

AN ABSTRACT OF THE THESIS OF

Sue Uland Stephenson for the degree of Doctor of Philosophy in College Student Services Administration presented on November 15, 1988.

Title: The Effect of a Cognitive-Behavioral Course in Assertive Training Procedures on Internalized Shame in College Students

Abstract approved: _____ *Redacted for Privacy* _____
THOMAS E. GIBSON ✓

The purpose of this study was to examine the effect of a course in assertiveness training on internalized shame in college students to determine if assertiveness training was effective in decreasing the feeling of shame in undergraduate college students. Assertiveness training was selected as the treatment to reduce shame because of the theoretical link between assertiveness and self-concept.

The study was an empirical investigation of a treatment for the emotion of shame. The experimental design used for the study was a Repeated Measures ANOVA with one grouping factor (treatment) and one within subjects factor (time). The treatment grouping factor had two levels: control and experimental. The within subjects factor, time, had two levels: pre and post. There were two main effects, treatment and time, and one two-way interaction, treatment \times time. The dependent variables were shame and assertiveness. The independent variables were treatment (control and experimental) and time (pre and post).

The instruments used to measure the dependent variables were the Rathus Assertiveness Schedule (RAS) and the Internalized Shame Scale (ISS). The experimental subjects were 76 students enrolled in Psychology 479-570, Assertive Training Procedures. The control group subjects were 97 students enrolled in Speech 391-100, Fundamentals of Speech. All subjects in the study were enrolled at the University of Wisconsin-Stout, Menomonie, Wisconsin, during fall semester, 1987.

Based on the results of the study, the following conclusion was reached: assertiveness training had a positive effect on lowering the level of internalized shame in college students. The experimental group, which had an assertiveness training class, experienced a statistically significant decrease in the level of shame compared to the control group, which did not receive assertiveness training.

This study provided evidence that assertiveness training was an effective short-term therapy to reduce internalized shame in undergraduate college students.

The Effect of a Cognitive-Behavioral Course in
Assertive Training Procedures on Internalized
Shame in College Students

by

Sue Uland Stephenson

A THESIS

submitted to

Oregon State University

in partial fulfillment of
the requirements for the
degree of

Doctor of Philosophy

Completed November 15, 1988

Commencement June 1989

APPROVED:

Redacted for Privacy

Associate Professor of Post-Secondary Education in charge of major

Redacted for Privacy

Division Chair of Foundations and Post-Secondary Education

Redacted for Privacy

Dean of School of Education

Redacted for Privacy

Dean of Graduate School

Date thesis is presented November 15, 1988

Typed by B. McMechan for Sue Uland Stephenson

Acknowledgements

The writer wishes to express appreciation to the many people who graciously responded when called upon for assistance during this study:

To Dr. Thomas E. Grigsby, my major advisor, and members of my doctoral committee, Drs. Charles Warnath, Les Dunnington, M. Edward Bryan, and Rebecca Johnson, for their guidance, direction, and suggestions, all of which contributed greatly to the completion of this work.

To Dr. David Cook, author of the Internalized Shame Scale, who so generously permitted use of his scale and offered helpful technical assistance.

To Dr. James Miller, Mr. Jerry Kirsling, Ms. Cece Simon, and Ms. Donna Weber, who instructed the classes which were utilized in this investigation.

To the students of the University of Wisconsin-Stout, who served as subjects in this study.

To the many friends and colleagues, who extended their encouragement, moral support, and interest in this investigation.

To Suzi Maresh, from the Oregon State Survey Research Center, who provided not only design and statistical assistance, but encouragement and support when the days of writing were the bleakest.

To the Office of the Dean of Students faculty, staff, graduate students and spouses, who gave so generously their love and support. Your affirmations and encouragement truly kept me going.

To Dr. Nancy Vanderpool, who was always there when I needed help and support and who was my friend, colleague, supervisor and mentor during this process. Her encouragement helped me to believe that it was all really possible.

To Dr. Roger Penn, who believed in me and gave me the chance to spread my wings as an administrator and who was there with help and support when I had questions or concerns.

To the graduate students in CSSA and Counseling, who were always interested in my progress and there to cheer me on.

