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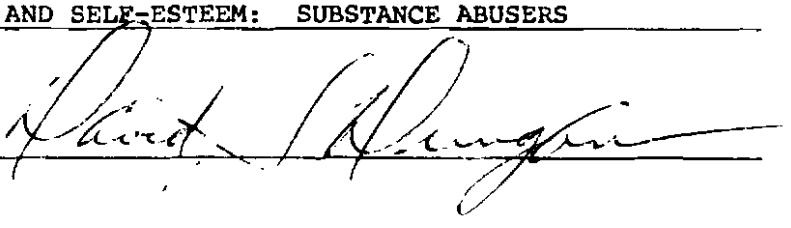
Title: ASSERTIVENESS AND SELF-ESTEEM: SUBSTANCE ABUSERS

Abstract approved: 

Assertion training has become a regular addition to inpatient treatments for alcohol and drug abusing patients. Although assertiveness training has proven therapeutic value, it seems to have been falsely assumed that substance abusers have an overall need for such training. A review of the literature reveals that the need for assertive training with substance abusers is generally based on conflicting data and questionable generalizations.

The present study sought to identify a possible related component which inhibits substance abusers from behaving assertively. The study sample consisted of 20 drug abusers, 19 alcohol abusers, and 50 non-substance abusers. Each subject was administered the Rathus Assertiveness Schedule and the Texas Social Behavior Inventory, a measure of self-esteem. Tests were scored and various techniques were employed to assess the results.

It was shown that: 1) alcoholics, as a group, are as assertive as non-substance abusers; 2) alcoholics have lower self-esteem than

non-substance abusers; 3) drug abusers, as a group, are as assertive as non-substance abusers; 4) drug abusers have lower self-esteem than non-substance abusers; 5) a statistically significant correlation exists between assertiveness and self-esteem.

ASSERTIVENESS AND SELF-ESTEEM:

SUBSTANCE ABUSERS

A Thesis

Presented to

the Department of Psychology

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CONTENTS

Chapter 1

INTRODUCTION

During recent years assertion training has become a regular addition to most inpatient treatments for alcohol and drug abusing patients. The addition of assertion training follows a movement away from generalized treatment for emotional or behavioral disorders in favor of a more specific approach which matches treatment and therapist with patient and problem (Hirsch, Rosenberg, Phelan, & Dudley, 1978).

Assertive behavior, or assertion, involves direct expression of one's feelings, preferences, needs, or opinions in a manner that is neither threatening nor punishing toward another person. Assertive behavior refers to all socially acceptable expressions of personal rights and feelings. Being assertive includes the honest, appropriate and relatively straightforward expression of feelings such as anger, dissatisfaction and resentment as well as the expression of love, affection and praise (Alberti and Emmons, 1970). In addition, assertion does not involve an undue or excessive amount of anxiety or fear (Galassi and Galassi, 1977). That is, an assertive person should not experience an inordinate amount of anxiety or fear when acting assertively. Lazarus (1973) had stated that the main components of assertive (or emotionally expressive) behaviors may be divided into four separate and specific patterns reflecting the ability to a) say "no", b) to ask for favors or to make requests, c) to express positive and negative feelings, and d) to initiate, continue, or terminate general

conversations. Alberti and Emmons (1970) stated that assertive behavior is that which enables a person to act in his own best interest, to stand up for himself without undue anxiety, to express his rights without denying the rights of others. Assertiveness training has been developed as a behavioral technique for teaching individuals to defend their prerogatives and express their feelings toward others. It provides patients with direct training in precisely those interpersonal and social skills lacking in their response repertoires. Assertive training represents one of the earliest forms of behavior therapy (Salter, 1949). The therapeutic value of behavioral training of assertive responses has been established in individual case studies (Lazarus, 1966; Wolpe, 1958, 1969). More recently the therapeutic value of assertiveness training with groups has also been established (Eisler, Miller & Herson, 1973; McFall & Lillesand, 1971; McFall & Marston, 1970; McFall & Twentyman, 1973; Young, Rimm, & Kennedy, 1973). The popularity of assertiveness for therapists, researchers, and writers is evidenced by the fact that articles related to assertiveness indexed in Psychological Abstracts increased from 20 in 1973 to 191 during the last 4½-year period (Harris and Brown, 1979).

