness inventories. Moreover, an attempt was made to support the hypothesis that the personality characteristics of participants are within normal range.
Methodology:

1. Personality Profile: Personality Research Form: PRF-E

The Personality Research Form is designed to yield conveniently a set of scores for personality traits broadly relevant to the functioning of individuals in a wide variety of situations. It is thus primarily focused upon areas of normal functioning, rather than upon psychopathology (Jackson 1974, p.4).

One of the goals of this test is "to provide an instrument for measuring broadly relevant personality traits in settings such as ... clinics and guidance centres" (Jackson, 1974, p.4), and it was adopted for this research project after consultation with a research psychologist. The PRF has been used extensively and has proven reliable and valid. It has the additional advantage of a convenient format and does not require especially-trained personnel to administer or score the results. In this study, the test was administered by the training group leader. The completed profiles were scored by the researcher.

2. Demographic Data:

Demographic data were collected on a questionnaire designed to satisfy another research objective and this instrument is described with Objective IV.

Sample:

The sample group for this first objective consisted
of all participants except two persons in three consecutive training groups in the spring of 1978 who volunteered to complete a personality inventory. It was necessary for the subject to attend at least the fourth session at which a personality inventory was administered. These twenty-three respondents did not necessarily complete the program. In the opinion of the trainers, these subjects were representative of persons referred to the program. Fifty respondents to a mail-out questionnaire supplied the demographic data.

Data Analysis:

The findings of this research project are presented here and in the following chapters in association with the delineation of the four objectives. The analysis of variance procedures used to test the hypotheses are described in the Statistical Package for the Social Sciences (Nie, Hull, Jenkins, Steinbremer & Bent, 1975).

Personality Characteristics and Demographic Characteristics:

1. Personality Assessment:

Crites (1969, p.181) suggested there was a trend emerging in psychological research to construct and
standardize personality inventories which were conceived to provide measures of the normal personality in contrast to those used primarily as measures of psychopathology, such as the Minnesota Multiphasic Personality Inventory. These more recent instruments have been developed from widely-known and recognized theories of personality instead of constituting an item pool from existing instruments. One of these inventories, the Personality Research Form, has been described as "the best example of a large-scale personality inventory developed under the construct point of view" (Wiggins, 1973, p. 409). The scales are based upon Murray's need constructs, published in 1938 and the inventory is recognized as relevant and useful for diagnosis and prognosis of adolescent and adult clients.

For each of the twenty variables measured by the PRF, Jackson developed a set of mutually exclusive, substantive definitions (Wiggins, 1973, p. 410). Thus, for example, a person who scores high on the scale entitled "Aggression" is described as "enjoys combat and argument; easily annoyed; sometimes willing to hurt people to get his way; may seek to "get even" with people whom he perceives as having harmed him" (Jackson 1974, p. 6). Similarly, a high scorer on the "Abasement" scale
is a person who "shows a high degree of humility; accepts blame and criticism even when not deserved; exposes himself to situations where he is in an inferior position; tends to be self-effacing" (Jackson 1974, p.6).

The construct of dominance was described in Chapter II as the ability to influence one's interpersonal environment and consequently related to assertive behaviour. The trait adjectives chosen by Jackson for the PRF "Dominance" scale further clarify the construct. They are: "governing, controlling, commanding, domineering, influential, persuasive, forceful, ascendant, leading, directing, dominant, assertive, authoritative, powerful, supervising" (Jackson 1974, p.6). Thus, for individuals scoring low on "Dominance" and high on either "Aggression" or "Abasement", it seems reasonable to formulate a diagnosis of nonassertive and to predict that such an individual will experience frustration or dissatisfaction in interpersonal relationships.

2. Personality Characteristics of the Sample:

The scores of the twenty-three subjects who completed the Personality Research Form will be described with reference to the scales mentioned above. The following hypothesis was formulated: the personality characteristics of participants in assertiveness training
are within normal range as measured by the PRF Form-E.

**Female**

Scores on all of the scales, except Desirability, were distributed within one standard deviation of the mean on the personality profile (see Appendix E). The following ten scales differed most from the norm:

Desirability, Play, Exhibition, Impulsivity, Sentience, Understanding, Autonomy, Dominance, Achievement, and Endurance with only Impulsivity having a score higher than the norm. The profiles indicated that the females in the study:

**Dy** 1. have a poor self-image

**Pl** 2. maintain a relatively serious attitude toward life, don't do many things "just for fun"

**Ex** 3. avoid drawing attention to self

**Im** 4. speak and act without deliberation

**Se** 5. prefer the familiar over new experiences; not particularly perceptive or aware of feelings

**Un** 6. pragmatic; not given to introspection or desirous of intellectual understanding

**Au** 7. comfortable with rules and regulations, compliant

**Do** 8. followers rather than leaders, yield to the influence and direction of others

**Ac** 9. lack motivation to tackle and complete difficult tasks

**En** 10. impatient, lack perseverance

These findings are similar to those of Hartsook
et al. (1976) which suggested that women in assertiveness training are highly concerned with the approval of others and are moderately inhibited in expressing their feelings.

Male

All of the scales except Understanding and Desirability are found within one Standard Deviation of the mean (see Appendix E). On the following five scales the sample mean was higher than the norm: Impulsivity, Dependence, Aggression, Succorance, and Nurturance. On five other scales, the sample mean was lower than the norm: Understanding, Dominance, Autonomy, Desirability, and Affiliation. The profiles indicated that the males in the study:

Im 1. speak and act without deliberation
De 2. take offense easily, are defensive in the face of criticism
Ag 3. are easily annoyed, enjoy an argument
Su 4. lack confidence, readily listen to advice
Nu 5. sympathetic to people in difficulty, paternal, protective
Un 6. pragmatic, not given to introspection or desirous of intellectual understanding
Do 7. followers rather than leaders, yield to the influence and direction of others
Au 8. comfortable with rules and regulations, compliant
By 9. poor self-image
Af 10. reserved, maintain social distance
The male and female populations shared some similarity in terms of Desirability, Impulsivity, Understanding, Autonomy, and Dominance. Thus, these subjects are persons who tend to act impulsively and are practical and not given to analyzing life or themselves in an introspective way. They are concerned about the feelings of others. However, they do not hold high opinions of themselves.

The males and females differed in that the males were more aggressive and defensive while the females focussed more on avoiding risk. It is suggested that the pattern of Nurturance in the male subjects coupled with a relatively low score on Affiliation is a reflection of both paternalistic, protective attitude toward women and discomfort with the expression of feelings, (especially by crying), by others.

The hypothesis that the personality characteristics of participants correspond to a profile of the normal personality was supported. That is to say, the group profile does not indicate abnormality or psychopathology. Notwithstanding this conclusion, some patterns emerge upon comparison of the sample means with normative scores. Thus the women in this sample may be characterized as being somewhat more than average dependent, depressed, passive and impulsive. The males differ from the norm
in being somewhat more dependent, passive or aggresive, impulsive and isolated. These subjects lack the characteristics associated with assertive behaviour, i.e. confidence in their feelings and conviction about their right to express an opinion. These findings suggest that a correct behavioural diagnosis has been made and that the referrals to assertiveness training were appropriate.