To Judy Glenn, Ed Brazee, Marjorie Knittel and Laurel Maughan for library assistance. Your helpfulness and friendly attitudes made the many and long hours of research not seem quite so tedious.

To the staff of the Newman Center for their warm support and many prayers.

To Dr. James Firth, a wonderful teacher and role model of a caring, empathic counselor.

To Ann, Ruth, Sandy, and Pat, a big hug and thank you for all your many thoughtful gestures.

To Chris Ness from the Computer Center at the University of Wisconsin-Stout for statistical and computer help.

To Sigma State of Delta Kappa Gamma International for the Hazel Duling Scholarship which provided financial assistance during the dissertation stage.

To all my nieces and nephews, thank you for believing in Aunt Sue, especially GuyLa who always seemed to know when I needed an extra boost of support.

Most of all the writer wishes to express her deep appreciation and love to her brothers and sisters, Mary, Ted, Kay, and Frank, for their abundant love, affection, encouragement, understanding and support in so many, many ways during my journey to this goal. Without them, this study would never have been completed. It is not possible to adequately express my love, affection and gratitude to them, except perhaps to say, "Thank you, God, for giving me my wonderful brothers and sisters and permitting me to be their sister."

Dedication

This dissertation is dedicated to the memory of my mother and father, who loved and believed in their children and in education.

Table of Contents

	<u>Page</u>
I INTRODUCTION	1
Intent and Scope of the Study	2
Purpose of the Study	2
Objectives of the Study	3
Rationale for the Study	3
Limitations of the Study	6
Delimitations of the Study	6
Summary	7
Definition of Terms	8
II REVIEW OF THE LITERATURE	10
Introduction	10
Early Appearance of Shame	13
Defining Shame	14
Physical Reactions to Shame	19
Shame Treatments	21
Shame and Self-Concept	24
Effects of Shame	27
Assertiveness	30
Shame and Assertiveness	32
Summary	35
III METHODOLOGY	37
Design of the Study	37
Sample	37
Experimental Group	37
Control Group	38
Treatment	40
Course Content of the Experimental Group	41
Reading and Laboratory Assignments	41
Physical Facilities	42
Instrumentation	42
Rathus Assertiveness Schedule	42
Test-Retest Reliability	43
Split-Half Reliability	43
Validity	43
Internalized Shame Scale	44
Development of the Scale	45
Reliability	47
Validity	47
Administration	50
Hypotheses	51
Analysis of Data	52
Summary	55

Table of Contents (continued)

	<u>Page</u>
IV PRESENTATION AND ANALYSIS OF THE DATA.....	56
Hypotheses	57
Additional Findings	57
Summary	68
V. SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS	70
Summary	70
Conclusions	74
Implications	77
Recommendations	78
BIBLIOGRAPHY	80
APPENDICES	91
A: Consent Forms	91
B: Standardized Tests	94

List of Figures

<u>Figure</u>		<u>Page</u>
1	Interaction of Treatment and Time: Shame	62
2	Interaction of Treatment and Time: Assertiveness	66

List of Tables

<u>Table</u>	<u>Page</u>
1 Sample Size, Number of Participants, Fall Semester, 1987	39
2 Alpha Reliability Coefficients and Test-Retest Correlations for ISS Scales	47
3 Factor Analysis and Item Statistics for ISS Subscales	48
4 Data Matrix for Two-Factor Repeated Measures	53
5 Main Effect Means: Shame	58
6 Total Sample Mean Scores: Shame	59
7 Results of Newman-Kuels Multiple Comparison Among Interactive Means	61
8 Interaction Means: Shame	61
9 ANOVA With Repeated Measures For Shame	63
10 Main Effect Means: Assertiveness	64
11 Total Sample Mean Scores: Assertiveness	65
12 Interaction Means: Assertiveness	66
13 ANOVA With Repeated Measures For Assertiveness	67
14 Estimated Sample Correlation Coefficients and Corresponding P-values for Dependent Variables	68
15 Summary of Results	69