The rationale behind incorporating assertion training into the treatment of alcoholics is based on clinical and experimental studies on alcoholism. These studies indicate that interpersonal situations which require assertive responses are stressful for alcoholics and frequently set the occasion for excessive drinking (Miller & Eisler, 1977). For example, Miller, Herson, Eisler, and Hilsman (1974) exposed both alcoholics and social drinkers to interpersonal encounters requiring assertiveness. Although equally stressed, alcoholics significantly

increased their drinking behavior subsequent to these situations whereas social drinkers did not. In a similar study, Marlatt, Kosturn, and Lang (1975) deliberately angered heavy drinking college students. The results indicated that subjects who were allowed to retaliate against the source of their arousal drank significantly less than those who were prevented from doing so. It was thus hypothesized that alcoholics who do not respond to interpersonal conflict (possibly because of deficits in assertion skills) would also drink to excess in response to similar situations. During recent years this hypothesis has been subjected to experimental investigation. For example, Hamilton and Maisto (1979) assessed male alcoholics and a matched group of non-alcoholic drinkers on self-report and behavioral tests of assertive behavior and discomfort. Although there were no significant group differences in assertive behavior, alcoholics did report more assertive discomfort on both tests. These findings suggest that assertive training with alcoholics might well focus on reducing psychological discomfort in assertion-required situations. Why this is so has yet to be determined; perhaps it is one factor or perhaps this psychological discomfort is caused by a multiplicity of factors. Moreover, it appears that the basic question regarding whether or not alcoholics, as a group, lack assertive skills and, hence, require assertiveness training needs more solid experimental validation than currently exists in the literature.

Although assertion training has been reported as a therapeutic modality in alcohol-abusing populations, it is apparently only theoretical rationales that have supported its necessity for use with the drug-abusing population. Little empirical validation exists for the notion that there is a significant deficit in assertiveness in this

population. For example, Callner and Ross (1976) demonstrated that thirty-two drug-abusing patients involved in a general inpatient drug program differed significantly from a matched sample of non-drug subjects on a variety of assertion variables. The inpatient drug subjects differed most from the non-drug subjects in the areas of verbally responding to turning down drugs and responding to negative feedback. It was again Callner and Ross (1978) who strived to accurately assess specific assertion problems in drug abusers. In this study an assertion questionnaire and verbal performance data were obtained from both a treatment and a no-treatment group prior to and following three weeks of assertion training. The results suggest that an intensive short-term program using a variety of behaviorally oriented techniques can show rapid improvements in assertion performance by increasing assertive behavior. Teaching assertiveness through behaviorally oriented techniques involves the use of role-playing and video taping situations, receiving feedback, and replaying the scene using modeling and role-reversal. Lindquist, Lindsay, and White (1979) reported that drug users are less assertive than non-drug using populations. Their study used a heroin-addicted population, psychotic outpatients, court-referred drug users, and a group of college students (N=114). The results showed the addicts and court-referred drug patients to be less assertive, less socially assertive, and more socially anxious than the two non-addict populations. In the discussion of their results, Lindquist et al. (1979) point out the obvious limitations of their study as the result of the small and possibly unrepresentative samples. So it appears that the drug abusing population, just as the alcohol abusing population, lacks a

significant amount of empirical clinical validation to support assertion training for either of these groups as a whole.

In working with alcohol and drug abusing clients on an outpatient basis in a Mental Health Center setting I regularly assess the need for assertiveness training. However, some clients simply do not respond to assertiveness training, even though they gain an understanding of the concepts and practices of assertive behavior. There is further evidence of this in working with the aftercare program in which clients are seen on an outpatient basis following inpatient treatment for alcohol or drug addiction. Aftercare clients are sometimes assessed as being extremely unassertive even though assertiveness training was included in their inpatient treatment. In short, the majority of these clients had an intellectual acceptance of assertiveness but seemed unable to put them into practice. Given this pattern of results, it would appear reasonable to attempt to ascertain what additional factors might be interfering with assertiveness.

