An Assertiveness Training Therapy Group For Women Who Have Been Sexually Victimized In Childhood or Adolescence

by

David R. Schwab

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Abstract

A review of the literature suggests that women sexually abused in childhood or adolescence frequently are passive individuals who experience difficulty within interpersonal relationships. This study systematically evaluated an assertiveness training therapy group which was designed, firstly, to provide previously abused women with the skills that would enable them to exert more direct control over their lives and environments and, secondly, to assist them in achieving more satisfaction in their personal relationships. The group participants were five women who were seeking therapy from the Psychological Service Centre, University of Manitoba.

The study employed the A-B basic single system design (Bloom & Fischer, 1982) to monitor targeted behaviours whereas the one group pretest-posttest design (Campbell & Stanley, 1963; Cook & Campbell, 1979) was used to evaluate the data of more global measures. The effectiveness of the study was evaluated by four instruments. Targeted behaviours were measured by the Target Complaint Scales (Mintz & Kiesler, 1982) which were administered repeatedly at specified intervals throughout the baseline, therapy, and at the follow-up. Global measures consisted of the Assertion Inventory (Gambrill & Richey, 1975) and the Hudson Index of Self-Esteem (Hudson, 1982). Data from these instruments was

collected prior to the program, at its completion and at the follow-up. A client satisfaction questionnaire was used to acquire the participants' perception of the helpfulness of the therapy.

The results of the study indicate that the program was successful in increasing the women's assertive responses, increasing their self-awareness, facilitating their acceptance of personal rights and modifying the difficulties they experienced in heterosocial relationships. It, however, was not adequate in eliminating anxiety or in reducing all unreasonable beliefs which impaired their capacity to engage in assertive behaviour.

Recommendations for future programs include: (1) to stimulate self-awareness, build self-esteem and establish a belief system of personal rights before specific skills are introduced, (2) to provide a greater focus on exercises designed to reduce anxiety, (3) to give the participants an opportunity to discuss issues relevant to the adult experiences of childhood sexual abuse victims, and (4) to use male and female co-therapists.

Introduction

The sexual abuse of children is a phenomenon that has received significant attention in both the public and professional sectors in recent years. It is defined as "a sexual act imposed on a child who lacks emotional, maturational and cognitive development" (Sgroi, 1982, p. 9), and who is much younger than the perpetrator (Finkelhor & Hotaling, 1984). Finkelhor and Hotaling (1984) suggest a minimum age disparity of five years for a child twelve years and under and ten years for a child thirteen to sixteen. This imposition upon children involves a wide spectrum of abusive behaviours ranging from exhibitionism to sexual intercourse (Finkelhor, 1979).

Although this form of child maltreatment has been an integral part of Western society for centuries, it has been largely a hidden problem until the late 1970's (Rush, 1980). As public attitudes toward sexuality have become increasingly relaxed and permissive, however, discussion of this perplexing and disturbing issue has become more overt (Dawson, 1982). Subsequently, child sexual abuse has moved from the status of an obscure issue to a prominent one.

Incidence of Child Sexual Abuse

The magnitude of the problem has been accentuated by studies of the incidence of child sexual victimization in both the United States and Canada. Although the data provided by these studies vary somewhat, their results are

remarkably consistent. They indicate that approximately one-fifth to one-half of all girls are sexually abused in some way (Finkelhor & Hotaling, 1983; Herman, 1981; Russell, 1983; Sexual Offences Against Children in Canada, 1984).

In response to this growing awareness of the scope of child sexual abuse, a number of interventive strategies have been developed to treat the immediate impact this experience has upon victims and their families (Beezley Mrazek, 1981; Dawson, 1982; Giaretto, 1981; Sgroi, 1982).

Long-Term Effects of Child Sexual Abuse

In addition to these endeavours to address the immediate problems arising from child sexual abuse, the last five years has witnessed heightened concerns regarding the long-term impact and traumatization which the encounter has upon the mental health and adjustment of victims. Bagley (1984) estimates that 25% of all girls who are subjected to intra-familial sexual abuse suffer serious long-term adjustment and behavioural difficulties. Briere (1984) suggests that one out of every five sexual abuse victims experience significant long term effects, and based on these figures, he speculates that 4% of the female population may encounter difficulties in adulthood arising from sexually abusive experiences in childhood.

It is difficult to ascertain the extent to which prob-

lems experienced by previously abused women can be attributed to their childhood victimization. The reason for this is the fact that incidence rates of long-term problems have been based primarily on selective subgroups of university students or clinical samples and/or have been obtained without the benefits of appropriate control groups (Briere, 1984). Also, other past or present factors in their lives such as family disorganization and disruption, societal and familial response to the abuses as well as current discordant relationships with their respective partners may interact to exacerbate the long-term traumatogenic component (Finkelhor, 1984; Jehu, McCallum, Klassen & Gazan, 1987; Meiselman, 1978). Although one is unable to conclude exclusively that the sequelae is a direct result of the sexual victimization, it would appear that such an experience increases a child's vulnerability to pathological developments and maladjustment in adulthood (Briere, 1984; Herman, 1981; Jehu, McCallum, Klassen & Gazan, 1987; Meiselman, 1978).

Some of the more common long-term effects identified as being possibly associated with victimization in childhood are emotional problems including low self-esteem, guilt and depression (Gelinas, 1983; Herman, 1981; Jehu, Klassen & Gazan, 1987a; Tsai & Wagner, 1978), difficulties in interpersonal relationships (Goodwin, McCarthy & DiVasto,

1981; Herman, 1981; Jehu, Gazan & Klassen, 1987; Meiselman, 1978; Tsai & Wagner, 1978), and sexual problems (Briere, 1984; Gelinas, 1983; Jehu, Klassen & Gazan, 1987b; Meiselman, 1978). A variety of programs have been developed to treat these identified problems (Gordy, 1983; Herman & Schatzow, 1982; Jehu, Klassen & Gazan, 1985-6; Tsai & Wagner, 1978).

Non-Assertive Behaviour

One area which has received limited attention in the victim literature is the passive, non-assertive behaviour frequently displayed by previously abused women. It is becoming increasingly more apparent, however, that child sexual abuse may be an important socialization variable contributing to this behavioural response tendency of many victims in their current interpersonal relationships (Bagley, 1984). The literature indicates that a number of women victimized as children or adolescents tend to be passive, dependent and insecure individuals who lack the self-confidence and self-sufficiency as well as the cognitive and social skills which are necessary for one to exercise control over her/his life and environment with respect to personal rights, needs and desires (Jehu, Gazan & Klassen, 1987; Meiselman, 1978; Steele & Alexander, 1981; Thorman, 1983).

The Purpose of This Study

The purpose of this study was to develop and systematically evaluate an assertiveness training group treatment program for women sexually abused in childhood or adolescence whose prominent behavioural patterns include non-assertiveness. The group was comprised of five women who were undergoing therapy at the Psychological Service Centre, University of Manitoba, for problems associated with their victimization.

The assertiveness group was a short-term treatment program which operated for ten weeks. It focused primarily on teaching assertive skills to the participants by means of various training techniques and structured exercises. In addition to the educational dimension, the program included a therapeutic emphasis in that it was designed to address issues related to assertiveness which appear to be particularly problematic for previously abused women. For example it utilized a male co-therapist in order to assist the women in resolving some of the conflicts frequently experienced by them in their heterosocial relationships. This role was performed by the writer of this report whereas Marjorie Gazan was the female therapist. The overall objectives of the group was, firstly, to provide the women with the skills that would enable them to exert more direct control over their lives and environments and, secondly, to

assist them in achieving more personal satisfaction in their interpersonal relationships.

A Review of the Literature

The passive, non-assertive person is one who does not honestly and appropriately express his or her feelings, thoughts, and beliefs and who allows his or her rights to be violated by another (Lange & Jakubowski, 1976). A review of the literature related to the longer term sequelae of child sexual victimization reveals that this limitation, which is frequently displayed in the behavioural patterns of women who were abused as children or adolescents, has been given limited attention. While several studies identify difficulties experienced by these individuals in their interpersonal relationships, and while others pinpoint passive-related components operational in the lives of victims, there have been minimal efforts to synthesize and provide extensive discussion of them. Subsequently, much of the information pertaining to non-assertiveness has been explicated within the contextual framework of other elements associated with victimization.

Limited Social Skills

An analysis of the available literature suggests that many previously abused women lack communication and social skills, with strong implications that assertive skills are lacking as well (Finkelhor, 1979; Herman, 1981; Jehu, McCallum, Klassen & Gazan, 1987; Sgroi, 1982). For example, many of the women participating in a group therapy program for childhood sexual victimization stated that they

had experienced an inadequate development of social skills which they attributed to elements circumscribing their molestation (Tsai & Wagner, 1978). Also, studies conducted by Herman (1981) and Meiselman (1978) indicate that adult victims of child sexual abuse have limited assertiveness skills. Similarly, Sgroi (1982) comments that the majority of adolescents who participated in group therapy for victims of intrafamilial sexual abuse were passive, compliant and unassertive at the outset of the program.

Jehu and his colleagues (Jehu, McCallum, Klassen & Gazan, 1987) are more precise in their conclusions, specifying that 82.4% (42) of 51 women who participated in their study exhibited limited social skills including assertiveness. Furthermore, Jehu, Gazan and Klassen (1987) conclude that many women victimized in childhood engage in adult relationships wherein they are often misused because they have not acquired the skills that are necessary to protect themselves and to assert their rights with their partners. In addition to this, they have limited perceptions of their personal rights in an interpersonal relationship.

Limited assertive skills were also evident in the self-reports of individuals who participated in an assertiveness training group for previously abused women (Gazan, 1985). The group members agreed that their lack of trust and avoidance of risk-taking behaviours were attributable

to the fact they did not possess the skills that would enable them to take control of their lives.

Interpersonal Relationships

General Relationships

This deficiency of assertiveness is most evident in the literature that focuses upon the interpersonal relationships of women who were sexually abused as children. The fact that previously abused women experience difficulties in their interpersonal relationships is well documented (Briere, 1984; Gelinas, 1983; Goodwin, McCarthy & DiVasto, 1981; Jehu, Gazan & Klassen, 1987; Meiselman, 1978; Tsai & Wagner, 1978). For instance, the comparison of a therapy group with incestuous histories to a matched control group demonstrated that the experimental group was more disturbed as exemplified, in part, by their difficulties in interpersonal relationships and greater marital conflicts (Meiselman, 1978).

There is evidence in the literature to suggest that the interpersonal relationships of previously abused women frequently are characterized by feelings of isolation (Briere, 1984; Herman, 1981; Jehu, Gazan & Klassen, 1987; Tsai & Wagner, 1978), difference from other people (Jehu, Gazan & Klassen, 1987) and mistrust of others (Gelinas, 1983; Herman, 1981; Jehu, Gazan & Klassen, 1987; Steele & Alexander, 1981; Tsai & Wagner, 1978).

On the basis of their experience with 51 previously abused women, Jehu, McCallum, Klassen and Gazan (1987) report that 62.7% (32) of the victims experienced feelings of isolation. Similarly, in a study conducted by Briere (1984), 64.2% of 67 women abused in childhood or adolescence reported feelings of isolation. In addition to this, Jehu, McCallum, Klassen and Gazan (1987) comment that 88.2% of those participating in their study identified feelings of difference from others while 78.4% expressed a mistrust of others. These variables have been observed, as well, by Herman (1981) in her study of father-daughter incest victims. She states that

> Many of the women described themselves as "different" or stated that they could never be "normal", even though they might appear so to others. The sense of being an outsider, cut off from ordinary human intercourse, often reached extreme proportions ... The isolation these women felt was compounded by their own difficulty in forming trusting relationships. The legacy of their childhood was a feeling of having been profoundly betrayed by both parents ... they came to expect abuse and disappointment in all intimate relationships: to be abandoned, as they felt their mothers had abandoned them, or to be exploited,

as their fathers had exploited them. (pp. 96, 99-100)

It is possible that the various difficulties experienced by these individuals in interpersonal relationships may be associated with their limited social skills and the inability to assertively communicate their feelings, beliefs and opinions.

Heterosocial Relationships

Relationships with males appear to be particularly problematic for some women victims of child sexual abuse. This is reflected in the difficulty they experience within intimate relationships with men (Jehu, Gazan & Klassen, 1984-5; Tsai, Feldman-Summers & Edgar, 1979), their tendency to oversexualize heterosocial relationships (Jehu, Gazan & Klassen, 1987) and their propensity to engage in dissonant relationships with males wherein they succumb to domination and exploitation (Gelinas, 1983; Herman, 1981; Jehu, Gazan & Klassen, 1987).

Intimacy. Empirical data procured by Jehu, Gazan and Klassen (1984-5) indicates that 77% (17) of a sample of 22 women sexually abused as children experienced a fear of intimate relationships with men. Additional support is provided for this postulate in that many previously abused women have a tendency to avoid long-term heterosocial relationships. In fact, Meiselman (1978) notes that 39% of the

father-daughter incest victims participating in her study had never married. This contrasted with 20% of the control group. Courtois (1979) reports similar statistics, indicating that 40% of 30 victims of childhood sexual abuse did not marry. Further to this, it is apparent that in avoiding long-term relationships with males, many of these individuals engage in those which are more serial and superficial (Jehu, Gazan & Klassen, 1987; Meiselman, 1978; Tsai et al, 1979).

Jehu, Gazan and Klassen (1984-5) suggest that previously abused women "have difficulty in maintaining a longer relationship with a man, because of the increasing closeness and intimacy this involves" (p. 34). Kaplan (1979) describes intimacy as

> ... a special quality of emotional closeness between two people. It is an affectionate bond, the strands of which are composed of mutual caring, responsibility, trust, open communication of feelings and sensations, as well as the non-defended interchange of information about significant emotional events. (p. 183)

Given the elements which comprise this component of hetero-social relationships, it is not surprising that individuals possessing limited social and assertive skills would fear it. Pursuant to this, it is possible that the fear of inti-

macy experienced by a number of previously abused women is related to an inability to express their feelings, needs and desires honestly -- the essence of assertiveness (Jakubowski-Spector, 1973), and an integral aspect of intimacy (Kaplan, 1979).

Oversexualization. The propensity of these women to engage in non-assertive behaviour may be a contributing factor to the oversexualization they frequently attach to their relationships. Both Herman (1981) and Meiselman (1978) speculate that the basis for such a tendency is related to the fact many of these individuals have learned to use sexual activity as a means of acquiring attention and affection. Jehu, Klassen and Gazan (1987a) provide some empirical support for this assertion. These investigators report that 64.7% (33) of 51 victims reported that they used their sexual abuse to obtain affection and/or attention from the offender while 41.2% (21) indicated that they used the sexual encounter to acquire material favours and rewards.

On this basis, one is able to speculate that these women have learned to utilize indirect and non-assertive methods to fulfill their goals. Although this behaviour may enable one to achieve the desired objective, it fails to promote direct control or ownership of the person's power or life events (Carlson & Johnson, 1975). Further-

more, this pattern of interaction impairs a person's ability to refuse undesired demands or requests.

Revictimization. An area discussed prominently in the literature which may be linked to the passivity of these individuals is revictimization. It would seem that women sexually abused as children have a predilection to establish relationships with apparently unsuitable partners who often are abusive and exploitive (Gelinas, 1983; Goodwin et al, 1981; Herman, 1981; Jehu, Gazan & Klassen, 1987; Tsai & Wagner, 1978).

This supposition has been confirmed empirically by several investigators. For instance, based on his research findings, Briere (1984) indicates that 49% of his sample of women seeking treatment for childhood sexual victimization had been subjected to physical abuse in an adult relationship compared to only 18% of the non-victim group. Herman (1981) found that 28% of the victims of father-daughter incest participating in psychotherapy had experienced battering as adults. Meiselman (1978) reports that 42% of the father-daughter incest victims in her study were masochistic, meaning the women had a tendency to seek out and passively submit to a relationship involving further abusive behaviour. The author observes that

> ... their willingness to tolerate mistreatment allowed them to endure relationships that a more

> mature, assertive woman would have ended or never begun at all ... Informally, therapists used such terms as "doormat", "punching bag", and "dish rag" to describe the passive, dependent woman who would suffer almost anything to be attached to a man. (p. 215)

Empirical studies demonstrate consistently that women sexually abused as children are vulnerable to revictimization in adulthood. The general conclusion is that these individuals have not acquired the normal self-protective mechanisms (Finkelhor, 1979; Herman, 1981) or the skills required to set limits or assert one's rights in a relationship (Jehu, Gazan & Klassen, 1987).

These non-assertive patterns also are evident in relationships with their children, in which some of the women experience child management difficulties. For example, at the initial assessment of 31 victims who had living children, 11 (35.5%) considered themselves to be inadequate parents whereas 19 (61.3%) believed they had been inadequate in the past (Jehu, Gazan & Klassen, 1987). Additionally, 22 (71%) said they had physically abused their children in the past while 6 (19.3%) reported that they continued to do so. In commenting on the parental difficulties of incest victims, Gelinas (1983) explains:

> Because they tend to feel depleted, helpless, and

> unself-confident, they have difficulty providing their children with an organizing structure and with a reasonable balance of discipline and affection ...
>
> [She] may also feel guilty setting limits, correcting behaviour and enforcing schedules. The children begin to learn that mother can easily be made to feel guilty and thus deflected from her purpose, so they become increasingly demanding and feel increasingly entitled to do so. The children participate in blaming their mother for all the imperfections in their mothering and at some point develop contempt for her weakness with them and with their father ... (p. 323).

Conversely, Herman (1981) suggests that many victims are good, caring mothers in that they continue "the caretaking role that had been imposed on them in childhood" (p. 106). At the same time, however, Jehu, Gazan and Klassen (1987) point out that some of these seemingly adequate mothers perceive themselves as failures because of the unrealistic standards of parenting they hold.

Subordination of Rights

One major reason for the difficulties experienced by these individuals within interpersonal relationships, par-

ticularly with males, is the fact many previously abused women have a tendency to subordinate their own rights to those of others (Gelinas, 1983). Verification of this has been provided by initial responses obtained by Jehu, Klassen and Gazan (1987a) on the Belief Inventory (Jehu, Klassen & Gazan, 1985-6), an instrument designed to determine the distorted beliefs of women who were sexually abused in childhood. For instance, item #9 which reads "It doesn't matter what happens to me in my life," was endorsed as being partly, mostly, or absolutely true by 29 (58%) of 50 victims. Similar endorsements were made by 27 (54%) of the victims for item #17, "I've already been used so it doesn't matter if other men use me," and by 24 (48%) for item #6, "I don't have the right to deny my body to any man who demands it."

The tendency of these women to subordinate their own rights to those of others frequently results from "parentification", a process whereby victims of father-daughter incest frequently occupy a parental role (Gelinas, 1983; Jehu, McCallum, Klassen & Gazan, 1987). In encountering this role reversal, Gelinas observes that the child learns

> ... to put, and does put, everyone's needs before her own. She begins to form her self-identity around the notion that she has responsibility of caring for people, but that they have no respon-

> sibility to care for her in return. Essentially, she has no rights to reciprocity. (p. 320)

As a result of this process, the victim learns that she has no rights with respect to her own needs. It follows that such individuals will be characteristically passive and non-assertive (Jehu, Gazan & Klassen, 1987). This is exacerbated by societal conditioning which frequently socializes women to place the needs of their spouse above their own (Carlson & Johnson, 1975).

Powerlessness and helplessness. The belief that they should subordinate their own rights to those of others may account for the feelings of powerlessness and helplessness which have been identified as being prevalent during the childhood abusive encounter as well as within the adult experiences of these victims (Finkelhor & Browne, 1984; Steele & Alexander, 1981). In fact, Finkelhor and Browne (1984) strongly suggest that powerlessness is one of the primary trauma producing factors in child sexual abuse. They assert that a "major effect of powerlessness is to impair a person's sense of efficacy and coping skills" (p. 12). This may provide additional understanding to the conceptual context for revictimization discussed previously in that the women "may feel powerless to thwart others who are trying to manipulate them or do them harm" (Finkelhor & Browne, 1984, p. 12). Subsequently, many of these indivi-

duals passively submit and adapt to further abuse and mistreatment.

Patriarchy

A factor identified in the literature as being instrumental in mitigating against the development of adequate communication and social skills, such as assertiveness in these women, is the patriarchal social structure which commonly comprises the environmental context of their socialization experiences. A patriarchal family structure is a social system in which the father dominates, controls and rules the family both physically and economically whereas the mother occupies a subordinate role in which she is expected to be passive, submissive, subservient and obedient (Herman, 1981; Summit, 1983; Thorman, 1983). Within this process, the women tend to be non-assertive (Sgroi, 1982) and frequently exhibit passive-dependent, masochistic personality traits (Meiselman, 1978). Subsequently, there is no concept of partnership or mutuality and the existent power differential creates an atmosphere in which the wife and the children become the rightful possessions of the dominant father (Herman, 1981).

The literature which focuses upon this issue concurs that patriarchally organized families are more vulnerable to intrafamilial child sexual abuse (Finkelhor, 1983; Herman, 1981; Jehu, McCallum, Klassen & Gazan, 1987; Meisel-

man, 1978; Sgroi, 1982; Stark, 1984; Thorman, 1983). For example, in a study of forty female psychotherapy outpatients interviewed retrospectively about their incestuous backgrounds, the women typically reported that their fathers were patriarchal individuals who would resort to force, if necessary, to establish their absolute authority (Herman, 1981). Finkelhor (1979) comments that

> ... cultural beliefs that underpin the male-dominated system contribute to making women and children sexually vulnerable. For example, to the extent that the family members are regarded as possessions, men can take unusual and usually undetected liberties with them. (pp. 30-31)

Thorman (1983) maintains that the patriarchal structure entails a power imbalance that increases the daughter's vulnerability to sexual assault because no family member has the power or authority to challenge the father in order to protect her. This is consistent with Summit's (1983) conclusion that "dependent children are helpless to resist or to complain" (p. 183) when they are sexually victimized.

Modelling Behaviour

The significance of patriarchal structures as a factor in the development of non-assertive personalities in sexually victimized women is related to modelling behaviour. The available literature suggests that girls raised in

these families generally follow the patterns modelled by their mothers or other significant female nurturers (Gelinas, 1983; Herman, 1981; Meiselman, 1978). Upon assessing the mothers of incest victims, Herman (1981) remarks:

> No matter how badly they were treated, most simply saw no option other than submission to their husbands. They conveyed to their daughters the belief that a woman is defenseless against a man, that marriage must be preserved at all costs, and that a wife's duty is to serve and endure. (p. 78)

Thus, female children with passive and powerless mothers learn through observation that oppression is to be expected by women and that love for a man is displayed through enslavement to him.

This is congruent with the argument put forth by Meiselman (1978). She posits that the dependent, passive and masochistic personality of the child sexual abuse victim discussed previously is modelled from her mother who displayed similar traits in her spousal relationships. Subsequently, while very young, the daughter learned "that women are helpless, suffering creatures at the mercy of men in their families" (p. 216). Finkelhor (1980) adopts a similar position. In a survey of college students, he identified an association between the oppression of wives and the

sexual abuse of their daughters. He purports that the daughter of a powerless mother is more vulnerable to victimization because the observation of subordination and dependency in her mother's marital relationship teaches the child that she may be powerless and obligated to obey as well.

The basic assumption gleaned from all this is the fact that female children with patriarchally organized families are more susceptible to sexual abuse because they do not learn effective social and coping skills as well as self-protective and assertive skills from their mothers. Antithetically, they are inculcated with passive, dependent and submissive behavioural patterns and are socialized to become selfless, deferential individuals.

Gil (1983) suggests that the passivity learned by victims of sexual abuse originally was an adaptive mechanism utilized by the child to facilitate her survival. In adulthood, however, this method of relating to others becomes dysfunctional because it prevents the individual from defending her rights and from pursuing her needs and desires. Furthermore, it provides inappropriate modelling patterns for her children. The implication of this is articulated by Jehu and Gazan (1983) who observe that

> ... oppressed and demoralized wives who are victims themselves are in a poor position to avoid

> these hazards. Thus the daughters of incapacitated mothers may well grow up to be incapacitated mothers themselves, whose daughters will in turn be vulnerable to sexual victimization. (pp. 75-76)

Although it is at variance with the literature emphasizing the passive tendencies of previously abused women, it is important to note that some victims engage in aggressive behavioural patterns which they have learned from observing abuse and mistreatment in their parents' relationships (Gil, 1983).

Social Isolation

The adverse socialization experiences of previously abused women are exacerbated by the fact that incestuous families are commonly characterized by social isolation (Herman, 1981; Sgroi, 1982; Stark, 1984; Watkins & Bradbard, 1982). Sgroi (1982) explains that these families tend to be closed and pathological systems which perceive the "outside" world as being hostile and threatening. This "fortress mentality" is maintained by the patriarchal father who uses his power and authority to prevent family members from establishing alliances with individuals in the community (Watkins & Bradbard, 1982). In fact, in many situations, the father is the primary communicator with "outsiders" (Sgroi, 1982).

