CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

ASSERTION TRAINING IN THE TREATMENT OF ALCOHOLISM

A thesis submitted in partial satisfaction of the requirements for the degree of Master of Arts in Psychology by

Rita L. Davis

May, 1975
The thesis of Rita L. Davis is approved:

Committee Chairperson

California State University, Northridge
May 15, 1975
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Dedication

To my parents for their loving and constant support and encouragement.
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ABSTRACT

ASSERTION TRAINING IN THE TREATMENT OF ALCOHOLISM

by

Rita L. Davis

Master of Arts in Psychology

May, 1975

Thirty-eight male inpatients in the Alcohol Treatment Program of the Sepulveda Veteran's Administration Hospital were randomly assigned to receive either assertion training, which utilized such techniques as behavioral rehearsal, modeling, and feedback in dealing with interpersonal problem situations, or to take part in a "rap" group in which problems of an interpersonal nature were discussed, but in which no assertion training techniques were employed. It was hypothesized that patients receiving the assertion training would show greater pre and post treatment attitudinal changes with respect to degree of assertiveness and locus of control over reinforcements. Both an analysis of variance and an analysis of covariance, utilizing age and severity of drinking as covariates,
revealed a significant difference \((p < .01)\) between the group mean difference scores for the two treatment groups on three separate assessment instruments. Implications of the results for possible future research were discussed.
SECTION I

INTRODUCTION

The view that addictive behaviors are operant and thus functionally related to their consequences has influenced treatment of obesity (Ferster et al, 1962; Stuart, 1971), cigarette smoking (Elliott and Tighe, 1968), and drug abuse (Polakow and Doctor, 1973; Polakow and Doctor, 1974). Recently, a wide variety of operant strategies have been widely applied to the treatment of alcoholism. Within the framework of a social learning approach to alcoholism, alcohol abuse is seen as a socially acquired, habitual behavior pattern maintained by reinforcement contingencies. Based on this view, a variety of therapies derived from the principles of conditioning have been used in alcohol treatment. A great number of studies have centered on the use of aversive conditioning techniques such as those employing emetics and electrical stimuli (Blake, 1965; Franks, 1966; Lavery, 1966; Quinn, 1967; and Rachman, 1969). Although some evidence exists in support of the former treatment method, it is yet unclear to what degree, if any, electrical aversion is an effective therapy procedure for alcoholism (Hunt and Azrin, 1973; Sobell and Sobell, 1972). In general, it appears that while aversion therapies may help to suppress urges in some patients temporarily, it is unlikely that they will provide a solution
to the complex problem of alcoholism (Miller and Barlow, 1973).

The view that alcoholics begin and continue drinking because the ingestion of alcohol is closely followed by a reduction in psychological stress or tension, i.e., that drinking is assumed to be reinforced by tension reduction, has long been advanced by proponents of both traditional and behavioral schools of thought (Fox, 1967; Jellinek, 1960; Wellman, 1955; Conger, 1956; and Ramond, 1964). Support for this hypothesis has come from self-reports of alcoholics and non-alcoholics (Alcoholics Anonymous, 1955; Jellinek, 1946; and Jellinek, 1952) as well as from animal laboratory studies describing the effects of alcohol on animals in stressful situations (Conger, 1951; Freed, 1968; Masserman and Yum, 1946; and Smart, 1965) and the self selection of alcohol by animals under these conditions (Cicero et al, 1968; Clark and Polish, 1960; and Wright et al, 1971). Studies relying mainly on the tension-reduction assumption have employed such behavioral techniques as covert sensitization (Cautela, 1966; Anant, 1967; and Ashem and Donner, 1968), systematic desensitization (Kraft, 1968), and relaxation training (Anant, 1967; Blake, 1965; and Lesser, 1969) as well as a combination of these procedures with aversive techniques (McBrearty, et al, 1968). The extent to which these approaches to the treatment of alcoholism constitute a practical advance
over aversion-only methods has not been assessed, but they do seem to represent a theoretical advance in that they attempt to modify drinking behavior by the manipulation of the factors presumed to be controlling the response, tension and its reduction (Hamberg, 1975).

More recently, the use of techniques aimed at eliminating tension via relaxation and desensitization have been deemphasized and instead, broader approaches have emerged that are designed to increase the probability of alternative responses in whatever situations have been most strongly related to drinking for the individual patient. This shift in emphasis appears to have been influenced by the literature supporting the relationship between interpersonal anxiety and assertiveness (Morgan, 1974). Assertiveness theory, first advanced by Wolpe (1958), assumes unadaptive social fears to be responsible for ineffectual behavior in social settings calling for assertive behavior. Assertive behavior in these same situations can be assumed to reciprocally inhibit fear (Wolpe, 1958). In his later writings, (Wolpe and Lazarus, 1966) Wolpe added that nonassertiveness may be due to a deficit of appropriate social skills in a person's repertoire.

Proponents of this view postulate that interpersonal situations requiring assertive behavior are tension provoking for alcoholics and trigger drinking because
alcoholics lack appropriate assertive behaviors (Hamberg, 1975). Support for this hypothesis comes from an experiment by Miller et al (1974) in which eight alcoholics and eight nonalcoholics were measured on the number of responses emitted to obtain alcohol after stress and nonstress social interactions. It was found that while both groups emitted about an equal number of responses to obtain alcohol after nonstress periods, alcoholics emitted a significantly greater number of responses in the stress situations than did nonalcoholics. The authors concluded that alcoholics are more likely than nonalcoholics to react to difficult interpersonal situations by increasing alcohol ingestion.