In researching components related to assertiveness the literature reveals anxiety, depression, and self-esteem to be three factors which have been validated to various degrees. Wolpe (1958, 1971) first suggested that assertive behavior and anxiety are incompatible; i.e., assertiveness and anxiety are negatively correlated. In support of this hypothesis several researchers (Morgan, 1974; Orenstein, Orenstein, & Carr, 1975; Gay, Hollandsworth, & Galassi, 1975; Pachman and Foy, 1978) have shown that anxiety is incompatible with assertive behavior. These data seem to imply that if a person can develop assertive behavior this, in turn, should help reduce their level of anxiety.

The relationship between lack of assertive social skills and depression has been theoretically and empirically reported by Lewinsohn and his colleagues (Lewinsohn, 1975; Lewinsohn & Schaffer, 1971; Lewinsohn, Weinstein & Alper, 1970; Libet & Lewinsohn, 1973). Lewinsohn (1975) contends that the essential antecedent condition in the development of depression is a pronounced deficit in assertive social skills. Therefore, assertiveness and depression are inversely related (Libet & Lewinsohn, 1973; Pachman & Foy, 1978). Again, much like the relationship between assertiveness and anxiety; a reasonable assumption being that if a person can develop assertive skills, this should help to reduce any amount of depression they might be experiencing. Although anxiety and depression can be viewed as compatible with unassertive behavior, they do not appear to be related to the cause of unassertive behavior.

It is the relationship between self-esteem and assertiveness that may perhaps hold the key to the inhibiting factor of developing assertiveness. Alberti and Emmons (1970) found assertiveness and self-esteem positively correlated. These investigations hypothesized that assertive individuals are more apt to be successful in interpersonal situations and, as a result, feel more positively about themselves. Percall, Berwick, and Beigel (1974) obtained support for this prediction via the demonstration of statistically significant correlations between scores on the Lawrence Interpersonal Behavior Test (Lawrence, 1969), an assertiveness measure, and the Self-Acceptance Scale of the California Psychological Inventory (Gough, 1957). Using the Multiple Affect Adjective Checklist, a paper and pencil test to assess self-esteem and assessing assertive social skills behaviorally by role-playing

standardized interpersonal situations, Pachman and Foy (1978) tested fifty-five inpatient male alcoholics. Unfortunately, Pachman and Foy found no relationship between self-esteem and any behavioral measures of assertive social skills. In summary, the literature reports conflicting data regarding whether or not assertive individuals have high self-esteem. A review of the literature indicates an extreme paucity of studies investigating self-esteem in the drug-abusing population. Additionally, nowhere in the literature has the issue of whether or not unassertive, drug-abusing individuals lack self-esteem been addressed. The present study was designed to help remedy the lack of data in these areas of research. More specifically, the purpose of the study was to address the following issues: 1) provide additional support for whether or not alcoholics, as a group, are less assertive than non-substance abusers; 2) provide data for whether or not alcoholics have lower self-esteem than non-substance abusers; 3) provide data for whether or not drug abusers, as a group, are less assertive than non-substance abusers; 4) establish whether or not drug abusers have lower self-esteem than non-substance abusers; 5) establish what, if any, relationship exists between assertiveness and self-esteem.

Chapter 2

METHOD

Subjects

Thirty-nine outpatients, seen through the Alcohol and Drug Services of a Community Mental Health Center, served as the substance abusing subjects. This patient sample consisted of 20 diagnosed drug (drug other than alcohol) abusing or dependent and 19 diagnosed alcohol abusing or dependent subjects. The drug clients consisted of 15 males and five females, while the alcohol clients consisted of 17 males and two females. The drug clients had a mean age of 26.8 years (range = 15 years to 36 years), while the alcohol clients had a mean age of 34.9 years (range = 22 years to 63 years).

The non-substance abusing sample consisted of 50 subjects who were residents of the same community as the substance abusing sample. The non-substance abusers were chosen at random by the examiner based simply on a willingness to complete the questionnaires. None of these subjects were currently receiving treatment at the Community Mental Health Center. This non-substance abusing sample consisted of twelve females and 38 males. The non-substance abusers had a mean age of 36.3 years (range = 17 years to 58 years).

