THE PERCEIVED THERAPEUTIC VALUE OF
ROLE-PLAYING VS. COVERT MODELING IN ASSERTIVENESS TRAINING

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ABSTRACT

Sixty-six male and female subjects, divided into two groups of potential clients, were asked to rate the perceived therapeutic value of role-playing vs. covert modeling in assertiveness training. Each subject viewed a fifteen minute video tape of a counseling session where the counselor's primary technique was either role-playing or covert modeling training. After the viewing of the tapes, each subject was required to answer four instruments, a biographical data sheet, the Assertiveness Inventory, The Value of Counseling Technique Questionnaire, and the Perceived Therapeutic Value Semantic Differential Scale. The results of The Perceived Therapeutic Value Semantic Differential Scale indicated a) that of the two counseling techniques, role-playing was perceived to be more therapeutically valuable in assertiveness training, b) the most important factor indicated by subjects that contributed to perceived therapeutic value was active participation, c) the least important factor contributing to perceived therapeutic value was counselor attractiveness.
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CHAPTER ONE
Introduction

Behavioral training approaches to psychotherapy are based on a response acquisition model of treatment. Within this model, maladaptive behaviors are construed in terms of the absence of specific response skills. (Rimm & Masters, 1974) The therapeutic objective is to provide clients with direct training in those skills lacking in their response repertoires. In behavioral training it is the assumption of the counselor, that as skillful, adaptive responses are acquired, rehearsed, and reinforced, the previous maladaptive responses will be displaced and soon will disappear. (Rimm & Masters, 1974) Until recently, there have been relatively few controlled studies on the therapeutic efficacy of the behavioral training approach to treatment.

There were clinical, anecdotal, and case study reports of the therapeutic success using such approach. (Alberti & Emmons, 1970; Corsini, 1966; Gittleman, 1965; Kelly, 1955; Lazarus, 1966; Moreno, 1946; Wolpe, 1969) Since much of the research on behavior change had been done with non-interpersonally oriented behaviors (such as phobias), Lazarus' study (1966) was specifically designed to examine
and investigate non-assertive behavior as the behavior to be changed.

This study has often been referred to as the first published report comparing assertive training with other treatment methods. Lazarus compared behavior rehearsal with a reflection-interpretation condition and with advice-giving. Each patient received no more than a total of four thirty minute sessions. The behavior-rehearsal condition included modeling by the therapist, practice by the patient, and relaxation induction when anxiety was indicated.

Details of the two control conditions are lacking. A patient was considered improved when evidence was provided for in vivo behavior change. Given the brevity of treatment, the results reported by Lazarus were highly impressive, with 92% of the behavior rehearsal patients showing improvement, compared with 44% for the group receiving advice, and 32% for the reflection-interpretation group. Since Lazarus served as a therapist for all three conditions, it is possible that his bias as a behavior therapist may have had an affect in the control groups. Nevertheless, the 92% improvement rate for behavior rehearsal is quite encouraging. Unfortunately, no follow-up was reported for this study.

In the field of counseling psychology, the principles
of behavior rehearsal have been widely used in helping individuals improve or modify many kinds of behaviors. Behavior rehearsal is a technique in which clients practice new or modified behaviors in place of old behaviors which have resulted in personal problems.

In the earlier research where clinical, anecdotal, and case study reports of the therapeutic success of behavioral training, these reports typically provided little in the way of procedural details. In the few instances in which details were provided, it usually seemed difficult to determine (1) what conceptual rationales guided the particular choice and arrangement of procedures and/or (2) what the relative contributions of the various procedures were to the reported outcomes.

Thus, despite the apparent promise and growing popularity of behavioral training as a therapeutic approach, it has tended to remain more of a vaguely articulated treatment orientation than a well-defined set of empirically grounded procedures. McFall and Lilleshand (1971) contend that behavior rehearsal is the most common treatment component in cases involving performance deficits of a social nature, (e.g. non-assertiveness).

The advantage of behavior rehearsal is that it allows response practice without regard to consequences.
Therefore, the client can be reinforced for any degree of effort, and not have to worry about punishment for assertive responses. When, using behavior rehearsal, the counselor should construct close approximations to real life situations, and try to take into consideration the probable consequences of such actions. Lazarus (1949) urges the use of techniques that will allow the client to progress in a step-by-step fashion starting with those situations that produce a small amount of anxiety.

Modeling which has been employed by many therapists is an additional technique used in assertiveness training. The advantage of modeling is to provide a picture of affective assertive behavior that is not punished. Often, during the role reversal, the counselor can model assertive responses which are crucial in initiating new behavior. (Katz, 1979)

Cautele (1971) has proposed a covert modeling procedure. In the standard modeling procedures, live or symbolic (e.g. films) models have been used. The covert modeling procedure can be conducted without visual models, since the client imagines both a model and himself or herself engaging in desired behaviors. In covert modeling, the client imagines someone else performing behaviors as he or she reads a script or hears instructions presented on audiotape or by the counselor.
A number of studies have found that clients who explored their problems by means of rehearsing new behaviors in comparison to those who just talked about them, demonstrated a higher degree of positive behavior change. (Carton, 1972; Rachar, 1965) Under the broad area of behavior rehearsal, two kinds of rehearsal techniques have been widely used: (1) roleplaying, and (2) covert modeling. Role-playing is a technique whereby a client "acts out" exchanges between the counselor and the client concerning anxiety provoking situations in the client's world or life. (Krumboltz & Thoresen, 1969; Wolpe, 1973)

The immediate objective of role-playing is to enable the client to rehearse a new or more effective mode of behavior as often as necessary without anxiety about its consequences. For role-playing to be of maximal effectiveness it should be conducted under conditions which are close to the clients real life situations. The ultimate aim of role-playing is to prepare the client to live or function without self-defeating fears or anxiety in his real world. (Krumboltz & Thoresen, 1969) Role-playing as used in assertiveness training and other forms of counseling consists of having a client to act out and rehearse new behavior for various aspects of a conflict situation. (Bohart, 1977) If the conflict involves
another person, the client constructs a dialogue between himself or herself, and the other person associated with that conflict.

In roleplaying the client plays himself or herself and then switches roles and plays the other person. As the process of the dialogue goes on Perls (1969) suggests there is a mutual learning until [the two sides] come to an understanding "... until [they] come to a oneness and intergration of two opposing forces." (p. 69) Gestalt counselors use role-playing in part, because it forces the client to "experience" his or her problem instead of "talking" about it. (Resnick, 1969)

As a client role-plays, the cues that are associated with the procedure make it more likely that he or she will have feelings that are similar to those experienced in an actual interaction with another person. Similarly, there appears to be an opportunity for insights into both the self and the other.

The other technique, modeling involves exposing the client to one or more individuals actually present (live) or filmed (symbolic) who demonstrate behaviors that the counselor would like for his or her client to adapt. The process of modeling also includes exposure to the cues, and situations that surround the models' behavior, so that not only the behavior, but its relationship (appropriateness)
to relevant stimuli is also demonstrated.

Furthermore, the effect of modeling may not be only the adoption of certain modeled behaviors by the client, but also the changes in the affective and attitudinal correlates of those behaviors. (Bandura, Blanchard, & Ritter, 1969)

Modeling has been established as an effective, reliable, and fairly rapid method for the acquisition of new skills (Bandura, 1969; Blanchard & Ritter, 1969; O'Connor, 1969) and has been applied to behaviors, situations, and populations relevant to psychotherapy.

Research on both these methods has reported positive behavior change as a result of clients participation in one or both these methods. (Teiger, Liberman and Baker, 1973; McFall and Marston 1970; McFall and Twentyman, 1973). The literature suggests that when role-playing and or modeling are employed with some form of instructions, in dealing with interpersonal oriented behavior, a significant degree of therapeutic value has been reported by both counselors and clients.

Ohsen (1977) compiled a list of commonly agreed upon values that clients as well as counselors reported most often. The list of therapeutic values for role-playing included such factors as these;

1. Participants are aided in achieving insight
into their own behavior and of others.

2. Participants attitudes are modified relating to self, family or social life.

3. Participants are aided in achieving new ways of dealing with problem situations.

4. Helps counselors develop diagnostic information concerning the style, and approaches of participants to certain types of problem situations.

It has been asserted in a vast amount of research that the facilitative relationship is necessary but insufficient for truly effective counseling and psychotherapy with clients with all types of problems. The counselor must be in possession of a versatile repertoire of therapeutic methods with which to supplement the counselor-client interpersonal encounter. (Smith, 1975)

Neither the relationship nor the application of therapeutic methods alone accounts for success in the counseling process. Rather, the client gains results from the combination of relationship parameters and the well-timed, skillful use of appropriate counseling technique and strategies. While the components of an effective relationship have a basic sameness for all counselor-client interactions, the selection of therapeutic methods varies with the uniqueness of each client-problem situation.

No single therapeutic method exists which can be
employed as the "cure-all" strategy in all counselor-client situations.

The two techniques that were examined in this study were role-playing and covert modeling.