Thus, from a behavioral perspective, excessive drinking can be seen to be functional for the alcoholic in that it enables him to avoid or escape from unpleasant anxiety-producing situations. In addition, it has been suggested that the alcoholic may, when intoxicated, exhibit more varied, spontaneous social behavior and gain increased social reinforcement (Miller and Barlow, 1973). As a treatment method, assertive training has long been recognized as an effective approach for individuals who are inhibited by anxiety in interpersonal situations or who exhibit interpersonal deficits (Lazarus, 1966). Several experiments in recent years have demonstrated that assertive training procedures have successfully modified
specific behaviors related to social anxiety and assertiveness. One class of behaviors generally thought to be based upon conditioned unadaptive interpersonal anxiety responses is sexual deviations (Wolpe, 1973). The development of appropriate interpersonal functioning through assertive training has proven to be a successful treatment for a number of sexual disorders including exhibitionism, shoe fetishism (Wolpe, 1958), pedophilia (Edwards, 1972) and others (Stevenson and Wolpe, 1960). In each case, success was attributed to the fact that the patient's anxieties were interpersonal rather than sexual. In addition to sexual disorders, assertion training has also been shown to be an effective technique when used with other interpersonally based maladaptive behaviors including stuttering (Wendlandt, 1974; Dalali and Sheehan, 1974), phobias (Rimm, 1973), and marital conflict (Eisler et al, 1974).

Several broad-spectrum (Hamberg, 1975) treatment approaches to alcoholism have utilized the components of assertion training, e.g., behavioral rehearsal, modeling, performance feedback, instructions, etc. (Hersen et al, 1973) in conjunction with other behavioral techniques both within and outside of the hospital setting. Mertens (1964) employed an operant learning approach aimed at increasing self-control and promoting behaviors which are incompatible with drinking. Within his program, alternative ways
of handling problem situations were taught and reinforced by staff members. In a recent study by Hedberg and Campbell (1974) a group of alcoholics receiving behavioral family counseling, which employed several behavioral techniques including assertive training, was compared with a covert sensitization treatment group, a systematic desensitization treatment group, as well as an aversive conditioning treatment group and was found to be more effective than all three.

In addition to treatment programs whose goal is total abstinence, these broad-spectrum (Hamberg, 1975) approaches have been employed in treatment programs whose goal is controlled drinking. The belief that alcoholics can be trained to maintain stable patterns or controlled drinking is a new and controversial issue among professionals concerned with the treatment of alcoholism. Traditionally, today abstinence has been assumed to be the only legitimate therapeutic treatment goal and is based upon the belief that a physiological condition peculiar to alcoholics known as "loss of control" is responsible for an irreversible chain reaction which leads to excessive drinking; this reaction is assumed to be set off upon the ingestion of very small amounts of alcohol, e.g., "the first drink" (Alcoholics Anonymous, 1955; MacLeod, 1955; Marconi et al, 1970). Although this theoretical formulation has received overwhelming support among professionals in the treatment
of alcoholism, as well as among the public in general, there is little scientific evidence to support it (Keller, 1972). Furthermore, recent clinical investigations have demonstrated that some chronic alcoholics can return to, and maintain, moderate social drinking patterns (Davies, 1962; Kendell, 1965; Bailey and Stewart, 1969; Gerard and Saenger, 1966; and Reinert and Bowen, 1968).

The most recent studies employing broad-spectrum (Hamberg, 1975) approaches to programs who offer controlled drinking either as a primary or alternative treatment goal have showed promising results. Lovibond and Caddy (1970) devised a treatment program in which punishment of heavy but not moderate drinking was combined with training based on behavioral feedback which enabled the patient to discriminate his own blood alcohol concentrations. In addition, the patient was taught to functionally analyze the stimuli controlling and maintaining his drinking behavior, and to utilize alternative responses to heavy drinking, such as changing the pattern of ordering drinks, when his blood alcohol concentrations reached a certain, specified level. Follow-up revealed that 77% of the patients were completely or considerably improved. Sobell and Sobell (1972) employed individualized behavior therapy with alcoholics whose goal was either controlled drinking or total abstinence, and conventional group psychotherapy with a corresponding comparison group. The behavioral training
procedure emphasized identifying situations which were cues for heavy drinking, creating alternative responses to those situations, and practicing the responses under simulated conditions. A one-year followup revealed that 80% of the behavioral group was functioning well in regards to their chosen goal, as compared to only 33% of the comparison group (Sobell and Sobell, 1973).

The above studies provide strong evidence that broad-spectrum behavior therapy programs which utilize the training of alternative, more adaptive responses to situations which cue excessive drinking behavior can be considerably effective in treating alcoholism. However, the critical components of these various programs need to be investigated in order to shed some light upon their apparent effectiveness. In view of the promising results obtained using assertive training with other populations who exhibit maladaptive behavior in stress-producing social situations, this treatment procedure would seem to be a likely candidate for experimental investigation in the area of alcoholism.

The purpose of the present study was to determine whether assertion training can be used as an effective therapeutic procedure in the treatment of alcoholism. More specifically, the primary focus was on whether direct training in precisely those skills lacking in a patient's response repertoire within the context of specific
anxiety-producing situations could effect changes in self-report questionnaires which would be reflective of both increased assertiveness in interpersonal situations as well as of a more internal locus of control.

The concept of internal vs. external locus of control has recently received some attention in relation to alcohol treatment. This construct was first advanced by Rotter (1966) and refers to the degree to which an individual attributes control over reinforcements to himself. Thus, according to the theory, if an individual perceives reinforcements as being primarily controlled by external forces which may occur independently of his own behavior, he is said to have a more external locus of control. Conversely, if the individual perceives a more causal relationship between his own behavior and environmental reinforcements, his locus of control is assumed to be primarily internal. Carothers (1971), using Rotter's Internal-External Scale, found that successfully rehabilitated alcoholics have a more internal locus of control than do intemperate alcoholics. In the present study, it was hypothesized that assertion training would effect changes in an alcoholic's locus of control that would be towards the internal end of the control continuum.