THE EFFECT OF A COGNITIVE-BEHAVIORAL COURSE IN ASSERTIVE TRAINING PROCEDURES ON INTERNALIZED SHAME IN COLLEGE STUDENTS

I. INTRODUCTION

Though terror speaks to life and death and distress makes of the world a veil of tears, yet shame strikes deepest into the heart of man. While terror and distress hurt, they are wounds inflicted from outside which penetrate the smooth surface of the ego; but shame is felt as an inner torment, a sickness of the soul. It does not matter whether the humiliated one has been shamed by derisive laughter, or whether he mocks himself. In either event he feels himself naked, defeated, alienated, lacking in dignity and worth. (Tomkins, 1963, p. 185)

Centuries have been spent studying the emotions of humans. However, there are few empirical studies available that have concentrated on the phenomenon of shame. The quest for an answer to "who am I?" is at the very core of human nature. The emotion of shame is inseparable from a person's journey in the search for him or herself. There is a negative evaluation of the self when one experiences shame.

Piers and Singer (1953) suggested that the worry of being abandoned was involved in shame. If an individual is found to be so inadequate that others walk away from him or her, then it is easy to see how the feeling

of self-concept becomes an issue in shame. Since there have been studies (Sisson, 1977; Stephenson, 1982) which have suggested that there was a positive relationship between assertiveness and self-concept, it seemed intuitively reasonable to hypothesize that assertiveness training could be a method to help people overcome their feelings of shame, e.g., abandonment, humiliation, imperfection, inferiority, rejection, the desire to hide or run away.

The physical expression of shame has been described as eyes downcast, shoulders slumped, face turned away, head lowered--all this in an attempt to become as small as possible in order not to be seen by others (Morris, 1971; Izard, 1977). These same nonverbal gestures were described in behavior therapy literature as the behavioral components of nonassertive communication (Alberti & Emmons, 1970; Lange & Jakubowski, 1976). It is possible, then, to intuitively believe that the development of assertive skills could very well modify the physical expressions of shame (downcast eyes, etc.) in addition to lowering the feeling of internalized shame, which can be a product of low self-esteem brought about by a painful emotional experience.

Intent and Scope of the Study

Purpose of the Study

The purpose of the study was to examine the effect of a course in assertiveness training on internalized shame in college students and to determine if assertiveness training was an effective treatment in decreasing the feeling of shame in undergraduate college students. The dependent variables were the internalized shame score and the assertiveness score. The independent variables were treatment (control and experimental) and time

(pre and post). Students who were enrolled in assertiveness training classes were compared with students from the same population who were not taking a class, nor had ever taken a class, or been part of a group engaged in assertiveness training. The subjects were also measured on an assertiveness scale to ascertain differences in assertive behavior.

Objectives of the Study

1. To review the existing literature related to internalized shame and to assertiveness.
2. To develop a methodology, including the identification of appropriate instrumentation, for research with internalized shame and with assertiveness.
3. To administer these instruments to a population of college students enrolled in assertive training classes at the University of Wisconsin-Stout, Menomonie, Wisconsin.
4. To determine if there is a relationship between internalized shame and assertiveness training.
5. To utilize the findings to suggest programming for student affairs divisions in colleges and universities.

Rationale for the Study

Most of the information on shame is based on theoretical and psychoanalytical papers prepared by psychiatrists and psychologists. Very few empirical studies have been carried out to study the emotion of shame, although the emotion is well-known clinically. In the psychoanalytic arena it has been acceptable to explain all emotions on the basis of drive theory. In this approach, shame was not considered important and therefore was not

worthy of scientific inquiry. Shame as a fountainhead of human discomfort has been overlooked when compared with investigations into other emotions like guilt. It is only recently that researchers have begun to investigate and challenge some of the beliefs and doctrines of theorists in the fields of psychology and psychoanalysis. The viewpoint that is emerging is that shame is a subject of growing importance (Kaufman, 1986; Lansky, 1987; Morrison, 1987; Nathanson, 1987). Fossum and Mason (1986) suggested that shame was the underlying problem which was manifested in compulsive, addictive, and abusive behavior. They found a high correlation between shame and different dependencies in families. Cook (in press) found a strong correlation of shame in people with addiction to alcohol. It is a known fact that colleges and universities have a problem with alcohol-related incidences on campuses, including damage in residence halls, fights and injuries at athletic events, and even deaths (Buchanan & Oliaro, 1984). Thus, an investigation into a treatment for shame in college students could provide a tool to deal with alcohol-related problems on college campuses.