There is another reason why assertiveness training would be an appropriate treatment for this population as indicated by PRT scores. Both male and female scores on the Understanding scale suggest a population which is concerned with practical matters rather than the abstract, is not especially introspective or analytical and prefers simple solutions. Behaviour modification as exemplified by assertiveness training would appear to compliment the personality trait. This population differs from a "normal" population only to the extent that nonassertiveness has been identified as a problem.

3. Demographic Characteristics of Respondents:

The follow-up questionnaire yielded socio-demographic data about the trainees.

The fifty respondents ranged in age from twenty to fifty-five with fifty-two percent being under thirty-five years and sixty-six percent under forty. This
distribution is reportedly typical of the groups at the hospital. Sixty-six percent of participants were female and thirty-four percent were male.

Of this group, fifty percent were married, twenty-six percent were single, sixteen percent were separated or divorced, four percent had common-law unions and two percent or one person were widowed. While they were in the training program, sixteen percent were in-patients, seventy-four percent were out-patients, and the remainder were persons whose patient status changed during the six-weeks of training. That means that at least thirteen persons or twenty-six percent had a formal psychiatric diagnosis and were receiving treatment.

In responding to a question about number of years of education, most people did not specify number of years completed, merely that they attended. Therefore, the profile of level of education cannot be accurately drawn. However, thirty-four percent attended college or university, fifty-two percent attended high school, eight percent had some vocational training, while the remainder, six percent or three persons, had completed only public school. In overview therefore, a significant proportion of this group were comparable in academic achievement or level of intelligence to the college undergraduates most frequently used as subjects in research and on whom normative data were based.
4. Participants Use of Spare Time:

It was believed that the pattern of spare-time activities, particularly socializing activities, would yield information about the rate of participation in interpersonal exchanges. Since non-assertive persons frequently avoid some social situations out of fear of discomfort due to limited social skills (Gambrill 1977), it is a measure of assertiveness if participants rate interpersonal situations as important to them in their spare time. Respondents were asked to rate eight activities as to their importance to them as spare time activities (Follow-up Questionnaire question nineteen, see Appendix C).

No comparison is available between the pre-test state and follow-up social patterns. However, the respondents' scores indicate that social exchange is "very important" in their lives. "Spending time with friends or family" was cited as very important by forty-six percent of respondents. Similarly, twenty-two percent cited "going out with friends to social or sports events", and fourteen percent chose "joining new groups".

Of note also, are the twenty-four percent who gave a high rating to "taking up new interests or hobbies". This can be interpreted as another facet of increased levels of assertiveness if it is assumed to reflect self-confidence and being more in control of one's life.
This may also be true for the twenty-two percent of respondents who said that reading and hobbies were very important to them. Only six percent said television was important.

Scores on each of these variables correlate strongly with both inventory scores. Therefore, it seems justifiable to describe this sample as persons leading active and full lives which provide adequate opportunity for reinforcement of new assertive skills.

This chapter presented a discussion of the classification of the research project, the population, a list of assumptions, and definition of relevant terms. It also described the first research objective, which was the description of demographic and personality characteristics of participants in the training program. The methods of data collection and analysis of findings are included.
CHAPTER IV
Research Objective and Analysis: Change in Levels of Assertiveness During Training

The second research objective was to evaluate the training objective which is to increase the level of assertive behaviour in participants. This required an evaluation of the test instrument.

Hypotheses:
Two hypotheses were examined. These were: 1) the hospital's inventory is a valid and reliable instrument for measuring assertiveness in persons referred to the program; and 2) persons who complete an assertiveness training program demonstrate an increased level of assertiveness.

Methodology:

Assertiveness Inventories 1) Hospital Inventory. From the inception of the program at Windsor Western Hospital, an assertiveness inventory was used as both pre-test and post-test. This inventory is comprised of fifty items and is in large part similar to the Assertiveness Inventory published by Alberti and Emmons (1974,
p. 117). The current version, revised in February 1977, has a maximum score of two hundred and interpretation as follows:

- below 90 - passive
- 90-110 - low assertiveness
- 110-125 - appropriately assertive
- over 125 - aggressive

There had been no attempt made to standardize or validate this inventory, and indeed, this author has not discovered any published data on the reliability of the Alberti and Emmons' instrument. The items on the hospital inventory have face validity, i.e. they appear to relate to issues of assertive behaviour (see Appendix A). Scores on this inventory were available for thirty-nine pre-test subjects, and twenty-seven post-test subjects.

2) Rathus Assertiveness Schedule (RAS). The RAS was developed by Spencer Rathus and published in 1973, (Rathus 1973). This is a thirty-item inventory which has been standardized and validated (Rathus & Nevid 1977). The items cover a wide range of behaviour and are scored on a plus and minus scale with the average score being between zero and +10 in a range of -90 to +90, (see Appendix B). Scores on this inventory were available for twenty-three pre-test subjects and eleven post-test
subjects after the instrument was introduced in December 1977.

Sample:

The sample for this second objective was made up of persons who had completed the training program between February 1977 and April 1978 and who had responded to assertiveness inventories as pre-test and post-test. Some portion of this group completed two sets of inventories at the two points in time in order to provide data for comparison of the instruments after the RAS was introduced. Thus, at pre-test there were thirty-nine hospital instruments available and twenty-three Rathus Assertiveness Schedules. At post-test, there were twenty-seven hospital inventories and eleven RAS.

Achievement of Assertiveness:

During the process of formulation of this research project, the author considered what data were available in hospital records for the measurement of assertiveness. A major objective was to examine the effect of training and the author had perforce to rely upon the hospital instrument which was used as pre-test and posttest. Hospital staff had apparently adopted this assertiveness inventory without investigating if it were standardized.
They also adopted an answer scale for which no documentation can be located.

Therefore, in order to assess changes in levels of assertiveness during the training program, it was necessary first to establish whether the instrument was statistically reliable and valid beyond face validity, i.e. whether the instrument was free from error and whether the test measures what it claims to measure. Only if that were established, could conclusions be drawn about the training objective.

**Assertiveness Inventory Evaluation:**

The first procedure in establishing the reliability of the instrument was an examination of variance. The total variance of a set of measurements is composed of two sources: true variance and error variance. These are documented in standard statistical texts (Guilford 1978, Freeman 1965).

Reliability theory provides a basic definition of the reliability of a set of measurements as "the proportion of the variance that is true variance" (Guilford 1978, p. 408).

An estimate of reliability is most appropriately applied to a test composed of equivalent units, i.e. the parts or items all measure the same trait.
same degree (Guilford 1978, p. 430). In behavioural and social measurement, the property of reliability depends upon the population measured as well as upon the measuring instrument (Guilford 1978, p. 408). Therefore, reliability refers to a set of measurements applied to a certain population under certain conditions.

An internal-consistency estimate of reliability can be operationalized with item-statistics which consider each item as a subtest in a larger composite and which refer to the relation of variance to item difficulty, to item correlations, to the range of item difficulty, and to total-score distribution (Guilford 1978, p. 421-424). Numerous formulae have been developed as an improvement on split-half methods. Coefficient alpha was selected as appropriate for the present data and because it was readily available as an optional subprogram of the Statistical Package for the Social Sciences.