A secondary purpose of the study was to lay the groundwork for future research which could direct itself toward evaluating the predictive value of the attitudinal
measures of assertiveness and locus of control in the
treatment of alcoholism. There has been an expressed need
in the literature on alcoholism for measures that would
estimate the probability of each patient's likelihood of
improvement so that the effect of a particular treatment
could be evaluated in relation to prediction. Some re-
search already conducted in response to this need has re-
vealed that attitudinal and mood measures are more predic-
tive of the prognosis of alcoholics than are life history
variables (Adamson et al, 1974). Evaluative research
regarding the predictive value of attitudinal measures
used in this study might shed further light on treatment
outcome of alcoholics.

Finally, the study attempted to provide data for pos-
sible follow-up research in which the efficacy of assertion
training as a detriment to drinking can be assessed.
SECTION II

METHOD

Subjects

Thirty-eight male inpatients admitted to the Alcohol Treatment Unit of the Sepulveda Veteran's Administration served as the sample for the study. The patients ranged in age from 26 to 64 with a mean age of 43. Patients on this treatment unit apply to the program on a voluntary basis and are admitted after careful screening by a team comprised of two to three staff members and one inpatient. During the screening procedure, each applicant is informed fully as to the nature and scope of the treatment program. (See Appendix A for a more complete discussion of the therapeutic procedures employed on the Alcohol Treatment Unit.) If admitted for treatment, the patient is required to sign a contract in which he agrees to abide by the rules and regulations of the ward and to cooperate fully with the treatment program. Patients remain in the program on an inpatient basis for four to five weeks and are followed up for two years.

Design

A repeated measures two treatment group design using two covariates was employed. The independent variable was group assertion training vs. a comparison "rap" group in
which problems of an interpersonal nature were discussed, but in which no assertion training took place. The covariables were age and severity of drinking. These variables were selected after a review of the literature revealed that conflicting results have been obtained in investigating their relationship to successful treatment outcome (Davies et al., 1956; Edwards, 1966; Edwards and Guthrie, 1967; Gibbins and Armstrong, 1959; Gillis and Keet, 1969; Kissin et al., 1968; Gerard and Saenger, 1966; Kinnin et al., 1971; McCance and McCance, 1969; Thiessen, 1968; Selzer and Holloway, 1957; and Wolff and Holland, 1964).

Patients were randomly assigned via a random numbers table to either receive assertion training in one of two ongoing assertion groups or to be placed in a "rap" group. Groups were run twice weekly for one-hour sessions until the appropriate number of subjects in each experimental group was accumulated. Patients remained in their assigned groups for the duration of their four to five-week inpatient status. Because the groups were ongoing, with new admissions joining and discharges leaving the groups continuously, the size of the groups varied from session to session. Generally, however, groups were run with six to ten patients per session.

All other therapeutic treatment received by patients in the experimental groups was standardized. (See Appendix A.)
Assessment Measures

The dependent variable measures were pre and post difference scores on Rotter's Internal-External Scale (Rotter, 1966), Assertion Questionnaire A, a somewhat modified version of the Wolpe-Lazarus Assertive Scale (Wolpe and Lazarus, 1966) and Assertion Questionnaire B, a questionnaire aimed at assessing the patient's degree of assertiveness in specific social situations which were likely to be of particular importance to the posttreatment alcoholic. Both the Internal-External Scale (Tolar et al, 1970) and the Wolpe-Lazarus Scale (McFall & Marsten, 1970) have been shown to be valid and reliable measurement instruments. The Internal-External Scale was administered in order to determine whether assertion training was related to the personality construct of locus of control and to assess the possible differences on this test between patients receiving assertion training and those not receiving the training. Questionnaire A was administered in order to assess the patient's degree of overall assertiveness pre and post treatment. Questionnaire B was designed specifically for the present study and contained seven Likert items each on a five point response scale including the following choices: 1) strongly agree, 2) agree, 3) undecided, 4) disagree, and 5) strongly disagree. Six positively stated statements dealing with the following were given: 1) turning down a drink, 2) conversing with
the opposite sex, 3) expressing opinions, 4) acquiring new friends, 5) expressing needs and 6) handling frustrating social situations. (See Appendix B.) An additional item was included to assess the patient's degree of comfort in social settings in general.

In addition to the above dependent variable measures, all patients were given the Drinking Patterns Questionnaire (Steinhilber, 1967) to assess the severity of alcoholism.

Procedure

Upon admission, each patient was given an intake interview to gather pertinent factual information. In addition, the Internal-External Scale, Questionnaire A, Questionnaire B, and the Drinking Patterns Questionnaire were administered. Procedures for the treatment groups were as follows:

Assertion Training Groups

Patients in the assertion training groups were primarily trained in social skills that would eventually be carried out in their natural environment. Patients were asked to relate to the group those interpersonal situations which had caused anxiety in the past or were likely to elicit anxiety in the future. These then became the training situations for each patient. Occasionally, a problem situation encountered within the hospital would be practiced, if its effective handling could be seen to have
practical utility in the patient's normal environment. Problem situations peculiar to the hospital (e.g., asking for medicine) were discouraged.

With respect to each situation, each patient, with the help of the therapist, decided on specific and attainable behavioral goals with priority given to constructive and functional behaviors. For example, one patient expressed a desire to "get the best of" his wife in their arguments concerning child-rearing practices. The behavioral goal for this situation became one of being able to express his opinions on the subject in an assertive rather than an aggressive manner so that his wife might be more willing to consider them. Behavioral goals that were set in the groups during the course of treatment covered a wide range of situations, interpersonal targets (e.g., family members, friends, co-workers, etc.) and settings (e.g., home, work, school, public environments). Typical practice situations carried out in the groups were categorized, in part, according to a system developed by Wood, et al, and are presented in Appendix B.