Apparatus

Each subject completed the Rathus Assertiveness Schedule (Rathus, 1973), a paper-and-pencil questionnaire designed to assess assertiveness. The Rathus Assertiveness Schedule (RAS) has 30-items providing item

scores of -3 to +3 and yields possible total scores of -90 to +90. See Appendix A for a copy of the RAS. Law, Wilson, and Crassini (1979) found the RAS measures situation-specific assertive behavior, aggressiveness, and a general assertiveness.

Each subject also completed the Short Form B of the Texas Social Behavior Inventory (TSBI), an objective measure of self-esteem. The original TSBI (Helmreich and Stapp, 1974) consisted of 32-items but has since been validated into two 16-item short forms (Helmreich & Stapp, 1974). Each item is given a score from 0 to 4 with 0 representing the response associated with lower self-esteem and 4 the score associated with highest self-esteem. A copy of TSBI Short Form B also appears in Appendix B. Using the SPSS (Nie, Hall, and Bent, 1970) Helmrich et al. (1974) found the 32-item TSBI scale to yield four coherent, correlated factors; for males - confidence, dominance, social competence, and social withdrawal; for females - confidence, dominance, social competence, and relations to authority figures.

Procedure

Two staff therapists of the Alcohol and Drug Service of the Mental Health Center, including myself, tested active therapy patients. Responding patients were asked by their therapists to complete the RAS and TSBI openly and honestly. Subjects took approximately 10 to 15 minutes during their regular individual therapy sessions to complete the two questionnaires. Instructions were always the same and no questions were answered while the subject was taking the tests. Tests were scored and results were discussed with subjects during their following therapy session, one to two weeks later. However, discussion of the tests before being administered was not allowed. Although follow-up, using

the testing, varied depending on the needs of each individual client, the original test results were not affected. Test data for the substance abusing sample was gathered over a three month period, from March thru May, 1981.

During August, 1981, I administered the RAS and TSBI to the participating non-substance abusers. The same instructions were given to complete the questionnaires openly and honestly. These subjects also took approximately 10 to 15 minutes to complete the two questionnaires. Instructions were always the same and no questions were answered while the subject was taking the tests. There was no feedback to the non-substance abusing subjects concerning test results and no follow-up.

Chapter 3

RESULTS

A variety of statistical techniques were used to compare the performance of the drug, alcohol, and non-substance abusing samples on the Rathus Assertiveness Schedule and the Texas Social Behavior Inventory. Initial assessment involved comparing measures of assertiveness between each group followed by comparing self-esteem for each group. Additional analysis was performed in order to determine correlations between self-esteem and assertiveness within each sample group and within the combined total sample. Raw scores for the drug abusing, alcohol abusing, and non-substance abusing samples can be found in Appendices C, D, and E respectively.

Means were first computed for each sample based on raw scores from the Rathus Assertiveness Schedule (Drug Abusers = +5, Alcohol Abusers = +13.6, and Non-Substance Abusers = +6.14). Since these raw data consisted of both positive and negative scores, they were corrected in order to yield only positive numbers for further analysis. This was done by adding +82 to each Rathus score obtained by the members of the three samples (+82 was added because -81 was the lowest negative score obtained). The corrected scores changed the means for the three groups to: Drug Abusers = +87, Alcohol Abusers = +95.6, and Non-Substance Abusers = +88.14. A one-way analysis of variance was used to compare scores between the three groups. The analysis of variance [$F(2, 86)$ =

.614, $p > .05$] revealed no significant differences between groups on the Rathus Assertiveness Schedule.

The scores of the Texas Social Behavior Inventory, or self-esteem scale, were also analyzed using a one-way analysis of variance to compare the drug, alcohol, and non-substance abusing samples. The mean score for each group was as follows: Drug Abusers = 39.1, Alcohol Abusers = 42.7, and Non-Substance Abusers = 46.8. The analysis of variance [$F(2, 86) = 4.51$, $p < .05$] showed a significant difference between the three groups. The Newman-Keuls technique was then used to make specific comparisons between the groups. The Newman-Keuls analysis showed that the scores of both the drug and alcohol abusing samples were significantly lower ($p < .05$) than those of the non-substance abusing sample.