Coefficient alpha for the responses to the fifty items of the hospital instrument yielded a value of 0.938 from which we conclude that this assertiveness inventory does possess internal reliability; it is an accurate measure. The square root of this value indicates that the minimum validity of the measure is 0.964 which is strong evidence for high construct validity of the instrument. It actually does measure assertiveness.
However, the variance of observed scores is also a reflection of error variance which can be measured by correlating scores by the same subjects on an independent but similar set of items, i.e. Rathus Assertiveness Schedule. In this instance, the focus is upon the error portion of the total variance rather than upon the true variance which was measured by the internal consistency coefficient described above.

This research used a standard coefficient of correlation, Pearson's product-moment coefficient in order to discover the relationship between the two instruments. Values of $r = 0.812$, $r^2 = 0.659$ were obtained which indicated a strong relationship between the two variables and suggests a relatively high predictive validity of one test on the other. This use of $r$ yields what is called a validity coefficient (Guilford 1978, p. 87). The error variance reflected here may indicate that the two inventories do not measure exactly the same aspects of assertiveness. Nevertheless, the high values of the two correlation coefficients enable us to support the hypothesis that the hospital inventory is a valid and reliable instrument for measuring assertiveness in persons referred to the assertiveness training program.
Comparison of Inventory Scores:

Scores were available for thirty-nine pre-test and twenty-seven posttest hospital assertiveness inventories and twenty-three pre-test and eleven posttest RAS. These raw scores are presented in Table Two: Comparison of Scores on Hospital Assertiveness Inventory Over Time, and Table Three: Comparison of Scores on Rathus Assertiveness Schedule Over Time. As noted in the preceding section, the two inventories appear not to measure exactly the same qualities of assertiveness. Interpretation is further complicated by a lack of documentation for each scale and by the fact that both are bipolar.

The hospital instrument scores will be discussed first, (Table Two). Reference will be made first to mean scores which show an increase from eighty-four to ninety-six out of a maximum score of two hundred. This indicates a level of low assertiveness based on the interpretation scale provided by hospital staff. A change of ten points is thought to be significant by personnel using this instrument and familiar with individual participants in the training. Therefore, conclusions about the effects of training are based on their expert opinions rather than upon any published evidence supporting the reliability
### TABLE 2. Comparison of Scores on Hospital Assertiveness Inventory Over Time

<table>
<thead>
<tr>
<th>SCORE</th>
<th>PRE-TEST</th>
<th>POST-TEST</th>
<th>FOLLOW-UP</th>
</tr>
</thead>
<tbody>
<tr>
<td>maximum = 200</td>
<td>n=39</td>
<td>n = 27</td>
<td>n=50 **</td>
</tr>
<tr>
<td>Over 125</td>
<td>9%</td>
<td>26%</td>
<td>16%</td>
</tr>
<tr>
<td>aggressive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>111-125</td>
<td>2</td>
<td>0</td>
<td>24</td>
</tr>
<tr>
<td>appropriately assertive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90-110</td>
<td>28</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>low assertiveness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>below 90</td>
<td>61</td>
<td>44</td>
<td>40</td>
</tr>
<tr>
<td>passive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>MEAN</td>
<td>84.46</td>
<td>96.77</td>
<td>96.28</td>
</tr>
<tr>
<td>STD.DEV.</td>
<td>26.44</td>
<td>33.88</td>
<td>28.73</td>
</tr>
</tbody>
</table>

* Intervals as used by Hospital Staff

** There is some overlap of persons in the sample groups. For only eight persons are there complete sets of data.
of the scale intervals. However, the significance of mean scores is confounded by the bipolar scale.

The distribution of scores provides an alternative mode of evaluation. At posttest no one achieved a score in the "appropriately assertive" range. There was a seventeen percent increase in aggressive level scores and a seventeen percent decrease in passive level scores. The concept of time-lag in changing self-perception may account for the small change in levels. The need for additional practice of newly acquired skills in everyday life may further account for the distribution of scores, particularly of those at the aggressive level.

The scores on the RAS indicate a similar distribution and bipolar shift, see Table Three. There is a gain of twenty points in the mean score from pre-test to posttest and Rathus claims such a change is significant (Rathus & Nevid 1977, p. 139). However, as noted above, the use of means is confounded by the bipolar scale. An interpretive scale has not been published for the RAS to this author's knowledge. Instead, percentile norms provide information on an individual's overall assertiveness relative to others in his social milieu (Quillin, Besing & Dinning, 1977, p. 418). Such norms are useful where only a gross index of assertiveness is
TABLE 3. Comparison of Scores on Rathus Assertiveness Schedule Over Time.

<table>
<thead>
<tr>
<th>SCORE Range</th>
<th>PRE-TEST</th>
<th>POST-TEST</th>
<th>FOLLOW-UP</th>
</tr>
</thead>
<tbody>
<tr>
<td>+31 and over</td>
<td>8.7%</td>
<td>0%</td>
<td>12.0%</td>
</tr>
<tr>
<td>+21 - +30</td>
<td>4.4%</td>
<td>9.1%</td>
<td>6.0%</td>
</tr>
<tr>
<td>+11 - +20</td>
<td>0%</td>
<td>36.4%</td>
<td>10.0%</td>
</tr>
<tr>
<td>0 - +10</td>
<td>4.4%</td>
<td>16.2%</td>
<td>14.0%</td>
</tr>
<tr>
<td>-1 - -10</td>
<td>21.7%</td>
<td>27.3%</td>
<td>14.0%</td>
</tr>
<tr>
<td>-10 - -20</td>
<td>13.0%</td>
<td>0%</td>
<td>24.0%</td>
</tr>
<tr>
<td>-21 - -30</td>
<td>13.0%</td>
<td>9.1%</td>
<td>8.0%</td>
</tr>
<tr>
<td>-31 and under</td>
<td>34.8%</td>
<td>0%</td>
<td>12.0%</td>
</tr>
</tbody>
</table>

| TOTAL        | 100%     | 100%      | 100%      |
| MEAN         | -16.52   | 4.00      | -2.06     |
| STD.DEV.     | 31.55    | 13.92     | 26.59     |

*Scale devised by author after Rathus (1977) and Quillin, Besing & Dinning (1977). It is suggested that a score of +31 and over is "aggressive".

** There is some overlap of persons in the sample groups. For only eight persons are there complete sets of data.
required. The data generated by Quillin et al. (1977) indicated that total RAS scores were not correlated significantly with sex. In order to provide some basis for comparison with the hospital inventory scale, the author devised the interpretation scale in Table Three with reference to Rathus' note that scores between zero and ten represent average assertiveness (Rathus & Nevid 1977, p. 139).

The change in the RAS scores between pre-test and post-test exhibits a shift similar to scores on the hospital inventory but without any dramatic increase at the "aggressive" level. The change in mean scores was from minus sixteen to plus four. Further interpretation of these results is of questionable value because of the small post-test sample, eleven persons.

The hypothesis stated that: persons who complete an assertiveness training program demonstrate an increased level of assertiveness. The research findings drawn from both instruments do not support this hypothesis. However, the pattern of change in scores suggests that the assertiveness training program at the hospital has had some effectiveness. Low mean scores may suggest that trainees who enter at a passive level achieve low assertiveness for the most part and may not accurately reflect the bipolar movement toward the appropriate level.
This chapter described the second research objective which was to evaluate the training objective. This examination of the change in levels of assertiveness during the training program required an evaluation of the hospital's assertiveness inventory. The methods of data collection and analysis of findings were presented in sequence.
CHAPTER V

Research Objective and Analysis: Maintenance of Assertiveness Over Time

The third research objective was to evaluate the degree to which participants maintain their achieved assertiveness over time.