This isolation insulates the family from environmental influences, thereby severely impairing the individual's potential for nurturance and support as well as growth and change (Hartman & Laird, 1983). For example, societal information and reinforcement patterns which enable the individuals to differentiate between the various appropriate familial roles and functions are unable to penetrate these rigid external boundaries (Alexander, 1985). Also, peer contact, a necessary component of healthy socialization, is minimal. Consequently, family members become extremely dependent upon each other for information, support, nurturance, and stimulation, and any pursuit of independence is extremely difficult. This observation is supported by Thorman (1983) who comments that "incestuous family systems create symbiotic ties among family members that restrict development of autonomy, result in low self-esteem and prohibit personal growth of family members" (p. 78). It is not surprising, therefore, that victims of intrafamilial sexual abuse frequently are non-autonomous individuals who possess few social communication skills such as assertiveness.

Low Self-Esteem

Another variable identified in the literature which appears to be related to the passivity and non-assertiveness displayed by women sexually abused as children or

adolescents is self-esteem. The fact that previously abused women experience low self-esteem is well documented in the literature (Bagley, 1984; Gelinas, 1983; Gil, 1983; Steele & Alexander, 1981; Thorman, 1983, Tsai & Wagner, 1978).

Several investigators provide empirical data to substantiate this. For instance, 87% of 30 incest victims who participated in Courtois's (1979) research study reported that their sense of self had been moderately to severely affected by their childhood victimization encounter. In a study of 40 father-daughter incest victims, Herman (1981) notes that 60% had a predominantly negative self-image. She comments that "with depressing regularity, these women referred to themselves as bitches, witches, and whores. The incest secret formed the core of their identity" (p. 97). In their study of adult victims of childhood sexual abuse, Jehu and his colleagues (Jehu, McCallum, Klassen & Gazan, 1987) found that 47 (92.2%) of 51 participants had low self-esteem. Responses elicited by these investigators on the Belief Inventory (Jehu, Klassen & Gazan, 1987a) provide additional information with respect to the negative self-concepts of this sample of victims. Item #16 which reads "I am inferior to other people because I did not have normal experiences," was endorsed as partly, mostly, or absolutely true by 90% (45) of 50 victims. Also, 78% (39)

of the victims responded similarly to item #2, "I am worthless and bad," and 38 (76%) to item #13, "I will never be able to lead a normal life, the damage is permanent." It is apparent that women sexually abused in childhood or adolescence frequently possess low self-esteem and perceive themselves as being "damaged," worthless and inferior individuals.

Although a number of theorists and clinicians have underlined the association between low self-esteem and non-assertiveness (Lange & Jakubowski, 1976; McVicar & Herman, 1983; Osborn & Harris, 1972; Stake & Pearlman, 1980), there is a paucity of information with respect to the relationship of these variables within the experiences of previously abused women. Gelinas (1983) maintains that the low self-esteem is related to their familial experiences which have socialized them to believe that they do not possess any rights, particularly in terms of their own needs. She comments that these individuals have been taught that

> ... nothing is owed them, inherently or because of their contributions, and they are allowed no claim to needs, reciprocity or even acknowledgement. With such fundamentally impaired self-esteem, incest victims tend to be extremely unassertive and passive, to the point of paralysis. (p. 322)

In addition to this, low self-esteem may be associated with the feelings of powerlessness and helplessness which have been discussed previously. It is reasonable to assume that individuals inundated with such feelings will not only possess low self-esteem, but likely will refrain from asserting themselves in order to promote change in their environments. Also, as Jehu, Gazan and Klassen (1984-5) suggest, their impaired self-esteem may be highly contributive to the revictimization many of these women experience. Citing the therapeutic efforts of Tsai and Wagner (1978), they note that the self-esteem of an adult victim of child abuse "is often so low that she may select partners who are beneath her and who do not embody high standards which she feels she cannot live up to" (p. 37).

Misattribution of Blame

An issue which is closely related to the low self-esteem experienced by previously abused women is misattribution of blame. Finkelhor (1983) as well as Jehu, Klassen and Gazan (1987a) suggest that victims commonly are self-blaming for the sexual abuse they experienced as children or adolescents. Some evidence of this is provided by Gold (in press) in a study of the attributional styles of previously abused women. The author reports that their style was marked by self-blame as indicated by the fact they were more likely than nonvictims to attribute bad events to

internal, stable and global factors.

Jehu and his colleagues (Jehu, Klassen & Gazan, 1987a) supply additional insight to the etiological understanding of this attributional pattern. They point out that many victims blame themselves because they responded to the abusive experience with passive compliance. This is verified by the fact 42 (84%) of 50 victims in their series indicated that the Belief Inventory statement, "I must have permitted sex to happen because I wasn't forced into it" (Item #5) was partly, mostly, or absolutely true. In addition to this, many of the participants believed they were responsible for the sexual encounter because they did not disclose it. For example, item #12 which reads "I must have been responsible for the sex when I was young because it went on for so long" was endorsed by 43 (86%) of the victims.

The fact that these individuals did not refuse the sexual advances of the offender or disclose the victimization which occurred, causes them to be self-blaming for the abusive experience. It is necessary to note, however, that the power imbalance existing between children and adults makes it extremely difficult for a child to resist the abuse (Sgroi, 1982). At the same time, the high incidence of revictimization of previously abused women enables one to speculate that this inability to exercise the freedom to say "No" continues into adulthood. It is apparent that

many of these women have not developed healthy self-concepts or acquired self-protective and assertive skills, elements which are necessary for one to resist the intrusive behaviour of other individuals (Bagley, 1984; Jehu, Gazan & Klassen, 1987).

Summary

Women sexually abused as children or adolescents have a tendency to be passive, dependent individuals who lack assertive skills. This is most obvious within their general interpersonal relationships which frequently are marked by isolation, difference from others and mistrust, and their heterosocial relations which are characterized by their fear of intimacy with males, the tendency to oversexualize the relationship, and the propensity to engage in those which are dissonant.

An integral factor in the development of this orientation is the patriarchal social structures in which these women commonly are socialized. The ideology of this system facilitates an atmosphere of subservience and intimidation wherein female family members are expected to be obedient and faithful to the patriarch under all circumstances and wherein these responses are modelled by the mother. Subsequently, the women do not acquire the appropriate self-protective and social skills which would enable them to exercise their rights and pursue their needs and desires

within their relationships with other people.

In addition to this, many previously abused women have impaired self-esteem and tend to think of themselves as being somehow responsible for the victimization. These factors further exacerbate their inability to utilize assertive behavioural responses.

Rationale for the Study

Assertiveness Training

Assertiveness training is a semi-structured methodology designed to promote behavioural change in individuals by facilitating their acquisition of assertive skills which enables them to exercise greater control and ownership over their lives (Lange & Jakubowski, 1976; Osborn & Harris, 1975). Assertiveness is defined as

> ... that type of interpersonal behavior in which a person stands up for her [his] legitimate rights in such a way that the rights of others are not violated. Assertive behavior is an honest, direct and appropriate expression of one's feelings, beliefs and opinions. It communicates respect (not deference) for the other person, although not necessarily for that person's behavior. (Jakubowski-Spector, 1973, p. 76)

Within this definitional framework, assertiveness training appears to be a viable treatment mode to address the assertive problems encountered by women who have been previously abused.

Assertiveness Training Programs

Assertiveness training has been used successfully both in non-clinical and clinical programs in order to produce increased assertiveness within individuals presenting a

broad spectrum of problems.

Non-Clinical Models

Within non-clinical models, such treatment was utilized to increase the assertive behaviour of non-assertive college students (Galassi, Galassi & Litz, 1974), to increase assertiveness as well as reduce discomfort experienced in assertive situations for middle-aged women (McVicar & Herman, 1983), and to provide women with the skills that would enable them to assert their needs and desires in sexual relationships (Carlson & Johnson, 1975; Liss-Levinson, Coleman & Brown, 1975). It has also been used to create a more appropriate sexual role belief system in non-assertive women (Carlson & Johnson, 1975) and to improve the sexual relationship between married couples (Osborn & Harris, 1975).

Clinical Models

Assertiveness training techniques also have been used increasingly to treat an array of clinical problems. For instance, it has had a favourable impact upon increasing the internal locus of control and in modifying the interpersonal behaviour of juvenile offenders (Ollendick & Hersen, 1979). Stake and Pearlman (1980) have demonstrated its effectiveness for low performance self-esteem women. Furthermore, it has been recommended for therapeutic targets such as depression, low self-esteem, social isolation,

parent-child conflicts, marital dysfunction and sexual communication (Richie, cited in Linehan, 1979).

Although assertiveness training has been advocated for battered wives (O'Leary, Curley, Rosenbaum & Clarke, 1985), it has been used to a very limited extent in the treatment schemes for sexually abused individuals. It has been employed in group therapy for adolescent female victims of incest (Sgroi, 1982). Also, it proved beneficial in a group program for previously abused women (Gazan, 1985). The investigator reports that a significant increase in assertive behaviour occurred in four of the six participants. It should be noted that the remaining individuals were assessed as functioning at an acceptable level of assertiveness prior to the implementation of the interventive program. In spite of the paucity of documented assertiveness training programs for women sexually abused in childhood or adolescence, however, it is apparent that this procedure has potential value for enhancing the skill levels of this clientele.

Theoretical Framework

The theoretical foundation of assertiveness training is formulated by Bandura's (1977) social learning theory. It embodies three primary assumptions which are relevant to this study. First of all, it assumes that an individual's functioning is influenced by the training to which they are

subjected early in life. Secondly, the theory maintains that different and more appropriate behaviours can be substituted for maladaptive patterns learned through the individual's various experiences. Thirdly, it suggests that these changes will produce other changes in functioning. For example, empirical data demonstrates that there is a positive correlation between increased assertiveness and both self-confidence and self-esteem (Osborn & Harris, 1975).

Conceptual Framework

The study employed a tripartite model of personality functioning which understands behaviour as occurring in one or in a combination of three response systems: the motor, cognitive and physiological systems (Linehan, 1979; Wolpe, 1978). Within this framework, assertive skill was understood conceptually as being comprised of behavioural, cognitive and affective elements. Behavioural elements refer to verbal and non-verbal motor behaviours such as vocabulary, content, voice tone and volume, gestures and body posture, eye contact as well as facial expression (Sank & Shaffer, 1984; Linehan, 1979). Cognitive elements consist of the specific thoughts and beliefs which facilitate appropriate assertive responses (Sank & Shaffer, 1984). These include "the cognitive capabilities (eg., accurate perception and coding of the situation, knowledge of

response outcomes) needed to decide when and how to engage in the action" (Linehan, 1979, p. 208). For example, an individual's perception of his or her legitimate personal rights is integral to this dimension. Affective elements refer to emotions such as anxiety, guilt and anger and one's ability to manage these within the situation in order that they do not impair the performance of the skills which have been acquired.

Contextual Framework

The context of the assertiveness training program was a behavioural therapy group. Rose (1985) defines this modality

> ... as the application of principles of behavior, cognitive-behavior, and problem-solving therapy to the treatment of children and adults within, and by means of, the small group. The focus of such treatment is learning and maintaining improved social problem-solving and cognitive skills which facilitate effective coping with problematic or stressful and problematic social situations. (p. 30)

There is strong support in the literature for employing the group format as the primary context in which to promote assertive behavioural change in individuals (Flowers, Cooper & Whiteley, 1975; Harris, 1979; Kelly, 1985;

Lange & Jakubowski, 1976; Osborn & Harris, 1975; Rose, 1985). Both Kelly (1985) and Harris (1979) underline its importance because modelling, behavioural rehearsal, performance feedback and social reinforcement -- elements which are essential for helping individuals acquire new social skills, can be introduced more efficiently within the group environment.

In addition to this, the group format has been an effective interventive modality in the treatment strategy for previously abused women (Gazan, 1985; Gordy, 1983; Herman & Schatzow, 1982; Tsai & Wagner, 1978). In their assessment of a group therapy program for previously abused women, Tsai and Wagner (1978) concluded that the primary curative component was "the sense of identification and emotional closeness instilled by a warm and supportive environment where a common bond was shared" (p. 417). This is consistent with the observations of Herman and Schatzow (1982). The women who completed follow-up questionnaires for a program designed to address issues related to child sexual abuse, unanimously reported that "the single most helpful thing about the group was the contact with other incest victims" (p. 12). Furthermore, Gazan (1985) has demonstrated the effectiveness of the group format for improving the assertive behaviour of women sexually abused as children or adolescents.

Male-Female Co-Therapy

In addition to the focus on assertiveness skill acquisition, the study encompassed a broader therapeutic emphasis in that it endeavoured to remediate problems related to non-assertive behaviour identified clinically as causing difficulties in the current adjustment and functioning of previously sexually abused women. With respect to this, the primary treatment component consisted of the utilization of male and female co-therapists. Female therapists are used extensively in the treatment programs of female sexual abuse victims in order to provide a positive "role-model of a competent, caring woman with a positive self-image" (Heber, 1984, p. 9). On the other hand, male therapists are used less frequently.

The employment of a male therapist in this study was premised upon the evidence which demonstrates that these women frequently experience difficulty in their heterosocial relationships. This is discussed in the previous section of this report. The presence of the male therapist was designed to provide the women with an opportunity to relate more positively to a male within a protective and supportive environment and to assist them in resolving some of the conflicts such as oversexualization as well as the fear and mistrust of men which are commonly encountered in their heterosocial relations. It was hypothesized that the

women's ability to differentiate between exploitive and non-exploitive experiences would be enhanced as the therapist demonstrated that the trust of a male is possible, that all men are not necessarily exploitive and abusive, and are capable of exhibiting genuine interest and caring. There is minimal data to substantiate the function of the male therapist in a treatment group for female sexual abuse victims. In one documented example, Tsai and Wagner (1978) used a male in tandem with a female therapist in order to address the women's inability to trust men. They observe that his presence "helped in facilitating a more differentiated response to men. As the male therapist reflected a compassionate individual who participated in the general discussion, women were required to face their feelings directly and not to simply engage in antimale sentiments" (p. 422). Also in an assertiveness training program for previously abused women, Gazan (1985) employed a male therapist during one of the sessions in order "to facilitate skill building, cognitive restructuring and promote discriminative learning specific to men and interactions with men" (pp. 10-11).

Assessment and Evaluation Procedures

Objectives

The overall purpose of this study was to develop and systematically evaluate an assertiveness training group treatment program for women sexually abused in childhood or adolescence whose prominent behavioural patterns included non-assertiveness. The specific goals of the intervention were fourfold: (1) to provide the women with the assertive skills whereby they would be equipped to openly express their needs and desires so as to acquire and exert greater control over their own lives and environments, (2) to develop a belief system with respect to assertive behaviour that would improve the individual's self-awareness and acceptance of their needs and rights, (3) to assist them in reducing the cognitions and anxieties which impaired their capacity to engage in assertive behaviour, and (4) to provide them with the opportunity to begin resolving the difficulties experienced in heterosocial relationships.

Subjects

The group was comprised of six women who were undergoing individual therapy at the Psychological Service Centre, University of Manitoba, for long-term trauma associated with sexually abusive experiences in childhood or adolescence. The participants ranged in age from 23 to 44 years with a mean age of 30.6. Four of the women were married while two were single. One of the individuals with-

drew from the program prior to its completion for personal reasons.

Admittance to this component of their treatment scheme was based on the following criteria:

1. The individuals had to be referred to the program by their individual therapists.

2. Each of the women must have been experiencing difficulty engaging in assertiveness behaviour as determined by the Assessment Interview Protocol for Assertiveness (Appendix A).

3. Each of the participants had to have access to their original therapists during the assertiveness training program. The rationale for this criterion was based on the assumption that the women may have required additional therapeutic support in the event there was an emergence of any problematic issues which threatened their stability or level of functioning (Herman & Schatzow, 1982). This raises a concern regarding treatment interaction effects (Isaac & Michael, 1981). In light of the potential emotionality of issues related to their victimization experiences, however, it would have been unethical therapeutically and morally to deny them this access.

4. The women were not to have been "in crisis" or under severe stress at the commencement of the group. This was based on the premise that such extraneous factors pos-

sibly may have impaired their capacity to acquire and develop assertive skills. Also, confronting crises went beyond the focus of the group objectives unless, of course, they emerged throughout the course of the group process.

5. The women were expected to be at a point in their therapy whereby they had begun to resolve some of the traumatizing elements of their victimization in order that they would be prepared emotionally to approach and work on the acquisition and development of assertive skills.

6. Each woman had to agree to participate in the program voluntarily.

Assessment Procedure

Prior to the implementation of the program, each of the individuals was assessed by means of the Assessment Interview Protocol for Assertiveness (Appendix A) in order to identify specific difficulties related to assertiveness which required modification. These target problems, then, were monitored by means of the Target Complaint Scales (Mintz & Kiesler, 1982) (Appendix B) which were completed by the participants on at least three occasions during the assessment period in order to establish a baseline representing the trend of the individual's current level of functioning (Bloom & Fischer, 1982).

The assessment protocol as well as the administration of the Target Complaint Scales within the assessment period

were completed by the women's individual therapists at the clinic. The rationale for this procedure was based on the fact that the therapists had been involved with the individuals for an extended period of time and, subsequently, would have been more familiar with their needs. Also, the women, undoubtedly, would have felt more comfortable with their original therapists at this particular juncture.

Variables Evaluated

Two variables were evaluated within this study, assertive behaviour and self-esteem. Assertive behaviour has been discussed at length above and, therefore, will not be addressed at this point. Self-esteem was used as a secondary variable to determine whether it was affected by the intervention. The basis for the selection of this variable was to replicate empirical data demonstrating a positive correlation between increased assertiveness and self-esteem (Lange & Jakubowski, 1976; McVicar & Herman, 1983; Osborn & Harris, 1975; Stake & Pearlman, 1980).

Measures

Target Complaint Scale (TCS)

The Target Complaint Scale (Mintz & Kiesler, 1982) (Appendix B), a version of the self-anchored scale (Bloom & Fischer, 1982), was used as the repeated measure for the study. The participants used the scales to monitor the current intensity of specific assertiveness problems by

rating them on a 13 point scale ranging from not at all to couldn't be worse. The TCS was designated as the primary measure because it is a highly individualized and focal instrument. For this reason, it can be developed to measure problematic aspects of assertiveness which are relevant and specific to the individual participants. In addition to this, Mintz and Kiesler (1982) describe this self-report method of rating improvement on target complaints as being an acceptable evaluative measure which appears to be sensitive to change.

Reliability and Validity

Presently, the reliability and validity data that is available for Target Complaint Scales is inadequate (Mintz & Kiesler, 1982). For the most part, it has been based on the scores of groups of subjects and, subsequently, may be inappropriate when applied to settings wherein individual clients are being evaluated. At the same time, however, Bloom and Fischer (1982) suggest that these scales have face validity because "they represent [the client's] most accurate portrayal of the circumstances, thoughts or feelings" (p. 169) related to the problem.

Limitations

There are two primary weaknesses of the TCS. Firstly, data to establish reliability and validity is rather weak and, therefore, there is limited confidence one can have

with respect to the instrument's stability over time and the extent to which it measures the specified target problems which are identified on the scales. Secondly, the self-report nature of this instrument makes it vulnerable to potential reactivity. Subsequently, response sets such as social desirability and compliance are liable to bias the data (Bloom & Fischer, 1982). It should be noted that all self-report measures, although being susceptible to reactivity, are the only ways of measuring certain variables such as the client's thoughts, feelings or private behaviour (D. Jehu, personal communication, September 25, 1986).

Based on the recommendations of Bloom and Fischer (1982), several steps were undertaken in order to minimize reactivity. First of all, specific instructions were given to the women at the administration of the scales, encouraging them to be honest and accurate in their evaluations. Secondly, the participants were informed that the data collected would be useful both for assessment and treatment purposes. Thirdly, more than one behaviour related to non-assertiveness was measured by the TCS. In fact, the minimum number of target complaints for any individual client was five. Fourthly, the results of the TCS were compared with those of a global measure of assertiveness in order to determine any consistency in the observed changes.

Assertion Inventory (AI)

The Assertion Inventory (Gambrill & Richey, 1975) (Appendix C) is composed of forty items and collects information on three levels: (1) response probability, a measure indicating the likelihood that an individual will behave assertively in specific situations; (2) degree of discomfort, a dimension which indicates the discomfort level experienced by the individual in these situations; and (3) the specific situations in which the person desires to be more assertive. The scale employs a five-point Likert format whereby the respondent indicates the likelihood of engaging in assertive behaviour (1=always do it and 5=never do it) and the level of discomfort experienced (1=none and 5=very much). Items are scored in the direction of low assertion and, subsequently, high scores on each dimension indicate a general tendency for non-assertiveness and discomfort respectively. The cutting point is 105 and above for low response probability and 96 and above for high degree of discomfort.

Reliability and Validity

For both dimensions of the scale, the test-retest reliability is high as indicated by a coefficient of r=.87 for discomfort and r=.81 for response probability (Gambrill & Richey, 1975). Therefore, the instrument appears to have good stability over time. Presently, there is no documen-

ted data on its internal consistency (Beck & Heimberg, 1983). There have been some efforts to substantiate the instrument's validity as well. For example, although the interscale correlation was not specified, a comparison of the AI with the Conflict Resolution Inventory and the Rathus Assertiveness Schedule indicated a high degree of convergent validity (Frankel, cited in Beck & Heimberg, 1983).

Limitations

The primary limitation of the AI is the fact it was developed from a college population and, therefore, may have limited usefulness when generalized to other populations. In addressing this concern, one is faced with a dilemma because a number of the assertiveness inventories having any significant degree of reliability and validity have been developed from college populations (Rich & Schroeder, 1976). There are two reasons, however, for selecting the AI for this program. Firstly, Lange and Jakubowski (1976), two prominent theorists and practitioners, suggest that it is useful for measuring assertiveness changes in individuals. Secondly, the AI is very useful in that it measures affect as well as behaviour, thereby providing a more extensive picture of the individual's assertiveness.

The second shortcoming of the AI is the fact its self-

report nature increases the potential for reactivity. This limitation, however, should have been reduced substantially because the instrument has high test-retest reliability (Bloom & Fischer, 1982). Furthermore, attempts were made to reduce potential reactivity by encouraging the participants to be honest and accurate in completing it and by informing them of the purpose for its administration.

Hudson Index of Self-Esteem (ISE)

This standardized measure (Hudson, 1982) (Appendix D) was used as a secondary measure to evaluate side effects of the interventive program. It is comprised of a twenty-five item scale by which respondents indicate their response to the items on a five-point Likert scale ranging from 1 (rarely or none of the time) to 5 (most or all of the time). The clinically significant cutting point for low self-esteem is 31 and above.

The ISE was utilized because it is an accurate and reliable measure of self-esteem and, reportedly, is extremely sensitive to change. It has high internal and test-retest reliability with correlations of 0.90 for each (Hudson, 1982). Furthermore, it has been demonstrated to have high face, concurrent and construct validity (Hudson, 1982). Its main limitation centres upon potential reactivity, although the high reliability should have minimized this.

Client Satisfaction Questionnaire

A client satisfaction questionnaire (Appendix E) was administered at the completion of the training program in order to give the group members the opportunity to evaluate the overall benefits of the group and to make recommendations for improvement. Pursuant to this, the instrument was used to evaluate the participants' perception of the usefulness of the various training procedures as well as to obtain feedback regarding the presence and helpfulness of the male co-therapist. In view of the fact these questionnaires can be subject to biases such as the desire to please the therapists, the participants once again were encouraged to be honest, overt, and accurate in their comments.

In summary, four measures were utilized in the measurement process. The Target Complaint Scales were administered on a weekly basis to provide a continuous measure of change in specific aspects of assertive behaviour whereas the Assertion Inventory and the Index of Self-Esteem were used to evaluate more global changes in assertiveness and self-esteem respectively. Finally, a questionnaire was completed to measure the client's satisfaction.

Evaluation Design

The interventive program utilized a combination of the

A-B basic single system design (Bloom & Fischer, 1982) and the one group pretest-posttest design (Campbell & Stanley, 1963; Cook & Campbell, 1979).

The A-B Basic Single System Design

This design, consisting of two distinct phases, was used to evaluate the target complaints. The A phase, which refers to the observation period, served two functions. First of all, it was used to assess the individuals by means of the Assessment Interview Protocol for Assertiveness (Appendix A) in order to identify specific difficulties related to assertiveness which required modification. This, then, was used to negotiate with the participants various problems which were used as target complaints. Secondly, the A Phase was used to establish a baseline which represented the participant's current level of functioning with respect to these target problems (Bloom & Fischer, 1982). The B phase refers to the intervention, that is, the various assertiveness training procedures and techniques which were used to facilitate change in the women.

Advantages

Bloom and Fischer (1982) identify four advantages of using the A-B design. First and foremost, it is a time-series design which enables the practitioners to obtain repeated measures of the participants' progress throughout

the assessment, intervention and follow-up periods. This formulates the basis from which the participants can be provided with feedback during the intervention in order to support and reinforce their change efforts and to enhance their motivation. Secondly, the design is useful for evaluative purposes because it enables one to compare the intensity of the target problems during the intervention period with the baseline established during the A phase. Thirdly, the baseline data helps to provide a more substantial and accurate assessment. Fourthly, the process of monitoring the participants' progress by means of repeated measures can be used as an accountability device for the practitioners, the participants, the agency, and society.