Since role-playing and covert modeling are the two primary techniques employed in individual as well as group assertiveness training it is vital that counselors are constantly aware of a clients perceptions of the therapeutic value of role-playing and/or covert modeling in fostering and strengthening more assertive responses. The general purpose of this study was to examine the two techniques role-playing and covert modeling, which is perceived more therapeutically valuable in assertiveness training as reported by college students at the Ohio State University. Perceived therapeutic value was operationally defined in this study as the degree to which a potential client feels he or she would become more assertive as a result of participating in role-playing or the covert modeling technique in individual assertiveness training. Stated more specifically this investigation had the following major purposes:

1. To identify the differences in responses of college students to the Assertive Inventory, the Value of Counseling Technique Questionnaire, the Perceived Therapeutic Scale, and three demographic variables sex, age and
college classification.

2. To determine if there was a statistically significant difference in the perceived therapeutic value between role-playing and covert modeling in individual assertiveness training.

3. To attempt to identify some of the factors (as reported by subjects) that led them to perceive one counseling technique more therapeutically valuable than the other, based upon the responses to the Value of Counseling Technique Questionnaire and the Perceived Therapeutic Value Semantic Differential Scale.

4. To support the hypothesis that role-playing would be perceived more therapeutically valuable by subjects than covert modeling in assertiveness training. This would be mainly due to active participation of the client, counselor expertise, and the degree to which a client would feel comfortable with this technique.

Recent research has strongly suggested that there are a variety of factors that contribute to the therapeutic value of the counseling techniques of role-playing and covert modeling. Friedman (1972) test a number of hypotheses concerning the value of role-playing and modeling in assertive training. Students (from introductory psychology classes) were assigned to one of six treatments of 5-10 minutes duration:
(1) modeling plus role-playing; (2) modeling; (3) directed role-playing; (4) improvised role-playing, and (5) non-assertive script. Students in modeling plus role-playing showed significantly larger gains in a Sum Assertion score than all groups except that for improvised role-playing. The results, which held up at the two week follow up provided strong support for the behavior rehearsal group where modeling was followed by role-playing. Overall success was highly impressive, considering that only 8-10 minutes of treatment were involved.

Eisler, Herson and Miller (1973) did a study with thirty male psychiatric patients to examine the effects of modeling on components of assertive behavior. There were three groups which were (1) videotaped modeling group; (2) practice-control group, and; (3) test-retest. The modeling and practice groups participated in a behavioral assertiveness test (devised by authors) six times during a three day period.

Results showed modeling group had significantly more change than the other two groups. Specifically, the modeling participants showed greater changes in five of the eight variables studied: (1) longest duration of reply; (2) greatest number of requests for new behavior; (3) greater effect; (4) louder speech, and; (5) greatest overall assertiveness. As counselors and/or group facilitators in providing assertiveness training, it is
essential to continuously develop ways to enhance the therapeutic efficacy of counseling techniques used in assertiveness training, to increase the likeliness of positive behavior change in assertive behavior. This study main attempt was to address itself to the need for counselors to be aware of the perceived therapeutic of role-playing and/or covert modeling by potential clients who might require assertiveness training in the future.

In past studies, that have usually been the basis for real life application in counseling practice, the use of specific counseling techniques have been employed based on the assumption if it was therapeutically valuable for previous clients, they would also be therapeutically valuable for future clients. This exploratory study sought to focus on potential clients perceptions of therapeutic value of role-playing and covert modeling, and determine what were some of the factors those perceptions can be attributed.
CHAPTER TWO

Review

Only recently have some initial studies of the therapeutic efficacy of role-playing and covert modeling in assertiveness training been conducted. The purpose of this chapter is to review examine pertinent research and theory in the area of the therapeutic efficacy of role-playing and covert modeling in assertiveness training. Initially, however the historical development of the concept of behavior rehearsal (i.e. role-playing) and covert modeling and its purpose in training individuals to be more assertive, or help others to become assertive, specifically in interpersonal situations will be reviewed. This will include various definitions of assertiveness from theoretical ideas as well as some experimental studies that included role-playing and or covert modeling in developing assertive behavior. Following this background investigation, the actual studies of the components of successful assertiveness training will also be reviewed and critiqued. The final section of this chapter will present those studies which provide a basis for considering the perceived therapeutic value in relationship to positive behavior change in
assertiveness training. As of now, no studies have looked specifically at the relationship between perceived therapeutic value of role-playing and covert modeling, and the degree of behavior change a client predicts he would accomplish.

Assertion training has been said to have become a blooming business (Lazrus, 1976). It has evolved overnight, and for some, has taken the place of the traditional T-group of the 50s and 60s (Weiskott & Belote, 1977). Assertiveness training has proven to be beneficial in enhancing one's personal effectiveness, particularly for those who lack cognitive and behavioral skills that are necessary for one to stand up for their individual rights as a person. People are constantly searching for new ways by which they can enhance their personal growth and development. Assertiveness training's primary aim has been to enable individuals to take control over his or her environment as opposed to feeling helpless or taken advantage of in their interactions with others. (Weiskott and Belote, 1977)

Assertiveness

Assertiveness is that behavior "which enables a person to act in his or her best interests, to stand up for himself without undue anxiety, or to exercise his own
rights without denying the rights of others (Alberti & Emmons, 1974, p. 2). Wolpe and Lazarus (1966) defined it more specifically as: a socially acceptable method of expressing personal rights; Wolpe (1969) defined it as a behavioral response which inhibits anxiety and McFall and Lillesand (1971), termed it as an ability and willingness to say "no" to unreasonable demands, and Hedquist and Weinhold (1970) labeled it as an effective and appropriate response to an interpersonally distressing situation. Assertive behavior involves high regard for one's self as opposed to deference toward others. An assertive individual would tend to experience feelings of self-worth, well-being and self-satisfaction. (Weissott & Belote, 1977) One is more likely to achieve goals because of personal choice, wherein an aggressive individual, whose behavior is self-enhancing, achieves goals at the expense of others.

Unassertiveness

In order to adequately assess or fully comprehend what makes an assertive individual, one must also study the unassertive individual's behavior. Unassertive behavior on the other hand is self-denying and self-inhibiting. Generally unassertive persons feel hurt, anxiety-ridden, and seldom achieve their personal goals.
because they allow others to make choices for them. (Alberti & Emmons, 1974) Hoffman (1974) describes the unassertive individual as lacking self-confidence, and being anxious and inept in interpersonal relationships. He notes that most unassertive persons are "afraid to act or speak appropriately for fear of some imagined or real reprisal that would leave them in psychological shambles." (Hoffman, 1974) Their behavior is often constrictive. They freeze up resorting to passive withdrawal and/or silence. These reactions, however may be situationally induced. Alberti and Emmons (1974) distinguish the situationally unassertive from the generally unassertive person. The former becomes anxious and displays ineffective behavior only in specific situations but on the whole can cope adequately. On the other hand, the generally unassertive behavior individual, is shy and timid in almost all situations. It is typical of this person to have low self-esteem along with a high degree of anxiety. Therapeutic techniques termed "assertive training" have been developed to help people learn more assertive behaviors.

Role-playing or behavior rehearsal has many variations but consists essentially of the acting out of exchanges between the counselor-therapist and the client concerning anxiety provoking situations in the clients world or life.
(Krumholtz & Thoresen, 1969; Wolpe, 1973) The immediate objective of role-playing is to enable a client to rehearse a new or more effective mode of behavior as often as necessary without anxiety about its consequences. The client is reinforced in a two-fold manner: in the first place, he or she is encouraged by the positive feedback he or she receives from the counselor-therapist for the improvement he makes toward his goal. (Smith 1975) Secondly, the client is reinforced as he gains confidence in his own ability to change or improve. The ultimate aim of role-playing is of course to prepare the client to live and function without experiencing self-defeating fears and anxieties in his or her real world. Thus for role-playing to be maximally effective, it should be conducted under situations which are similar to those found in the clients' in vivo real life situations. Behavior rehearsal, a word coined by Lazarus (1966) has sometimes been referred to as "behavioristic psychodramas" (Wolpe 1968) or role-play. However behavior rehearsal as used by Lazarus has a specific meaning that differentiates behavior rehearsal from role-play activity. Lazarus, (1966, p.209) defined behavioral rehearsal as a 'specific procedure which aims to replace deficient or interpersonal responses by efficient and effective behavior patterns. The client patient achieves this by the practice of desired forms of
behavior under the direction and supervision of the therapist." Behavior rehearsal has three purposes: (1) the client can evaluate his or her present behaviors; (2) the new behaviors can be tried out by the client, and; (3) the client can evaluate and/or identify the immediate consequences (usually on others) resulting from the new behaviors. (Cormier and Cormier, 1975)

Kanter and Phillips (1970, p. 187) pointed out that the extent to which an individual's observed behavior may change is a function of (1) observation; (2) memory or storage, and; (3) test for reproduction of observed behaviors. The specific elements of behavior rehearsal that contribute to the process of change in behavior need further investigation and clarification.

Early research evidence stemmed from applications of Moreno's psychodrama technique (1946) in which an individual was assigned a role to act out, usually with the intent of producing attitudinal and/or emotional change. Janis and Mann, 1965 and Mann (1967) conducted a series of studies investigating the effects of types of role-play procedures on cigarette smoking. These studies indicated that role-play was more effective (i.e. produced greater changes in reduction of smoking) for groups that had an emotional or live role-play experience in which subjects were told to act as though they had lung cancer.
and were instructed to experience pain and early death.