The training began by having the patient role-play the problem situation, choosing, if it were appropriate, a member of the group whom he felt to be most similar to the interpersonal target. If a patient was initially unwilling to participate in role-playing, the therapist and an experienced group member role-played the scene, approximating
the content as accurately as possible from the patient's description. The patient then role-played the scene, and his performance was followed by enthusiastic positive feedback from the group, after which the therapist identified specific and modifiable behavioral deficits and excesses. One behavior, usually non-verbal, such as eye contact or facial expression was chosen as the target behavior to be worked on. The therapist or another group member then modeled a more appropriate way to behave in the situation, emphasizing how the identified behavior could be more effectively performed. The patient was then asked to repeat the performance, paying particular attention to the target behavior. This shaping procedure of behavioral rehearsal, positive feedback, and constructive suggestion was repeated, and new behaviors were added until the performance Gestalt was achieved. Special techniques such as multiple modeling and role-reversal were often employed. In multiple modeling, several group members in rapid succession modeled a specific behavior for a patient so that he could be exposed to several appropriate performance styles. In role-reversal, the patient was asked to role-play the part of the interpersonal target while the therapist or group member modeled the appropriate behavior to be performed by the patient. Through utilization of this technique, the patient could view the problem situation from another perspective, and could experience more
directly the effect his assertive behavior might have in the particular situation. In addition, through role-reversal, the interpersonal target was more clearly defined for the group, making role-playing of that individual more accurate. On occasion, a patient had the opportunity to apply what he had learned in the group to a real-life situation. In this event, he was asked to role-play for the group the outcome of the interaction.

To enhance the effectiveness of training, each group member was fully informed as to the goals of assertion training. When a new patient joined the group, an experienced group member was asked to review these goals for the new member. Briefly outlined these were:

1) Emphasis on the non-verbal and verbal components of assertive behavior: How eye contact, facial expression, posture, gestures, voice volume, voice intonation, speech fluency, and speech content can work together to produce assertive behavior.

2) Emphasis on positive feedback: Positive feedback should follow every performance and negative comments should take the form of constructive suggestions, not criticism.

3) Usefulness of practice via role-playing: The principle that changes in attitude follow, rather than precede, changes in behavior was emphasized.
4) Expectation of participation after first group session.

"Rap" Group

The "rap" group served as a comparison group limited to discussion only. Interpersonal and other problems were discussed but no behavioral rehearsal occurred. The procedures followed in this group were likened to those generally employed in other psychotherapy groups that took place on the ward (See Appendix A).

Before being discharged, each patient was again administered the Internal-External Scale, Questionnaire A, and Questionnaire B.
SECTION III

RESULTS

A general multiple regression analysis subsuming analysis of variance and analysis of covariance was performed on the group mean difference scores for each assessment instrument. Each revealed a clear and significant difference between the two treatment groups. The results of an analysis of difference scores for the Internal-External Scale, Questionnaire A and Questionnaire B without the covariates age and severity of drinking are shown in Table 1. This analysis revealed that in comparison to the

<table>
<thead>
<tr>
<th>Scale</th>
<th>Treatment Group</th>
<th>Group Mean</th>
<th>F Value</th>
<th>d.f.</th>
<th>p</th>
<th>$R_{pb}$</th>
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<tr>
<td>Internal-External</td>
<td>Assertion</td>
<td>5.55</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>&quot;Rap&quot;</td>
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<td>28.11**</td>
<td>1,36</td>
<td>&lt;.01</td>
<td>.66</td>
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<td>Questionnaire A</td>
<td>Assertion</td>
<td>5.60</td>
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<td>&quot;Rap&quot;</td>
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<td>10.96**</td>
<td>1,36</td>
<td>&lt;.01</td>
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<td>Assertion</td>
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<td>&quot;Rap&quot;</td>
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<td>24.58**</td>
<td>1,36</td>
<td>&lt;.01</td>
<td>.63</td>
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$** = p < .01.$

$R_{pb}$ = multiple partial of group membership with experimental change.
patients in the "rap" group, patients in the assertion training group consistently showed greater change scores in the expected direction on pre and post measures of the Internal-External Scale ($p = \leq .01$), Questionnaire A ($p = \leq .01$), and Questionnaire B ($p = \leq .01$). Furthermore, this difference was sustained even when covariates were applied in the analysis. An examination of Table 2 reveals that a multiple covariance analysis of the difference scores using the covariates age and severity of drinking yielded a significant difference between the two treatment groups on the Internal-External Scale ($p = \leq .01$), Questionnaire A ($p = \leq .01$), and Questionnaire B ($p = \leq .01$).

<table>
<thead>
<tr>
<th>Scale</th>
<th>d.f.</th>
<th>ss</th>
<th>ms</th>
<th>$F$</th>
<th>$R_{pb}$</th>
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<td>Internal-External</td>
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<td>146.8</td>
<td>29.33**</td>
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<td></td>
<td>Adjusted Within</td>
<td>34</td>
<td>170.24</td>
<td>5.0</td>
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<td>Adjusted Total</td>
<td>35</td>
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<td>210.99</td>
<td>210.99</td>
<td>10.25**</td>
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<td>Adjusted Within</td>
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<td>699.29</td>
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<td>Adjusted Total</td>
<td>35</td>
<td>910.38</td>
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<td>10.47</td>
<td>23.97**</td>
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<td></td>
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<td>.43</td>
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<td>35</td>
<td>25.33</td>
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$** = p \leq .01$.

$R_{pb} = $ multiple partial correlation of group membership with experimental change controlling for age and drinking severity.
It is observed that in all cases of group change over the full multiple covariate analysis, there was a significant difference between the treatment groups consistent with the assessment instruments. Table 3 shows the product moment correlations among the three assessment measures:

<table>
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<th>Internal-External</th>
<th>Questionnaire A</th>
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<tr>
<td>Difference Internal-External</td>
<td>1.00</td>
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<td>.62</td>
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<td>Difference Questionnaire A</td>
<td>1.00</td>
<td>.30</td>
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<td></td>
<td></td>
<td>1.00</td>
</tr>
</tbody>
</table>

In evaluating the relative linear independence of these change criteria, it should be noted that while the Internal-External Scale and Questionnaire B were somewhat correlated ($r = .62$), they were not correlated to the extent that one instrument replaced the other. Questionnaire A was not significantly correlated with either the
Internal-External Scale \((r = .25)\) or with Questionnaire B \((r = .30)\). Thus, the three instruments yielded somewhat correlated measures of change, but these measures were sufficiently unique so that collapsing or eliminating any of them would not have yielded the same clarity of results.
SECTION IV

DISCUSSION

The results obtained clearly support the hypothesis that assertion training leads to self-reports indicative of both a greater degree of assertiveness in interpersonal situations and of a more internal locus of control over reinforcements. That these results were obtained in only eight to ten sessions of assertion training and were not affected by variables such as age or severity of drinking is evidence that assertion training is an alternative and potentially powerful technique that can be employed in a program for the treatment of alcoholism.