Limitations

The primary limitation of the A-B design is the fact it does not control for threats to internal validity. Subsequently, extraneous factors such as history or maturation effects could be alternative explanations for any changes which did occur (Bloom & Fischer, 1982). For example, the threat of history, meaning other events which coincide with the intervention, may have confounded the results. It would not have been appropriate to attempt to minimize these threats by utilizing the basic experimental time series design (Bloom & Fischer, 1982) which removes and, then, reintroduces the intervention, because asser-

tiveness training procedures are irreversible. Subsequently, one would not expect a concomitant variation between the withdrawal of the intervention and the pattern of the target complaints (Bloom & Fischer, 1982).

The practitioners, however, did endeavour to reduce threats to internal validity by noting any changes in the situations of the participants during the intervention which may have effected the results. This was facilitated by means of a "group-go-around," a period at the beginning of each group session in which members were encouraged to share experiences from the previous week. In addition to this, the replication of the A-B design across subjects was used to reduce these threats as well. For example, the chance of extraneous effects confounding the results are lessened if change occurs in each of the participants (D. Jehu, personal communication, September 25, 1986). Finally, replication of this interventive program eventually will help to overcome threats to internal validity.

One Group Pretest-Posttest Design

In addition to A-B design, this study utilized the one group pretest-posttest design (Campbell & Stanley, 1963; Cook & Campbell, 1979). This quasi-experimental design was used to evaluate the data of the Assertion Inventory and the Hudson Index of Self-Esteem which was obtained at the assessment, termination of treatment and follow-up periods.

This design was used for these inventories in order to minimize potential reactivity by limiting the number of data points for each.

The design does not exclude the various threats to internal validity discussed above. The steps taken to reduce these threats within the A-B design, however, apply here as well.

It is necessary to add one final comment regarding the design of this intervention. In view of the fact the sample was not randomly selected, one is unable to generalize the findings to other populations. Similarly to internal validity, however, this limitation of external validity will be overcome as the program is replicated over time (Bloom & Fischer, 1982).

Data Collection

The TCS, measuring the target problems identified from the assessment protocol discussed previously, were completed by the participants on at least three occasions at weekly intervals during the A phase in order to establish a baseline. Bloom and Fischer (1982) recommend that at least three separate data points be used during the A phase so that a trend of the individual's current level of functioning will be established prior to the application of the treatment. The TCS, then, were completed on a weekly basis

throughout the intervention or B phase as well as at the follow-up session. During this phase, the scales were administered at the beginning of each group session. In addition to the series of TCS, the women completed the AI and the ISE at the initial and termination sessions of the B phase and at the six-week follow-up session. Finally, the client satisfaction questionnaire was distributed at the termination session of the program.

Intervention Procedures

Treatment Techniques and Procedures

The treatment program employed several techniques and procedures to facilitate the acquisition of assertive skills by the group participants. These various components are discussed below.

Modelling

Modelling or observational learning is a procedure whereby taped or live models, such as films and group therapists respectively, are used to demonstrate appropriate assertive behaviour for specific situations (Linehan, 1979). It is based on the premise that the skills are acquired vicariously as the trainee observes the modelled behaviours and their results (Lange & Jakubowski, 1976). The relevance of modelling procedures to assertiveness training is well documented in the literature (Clionsky, 1983; Kelly, 1985; Lange & Jakubowski, 1976; Linehan, 1979; Osborn & Harris, 1975). Lange and Jakubowski identify three advantages of this technique: (1) it is a relatively easy method for providing individuals with various assertive behaviours, (2) it gives "permission" to the group participants to behave similarly, and (3) it reinforces assertive skills already learned.

The program utilized both formal and informal modelling procedures. The formal modelling, which consists of audio or video tapes (Lange & Jakubowski, 1976) was pro-

vided by the film "Responsible Assertion" (Baxley, 1978). It employs several models to enact the difference between assertiveness, aggression, and passiveness. The film was particularly useful because it enabled the women to observe the models' facial expressions, hand gestures and voice tones -- nonverbal behaviours which are an extremely important component of assertiveness (Lange & Jakubowski, 1976; Sank & Shaffer, 1984).

Informal modelling, the procedure whereby the group therapists and participants demonstrate assertive responses for other group members (Lange & Jakubowski, 1976), was used more extensively than formal modelling. The advantage of the informal modelling provided by the therapists or group participants "is that the situations can be tailored to fit the client's needs" (Linehan, 1979, p. 219). During the initial stages of the group, the group therapists comprised the primary informal models. This occurred by means of instructional examples of specific assertive responses, informal role plays and informal displays of appropriate assertive behaviour in their general interpersonal interactions with each other and with the various group members. As the women began to develop various assertive skills, however, they provided modelling behaviour for each other as well.

Behavioural Rehearsal

Behavioural rehearsal or role playing is an integral instructional component of assertiveness training programs (Clionsky, 1983; Lange & Jakubowski, 1976; Linehan, 1979; Osborn & Harris, 1975; Sank & Shaffer, 1984). Essentially, it consists of simulated situations wherein the trainee practices appropriate assertive responses (Linehan, 1979). The underlying assumption of behavioural rehearsal is that an individual's behaviour is able to change by means of modelling or observational learning, reinforcement and practice (Osborn & Harris, 1975). It is particularly effective when used collectively with modelling, the benefit being that the "trainee can both observe how another person would assert himself [herself] and repeatedly practice the observed behavior" (Osborn & Harris, 1975, p. 60).

Covert Behavioural Rehearsal

Behavioural rehearsal exercises were introduced slowly and cautiously into the training procedures because, as discussed previously, women who have been sexually victimized as children or adolescents, frequently have impaired social skills and low self-esteem, and experience difficulty in trusting others. This latter element is particularly relevant because in behavioural rehearsal, one must be able to trust that other group members will be suppor-

tive in providing honest feedback. Furthermore, as M. Gazan (personal communication, September 11, 1985) observes, these women have a tendency to fear failure, particularly in situations such as a group setting wherein they potentially could be ridiculed. In fact, individuals participating in an assertiveness training group for previously abused women reported that they had extreme difficulty engaging in behavioural rehearsal because they found such exercises to be overly threatening (Gazan, 1985).

On this basis, overt behavioural rehearsal, the procedure by which the individual verbalizes and role plays specific situations (Linehan, 1979), was considered by the therapists to be too threatening and anxiety-provoking to be employed during the earlier sessions of the program. Subsequently, the initial emphasis with respect to this instructional technique was upon covert behavioural rehearsal or imagery rehearsal, to which it is sometimes referred, the process whereby the individual practices the desired behaviour imaginatively (Lange & Jakubowski, 1976; Meichenbaum, 1985). In other words, this procedure teaches individuals to provide themselves with a model of appropriate assertive interaction. Linehan (1979) posits that this method of response practice is effective in facilitating the acquisition of assertive skills. The underlying

assumption of this approach is that "reinforcement of social consequences which effectively influence behaviour in real life are also effective when they are imagined" (Osborn & Harris, 1975, p. 59).

Overt Behavioural Rehearsal

As the women began to experience less anxiety as well as increased comfort within the group environment, the training emphasis shifted from covert to overt practice methods. In doing this, however, two steps were taken to minimize any discomfort or difficulty the women may have experienced. First of all, many of the exercises were structured as written assignments which could be practised individually, in dyads as well as within the entire group. During the response practice, the individuals were able to read their scripts in order to reduce any discomfort they may have experienced. Sank and Shaffer (1984) suggest that it is appropriate for individuals to read scripts or prepared assertive responses in role play exercises. This methodology was designed for those women who were reluctant to participate in overt behavioural rehearsal or for those who had extreme difficulty in doing so.

Secondly, based on the recommendation of Osborn and Harris (1975), the group participants were asked to role play non-targetted, hypothetical scenarios prior to rehearsing specific situations they had been encountering. Sank

and Shaffer (1984) observe that this level of rehearsal "is often less threatening than dealing with one's own problem in front of the group and yet does serve the purpose of easing the participants into role playing and giving them practice with the techniques they will be learning" (p. 121).

Response Feedback, Coaching and Reinforcement

Three similar tools used in conjunction with behavioural rehearsal to shape and strengthen the women's assertive responses were response feedback, coaching and reinforcement. In response feedback, the individuals "are usually given an explicit description of their performance" (Linehan, 1979, p. 220). Kelly (1985) suggests that the feedback which is provided should be positively toned. Subsequently, it should endeavour to identify strengths before providing constructive criticism. For example, the therapist might inform the participant that the verbal content of the assertive message was appropriate while pointing out that she or he failed to maintain adequate eye contact. It is important that this positive context is established by the therapists in order that appropriate feedback response patterns are modelled for the group members (Kelly, 1985).

Coaching is a procedure which enables the therapists and other group members to describe the ways in which an individual's behaviour can be improved in a specific situ-

ation (Linehan, 1979). For example, someone might suggest that the trainee incorporate more "I" statements into her or his assertive response. Rose (1985) suggests that coaching within group contexts is beneficial not only to those receiving the constructive ideas and advice, but to those who offer them as well.

Reinforcement involves the provision of positive responses such as verbal praise and acknowledgement by the therapists and group members to assertive behaviours displayed by other participants (Lange & Jakubowski, 1976).

Cognitive Restructuring

Cognitive restructuring is a therapeutic procedure whereby an individual, first of all, is made aware of distorted beliefs which evoke dysfunctional moods and impair his or her behaviour and, secondly, is assisted in changing these cognitive patterns so that they become facilitative of more appropriate responses (Lange & Jakubowski, 1976; Sank & Shaffer, 1984). In their analysis of the process and rationale of this strategy, Jehu and his colleagues (Jehu, Klassen & Gazan, 1985-6) comment:

> Cognitive restructuring is based on the premise that beliefs have a significant influence on feelings and actions. If the beliefs are distorted or unrealistic, then feelings and actions are likely to be distressing and inappropriate.

> In this way distorted beliefs may contribute to many emotional and behavioral problems. It follows that the correction of distorted beliefs is likely to be accompanied by the alleviation of such problems. (pp. 49-50)

This procedure was incorporated into the treatment framework of this study because nonassertiveness can be associated with distorted thinking as well as with behavioural deficits (Sank & Shaffer, 1984). It was used to assist the women in acquiring the capacity to assess their cognitions as well as the impact these have upon feelings and behaviour, and in replacing irrational beliefs with those which were more reasonable. For example, it was used to engender the development of a personal belief system which justified the women's right to be assertive.

Structured Exercises

In most sessions, structured exercises focusing on various elements of assertiveness were introduced in order to increase the member's participation and to give them practical experience in the application of various skills. Lange and Jakubowski (1976) underline three reasons for using structured exercises: (1) to assist group members in learning a number of procedural components such as cognitive restructuring and personal script writing (refer to content of sessions, Session 6) which could be used to pro-

mote the follow-through of assertive behaviour upon the termination of the program, (2) to assist members in developing the communication skills required for assertive behaviour, and (3) to increase their confidence while concurrently reducing anxiety in approaching assertive situations.

Didactical and Printed Materials

The program consisted of several mini-lectures which were designed to broaden the participants' knowledge with respect to assertive behaviour. For example, one session was devoted to the importance of interpersonal rights and the way in which they can be identified in a given situation. These instructional presentations were intended to provide the women with verbal, cognitive and arousal management guidelines which would enhance their ability to behave assertively.

In addition to this, printed "handouts" were distributed during several of the group sessions in order to supplement the didactical material and to provide the women with concrete reference material which would be helpful after the group had terminated. The sources for both the instructional and printed materials utilized are identified in the section of this report which discusses the content of the group sessions.

Homework Assignments

Homework assignments were used to assist the women in generalizing or transferring newly acquired assertion skills to situations and experiences beyond the parameters of the group milieu (Kelly, 1985; Lange & Jakubowski, 1976). Theorists and clinicians such as Kelly (1985), Lange and Jakubowski (1976), Rose (1985) and Sank and Shaffer (1984) unanimously recognize the importance of homework assignments in assertiveness training. Their usefulness, in fact, has been demonstrated in specific training programs by Galassi, Galassi and Litz (1974) and Rathus (1973).

Within this study, the women were given assignments to complete or practice between sessions. They were expected to monitor these "in vivo" responses, observing the specific response utilized in the assertive situation and describing the subsequent consequences.

In addition to providing the women with opportunities to practice the various assertive skills within the environments of their daily lives, homework assignments enabled the therapists to monitor the women's progress and to identify any additional problems which needed to be alleviated (Osborn & Harris, 1975).

Content of Group Sessions

The assertiveness training program was comprised of ten, two-hour sessions which were held weekly at the

Psychological Service Centre, University of Manitoba. Each session focused upon one or more assertive themes which were taught by means of the various techniques described above. Much of the resource material for the sessions was taken from programs developed by Lange and Jakubowski (1976) and Osborn and Harris (1975). Although these sources adopt slightly different perspectives, each provides trainers with a solid foundation in assertiveness training techniques and identifies a number of excellent, practical exercises which can be used in the context of a group. Lange and Jakubowski emphasize the cognitive, affective and behavioural elements of assertion and, generally, are more consistent with a cognitive perspective whereas Osborn and Harris promote self-awareness, self-confidence and self-esteem.

In addition to these materials, a number of other available sources were used as well (Baer, 1976; Bloom, Coburn & Pearlman, 1975; Bower & Bower, 1976; Butler, 1981; Phelps & Austin, 1975). These were used to a lesser extent because they have been designed primarily as self-instructional tools and, subsequently, the exercises they outline are not as amendable to the group environment.

One of these sources, "The New Assertive Woman," (Bloom, Coburn & Pearlman, 1975) was used as homework reading material in order to supplement the various issues discussed in the group sessions. The book was selected for

this purpose because it is inexpensive, readable and practical, and provides an excellent description of the verbal mechanics of assertive behaviour. In addition to this, it addresses a wide range of topics integral to assertion such as individual rights, irrational beliefs, anxiety reduction, active listening and non-verbal behaviour.

The following is a description of the individual sessions.

Session 1

The objectives of the initial session were to orient the women to the group goals and norms, to establish an atmosphere of comfort and trust, and to introduce them to a general overview of assertive behaviour.

Administration of the Evaluative Measures

Following a brief introduction of the group facilitators, the three measures being used to evaluate the study, the Target Complaint Scales (Mintz & Kiesler, 1982) (Appendix B), the Assertion Inventory (Gambrill & Richey, 1975) (Appendix C) and the Hudson Index of Self-Esteem (Hudson, 1982) (Appendix D), were administered. As discussed previously, the respondents were informed that the information would be used for assessment and treatment purposes and, subsequently, were encouraged to be honest and accurate in their evaluations.

Introductions of Group Members

Each participant was asked to introduce herself, to provide a brief sketch of her present life situation identifying such factors as marital status, vocation, leisure activities, and to explain briefly the purpose for her participation in the assertiveness training program.

Explication of the Program's Goals

The women were informed of the group's objectives in order that they would be aware of what to expect in the various sessions of the program. These goals were modified slightly from the objectives discussed previously to ensure their comprehensibleness. They were described as follows:

1. To assist the participants in realizing that they have both rights and choices in all situations.

2. To assist them in acquiring and improving their assertive skills so that they would become enabled to express their needs, desires and opinions more openly and directly.

3. To assist them in reducing discomfort which impaired their capacity to engage in assertive behaviour.

4. To assist them in achieving more personal satisfaction in their interpersonal relationships.

5. To provide them with the opportunity to begin resolving the difficulties they experienced within heterosocial relationships by interacting with the male therapist

in a positive environment. With respect to the role of the male therapist, the group members were informed that this study was a requirement for his academic program and, therefore, necessitated that he assume the majority of the leadership within the group. This information was important so as to mitigate against the emergence of any misconceptions such as the belief that he was usurping power and authority at the expense of the female therapist.

Identification of Group Rules

Following the discussion of the group goals, the therapists laid out the norms which were to be observed throughout the program. This ensured that the participants would be cognizant of what was expected of them. The following norms were identified:

1. The women were requested to be punctual in order that each session could be started at the specified time.

2. The women were requested to attend each session unless uncontrollable circumstances made it impossible for them to do so.

3. The women were informed of the importance of confidentiality and were asked to refrain from discussing any such information beyond the group's setting. At the same time, the group therapists explained that pertinent information would be shared with each woman's individual therapist.

4. The therapists specified that the women were under no obligation or pressure to divulge any information circumscribing their abusive experiences which they did not wish to disclose. This norm was intended to protect their privacy and to minimize any discomfort they may have been experiencing.

Break

Each week, a break was included in the group's agenda. Its purpose was to give the participants an opportunity to interact without the therapists in order to establish friendships which would continue following the group's termination.

An Introduction to Assertiveness

Assertive behaviour was defined as "an honest, direct and appropriate expression of one's feelings, beliefs and opinions" (Jakubowski-Spector, 1973, p. 76). Two procedures were utilized to explain this concept to the participants.

Mini-lecture. First of all, a didactic outlining the differences between assertiveness, passivity and aggression was presented by one of the therapists. It was designed to provide the women with a conceptual foundation for assertion. The material for this presentation was based on a program of self-assertion developed by Butler (1981). In differentiating between these three behaviours, she utilizes the framework developed by Harris (cited in Butler,

1981) to identify the basic attitude which underlies each. These can be summarized as follows: assertive behaviour (I'm okay - You're okay), passive behaviour (I'm not okay - You're okay), and aggressive behaviour (I'm okay - You're not okay).

This information was supplemented by a graphic display of these three positions (Butler, 1981) (Appendix F). In addition to this, the women were provided with printed materials developed by Clionsky (1983) (Appendix G) and Liberman, King, DeRisi and McCann (1975) (Appendix H). These sources summarize and compare the basic elements of assertiveness, passivity and aggression. Also, a table (Butler, 1981) (Appendix I) identifying various situations with examples of each response was distributed as well.

Film: "Responsible Assertion" (Baxley, 1978)

Secondly, "Responsible Assertion," a film which provides the viewer with instruction as well as a series of situational role plays to distinguish between assertiveness, passivity and aggression, was employed in order to reinforce the didactical presentation. It was particularly useful because it demonstrates appropriate modelling of both verbal and nonverbal assertive responses. The film was followed by a discussion of the participants' reactions and observations.

Wrap-Up

At the closure of the session, one of the therapists briefly summarized the activities of the evening and gave the women an opportunity to share any insights they may have had. In addition to this, the therapists used this period of time to determine whether there were any concerns or "unfinished business" which needed to be addressed before ending the session.

Homework Assignments

Collage (Osborn & Harris, 1975). In this assignment each participant was instructed to prepare a collage depicting her real self and her ideal self. The real self referred to the way in which she felt about herself at that time whereas the ideal self represented an expression of the person she desired to be. The individuals were given the option of drawing, painting, pasting, writing or using ceramics to complete this exercise. It was intended to assist the women in becoming aware of the feelings they had regarding themselves and to share these with the other group members in the following session.

The therapists agreed to participate in this assignment as well. There were two reasons for this. First of all, the exercise had the potential to be difficult emotionally for this clientele and the practitioners believed that their participation would "break the ice" during the

presentations which occurred in the following session. Secondly, in completing the exercise, the therapists were able to demonstrate their willingness to identify with the group members.

Assigned reading. The women were asked to read chapters 1, 3 and 4 in "The New Assertive Woman" (Bloom, Coburn & Pearlman, 1975).

Session 2

The second session was designed, first of all, to promote self-awareness and, secondly, to provide the participants with a model for challenging irrational beliefs.

Completion of the Target Complaint Scales

This component is described in Session 1 of the report.

Group-Go-Around (Sgroi, 1982)

Following the completion of the Target Complaint Scales, a group-go-around was used to provide each participant with the opportunity to give a brief synopsis of these experiences during the previous week. This procedure promoted member participation and informed other group members of one's current situation. This latter point was particularly significant because it was one method by which the therapists were able to monitor the women's progress.

Discussion of Homework

During each session, a period of time was set aside to review the homework which had been assigned the previous

week. In this session, the personal collage, which had been designed to depict one's real self and ideal self, formulated the focal point of this component. The presentation of the collages was followed by a discussion which emphasized the way in which negative self-images often are maintained by irrational beliefs individuals have regarding various elements of their real self as well as by unreasonable expectations they have for their ideal self. The therapists underlined the importance of accepting one's real self with its accompanying strengths and weaknesses while at the same time pursuing the realistic goals and dreams identified in the ideal self.

Mini-Lecture: Irrational Beliefs (Lange & Jakubowski, 1976)

A mini-lecture which explained the concept of irrational beliefs was presented by one of the therapists. Its purpose was to describe the effect irrational beliefs have upon an individual's behaviour and to demonstrate the way in which a person's thinking can be restructured in order that it does not prevent him or her from behaving assertively. The didactic was based on Albert Ellis' rational-emotive therapy (cited in Lange & Jakubowski, 1976) which utilizes an A-B-C-D-E paradigm to describe the relationship between thinking, feeling and behaving. Point A refers to an activity or a specific situation which is particularly difficult for the individual, such as refusing requests for

assistance from a friend. Point B represents the thoughts or the assumptions the individual has about the situation. The person might irrationally assume: "If I do not help my friend, she will become upset and will not like me anymore, and that would be unbearable." At point C, these beliefs cause the individual to feel anxious, thereby mitigating against an assertive response.

Points D and E of the paradigm refer to the steps that can be taken to restructure the individual's thinking. At point D, the irrational beliefs are identified and challenged. For example, he or she might think: "What would be so 'terrible' if my friend becomes upset because I am unable to help her? Would it be the end of the world if she no longer considers me to be a friend?" At point E, the individual substitutes rational thoughts for those which are unreasonable and self-defeating: "I would like my friend to understand that I am unable to help her at this time. If she becomes upset, it will be inconvenient and upsetting for me, but it will not be catastrophic. Besides, if she does become angry, I can handle it."

Although undesired responses from the other individual may result in displeasure and frustration, this approach to interpersonal interactions reduces anxiety and increases an individual's capacity to be assertive in specific situations. In addition to this, it is facilitative of increased

self-esteem because it enables one to feel positive about the fact that they were able to pursue their goal to behave assertively.

Break

The purpose as well as the process of this agendum was described previously in Session 1.

Structured Exercise: Rational Self-Analysis (Lange & Jakubowski, 1976)

This exercise involves having the individuals write down a specific situation in which they desire to be more assertive but in which affective factors such as guilt or anger elicit aggressive or passive responses. Secondly, they are asked to identify and write down the negative or self-defeating thoughts that arise when they think of engaging in assertive behaviour in that situation. Thirdly, they are asked to develop challenges to these thoughts. Prior to the exercise, an example was used to give the individuals direction as well as a concrete pattern to work with. An outline of the format used in this procedure is provided in Appendix J.

This exercise was intended to identify and challenge irrational cognitions which produce emotional responses such as anxiety, anger and guilt, and thereby inhibit the use of assertive behaviour in specific situations.

Wrap-Up

The wrap-up was completed as described in Session 1 of this report.

Homework Assignments

Like yourself (Phelps & Austin), 1975). The women were given a handout (Appendix K) which outlined the instructions for this assignment and provided space for its completion. The exercise involved having the participants write down at least five positive statements about themselves; for example, "I like the fact that I am endeavouring to become more assertive." The individuals, then, were asked to stand in front of a mirror and read the list audibly while practising good eye contact and verbally or non-verbally acknowledging each compliment they gave themselves. This procedure was structured to increase the participants' awareness of their positive traits so as to provide a basis for increased self-esteem and an improved self-concept.

Rational self-analysis. The women were asked to repeat the self-analysis procedure discussed above on at least two occasions during the week.

Assigned reading. The group was instructed to read chapters 2, 5 and 6 in Bloom, Coburn and Pearlman (1975).

Session 3

The objectives of this session were to generate an

awareness of interpersonal rights and to emphasize the fact that everyone has the right to their personal beliefs, feelings and opinions.

Introductory Procedures

The session began with the completion of the Target Complaint Scales, the group-go-around and a review of the previous week's homework assignments. These components are discussed in Sessions 1 and 2 of this report.

Mini-Lecture: Interpersonal Rights (Lange & Jakubowski, 1976)

The purpose of this presentation was to assist the group members in developing three basic beliefs which undergird a philosophy of responsible assertion: (1) the belief that assertiveness, rather than passivity, aggression or manipulation invokes self-respect as well as respect for others and, subsequently, leads to increased satisfaction within interpersonal relationships, (2) the belief that everyone has the right to act assertively and to express honestly their beliefs, opinions and feelings, and (3) the belief that the acceptance of one's rights necessitates that the rights of others are respected as well. For example, in accepting the right to make a mistake, an individual must be prepared to accept the right of others to make mistakes as well.

This didactic on interpersonal rights was important

because it provided the participants with a basis by which they were able to justify assertive behaviour. Furthermore, the identification and acceptance of interpersonal rights functions to reduce several internal injunctions which frequently inhibit assertive behaviour in individuals. Some of these are described by Lange and Jakubowski (1976) as follows: "Don't ever inconvenience other people; Don't ever refuse to help a friend; Don't ever feel mad; Don't be weak and ask for help; Don't ever make someone else feel bad" (p. 57). Another injunction which was commonly experienced by the group participants was the fact that they were not to contradict their partners. This, however, was restructured in the following manner: "I have the right that my feelings, opinions and beliefs are given the same consideration as those of my spouse."