The groups experiencing this "emotional" role-play strategy were more affected than the control groups and those groups who experienced "cognitive" role-play in which the advantages and hazards of smoking were discussed. (Janis and Mann, 1965; Mann, 1967) Furthermore, factual information about the hazards of smoking did not decrease the participants' level of smoking, although it did enhance the effects of the role-play procedure. (Mann and Janis, 1968) These findings strongly support Bandura's (1969) evidence that live participation is an essential component in the elimination of behavioral deficits and in the acquisition of new responses.

Consequently, the probability of the clients' experiencing success with a new behavior pattern in the environmental setting is increased.

Several researchers (Lazarus, 1966; McFall and Marston, 1970; McFall and Lillesand, 1971) have investigated the efficacy of behavior rehearsal in therapeutic settings. In these studies, behavior rehearsal has produced significantly more behavior change on the dependent variables than the therapeutic techniques of (1) reflection-interpretation, and; (2) advice-getting. For example, Lazarus (1966) completed a study comparing (1) reflection-interpretation; (2) advice, and; (3)
behavior rehearsal in effecting behavior change (defined as observable action outside of the interview) for seventy-five patients. Lazarus, found that in the "behavior rehearsal" group, ninety-two percent of the clients changed, while thirty-two percent changed in the reflection-interpretation group, and forty percent changed in the advice giving group.

Lazarus (1966, p. 212) concluded that "behavior rehearsal is significantly more effective in resolving specific social and interpersonal problems than direct advice on non-directive therapy. However, the results of the study should cautiously be interpreted, since Lazarus administered all three treatments, and the possibility of experimenter bias may pose some threat to the validity of this study. The findings of Lazarus' study support the evidence of Bohart's (1977) study that the role-play procedure was most effective in comparison to a discharge and intellectual analysis procedure in reducing anger, hostile attitudes, and behavioral aggression in interpersonal conflict situations.

Role-playing was indicated to provide opportunity for both intellectual insight and emotional experience, wherein a discharge procedure de-emphasized insight, and intellectual analysis, thus de-emphasizing emotional experience.
Resnick (1969) found in his study in personal communication that an e-client role-plays the cues associated with the procedure make it more likely that he or she will have feelings similar to those experienced in an actual interaction with another person. Similarly, there appears to be opportunity for insights into both the self and the other. Thus, role-playing seems to be an example of a procedure that combines both insight and affect. Brandzel (1975) conducted a study using role-playing as a training device in preparing multiply-handicapped youth for employment. The results of this study indicated the role-playing training with multiply-handicapped youth was valuable as a diagnostic tool, a training method of teaching patterns of response to new situations and for developing sensitivity to possible consequences of behavior, as a tool for developing spontaneity and ease in social situations, and an opportunity for safe practice of "real life situations."

McFall and Marston (1970) conducted an investigation of the effects of behavior rehearsal in assertive training of forty-two "non-assertive" college undergraduate volunteer subjects.

The subjects were assigned randomly to two experimental conditions and two control conditions. The
Experimental conditions were (1) behavior rehearsal with performance feedback; and (2) behavior rehearsal without feedback. The control conditions were (1) placebo insight therapy, and (2) waiting-list-no-treatment control. In all three of the dependent variable measures (behavior, self-report, and autonomy) the subjects in the behavior rehearsal groups showed significantly more positive change than the subjects in the control groups. Furthermore, the behavior of subjects who received performance feedback as a part of behavior rehearsal changed more. Not only did behavior rehearsal seem to be more effective than no treatment, but the added component of feedback appeared to enhance the behavior change. McPail and Lillesand (1971) compared the effects of two types of behavior rehearsal (overt and covert) with a control group on one aspect of assertive behavior: the ability to refuse (say "no") to engage in an unreasonable request. Thirty-three college undergraduate volunteer subjects were assigned randomly to one of three conditions: (1) overt behavior rehearsal with modeling and coaching; (2) covert behavior rehearsal with modeling and coaching, and; (3) placebo-control. On the general measures, no differences were found between the treatment and control subjects.

On every specific measure of refusal behavior, the
treatment subjects improved significantly more than the control subjects, whose behavior essentially remained the same. These researchers also found that covert behavior rehearsal was as effective, and on some measures more effective than overt rehearsal. Thus, a major implication for using behavior rehearsal as a counseling strategy is that counselors have two types of behavior rehearsal procedures available for use with clients: (1) overt, in which the client rehearses the response aloud; (2) covert, in which the client imagines and reflects on the response.

Some clients might find that covert rehearsal more useful since it may be less threatening. On the other hand, some clients benefit more from the overt rehearsal because it permits greater monitoring and feedback from the counselor. The major components of assertion training include instruction, modeling, role-played practice, trainer feedback and reinforcement. (Otis and Rainey, 1977) Several analogous studies commonly cited in the assertiveness training literature have indicated that practice, regardless of performance feedback (McFall and Lillesand, 1971) and modeling plus role-playing (Friedman, 1971) have increased assertiveness and decreased self-reported anxiety.

Hersen, Eisler, Miller, Johnson and Pinkston (1973) found that modeling plus instructions was most effective
for increasing assertiveness in psychiatric patients.

Comparisons between these studies and extensions to counseling practice are difficult due to the lack of a well-defined common training program. Treatment time in assertion training has varied from twenty minutes to four hours. The practice of role-playing and modeling by role-reversal was first labeled by Ditterman (1965) as behavior rehearsal. However, behavior rehearsal has been used to convey different procedures in the assertion-training studies.

Studies in assertion training have generally left unspecified the role of trainer reinforcement and relationship variables in the training process. Although some procedural guidelines are provided by Alberti and Emmons (1974) and Riem and Masters (1974) research on training packages appropriate for counseling practice is needed.

Galassi, Galassi and Litt (1974) conducted a study that investigated the effectiveness of a multi-faceted group assertive training. The assertive training consisted of video-tape modeling, behavior rehearsal, video-taped peer and trainee feedback, bibliotherapy and homework assignments. Significant differences were found between the assertive training groups, and the control groups on the College Self-Expression Scale and on
role-play situations.

The results of this study, suggests that assertive training can be an effective counseling strategy in both group and dyadic and group settings. Overt and covert behavior rehearsal is one of the primary components of assertive training.

In four studies assessing the relative contributions of components of assertive training McFall and Twentyman (1973) found that rehearsal and coaching made significant additive contributions to performance on self-report and behavioral assertion measures. In these same four studies, symbolic models of assertive behavior added little to performance of the subjects. The modeling component was relatively unimportant regardless of the type of model presented (tactful versus abrupt) or the media used to present the model (audio-visual versus auditory only). (McFall and Twentyman, 1973)

It is important to examine the component of covert modeling in assertion training, and its use in the assertiveness training procedure. In a variation on the application of social modeling principles to reduce avoidance behaviors, Cautela (1971) has proposed a covert modeling procedure.

In the standard modeling procedures, live or symbolic (e.g. films) models have been used. The covert
modeling procedure can be conducted without visual models, since the client imagines someone else performing behaviors as he or she reads a script or hears instructions presented on audio-tape or by the counselor. This modeled script usually contains a description of the specific target behaviors, the controlling cues (antecedents and consequences) of the behaviors' reinforcing consequences, and a description of appropriate affect for the specific situation. (Flannery, 1972) After imagining someone else performing the script, the client then imagines himself/herself carrying out the instructions.

The latter procedure can be appropriately labeled covert self-modeling since the individual compares his or her positive or desired performance to an image of himself or herself. Cautela, Flannery and Hanley (1974) conducted a study where covert modeling was as effective as overt modeling in reducing college students' fears of laboratory rats. Covert modeling was empirically supported in a study conducted by Kazdin (1973) who reported the success of three covert modeling treatments in increasing approach behavior and in decreasing emotional arousal and anxiety.

Kazdin's research also indicates that the type of model presented in a script and imagined by the subject may have an important effect on subsequent behavior change.
In this study, a greater reduction of avoidance behavior was demonstrated by subjects who were instructed to imagine a coping model as opposed to a mastery model. The coping model was presented initially anxious but gradually overcoming the anxiety, while the mastery model was presented as completely fearless. (Kazdin, 1973) This element of the covert modeling process, as well as the self-modeling element, supports the idea that similarity of the model to the client is an important variable in any social modeling procedure. (Nlanders 1968; Bourdon, 1970) A critical assumption of all the covert self-management procedures is that covert behavior can predictably influence overt processes in the same manner that manipulation of overt behaviors can maintain and modify other overt responses. (Cormier & Cormier, 1975)

Counselors must be aware that procedures such as covert modeling are branded with potential reactivity and unreliability of client self-recording. Reactivity refers to a behavior change that occurs as a function of the self-recording procedure while reliability refers to the degree of consistency.