This study was unique and pertinent: (1) Only one empirical study was found that came close to identifying a treatment for shame, although the researcher was actually seeking a way to dispel resentment (Retzinger, 1985). One theorist of emotions defined resentment as a compound of shame and anger (Scheff, 1985); (2) there was no literature available, other than clinical observations, that reports on how to lower internalized shame; and (3) there have been no studies thus far which have examined the relationship between the variables of assertiveness and shame.

This study proposed assertiveness training as a treatment to modify the emotion of shame in college students. Assertiveness training was chosen as the therapy to reduce shame because of the theoretical link between

assertiveness and self-concept. Research has shown that shame results in a loss of self-concept (Kohut, 1971, 1977; Miller, 1985; Modigliani, 1971). In addition, it has been shown that self-concept increases after assertiveness training (Sisson, 1977; Stephenson, 1982). Therefore, if assertiveness raised self-concept and self-concept was diminished by shame, assertiveness training should lower the feeling of shame. One of the focuses of this study was to contribute to the body of literature since no study was found which examined assertiveness and shame. If indeed a relationship exists between assertiveness training and shame, colleges and universities would have a potential mechanism to deal with a major problem on campuses.

This study did not deal with guilt, although very often shame and guilt are thought of as similar and are not distinguished by their differences. Guilt is self-criticism, an internal sanction, which occurs when one violates his/her value system. Shame, on the other hand, results from criticism by others, an external sanction, which occurs when one does not live up to a goal or ideal. Guilt has an implication of wrong-doing with an expected punishment. A person knows what value has been violated and can usually choose whether or not to do something about it, such as apologizing or asking for forgiveness. Shame, however, has an emphasis on the self with a feeling that the self is worthless. The shamed person perceives a negative evaluation from someone whose opinion is valued. Shame involves a complete change in self-image; guilt does not involve a change in self-image. In guilt, one does a bad thing, but is not a bad person. In shame, the feeling is that one is a bad person because one is incompetent or inadequate.

Limitations of the Study

Generalization of the findings may be limited by:

1. The extent that the sample was representative of the students who enroll in college level courses of assertiveness training.
2. The limitations of the instruments. Two self-reporting instruments were chosen: The Internalized Shame Scale (Cook, in press) and the Rathus Assertiveness Schedule (Rathus, 1973). Self-report measures are common methodologies for assessment; however, they do possess certain weaknesses (Wylie, 1961):
 - a) Subjects may only reveal what they want to reveal, which may not be their true feelings;
 - b) Subjects may respond with the way they see themselves, or the way they would like to be, rather than the way they really are or the way they really do respond in certain situations; and
 - c) Subjects can be influenced by their unique habits of language, self-analysis, and self-examination.
3. The discrimination of the ISS, which is a fairly new standardized instrument, copyrighted in 1986.

Delimitations of the Study

Generalization of the findings is delimited by:

1. The choice of the course curriculum which was used in three classes of assertiveness training at the University of Wisconsin-Stout.
2. The study did not have a follow-up measure to reveal whether changes in attitude and/or behavior were maintained over a period of time.

Summary

This study explored a treatment for the emotion of shame in college students. The treatment proposed was that of assertiveness training. Studies have shown that a cognitive-behavioral course in assertiveness training raised self-concept in college students (Sisson, 1977; Stephenson, 1982). The shame literature described and defined shame as a feeling of inferiority (Kaufman, 1974; Kohut, 1971) in which the sense of self was diminished (Miller, 1985) and self-esteem was lost or damaged (Isenberg, 1949; Kaufman, 1985; Lynd, 1958; Piers & Singer, 1953; Richards, 1971). If these theories of shame are correct, given that self-concept is significantly higher after a structured experience in assertiveness training (Sisson, 1977; Stephenson, 1982), then assertiveness training should lower feelings of shame which otherwise serve to lower self-concept.

The rationale for the study was threefold: (1) The lack of empirical data on treatments for shame, (2) the correlation of shame with individuals who have an addiction to alcohol, and (3) the high rate of alcohol related problems on college campuses. A treatment for the emotion of shame would be a way to help deal with this problem. A list of terms pertinent to this study were defined as they related to this investigation.

Definition of Terms

The following definitions are included to provide the reader an operational definition of how these terms are being used and measured in this study.