Furthermore, the results of this study lend additional support to the efficacy of treatment programs which have employed approaches aimed at training the alcoholic in alternative responses to anxiety in interpersonal situations so that these new behaviors, which are incompatible with drinking, can be reinforced while excessive alcohol consumption is being suppressed (Mertens, 1964; Hedberg et al., 1974; Lovibond and Caddy, 1970; Sobell and Sobell, 1972; and Hunt and Azrin, 1973). In light of the findings of the present research, programs of this nature might make even greater use of assertion training procedures. As Miller and Barlow (1973) have pointed out, while some patients possess adequate interpersonal skills that provide
them with sufficient alternative behaviors to achieve gratification in the absence of alcohol, others are in need of treatment which would establish new social behavior patterns, such as assertion training and vocational training.

In addition to the obvious implications these findings have for future treatment approaches, a less salient implication of the results is that assertion training can be used as a means by which alcoholics can be trained to maintain stable patterns of controlled drinking. Thus, it would seem plausible that alcoholics whose goal is controlled drinking could be trained, through assertion training techniques, in those aspects of drinking behavior which are characteristic of social drinkers.

The results obtained also have implicit value in relation to alcohol related research not directly involved in behavioral training. Based on the findings of a series of studies in which the social, affective and drinking behavior of alcoholics vs. nonalcoholics were evaluated on an operant task, Nathan and O'Brien (1971) have proposed that social isolation may serve as a cue for alcohol consumption, and that reduction in the alcoholic's social isolation may help reduce his alcohol consumption. These descriptive findings, along with the findings of the present study suggest that assertion training could offer promise as a possible detriment to drinking.
behavior; that is, a greater awareness that his behavior can influence social interactions with others in a positive manner can be hypothesized to lead to increased social activity on the part of the socially isolated alcoholic, and, in turn, to decreased drinking.

The differences obtained in the pre and post treatment attitudinal measures between the two experimental groups are encouraging in that the attitudinal measures of personality constructs such as assertiveness and locus of control may prove to have utility as possible predictive criteria for alcohol treatment outcome. Given the post hoc findings of Carothers (1971) it would be especially interesting to determine whether the Internal-External Scale also has predictive value. Additionally, it would seem to be of great value to be able to predict better treatment outcome as a result of attitudinal changes due to assertion training. Future research is needed to substantiate these speculations.

A tacit, yet important issue is whether or not the observed attitudinal change will endure after the patient returns to his natural environment. Since changes in attitude follow changes in behavior, and behavior, in turn is increased by its consequences (Thorndike, 1913), it seems logical that maintenance of attitudinal change will be determined by how well the particular patient is able to generalize his newly acquired interpersonal skills beyond
the limited group session and whether or not he will be reinforced for this behavior. In speculating upon the issue of generalizability, it would seem that because of the emphasis placed upon positive reinforcement for assertive behavior in the training groups, the patient will have come, through his practice sessions, to expect positive reinforcement for assertive behavior. Based on some research findings, Morgan (1974) has suggested that there are differences with respect to expectations and rewards for assertive behavior and that high expectations and rates of reinforcement will tend to maintain assertive behavior. If this hypothesis is valid, the prospects for generalization of assertive behavior would appear to be good. In addition, Herson et al (1974) found that, consistent with learning theory, generalization of assertive behaviors is strongest in situations which most closely resemble those practiced in training sessions. Since the patients in this study were given direct training in precisely those interpersonal situations with which they had experienced or expected difficulty, the prognosis for generalizability to the natural environment is even more promising.

Obviously, it is not possible to predict the kind of consequences for assertive behavior each patient's social environment will provide him with. Almost assuredly, he will not be maximally rewarded each time he exhibits
assertive behavior in a problem situation. However, it does seem probable that with an increased number of effective social skills available to him, the patient will be in a better position to elicit rewards from his environment than he was prior to training.

Finally, it seems that the observed effects of the training sessions could be even further augmented through the use of performance feedback aids such as videotape and audiotape, as well as through specially designed instruments such as the "bug-in-the-ear" device. In any case, in order to fully utilize the results obtained in this study, and thus assess the general effectiveness of assertion training with alcoholics, their validity in relation to drinking in the natural environment must be assessed. Future research might well be directed towards this end.
NOTES

1 A test of significance for the difference between mean difference scores on pre and post measures for the two assertion groups revealed no difference due to group placement. Difference I.E. = .13 $\sigma_{ar} = 2.25$; Difference QA = 2.84 $\sigma_{ar} = 4.48$; Difference QB = .54 $\sigma_{ar} = .64$.

2 Patients were admitted to the program in differing degrees of intoxication. Assessment instruments were administered as soon as the patient was detoxified and deemed able to perform adequately. In general, most patients completed the instruments within three days of their admission into the program.

3 This device is available in many different forms, ranging from "homemade" varieties to sophisticated electronic equipment. Basically, the device provides long distance communication between the patient and the therapist so that the therapist can coach and/or reinforce the patient in an unobtrusive manner while the patient is in a role-play situation.
REFERENCES


APPENDICES
APPENDIX A

GENERAL PSYCHOLOGICAL TREATMENT

Alcohol Treatment Unit

Treatment Coordinator

Each patient on the program is assigned to an individual treatment coordinator who has responsibility for being knowledgeable about the patient and follows the patient from admission to discharge. The treatment coordinator may be a member of the nursing, psychology, or social work staff. Primary responsibilities in this position include keeping checks on the performance of the patient regarding appointments, assignments and group attendance. In cases of non-compliance with the treatment program, or infringement of ward rules, the coordinator discusses the matter with the patient, takes appropriate action, and informs the patient of the action. In addition, the treatment coordinator obtains feedback from the patient, sees the patient in counseling sessions on a regular basis and helps in future planning.