Unreliability of client self-recording may present difficulties in monitoring the results of a therapeutic procedure unless other indices of change are apparent.
To summarize, there have been many studies that have looked at various assertion training packages on the whole, and studies that have looked specifically at components particularly role-playing, behavior rehearsal and modeling covert and overt. The present study will investigate the two essential components of assertion training behavior rehearsal (i.e., role-playing) and covert modeling, and the perceived therapeutic value of both these techniques.
Chapter Three
Methodology

Purpose

The purpose of this study was to determine which counseling technique (role playing or covert modeling) would be perceived more therapeutically valuable in individual assertiveness training. This would be based upon a viewing of a 15 minute video-taped counseling session, where a counselor used role playing or covert modeling as the primary technique with a client that requires assertiveness training.

Subjects

The 66 subjects were students at the Ohio State University, 56 of which were recruited from the Psychology 100 subject pool during the Summer Quarter of 1979. These students were participating in this study in partial fulfillment of the research requirements for the course. Due to a shortage in the Psy 100 subject pool, the additional 10 subjects were recruited from an introductory counseling course (Psy 540) who participated on a strictly voluntary basis. Thirty-three subjects were randomly assigned to the role playing condition or the covert modeling condition. The sixty-six students presented themselves at the designated
times which resulted in experimental groups 1 and 2 respectively. The mean age of the subjects was 22 years and the range was 18 to 45 years of age. The majority of the students were freshmen and juniors with 12 seniors and 14 sophomores. The sex breakdown of the 66 participants was 36 females and 30 males.

Counselors

The counselor was a second year graduate student who had completed at least three counseling practicums, with some experience in assertiveness training. Demographically, the counselor was a white female in her mid twenties. Two scripts were given to the counselor of the counseling session segment two days prior to the videotaping. The instructions were to become familiar with the written counseling sessions scripts and to make changes which she felt would make it more comfortable for her. The scripts (See Appendix B & C) differed by counseling technique, one where role playing was the primary technique used, and the other script where covert modeling was the primary technique.

A discussion of the contents of the scripts and desired counselor behavior, as well as the desired effect for the tape preceded the actual videotaping. Changes in the script were made jointly with the experimenter, counselor, and client. Practice sessions continued until the experimenter, the counselor and client agreed that the perform-
ance of their roles would be perceived as realistic counselor and client behavior. The practice videotaped sessions also continued until the counseling techniques were thought to be presented accurately and clearly to subjects that participated.

After several practice sessions were completed and reviewed, the videotaping of the counselor and client performing both scripts resulted in the two tapes that were actually used for this study.

Client

The client's role was portrayed by a second year graduate student who had also completed at least three counseling practicums. Demographically, the client was a white female in her mid twenties. Two scripts were also given to the client two days prior to the videotaping. The same instructions were given to become familiar with the written counseling scripts and make changes that would make her more comfortable in her role. The client role focused on the client's inability to express feelings, ideas, needs, opinions, etc., to others, particularly her parents, and specifically requests assertiveness training. The client's role is marked by a lack of self-confidence and fear of expressing true feelings.
Scripts

The two scripts (See Appendix B & C for actual scripts) were devised to represent two different and contrasting counseling techniques used in individual as well as group assertiveness training. Script 1 was entitled the role playing technique which was based on similar scripts used in sample individual assertiveness training sessions used as related by Rimm & Masters in *Behavior Therapy* (1974). Script 2 was entitled the covert modeling technique, which was also based on the same scripts as related by Rimm and Master's *Behavior Therapy* (1974), while substituting covert modeling techniques in the covert modeling videotape. Two issues which became areas of consideration when devising the tapes were comparability and differentiation of the two techniques.

The experimenter wanted to insure that the only difference between the tapes was due to a manipulation of the counseling technique. Comparability was attempted by devising the tapes in such a manner that the length and content area of both Script 1 and 2 were similar.
The purpose of this study is to examine, of the two techniques, role playing and covert modeling, which one would be perceived more therapeutically valuable in individual assertiveness training. Perceived therapeutic value will be defined in this study as the degree to which a potential client feels he or she would become more assertive as a result of participating in the counseling technique (treatment) the counselors use in the 15 minute videotaped counseling session. The second purpose of this study will be to attempt to identify some of the factors that seem most significant in affecting one's perceived therapeutic value of that technique (role playing or covert modeling) which is rated significantly higher in this study.

The subjects' tasks in this session will be the following:

1. Fill out the biographical data sheet and answer the general questions on assertiveness after carefully reading the definition of assertiveness.

2. Answer the Assertive Inventory (Cheek's 1976) as honestly as possible to get a general idea of how assertive you see yourself. This kind of inventory is sometimes given to clients to help the counselor as well as yourself assess the need for assertiveness training.

You are about to view two tapes of two different
counseling techniques that are both used in individual as well as group assertiveness training. After viewing these tapes, I would like for you to record your reactions immediately on the Value of Counseling Technique Questionnaire and then the Perceived Therapeutic Value Semantic Differential Scale. Please watch these tapes closely, and imagine yourself the client in these tapes, and rate on the VCT questionnaire and the PTV Scale how therapeutically valuable (the degree to which you would become more assertive by participation in the counseling technique) this counseling technique would be for you.

We will now go through the questionnaires together. Please feel free to ask any questions you may have about the questionnaires or the experiment in general. If you wish to receive information about the results of this study, please write your name, address, and telephone number on the biographical data sheet. I will provide you a summary of the study as soon as it is available.

At the end of each session, interested subjects were informed of the exact purpose of the experiment in more depth. The statement given was:

My interest as an experimenter was to look only at your perceived therapeutic value of role playing and/or covert-modeling, and determine which of the two, was perceived more therapeutically valuable, and to identify those factors that
were rated most significant in influencing your perceived therapeutic value.

**Conditions**

Two treatment conditions were utilized as the two counseling techniques were examined by the difference or non-difference in perceived therapeutic value in individual assertiveness training. Subjects were randomized across the counseling technique variable.

**Instrumentation**

Four instruments were used in this exploratory study of perceived therapeutic value in assertiveness training. At the beginning of each experimental session, each subject
was given a biographical data sheet (See Appendix A) to collect demographical information, included questions to assess the subjects familiarity with assertiveness training, and questions to give the subject an opportunity to do a brief self-assessment of their assertiveness skills. (See Appendix D).

The second instrument that was given to all subjects prior to the viewing of the tape was the Assertive Inventory (Cheeks 1976). This 20 item inventory was given to each subject primarily to serve as a self-assessment tool, in order to provide a rough picture of the extent to which the respondent thinks he or she needs help in being assertive.

The particular problems to which the client answers "yes" provide specific areas for the counselor/therapist to focus upon and later use for practice. Answers to the last four questions (#17, #18, #19 and #20) were designed specifically to provide insight into how the client is socialized and influenced by parents, teachers, or others. (Cheeks, 1976). These questions were developed to provide clues as to how much time may need to be spent in reorienting the client and preparing him or her to appreciate the value of assertiveness (Cheeks, 1976). Particular attention to several of the items of the Inventory (#2, #7, #8, #9, #10, #12, #16, #18, #19) will
assist the counselor to determine the extent to which anxiety is a major factor limiting the client's assertiveness (Cheeks, 1976). If the answer to all these items is yes, the facilitator or counselor may wish to examine the anxiety factor in greater depth.

The Assertive Inventory (Cheeks, 1976), even though it is fairly new and has not been widely researched, it has been the assertiveness inventory most commonly used at the Counseling and Consultation Services at the Ohio State University in their individual and group assertiveness training. Most likely if one of the subjects (a potential client for assertiveness training) in this study were to request assertiveness training, the Assertive Inventory (Cheeks, 1976) would be given to them prior to the actual assertiveness training.

After the viewing of the 15 minute videotaped counseling session, a third instrument was given to the subjects, The Value of Counseling Technique Questionnaire (Powell, 1979), which was developed by extracting items from Treatment Credibility/Expectancy for Improvement Scale by Borkovec-Nau (1972). Subjects were asked to indicate their feelings about their own treatment procedure by responding to each of the five CRED items on a 10 point scale. (See Appendix F). Credibility rating scores are summed over
the five items of the scale. While Borkouec and Nau (1972) do not present reliability data, some evidence for the scale's validity is provided by Nau, Caputo and Borkouec (1974). For example, credibility ratings were found to correlate positively with simulated treatment responses in three different experiments (r=30, 38 and 60, respectively).

The Value of Counseling Technique Questionnaire is an experimental instrument, and was tested for reliability in this study in measuring the subject responses to the perceived therapeutic value (r=86).

The fourth instrument the subjects completed to measure for the perceived therapeutic value of role playing and covert modeling was the Perceived Therapeutic Semantic Differential Scale. Items were selected to assess a subject's perceived therapeutic value of role playing or covert modeling.

Although the semantic differential is often referred to as if it were some kind of test, having some definite set of times and a specific score, this is not the case. To the contrary, it is a very general way of getting at a certain type of information, or a highly generalized technique of measurement which must be adapted to the requirement of each research problem to which it is applied.

There are no standard concepts, and no standard scales. Rather the concepts and scales used in this study depended
upon the purposes of the research. Standardization and hence comparability lies in the allocation of concepts to a common semantic space defined by a set of general factors, despite the variability in the particular concepts and the scales employed. (Osgood, Suci and Tannebaum, 1971).