COGNITIVE: An intellectual process of thoughts, perceptions, insights, or ideas, e.g., self-statements, images, self-evaluations.

An internal dialogue of what a person says to one's self.

BEHAVIORAL: Rehearsal of the situation with others (role play), practice situations, homework assignments. It includes verbal and nonverbal behaviors.

SHAME: A feeling of being defective or unworthy as a person, feeling "less than." A fear of exposure, weaknesses discovered by or displayed for significant others to see. The painful emotional reaction of feeling inferior, which sometimes requires defenses to lessen the pain, e.g., anger, running away, hiding.

INTERNALIZED SHAME: The painful emotional reaction experienced with or without an audience by way of mental imagery or cognition. A reliving of the event or experience leading to the feeling of shame.

ASSERTIVENESS: A style of communication that is direct, honest, and appropriate to the situation. It is based on one's interpersonal rights and recognizes and is respectful of the rights of others. It includes expression of feelings, thoughts, and ideas that are self-focused and goal directed.

ASSERTIVENESS TRAINING: Skill training that incorporates semi-structured group techniques using role-play exercises in addition to other procedures, including value clarification, effectiveness training, negotiation and conflict resolution, and cognitive restructuring.

II. REVIEW OF THE LITERATURE

Introduction

This chapter is presented in nine sections: introduction, the early appearance of shame, definitions of shame, the physical reaction to shame, shame treatments, shame and self-concept, effects of shame, assertiveness, and shame and assertiveness.

A review of the literature relevant to internalized shame was examined in order to define the term and to understand the emotion, shame. The relationship of shame and self-concept was examined since they provide the theoretical link between shame and assertiveness. Studies identifying the theoretical background of assertiveness training and the identification of studies showing a relationship between assertiveness training and self-concept were reviewed. Although shame is a measurable phenomenon (Beall, 1972; Binder, 1970; Cook, in press; Smith, 1972), this review of the literature revealed that there were few empirical studies which have focused upon the phenomenon of shame, but that a number of clinical psychoanalytical studies of the nature of this emotion have been completed.

Shame has been dealt with and understood in a variety of ways. It has either been ignored or mentioned only in passing and regarded, for all practical purposes, as indistinguishable from guilt. It has also been associated with an individual's sense of self-concept and self-esteem.

This review does not address the difference between shame and guilt, although there are those who view the two synonymously (Brandt, 1958;

Hartman & Lowenstein, 1962; Solomon, 1977). Nor does it deal with shame from an anthropological point of view, examining different cultures. "The role of shame varies from culture to culture, . . . nevertheless, the source, the power, and the consequences of shame are similar" (Carroll, 1985, p. 224). Shame in the sense understood in this study was limited to characteristics of people in modern western societies such as our own, providing an overview of the literature relevant only within this limiting factor.

Throughout the history of psychology, it is interesting to note the disparity in investigations of the emotion of guilt in comparison to those directed at the emotion of shame. This could be due to the fact that shame and guilt are often thought of as similar emotions and are not distinguished for their differences. As late as the 1960s, theoreticians were noting the lack of literature of shame, although an enormous amount of literature existed on the emotion of guilt (Bilmes, 1967). Shame and guilt began with Freud's construct of the "super ego," which can be described as an individual conscience or internal monitor. It is the means by which people evaluate themselves and their behavior. Guilt and shame are among the emotions induced by this internal monitor.

Several theorists have noted that shame and guilt have been considered compositely because they both function as drive controls (Erikson, 1950; Piers and Singer, 1953; Wallace, 1963). Lewis (1971) wrote that "this grouping, however, tended to direct attention to guilt as the generic term for both shame and guilt, to the neglect of distinctive shame phenomena" (p. 19). It appears that theorists have preferred to study guilt rather than shame. It can be argued that guilt is less painful and unpleasant, while on the other hand shame is more intimate, exposing feelings closely associated with inferiority. Lynd (1958) argued that shame is a stronger emotion than guilt

because ego ideals can be more basic and powerful than a violation of standards or values of the super ego.