Therapeutic Community/Ward Government

All patients and staff members attend a therapeutic community meeting each morning, Monday through Friday, before the day's activities begin. There is no group leader and the group is open for discussion to any member
who wishes to express himself on personal or ward community matters. One morning group per week is scheduled for Ward Government, in which work assignments are delegated and ward matters are specifically discussed.

**Psychotherapy Groups**

All patients attend general psychotherapy groups for one and one half hours each morning, Monday through Friday. There is a group leader who facilitates and directs discussion. The approach taken in the groups is eclectic, but, in general, emphasis is placed upon the following procedures:

1. Questions are avoided whenever possible and replaced by statements. For example, "Are you ...?" is replaced by "You look ..."

2. When questions are used, open-ended and "how" questions are employed and "why" questions are avoided.

3. Behavioral descriptions are encouraged and interpretations avoided. In the case where an interpretation is given, it is made justifiable. Behavioral events are given first, such as "You're tapping your foot rapidly, John," and are then accompanied by limited self-disclosure and interpretation, e.g., "That makes me feel as if you're inpatient with me."
4. Perception checks are used often to help clear up vague verbalizations. A statement such as "You seem to be saying you feel apprehensive," is made and then checked out with the patient.

5. Paraphrasing is encouraged. The gist of the patient's intended communication is repeated, and, if possible, carried a bit further. For example, "You seem to be saying that your wife never listens to what you say (paraphrase) as if you feel that she doesn't consider it important" (addition).

**Alcoholic's Anonymous**

All patients are required to attend weekly A.A. meetings held on the ward.

**Milieu Therapy**

Patients are encouraged to engage in milieu therapy during periods when there is no other scheduled activity.
## APPENDIX B

### ASSERTION TRAINING PRACTICE TOPICS

#### Social Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conversation</td>
<td>Initiating, continuing, concluding talk with a friend, relative, or acquaintance</td>
</tr>
<tr>
<td>Information</td>
<td>Conversation on a specific topic for purposes of information exchange</td>
</tr>
<tr>
<td>Social Approach</td>
<td>Meeting new people, arranging for dating or other social contact with the purpose of making new friends</td>
</tr>
<tr>
<td>Personal Request</td>
<td>Asking a reasonable favor of a relative or friend</td>
</tr>
<tr>
<td>Family Diplomacy</td>
<td>Exchanging ideas with family members, making needs known, receiving and giving constructive suggestions</td>
</tr>
</tbody>
</table>

#### Affect/Assertion

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expressions</td>
<td>Using facial and motor expressions to show happiness, pleasure, or delight, affection or love, anger or sadness as they are appropriate to the situation</td>
</tr>
<tr>
<td>Emotional Exchange</td>
<td>Expressing happiness, pleasure, delight, love and affection, anger, irritation or frustration; coping with these emotions when displayed by others</td>
</tr>
<tr>
<td>Compliments</td>
<td>Giving and receiving compliments</td>
</tr>
<tr>
<td>Criticism</td>
<td>Giving and receiving criticism and advice</td>
</tr>
<tr>
<td>Resistance</td>
<td>Dealing with non-compliance, marital discord, romantic breakup, not complying with unreasonable wishes or demands of others</td>
</tr>
<tr>
<td><strong>Interviews</strong></td>
<td>Interviews for work as well as other types of interviews (apartment rental, school, etc.) from inception to finish</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Follow-up</strong></td>
<td>Follow-up contracts for jobs, check upon status of applications, arranging for future contact, getting specific information not freely offered, etc.</td>
</tr>
</tbody>
</table>
APPENDIX C

MEAN GROUP SCORES AND STANDARD DEVIATIONS OF PRE AND POST MEASURES FOR ASSERTION AND "RAP" GROUPS

<table>
<thead>
<tr>
<th></th>
<th>Assertion Groups</th>
<th>&quot;Rap&quot; Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 20</td>
<td>N = 18</td>
</tr>
<tr>
<td></td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td><strong>Pretest</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal-External Scale</td>
<td>14.45 3.66</td>
<td>15.83 4.84</td>
</tr>
<tr>
<td>Questionnaire A</td>
<td>9.85 5.93</td>
<td>6.56 3.65</td>
</tr>
<tr>
<td>Questionnaire B</td>
<td>2.88 0.61</td>
<td>2.34 0.98</td>
</tr>
<tr>
<td><strong>Posttest</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal-External Scale</td>
<td>20.00 2.51</td>
<td>17.50 3.97</td>
</tr>
<tr>
<td>Questionnaire A</td>
<td>4.25 2.84</td>
<td>5.89 4.04</td>
</tr>
<tr>
<td>Questionnaire B</td>
<td>1.68 0.69</td>
<td>2.19 0.86</td>
</tr>
</tbody>
</table>
APPENDIX D
STATISTICAL AND DATA PROCESSING NOTES

The analyses of variance and multiple covariance were accomplished by means of a general regression approach such as described in Li (1964) and Kerlinger and Pedhazur (1973). In the first case, pre and post difference scores were regressed on an "effect coded" design vector with the results giving a one-way analysis of variance on these difference scores. In the second case two covariates were added to the model and the difference scores were regressed on the design vector plus the two covariates and then on the two covariates alone, thereby yielding adjusted sums of squares for "total" and "error" so that a multiple covariance analysis of the difference scores could be obtained. In the third case a "full" multiple covariance analysis was performed but not reported because the results were identical to those found in the previous analyses. This analysis was accomplished by considering the pre score as a third covariate, in which case the post score was regressed on the design vector, the pre score, plus the two covariates so that an adjusted "error" term could be obtained; the adjusted total was obtained by regressing the post score on the pre score plus the two covariates. As appropriate the adjusted sum of squares "between" was obtained by subtracting the
adjusted error sum of squares from the adjusted total sum of squares thereby giving the basis for constructing the multiple analysis of covariance summary table.
APPENDIX E

QUESTIONNAIRES

DRINKING PATTERNS QUESTIONNAIRE

Directions
Please indicate number of times the incident occurs and circle the appropriate time period.