The selection of the scales used in the Perceived Therapeutic were based on the three Value Semantic Differential following criteria:

1. **Factorial Composition** - five scales were selected to represent each factor, these being maximally loaded on that factor and minimally others. This provided the subjects with a balanced space which he or she actually used as they saw fit, if he or she made more discriminative use of the evaluative factor relative to others this would be shown in our data.

2. **Relevance to concepts being used** - for example in judging a concept like role playing, the evaluative scale used (worthless-valuable) is highly relevant to perceived therapeutic value of role playing, wherein large or small scales would have had no relevance to this study. This is a valid concern for construction of the scales for this instrument, due to their resulting in neutral response (which would be 4 on the 1 through 7 scale) which also reduces the amount of information that would be gained with a given number of scales.
3. **Semantic stability** - this refers to whether the scales provided for each concept could be expected to be stable across a set of counseling concepts.

**T-Test for differences** - due to the small sample of 66 subjects and the experimenter's primary interest to explore for significant difference of the perceived therapeutic value of role playing vs. covert modeling, a standard t-test was employed for statistical analysis of this study.
CHAPTER FOUR

Results

This chapter presents the results of the analysis of the data obtained from in each of the two conditions in this study. Initially the means and standard deviations for each of the pertinent scores will be presented for both groups and compared.

**Perceived Therapeutic Value** - The experimental hypothesis for this study was that the role-playing subjects will score significantly more positive on the Perceived Therapeutic Value Semantic Differential Scale than the covert modeling subjects. Based on the results of the statistical analysis of the data, role-playing was perceived more therapeutically valuable than covert modeling. The t-test differences for the separate variance estimate of perceived therapeutic value can be found in Table 1.

The means and standard deviations for the perceived therapeutic value of the role-playing and covert modeling subjects is illustrated in Table 6. In the final analysis of the perceived therapeutic value, there was significant difference.

On the perceived therapeutic semantic differential
scale, the role-playing subjects reported higher perceived therapeutic value than the covert modeling subjects. Of the three variables measured, the perceived therapeutic value was the primary variable under question. There was a significant difference between the role-playing and covert modeling group.

After the subjects in each condition viewed the role-playing or the covert modeling technique, the role-playing group had a mean value of 266.06.

While their covert-modeling counterparts achieved a mean value of 239.45. This is a strong indication that the role-playing group scored higher on the Perceived Therapeutic Semantic Differential Scale, than the covert modeling group with a significant T-value of 2.19.

The role-playing group responded in a significant and more positive way. They hypothesis was proven to be true which stated that the role-playing group would score significantly more positive than the covert modeling group.

Using the t-tests to measure for significant differences, the active participation, expertness, and attractiveness dimension were the main differentiating factors contributing to the role playing technique showing a significantly higher degree of perceived therapeutic
value than the covert modeling technique.

It was found that active participation in a counseling technique was the most important factor that contributed to high perceived therapeutic value and that the counselor's attractiveness was the least important factor that contributed to perceived therapeutic value.

Assertiveness - The hypothesis that the role-playing group might perceive themselves more assertive than the covert modeling group, was analyzed through the Assertive Inventory. This instrument was used to examine for a subject's perceived need for assertiveness.

This hypothesis did not prove to be true, and no significant difference was found on the perceived assertiveness variable between the two groups. The t-values for the perceived assertiveness variable can be found in Table 2.

The means and standard deviations for the perceived assertiveness variable can be found in Table 3.

Value of Counseling Technique - On the Value of Counseling Technique Questionnaire measuring for the subject's perceived therapeutic value of the counseling technique role-playing or covert modeling, Group 1 (the role-playing group) also scored higher on this variable. Even though the role-playing group did score higher on this variable, the analysis of the value of counseling technique indicated
no significant difference between the two groups.

There is a slight positive direction in the means between the two groups (See Table 4). This could be due to the test items lack of sensitivity to successfully measure the subject's attitudes towards the value of the counseling technique of role playing or covert modeling. These results are illustrated in Tables 4 and 5.

The reliability data of the instruments used in this study can be found in Table 7. This table was included in the results section to illustrate the reliability results of the instruments which were designed and used for the first time in this study. These results can be found in Table 7.
Table 1
T-Test Separate Variance Estimate of Perceived Therapeutic Value Scale between the Role-Playing and Covert Modeling Groups.

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>T-Value</th>
<th>Degree of Freedom</th>
<th>1-tail Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role-playing</td>
<td>33</td>
<td>2.19</td>
<td>51.85</td>
<td>*</td>
</tr>
<tr>
<td>Covert Modeling</td>
<td>33</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Probability less than .05
* p < .05
Table 2
Means and Standard Deviations for Perceived Assertiveness in Role-playing and Covert Modeling Groups.

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>Means</th>
<th>Standard Deviations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role-playing</td>
<td>33</td>
<td>28.12</td>
<td>4.241</td>
</tr>
<tr>
<td>Covert Modeling</td>
<td>33</td>
<td>25.12</td>
<td>6.146</td>
</tr>
</tbody>
</table>
Table 3
T-Values for Perceived Assertiveness in Role-playing and Covert Modeling Groups.

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>t-Value</th>
<th>Degrees of Freedom</th>
<th>2-Tail probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role-playing</td>
<td>33</td>
<td>1.77</td>
<td>64</td>
<td>0.41</td>
</tr>
<tr>
<td>Covert Modeling</td>
<td>33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>n</td>
<td>Mean</td>
<td>Standard Deviation</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>----</td>
<td>-------</td>
<td>--------------------</td>
<td></td>
</tr>
<tr>
<td>Role-playing</td>
<td>33</td>
<td>101.8091</td>
<td>15.477</td>
<td></td>
</tr>
<tr>
<td>Covert Modeling</td>
<td>33</td>
<td>100.3059</td>
<td>12.802</td>
<td></td>
</tr>
</tbody>
</table>
Table 5
T-Test Pooled Variance Estimate for Role-Playing and Covert Modeling Subjects on the Value of Counseling Technique Questionnaire.

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>T-Value</th>
<th>Degrees of Freedom</th>
<th>2-Tail Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role-playing</td>
<td>33</td>
<td>.38</td>
<td>64</td>
<td>.706</td>
</tr>
<tr>
<td>Covert Modeling</td>
<td>33</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 6
Means, Standard Deviations for Role-playing and Covert Modeling on the Perceived Therapeutic Semantic Differential Scale.

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role-playing</td>
<td>31</td>
<td>266.06</td>
<td>60.125</td>
</tr>
<tr>
<td>Covert Modeling</td>
<td>33</td>
<td>239.45</td>
<td>35.487</td>
</tr>
</tbody>
</table>
Table 7
Alpha Coefficients for the Instruments Used in Study Based on All Subjects.

<table>
<thead>
<tr>
<th>Name of Instruments</th>
<th>No. of Items</th>
<th>N-Count</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>VCT</td>
<td>14</td>
<td>66</td>
<td>.86</td>
</tr>
<tr>
<td>F</td>
<td>21</td>
<td>66</td>
<td>.30</td>
</tr>
<tr>
<td>E</td>
<td>23</td>
<td>66</td>
<td>.81</td>
</tr>
<tr>
<td>D</td>
<td>13</td>
<td>66</td>
<td>.82</td>
</tr>
<tr>
<td>C</td>
<td>9</td>
<td>66</td>
<td>.66</td>
</tr>
<tr>
<td>B</td>
<td>14</td>
<td>66</td>
<td>.73</td>
</tr>
<tr>
<td>A</td>
<td>20</td>
<td>66</td>
<td>.68</td>
</tr>
</tbody>
</table>

Note: This chart was included in the results section, even though these scales are scales by definition, not by measurement by quality. All these scales were specifically designed for this study, and were constructed from items on already existing scales. Overall, all these scales proved to be sufficiently reliable in measuring the variables under investigation.
Table 8
Alpha Coefficients for the Instruments Used in Study Based on All Subjects.

<table>
<thead>
<tr>
<th>Name of Instruments</th>
<th>No. of Items</th>
<th>N-Count</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>VCT</td>
<td>14</td>
<td>66</td>
<td>+.86</td>
</tr>
<tr>
<td>F</td>
<td>21</td>
<td>66</td>
<td>+.50</td>
</tr>
<tr>
<td>E</td>
<td>23</td>
<td>66</td>
<td>+.85</td>
</tr>
<tr>
<td>D</td>
<td>13</td>
<td>66</td>
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<td>C</td>
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<td>+.66</td>
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<td>B</td>
<td>14</td>
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<td>A</td>
<td>20</td>
<td>66</td>
<td>+.68</td>
</tr>
</tbody>
</table>

Note: This chart was included in the results section, even though these scales are scales by definition, not by measurement by quality. All these scales were specifically designed for this study, and were constructed from items on already existing scales. Overall, all these scales proved to be sufficiently reliable in measuring the variables under investigation.
CHAPTER FIVE

Summary and Conclusions

The assertiveness training movement has had a significant impact on many areas of the counseling field. The basic tenet in the movement is to make individuals aware of their individual rights to openly express their feelings in an open, honest and direct manner. Several theoreticians--Andrew Salter, Joseph Wolpe, Arnold Lazarus, Robert Alberti, and Michael Emmons--are usually credited with developing the major concepts employed in assertiveness training.