Hypothesis:

It was hypothesized that persons who complete an assertiveness training program are able to maintain the level of assertiveness they achieved in training.

Methodology:

A follow-up study was initiated in which graduates of the training were asked to complete the two assertiveness inventories which had been used as pre-test and post-test, that is the hospital inventory and the Rathus Assertiveness Schedule described above (Chapter IV). Ninety-five sets of instruments were mailed out and fifty were returned.

Sample:

The sample for the measurement of temporal stability of gains consisted only of persons who had
completed the six-week training program between its inception in October 1975 and April 1978 when the author began her research. The sample was limited to persons who had completed the training based on the conviction that the effects of assertiveness training could best be measured for persons who completed the full program. Fifty persons responded to the mail-out survey.

Maintenance of Change in Assertiveness Over Time:

At follow-up, scores on both inventories were available for fifty participants. The pattern of change over time of the hospital instrument scores (Table Two) shows a distinct movement or regression towards appropriate assertiveness from both extremes, i.e. "passive" and "aggressive". Additional practice with assertive behaviour together with the effect of time-lag on change in self-perception may account for this improvement. At follow-up, twenty-four percent achieved a score in the "appropriately assertive" range while no one did so at posttest. This suggests that trainees are indeed able to maintain a level of skill.

The scores on the RAS yield a somewhat different distribution (Table Three) but a similar pattern overall. At follow-up, the mean score dropped by six points which may indicate that participants who were quite passive are not maintaining the level of assertiveness achieved in training. The distribution of scores from posttest to
follow-up toward the extreme values is in contrast to the distribution of scores on the hospital inventory.

Future research in item analysis for both instruments could yield item norms and provide information as to relative assertiveness in specific target situations and provide some explanation for the different patterns in the gross indices of these instruments. The author speculates that the different distribution of scores is related to the item composite of each inventory. It would be of very limited value to statistically transform scores from either scale to the other since in neither case has the reliability of the scale been established.

The research project hypothesized that: persons who complete an assertiveness-training program are able to maintain the level of assertion they achieved in training. Mean scores could not be used to support the hypothesis. The distribution of scores on the hospital inventory suggests some degree of maintenance, but the pattern of scores on the RAS shows some loss of skill.

Nevertheless, to the follow-up question whether the participants believed they were maintaining the level of assertiveness achieved in the group, forty-two percent responded "somewhat" and twenty-two percent said "a lot" (see Table Four). The women expressed somewhat stronger
belief than the men, (twenty-four percent as opposed to seventeen percent reporting "a lot"). It may well be that, for this population, any movement out of the polarized nonassertive positions is therapeutic and important to the individuals. The patients' opinions support this assumption.

TABLE 4. Participants' Opinions About Maintenance of Assertiveness.

"Do you believe that you are maintaining the level of assertiveness that you achieved in the group?"

<table>
<thead>
<tr>
<th></th>
<th>Male (n=17)</th>
<th>Female (n=33)</th>
<th>Composite (n=50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>11</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>A little</td>
<td>30</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td>Somewhat</td>
<td>42</td>
<td>43</td>
<td>42</td>
</tr>
<tr>
<td>A lot</td>
<td>17</td>
<td>24</td>
<td>22</td>
</tr>
</tbody>
</table>

100% 100% 100%
This chapter described the third research objective which was to evaluate the degree to which participants maintain their achieved assertiveness over time. The methodology and findings were also presented.
CHAPTER VI

Research Objective and Analysis: Evaluation of Training Program by Participants

The fourth objective of the study was to report participants' self-perception around issues of assertiveness including their opinions as to the value of the program, and their belief that they were able to generalize from the training experience.

Hypotheses:

The following two hypotheses reflect the goal of documenting the trainees' self-reports:
1. Persons who complete assertiveness-training are satisfied with the training program.
2. The system by which referral is made to the program is satisfactory to the patients.

In more general terms, the research will address the question of what aspects of the program are judged most important by the participants. In addition, it will explore the reactions of other people to trainees who are working on changing their interpersonal behaviour. For all of the above questions, reference will be made to participants' perception of change and their scores on instruments which purport to measure such change.
Methodology:

The research objective described above took the form of a follow-up study in order to yield objective evaluation of the program, to contribute to documentation of assertiveness training with a psychiatric out-patient population, to contribute to the area of follow-up studies, and to indicate the appropriateness of referrals to the program.

A mail-out format was judged most expedient, (in part, because people were being asked to complete assertiveness inventories for the third time), for the number of persons involved, (ninety-five), their diffused geographic distribution in Essex County, and economic restraints. Therefore, it was necessary to develop an instrument which would complement the inventories and which would elicit subjective responses to questions about the degree to which persons could transfer acquired skills to novel situations. After consultation with staff at Windsor Western Hospital, with faculty members and fellow students at the School of Social Work, and reflection upon the issues raised in the literature, a self-report questionnaire of twenty-eight items was devised, (see Appendix C). In addition to answering the twenty-eight questions, subjects were invited to submit comments about any aspect of the program.
Sample:

The sample group for the follow-up study was the same as that identified in Chapter V, that is, the ninety-five persons who completed the training program between October 1976 and April 1978 and for whom addresses could be found. Fifty persons returned the completed questionnaire.

Clients' Perception of Personal Assertiveness:

A major focus of the follow-up study was the reporting of participants' awareness of past and present problems of non-assertiveness, of their perception of the role of assertiveness training in handling these problems, and of their assessment of the effectiveness of their interpersonal behaviour, or level of assertiveness after training. (These represent the nine variables of questions 3, 9, 10, 13, 14, 15, 16, 17, 18 on the Follow-up Questionnaire, Appendix C).

Responses to questions about interpersonal functioning were correlated with scores on each of the two assertiveness inventories which participants completed at follow-up.

Relationships among the variables were measured by the statistic eta which is appropriate for correlating interval level data with ordinal data. For the purpose of
this research, it is assumed that scores on the two assertiveness inventories represent interval scales and that the relationship among variables is curved rather than linear which is encountered when non-test variables are correlated with test scores (Guilford 1978, p. 296). A high value of the eta coefficient assures that a relationship exists between variables and tells us about the degree of relationship (Guilford 1978, p. 300). Moreover, eta squared provides an interpretation of the proportion of variance in the dependent variable (Nie et al. 1975, p. 230).

For each of the variables about awareness of assertiveness, the correlation yielded high eta values, from 0.83 to 0.99. Consequently, the proportion of variance accounted for was similarly high, from sixty-eight percent to ninety-eight percent. Therefore, it is reasonable to conclude that there is a strong relationship between the scores on the tests and the pattern of response of participants' awareness of their level of assertiveness.

The frequency distribution of responses to individual questions contributes further to an understanding of the nature of change in clients. Only four percent of respondents said they had not achieved any assertiveness in the problems they had when first entering training. Fifty-
four percent reported they had achieved some assertiveness and forty-two percent claimed "a good deal of assertiveness".