Centuries of effort have been devoted to the pursuit of knowledge about the emotions and the emotional makeup of humanity. The emotion of shame, however, has lacked the attention that has been afforded the study of other emotions. According to Kaufman (1974),

shame has been one of the least known and understood dimensions of human experience and is paradoxically one of great significance. Part of the reason for this stems from the lack of words in our language that clearly identify shame experiences. (p. 568)

Despite the important role shame plays in human affairs, it has been studied much less than guilt, anger, fear, or anxiety (Izard, 1977). Erikson (1963) believed that "shame is an emotion insufficiently studied, because in our civilization it is so early and easily absorbed by guilt" (p. 252). In a study conducted by Shimanoff (1984), shame was one of the least frequently discussed emotions by people between the ages of 20 and 50.

The far reaching effects of shame can be overwhelming. Our personal experience of shame can be the beginning of the realization that we too can incapacitate others by using shame as an arsenal. This vicious weapon can create harm that is passed from one generation to the next. Lansky (1984) found that when shame was used as a weapon, fighting escalated dramatically between people.

When it comes to defining shame, there is not a long history of attention in the psychological literature. Shame does not appear to be a commonly discussed emotion. Freud, often referred to as the "father of psychoanalysis," did not deal with shame as an emotion. He viewed morality as the reason for shame and regarded shame as a defense or smoke-screen

without an expressive function, related only to exhibitionism. It is possible to speculate that Freud's early labeling and lack of interest in shame accounts for some of the neglect of studies focusing upon this emotion. Binder (1970) suggested that although studies of shame have appeared periodically, they have been stimulated by practitioners' clinical experiences.

People experiencing shame do not go for therapy as frequently as people experiencing guilt, therefore clinicians have access to less information on this affect. Shame has been such an ignored affect that it was not until May, 1984, according to the American Psychoanalytic Association, that specialists in either psychiatry or psychoanalysis (in either Europe or the American continent) held a meeting which focused exclusively on shame (Nathanson, 1987).

Early Appearance of Shame

Feelings of shame begin to emerge at the very formation of an infant's sense of self. Psychoanalysts trace an extreme sense of shame in the adult personality to early childhood when parents or principal caregivers failed to respond with attention and empathy to children's efforts to show their abilities or qualities. Tomkins (1963) hypothesized that as soon as infants can recognize a difference between the face of the mother from the face of a stranger, infants are able to experience shame. This can occur as early as the age of four months. Spitz (1965) described shame in children as young as six to eight months old. Broucek (1982) also supports the theory that children in the first year of life manifest the affect of shame. In a 1974 study, Zimbardo, Pilkonis, and Norwood found that shame was important in the socialization process and in the development of individual

personality. Edwards (1979) also postulated that shame may be one of a person's earliest experiences in life, crediting Erik Erikson with being the first psychoanalyst interested in looking at shame as being different than guilt when he labeled two of the maturational stages of childhood as autonomy vs. shame and initiative vs. guilt. Nathanson (1987) states that "shame is a major force in shaping the infantile self, and remains so throughout life" (p. 27). He further suggests an adult's idea of what it means to be lovable and the development of this concept of self is based on the early shame experiences of individuals. In other words, the adult experience of shame is linked to early shame experiences.

Defining Shame

The lexicographical definition of shame is a state of mind, a painful, emotional reaction when one feels belittled, dishonored, exposed to criticism, or disgraced by a deed(s) or shortcoming(s) done either in the past, present, or future which were improper or ridiculous. The painful feelings are caused by a lowering of one's self-respect created by the consciousness or by the exposure of unworthy or indecent conduct or circumstances. It is a humbling in the estimation of others (*American College Dictionary*, 1963; Rostenreich, 1965; *Webster's Third New International Dictionary*, 1981).

From the literature, a definition of shame emerges as a feeling of inferiority and a fear of exposure. "The experience of shame is a fundamental sense of being defective as a person" (Kaufman, 1974, p. 13). The feeling of exposure is a large component of shame (Kaufman, 1974, 1985; Levin, 1967; Lewis, 1971; Nathanson, 1987) and later, following occurrence of the experience, an anger develops to protect oneself. This anger or rage

protects the self against further shame experiences by keeping others away (Kaufman, 1985). This position was supported by Levin, who in 1967 wrote: "Shame may be experienced in relation to past, present and future events, and in all three instances self-exposure is usually a major component" (p. 269). Shame is a response to a feeling of self-exposure when rejection is experienced through criticism or ridicule. Kohut (1977) considered that one of the magnitudes of shame is that it not only creates a feeling of inferiority, thus inhibiting an individual's full development, but the experience of the self as inferior also creates a negative feeling which can lead to the collapse of self-esteem. Shame is a very disagreeable, ugly feeling.