This mini-lecture was supplemented by printed materials developed by Lange and Jakubowski (1976). First of all, a list of basic rights one has with respect to his or her thoughts, feelings and beliefs (Appendix L) was distributed. A second handout (Appendix M) described the effect several socialization messages have upon a person's perception of rights and his or her capacity to behave assertively, and provided a a healthy response to the various societal injunctions.

Break

During this session, the break began to be a very important time for the participants. They went "for coffee" together and appeared to be developing cohesiveness as well as a strong sense of comaraderie. When they returned to resume the activities of the group, they indicated that they wanted to be assembled around a table, maintaining that this change would cause the group to become closer both physically and emotionally. To this point in the program, the participants had been seated in a semi-circle, an arrangement which had enabled two of the members to distance themselves from the group physically. They believed that being seated around a table would help to minimize this. Also, they suggested that the male therapist be situated in the middle, rather than at the "head" of the table.

Their willingness to offer these assertive suggestions reflected the cohesion and high level of trust which had begun to develop. Also the remarks directed at the male therapist indicated that the women were beginning to accept his presence within the group.

Structured Exercise: Identifying Personal Rights and Accepting Personal Rights in Fantasy (Lange & Jakubowski, 1976)

The exercise was introduced in order to increase the

participants' awareness of the positive aspects of accepting the right to be assertive. It was comprised of two components. The first part of the exercise consisted of a brainstorming session in which the participants were asked to identify all the personal rights they were able to think of. Their responses were written on a chalkboard by one of the therapists. Some of the rights expressed are as follows: the right to say "No"; the right to express one's feelings; the right to like oneself; the right to make a mistake; the right to do nothing.

Secondly, the individuals were asked to study the list and to select silently the right which was most difficult for them to accept in their individual lives. The women, then, were asked to fantasize, first of all, what life would be like if they were able to accept the right and, secondly, what life would be like without it. The fantasy was guided by instructions dictated by one of the therapists.

Following the fantasy, the participants were divided into dyads and were asked to discuss the right they had selected, the feelings experienced when the right was accepted, the way in which they behaved differently when it was accepted, and any insights they had about themselves during the exercise.

Wrap-Up

This procedure was completed as discussed previously in Session 1.

Homework Assignments

Accepting personal rights in fantasy. The women were asked to repeat daily the fantasy exercise in which they would accept the right selected in the exercise described above. As they did this, they were instructed to give particular attention to the feelings they experienced during the fantasy.

Reading assignment. Chapters 7 and 8 in Bloom, Coburn and Pearlman (1975) were assigned as reading for the following week.

Satisfactions, achievements, successes (Osborn & Harris, 1975). In this assignment the participants were given a form (Appendix N) on which they were requested to record specific situations during the week which were successful or satisfying for them and to check the given statements which represented the positive elements of the experience.

This exercise had two objectives. First of all, its emphasis on positive experiences was intended to build self-esteem and self-confidence. Secondly, it was a method by which the individuals' behaviour could be monitored by the therapists.

Session 4

This session was designed to build verbal assertive skills and to begin preparing the group members for behavioural rehearsal exercises.

Introductory Procedures

The administration of the Target Complaint Scales, the group-go-around and the discussion of homework assignments were completed as described in Sessions 1 and 2.

Group Evaluation

During this session, the women were given an opportunity to provide verbal feedback and to make recommendations for subsequent sessions. The evaluation was included at this point in the program in order to determine whether the content and structure of the sessions were suitable to the needs of the participants and to enable the therapists to make any necessary modifications to improve its effectiveness. At this particular time, changes were not made to the approach being employed by the practitioners.

Mini-Lecture: The Ownership of Messages (Osborn & Harris, 1975)

This didactic emphasized the importance of expressing oneself in such a way that he or she assumes ownership of the messages directed at another person. Osborn and Harris (1975) comment that "this encourages them to clarify their 'wants' in their own minds and assists them in developing

communication skills which lead to greater autonomy" (p. 111). Two techniques which can be used to demonstrate ownership of one's messages were described. First of all, the group members were instructed to use "I" statements in expressing their beliefs, thoughts or feelings. This procedure assists individuals in accepting responsibility for their statements rather than projecting blame on another individual. For example, in the statement, "I feel angry because you did not phone to say you would be late for supper", the person accepts responsibility and ownership of his or her message. Conversely, the statement, "You are late again! You really don't care about anyone else around here", is indirect and does not represent ownership or personal responsibility for the message.

The second method for "owning" messages which was described involves paraphrasing remarks made by others into the form of questions. For example, an effective paraphrase to an angry remark made by another person would be: "Are you feeling frustrated with me?" This procedure is important because it facilitates verbal interaction rather than impairing it.

Break

This component is discussed in Session 1.

Structured Exercise: Assertive Statements and Questions (Osborn & Harris, 1975)

The exercise involved rehearsing a number of assertive statements and questions (Appendix O) individually and in dyads. It was intended to develop verbal assertive responses which were reinforced with appropriate non-verbal behaviours. Also, it provided the participants with the opportunity to practice "owning" their messages by using "I" statements and paraphrased questions.

The exercise was comprised of three segments. First of all, the participants read through the list of statements and questions individually. Secondly, this procedure was repeated in dyads so as to enable the women to practice the assertive responses within a personal interaction. In this aspect of the exercise, the individuals were asked to concentrate on their non-verbal behaviours as well. Thirdly, each woman was asked to transcribe their target complaints into "I" statements which, then, were rehearsed in dyads. This final procedure was designed to personalize the exercise in order that it would be more meaningful for the group members.

Wrap-Up

This item on the agenda was completed as it is described in the first session.

Homework Assignments

Data sheet. The data sheet which was developed by Richey (cited in Osborn & Harris, 1975) (Appendix P) was a method by which the trainees were able to collect data regarding their assertive behavioural responses in specific situations during the week. The participants were asked to record the assertive behaviour and to rate the response they received from others as well as the degree of discomfort they experienced. This assignment enabled the women to self-monitor their progress and to identify situations which were problematic for them.

Satisfactions, achievements, successes. Similarly to the last session, the participants were instructed to complete this form during the following week.

Reading assignment. The women were asked to read chapters 9 and 11 in Bloom, Coburn and Pearlman (1975).

Session 5

The purpose of session five was to build assertive skills in the participants and to increase their exposure to behavioural rehearsals.

Introductory Procedures

The Target Complaint Scales and the group-go-around were completed as discussed previously in Sessions 1 and 2.

Discussion of Homework

During this component of the session's agenda, a spon-

taneous, yet extremely important discussion emerged. It focused on the discomfort the women were beginning to experience with respect to being assertive. Two significant themes were identified within the discourse. First of all, the women indicated that their newly acquired skills were not being positively reinforced by their significant others. Subsequently, they were feeling frustrated, disappointed and discouraged. One group member (Kelly) remarked that her husband walked away whenever she used "I" statements. Another individual (Alison), who had recently experienced the death of her mother was feeling particularly uncomfortable because she was "learning to be assertive when everything out there [society] speaks against it." She stated that her mother was a well-loved, yet non-assertive, woman who constantly did things for other people. On this basis, the group member feared that she would not be loved if she became assertive.

The therapists used the discussion to identify four elements which are associated with the acquisition of assertive skills. Firstly, assertiveness, is a goal individuals pursue because they are unhappy with their current situation. Secondly, assertive people are able to do things for other individuals, however, they do so because it is a choice they make rather than an expectation to which they succumb passively. Thirdly, the changes which

occur in an individual's personality and behaviour as a result of the acquisition of new social skills frequently causes significant others to react negatively and, for this reason, it is important that one is persistent in his or her assertiveness. Fourthly, being assertive involves risks in that significant others may not necessarily respect one's rights, beliefs or feelings. For these reasons, the therapists recommended that each participant assess the personal advantages and disadvantages of assertiveness in order to determine the significance of this behaviour for her.

The second theme which emerged in this discussion focused on power and control within interpersonal relationships. It was apparent that some of the discomfort being experienced by the women at this point in the program was associated with the fact that they were equating personal control and ownership of one's life with the licence to manipulate and exert power over other individuals. The therapists, however, stressed that assertive skills are not intended to be used in controlling or manipulating others. Antithetically, their objective is to enable a person to accept responsibility for one's cognitions, feelings and behaviours, and to exert control over one's own life while, at the same, respecting the rights of others.

Break

The purpose and format of this component are described in Session 1.

Mini-Lecture: Unreasonable Requests

The lecture on unreasonable requests was adapted from material developed by Baer (1976). Its objectives, first of all, were to emphasize the importance of learning to say "No" when one does not wish to comply with a request. Secondly, it was designed to provide the participants with specific verbal assertive skills which could be utilized in response to unreasonable demands or inconvenient requests. Pursuant to this, three suggestions outlined by Baer were presented to the group members. These guidelines for refusing requests are as follows: (1) begin the response with the word "No", (2) speak in a firm voice, and (3) keep the answer short and clear.

Behavioural Rehearsal

The therapists had intended to provide the participants with two non-targeted scenarios to be role played in order to have the participants rehearse the process of refusing requests. One of the group members (Kelly), however, wanted to discuss a situation in which she did not say "No" to a request from an estranged friend and, subsequently, was experiencing anger, resentment and frustration. The individual felt that she was being used and for

this reason, wanted to telephone the friend in order to express her feelings. Pursuant to this, she asked the other group members for advice in responding to the situation appropriately. Following supportive and helpful input, the individual agreed to role play the situation, identifying the feelings she hoped to share with her friend.

Wrap-Up

The wrap-up was completed similarly to the description provided in the first session.

Homework Assignments

The women were again asked to complete the satisfactions, achievements, successes as well as the data sheets during the following week. These are discussed in Sessions 3 and 4 respectively.

Writing your own DESC scripts (Bower & Bower, 1976). The participants were given a handout (Appendix Q) developed by these authors which describes the way to write a script which can be used in interpersonal conflicts. This was presented as reading material and was discussed and utilized in the following session.

Session 6

The purpose of this session was to build and strengthen assertive skills.

Introductory Procedures

The Target Complaint Scales and the group-go-around were completed at the outset of the session. These components are described in Sessions 1 and 2 of this report.

Discussion of Homework

During the discussion of the previous week's homework, it became apparent that the participants were no longer having reservations about becoming assertive. Conversely, they stated that they were beginning to become cognizant of the benefits of the new beliefs and skills which they were acquiring.

Structured Exercise: Using Expressive Talk to Show Feelings (Bower & Bower, 1976)

The participants were asked to list several feelings or emotions they had experienced during the past week in reaction to specific events or activities and, then, to write sentences identifying expressions which could be used to describe the emotions they experienced. Examples of this include the following statements: "It was exhilarating to see the sun shining when I woke up this morning"; "It was frustrating driving to the university this evening because the traffic was extremely slow." When the sentences had been completed, they were rehearsed in dyads. In practicing their statements, the women were asked to concentrate on elements such as voice tone and hand gestures

and to provide feedback for each other with respect to these non-verbal behaviours.

The purpose of this exercise was to provide the group members with the skills which would enable them to express their feelings both overtly and honestly in specific situations. Furthermore, this form of disclosure was intended to enhance their communication skills as well as their ability to initiate and maintain friendships.

Break

This agendum is discussed in Session 1.

Structured Exercise: Writing Your Own DESC Script (Bower & Bower, 1976)

The DESC script was introduced in order to assist the participants in approaching conflicts in interpersonal relationships. DESC is an acronym whereby the letters represent the four steps constituting the script: (1) D: describe the problem to the other person, (2) E: express in a positive way the feelings experienced as a result of the other person's behaviour, (3) S: specify the changes which are desired in the behaviour of the other individual, and (4) C: identify the consequences which will be delivered if the other person changes his or her behaviour, as well as if he or she refuses to do so.

The exercise was divided into two separate components. First of all, the non-targeted situation identified in the

opening page of the handout provided as reading material at the last session (Appendix Q) was completed and discussed. Secondly, the individuals were asked to identify a conflict or difficulty they had been experiencing in a relationship and to write a DESC script which could be used to facilitate a resolution to the problem. When the scripts had been completed, each participant was given an opportunity to rehearse her script in dyads. During these role plays, the second individual was instructed to be initially angry and noncompliant to the message of the script so that the participants were given practice in dealing with negative responses and in being persistent in the pursuit of their goals.

Following the rehearsal in dyads, one of the individuals (Alison) volunteered to discuss and role play her script in the group setting. Feedback provided by other group members as well as modelling demonstrated by one of the therapists was extremely helpful in assisting her to improve her script.

Wrap-Up

This component is discussed in Session 1.

Homework Assignments

In addition to completing the satisfactions, achievements, successes and the data sheet discussed previously in Sessions 3 and 4, the women were asked to write a DESC

script based on one of their target complaints and to utilize expressive talk to describe their feelings at least once a day during the following week.

Session 7

This session was to have been used in order to rehearse the DESC scripts assigned as homework the previous week. The objective changed, however, because a significant portion of the session was used to respond to a problem being experienced by one of the group members.

Introductory Procedures

The Target Complaint Scales and the group-go-around were completed as in previous sessions. These items are described in the first and second sessions of this report.

Discussion of Homework

During this component of the session, Alison identified a problem which had emerged following a conversation she had had with her husband. In the previous session, this individual had written and rehearsed a DESC script for a conflict she was having with her husband. When it was introduced to the "in vivo" situation for which it had been prepared, his initial response was positive. The following day, however, he was aloof and nonresponsive to her and as the week progressed, became emotionally abusive, something he had done repeatedly in the past. He made remarks such as: "Now I'm beginning to see your real personality." In

addition to this, he pointed out that the long-term effects of her childhood sexual victimization were being experienced because she chose to experience them. Furthermore, the individual related that her husband continued to blame her for the abuse which occurred.

During the discussion of these circumstances, the other participants were noticeably empathetic, supportive and encouraging. One group member (Kerri) recommended that she should continue to be assertive with her husband, and suggested that he, perhaps, will require time and understanding as he worked through the changes he was observing in his wife. On the other hand, however, the group recognized that it might be necessary for her to terminate the relationship if her husband was unable to refrain from the emotional abuse he frequently initiated.

Break

This component is discussed in Session 1 of this report.

Wrap-Up

Following the break, the group members requested to discuss the agenda for the remaining three sessions. They suggested that the focus for sessions 8 and 9 be shifted from behavioural rehearsals to a discussion of specific issues associated with their victimization experiences which currently were impairing their efforts to become

assertive. They stated that role plays could be incorporated into the discussion, however, they recommended that it should be optional because some of the women had indicated that they experienced difficulty participating in this aspect of assertiveness training. The group decided that the theme of the following session would be personal rights within intimate relationships. In addition to discussing the changes for the following two sessions, the group members began to plan for the final session.

Homework Assignments

The women were requested to read chapters 12, 13 and 14 in Bloom, Coburn and Pearlman (1975) and to complete the satisfactions, achievements, successes sheet and the data form described previously in Sessions 3 and 4. Also, they were asked to think of a situation related to rights in intimate relationships which they would be prepared to rehearse in the following session.

Session 8

As discussed in the previous session, the group participants requested a shift in the format of the program. In response to this suggestion, Sessions 8 and 9 were structured to be more therapeutic rather than educational in their focus. In this session, the issue selected for discussion was interpersonal rights within intimate relationships.

Introductory Procedures

This component was used to administer the Target Complaint Scales, and to complete the group-go-around. These procedures have been discussed previously in Sessions 1 and 2.

Group Discussion

The content of this session consisted of a discussion about intimacy which was defined by the participants as being a relationship characterized by mutual acceptance, trust, honesty, respect, caring, sensitivity, sharing of values, and vulnerability. The discourse identified three themes which had particular importance and relevance to the group members.

A difficulty with intimacy. First of all, four of the five women (Sara, Kelly, Alison and Kerri) indicated that they had difficulty interacting within intimate relationships. Although intimacy generally was problematic, the focus of this difficulty varied. Sara and Kelly indicated that it was easier for them to be intimate with men than with women. They stated that women tend to be more competitive and, generally, less supportive of each other. At the same time, however, each of these individuals indicated that she was experiencing or had experienced a negative relationship with her mother. Kelly associated this with the fact that her mother did not protect her from abuse whereas

Sara observed that her mother had been extremely denigrating towards her.

On the other hand, Alison reported that her inability to trust males made it more difficult for her to be intimate with men as opposed to women. Kerri stated that she had difficulty with intimacy generally, particularly after she had disclosed her sexual abuse to an individual. A fifth group member (Ruth) indicated that intimacy was not a difficult issue for her.

The relationship between risk and rights. The second theme identified involved the relationship which exists between risks and rights. The women indicated that it was more difficult for them to accept their rights in intimate relationships because of the increased risk and potential for rejection which characterizes them. For this reason, they reported that they have been more tolerant of subtle coercion, manipulation and emotional abuse in past, and in some cases, current relationships.

The group indicated that it was necessary that people find a balance between rights and risks. They suggested that this could be achieved as individuals in a relationship make themselves accessible and available to each other while concurrently assuming personal responsibility to be intolerant and unaccepting of any form of abuse, exploitation or manipulation. This necessitates, first of all,

that the individuals establish clear limits and boundaries for the relationship and, secondly, that they express honestly their feelings and opinions, as well as their pains and frustrations.

Intimacy and victimization experiences. The third issue which emerged in the group discussion emphasized the normalcy of difficulties experienced in intimate relationships by previously abused women. Subsequently, the women encouraged each other to realize that any difficulties they experienced with intimacy were associated with the fact that they had been sexually abused as children. In summarizing the problems with intimacy encountered in a past relationship, Ruth commented: "I did the best I could and what I did was the result of past abuse and not because I was crazy."

Wrap-Up

The group decided that the following session would be used to discuss sexuality within intimate relationships. Also, the participants and therapists agreed that an informal party would be held at the last session.

Session 9

Following the completion of the Target Complaint Scales and the group-go-around described in Sessions 1 and 2, the group discussed sexuality in intimate relationships. A number of themes which were identified by the participants are

discussed below.

The Difference Between Male and Female Sexuality

First of all, the group members indicated that there is a basic difference in society's perception of male and female sexuality. They pointed out that male sexuality frequently is used to symbolize power and strength whereas female sexuality is equated with powerlessness. They suggested that the implication of this is the fact that female sexuality is designed to please men and, subsequently, causes many women to become "dishmops" and to accept any "garbage" which might be directed at them by males.

Control of Sexuality in Intimate Relationships

The element of control within intimate relationships was another issue underlined in this discussion. Each of the four individuals who attended this session indicated that the difficulties they experienced in this area was associated with the need for them to maintain control of their sexuality within intimate relationships. For example, the women commonly reported that it was both difficult and frightening for them to request sexual pleasure from a partner because, in their opinion, such behaviour causes one to relinquish personal control to the other person. In addition to this, the participants indicated that they use different means to maintain control of their sexuality.

The choice to be non-responsive. Alison and Kerri

reported that they avoid all sexual sensations because, for them, sexual pleasure represents a loss of control and causes them to experience intense guilt. They apparently believe that their bodies betrayed them during the abusive encounters because of the involuntary pleasurable response to sex which they experienced. Furthermore, the belief that they participated in the victimization encounter willingly, causes them to feel that they were responsible for it, thereby inundating them with guilt. Subsequently, any sexual sensations which occur in their current relationships cause them to feel guilty and to fear that they will lose control.

This creates difficulties for each of these women within sexual relationships. For example, Alison commented: "Whenever I feel any sexual sensation, it tells me I'm in trouble, that I am out of control." For this reason, she will not allow herself to get to the point at which her body will respond to something she cannot control because she feels it would increase the risk of being revictimized. This individual protects herself from this risk by allowing herself to become "numb" during sexual experiences with her husband in order that she will not feel any pleasure. Kerri, on the other hand, stated that she protects herself from further loss of control by avoiding sexual relationships altogether.

The choice to be responsive. The experiences of Sara and Ruth were somewhat different. Each of these individuals indicated that they did not experience any pleasure during the sexual abuse because they disassociated themselves from the encounter as a means of maintaining a sense of control. Sara reported that she would detach herself from the situation emotionally by "going off to the other side of the room" and, although this made her father "damned mad", she refused to be responsive in order to maintain control and, thereby, protect herself.

In addition to this, both participants stated that they have difficulty achieving orgasms in their current sexual relationships with their husbands. In view of the fact these individuals feel compelled to maintain control of the sexual relationship, they stated that they have to give themselves permission to decide cognitively whether or not they will be orgasmic in a specific situation.

The Need to Separate the Past from the Present

A third theme which was identified centred on the importance of separating the past from the present if previously abused women are to achieve any satisfaction in their sexual relationships. Sara and Ruth, who appeared to be more adjusted in their sexuality, emphasized that the satisfaction they enjoyed in their current relationship was dependent on their ability to separate the experiences of

the sexual victimization from those of the present. They indicated that an important factor in this is the recognition of choice. For example, Ruth stated that she needs to remind herself that she relates to her husband sexually because it is a choice she makes rather than a response to coercion. Also, both women pointed out that a key to accepting and experiencing their sexuality was the ability to distinguish the offender from their partner.

Wrap-Up

Prior to ending the group for the evening, the participants and therapists volunteered to bring specific food and beverage items for the social time to be held following the completion of the various evaluative measures in the final session.

Session 10

Administration of the Evaluative Measures

The participants completed the Target Complaint Scales, the Assertion Inventory and the Hudson Index of Self-Esteem similarly to the description provided in Session 1. Also, a client satisfaction questionnaire (Appendix E) was distributed in order to obtain feedback on the overall benefits of the program and to give the group members an opportunity to make recommendations for improving subsequent groups of this nature. In addition to the completion of the measures, this time was used to inform

the participants that a six-week follow-up session would be held. The therapists indicated that each member would be reminded of this session by telephone.

Wrap-Up

The remainder of the evening was used for a social gathering which was intended to give the program a sense of closure within an informal and pleasant structure.

Follow-Up Session

The follow-up was held six weeks following the group's termination. Its purpose was twofold: (1) to administer the evaluative measures and (2) to discuss any current assertiveness problems the individuals may have been expe-riencing.

Completion of the Evaluative Measures

The participants completed the Target Complaint Scales, the Assertion Inventory and the Hudson Index of Self-Esteem. The procedure for the administration of these measures has been discussed previously in Session 1.

Discussion of the Participants' Current Situation

When the administration of the measures was completed, the individuals were given an opportunity to share any experiences of the previous six weeks. The discussion that followed focused on the progress each individual had made in consolidating the assertive changes which had occurred in her life. These will be addressed in the following section of this report.

Results

Analysis of Data

Target Complaint Scales (TCS) (Mintz & Kiesler, 1982)

(Appendix B)

The data obtained by the TCS was analyzed by means of visual graphs which were used to compare any changes which occurred between the A and B phases of the design. There were two underlying assumptions contained in this procedure. First of all, the patterns identified in the A phase were expected to continue over time unless an intervention to promote change was implemented (Bloom & Fischer, 1982). Secondly, the assertiveness training, introduced during the B phase, was a systematic intervention designed to modify these target problems. A comparison of the intensity of the problematic behaviour during these phases enabled the practitioners to determine whether changes occurred in the desired direction (Bloom & Fischer, 1982).

The visual inspection of the graphs considered three attributes: (1) level, (2) trend, and (3) stability (Bloom & Fischer, 1982). The level refers to the magnitude of the data. The trend or the slope refers to the directionality of the data within one phase and indicates a pattern which represents either an increasing, decreasing or flat level of magnitude. Stability refers to the extent the direction of the data can be predicted from a prior to a later period. In the comparison of the baseline and intervention period,

these attributes were used to determine three factors: (1) any discontinuities, meaning changes in levels between the two phases, (2) changes in the trend of the data, and (3) a pattern of stability or consistency in the trend during the intervention.

Within this analysis, greater magnitudes of the TCS represent a deterioration and, subsequently, were undesired. It was expected that the introduction of the assertiveness training program within the B phase would be followed by a decrease in the levels of the problems as well as a change in the trend of the data across phases. With respect to this latter element, it was expected that a flat or rising baseline would be followed by a deceleration of the data throughout the intervention.

Clinically significant change was determined by scores of 4 or less on a TCS at termination and follow-up. This score indicated that the targeted problem no longer existed or that it was very slight. It is an arbitrary criterion, however, it does have face validity.

Global Measures

The data from the Assertion Inventory (AI) (Gambrill & Richey, 1975) (Appendix C) and the Hudson Index of Self-Esteem (ISE) (Hudson, 1982) (Appendix D) were evaluated by means of visual graphs. Similarly to the TCS, greater magnitudes are undesired and, therefore, a decrease in the

level of the scores between the pretest and posttest was expected. Furthermore, assertiveness training is designed to provide participants with the skills which enable them to improve their behaviour on a continued basis. For this reason, a further decrease in the level of the data for both instruments was predicted between the posttest and follow-up test.

The clinical significance of the changes were determined by scores which were below the recommended cutting points for each measure. On the basis of this criterion for both dimensions of the AI, 96 and above is indicative of a high degree of discomfort while 105 and above signifies low response probability. A score of 31 and above on the ISE represents clinically significant low self-esteem.