The success of the teaching component of the program is reflected in the fact that fifty-four percent of respondents recognized that they had one or two other areas in their lives where they were nonassertive. Forty-two percent reported that they discovered three or more additional problem areas during the group training. Moreover, forty-six percent of respondents claimed that the training program was very important in helping them to handle these additional areas of nonassertiveness. These figures represent the degree to which participants were able to generalize from the specific training experience to other areas in their lives and provide major support for the continuing use of assertiveness training programs with psychiatric out-patients who suffer from low self-esteem and have limited interpersonal skills.

All respondents reported a change in their awareness of their own needs in any given situation; forty percent reported a great change. More to the point, sixty-four percent felt at least "somewhat" confident about asserting themselves, the women more so than the men. These patterns of awareness and confidence probably reflect integration of the belief that individuals have a
right to their feelings and opinions and have the right to express these.

There is little doubt that respondents did learn to understand and define assertiveness, both generally and personally. They were able to describe themselves as they were at the start of training and as they were at follow-up. These self-reports corresponded to the general pattern of scores on the inventories and, at follow-up, tended toward the norm from both polarities. They are illustrated in Table Five. Comparison of Self-Definition of Assertiveness Over Time.

<table>
<thead>
<tr>
<th>Level of Assertiveness</th>
<th>Start of Training</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>male</td>
<td>female</td>
</tr>
<tr>
<td></td>
<td>n=17</td>
<td>n=33</td>
</tr>
<tr>
<td>generally passive</td>
<td>47%</td>
<td>39%</td>
</tr>
<tr>
<td>sometimes passive</td>
<td>29%</td>
<td>40%</td>
</tr>
<tr>
<td>sometimes assertive</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>generally assertive</td>
<td>18%</td>
<td>15%</td>
</tr>
<tr>
<td>sometimes aggressive</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>generally aggressive</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
It is interesting that none of the respondents perceived themselves as "aggressive" in contradiction to the inventory scores which recorded twelve to sixteen percent as aggressive. Perhaps these patients are over-enthusiastic, or perhaps the test answer scales need to be revised. It is possible that a very assertive person could score as "aggressive".

It is clear that increased assertiveness has not created significant problems for the trainees in their interpersonal relationships. This is an important finding because a frequently expressed fear of nonassertive persons is that of rejection, of eliciting anger or hurt feelings in another if they express their feelings or opinions. Very few respondents recorded "more critical" or "more hostile" reactions from others since they attended assertive training. Many reported "no difference", but most said people were reacting in a "more friendly" or "more accepting" way. (The categories polled were: strangers, co-workers, boss, friends, spouse, family, other, none).

As noted earlier, about sixty-five percent of respondents believe they are maintaining a new level of assertiveness "somewhat" or "a lot". Although mean test scores indicate that for the most part they are functioning at a level of assertiveness, which is less than "appropriate" or ideal, the respondents themselves say the change
is important.

**Clients Opinions About the Training Program**:

The focus of this research project excluded evaluation of the content or operation of the assertiveness training program. However, a follow-up study afforded a good opportunity to collect more specific feedback about the program than the trainers have previously received. Moreover, the trainers wanted to know if there was a relationship between scores on inventories and patients' judgement of whether the program had been helpful to them and whether they would recommend it to others.

Correlation of twenty-three variables with test scores yielded high values of the $\eta$ coefficient (0.80 to 0.97) and of $\eta^2$ (64% to 94%). See Table Six: Comparison of Scores on Inventories with Responses to Follow-up Questionnaire. In the frequency distribution of responses, fifty percent gave the highest rating to the question about finding the training group helpful while an additional thirty-six percent reported the training as "somewhat" helpful. A parallel pattern of response was found to the question of whether trainees would recommend the group to others. Sixty percent said "a lot" and an additional thirty-four percent said "somewhat".

These findings together with the factors of con-
### TABLE 6. Comparison of Scores on Hospital and Rathus Inventories with Responses to Follow-up Questionnaire: Clients' Opinions About the Training Program

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>eta</th>
<th>Hospital Inventory</th>
<th>Rathus Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GROUP FACTORS:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>opportunity to share problems</td>
<td>.85</td>
<td>.90</td>
<td></td>
</tr>
<tr>
<td>opportunity to hear other people's difficulties</td>
<td>.87</td>
<td>.87</td>
<td></td>
</tr>
<tr>
<td>opportunity to learn assertiveness</td>
<td>.92</td>
<td>.90</td>
<td></td>
</tr>
<tr>
<td>opportunity to practice behavior and language</td>
<td>.93</td>
<td>.88</td>
<td></td>
</tr>
<tr>
<td>meeting other people</td>
<td>.86</td>
<td>.93</td>
<td></td>
</tr>
<tr>
<td>getting to know the therapists</td>
<td>.88</td>
<td>.87</td>
<td></td>
</tr>
<tr>
<td>identifying problem areas and keeping a log</td>
<td>.89</td>
<td>.88</td>
<td></td>
</tr>
<tr>
<td>time of group meetings</td>
<td>.87</td>
<td>.91</td>
<td></td>
</tr>
<tr>
<td>location of group meetings</td>
<td>.90</td>
<td>.91</td>
<td></td>
</tr>
<tr>
<td>time spent completing inventories of assertiveness</td>
<td>.78</td>
<td>.95</td>
<td></td>
</tr>
<tr>
<td><strong>TRAINING FACTORS:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>role playing yourself</td>
<td>.86</td>
<td>.87</td>
<td></td>
</tr>
<tr>
<td>watching others role play</td>
<td>.88</td>
<td>.89</td>
<td></td>
</tr>
<tr>
<td>listening to therapists teach assertiveness</td>
<td>.92</td>
<td>.85</td>
<td></td>
</tr>
<tr>
<td>listening to therapists share experiences</td>
<td>.77</td>
<td>.87</td>
<td></td>
</tr>
<tr>
<td>practicing outside the group</td>
<td>.94</td>
<td>.88</td>
<td></td>
</tr>
<tr>
<td>sharing your experience with the group</td>
<td>.88</td>
<td>.93</td>
<td></td>
</tr>
<tr>
<td>sharing your experience with friends and family</td>
<td>.74</td>
<td>.93</td>
<td></td>
</tr>
<tr>
<td>role playing plus instruction</td>
<td>.91</td>
<td>.89</td>
<td></td>
</tr>
<tr>
<td><strong>OTHER FACTORS:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>importance of training</td>
<td>.84</td>
<td>.93</td>
<td></td>
</tr>
<tr>
<td>support from friends and family</td>
<td>.90</td>
<td>.88</td>
<td></td>
</tr>
<tr>
<td>helpfulness of training</td>
<td>.80</td>
<td>.95</td>
<td></td>
</tr>
<tr>
<td>recommend this group to others</td>
<td>.73</td>
<td>.97</td>
<td></td>
</tr>
</tbody>
</table>
confidence in asserting oneself and the belief that one is maintaining an improved level of assertiveness, provide further support for the contention that the gains from the program, although small, are important to the participants.