Shame is a state of disgrace or dishonor. The word, "shame," is derived from the Germanic roots *skam/skem*, meaning a sense of shame, being shamed, or disgrace. The English word for shame comes from the Gothic word, *skama*, which means to cover or to hide. Tomkins (1962, 1963) two volumes on affect theory are often credited in the literature as the place to start when defining shame and can be seen as a major influence in the writings of Gershen Kaufman (1974, 1985) and Donald Nathanson (1987). Wurmser (1981) defines shame as

the *fear* of disgrace, it is the *anxiety* about the danger that we might be looked at with contempt for having dishonored ourselves. Second, it is the feeling when one is looked at with such scorn, . . . the *affect of contempt* directed against the self One feels ashamed for *being exposed* . . . in a way that reflects poorly upon oneself, . . . of failing someone else's expectations or failing the demands of performance by one's own conscience To disappear into nothing is the punishment for such failure. (p. 67)

It is generally accepted that shame is the result of an inner striving, an unrest between the ego and ego ideal. Piers and Singer (1953) distinguished shame as occurring when one failed to live up to an ideal or achieve a goal that was basic to one's self-concept, i.e., the emotion the individual feels about his/her shortcomings or the failure to live up to the individual's sense of personal identity.

Shame can occur whenever a deficiency that has been hidden is revealed, either to the self or to someone else. Shame can include the feeling experienced after others laugh at or otherwise ridicule an individual, or the feeling experienced prior to knowing whether or not others are going to reject or accept an individual (Ward, 1972). Kaufman (1985) traces the interpersonal origins of shame, most often in relationships that are meaningful to a person. The way shame is experienced in life is an individual matter. Yet, experiences of shame have common elements. To feel ashamed refers to an awareness of others. One has to care about what others think; it has to matter what others think of you in order to experience shame. According to Lewis (1971), shame can occur only in the context of an emotional relationship with someone whose opinion and feelings are valued. Thomas Scheff is quoted by Coleman (*New York Times*, 1987) to the effect that "shame is a master emotion, regulating the expression of other feelings." It disrupts social relationships.

Shame is a response to an intrusion into inner privacy and represents a danger. In every shaming circumstance, the effort to hide from scrutiny and to release anger toward the source of shame, as well as the desire not to completely cut ties with the shaming object, are apparent (Spero, 1984). Shame is an affect (emotion) that can be short-lived or enduring. The latter occurs when shame becomes internalized, i.e., a person can trigger

shame without the original activating event. Shame is a feeling which occurs and then moves on or leaves. However, when shame becomes internalized, it can be indefinitely maintained. Piers and Singer (1953), in their early work, also believed that shame did not always need an external sanction (mechanism) to trigger the emotion when shame was strongly enough developed to become an internal sanction, i.e., internalized. Kaufman (1985) describes internalized shame occurring when the emotion is triggered by events, experiences, or people having little or nothing in common with the original activating event or circumstance. He describes people who have internalized shame as having a "shame-based identity." Shame experiences can become internalized through imagery. Tomkins (1961, 1963) describes them as internal images or scenes. These shame reproducing events can exercise continuous control over the further development of an individual.

Shame can be difficult to describe because it creates differing degrees of reaction, from mild to intense, of unpleasant feelings. Even though it creates unpleasant feelings there are perceptions that shame occurs when people are experiencing positive emotions of interest, enjoyment, excitement, and joy (Binder, 1970; Bartlett & Izard, 1972; Tomkins, 1963). Shame, according to this point of view, is the result of an interruption, reduction, or barrier to the exploration of interest and enjoyment. These interruptions or barriers create a heightened self-consciousness and/or call undue attention to the self. If they do not, shame will not result; if they do, shame is elicited. Feldman (1962) pointed out that there are sensitive people who experience shame when things go well. Any attention, whether it brings praise or degradation, can create the emotion.