Individual Results

Sara

Targeted Behaviours

Eight target complaints were identified during the assessment of this subject. These targeted behaviours as well as the results obtained at the baseline, termination and follow-up are provided in Table 1. Data obtained at the termination of the program indicated that clinically significant changes occurred in 75% (6) of the targets. In other words, these problems bothered this individual only a little or not at all. At the follow-up this index

TABLE 1
TCS Raw Scores for Sara

Targeted Problem	Baseline			Termination	Follow-Up
1. Realizing that my opinion is still valid even if it is different from that of my husband or another close person and that I can choose to act in opposition to their wishes.	8	7	7	4	3
2. Friends - making demands on my time	7	9	10	7	6
3. Not knowing when I have the right to express my feelings, particularly when I know or anticipate they are directly opposed to my husband or another close person.	8	10	7	4	3
4. Friends - making demands on them	7	7	8	7	4
5. Asking for help from working colleagues	8	7	8	4	3
6. I can't be assertive until I can recognize what I like/dislike or want/don't want.	11	10	10	4	4
7. I'm often afraid to ask questions of sales personnel or doctors about products, programs or needs I have.	7	9	6	4	4
8. I want to have a greater sense of control with ill-behaved children in my classroom.	10	7	5	4	4

NOTE: Maximum Score = 13 (couldn't be worse) Minimum Score = 1 (not at all)

increased to include 87.5% of the targets. Only target #2 continued to be a problem for this subject at the follow-up.

Two of the behaviours which were modified were particularly significant. First of all, Sara reported that the amount of disturbance she felt because of target #1 which reads, "Realizing that my opinion is still valid even if it is different from that of my husband or another close person and that I can choose to act in opposition to their wishes", was pretty much to very much during the baseline. At the termination, she reported that the problem bothered her a little whereas follow-up results reflected additional improvement. Substantiation for these changes were provided in comments made by Sara at the follow-up session. She observed:

> [Prior to the assertiveness training,] I would not have feelings because I had to look after the feelings of others. Their feelings were more important than mine. Now I don't have to be responsible for their feelings or reactions, that is, their reactions do not have to control me.

Secondly, complaint #3, "Not knowing when I have the right to express my feelings, particularly when I know or anticipate they are directly opposed to my husband or

another close person," was reported as being very much a difficulty for this subject prior to the introduction of the assertion program. Results obtained at termination and follow-up, however, demonstrated that this target no longer continued to be a significant problem. This was validated at the follow-up session as well, in that Sara reported that the training had helped her to recognize and accept the fact that she has rights in interpersonal relationships.

Global Behaviours

Assertion inventory (AI) (Gambrill & Richey, 1975) (Appendix C). Results obtained on the two dimensions of the AI prior to the treatment program indicated that this individual experienced a high degree of discomfort and was likely to be non-assertive (Response Probability) when confronted with specific assertive situations (See Figures 1 and 2). Although the scores were reduced substantially, Sara continued to experience difficulty with discomfort at both the posttest and follow-up test. On the second dimension of the scale, posttest data continued to show low response probability, however the score obtained at the follow-up was below the recommended cut-off point, meaning that the likelihood of her engaging in assertive behaviour was high.

Hudson index of self-esteem (ISE) (Hudson, 1982) (Appendix D). On the basis of the recommended cut-off point, results obtained on the ISE at the pretest indicated that Sara had clinically significant low self-esteem (see Figure 3). There, essentially, was no change in this problem at the posttest. Improvement had occurred at the completion of the follow-up period; however, her low self-esteem continued to have some significance clinically.

Summary

Of the eight targeted behaviours identified in Sara's assessment, 75% (6) and 87.5% (7) were no longer significant problems at the termination and follow-up respectively. Also, the score on the Response Probability dimension of the AI was reduced below the recommended cutting point at the follow-up test. The degree of discomfort, although being substantially reduced, continued to be problematic. In addition to this, Sara continued to have clinically significant low self-esteem at the follow-up; however, the problem was less severe than it had been at the pretest.

Kelly

Targeted Behaviours

Six target complaints were identified in the assessment scheme of this individual (see Table 2). At both the termination and follow-up of the assertiveness training, clinically significant changes were recorded in all six

TABLE 2
TCS Raw Scores for Kelly

Targeted Problem	Baseline			Termination	Follow-Up
1. To have confidence in my own opinion with my in-laws.	6	4	4	2	2
2. Being able to say "No" without feeling guilty.	9	7	11	1	2
3. Being able to say "I'm sorry" without feeling inferior or guilty.	9	4	6	2	2
4. It's for me to admit I'm wrong even when I know I'm wrong.	9	7	5	2	2
5. Being able to express myself without blowing up when I'm angry.	6	4	9	4	4
6. To have confidence in my own opinion with my colleagues at work.	6	4	4	2	2

NOTE: Maximum Score = 13 (couldn't be worse) Minimum Score = 1 (not at all)

targets. The most substantial change occurred in target #2 which reads, "Being able to say 'No' without feeling guilty." Prior to the training, the client rated the intensity of the problem as being between the very much and couldn't be worse range whereas at termination, she indicated that this difficulty no longer disturbed her. There was a slight deterioration at the follow-up, however, the problem continued to be very slight.

Global Behaviours

Assertion inventory. As displayed in Figures 1 and 2, the initial administration of the AI demonstrated, firstly, that this subject experienced a high degree of discomfort in specific situations and, secondly, that she was unlikely to assert herself in these situations. Posttest and follow-up data showed a significant decrease in the degree of discomfort as well as an increase in the number of assertive responses. Subsequently, these elements were no longer problematic for this individual.

Index of self-esteem. As displayed in Figure 3, results of the ISE obtained before the assertion program indicated that Kelly did not have a significant problem with low self-esteem. At the same time, however, posttest and follow-up data demonstrated that there had been an increase in self-esteem following the program.

Summary

Clinically significant changes occurred at both the termination and follow-up of the program in 100% of the target complaints which had been identified in the assessment scheme for Kelly. This was consistent with changes recorded by the AI. At both the posttest and follow-up test, the scores reflected low discomfort and high response probability. Low self-esteem was not a problem for this individual.

Ruth

Targeted Behaviours

The targeted behaviours as well as the scores for this individual are displayed in Table 3. Results of the TCS indicated that change had occurred in the desired direction for each of the five targets, however, these changes were clinically significant only in 20% (target #1) and 40% (targets #1 and 2) at termination and follow-up respectively. At the baseline, the amount of disturbance caused by target #1 which reads, "Being able to state my point of view to people I'm close to without fear of being rejected", was rated as couldn't be worse by the subject. At the completion of the assertion program, the problem bothered her only a little while at the follow-up it had been almost negated entirely. Similarly, Ruth indicated that during the baseline, target #2, which reads, "turning

TABLE 3
TCS Raw Scores for Ruth

Targeted Problem	Baseline			Termination	Follow-Up
1. Being able to state my point of view to people I'm close to without fear of being rejected.	13	13	10	4	2
2. Turning down a request for a favour, borrowing or helping in some way.	13	13	10	6	4
3. I would like to be able to express myself honestly with both men and women.	10	10	10	7	6
4. Being able to say "No" without getting angry or being afraid that they will become angry, especially with people who think they are better than me.	13	13	13	9	7
5. Being able to talk to men as an equal without fearing that the interaction will become sexual.	10	13	10	9	6

NOTE: Maximum Score = 13 (couldn't be worse) Minimum Score = 1 (not at all)

down a request for a favour, borrowing or helping some way", couldn't be worse. At the termination, she reported that it was between the pretty much and a little range. Follow-up data indicated that the problem had been reduced so that it disturbed her only a little. Three of the behaviours (targets #3, 4 and 5) continued to be problematic for this client at the follow-up.

Global Behaviours

Assertion inventory. Results obtained prior to the introduction of the assertiveness training reflected a high degree of discomfort and a low response probability for this individual (see Figures 1 and 2). At the completion of the program, the scores had been reduced below the respective cutting-points for each dimension. Measures taken at the follow-up indicated that the improvement in assertive responses had been maintained, however, the level of discomfort had deteriorated to the point that it was a significant problem once again.

Index of self-esteem. A comparison of the three data points obtained by the ISE indicated that there had been a substantial increase in the self-esteem of this individual following the assertiveness training (see Figure 3). The pretest score was indicative of a clinically significant problem, however, the additional data points demonstrate that it had been negated at the completion of the therapy

group as well as at the follow-up session.

Summary

Data obtained by the TCS, demonstrated that Ruth's behaviour had been modified in each of the five targets identified during the baseline. One (20%) of these changes was clinically significant at the completion of the group sessions while two (40%) were significant at the follow-up. A comparison of the AI test results showed a significant improvement in the number of assertive responses at termination and follow-up. Also, there was a marked decrease in discomfort experienced in assertive situations, however, this issue continued to create difficulty for Ruth. Following the assertiveness training, low self-esteem discontinued to be problematic. This improvement was sustained throughout the follow-up period as well.

Alison

Targeted Behaviours

During the assessment of this individual, ten target complaints were identified. They are described in Table 4 along with the baseline, termination and follow-up scores. An analysis of the data indicated that clinically significant change was evident in targets #3 and #8 at both termination and follow-up. Prior to the therapy group, the subject rated the intensity of the difficulty created by target #3 which reads, "when my husband grabs me or teases",

TABLE 4
TCS Raw Scores for Alison

Targeted Problem	Baseline				Termination	Follow-Up
1. Expressing my opinions and feelings in situations.	10	12	11	10	7	3
2. When my husband makes a sexual advance and I don't wish to respond.	12	12	12	12	7	4
3. When my husband grabs me or teases me.	12	12	10	7	4	2
4. When my husband makes hurtful remarks.	10	12	11	4	2	6
5. When my children are dawdling either getting ready to go out or when getting ready for bed.	13	11	12	12	7	9
6. When my children are teasing or fighting each other.	13	12	12	12	5	10
7. When I want to buy or have bought something.	10	13	9	12	7	2
8. When my husband questions me about spending money.	11	13	11	12	4	2
9. When my father or brother ask to take the children out alone.	12	12	12	10	4	8
10. When my father acts unkindly or negatively towards the children.	12	12	12	11	7	10

NOTE: Maximum Score = 13 (couldn't be worse) Minimum Score = 1 (not at all)

between the very much and couldn't be worse range whereas target #8, "When my husband questions me about spending money", was described as couldn't be worse. At termination, however, these difficulties bothered her only a little and by the follow-up, further improvement indicated that they had practically cleared up.

In addition to this, significant changes occurred in targets #1, #2 and #7 at the follow-up only. For example, target #2 which reads, "When my husband makes a sexual advance and I don't wish to respond", was scored between very much and couldn't be worse during the baseline. At the follow-up, this troubled her only a little. Comments made by Alison at the follow-up session provide additional support for the changes reflected in this target. At that time, she reported that the assertiveness training had made her cognizant of the fact she has the right to make choices in situations. She stated: "Regardless of what I do, or how the other person responds, I can choose what I do. It feels good."

Results obtained at the termination of the program indicated that clinically significant changes had occurred in targets #4 and 9, however, these changes were not sustained throughout the follow-up period. Subsequently, five (50%) of the targets continued to be a significant problem for this individual. Conversely, five (50%) of the com-

plaints had been minimized.

Global Behaviours

Assertion inventory. The results obtained on the AI at the pretest indicated that Alison experienced significant discomfort when confronted with specific assertive situations (see Figures 1 and 2). Additionally, the data demonstrated that the probability of this individual engaging in assertive behaviour was low. Data collected at the posttest and follow-up showed that little change had occurred in her difficulty with discomfort. The follow-up data point, however, demonstrated a marked increase in response probability so that there was no longer a clinically significant problem in this area.

Index of self-esteem. Following the initial administration of the ISE, Alison was classified as having a clinically significant problem with respect to low self-esteem. The results are displayed in Figure 3. The posttest measurement indicated that there had been a deterioration in this difficulty. At the completion of the follow-up period, there was an improvement; however, the individual's low self-esteem continued to be clinically significant.

Summary

During Alison's assessment, ten targeted behaviours were identified. At both the termination and follow-up of the program, change had occurred in the desired direction

for all of the targets. Clinically significant change was achieved in 40% (4) and 50% (5) of the behaviours at termination and follow-up respectively. Results obtained on the AI demonstrated a significant improvement in assertive responses, however the degree of discomfort remained above the cutting point. Follow-up data of the ISE showed that the assertivenes training did not have an impact on the low self-esteem of this individual.

Kerri

Targeted Behaviours

The assessment scheme of this individual was used to identify six targeted behaviours which are described in Table 5. Data collected at the termination and follow-up sessions indicated that clinically significant change had occured in one (17%) of the targets (target #3). This target which reads "I am confused between what is aggression and what is assertion" was reported to be very much a problem for this individual during the baseline. At the completion of the program, however, the extent of this problem was rated as being a little and, at follow-up, it was scored between a little and not at all.

Although the change was not clinically significant, substantial improvement, however, did occur in target #4 as well. During the baseline, the extent of the difficulty caused by this target which reads, "I have difficulty with

TABLE 5
TCS Raw Scores for Kerri

Targeted Problem	Baseline			Termination	Follow-Up
1. I have difficulty expressing my emotions to others.	9	11	9	8	6
2. I cannot ask for my own needs to be met.	12	9	10	7	8
3. I am confused between what is aggression and what is assertion.	8	10	9	4	3
4. I have difficulty with males in power positions.	10	9	11	8	6
5. I have difficulty with intimacy in relationships with males.	10	10	10	10	9
6. I cannot be assertive sexually.	12	10	10	10	9

NOTE: Maximum Score = 13 (couldn't be worse) Minimum Score = 1 (not at all)

males in power positions," was rated in the range of very much to couldn't be worse. By the follow-up session, it had been reduced so that it was within the pretty much and a little range. Observations offered by Kerri during the latter part of the training program affirmed this change. At that time, she stated that she was beginning to realize all males do not abuse and exploit positions of power. In fact, she indicated that, in some case, gentleness in males could be equated with positions of power, a belief which she previously had been unable to accept. Furthermore, she reported at the follow-up session that it had become easier for her to accept males in positions of power and authority as long as she remained relaxed and took the time to clarify her rights in the situation.

Global Behaviours

Assertion inventory. As displayed in Figures 1 and 2, responses obtained on the AI prior to the therapy group reflected a high degree of discomfort and a low response probability for this individual. The score on the discomfort dimension of the scale remained constant throughout the program, however it dropped below the cut-off point at the follow-up. Results obtained on the response dimension indicated that a change in the desired direction had occurred at both the termination and follow-up. In fact, the score at the final data point had been reduced to the

extent that it was equivalent to the cutting point for low response probability.

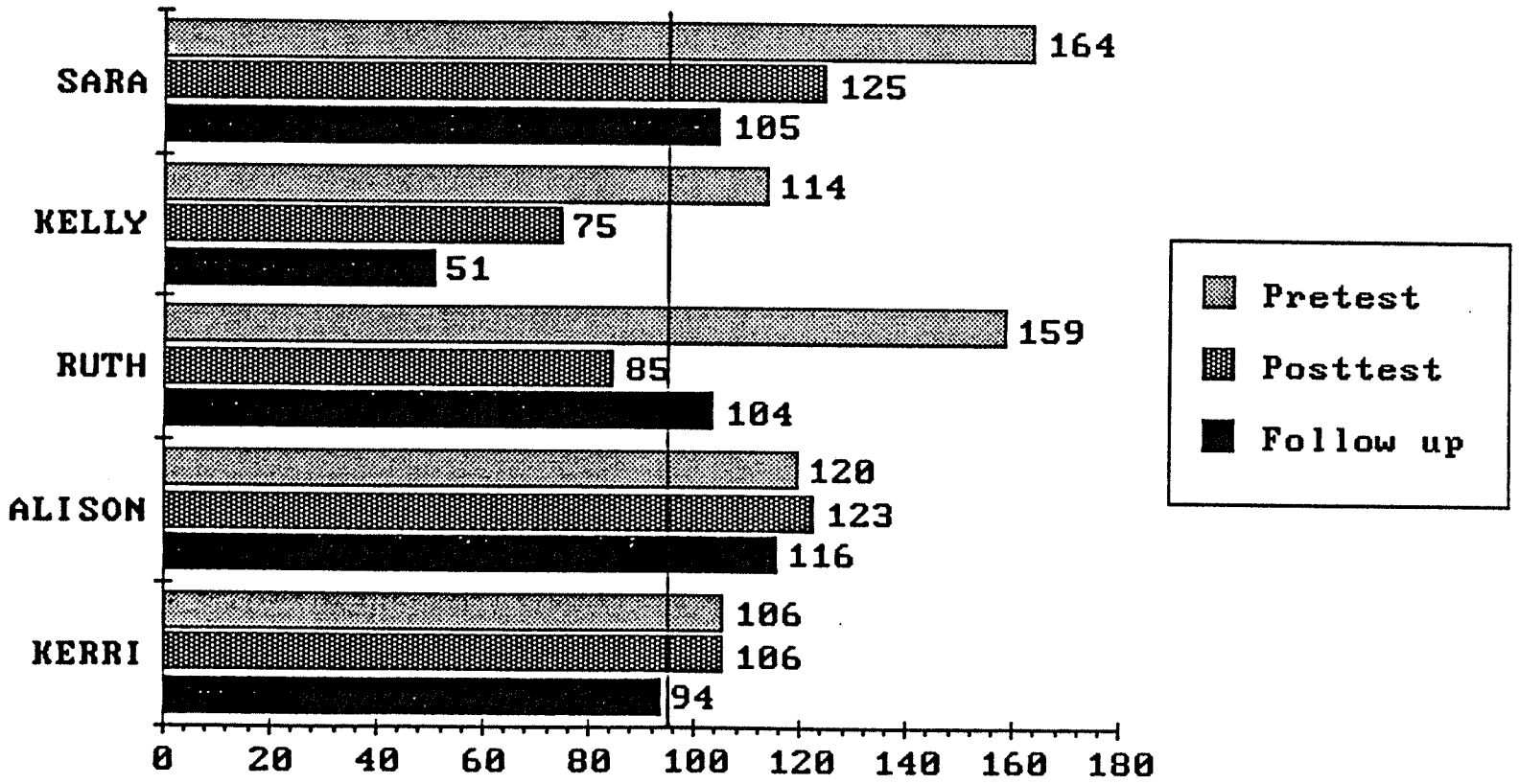
Index of self-esteem. Results obtained at the pretest identified the existence of a clinically significant problem for this individual (see Figure 3). Data collected at the posttest and follow-up, however, indicated that this low self-esteem had been modified so that it no longer was a significant problem.

Summary

Six target complaints were identified in the assessment scheme of this individual. At both the termination and follow-up of the program, the amount of disturbance she felt had been reduced in each of the targets. Only one (17%) of these behaviours, however, ceased to be a clinically significant problem. Scores obtained at the pretest of the AI indicated that Kerri experienced a high degree of discomfort in assertive situations and that the likelihood of her behaving assertively in these situations was low. At the follow-up, an improvement was evident on both dimensions. At that time, discomfort was no longer classified as a significant problem whereas response probability had been reduced to the cut-off point. In addition to this, results of the ISE demonstrated that a clinically significant change had occurred in Kerri's self-esteem between the pretest and follow-up test.

FIGURE 1

Individual Scores for the Assertion Inventory: Degree of Discomfort (Gambrill & Richey,1975)

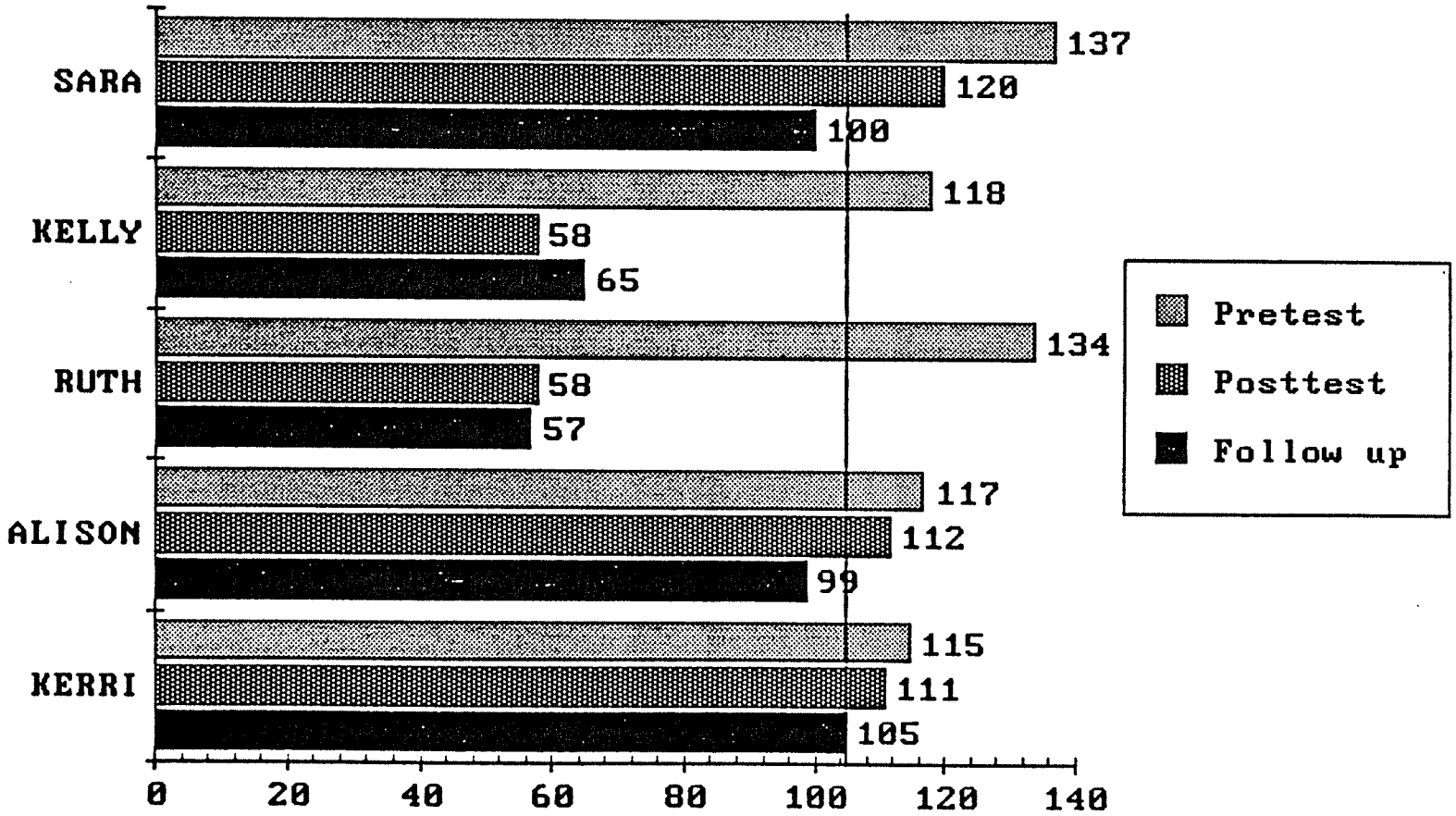


NOTE: ≥96 = High Degree of Discomfort

≤95 = Low Degree of Discomfort

FIGURE 2

Individual Scores for the Assertion Inventory: Response Probability (Gambrill & Richey, 1975)

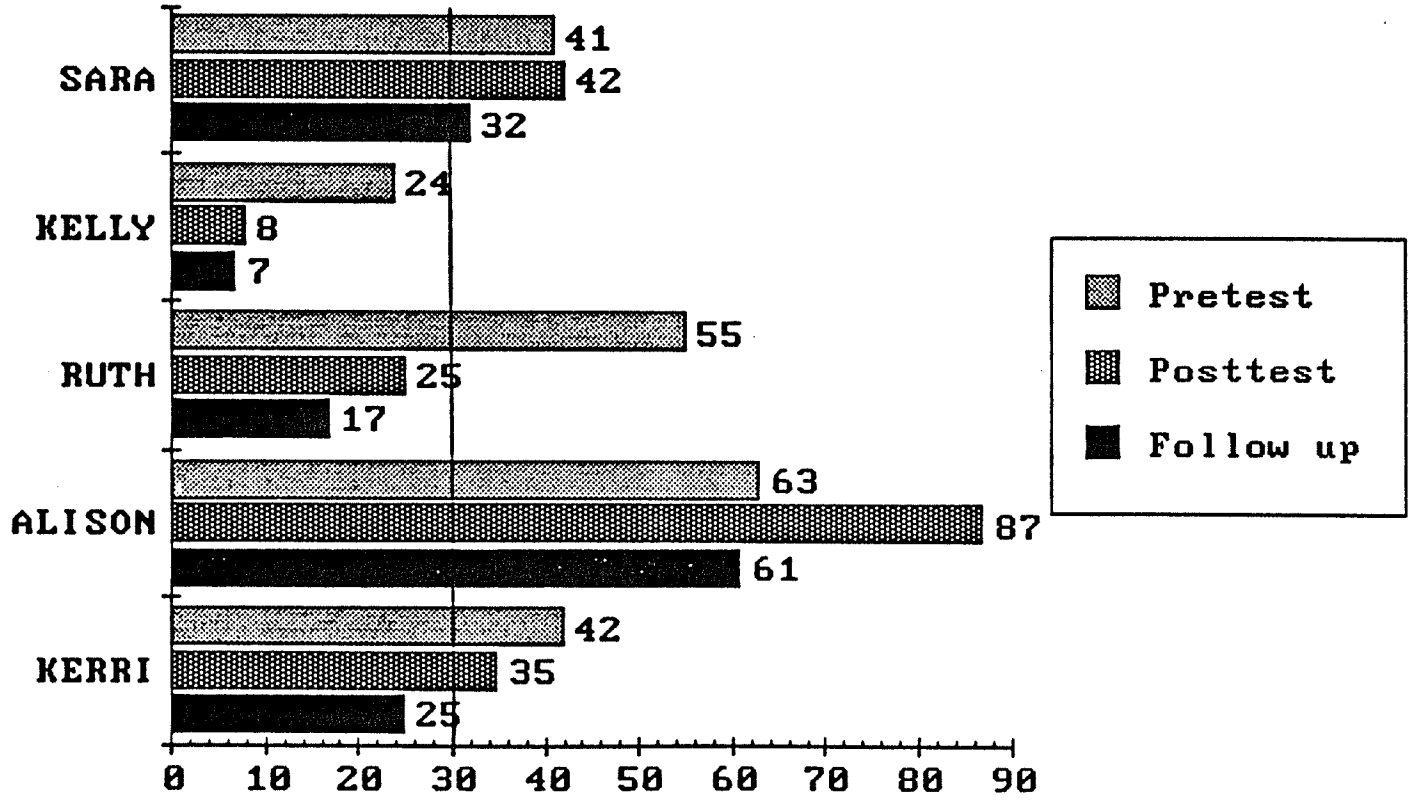


NOTE: ≥105 = Low Response Probability

≤104 = High Response Probability

FIGURE 3

Individual Scores for the Hudson Index of Self-Esteem (Hudson, 1982)



NOTE: ≥31 = Clinically Significant Problem

≤30 = No Clinically Significant Problem

Group Results

Targeted Behaviours

Of the various themes reflected in the target complaints of the group participants, four were common to, at least, two of the subjects: (1) the expression of opinions, feelings and beliefs, (2) saying "No" or turning down requests, (3) understanding and accepting personal rights, and (4) requesting help in specific situations.