Trainees are able to recall which aspects of the training program were the most important in helping them to be assertive. In order of importance (percentage rating as "very important") the significant components were:

- role playing plus instruction
- watching others role play
- sharing your experience with the group
- listening to the therapists teach about assertiveness
- practicing outside the group
- listening to the therapists share their own experiences

The experience of a group program was distinguished from the training techniques reported above in an attempt to measure the significance of a group approach in assertiveness training, (since the training is not, by definition, exclusively a technique to be used in groups). Overall, fewer respondents scored the group variables as "very important". It is possible that there was some confusion between the two questions. However, it might also be concluded that participants did indeed rate the training aspect of their experience higher than the group factors.
The group factors which were rated as "very important" by at least a third of respondents were:

- opportunity to practice new behaviour and language
- opportunity to learn about assertiveness
- opportunity to hear about other people's difficulties

These findings provide some support for the use of assertiveness training in a group setting for persons who are functioning at the level of this sample.

The Process of Referral:

The research project investigated five variables identified as pertaining to the referral process and hypothesized that the system by which referral is made to the program is satisfactory to the patients. The intent was to monitor the role of staff in providing sufficient information to patients being referred to assertiveness training in the belief that informed patients would be more motivated to participate and complete the program. The referral process should also reflect staff's nominating only those persons for whom assertiveness training was an appropriate treatment.

Respondents reported that adequate explanation of the reason for the referral was given to seventy percent and of the function of the group to sixty-six percent. Only ten percent indicated that they would have liked
"a lot" more information beforehand, while forty-two percent said they wanted no more information at all.

The correlation of responses on these items with scores on the two inventories yielded high eta values which suggests a strong relationship between the achievement of assertiveness and satisfaction with the referral. Therefore, the hypothesis that the system by which referral is made to the program is satisfactory to the patient was supported.

This chapter described the fourth research objective which was to report participants' self-perception around issues of assertiveness and to report their opinions about components of the training and of the referral process. The methodology and analysis of findings were also presented.
CHAPTER VII

Summary and Conclusions

The purpose of this study was an evaluation of an assertiveness training program for psychiatric outpatients at a public general hospital in Windsor, Ontario. Four objectives were identified. These were: 1) description of personality and demographic characteristics of trainees, 2) measuring of change in levels of assertiveness from beginning of training to completion of training, 3) measuring maintenance of levels of assertiveness over time, and 4) reporting participant's evaluation of the program and self-perception of change. In order to accomplish the two measurement goals, it was necessary to evaluate a test instrument for reliability and validity.

The research represented the first evaluation of this assertiveness training program which had been in operation for two years in the Department of Psychiatry at a general hospital in Windsor.

The demands of the program evaluation on the design of the research project were satisfied through an analysis of covariance program from the Statistical Package for the Social Sciences (Nie et al. 1975).
The following summary is organized around the four research objectives.

**Personality and Demographic Characteristics:**

The personality traits of participants were measured with the Personality Research Form-E developed by Douglas Jackson. The sample for the testing was drawn from persons actively involved in training while the author was doing her research and is made up of twenty-three persons who volunteered to complete the standardized inventory and who were described as "typical" by hospital staff.

Interpretation of participants' responses on the Personality Research Form indicated that the sample scored within the normal range of the twenty scales measured. The pattern of responses was judged typical of persons with low self-esteem who are compliant, impulsive, seeking approval, and not introspective. Assertiveness training was suggested as an appropriate mode of treatment for this group of out-patients.

**Measure of Change in Levels of Assertiveness:**

In order to assess the effects of training, an evaluation of the hospital's assertiveness inventory was necessary. The assertiveness inventory which was evaluated
for its reliability and validity was a fifty-item test adapted by hospital staff and in use as pre-test and post-test for two years. A recognized, standardized inventory, the Rathus Assertiveness Schedule was introduced at this author's request in December 1977 to provide a basis for comparison of scores. Item-analysis yielded a coefficient of reliability, $\alpha$, of 0.938 which established the internal reliability of the instrument. In addition, scores on two test instruments were compared and a validity coefficient, Pearson's product-moment coefficient, yielded a value of 0.812 which suggests a high predictive validity. The hypothesis related to the reliability and validity of the instrument was accepted.

To assess the effects of training, scores on two inventories of assertiveness at pre-test and post-test were compared. Because of weakness in the interpretation scales, changes in scores did not support the hypothesis that persons in training do increase their level of assertiveness. Mean scores on the hospital inventory indicate that subjects were functioning at a level of low assertiveness at post-test and probably reflects the preponderance of passive trainees. This finding relates also to the characteristics of participants as described by the
PRF-E.

Those persons who had completed the training and for whom scores on inventories were available at pre-test and posttest represented the sample for this research objective.

Measure of Temporal Stability of Assertiveness:

The measurement of maintenance of levels of assertiveness over time used a sample drawn from a population of ninety-five who had completed the training of whom fifty or fifty-two percent responded to a mail-out request for completion of the two assertiveness inventories used in the program as pre-test and posttest. A follow-up questionnaire also asked for participants' perception of how well they were maintaining their assertive skills.

Scores on the inventories at posttest and follow-up were correlated along with self-reports about the maintenance of increased levels of assertiveness. Support was not established for the hypothesis that persons who complete training are able to maintain the level of assertiveness they achieved. The pattern of change showed some maintenance and it is suggested that the gains, although relatively small, are nevertheless important for this population.
Participants' Evaluation of the Training Program:

The reporting of participants' evaluation of the program was accomplished through a fourth instrument designed by the author as a follow-up questionnaire. The sample was the same fifty graduates of the training who responded to a mail-out request for completing the inventories as described above for the third objective.

Correlation of test scores with reports of interpersonal functioning and awareness of needs yielded high \( \eta \) values, 0.83 to 0.99 over nine variables. This suggests that participants integrated a good deal of the theoretical content of the program and relates to the issue of generalization of training to novel situations. Participants were able to generalize during the six-weeks of training, but it is not known to what specific degree this was maintained.

The hypothesis that persons who complete assertiveness training are satisfied with the program was supported.

There was a strong correlation between test scores and variables relating to the referral process by which persons enter the training program. This indicated that patients had sufficient information beforehand and that staff were referring appropriate patients. The hypothesis
that the referral system was satisfactory to the patients was supported.

Implications:

The follow-up evaluation of the Windsor Western Hospital assertiveness training program could not establish whether the training was effective in increasing the level of assertiveness in participants or whether changes were maintained for up to two years after training.

An extension of the program by two to four sessions might be a means of enabling patients to make more significant gains. A mini-program or refresher course after a few months might contribute to improved ability to generalize from the training experience as well as to maintain or increase assertiveness. Future programming might be more effective if trainers give more consideration to the components rated as very important by participants as discussed in Chapter VI.

Limitations:

The interpretation of the findings of the research is influenced by the following limitations.

Although the results suggested improved functioning
of this out-patient population, it is not likely that these can be generalized to chronic or long-term patients who may be attending an out-patient mental health clinic. Nor can the results be generalized to participants in self-improvement programs offered by other community agencies.

A possible confounding factor is alternate and/or continuing psychotherapy for these subjects. It is not known how many persons received additional therapy, nor what form this might have taken. Such treatment, by further reducing stress levels, would likely contribute to maintaining and/or increasing assertiveness.

It should be remembered also that this program evaluation considered only outcome, not content, process, structure, or impact.

Suggestion for Further Study:

Assertiveness training as an intervention strategy with out-patients would benefit from a comparison of its effectiveness with a control group and with other training groups in the community, such as those sponsored by social service agencies, community colleges, the "Y", university counselling centres, and private consultants. Such a comparison should include same-sex groups as well
as mixed groups. Future research should take into account the effects of other forms of psychotherapy the patients may be receiving.