A Pearson product moment correlation (Pearson r) was employed to compare scores between the Rathus Assertiveness Schedule (corrected scores) and the Texas Social Behavior Inventory within each sample group and within the combined total sample. The Pearson r proved significant at the $p < .01$ level for each of the groups: Drug Abusers, $r = 0.8$; Alcohol Abusers, $r = 0.7$; Non-Substance Abusers, $r = 0.7$; Combined Groups, $r = 0.7$. This established a significant correlation between assertiveness and self-esteem within each sample group and within the combined total sample.

Chapter 4

DISCUSSION

The original purpose of this study was to test and provide additional data for five areas in question: 1) are alcoholics, as a group, less assertive than non-substance abusers, 2) do alcoholics have lower self-esteem than non-substance abusers, 3) are drug abusers, as a group, less assertive than non-substance abusers, 4) do drug abusers have lower self-esteem than non-substance abusers, 5) what, if any, relationship exists between assertiveness and self-esteem.

First, there was no significant difference between alcohol abusers and non-substance abuser scores in the area of assertiveness. This finding serves as additional support for Hamilton and Maisto (1979) whose research found no significant difference between male alcoholics and non-alcoholic drinkers. Regarding the other research presented in the first part of this paper, referring to alcoholics and assertiveness; all three studies (Hamilton & Maisto, 1979; Miller & Eisler, 1977; Miller, Hersen, Eisler, & Hilsman, 1974) reported that alcoholics find situations requiring assertive responses to be stressful and uncomfortable. Only Hamilton and Maisto (1979) addressed whether or not alcoholics actually lack assertive skills, finding, as this study did, that they do not.

Secondly, this study shows that alcoholics do have significantly lower self-esteem than the general population. This is an important finding since this subject has not been directly addressed in the

literature before. The review of literature revealed two studies (Alberti & Emmons, 1970; Percall, Berwick, & Beigel, 1974) supporting a positive correlation between assertiveness and self-esteem and one study, (Pachman & Foy, 1978) using inpatient male alcoholics, that showed no relationship between assertiveness and self-esteem. However, this study does indeed support a positive correlation between assertiveness and self-esteem for alcohol abusers. With the establishment of this positive correlation, a possible hypothesis would be that alcoholics find assertiveness-requiring situations stressful because of low self-esteem. This low self-esteem may have been inappropriately labeled as in the Hamilton and Maisto (1979) study which found alcoholics to be assertive but "psychologically uncomfortable" when acting assertively. The findings of alcoholics being as assertive as non-substance abusers could imply that assertiveness training programs in many inpatient alcoholic treatment centers are not totally addressing a true problem of the alcoholic but rather a related problem, that is, working directly on assertiveness without first addressing the issue of self-esteem.

In addressing the third question in this study, there was no significant difference between the drug abusing and non-substance abusing samples in the area of assertiveness. This finding does not support the research data reported by Callner and Ross (1976) or Lindquist, Lindsay, and White (1979); both studies reporting that drug abusers were significantly less assertive than the general population. The findings of these studies to be noted are that Callner and Ross (1976) found drug abusers most significantly differing on turning down drugs and responding to negative feedback. In the Lindquist et al. (1979) study

the heroin addicts and court-referred drug abusers were significantly less assertive than a group consisting solely of psychotic outpatients and college students. The findings of this study compared to others suggests that further similar studies are needed in order to establish whether or not drug abusers are as assertive as the general population.

Fourth, drug abusers had significantly lower self-esteem than the non-substance abusing sample. This issue had not been addressed in the literature prior to the time this study was conducted. In addition, with the establishment of a positive correlation between assertiveness and self-esteem for drug abusers, further investigation with these two variables should be done.

Assertiveness training has been incorporated into the inpatient treatment of drug abusers based on the studies presented plus a generalization that alcoholics and drug abusers require similar treatment. Based on the sketchy amount of research available plus possible false generalizations, the need for further studies involving drug abusers, assertiveness, and self-esteem are needed.