The Expression of Feelings, Beliefs and Opinions

During the assessment period, each of the individuals were identified as having clinically significant problems in expressing their feelings, beliefs and opinions (see Figure 4). The subjects as well as their targeted behaviours are listed below.

1. Sara: Realizing that my opinion is still valid even if it is different from that of my husband or another close person and that I can choose to act in opposition to their wishes.

2. Kelly: To have confidence in my opinion with my in-laws.

3. Ruth: Being able to state my point of view to people I'm close to without fear of being rejected.

4. Alison: Expressing my opinions and feelings in situations.

5. Kerri: I have difficulty expressing my emotions to others.

FIGURE 4

Target Complaint Scale scores for the expression of feelings, beliefs and opinions

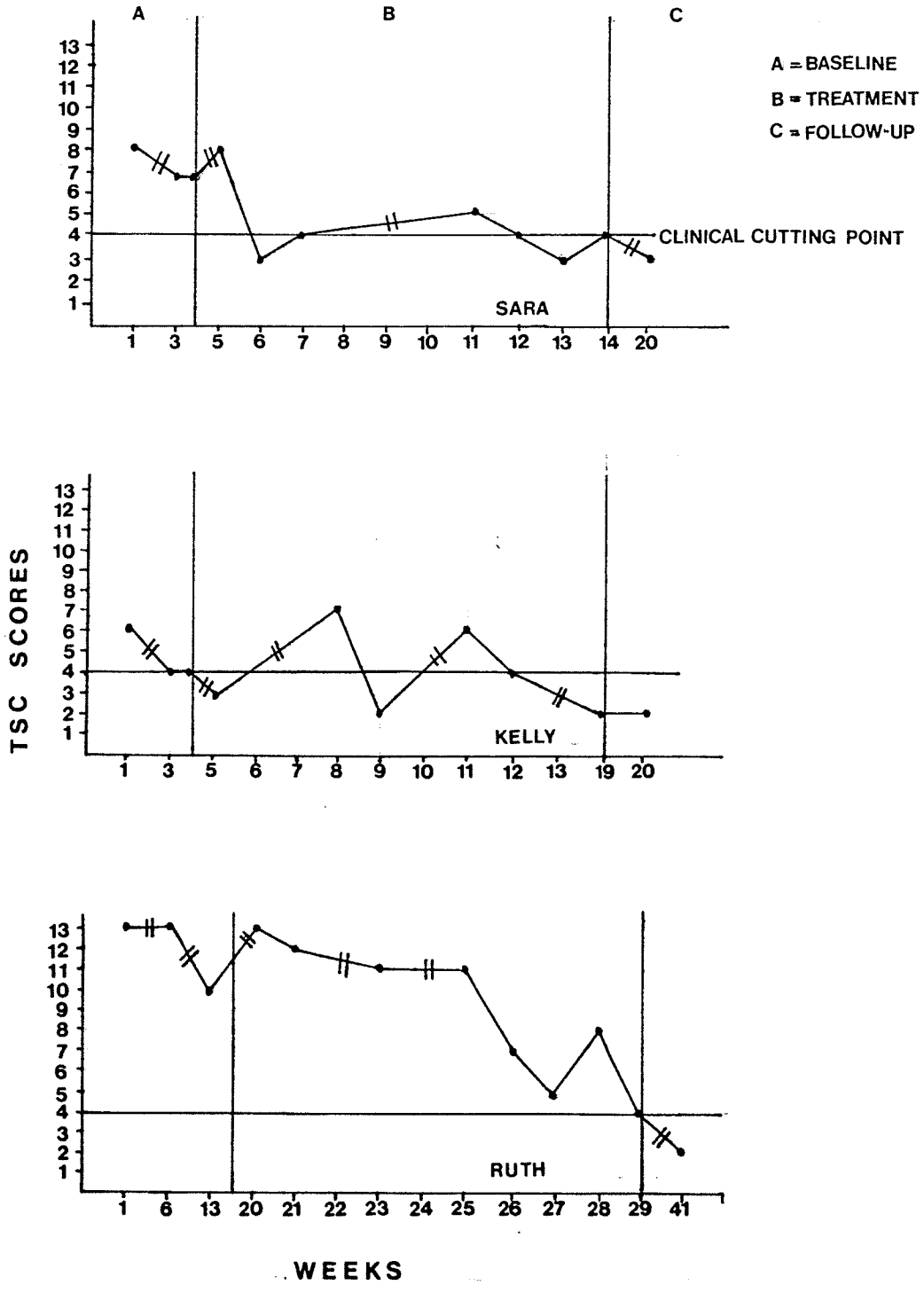
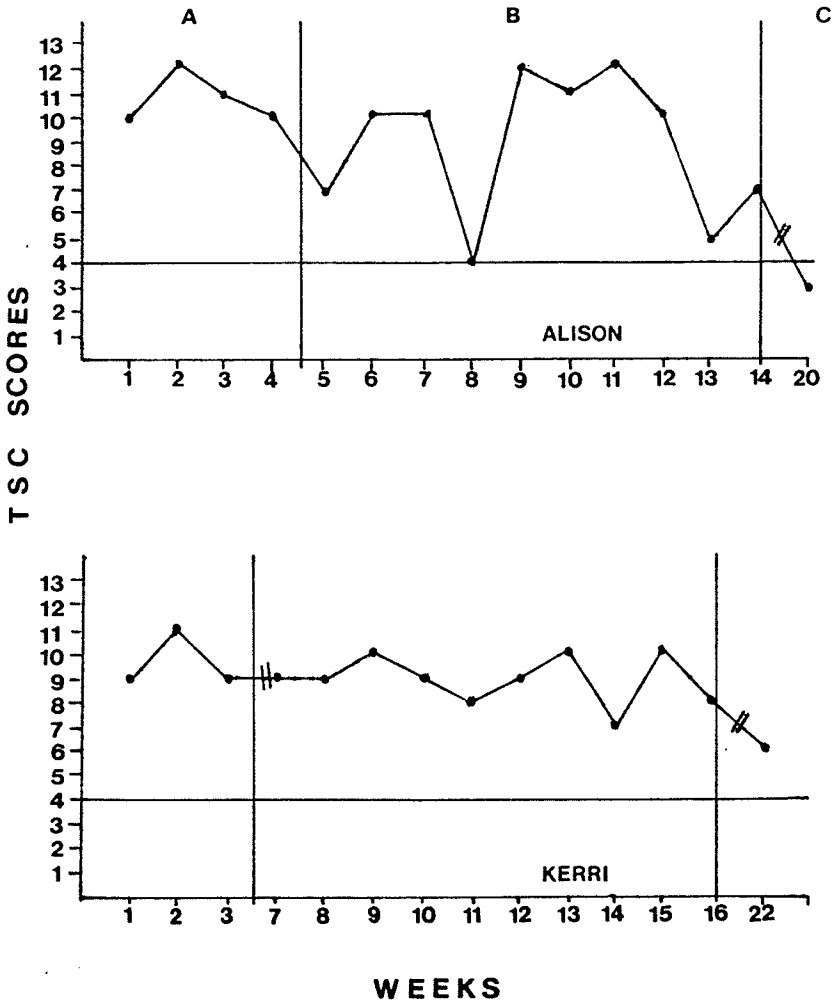


FIGURE 4 (con't)



Results obtained by the Target Complaint Scales indicated that change had occurred in the desired direction for each of the five subjects. Of these changes, three (60%) were clinically significant at the completion of the assertion training and four (80%) at the six-week follow-up.

Saying "No" or Turning Down Requests

Baseline data indicated that four participants had extreme difficulty refusing requests (see Figure 5). They are as follows:

1. Sara: Friends -- making demands on my time.

2. Kelly: Being able to say "No" without feeling guilty.

3. Ruth: Turning down a request for a favour, borrowing or helping in some way.

4. Alison: When my husband makes a sexual advance and I don't wish to respond.

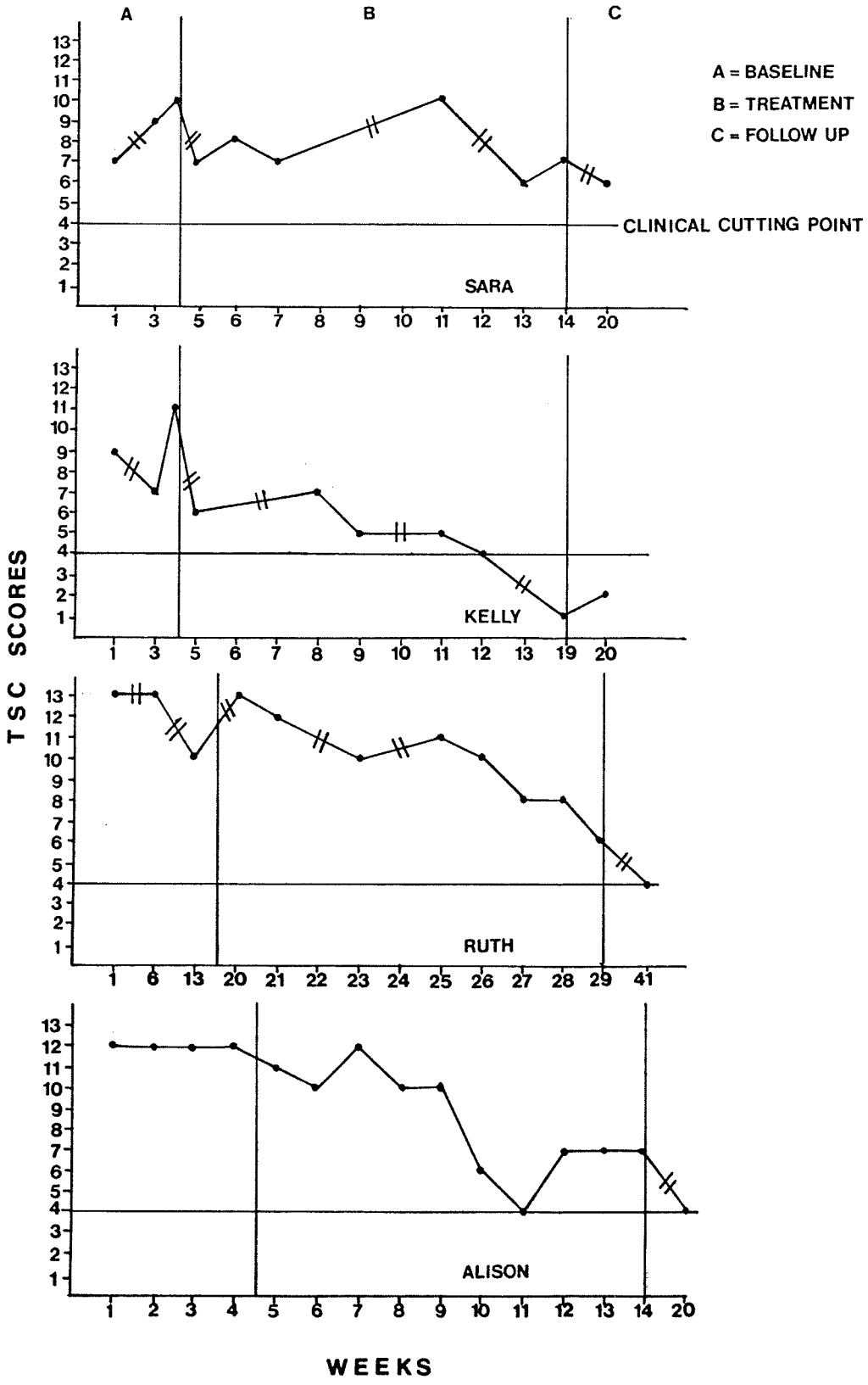
Results obtained at the completion of the training program showed an improvement in the targeted behaviours for each of the subjects, however, only one (25%) of the changes had clinical significance. At the completion of the follow-up period, significant changes had occurred in 3 (75%) of the targets.

Understanding and Accepting Personal Rights

Prior to the assertiveness training, the capacity to understand and accept personal rights was significantly

FIGURE 5

Target Complaint Scale scores for refusing requests



problematic for Sara, Kelly, Ruth and Alison (see Figure 6). The target complaints for these individuals are described below:

1. Sara: Not knowing when I have the right to express my feelings particularly when I know or anticipate they are directly opposed to my husband or another close person.

2. Kelly: Being able to say I'm sorry without feeling inferior or guilty (this target is associated with the right to make mistakes).

3. Ruth: I would like to be able to express myself honestly with both men and women.

4. Alison: When my husband makes a sexual advance and I don't wish to respond.

Results obtained at the termination of the program showed that clinically significant changes occurred in 2 (50%) of the targets whereas at the follow-up, this index increased to 3 (75%).

Requesting Help

During the baseline period, two subjects were assessed as having significant difficulty in requesting help from other individuals (see Figure 7). They are as follows:

1. Sara: Friends -- making demands on them.

2. Kerri: I cannot ask for my own needs to be met.

FIGURE 6

Target Complaint Scale scores for understanding and accepting rights

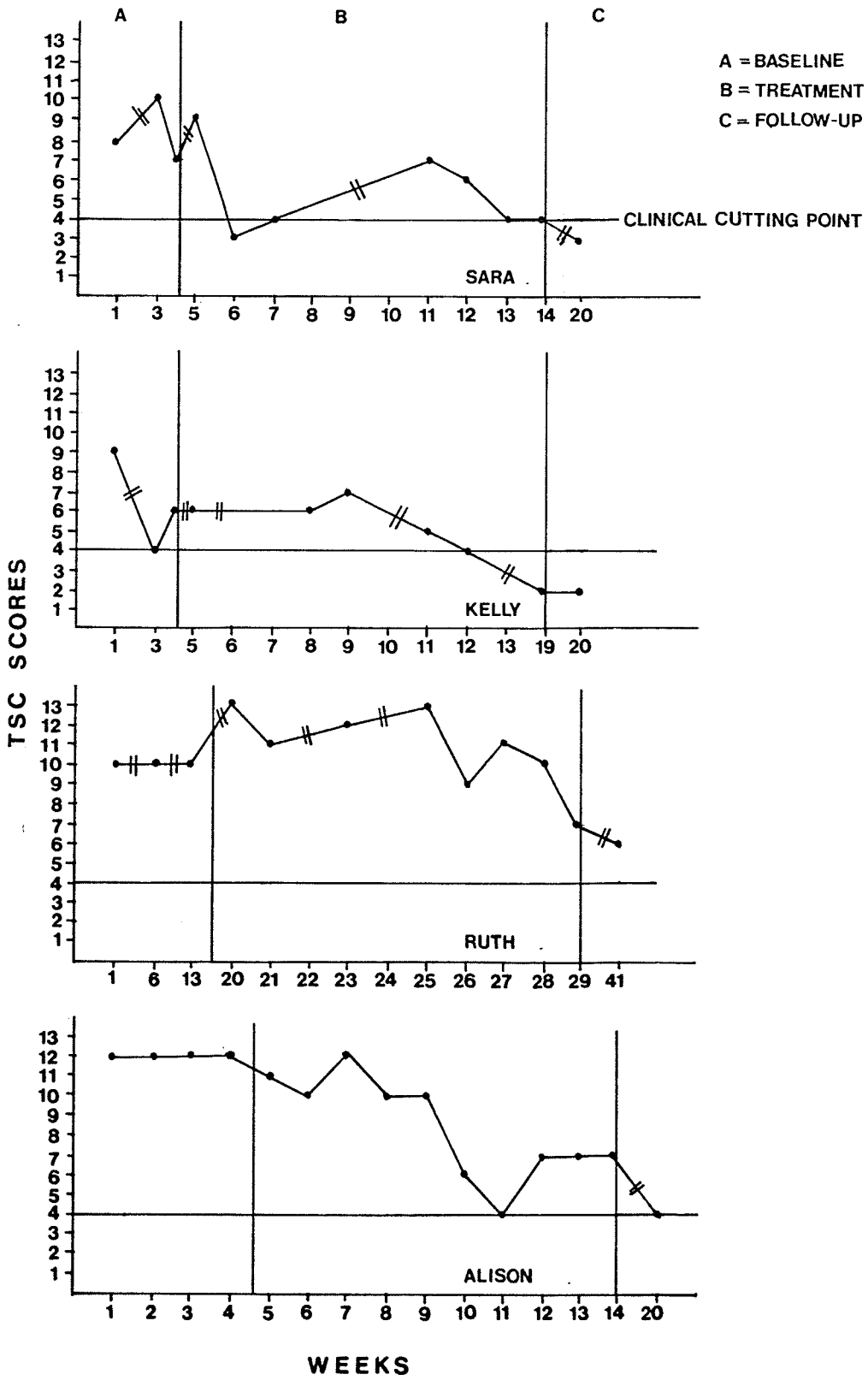
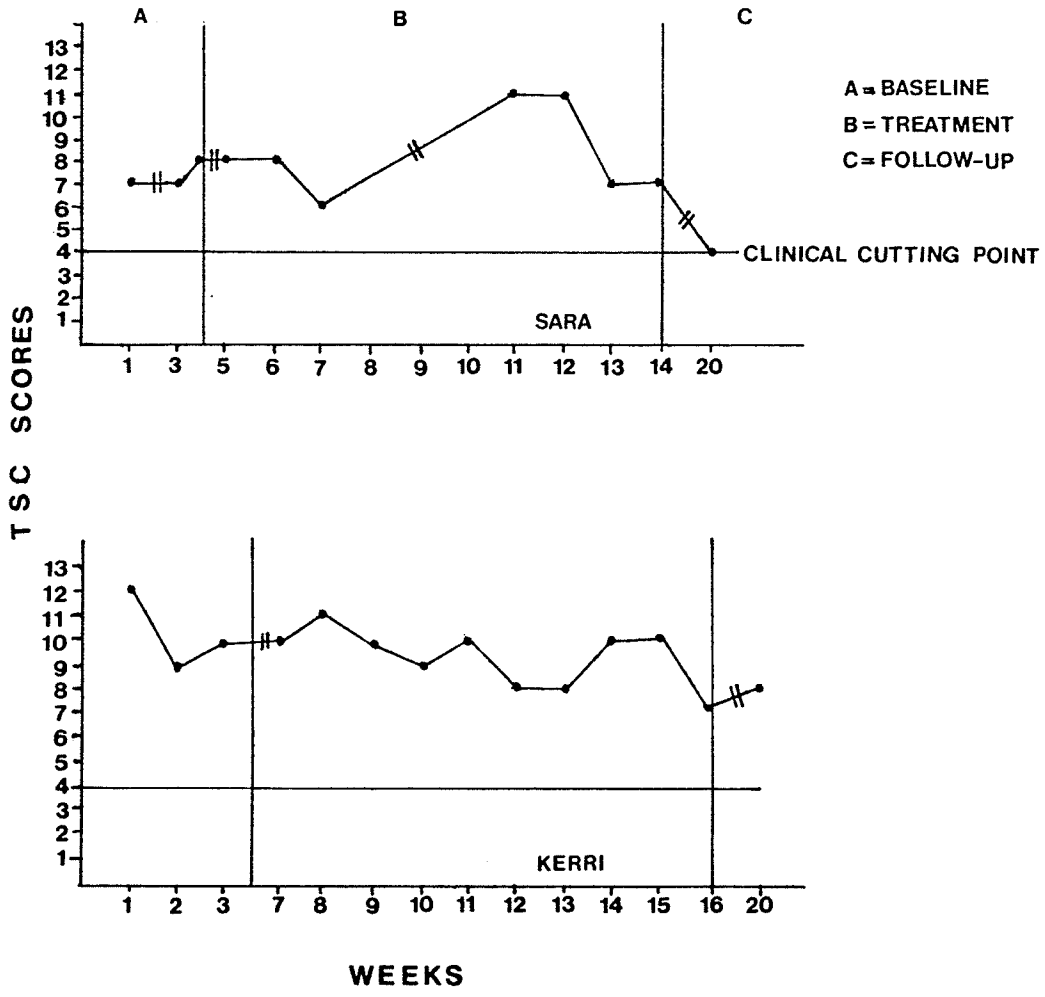


FIGURE 7

Target Complaint Scores for requesting help



Although results obtained at the termination and follow-up showed an improvement in each behaviour, the only change of clinical significance was recorded at the follow-up in 1 (50%) of the targets.

Additional Themes

Another theme identified by the participants as being problematic for them was the "caretaking syndrome" which refers to the compulsion they had to assume responsibility for the needs of other individuals, frequently at the expense of their own. This issue was not identified as a target during the baseline period and, subsequently, statistical data is not available. Four (Sara, Kelly, Alison and Kerri) of the group members, however, reported that the assertiveness training helped to liberate them from this responsibility. They stated that the program, firstly, enabled them to realize that they are not responsible for the needs, feelings and behaviour of all significant others. Secondly, it caused them to realize that it is their choice to determine whom they will help in specific situations and, thirdly, that they do not have to feel guilty when they decide it is inappropriate or inconvenient to assume responsibility for the needs of another.

Global Behaviours

Assertion Inventory

Degree of discomfort. The results of the dimension of the AI are displayed in Table 6. At the pretest, the scores of the five subjects exceeded the recommended cutting point, indicating that each one experienced a high degree of discomfort when confronted with assertive situations. Results obtained at the termination of the program indicated that clinically significant changes had occurred for two (40%) of the subjects (Kelly and Ruth). At the follow-up, Kelly showed continued improvement whereas Ruth had deteriorated to the extent that discomfort was a significant problem once again. For a third subject (Kerri), this issue no longer had clinical significance at the follow-up. Thus, clinically significant changes occurred

TABLE 6

Group results for the Assertion Inventory: Degree of Discomfort (Gambrill & Richey, 1975)

		≥96	≤95
N	Pretest	5	0
	Posttest	3	2
	Follow-Up	3	2

NOTE: ≥96 = High Discomfort
≤95 = Low Discomfort

in 2 (40%) of the subjects at the completion of the follow-up period. Three (60%) of the subjects continued to have difficulty on this dimension.

Response probability. As shown in Table 7, the scores of 5 (100%) of the paticipants indicated a low response probability prior to the intervention. Results obtained when the scale was administered at termination and follow-up, however, showed an increase in assertive responses for all five subjects. At the posttest, two (40%) of the subjects (Kelly and Ruth) scored below the cut-off point whereas four (80%) (Kelly, Ruth, Sara and Alison) did so at the follow-up. Thus, at the completion of the follow-up period, clinically significant change had occurred with respect to response probability in four (80%) of the subjects. The score for the fifth individual (Kerri), reflected low

TABLE 7

Group results for the
Assertion Inventory: Response Probability
(Gambrill & Richey, 1975)

		≥105	≤104
N	Pretest	5	0
	Posttest	3	2
	Follow-Up	1	4

NOTE: ≥105 = Low Response Probability
≤104 = High Response Probability

response probability, however, her score was on the cutting point.

Hudson Index of Self-Esteem

Results for the ISE are shown in Table 8. At the pretest, only one (20%) subject (Kelly) was classified as having high self-esteem. Scores for the other four (80%) individuals were indicative of low self-esteem. Posttest data demonstrated that this problem had been significantly modified in one (25%) of the subjects (Ruth), a change which was sustained throughout the follow-up as well. In addition to this, a second subject (Kerri) no longer had low self-esteem at the follow-up. Thus, change that was clinically significant occurred in two (50%) of the subjects who had low self-esteem prior to the intervention whereas the scores for two (50%) of the subjects remained above the cutting point.