Example
How often do you go to the movies?

4 times a day week month year
or
0 times a day week month year
(if "0" times, do not circle)
Drinking Patterns-1

<table>
<thead>
<tr>
<th>NAME</th>
<th>Subj. No.</th>
<th>Date</th>
</tr>
</thead>
</table>

Within the past ___ months:

1. How often do you look forward to the end of a day's work so that you can have a couple of drinks and relax?
   
   _____ times a day week month year

2. How often do you look forward to the end of the week so that you can have some fun drinking?
   
   _____ times a day week month year

3. How often does the thought of drinking enter your mind when you should be thinking of something else?
   
   _____ times a day week month year

4. How often do you feel the need to have a drink at a particular time of day?
   
   _____ times a day week month year

5. How often do you drink to calm your nerves or reduce tension?
   
   _____ times a day week month year

6. How often do you use alcohol as a nightcap to help you get to sleep at night?
   
   _____ times a day week month year

7. How often do you use alcohol to relieve physical discomfort?
   
   _____ times a day week month year

8. How often do you stop in a bar and have a couple of drinks by yourself?
   
   _____ times a day week month year

9. How often do you drink at home alone or when no one else is drinking?
   
   _____ times a day week month year
10. How often do you hide a bottle in the house in the event you may need a drink?

____ times a day week month year

11. How often do you keep a bottle in your car just in case you may need a drink?

____ times a day week month year

12. How often do you stop in to have two or three drinks and have several more than you had planned?

____ times a day week month year

13. How often do you find yourself stopping in for a drink when you had planned to go straight home or somewhere else?

____ times a day week month year

14. How often does your wife (husband) complain that you drink too much?

____ times a day week month year

15. How often does your wife (husband) object to your drinking?

____ times a day week month year

16. How often do you drink when though you cannot afford to?

____ times a day week month year

17. How often does drinking become so important or time consuming that previous hobbies or interests are neglected?

____ times a day week month year

GO TO NEXT PAGE
Directions

Please indicate the percent of time by drawing a slash through the scale:

Example

What percent of the time do you watch TV?

(If your answer is 35% slash the line between 30 and 40%, as—)

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

(If your answer of 0% you would slash the line at the "0" point, as—)

0% 10 20 30 40 50 60 70 80 90 100%
18. What percent of the time do you find that you can drink more than others and not show it too much?

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

19. What percent of the time do people comment on your ability to hold your liquor?

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

20. What percent of the time do you wonder about your increased capacity to drink and perhaps feel somewhat proud of it?

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

21. What percent of the time do you order a double or like to have your first two or three drinks quickly?

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

22. What percent of the time do you have a couple of drinks before going to a party or out to dinner?

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

23. What percent of the time do you find it difficult to enjoy a party or dance if there is nothing to drink?

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

24. What percent of the time in the morning after an evening of drinking do you have the experience of not being able to remember everything that happened on the night before?

|  |  |  |  |  |  |  |  |  |  |  |
|---|---|---|---|---|---|---|---|---|---|
| 0% | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100% |
25. What percent of the time do you have difficulty recalling how you got home after a night's drinking?

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

26. What percent of the time are you one of the last ones to leave a bar or a drinking party when you had planned to go home earlier in the evening?

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<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

27. What percent of the time do you drink more than you think you should?

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<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

28. What percent of the time is your drinking different from what you would like it to be?

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

29. What percent of the time do you have the shakes or tremors of the hands after a night of drinking?

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

30. What percent of the time do you take a drink in the morning to help you over a hangover?

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

31. What percent of the time have you missed work because of a hangover?

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

32. What percent of the time has your drinking caused you to be less efficient in your work?

|   | 0% | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100% |
33. What percent of the time do you prefer to associate with people who drink rather than those who do not?

<table>
<thead>
<tr>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

34. What percent of the time do you do things while drinking that you are ashamed of later?

<table>
<thead>
<tr>
<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
<th>60</th>
<th>70</th>
<th>80</th>
<th>90</th>
<th>100%</th>
</tr>
</thead>
</table>

35. How many times has your spouse threatened to leave you because of your drinking?

_____ times

36. How many times have you lost a job because of drinking?

_____ times

37. How many times have you been threatened with loss of a job because of drinking?

_____ times

38. How many times has a doctor told you to cut down or stop your drinking for any reason at all?

_____ times

39. How many times have you been hospitalized because of drinking or from a complication due to your drinking?

_____ times

Do you consider yourself an alcoholic?

Yes _____ No _____
INTERNAL-EXTERNAL SCALE

NAME ____________________________

Directions

Circle either a or b for each item.

1. a. Children get into trouble because their parents 
   punish them too much.
   b. The trouble with most children nowadays is that 
   their parents are too easy with them.

2. a. Many of the unhappy things in people's lives are 
   partly due to bad luck.
   b. People's misfortunes result from the mistakes 
   they make.

3. a. One of the major reasons why we have wars is be­
   cause people don't take enough interest in 
   politics.
   b. There will always be wars, no matter how hard 
   people try to prevent them.

4. a. In the long run people get the respect they 
   deserve in this world.
   b. Unfortunately, an individual's worth often 
   passes unrecognized no matter how hard he tries.

5. a. The idea that teachers are unfair to students 
   is nonsense.
   b. Most students don't realize the extent to which 
   their grades are influenced by accidental 
   happenings.

6. a. Without the right breaks one cannot be an effec­
   tive leader.
   b. Capable people who fail to become leaders have 
   not taken advantage of their opportunities.