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APPENDIXES

APPENDIX A

RATHUS ASSERTIVENESS SCHEDULE

RATHUS ASSERTIVENESS SCHEDULE

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

+3 very characteristic of me, extremely descriptive
+2 rather characteristic of me, quite descriptive
+1 somewhat characteristic of me, slightly descriptive
-1 somewhat uncharacteristic of me, slightly nondescriptive
-2 rather uncharacteristic of me, quite nondescriptive
-3 very uncharacteristic of me, extremely nondescriptive

___ 1. Most people seem to be more aggressive and assertive than I am.
___ 2. I have hesitated to make or accept dates because of "shyness."
___ 3. When the food served at a restaurant is not done to my satisfaction, I complain about it to the waiter or waitress.
___ 4. I am careful to avoid hurting other people's feelings, even when I feel that I have been injured.
___ 5. If a salesman has gone to considerable trouble to show me merchandise which is not quite suitable, I have a difficult time in saying "No."
___ 6. When I am asked to do something, I insist upon knowing why.
___ 7. There are times when I look for a good, vigorous argument.
___ 8. I strive to get ahead as well as most people in my position.
___ 9. To be honest, people often take advantage of me.
___ 10. I enjoy starting conversations with new acquaintances and strangers.
___ 11. I often don't know what to say to attractive people of the opposite sex.
___ 12. I will hesitate to make phone calls to business establishments and institutions.
___ 13. I would rather apply for a job or for admission to a college by writing letters than going through with personal interviews.
___ 14. I find it embarrassing to return merchandise.
___ 15. If a close and respected relative were annoying me, I would smother my feelings rather than express my annoyance.
___ 16. I have avoided asking questions for fear of sounding stupid.
___ 17. During an argument, I am sometimes afraid that I will get so upset that I will shake all over.
___ 18. If a famed and respected lecturer makes a statement which I think is incorrect, I will have the audience hear my point of view as well.
___ 19. I avoid arguing over prices with clerks and salesmen.
___ 20. When I have done something important or worthwhile, I manage to let others know about it.
___ 21. I am open and frank about my feelings.
___ 22. If someone has been spreading false and bad stories about me, I see him (her) as soon as possible to "have a talk" about it.
___ 23. I often have a hard time saying "no."
___ 24. I tend to bottle up my emotions rather than make a scene.
___ 25. I complain about poor service in a restaurant and elsewhere.

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

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

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

___ 29. I am quick to express an opinion.

___ 30. There are times when I just can't say anything.

APPENDIX B

TEXAS SOCIAL BEHAVIOR INVENTORY

TEXAS SOCIAL BEHAVIOR INVENTORY

The Texas Social Behavior Inventory is designed to gather background and social behavior data. Please answer every question. When you decide which letter is the best answer for a particular question, mark an X on that letter; example: a b **X** d e.

---

1. I would describe myself as socially unskilled.

a	b	c	d	e
Not at all characteristic of me	Not very	Slightly	Fairly	Very much characteristic of me

2. I frequently find it difficult to defend my point of view when confronted with the opinions of others.

a	b	c	d	e
Not at all characteristic of me	Not very	Slightly	Fairly	Very much characteristic of me

3. I would be willing to describe myself as a pretty "strong" personality.

a	b	c	d	e
Not at all characteristic of me	Not very	Slightly	Fairly	Very much characteristic of me

4. When I work on a committee I like to take charge of things.

a	b	c	d	e
Not at all characteristic of me	Not very	Slightly	Fairly	Very much characteristic of me

5. I usually expect to succeed in the things I do.

a	b	c	d	e
Not at all characteristic of me	Not very	Slightly	Fairly	Very much characteristic of me

6. I feel comfortable approaching someone in a position of authority over me.

a	b	c	d	e
Not at all characteristic of me	Not very	Slightly	Fairly	Very much characteristic of me

7. I enjoy being around other people, and seek out social encounters frequently.

a	b	c	d	e
Not at all characteristic of me	Not very	Slightly	Fairly	Very much characteristic of me

8. I feel confident of my social behavior.

a	b	c	d	e
Not at all characteristic of me	Not very	Slightly	Fairly	Very much characteristic of me

9. I feel I can confidently approach and deal with anyone I meet.

a	b	c	d	e
Not at all characteristic of me	Not very	Slightly	Fairly	Very much characteristic of me

10. I would describe myself as happy.

a	b	c	d	e
Not at all characteristic of me	Not very	Slightly	Fairly	Very much characteristic of me

11. I enjoy being in front of large audiences.

a	b	c	d	e
Not at all characteristic of me	Not very	Slightly	Fairly	Very much characteristic of me