TABLE 8

Group results for the
Hudson Index of Self-Esteem (Hudson, 1982)

		≥31	≤30
N	Pretest	4	1
	Posttest	3	2
	Follow-Up	2	3

NOTE: ≥31 = Clinically significant problem
≤30 = No clinically significant problem

Client Satisfaction Questionnaire (Appendix E)

The results of the client satisfaction questionnaire are shown in Table 9. For evaluative purposes, this measure can be divided into three categories: (1) the structure and the components of the sessions (items 1 to 8), (2) the presence of the male therapist (items 9 and 10), and (3) issues related to the needs of the participants (items 11 to 16).

The Structure and the Components of the Sessions

All the participants rated the helpfulness of the group structure (Item #1) as moderately helpful to very helpful. Of the various instructional components utilized in the program, structured exercises (Item #2), selected group discussions (Item #5), printed handouts (Item #6) and assigned readings (Item #7), generally were rated as being the most useful. Behavioural rehearsals (Item #4) and homework assignments (Item #8), on the whole, were less helpful.

The Presence of the Male Therapist

Results obtained on Item #9 indicate that four participants considered the presence of a male therapist to be very helpful whereas, in the opinion of one individual, it was slightly helpful. In the space provided for additional comments (Item #10), the group members commonly reported that the availability of a male opinion and perspective was

extremely useful. Furthermore, individuals reported a male therapist assisted them in learning to differentiate trustworthy males from those who are abusive and exploitive. Examples of specific comments are provided in Table 9.

The Needs of the Participants

All five participants indicated that the assertiveness training was moderately helpful to very helpful in meeting their needs (Item #11). The group experience was most helpful in that it introduced the participants to other women who had been sexually victimized in childhood (Item #14). Four subjects reported that this was very helpful for them while the fifth subject indicated it was moderately helpful. Also, the program was considered to be moderately helpful to very helpful in reducing irrational beliefs about behaving assertively (Item #13). Four individuals responded to Item #16 by stating that more sessions were required to address the various issues adequately, whereas one individual was undecided.

TABLE 9

Assertiveness Training Group: Evaluation Questionnaire

Please help us to improve our program by answering some questions about the group you attended. We are interested in your honest opinions, whether they are positive or negative. Please check (✓) in the column that best indicates your response to the question. We also request your additional comments and suggestions. Thank you very much for your co-operation. We appreciate your help.

A) Questions Related to the Components of the Training Program

		Not Helpful	Slightly Helpful	Moderately Helpful	Very Helpful
1.	The structure of the group sessions consisted of sharing experiences of the past week, discussing homework, a mini-lecture which focused on some assertion issue, coffee break, structured exercises and discussion. Was this structure helpful?			2	3
2.	To what extent were the structured exercises performed in the group sessions helpful?			2	2
3.	To what extent were the mini-lectures (presented material) helpful?		1	1	2
4.	To what extent were the behavioural rehearsals helpful?	1	1	1	2
5.	To what extent were the group selected discussion topics of intimacy and sexuality helpful?			2	3
6.	To what extent were the various handout materials helpful?			2	3

		Not Helpful	Slightly Helpful	Moderately Helpful	Very Helpful
7.	To what extent were the assigned readings from the book helpful?			2	3
8.	To what extent were the homework exercises helpful?		3	1	1
9.	To what extent was the presence of a male therapist in this kind of group helpful?		1		4

10. Could you please specify your reasons for the answer provided in Question 9. If additional space is required, please use the back of this page.

- There is something reassuring about being able to see a so-called "healthy" male in a communicating situation; it's hard for me to discriminate sometimes between males you can trust and ones who are on an ego trip, etc.
- For some of us who have an image of what most men are like, it broke that image -- that is, being a negative one. Because of our life experiences, most of us were mistreated by men and, therefore, feel that all men are jerks.
- It allowed for acceptance of a male who was aware of the abuse and made me aware that some males would react differently towards a situation than my husband.
- The male opinion was also important when you needed a balance of ideas from the male perspective.
- I don't think a woman could have done a worse or better job; I feel this kind of therapy is based on personalities, not sex.
- I don't think I was particularly aware of the sex of the therapists.

B) General Questions

	Not Helpful	Slightly Helpful	Moderately Helpful	Very Helpful
11. To what extent was the training you received helpful in meeting your needs?			4	1
12. To what extent was the training helpful in terms of increasing your self-confidence?		2	1	2
13. To what extent was the training helpful in reducing your irrational beliefs about behaving assertively?			3	2
14. To what extent was the group experience helpful by introducing you to other women who had been sexually victimized?			1	4
15. Overall, to what extent was this group experience helpful?			2	3

16. Were the number of sessions adequate? Please comment.

- I think more sessions are necessary and it would be helpful to have a support group established after the trust in the group is established.
- I think for a real change in my assertive behaviour, it would take a much longer, much more intensive training period.
- Yes and No. I think if we were involved in a group for abused people we could have shared a lot of the things we shared at this group and would have been able to concentrate more on assertion training.

Additional Comments and Suggestions:

Discussion

This present study sought to develop and systematically evaluate an assertiveness training program for women sexually abused in childhood or adolescence whose prominent behavioural patterns included non-assertiveness. The group had a twofold emphasis. First of all, it focused on teaching assertive skills to the participants by means of various training techniques and structured exercises. Secondly, it endeavoured to remediate problems identified clinically as producing difficulties in the individuals' current adjustment. With respect to this, a male co-therapist was utilized in order to assist the women in resolving the problems they encountered within heterosocial relationships. Additionally, stress-provoking issues such as intimacy and control of sexuality, identified during the group process, were addressed as well.

The Effectiveness of the Assertiveness Training

The effectiveness of this study was evaluated by four measures. The Target Complaint Scale (Mintz & Kiesler, 1982) (Appendix B) was used to evaluate focused behaviours on a repeated basis throughout the program. The Assertion Inventory (Gambrill & Richey, 1975) (Appendix C) and the Hudson Index of Self-Esteem (Hudson, 1982) (Appendix D) were used to measure changes in assertiveness and self-esteem between the pretest and posttest as well as to determine the persistence of these changes between the post-

test and follow-up. Finally, a client satisfaction questionnaire (Appendix E) enabled the participants to rate the helpfulness of the various components of the program. The efficacy of the assertion program can be best determined when the changes measured by these instruments are juxtaposed against the overall objectives of the treatment. The objectives were as follows: (1) to provide the women with the assertive skills whereby they would be equipped to openly express their needs and desires so as to acquire and exert greater control over their own lives and environments, (2) to develop a belief system with respect to assertive behaviour that would improve the individuals' self-awareness and acceptance of their needs and rights, (3) to assist them in reducing the cognitions and anxieties which impaired their capacity to engage in assertive behaviour, and (4) to provide them with the opportunity to begin resolving the difficulties experienced in heterosocial relationships.

The results of the study indicate that the assertiveness training therapy group was successful in assisting the participants to achieve, in varying degrees, these objectives. Each of these is discussed below.

The Acquisition of Assertive Skills

Data indicates that the assertiveness training was effective in assisting the participants to achieve the first

objective. Scores obtained on the Response Probability dimension of the Assertion Inventory were reduced below the recommended cut-off point in four (80%) of the five subjects. This demonstrates that there had been a significant increase in the likelihood that these individuals would behave assertively when confronted with a variety of situations.

This increase in assertiveness was substantiated by an improvement in two targeted behaviours across subjects. First of all, the difficulty surrounding the expression of feelings, beliefs and opinions was significantly reduced in three (60%) of the subjects at the completion of the group sessions and in four (80%) at the follow-up. Secondly, the capacity to refuse requests was sufficiently increased in three (75%) of four subjects by the end of the follow-up period to minimize the disturbance this difficulty caused for each person. A third target, which focused on requesting help, was modified in one subject only. The results of the Assertion Inventory as well as the replication of these changes in the targeted behaviours across subjects demonstrate that the assertion group had a positive impact in assisting the women to improve their assertive responses, particularly with respect to the expression of feelings, beliefs and opinions and to refusing requests.

The pace with which skill acquisition exercises were introduced into the assertiveness training program appeared

to be appropriate for this clientele. It was hypothesized that the participants would be unable to utilize specific behavioural skills if they did not have positive self-feelings or if they were unable to accept the rights which justify assertive responses. For this reason, before specific skills were addressed the sessions were designed, firstly, to stimulate self-awareness and positive self-esteem and, secondly, to develop a belief system of personal rights. This perspective, also, enabled the group members to maintain a certain element of social distance until trust, which is required for the dyadic and triadic format used in many assertive exercises, had been established.

Self-Awareness and the Acceptance of Rights

Results also indicated that this program was successful in assisting the women to achieve the second goal of the therapy group: to develop a belief system with respect to assertive behaviour that would increase self-awareness and acceptance of their needs and rights. This aspect of the assertiveness training appeared to be most effective in assisting the participants to undestand and accept the rights they have within interpersonal relationships. This is evident in data obtained by the Target Complaint Scales at the follow-up session. It demonstrated that clinically significant changes were replicated in three (75%) of four subjects who had been assessed as having difficulty in

accepting rights.

In addition to this, the women commonly indicated that the acceptance of rights had enabled them to modify the caretaking role which, previously, they had been compelled to assume. In the past, each of these women believed that they had to take care of the "world." This, perhaps, was associated with the parentification process which socializes childhood victims of abuse that the needs of others supercede their own needs (Gelinas, 1983). Relinquishing this role means that they have to be able to trust that there are other individuals who are able to pick up the slack and to provide care in situations these women choose to avoid. In view of the fact these women grew up in an environment devoid of trust, the capacity as well as the willingness to abandon this caretaking role was a big step for them.

During the group process, it became apparent that necessary precursors to the development of a belief system which enables one to accept personal rights and needs are self-acceptance and a healthy self-esteem. In this program, feelings of low self-esteem clearly inhibited participants from accepting their rights to behave assertively in specific "in vivo" situations.

The collage exercise (Osborn & Harris, 1975), discussed previously in Sessions 1 and 2 of the group content,

was extremely helpful in making the individuals aware of their self-feelings and the way in which unreasonable beliefs and expectations are facilitative of negative self-images. Also, satisfactions, achievements and successes (Osborn & Harris, 1975) (see Session 3), which is designed to reinforce positive behaviour, appeared to enhance the self-esteem of some participants. On several occasions, group members reported that the completion of this homework assignment caused them to feel good about themselves. They pointed out that the analysis of seemingly insignificant activities and experiences helped "to pick them up" on particularly difficult days. This suggests, perhaps, that the reinforcement that results from repeated performance of positive and successful behaviours is a key to strengthening self-esteem with this clientele.

Group affiliation, perhaps, was another factor which contributed to the increase in self-esteem which occurred in four of the five participants. These individuals commonly stated that the opportunity to associate with other previously abused women helped to normalize the negative effects of the victimization (e.g. difficulties with intimacy) which were being experienced in their current relationships. This attests to the advantages of utilizing the group modality at some point in the treatment scheme of women who have been sexually abused in childhood.

Reducing Anxiety and Unreasonable Cognitions

The assertiveness training had a limited impact on reducing the anxieties and cognitions which impaired the participants' capacity to engage in assertive behaviour.

Discomfort

First of all, results obtained on the discomfort dimension of the Assertion Inventory indicated that three (60%) of the women continued to experience a high degree of discomfort in assertive situations at both the termination and follow-up of the program. A fourth individual scored slightly below the cutting point.

A comparison of these results with those of the Response Probability dimension of the scale in which there was a significant improvement in four (80%) of the participants suggests, perhaps, that the difficulty for this clientele is not a skill deficit as much as the performance of those skills which frequently is impaired by feelings of discomfort. There is support for this assumption in comments made by the participants during one of the sessions. They generally agreed that the key for them to utilize assertive responses was the capacity to understand and accept their personal rights in specific situations. In commenting on this, Sara stated that "my biggest problem is knowing or deciding what my rights are in a situation. When I become aware of that, I can be assertive." This may

provide an explanation for responses obtained on specific items of the client satisfaction questionnaire. For example, homework exercises which were structured to provide the women with opportunities to practice assertive responses "in vivo" and role plays designed to rehearse specific assertive behaviours and techniques were considered to be less helpful than other instructional aids. On the other hand, structured exercises, which had a greater focus on reducing anxiety and restructuring irrational beliefs were considered to be more useful.

There are two possible explanations for the discomfort these individuals experienced in engaging in assertive behaviour. First of all, as discussed previously, the assertiveness training had been successful in assisting the participants to understand and accept their personal rights. Concurrently, however, the women indicated that they had difficulty justifying this behaviour. Thus, they had become enabled to accept their rights, however, were inundated with discomfort as they did so. Their childhood environment had socialized them to accept the misconception that they do not possess any personal rights and, subsequently, they may have been experiencing "growth pains" as they accepted the right to live and interact in a different manner to which they had been accustomed. On this basis, practitioners involved in future programs of this nature should be prepared to vali-

date these feelings as the group participants struggle to accept their rights. Also, it might be appropiate to provide a greater emphasis on exercises which will help individuals to cognitively restructure the acceptance of rights as well as those which reinforce this behaviour.

A second possible explanation for the high degree of discomfort experienced by the majority of participants was the lack of reinforcement they received from significant others for their changed behaviour. For example, Kelly stated: "I try to express myself with 'I' statements, however, it is frustrating because I don't seem convinced that screaming doesn't work better." In the past, these women had been reinforced for non-assertive behaviour, and now that this behaviour was being modified, the social feedback had become aversive. This was clearly the case with Alison whose husband appeared to have extreme difficulty accepting the changes he had observed in his wife.

In retrospect, it may have been helpful if the women had been more prepared at the outset of the program for the responses they could expect from significant others. This, perhaps, would have cushioned the disappointment, frustration and discomfort they experienced. Furthermore, in subsequent programs, it might be appropriate to meet with each couple in an individual session in order to address the changes which occur in a family system when one of its

members becomes more assertive. This session could be used to demonstrate to the partner that assertiveness training is not a conspiracy against him, but a process by which his wife "is becoming more aware of her personal rights and [is] working toward being more direct in expressing her thoughts, feelings and needs" (Lange & Jakubowski, 1976, p. 302). This, very well, may make it easier for a partner to accept the changes in his wife.

Irrational Beliefs

Although responses obtained on the client satisfaction questionnaire indicate that the group experience was moderately helpful to very helpful in reducing their irrational beliefs about behaving assertively, the women continued to have difficulty in this area. This was most evident in the negative cognitions the women have with respect to control of sexuality within intimate relationships. In discussing this issue, the women indicated that the need to control sexual relationships was a pervasive problem for them. Each of the women perceived sexuality as a weapon which had been used against them in the past and, subsequently, they were having difficulty normalizing this aspect of intimacy in their current relationships.

The basic assumption they held was the belief that they would be at risk to danger and exploitation if they relinquished or shared control of their sexuality. This

was associated with their victimization experiences in which they were overwhelmed by the power differential existing between children and adults and, thereby, received the message that they must maintain control if they are to remain safe.

In light of the fact that intimacy involves taking risks as well as sharing control and decision making, the need to maintain control creates a serious dilemma for these individuals. For this reason, subsequent asertiveness training programs for previously abused women should endeavour to address this issue of control more adequately. Techniques which would be helpful in doing this are cognitive restructuring of irrational beliefs and assumptions, and an emphasis upon "I" messages which facilitate an honest expression of fears, concerns and difficulties with their partners. In addition to this, group discussion as well as the support and affiliation it engenders can be a powerful therapeutic influence.

The Resolution of Difficulties in Heterosocial Relationships

The assertiveness training therapy group was effective in assisting the women to begin resolving the difficulties they experienced in their relations with men. In responding to the client satisfaction questionnaire, four (80%) of the subjects rated the helpfulness of the male

therapist as being very helpful. One (20%) individual indicated that it was slightly helpful, although this person admitted that it was much easier for her to relate to men than to women.

The women identified two primary benefits of a male therapist. Firstly, his presence made it possible for a male opinion and perspective to be provided in specific situations. Secondly, and more importantly, it enabled the women to differentiate abusive and exploitive males from those who are trustworthy. For example, one of the individuals stated that she had never equated gentleness in males with positions of power and authority because power was perceived by her as being abusive. The context of her remark clearly indicated that she was referring to the role of the male therapist. The women reported that the important ingredients in therapy with adult victims of child sexual abuse is not gender, but personality. On this basis, the speculation herein is that the key to the therapists is not so much gender as it is the capacity and willingness to empathetically, compassionately and supportively understand the pain of these individuals.

Summary

On the basis of these results, it can be concluded that the therapy group was effective in meeting three of its original objectives: the acquisition of assertive

skills, increased self-awareness and the acceptance of personal rights, and the modification of difficulties experienced in heterosocial relationships. It, however, was not adequate in eliminating anxiety or in reducing all unreasonable beliefs which impaired the participants' capacity to engage in assertive behaviour. Also, it is necessary to reiterate that the changes achieved are not necessarily attributable to the assertiveness training alone because the women were involved in concurrent individual therapy.

Implications for Future Programming

This present study developed and systematically evaluated an assertiveness training therapy group for women who were sexually victimized in childhood or adolescence. The results indicate that an improvement occurred in the overall assertive behaviour of each woman who participated in the group. This increase in assertiveness was confirmed by a focal evaluation of specific targeted behaviours as well as by a global measure of assertiveness.

The consistency of these diverse forms of measurement has functioned to increase the practitioners' confidence in the effectiveness of the intervention. This has been further enhanced by the fact three of the targeted behaviours were replicated across subjects. At the same time, however, the results which occurred should be treated with caution because threats to internal validity which have

been discussed previously could represent alternative explanations. Therefore, the replication of this treatment program with suitable controls is necessary before one is able to be more conclusive regarding its effectiveness.

Programs which are designed to replicate this study, perhaps, would benefit from a number of recommendations which have been formulated on the basis of the findings of this present study. First of all, it is necessary that a person feel good about herself or himself so that she or he is able to accept the personal rights which enable a person to behave assertively. For this reason, it is important that group facilitators endeavour to stimulate self-awareness, build self-esteem and establish a belief system of personal rights before specific skills are introduced. This is particularly important with previously abused women because, generally, they experience low self-esteem and have a tendency to deny themselves personal rights.

Secondly, there is some evidence in this present study to indicate that the difficulty this clientele has with assertiveness may be related to the performance of skills, rather than to skill deficit. Subsequently, a greater focus on exercises structured to reduce the discomfort these individuals seemingly experience in assertive situations might be more congruent with their needs.

Thirdly, the length of the program should be extend-

ed, at least, to twelve sessions in order to provide more opportunity to discuss issues which are relevant to the adult experiences of childhood sexual abuse victims. During this present study, the focus on intimacy and sexuality was both necessary and helpful. Time constraints, however, made it difficult to address these issues adequately. The therapy of these women might be expedited if more emphasis was given to group discussion of these and similar themes.

Fourthly, it is important that previously abused women who experience difficulty in heterosocial relationships learn to make discriminating choices between men who can be trusted and those who cannot. Therefore, group work with this clientele should incorporate a male therapist into the program in order that an appropriate exposure to males will enable them to realize that all men are not predatory and exploitive.

It is believed that incorporating these changes into assertiveness training therapy groups for women sexually abused in childhood or adolescence will increase the effectiveness of efforts aimed at assisting these individuals to exert greater control over their lives and environments. In so doing, it increases the likelihood that they will cease to be victims in order that they might become survivors.

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Appendices

Appendix A

Assessment Interview Protocol for Assertiveness

1. Physical description of the client

   Including dress and general appearance as well as any noteworthy physical features.

2. Observation of the client during interview(s)

   Including brief description of verbal and nonverbal behavior and how she relates to the therapist.

3. Client's description of assertiveness problems and goals in her own words.

4. Operational definitions of problems and goals.

5. Effects of unassertiveness on client's life functioning

   Extent to which unassertiveness may limit the client in significant areas of her life.

6. Consequences of being more assertive

   Is client aware of these consequences and willing to risk any adverse consequences (e.g. for marital relationship).

7. Assertiveness in specific areas

   (a) Same sex relationships

   (b) Opposite sex relationships

   (c) Casual relationships

   (d) Intimate relationships

   (e) Interactions with family members

   (f) Interactions with authority figures

   (g) Group situations

(h) Initiating social interactions

(i) Maintaining and developing social interactions

(j) Expressing positive feelings towards others

(k) Asking for help; letting someone know specifically what you would like them to do for you

(l) Refusing unreasonable requests

(m) Standing up for one's rights

(n) Expressing disagreement, displeasure or criticism

8. Estimates of social skill, social anxiety and self-evaluations in each of above areas.

9. Inhibition of assertive responding by intense feelings

(a) Can client handle her own intense feelings such as anxiety or anger and still respond assertively

(b) Can she handle other people's anger or hostility and still respond assertively

10. Cognitions relating to assertiveness

(a) Client's irrational assumptions, unrealistic standards and expectations regarding social interactions.

(b) Client's knowledge of what she is feeling in problematic situations.

(c) Client's knowledge of what she wants in problematic situations.

(d) Client's knowledge of her rights in problematic situations.

(e) Client's ability to articulate her goals in social interactions.

(f) Client's knowledge of when to be and when not to be assertive.

(g) Client's self-evaluative thoughts when assertive behavior is not engaged in.

11. Current living situation with particular reference to actual or potential social contacts.

12. Description of a typical day with particular reference to social contacts.

13. Interests and leisure activities.

14. History of unassertiveness

(a) Description of onset (or note if primary)

(b) Description of period of "best" social functioning

(c) Description of period of "worst" social functioning

15. Other problems that may impede assertiveness

16. Cultural factors that may impede assertiveness (past/current)

Appendix B

Target Complaint Scale
(Mintz & Kiesler, 1982)

Target Complaint Scale

Name _____ Date _____

Problem: _____

_____

_____

_____

_____

_____

_____

_____

In general, how much does this problem or complaint bother you? Check the box which best describes the amount of disturbance felt because of this problem.

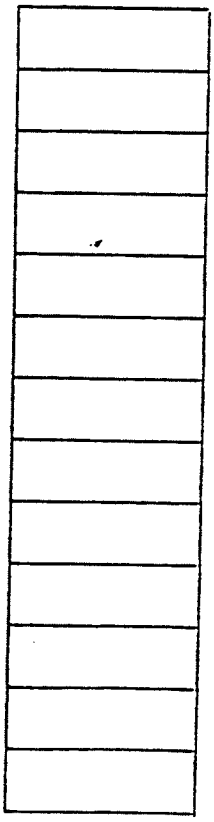
couldn't be worse

very much

pretty much

a little

~~not~~ at all



Appendix C

Assertion Inventory
(Gambrill & Richey, 1975, pp. 552-553)

The Assertion Inventory

Many people experience difficulty in handling interpersonal situations requiring them to assert themselves in some way, for example, turning down a request, asking a favor, giving someone a compliment, expressing disapproval or approval, etc. Please indicate your degree of discomfort or anxiety in the space provided *before* each situation listed below. Utilize the following scale to indicate degree of discomfort:

1 = none
2 = a little
3 = a fair amount
4 = much
5 = very much

Then, go over the list a second time and indicate *after* each item the probability or likelihood of your displaying the behavior if actually presented with the situation.* For example, if you rarely apologize when you are at fault, you would mark a "4" after that item. Utilize the following scale to indicate response probability:

1 = always do it
2 = usually do it
3 = do it about half the time
4 = rarely do it
5 = never do it

**Note.* It is important to cover your discomfort ratings (located in front of the items) while indicating response probability. Otherwise, one rating may contaminate the other and a realistic assessment of your behavior is unlikely. To correct for this, place a piece of paper over your discomfort ratings while responding to the situations a second time for response probability.

Degree of discomfort	Situation	Response probability
_____	1. Turn down a request to borrow your car	_____
_____	2. Compliment a friend	_____
_____	3. Ask a favor of someone	_____
_____	4. Resist sales pressure	_____
_____	5. Apologize when you are at fault	_____
_____	6. Turn down a request for a meeting or date	_____
_____	7. Admit fear and request consideration	_____
_____	8. Tell a person you are intimately involved with when he/she says or does something that bothers you	_____
_____	9. Ask for a raise	_____
_____	10. Admit ignorance in some area	_____
_____	11. Turn down a request to borrow money	_____
_____	12. Ask personal questions	_____
_____	13. Turn off a talkative friend	_____
_____	14. Ask for constructive criticism	_____
_____	15. Initiate a conversation with a stranger	_____
_____	16. Compliment a person you are romantically involved with or interested in	_____
_____	17. Request a meeting or a date with a person	_____
_____	18. Your initial request for a meeting is turned down and you ask the person again at a later time	_____
_____	19. Admit confusion about a point under discussion and ask for clarification	_____
_____	20. Apply for a job	_____
_____	21. Ask whether you have offended someone	_____
_____	22. Tell someone that you like them	_____
_____	23. Request expected service when such is not forthcoming, e.g., in a restaurant	_____
_____	24. Discuss openly with the person his/her criticism of your behavior	_____
_____	25. Return defective items, e.g., store or restaurant	_____
_____	26. Express an opinion that differs from that of the person you are talking to	_____
_____	27. Resist sexual overtures when you are not interested	_____
_____	28. Tell the person when you feel he/she has done something that is unfair to you	_____
_____	29. Accept a date	_____
_____	30. Tell someone good news about yourself	_____
_____	31. Resist pressure to drink	_____
_____	32. Resist a significant person's unfair demand	_____
_____	33. Quit a job	_____
_____	34. Resist pressure to "turn on"	_____
_____	35. Discuss openly with the person his/her criticism of your work	_____
_____	36. Request the return of borrowed items	_____
_____	37. Receive compliments	_____
_____	38. Continue to converse with someone who disagrees with you	_____
_____	39. Tell a friend or someone with whom you work when he/she says or does something that bothers you	_____
_____	40. Ask a person who is annoying you in a public situation to stop	_____

Lastly, please indicate the situations you would like to handle more assertively by placing a circle around the item number.