Andrew Salter is recognized as the first therapist to deal systematically with assertiveness, although using somewhat a different term. (Salter, 1949) In his 1949 book, Conditioned Reflex Therapy, he presented the concept of "excitatory behavior" and discussed the importance of "feeling talk"--an uninhibited direct expression of feelings. Similarly, Wolpe (1969), first to use the term "assertive training", refers to getting rid of inhibiting feelings as "deconditioning" of unadaptive anxiety habits of response to people whom the patient interacts. The whole idea is to teach individuals to behave in such a way as to deal with or control their fears, anxieties and inhibitions which prevent them
from expressing their real feelings. As Wolpe says, "Assertive behavior is defined as the proper expression of an emotion other than anxiety towards another person."

Lazarus (1971), taking a somewhat different position, has warned us that many people associate assertive training with one-upmanship and other deceptive games and ploys which Wolpe includes under this heading and which have no place in the forthright and honest expression of one's basic feelings. Thus, Lazarus feels there are other areas of expression which are not included in the concept of assertiveness. He contrasts assertiveness with the idea of "emotional freedom" which would include subtleties of love and affection, empathy and compassion, admiration and appreciation, curiosity and interest, as well as anger, pain, remorse, skepticism, fear and sadness. Lazarus points out that training in "emotional freedom" implies the recognition and appropriate expression of each and every affective state. Although the goals of assertive behavior training are geared to the freedom of people to express themselves, it must be recognized that other modes of expression are also available.

How a person may develop assertive responses for situations which had in the past encouraged aggressive or non-assertive behavior is dealt with by Alberti and Emmons. In their book, Your Perfect Right (1974) they provide a clear distinction between behavior that is assertive and behavior
that is aggressive or non-aggressive. In a non-assertive response, the person is typically denying self and is inhibited from expressing his or her actual feelings. Aggressive behavior commonly results in a "put down" of the recipient. The person's rights have been denied, and he or she feels hurt, defensive and humiliated.

Assertive behavior is self-enhancing for that person, and an honest expression of his or her feelings. There are two additional writers who have contributed directly or indirectly to present day assertive training techniques. One is J. L. Moreno (1946, 1955), who is most recognized as the founder of psychodrama.

Psychodrama involves the staged dramatization of the real life attitudes and conflicts of the participating clients. It strongly emphasizes spontaneity and improvisation, elements that Salter stressed. As a role-playing strategy, psychodrama is similar to one of Wolpe's principal assertive techniques, behavior rehearsal.

However, the goals of psychodrama, including catharsis and insight, are not usually thought of as consistent with a behavioral approach. A second writer whose contributions are at least indirectly related to current assertive training practices is G. Kelly (1955). In brief, the approach which is a mixture of cognitive and behavioristic psychology, involves deriving a personality sketch of a fictitious individual
who is free of the anxieties and behavioral inadequacies troubling the client; and the client is then instructed to assume this role.

This includes behaving in a manner consistent with the role, but in addition, adopting the fictitious person's way of perceiving the world, hopefully until he no longer feels he is assuming a role. The role-playing features of fixed-role therapy are rather similar to behavior rehearsal techniques used in assertive training. Although assertive training does not specifically aim at modifying cognitions, some case histories suggest that individuals do indeed undergo attitude change as a consequence of treatment, especially in relation to self-perception. It has not been uncommon for some clients who have successfully completed assertive training to describe him or her self as a "new person." Similarly, although the goal of fixed-role therapy is not specifically stated in terms of increased assertiveness, it appears likely that such would often be a consequence of treatment.

All these theories have had a widespread influence on the techniques that have been used in modern assertive training programs. Role-playing and covert modeling have been the two primary techniques that have been used in individual as well as group assertiveness training.
Two major types of research that have been conducted in this area are empirical studies that have done numerous case histories and controlled experimental studies for individual and group assertiveness training. In recent years, a rather large number of case histories employing assertive training procedures have been published. In the vast majority of these reports, assertive training was not the only method used. Frequently, relaxation training and systematic desensitization were also employed, as in the large-scale reports of Wolpe (1958) and Lazarus (1963).

Thus, improvement rates for assertive training per se, based upon a large enough sample to be reliable, are not presently available. A more valid assessment of the efficacy of assertive procedures can be found in the controlled experimentation studies.

One type of study which seems to be a logical next step from this present study would be to increase the number of subjects to 100, select subjects based upon a reported high degree of need for assertiveness training, have all subjects actually participate in individual assertiveness training with a counselor, with half the sessions using role-playing and the other half using covert modeling for a prescribed amount of time. After the completion of training, the students' progress should be compared between the two techniques, as to what is reported to be the most therapeutically valuable.
by the subject, along with comparing the student's actual progress under each technique. The purpose of this study was to examine the perceived therapeutic value in an analogue study, but also to include relative measures of the impact and importance of perceived therapeutic value in affecting the success of assertive training as reported by potential clients.

The most significant finding in this research was the differential rating the perceived therapeutic value of role-playing and covert-modeling between the two groups of subjects on the Value of Counseling Technique Questionnaire and the Perceived Therapeutic Value Semantic Differential Scale.

Implications and Recommendations for Future Research

One of the major purposes of this methodology was to simulate actual counseling center practices, where the Assertive Inventory (Cheeks, 1976) serves as intake instrument to find out clients perceived need for assertiveness training. The client is then given a chance to select role-playing or covert modeling as the primary technique to be used. Based on information provided by the client, the counselor would select the technique perceived most valuable by the client in developing assertive behavior.
It is unrealistic to expect that the client's high perceived therapeutic value of one technique over another would be ignored to the point that he or she would not be given preference of a technique by his or her counselor.

In the case of this exploratory study, if the number of subjects was greater and actual assertive behavior measures were included in the design, a stronger statement could be made for the significant results. In addition, this study in essence examined subject's perceived therapeutic value of role-playing or covert-modeling based on fifteen minute excerpts of individual assertive training sessions. No actual measure of how the perceived therapeutic value may affect the outcome of assertiveness training was indicated. A recommendation for further research would be to use this design for the duration of an actual counseling relationship, and determine if the effects differ from what resulted in this study. Whatever the recommendation may be, this research implies that at least in terms of perceived therapeutic value of counseling techniques used in counseling situations, specifically in assertive training, it is indeed impactful on the success of therapy as well as the counselor-client relationship. Further research examining perceived therapeutic value of other counseling techniques is needed to determine if this significant finding that role-playing was perceived more therapeutically valuable
than covert modeling in assertiveness training can be general-
ized to the perceived therapeutic value of other counseling
techniques in counseling situations other than asser-
tiveness training.

It is essential, through constant
research, clients and potential clients are given the oppor-
tunity to accurately report and provide feedback through
experimental and exploratory studies as to what techniques
are "viewed" therapeutically valuable, as well as those
techniques which "actually" are therapeutically successful
in specific counseling situations through reliable instru-
ments of measurement.

The field of counseling psychology has a constant
need for studies of the actual counseling process, for the
success of the counseling process is the core of all other
aspects of research conducted under this field.

Conclusions

The following conclusions can be made from the
results of this study:

1. In the descriptive data both groups modal response
implied that the most important factor to the therapeu-
getic value of a counseling technique (role-playing,
specifically) was active participation.
2. The least important factor to the therapeutic value of a counseling technique as reported by both groups of subjects was on the counselor attractiveness dimension.

3. Due to the exploratory nature of the study, for the study, and the small number of subjects used, the results of this study should only serve as a foundation study for a more intensive experimental study with an increase of subjects.
Biographical Data

Please provide the information requested below. All information will be used strictly for the purpose of this study and will be kept confidential.

Major

Age

Sex

Class rank

Have you ever read any articles or books about assertiveness?

Yes  No

Have you ever participated in an assertive training workshop or group?

Yes  No

Assume that assertiveness is defined as behavior that enables a person to act in his or her best interests, to stand up for herself or himself without undue anxiety, to express honest feelings comfortably or to exercise personal rights;

1. In general, how assertive are you?
   
   1  2  3  4  5  6  7
   (Not at all) (Extremely assertive)

2. How much do you vary from one situation to another in how assertive you are?
   
   1  2  3  4  5  6  7
   (Not at all) (Extremely Variant)

3. There are some areas in my interpersonal relationships where I should be more assertive.
   
   1  2  3  4  5  6  7
   (Not at all) (Extremely needed)
APPENDIX B
Script for Video-Tape  Role-playing Condition

Counselor: Based on our last session you said you were unable to express your true feelings to your parents about not wanting to come home for the summer. It seems as though you felt a lot of anger and resentment toward your parents who were insisting you come home.

Client: Yes I do feel angry and resent their disregard for my feelings and they make me feel so guilty, and I am so tired of going out of my way to please them.

Counselor: What other feelings do you have when you talk to your parents?

Client: Like I said I feel angry, guilty whenever I talk to them about plans I think they won't approve of. I get really tense and nervous whenever I start discussing my plans for the future, and sometimes my stomach gets in knots.

Counselor: So in other words your parents' actions make you angry and anxious to the point your stomach muscles tense up. Sounds like you are pretty miserable when the three of you have these discussions about your future.

Client: Yes I am, as long as I am going along with my parents plans for me everything is fine, but the minute I want to speak up for "my" plans I feel myself getting angry, nervous and feel like a defenseless child.