12. When I meet a stranger, I often think that he is better than I am.

a	b	c	d	e
Not at all characteristic of me	Not very	Slightly	Fairly	Very much characteristic of me

13. It is hard for me to start a conversation with strangers.

a	b	c	d	e
Not at all characteristic of me	Not very	Slightly	Fairly	Very much characteristic of me

14. People seem naturally to turn to me when decisions have to be made.

a	b	c	d	e
Not at all characteristic of me	Not very	Slightly	Fairly	Very much characteristic of me

15. I feel secure in social situations.

a	b	c	d	e
Not at all characteristic of me	Not very	Slightly	Fairly	Very much characteristic of me

16. I like to exert my influence over other people.

a	b	c	d	e
Not at all characteristic of me	Not very	Slightly	Fairly	Very much characteristic of me

APPENDIX C

DRUG ABUSING SAMPLE

DRUG ABUSING SAMPLE

Subjects	Rathus Assertiveness Schedule	Texas Social Behavior Inventory
S_1 (female)	+10	46
S_2 (female)	+56	41
S_3 (female)	+ 1	31
S_4 (female)	+59	50
S_5 (female)	-10	44
S_6	+36	47
S_7	+39	43
S_8	-21	25
S_9	+25	46
S_{10}	- 4	47
S_{11}	-25	36
S_{12}	-38	30
S_{13}	-81	6
S_{14}	- 4	42
S_{15}	+24	49
S_{16}	-25	27
S_{17}	+23	41
S_{18}	+29	43
S_{19}	+ 2	43
S_{20}	+ 4	45

APPENDIX D

ALCOHOL ABUSING SAMPLE

ALCOHOL ABUSING SAMPLE

Subjects	Rathus Assertiveness Schedule	Texas Social Behavior Inventory
S_1 (female)	+33	55
S_2 (female)	+48	56
S_3	+16	51
S_4	+51	46
S_5	+ 3	31
S_6	- 2	40
S_7	+ 5	31
S_8	+58	51
S_9	+35	62
S_{10}	- 8	40
S_{11}	+ 4	39
S_{12}	- 2	44
S_{13}	-26	42
S_{14}	+34	49
S_{15}	-56	18
S_{16}	+36	36
S_{17}	+16	49
S_{18}	+ 8	33
S_{19}	+ 6	39

APPENDIX E

NON-SUBSTANCE ABUSING SAMPLE

NON-SUBSTANCE ABUSING SAMPLE

Subjects	Rathus Assertiveness Schedule	Texas Social Behavior Inventory
S_1 (female)	+22	53
S_2 (female)	-16	46
S_3 (female)	+12	34
S_4 (female)	+11	57
S_5 (female)	-21	36
S_6 (female)	-48	23
S_7 (female)	+ 8	50
S_8 (female)	-65	28
S_9 (female)	-23	49
S_{10} (female)	-16	38
S_{11} (female)	+42	47
S_{12} (female)	+14	54
S_{13}	+21	59
S_{14}	+35	51
S_{15}	+34	48
S_{16}	+14	50
S_{17}	+ 4	53
S_{18}	+37	59
S_{19}	- 8	47
S_{20}	+55	62
S_{21}	+20	53
S_{22}	+ 2	32
S_{23}	+20	50
S_{24}	+25	52
S_{25}	-23	41

Appendix E-continued

Subjects	Rathus Assertiveness Schedule	Texas Social Behavior Inventory
S_{26}	+ 8	59
S_{27}	+ 2	50
S_{28}	- 4	47
S_{29}	+20	53
S_{30}	-35	24
S_{31}	+42	63
S_{32}	+46	63
S_{33}	+11	52
S_{34}	+28	49
S_{35}	+ 4	42
S_{36}	+12	45
S_{37}	+ 4	47
S_{38}	- 9	43
S_{39}	-33	48
S_{40}	- 8	42
S_{41}	+ 1	42
S_{42}	+ 3	38
S_{43}	+ 2	54
S_{44}	+28	40
S_{45}	+ 9	52
S_{46}	+10	41
S_{47}	- 5	39
S_{48}	+ 4	42
S_{49}	+40	56
S_{50}	-29	35