7. a. No matter how hard you try some people just 
   don't like you.
   b. People who can't get others to like them don't 
   understand how to get along with others.

8. a. Heredity plans the major role in determining 
   one's personality.
   b. It is one's experiences in life which determine 
   what they're like.
9. a. I have often found that what is going to happen will happen.
   b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

10. a. In the case of the well prepared student there is rarely if ever such a thing as an unfair test.
    b. Many times exam questions tend to be so unrelated to course work that studying is really useless.

11. a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
    b. Getting a good job depends mainly on being in the right place at the right time.

12. a. The average citizen can have an influence in government decisions.
    b. This world is run by the few people in power, and there is not much the little guy can do about it.

13. a. When I make plans, I am almost certain that I can make them work.
    b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

14. a. There are certain people who are just no good.
    b. There is some good in everybody.

15. a. In my case getting what I want has little or nothing to do with luck.
    b. Many times we might just as well decide what to do by flipping a coin.

16. a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.
    b. Getting people to do the right things depends upon ability, luck has little or nothing to do with it.

17. a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.
    b. By taking an active part in political and social affairs the people can control world events.
18. a. Most people don't realize the extent to which their lives are controlled by accidental happenings.
   b. There really is no such thing as "luck".

19. a. One should always be willing to admit mistakes.
   b. It is usually best to cover up one's mistakes.

20. a. It is hard to know whether or not a person really likes you.
   b. How many friends you have depends upon how nice a person you are.

21. a. In the long run the bad things that happen to us are balanced by the good ones.
   b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22. a. With enough effort we can wipe out political corruption.
   b. It is difficult for people to have much control over the things politicians do in office.

23. a. Sometimes I can't understand how teachers arrive at the grades they give.
   b. There is a direct connection between how hard I study and the grades I get.

24. a. A good leader expects people to decide for themselves what they should do.
   b. A good leader makes it clear to everybody what their jobs are.

25. a. Many times I feel that I have little influence over the things that happen to me.
   b. It is impossible for me to believe that chance or luck plays an important role in my life.

26. a. People are lonely because they don't try to be friendly.
   b. There's not much use in trying too hard to please people, if they like you, they like you.

27. a. There is too much emphasis on athletics in high school.
   b. Team sports are an excellent way to build character.
28. a. What happens to me is my own doing.
   b. Sometimes I feel that I don't have enough control over the direction my life is taking.

29. a. Most of the time I can't understand why politicians behave the way they do.
   b. In the long run the people are responsible for bad government on a national as well as on a local level.
QUESTIONNAIRE A

NAME ____________________________________________

YES  NO

___ ___ 1. When a person is blatantly unfair, do you usually fail to say something about it to him?

___ ___ 2. Are you always very careful to avoid all trouble with other people?

___ ___ 3. Do you often avoid social contacts for fear of doing or saying the wrong thing?

___ ___ 4. If a friend betrays your confidence, do you tell him how you really feel?

___ ___ 5. If you had a roommate, would you insist that he or she do their fair share of cleaning?

___ ___ 6. When a clerk in a store waits on someone who has come in after you, do you call his attention to the matter?

___ ___ 7. Do you find that there are very few people with whom you can be relaxed and have a good time?

___ ___ 8. Would you be hesitant about asking a good friend to lend you a few dollars?

___ ___ 9. If someone who has borrowed $5 from you seems to have forgotten about it, would you remind this person?

___ ___ 10. If a person keeps on teasing you, do you have difficulty expressing your annoyance or displeasure?

___ ___ 11. Would you remain standing at the rear of a crowded auditorium rather than look for a seat up front?

___ ___ 12. If someone keeps kicking the back of your chair in a movie, would you ask him to stop?

___ ___ 13. If a friend keeps calling you very late each evening, would you ask him to stop?
14. If someone starts talking to someone else right in the middle of your conversation, do you express your irritation?

15. In a plush restaurant, if you ask for a medium steak and find it too raw, would you ask the waiter to have it recooked?

16. If the landlord of your apartment fails to make certain necessary repairs after promising to do so, would you insist upon it?

17. Would you return a faulty garment you purchased a few days ago?

18. If someone you respect expresses opinions with which you strongly disagree, would you venture to state your own point of view?

19. Are you usually able to say "no" if people make unreasonable requests?

20. Do you think that people should stand up for their rights?

21. Do you protest out loud when someone pushes in front of you in life?

22. Are you inclined to be overapologetic?

23. If a friend unjustifiably criticizes you, do you express your resentment there and then?

24. Are you able to contradict a domineering person?

25. If you heard that one of your friends was spreading false rumors about you, would you hesitate to "have it out" with him?

26. Do you really keep your opinions to yourself?

27. Are you able openly to express love and affection?
28. Do you usually keep quiet "for the sake of peace?"

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

30. If after leaving a shop you notice that you have been given short change, do you go back and point out the error?
This questionnaire will help clarify your problems in social situations. We are interested only in your self-perceptions, so answer each question as you honestly see yourself at this time. Read each question carefully, and circle the appropriate number on each line. Remember, there are no right or wrong answers.

1. I can easily turn down a drink if offered one.

   1  2  3  4  5
   strongly agree agree undecided disagree disagree

2. I can express myself in social situations with the opposite sex.

   1  2  3  4  5
   strongly agree agree undecided disagree disagree

3. I can easily express my opinion to other people.

   1  2  3  4  5
   strongly agree agree undecided disagree disagree

4. I can easily break away from my hard-drinking friends and meet new people.

   1  2  3  4  5
   strongly agree agree undecided disagree disagree

5. I can express my needs to the important people in my life.

   1  2  3  4  5
   strongly agree agree undecided disagree disagree
6. I know how to handle frustrating situations.

   strongly agree  agree  undecided  disagree  strongly disagree

7. I feel relaxed and confident in most social situations.

   strongly agree  agree  undecided  disagree  strongly disagree