The writer would also recommend an investigation of the use of assertiveness training for mental health professionals who are involved in counselling persons for whom nonassertiveness is a problem. The writer believes that personal assertiveness is a prerequisite for any trainer in a position to influence clients so that he/she may communicate both positive and negative feelings to clients more effectively.

During this study, no contact was established with persons who had dropped out of the training program. Since the referrals were probably appropriate and these persons could benefit from assertiveness training, it is important to investigate why they were not motivated to complete the program.

Recommendations:

Although the research did not establish conclusively that the assertiveness training program at Windsor Western Hospital was effective in helping a population of psychiatric out-patients to improve their level of assertiveness or to maintain their improvement, the author recommends
that the program be continued on the basis of the pattern of change towards appropriate assertiveness. It is suggested that follow-up to the training be expanded from the present single two-hour session to two or three sessions in order to consolidate gains and to increase participants' ability to generalize their skills to a wide variety of situations. In addition, the program should be expanded to include both day and evening groups.

Future research should address itself to the problem of interpreting the answer scales of instruments such as these assertiveness inventories.

The findings of the research study were presented in this chapter. The implications of these findings and the limitation of the findings were also discussed. The author made some suggestions for further studies and made some recommendations for future programming.
ASSERTIVENESS INVENTORY

The following questions will be helpful in assessing the degree of your "assertiveness" and "non-assertiveness" in various everyday situations.

Please read each item carefully and then draw a circle around the number of a rating scale (from 0 to 4) which describes you best.

Your scores will be tallied and interpreted for you by our examiners. You must answer every item in order to obtain a valid assessment.
Do not skip any items and answer as honestly as you can.

Key: 0 - "no" or "never"
   1 - "somewhat" or "sometimes"
   2 - average
   3 - "usually" or "a good deal"
   4 - "yes" or "always"

1. I speak out in protest when someone takes my place in line.................. 0 1 2 3 4
2. I have confidence in my own judgement........................................... 0 1 2 3 4
3. I speak up in a discussion when I disagree with what is said.............. 0 1 2 3 4
4. If a person has borrowed something from me and is overdue in returning
   it, I mention it.......................................................... 0 1 2 3 4
5. I continue to pursue an argument even though the other person has
   had enough............................................................... 0 1 2 3 4
6. If someone keeps kicking my chair in a movie or lecture I'll tell
   them to stop............................................................. 0 1 2 3 4
7. When a latecomer is waited on before me I call attention to it........... 0 1 2 3 4
8. I am able to openly express love and affection................................ 0 1 2 3 4
9. I tend to step in and make decisions for others............................... 0 1 2 3 4
10. I can refuse unreasonable requests made by friends.......................... 0 1 2 3 4
11. I am inclined to finish people's sentences for them........................ 0 1 2 3 4
12. I get into verbal/physical fights with others, especially strangers..... 0 1 2 3 4
13. At family gatherings I control the conversation............................. 0 1 2 3 4
14. When meeting a stranger I am first to introduce myself and begin
    a conversation....................................................... 0 1 2 3 4
15. I think I am right in most arguments or debates............................. 0 1 2 3 4
Keys: 0 - "no" or "never"
1 - "somewhat or "sometimes"
2 - "average"
3 - "usually" or "a good deal"
4 - "yes" or "always"

16. I often step in and make decisions for others..........................0 1 2 3 4
17. When I discover faulty merchandise, I return it for adjustment...........0 1 2 3 4
18. In a restaurant, when my meal is improperly served or cooked I will ask the waiter/waitress to correct the situation.........................0 1 2 3 4
19. I am inclined to look at a person in the eyes when speaking to him/her...0 1 2 3 4
20. When I arrive late at a meeting, I take a front seat rather than stand at the back and wait for a half-hour of intermission.....................0 1 2 3 4
21. I am inclined to disagree directly with a person whom I think is too domineering.........................................................0 1 2 3 4
22. When a friend has gone out of his/her way on my behalf but I didn't like what was done, I mention it to him/her..................................0 1 2 3 4
23. If a close and respected relative annoys me, I express my feelings to him/her.................................................................0 1 2 3 4
24. I find it easier to show anger towards people of the opposite sex than to members of my own sex..................................................0 1 2 3 4
25. When a respected person makes a statement that I consider incorrect, I question it............................................................0 1 2 3 4
26. If a policeman forbade me to enter premises that I had full rights to enter, I would argue with him............................................0 1 2 3 4
27. I have a close friend with whom I can discuss anything..................0 1 2 3 4
28. I enjoy expressing my opinions...................................................0 1 2 3 4
29. If one of my friends was spreading false rumors, I would talk to him/her about it..............................................................0 1 2 3 4
30. When a cashier short-changes me a small amount I mention it...........0 1 2 3 4
31. When I dislike someone's company I let them know it....................0 1 2 3 4
32. I am as outspoken as my peers....................................................0 1 2 3 4
33. My sex life is satisfactory..........................................................0 1 2 3 4
1 - "somewhat" or "sometimes"

2 - average

3 - "usually" or "a good deal"

4 - "yes" or "always"

34. It's best to speak up when I'm in trouble. 0 1 2 3 4

35. In situations where others seem to have neglected me, my feelings are hurt. 0 1 2 3 4

36. If my boss or supervisor tries to make things difficult for me, I demand an explanation. 0 1 2 3 4

37. I have been told that I have acted without thinking. 0 1 2 3 4

38. I can easily convince other people of the truth. 0 1 2 3 4

39. I believe in doing things for myself. 0 1 2 3 4

40. It is easy for me to make decisions. 0 1 2 3 4

41. Even when I'm wrong I stick to my point of view. 0 1 2 3 4

42. People understand my intentions. 0 1 2 3 4

43. Even if I do something that displeases others I can stand up for my rights. 0 1 2 3 4

44. When I speak up people know where I stand on an issue. 0 1 2 3 4

45. I can defend my opinion. 0 1 2 3 4

46. It is easy for me to start a discussion in a group. 0 1 2 3 4

47. Once my mind is made up, it's made up. 0 1 2 3 4

48. People listen to me. 0 1 2 3 4

49. It is easy for me to ask favours from friends. 0 1 2 3 4

50. I make more telephone calls than I receive. 0 1 2 3 4
ASSERTIVENESS INVENTORY II

Code Number: __________________________

Date: __________________________

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

3 very much like me.
2 rather like me
1 slightly like me
-1 slightly unlike me
-2 rather unlike me
-3 very unlike me

1. Most people seem to be more aggressive and assertive than I am.
2. I have hesitated to make or accept dates because of "shyness".
3. When the food served at a restaurant is not done to my satisfaction, I complain about it to the waiter or waitress.
4. I am careful to avoid hurting people's feelings, even when I feel that I have been injured.
5. If a salesman has gone to considerable trouble to show me merchandise which is not quite suitable, I have a difficult time in saying "No."
6. When I am asked to do something, I insist upon knowing why.
7. There are times when I look for a good, vigorous argument.
8. I strive to get ahead as well as most people in my position.
9. To be honest, people often take advantage of me.
10. I enjoy starting conversations with new acquaintances and strangers.
11. I often don't know what to say to attractive persons of the opposite sex.
12. I will hesitate to make phone calls to business establishments and institutions.
3 very much like me
2 rather like me
1 slightly like me
-1 slightly unlike me
-2 rather unlike me
-3 very unlike me