Appendix D

Hudson Index of Self-Esteem
(Hudson, 1982)

INDEX OF SELF ESTEEM (ISE) Today's Date

NAME:

This questionnaire is designed to measure how you see yourself. It is not a test, so there are no right or wrong answers. Please answer each item as carefully and accurately as you can by placing a number by each one as follows:

1 Rarely or none of the time
2 A little of the time
3 Some of the time
4 A good part of the time
5 Most or all of the time

Please begin.

1. I feel that people would not like me if they really knew me well _____
2. I feel that others get along much better than I do _____
3. I feel that I am a beautiful person _____
4. When I am with other people I feel they are glad I am with them _____
5. I feel that people really like to talk with me _____
6. I feel that I am a very competent person _____
7. I think I make a good impression on others _____
8. I feel that I need more self-confidence _____
9. When I am with strangers I am very nervous _____
10. I think that I am a dull person _____
11. I feel ugly _____
12. I feel that others have more fun than I do _____
13. I feel that I bore people _____
14. I think my friends find me interesting _____
15. I think I have a good sense of humor _____
16. I feel very self-conscious when I am with strangers _____
17. I feel that if I could be more like other people I would have it made _____
18. I feel that people have a good time when they are with me _____
19. I feel like a wallflower when I go out _____
20. I feel I get pushed around more than others _____
21. I think I am a rather nice person _____
22. I feel that people really like me very much _____
23. I feel that I am a likeable person _____
24. I am afraid I will appear foolish to others _____
25. My friends think very highly of me _____

3,4,5,6,7,14,15,18,21,22,23,25

Appendix E

Client Satisfaction Questionnaire

Assertiveness Training Group: Evaluation Questionnaire

Please help us to improve our program by answering some questions about the group you attended. We are interested in your honest opinions, whether they are positive or negative. Please check (✓) in the column that best indicates your response to the question. We also request your additional comments and suggestions. Thank you very much for your co-operation. We appreciate your help.

A) Questions Related to the Components of the Training Program

		Not Helpful	Slightly Helpful	Moderately Helpful	Very Helpful
1.	The structure of the group sessions consisted of sharing experiences of the past week, discussing homework, a mini-lecture which focused on some assertion issue, coffee break, structured exercises and discussion. Was this structure helpful?				
2.	To what extent were the structured exercises performed in the group sessions helpful?				
3.	To what extent were the mini-lectures (presented material) helpful?				
4.	To what extent were the behavioural rehearsals helpful?				
5.	To what extent were the group selected discussion topics of intimacy and sexuality helpful?				
6.	To what extent were the various handout materials helpful?				

	Not Helpful	Slightly Helpful	Moderately Helpful	Very Helpful
7. To what extent were the assigned readings from the book helpful?				
8. To what extent were the homework exercises helpful?				
9. To what extent was the presence of a male therapist in this kind of group helpful?				

10. Could you please specify your reasons for the answer provided in Question 9. If additional space is required, please use the back of this page.

B) General Questions

	Not Helpful	Slightly Helpful	Moderately Helpful	Very Helpful
11. To what extent was the training you received helpful in meeting your needs?				
12. To what extent was the training helpful in terms of increasing your self-confidence?				
13. To what extent was the training helpful in reducing your irrational beliefs about behaving assertively?				
14. To what extent was the group experience helpful by introducing you to other women who had been sexually victimized?				
15. Overall, to what extent was this group experience helpful?				

16. Were the number of sessions adequate? Please comment.

Additional Comments and Suggestions:

Appendix F

Handout Displaying the Difference Between Passive, Aggressive and Assertive Behaviours (Butler, 1981, p. 127)

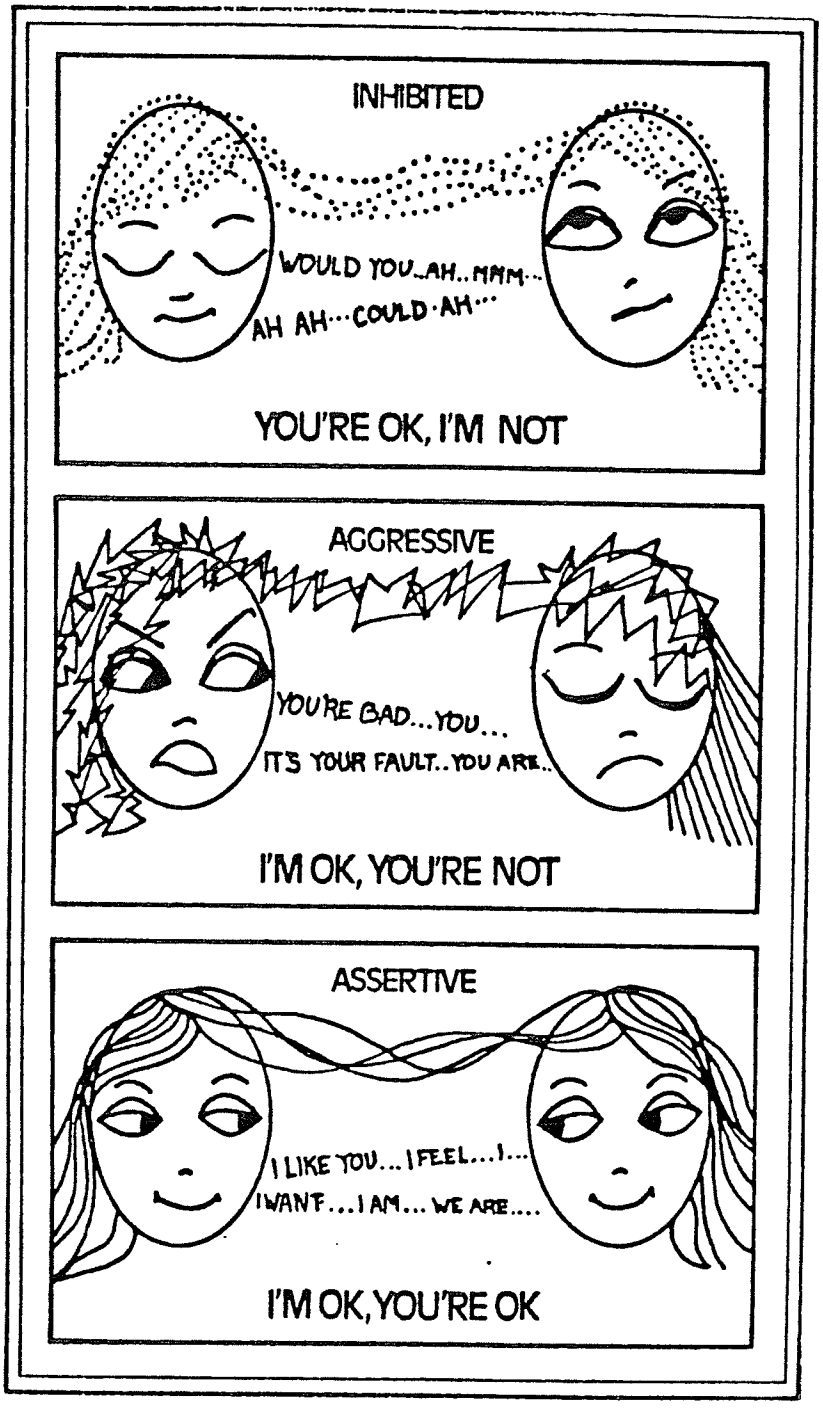


FIGURE 7.1 Which life position fits you? Are you passive, assertive, or aggressive in your interactions with other people?

Appendix G

Handout Summarizing Response Alternatives and Results (Adapted from Clionsky, 1983, p. 150)

SUMMARY OF RESPONSE ALTERNATIVES AND RESULTS

	BASIC MESSAGE	HONESTY	DIRECTNESS	FAIRNESS
Assertive Behavior	We both count	Honest facts and feelings	Direct approach	Fair to both parties
Passive Behavior	I don't count	Dishonest denial of facts and feelings	Indirect approach	Unfair to yourself
Aggressive Behavior	You don't count	Tactlessly honest facts and feelings	Overly direct approach	Unfair to others

Appendix H

Handout Demonstrating the Difference Between Assertiveness, Passivity and Aggressiveness on Behavioural Dimensions (Liberman, King, DeRisi and McCann, 1975, p. 6)

How Assertiveness Differs from Passivity and Aggressiveness

on Behavioral Dimensions

PASSIVE PERSON	ASSERTIVE PERSON	AGGRESSIVE PERSON
Has rights violated; is taken advantage of	Protects own rights and respects the rights of others	Violates rights; takes advantage of others
Does not achieve goals	Achieves goals without hurting others	May achieve goals at expense of others
Feels frustrated, unhappy, hurt and anxious	Feels good about self; has appropriate confidence in self	Defensive, belligerent; humiliates and depreciates others
Inhibited and withdrawn	Socially and emotionally expressive	Explosive; unpredictably hostile and angry
Allows others to choose for him	Chooses for self	Intrudes on others' choices

Adapted by James Teigen from Your Perfect Right by R. E. Alberti And M. L. Emmons. San Luis Obispo, CA: Impact Press, 1974.

Appendix I

Handout Providing Examples of Passive, Assertive and Aggressive Responses for Specific Situations (Butler, 1981, pp. 130-131)

TABLE 7.1

Situation: I am asked by telephone to be in charge of a charitable campaign in my neighborhood. This is a responsibility I do not want to accept. I respond:

Passively	*Assertively*	*Aggressively*
I say "yes," then slam down the telephone.	I really don't want to take on that responsibility this year.	Don't you realize that other people are busy?

Situation: A friend is talking on and on, and I have to get dinner. I respond:

Passively	*Assertively*	*Aggressively*
I tell my son to go ring the doorbell. Then I say "I've got to hang up now. Someone's at the door."	I have to go now. I need to start dinner.	It's six o'clock. You know I have to get dinner. You don't think about anyone but yourself.

Situation: I am seated in the window seat on an airplane. A honeymooning couple in the seats beside me are waiting for everyone to leave before getting up. I have to connect with another plane. I respond:

Passively	*Assertively*	*Aggressively*
I sit until they leave. I get a stomach ache.	Would you mind letting me get past? I have to make a close connection.	Are you two ever going to leave this plane.

TABLE 7.1 *(cont'd.)*

Situation: I am not pleased with the service in a restaurant. I respond:

Passively	*Assertively*	*Aggressively*
I leave a penny tip.	I don't feel that I was given adequate service.	You are the rudest waitress I've ever encountered.

Situation: My husband has not been helping me clean up the dishes after we have had guests for dinner. I respond:

Passively	*Assertively*	*Aggressively*
I make a show of cleaning the dishes—banging several pans together. Then I stalk to bed without saying goodnight.	I don't want to clean up by myself. I expect you to do half.	With sarcasm: I just love to wait on you and your friends. It's my life's ambition.

Situation: My male friend arrives to pick me for our date thirty minutes late. We have missed the first part of the movie we planned to see. I respond:

Passively	*Assertively*	*Aggressively*
I say *nothing*, not even hello, as we ride to the movie.	I am annoyed that you are thirty minutes late. I don't like to miss the beginning of a movie.	You are so inconsiderate. You shouldn't make commitments you can't keep.

Appendix J

Handout Outlining the Steps of Rational Self-Analysis (Lange & Jakubowski, 1976)

RATIONAL SELF-ANALYSIS*

STEPS:

1. Write a specific situation in which you would like to be more assertive but in which your emotions cause you to act aggressively or nonassertively.
2. Write down the negative thoughts that come to mind as you think about acting assertively in the situation (i.e. thoughts which would produce negative feelings in you)
3. Develop written challenges to these negative (irrational) thoughts.

   Two ways to do this:

   (i) Identify the flaw in the self-message (e.g. is this 100% true?)

   (ii) This involves asking yourself two questions:

      a) Even if this bad event happened, is it a catastrophe? Could I handle it?

      b) What implications does this bad event have for me? Does it make me a bad or worthless person?

*This format was adapted from the work of Maxie Maultsby (cited in Lange & Jakubowski, 1976).

Appendix K

Handout for the Exercise, "Like Yourself" (Phelps & Austin, 1975, p. 75)

Action exercises

Like yourself first

Fill in the blanks with ten positive statements about yourself—things you like about *you* as a person, e.g. "I like the fact that I'm trying to become a more assertive person." Stand in front of a mirror and read each item on your list aloud. While practicing good eye contact and smiling appropriately, acknowledge each compliment that you give yourself either verbally or non-verbally. Practice adding some free information to some of your "thank-you's."

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

This is not only a good list to refer to when you feel rejected. Use it to gain confidence in self-assertion. Refer to the list daily and add to it regularly by telling someone, in regular conversation, something positive about yourself.

Appendix L

Handout of Basic Rights for Assertive Behaviour (Lange & Jakubowski, 1976, p. 56)

A second basic belief in an assertive philosophy is that *everyone is entitled to act assertively and to express honest thoughts, feelings, and beliefs.* More specifically this involves beliefs such as:

1. We all have the right to respect from other people.
2. We all have the right to have needs and to have these needs be as important as other people's needs. Moreover, we have the right to ask (not demand) that other people respond to our needs and to decide whether we will take care of other people's needs.
3. We all have the right to have feelings—and to express these feelings in ways which do not violate the dignity of other people (e.g., the right to feel tired, happy, depressed, sexy, angry, lonesome, silly).
4. We all have the right to decide whether we will meet other people's expectations or whether we will act in ways which fit us, as long as we act in ways which do not violate other people's rights.
5. We all have the right to form our own opinions and to express these opinions.

Appendix M

Handout Describing How Socialization Messages May Negatively Effect Assertion (Lange & Jakubowski, 1976, pp. 66-68)

How Socialization Messages May Negatively Effect Assertion

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

Socialization Message	*Effect on Rights*	*Effect on Assertive Behavior*	*Healthy Message*
Be sensitive to other people's feelings. Don't hurt other people.	I have no right to do anything which might hurt someone else's feelings or deflate someone else's ego.	I will not say what I really think or feel because that might hurt someone else. I will inhibit my spontaneity so that I don't impulsively say something that would accidentally hurt someone else.	It is undesirable to deliberately try to hurt others. However, it is impossible as well as undesirable to try to govern your life so as to *never* hurt *anyone.* You have a right to express your thoughts and feelings even if someone else's feelings get occasionally hurt. To do otherwise would result in your being phoney and in denying other people an opportunity to learn how to handle their own feelings. Remember that some people get hurt because they're unreasonably sensitive and others use their hurt to manipulate you. If you accidentally hurt someone else, you can generally repair the damage.

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Appendix N

Satisfactions, Achievements, Successes Assignment (McHolland & Trueblood, cited in Osborn & Harris, 1975, p. 120)

Name _____

Date _____

SATISFACTIONS, ACHIEVEMENTS, and SUCCESSES	1.	2.	3.	4.	5.	6.	7.
(a) I felt what I did was important							
(b) I like to try new experiences (adventure)							
(c) I enjoyed doing it							
(d) I gave love, affection							
(e) I used skill or know-how							
(f) I was free to decide what I did or how I did it							
(g) I influenced the behavior of somebody							
(h) I learned something new							
(i) I like to meet a challenge							
(j) I was creative							
(k) I received respect, recognition or appreciation for what I did							
(l) Others felt what I did was important							
(m) I received money or its equivalent							
(n) I made others happy							
(o) I received security							
(p) I received approval of others							
(q) I received love/affection							

Appendix O

Assertive Statements and Questions Assignment
(Osborn & Harris, 1975, pp. 111-113)

The following list of statements and questions can be rehearsed alone, then in dyads or in the training group.

1. I'm not able to speak with you right now. Please give me your number and I'll return your call before noon.
2. I've been waiting in line for half an hour, and I'm not willing to let you go in front of me.
3. I'd prefer to stay here; it's too cold outside.
4. I am disgusted by your behavior.
5. I resent your duplicity.
6. I am angry about your lack of concern for my feelings.
7. I won't be able to attend your party. I have already made other plans.
8. I don't want to respond to that question.
9. If you continue to arrive late, I am not going to make future appointments with you.
10. I am unwilling to run errands on my lunch hour. It is not part of my job.
11. Please wait your turn.
12. I'm interested in hearing what you have to say, but I want to finish reading this article first.
13. I don't agree with you.
14. I think that you have been very distant towards me lately.
15. I would appreciate your going to the store for me.
16. You ate the last piece of pie. I was going to eat it for lunch.
17. You started talking before I had finished my statement.
18. I admire your skill.
19. That was a clever thing to do.
20. I'm excited about my trip.
21. I'm feeling especially happy (or sad) today.
22. I am very interested in what you do in your line of work.
23. I am depressed because I wanted Martha to be here on my birthday, and she just called to say she couldn't come.
24. I am disappointed in myself because I wanted to complete the report on time and I didn't.
25. I am confused because I wanted more information than was provided.
26. I am interested in your report because it presents several pieces of information I needed.
27. I feel tense because I want to know definitely how well I did on the test, but the teacher hasn't finished scoring it.
28. That's a beautiful outfit you are wearing.
29. You look terrific.
30. I really enjoyed your thoughtful comment.
31. I love you.
32. I admire your willingness to behave in a nonsexist way.
33. That was an honest and forthright statement of your feelings. I admire your ability to take the risk to be so candid.
34. I really like your openness.

35. I like your efforts to work out a solution to our mutual problem.
36. I am unable to see the speaker and am frustrated. Would you please move a little to the left?
37. I am having difficulty hearing the performance. Would you please stop talking?
38. I've had trouble carrying groceries up my stairs. Would you please put the heavy items in a double bag?
39. I am annoyed at you. Why are you late?
40. I'm feeling too warm. Would you be willing to turn down the heat?
41. Would you please help me? My packages are heavy.
42. (To the stewardess on a flight that is late for a connection) Would you please arrange to send a telegram to the party who is expecting me at noon in Chicago? I am being extremely inconvenienced by this delay.
43. I find your terminology offensive. Would you please phrase the question differently?
44. Are you worried because of the amount of money I have been spending and you want me to spend less?
45. Are you hurt because I told you what I really think?
46. Are you irritated with how much time I'm taking, and do you want me to go?
47. Are you disappointed with my report, and do you want me to listen to the changes you think would improve it?
48. Are you saying that you are feeling very depressed but that you would like me to stay and talk with you?
49. Are you feeling disappointed because you think that you deserve to be promoted?
50. Are you feeling frustrated with me?

Appendix P

Data Sheet
(Richey, cited in Osborn & Harris, 1975, p. 64)

DATA SHEET

Name: _____ Dates: from _____ to _____

Date	Situation	Time Interval	Your Assertive Behavior	Response of Others (+0-)*	Degree of Your Discomfort (1-5)**

* Response to others: + positive
0 neutral
- negative

** Degree of Your Discomfort: 1 none 4 much
2 some 5 a great deal
3 a moderate amount

Appendix Q

Outline for Writing DESC Scripts
(Bower & Bower, 1976, pp. 123-127)

7

Writing Your Own DESC Scripts

Nothing will ever be attempted if all possible objections must be first overcome.

SAMUEL JOHNSON

In this chapter, you'll analyze your situation from Worksheet #3, page 21, and write a DESC script to fit that situation. But first, you'll get some writing practice in the following exercise.

Situation. Last week you bought a blouse (if you are a woman) or shirt (if you are a man) in a high quality store, and it shrank beyond use during its first washing. You want a new blouse (shirt) to replace it, or credit at the store. You are a little nervous about returning merchandise, so you work out a script to say to the salesclerk.

Write something down as a first approximation. You can always edit and revise it. Take a pen or pencil and write out the best lines you could say to the salesperson. Make your DESCRIBE step a statement of the problem as you see it rather than a description of the clerk's behavior (which is not at issue here). Then plan the other steps.

DESCRIBE _____

_____

_____

EXPRESS _____

_____

_____

SPECIFY _____

_____

CONSEQUENCES *Positive:* _____

_____

[*Negative:* _____

_____]

Now check whether you have followed the rules for good scripts (Chapter 5, page 100). Compare your script with the model script below.

DESCRIBE I bought this blouse (shirt) here last week. It shrank so much when I first washed it that I can't wear it.

EXPRESS I think that a blouse this expensive should be preshrunk.

SPECIFY I want this store to give me full credit on this blouse. Will you do that?

CONSEQUENCES *Positive:* If so, I will apply that to buying another blouse here to match my outfit.
[*Negative:* If not, then I will not patronize this store again.]

WRITING A SCRIPT FOR YOUR PROBLEM SCENE

The way to begin writing a script is to force yourself to start, and then reward yourself for small accomplishments. Although you can refer to the rules in Chapter 5, don't get bogged down trying to apply them before you even put pencil to paper; that will just inhibit your first efforts. You can always revise and reshape your lines later for a better effect.

To begin, turn back to Worksheet #3 in Chapter 1 (page 21) and review the moderately threatening scene for which you want to work out a script. On that worksheet, you summarized the who, what, and when of your problem scene. As a preliminary step, review that information quickly and objectively.

1. Who are the people in this scene? You and who else?

_____

2. What was the place and time of the old scene?

_____

_____

3. What happened in that old, bad scene? Describe your Downer's behavior and your behavior.

_____

_____

_____

_____

4. Roughly speaking, how do you feel about this situation?

_____

_____

_____

_____

Now, using the guidelines on page 126, begin writing your lines. Using pencil (so you can erase later if necessary), write out the words you could imagine yourself saying when you play the role of the assertor. Keep each step in your script brief — only one or two sentences. When you have finished, return to this page and continue reading below.

Editing Your Script

Once you have put on paper some ideas of what you want to say, you can review your script and refine your wording. Your objective now is to replace those first hurried phrases with the exact words you will say. To do this, first look over your lines and check them against the rules on page 100. Correct any glaring violations of the rules. Now, try reading your lines and "listening" for exaggerated or emotionally loaded overtones. Again, where necessary, rewrite your lines, this time aiming for restraint. Remember that your script should be short and to the point; a sentence or two at each step is enough.

As a final check, read the questions on page 127 and make further changes if they are needed. Then continue reading on page 128.

Step 1. DESCRIBE the other person's offensive behavior in objective terms. Look, observe, examine exactly what he or she has been saying and doing. Describe the behavior concretely here. (If it is an impersonal problem with a company, describe the problem.)

_____

_____

_____

_____

Step 2. EXPRESS your feelings or thoughts about this behavior or problem in a positive, new way.

_____

_____

_____

_____

_____

_____

Step 3. SPECIFY one behavior change you want the other person to make. Ask for agreement.

_____

_____

_____

_____

Step 4. Stipulate the CONSEQUENCES you will deliver (or what will happen) if the other person keeps the agreement to change.

Positive: _____

If necessary, tell your Downer what negative consequences you will provide if there is no change. Write them here, but understand that you do not say them unless it becomes necessary:

[*Negative:* _____

_____

[*Return to page 125.*]

Your DESCRIBE Lines

- Does your description clarify the situation, or does it just complicate it? Replace all terms that do not objectively describe the behavior or problem that bothers you. Be specific.
- Have you described a single specific behavior or problem, or a long list of grievances? Focus on one well-defined behavior or problem you want to deal with now. One grievance per script is generally the best approach.
- Have you made the mistake of describing the other person's attitudes, motives, intentions? Avoid mind-reading and psychoanalyzing.

← Revise your DESCRIBE lines now, if necessary.

Your EXPRESS Lines

- Have you acknowledged your feelings and opinions as your own, without blaming the other person? Avoid words that ridicule or shame the other person. Swear words and insulting labels (*dumb, cruel, selfish, racist, idiotic, boring*) very likely will provoke defensiveness and arguments.
- Have you expressed your feelings and thoughts in a positive, new way? Avoid your "old phonograph record" lines that your Downer is tired of hearing and automatically turns off.
- Have you kept the wording low-key? Aim for emotional restraint, not dramatic impact.

← Revise your EXPRESS lines now, if necessary.

Your SPECIFY Lines*

- Have you proposed only one small change in behavior at this time?
- Can you reasonably expect the other person to agree to your request?
- Are you prepared to alter your own behavior if your Downer asks you to change? What are you prepared to change about your behavior?
- What counterproposals do you anticipate and how will you answer them?

← Revise your SPECIFY lines now, if necessary.

Your CONSEQUENCES Lines*

- Have you stressed positive, rewarding consequences?
- Is the reward you selected really appropriate for the other person? Perhaps you should ask what you might do for the other person?
- Can you realistically carry through with these consequences?

← Revise your CONSEQUENCES lines now, if necessary.

---

*The rules of contracting (Appendix C) very often apply directly to the SPECIFY and CONSEQUENCES steps, and you may wish to read through these rules now as an additional check.