Counselor: Just pretend for a minute you were the sort of person who could tell someone off whenever they were bothering you. Whenever your parents get on your back. How would you feel then?

Client: Well, if I did tell them off, they would either be so hurt, say I was disrespectful which would make me feel guilty and get angry with myself as well as them for always backing down for things I really want. It's just not worth the headache.

Counselor: No, wait. Suppose you were good at telling your parents what you were going to do and they would listen to what you had to say. How would you feel then?
Client: Right now it's hard to imagine if I will ever be able to tell them what I want for myself without feeling guilty or nervous. I just want them to let me run my own life, and wouldn't mind visiting home more often. But it's so hard telling them what I want I just wasn't raised that way.

Counselor: Could you tell me what you mean.

Client: Well, I guess I've always felt telling people off, especially parents, or attacking them, was wrong. After all my parents are helping me finance my college expenses, even though I do work and they send me money when I run out. I guess I don't even have the right to tell them off.

Counselor: Do you think your parents have the right to run your life, just because they help you financially?

Client: No. But I guess way down deep I must think they do because they are my parents. (Pause) But they really don't. It is wrong.

Counselor: So, in other words people, not even parents, have the right to hurt your feelings and run your life for you.

Client: (Pause) Yes, I'll agree with that.

Counselor: Then don't you think people who dominated or attacked have the right to defend themselves? Even if it means defending themselves in a natural and reasonable controlled way.

Client: Well, I don't know (tentatively) Yes, I can see your logic I guess it would make more sense for me to defend myself. But I always clam up when anyone criticizes me especially my parents.

Counselor: I think there are somethings we can do to help you express yourself more freely and help you to defend yourself and not clam up. What I would like for us to try for a few minutes is to act out as exact as you can remember the last incident when you told your parents you had a job in Columbus and didn't want to come home for the summer.

Client: How should I start this? (displaying some nervousness)
Counselor: Well, I want you to set the stage for the discussion, you play the role of you of course and I'll be your parents. Pretend that I am your parents and you've just told them you want to talk to them about your plans for the summer. Make sure I act like your parents.

Client: Okay, I'll try to start. Mom and Dad I know you want me to come home for the summer and work on my old job, but I already have a job in Columbus and want to keep it through the summer.

Counselor: (Father) Well, Mary, we already have made arrangements with your old employer and promised your grandparents we would visit them this summer. We don't think you should keep that job at McDonald's, it's just not a "real" job anyway, it couldn't possibly be paying much.

Client: (Angrily) You always do that without checking with me first! Now Mr. Jackson is expecting me to work, and Grandma and Granddad will think I don't want to see them because it's been 2 years since I visited them because they've been in Switzerland (long sigh) well ... I guess I might be able to change my plans since you've promised them already.

Counselor: Well let's stop here, you began by first acknowledging what your parents wanted first, and your wants second and you sounded kind of apologetic for having made your own plans. It seems as though you put your wants second, and should just acknowledge your wants first. After your father said his piece, you got angry, you backed down and immediately started juggling plans out of guilt in not pleasing others involved. Let's try reversing roles for a minute. You be your father and I'll be you.

Client: O.K. ... (as father) We have already arranged for you to get your old summer job and told your grandparents you would be coming with us to visit them and anyway your job at McDonald's is not a (emphasize) "real" job. Your mother and I know you do better than that here in Maryland (with a slight laugh).
Counselor: (As the client) I have already made arrange-
ments to work through the summer along a work
study job in my field and it’s what I really
want to do this summer, and I’ll be starting
next week.

Client: (As father) Your mother and I insist you come
home after the spring quarter. You really can
do better than McDonald’s at the auto factory
and your grandparents would be so disappointed
if you don’t go with us to visit them. Besides
we deserve some of your time to spend with us.
So change your plans as soon as you can, and
make arrangements to come back home after the
spring quarter.

Counselor: (As client) Dad, I know you and mom care a
great deal about me and that is important.
But I told you I would be staying in Columbus
if I had a job, especially on campus with the
social work department and have made arrange-
ments to work here for the summer to get some
experience in my field.

Counselor: Now, why don’t you try something like that?
you be yourself and I’ll be your father.
(As father) I insist you come home, your
mother and I are looking forward to you coming
home. We only want what is best for you dear.

Client: I know you love me and I do appreciate it, but
I’ve given it a lot of thought and I think it
would be best for me to stay in Columbus
so I get some experience in my field, so I
can apply for one of the better internships
that require some experience in order to apply.

Counselor: That was certainly better! How did you feel?

Client: A little anxious, but I felt really confident
and felt good about telling them what was best
for me, and feeling they would actually be
listening to me.

Counselor: Do you think you feel comfortable enough to
try that sort of thing out?

Client: Yes, but with a little more practice.

Counselor: Okay, let’s go through the whole thing now.
Counselor: Based on our last session you said you were unable to express your true feelings to your parents when you had made plans and most recently when you told your parents you weren't coming home for the summer and they insisted that you come home. It seems as though you feel angry and guilty toward your parents about wanting to do what your parents want and not being able to stand up to your parents.

Client: Yes, I do feel angry when my parents disregard my feelings and guilty and they always have a way of making me feel I am obligated to let them play my life. I am so tired of going out of my way to please them.

Counselor: It sounds like you are very frustrated and really want to do something to relieve those feelings of anger.

Client: Like I said before I feel angry, guilty whenever I talk to them about plans made on my own I think they won't approve of. I get really tense and nervous whenever I start discussing my plans for the future and sometimes my stomach gets into knots.

Counselor: So it seems as though your parents responses make you angry and anxious to the point your stomach muscles tense up. Sounds like you are pretty miserable when the three of you have these discussions about your future.

Client: Yes, I am as long as I am going along with my parents and their plans for me, everything is fine, but the minute I want to speak up for my own plans I feel myself getting angry, nervous and feel like a child.

Counselor: From what I'm hearing you really want to be able to freely express yourself to your parents and take control of making plans and decisions for your own self. I think we can do some things in our sessions to help you become more assertive in your interactions with your parents, and others as well. Would you be interested in working on these concerns?
Client: Yes, I really want to be able to express myself and be more open and honest in my relationships particularly with my parents by standing up for my own interests and rights as my own person.

Counselor: Well, maybe we will start what we call some assertiveness training which simply are methods of dealing with specific situations where you want to express yourself more freely, express that justified anger toward your parents or anger with self-control and whatever other situations you would like to work through.

Client: Well, I'm ready to start whenever you are. What will I have to do?

Counselor: Well, first I would like to set up a situation as closely as possible to the feelings and experiences you would have in a real life situation. Let's use the situation with you telling your parents about your plans for the summer.

Client: Okay, what will I have to do now?

Counselor: Now, I would like for you to go over the situation in your imagination. Now, close your eyes and imagine yourself bringing up your plans for the summer to your parents. Let yourself respond in whatever way you feel.

Client: Silent, imagines scene.

Counselor: Well, what do you feel, what happened this time?

Client: Well, I imagined myself telling my parents I was old enough and mature enough to make my own decisions and I think I had deserved a chance to start making my own plans and decisions for my best interests.

Counselor: How were you feeling while imagining yourself expressing yourself freely to your parents?

Client: I was nervous, but still I was very confident about myself, and began to feel I was gaining a sense of independence from my parents.

Counselor: How did you imagine your parents responding?
Client: They were still insisting I come home but they began to listen to what I had to say.

Counselor: How did that make you feel?

Client: I felt relieved to know that I had finally got them to begin to see my point of view, and accept my judgement for my own self.

Counselor: What were some things that you did not include in your imagined scene that you think were important?

Client: I was afraid to imagine how it would have been if my mother started crying as she sometimes does, nor my father making me feel guilty about taking money, and not spending time with them in return to show my appreciation.

Counselor: Okay, this time I want you to go over the same situation in your imagination adding these two factors. Close your eyes and imagine yourself in having started the discussion, and your mother is crying by now, and next your father is talking about the money he spends to help support you. Let yourself respond to whatever you feel.

Client: Silent, imagines scene.

Counselor: Okay, I'll be you for a few minutes, okay tell me what's happening and how you're feeling.

Client: I am yelling at my father for making plans and apologizing to my mother for making her cry and telling her I still like home but I really want to stay in Columbus, but if it upsets her that much I'll change my plans.

Counselor: What if you said something like this, "Mom and Dad, I know you both care for me a great deal and are concerned about my welfare, but I don't think you realize how hard it is for me to continue pleasing everyone but myself and feeling angry, resentful, guilty, but then wanting to be in control of my life and decisions. I need to start acting in my best interests right now, and I've got to learn to take care and be responsible for myself in order to make it. So, I'm making a start this summer and I think it's what is best for me,"
if I find out otherwise I will have to live with the decision by correcting my mistakes and doing better the next time.