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

14. I find it embarrassing to return merchandise.

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

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

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

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

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

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

21. I am open and frank about my feelings.

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

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

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

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

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

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

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

29. I am quick to express an opinion.

30. There are times when I just can't say anything.
FOLLOW UP EVALUATION OF ASSERTIVENESS TRAINING

AT

WINDSOR WESTERN HOSPITAL CENTRE

I.O.D.E. UNIT

1. Age: ______ 2. Sex: m., f., ______

3. How many years of education or training have you completed?
   - In public school ______
   - In high school ______
   - College or university ______
   - Vocational training ______

4. Current Marital Status: single ______ married ______ separated ______
   - divorced ______ common-law ______ widowed ______

5. Patient status while in group: In-patient ______ Out-patient ______

6. Today's Date: ______ 7. Last day of group you were in: ______

8. When you joined the group, you were asked to identify areas where you had problems being assertive. Do you think that you have achieved assertiveness in these areas?
   - No assertiveness ______
   - Some assertiveness ______
   - A good deal of assertiveness ______
   - Complete assertiveness ______

9. During the group, did you discover areas where you were non-assertive in addition to those referred in Question 8?
   - No ______
   - One or two areas ______
   - Three or more areas ______

10. How important was the assertiveness training in helping you to handle these additional areas of non-assertiveness?
    1. not at all important ______
    2. of little importance ______
    3. somewhat important ______
    4. very important ______
    5. extremely important ______
Use the rating scale for the next two questions.

<table>
<thead>
<tr>
<th>not at all</th>
<th>of little</th>
<th>somewhat</th>
<th>very</th>
<th>extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>important</td>
<td>importance</td>
<td>important</td>
<td>important</td>
<td>important</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

11. How important were each of the following to you during the group? Use the rating scale.

- opportunity to share my problems
- opportunity to hear about other people's difficulties
- opportunity to learn about assertiveness
- opportunity to practice new behavior and language
- meeting other people
- getting to know the therapists
- identifying my problem areas and keeping a log
- time of group meetings
- location of group meetings
- time spent in completing inventories of assertiveness

other: specify

12. What did you find the most important in helping you to be assertive? Rate each item using the scale.

- role playing yourself
- watching others role play
- listening to the therapists teach about assertiveness
- listening to the therapists share their own experiences
- practicing outside the group
- sharing your experience with the group
- sharing your experience with friends or family
- role playing plus instruction

other: specify

13. In what way are people reacting differently to you since the group? Check whichever apply and indicate the change.

<table>
<thead>
<tr>
<th></th>
<th>more friendly</th>
<th>more accepting</th>
<th>no difference</th>
<th>more critical</th>
<th>more hostile</th>
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<tbody>
<tr>
<td>strangers</td>
<td></td>
<td></td>
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<td>co-workers</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>boss</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>friends</td>
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<tr>
<td>none, does not apply</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
14. At the start of the group, how would you have described yourself?  
(check one)  
- generally passive  
- sometimes passive, sometimes assertive  
- generally assertive  
- sometimes assertive, sometimes aggressive  
- generally aggressive  

15. How would you describe yourself now?  
- generally passive  
- sometimes passive, sometimes assertive  
- generally assertive  
- sometimes assertive, sometimes aggressive  
- generally aggressive  

16. Since the training program, is there any change in your awareness of your own needs in any given situation?  
- not at all  
- a little  
- somewhat  
- a lot  

17. Do you feel confident about asserting yourself?  
- not at all  
- a little  
- somewhat  
- a lot  

18. Do you believe that you are maintaining the level of assertiveness that you achieved in the group?  
- not at all  
- a little  
- somewhat  
- a lot  

19. How are you spending your spare time? Rate each item in order of importance.  

<table>
<thead>
<tr>
<th>importance</th>
<th>of little importance</th>
<th>somewhat important</th>
<th>very important</th>
<th>extremely important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

- spending time with friends or family  
- going out alone to social or sports events  
- going out with friends to social or sports events  
- joining new groups  
- taking up new interests or hobbies  
- watching T.V.  
- reading, hobbies  
- other: specify
20. How did you hear about the group?

hospital staff  
other patients
friends/family

21. Who referred you to the group

social worker  
psychiatrist
psychologist  
physician
other: specify

22. Did this person explain the reasons for the referral?

not at all  
a little  
somewhat  
a lot

23. Did this person explain what the group was about?

not at all  
a little  
somewhat  
a lot

24. Would you have liked more information beforehand?

not at all  
a little  
somewhat  
a lot

25. Were your friends or family supportive of your efforts at being assertive?

not at all  
a little  
somewhat  
a lot

26. Would it have been helpful for you if your friends or family had been taught something about assertiveness training?

not at all  
a little  
somewhat  
a lot

27. Did you find this training group helpful for you?

not at all  
a little  
somewhat  
a lot

28. Would you recommend this group to someone you know?

not at all  
a little  
somewhat  
a lot

Are there any other comments you would like to make? Use the back of this page if you need more space.
APPENDIX E
## APPENDIX E. Comparison of Sample PRF-E Data with Norms

<table>
<thead>
<tr>
<th>TRAITS</th>
<th>MALES n=8</th>
<th>FEMALES n=15</th>
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<td>Norm†</td>
<td>Norm‡⁴</td>
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<tr>
<td>Abasement</td>
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<td>Achievement</td>
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<td>Aggression</td>
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<td>Change</td>
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<td>Cognitive Structure</td>
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<td>Harmavoidance</td>
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<td>Impulsivity</td>
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<td>Nurturance</td>
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<td>Sentence</td>
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<td>Social Recognition</td>
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<td>Understanding</td>
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<tr>
<td>Desirability</td>
<td>7.68</td>
<td>10.78</td>
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</table>

†Normative for Psychiatric Population, No Sex Differentiation

‡⁴ Normative for College Students

Source: Jackson, Douglas N., Personality Research Form Manual
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UNPUBLISHED MATERIAL:


Zeiss, A.M., Lewisohn, P.M., & Munoz, R.F. "Non-specific improvement effects in depression using interpersonal skill training, pleasant activity schedules, or cognitive training". unpublished manuscript, Dept. of Psychology, University of Oregon, 1978.
Vita

Heather Jill Doney was born in Winnipeg, Manitoba on June 21, 1944. She received her secondary school education at the High School for Girls in Montreal, Quebec and graduated with a B.A. in geography and sociology from McGill University in 1965.

She was employed as a geographer in Ottawa, Halifax, and Calgary until she enrolled in the graduate program at the University of Western Ontario, London in 1969. She received a M.A. degree in geography in 1973 while concurrently employed as a town planner in Toronto.

In 1975 Ms. Doney entered the Bachelor of Social Work program at the University of Windsor and graduated in May 1976. She was employed as a social worker at St. Thomas Psychiatric Hospital until her return to the University of Windsor, Master of Social Work program in September 1977. She expects to graduate in May 1979.

Her MSW field placement was in the Social Work Department at Windsor Western Hospital, L.O.D.E. Unit. Ms. Doney is currently employed as a social worker at the Queen Elizabeth Hospital, Toronto.