Client: In my imagined scene all I saw was me getting angry and feeling guilty which leads me to just give in. I have never been able to express my feelings and to stand up for myself at the same time. I would really like to try that with you.
APPENDIX D
<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
<th>Not Sure</th>
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<tbody>
<tr>
<td>1.</td>
<td>I would hesitate to write a complaining letter to a business or company</td>
<td>yes</td>
<td>no</td>
<td>not sure</td>
</tr>
<tr>
<td>2.</td>
<td>At times I want to say things but I don't</td>
<td>yes</td>
<td>no</td>
<td>not sure</td>
</tr>
<tr>
<td>3.</td>
<td>I hesitate to take things back to the store</td>
<td>yes</td>
<td>no</td>
<td>not sure</td>
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<td>4.</td>
<td>I get convicted to do things that I don't want to do</td>
<td>yes</td>
<td>no</td>
<td>not sure</td>
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<tr>
<td>5.</td>
<td>I find it hard to tell someone near me to stop smoking</td>
<td>yes</td>
<td>no</td>
<td>not sure</td>
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<tr>
<td>6.</td>
<td>It is difficult for me to ask my friends for help</td>
<td>yes</td>
<td>no</td>
<td>not sure</td>
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<tr>
<td>7.</td>
<td>I spend a lot of time avoiding conflicts</td>
<td>yes</td>
<td>no</td>
<td>not sure</td>
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<tr>
<td>8.</td>
<td>I find it difficult to openly express love and affection</td>
<td>yes</td>
<td>no</td>
<td>not sure</td>
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<tr>
<td>9.</td>
<td>I find it hard to tell people no</td>
<td>yes</td>
<td>no</td>
<td>not sure</td>
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<tr>
<td>10.</td>
<td>I frequently have opinions that I don't express</td>
<td>yes</td>
<td>no</td>
<td>not sure</td>
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<tr>
<td>11.</td>
<td>I find it hard to disagree with people close to me</td>
<td>yes</td>
<td>no</td>
<td>not sure</td>
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<tr>
<td>12.</td>
<td>I hesitate to speak up in a group discussion or argument</td>
<td>yes</td>
<td>no</td>
<td>not sure</td>
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<td>13.</td>
<td>When I plan to be busy, people can keep me from doing things</td>
<td>yes</td>
<td>no</td>
<td>not sure</td>
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<tr>
<td>14.</td>
<td>I usually would rather go along with someone I don't really know rather than have a disagreement or argument</td>
<td>yes</td>
<td>no</td>
<td>not sure</td>
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</table>
15. I usually have to get angry before I say what I want to say
   yes  no  not sure
16. I have a lot of concern about expressing myself and hurting someone's feelings
   yes  no  not sure
17. I have been taught it is not right to raise your voice or risk hurting someone's feelings
   yes  no  not sure
18. I consider it wise to avoid arguments
   yes  no  not sure
19. I believe that people should keep their angry feelings to themselves
   yes  no  not sure
20. Being liked is very important to me
    yes  no  not sure
Value of Counseling Technique Questionnaire

Listed below are fourteen questions designed to assess your reactions to the treatment given to the client in the video tape. Please answer each question as if you were the client in the tape, by placing an "X" at the point of the scale which most closely approximates your feelings about the technique.

1. How logical does this type of treatment seem to you?
   1  2  3  4  5  6  7  8  9  10
   Not at  Extremely all logical logical

2. How confident would you be that this treatment would be successful in helping you become assertive in your interpersonal relationship with others?
   1  2  3  4  5  6  7  8  9  10
   Not at  Extremely all confident confident

3. How confident would you be in recommending this kind of treatment to a friend in actual counseling situation specifically in dealing with or developing assertive skills to deal with interpersonal interactions?
   1  2  3  4  5  6  7  8  9  10
   Not at  Extremely all confident confident

4. If you were extremely anxious and non-assertive in interpersonal interactions with others (such as parents, teachers, friends, etc.) would you be willing to undergo such a treatment technique?
   1  2  3  4  5  6  7  8  9  10
   Not at  Extremely all willing willing
5. How successful do you feel this treatment technique would be in increasing a person's assertiveness in most situations in general?

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<tr>
<td>Not at all successful</td>
<td>Extremely successful</td>
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6. How much control would you have as a client undergoing this treatment?

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<tr>
<td>No control</td>
<td>Extremely too much control</td>
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7. How much control would the counselor have in providing this treatment?

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<tr>
<td>No control</td>
<td>Extremely too much control</td>
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8. Do you feel that active participation of the client in a counseling method is important to the success of treatment in assertiveness training?

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<tr>
<td>Not important</td>
<td>Extremely important</td>
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9. How useful would this counseling technique be in dealing with other counseling concerns you would have in the future?

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<th>7</th>
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<th>9</th>
<th>10</th>
</tr>
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<tbody>
<tr>
<td>Not at all useful</td>
<td>Extremely useful</td>
<td></td>
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<td></td>
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</table>
10. How important would it be for the counselor to give feedback throughout the treatment?

1 2 3 4 5 6 7 8 9 10
Not at all important
Extremely important

11. How valuable would the counseling technique used in assertiveness training be for you?

1 2 3 4 5 6 7 8 9 10

12. How comfortable would you feel with the counselor using this technique in actual counseling?

1 2 3 4 5 6 7 8 9 10
Not at all comfortable
Extremely comfortable

13. How much influence does the counselor's expertness have on the technique being therapeutically valuable?

1 2 3 4 5 6 7 8 9 10
No influence at all
Extremely influential

14. How much does a counselor's attractiveness have on the success of the treatment?

1 2 3 4 5 6 7 8 9 10
Not at all important
Extremely important
Perceived Therapeutic
Value Semantic
Differential Scale

On Answer Key
Instructions: The purpose of this instrument is to measure your personal meanings of certain concepts by having you judge them against a series of descriptive scales. In taking these tests, please make your judgements on the basis of what these things mean to you. On each page you will find five different concepts to be judged and beneath each set of scales you are to rate the concept on each of these scales in order.

If you feel that the concept is very closely related to one end of the scale, you should place a checkmark as follows:

fair X::: unfair
or
fair ::::: X unfair

If the concept is quite closely related to one or the other end of the scale, place a checkmark as follows:

rough :::: smooth
or
rough ::::: X smooth

If the concept seems only slightly related to one side as opposed to the other side then check as follows:

active ::::: passive
or
active ::::: X passive
If you consider the concept to be neutral on the scale, both sides of the scale seem equally associated with the concept, or if the scale is completely irrelevant, unrelated to the concept, then place a checkmark in the middle space:

safe __________ X __________ dangerous

Make each scale a separate and independent judgement, do not look back and forth through the items, or try to remember how you checked items earlier in the test. Work at fairly high speed through this test without puzzling or worrying over individual items. It is your immediate feelings about the item that we desire.

IMPORTANT:
Place checkmarks in the middle of the spaces. Be sure you check every scale for every concept. Never put more than one checkmark on a single scale.

TURN THE PAGE
AND BEGIN
assertive unassertive
expressive unexpressive
honest dishonest
direct indirect
superior inferior
confident unconfident
sensitive insensitive
pursuing avoiding
outspoken quiet
sociable unsociable
incredulous gullible
brave cowardly
active passive
objective subjective
Concept # 2 Counseling

pleasureable :___:___:___:___:___:___ painful
reputable :___:___:___:___:___:___ disreputable
meaningful :___:___:___:___:___:___ meaningless
beneficial :___:___:___:___:___:___ harmful
approving :___:___:___:___:___:___ disapproving
critical :___:___:___:___:___:___ indiscriminate
important :___:___:___:___:___:___ unimportant
comfortable :___:___:___:___:___:___ uncomfortable
interesting :___:___:___:___:___:___ boring
Concept #3 Counselor

insincere ____________ sincere

cold ____________ warm

worthless ____________ valuable

ineffective ____________ effective

complicated ____________ simple

experienced ____________ inexperienced

expert ____________ inexpert

skillful ____________ unskillful

alert ____________ unalert

analytic ____________ diffuse

intelligent ____________ stupid

prepared ____________ unprepared

confident ____________ unsure
Concept: Role-playing

worthless ___:____:____:____:____:____:____ valuable
ineffective ___:____:____:____:____:____:____ effective
beneficial ___:____:____:____:____:____:____ harmful
comfortable ____:____:____:____:____:____:____ uncomfortable
useful ___:____:____:____:____:____:____ useless
meaningful ___:____:____:____:____:____:____ meaningless
therapeutic ___:____:____:____:____:____:____ untherapeutic
prohibitive ___:____:____:____:____:____:____ permissive
constrained ___:____:____:____:____:____:____ free
active ___:____:____:____:____:____:____ passive
complex ___:____:____:____:____:____:____ simple
sufficient ___:____:____:____:____:____:____ insufficient
progressive ___:____:____:____:____:____:____ regressive
Concept # 5  Covert Modeling

worthless _______ _______ _______ _______ _______ valuable
beneficial _______ _______ _______ _______ _______ harmful
comfortable _______ _______ _______ _______ _______ uncomfortable
ineffective _______ _______ _______ _______ _______ effective
useful _______ _______ _______ _______ _______ useless
meaningful _______ _______ _______ _______ _______ meaningless
prohibitive _______ _______ _______ _______ _______ permissive
limited _______ _______ _______ _______ _______ unlimited
active _______ _______ _______ _______ _______ passive
complex _______ _______ _______ _______ _______ simple
sufficient _______ _______ _______ _______ _______ insufficient
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