Lynd (1961) noted that some situations can create the belief that personal behavior is inappropriate or incongruent, bringing forth feelings of

shame, while in other situations incongruity brings forth interest or excitement. Izard (1977) suggests that situations that bring about shame in one person may produce excitement in another, anger and hostility in a third, and distress or fear for yet others. Even within the same person, a situation or condition may produce shame, yet another time and another place the same situation will not have a shaming effect on the individual.

The most common and ubiquitous objects involved in the activation of shame are the self (or self-concept), the body, love, work, friendship, close interpersonal relationships, or even brief encounters that have special meaning for the individual. (p. 397)

Wurmser (1987) sees shame as concern about the risk that we might be viewed with disgust for having discredited ourselves. It is also a feeling which results when an individual is looked at disparagingly. "It is, in other words, the *affect of contempt* directed against the self--by others or by one's conscience. One feels ashamed for *being exposed*, or failing the demands of performance by one's own conscience" (p. 67). For some theorists, the experience of shame appears to be a social experience. It happens before or in front of somebody and there is a recognition that we are as the other person sees us (Kaufman, 1980; Lewis, 1971; Lynd, 1958; Morrison, 1984; Piers, 1953, 1971). Shame as a response to exposure is a view also expressed by Nathanson (1984), Kaufman (1985), Wurmser (1981), and Lewis, who proposed that the innate purpose of shame is to act as a regulator of social interaction. Piers (1953) insisted that shame demands achievement of a positive goal, which he perceived as a reaction to the ego-ideal. It is a reaction to being viewed by others in a negative manner as an inferior. The only serious dissenting view was stated by Kinston (1983),

who feels that the social theory of shame, in which the basic crux is being seen, ridiculed, or rejected by another, is superficial.

Kopp (1976) described shame as an overwhelming experience, occurring when our weaknesses are seen and displayed before significant others. Because of personal failings, the individual is not able to live up to the expectations of significant others and feels ashamed of who he/she is. The self is exposed, disapproved of, and seen as inadequate and inferior. Shame creates the feeling that "I am weak because of that which I basically am" (Lynd, 1958, p. 22). Ultimately, to experience shame is to wish a hole would open up and swallow us (Kaufman, 1985). "Betrayal, treachery, and abandonment can activate shame" (Nathanson, 1987, p. 4). Fossum and Mason (1986) define shame in experiential terms, regarding it as more than loss of face or embarrassment:

Shame is an inner sense of being completely diminished or insufficient as a person. It is the self judging the self. A moment of shame may be humiliation so painful or an indignity so profound that one feels one has been robbed of her or his dignity or exposed as basically inadequate, bad, or worthy of rejection. A pervasive sense of shame is the ongoing premise that one is fundamentally bad, inadequate, defective, unworthy, or not fully valid as a human being. (p. 5)

Physical Reactions to Shame

"Emotions have some human action as a part of their definition" (Kinston, 1983, p. 218). The action element of shame is the desire to hide. The physical experience of shame can involve uncomfortable feelings, such as blushing, feeling weak and trembling, the wish that the floor would open

up and swallow one, or a strong desire to run or get away (Ward, 1972). The studies of Lindsay-Hartz (1984) showed that people want to hide so that others cannot see them, while Carroll (1985) reported one expression of shame as the hiding of the face. Lewis (1971) noted that shame is regarded as an irrational reaction and childish. The irrational label comes about as a result of bodily functions (blushing, sweating, rage) which often occur when the self falls short of its ideal. Adults are often ashamed of being ashamed, which further compounds the feeling.

The physical characteristics of shame are often difficult to describe because some people reportedly feel shame without indicating outward manifestations such as blushing (Izard, 1977). Tomkins (1963) suggests that blushing is often an immediate effect of shame. Blushing is a reaction of the autonomic nervous system which causes the contraction of the capillaries of the face, permitting them to fill with blood. The increased flow of blood creates a red or rosy tint to the face. Lewis (1981) postulated an interesting idea when she suggested that the blush developed to let others know that we want to be accepted back in the group or social system.

Not only are there harmful body stimuli from blushing, but sometimes tears and rage result when the shame creates distress and anger (Izard, 1977; Lewis, 1984; Scheff, 1985). Consequently, shame disrupts social relationships. Tomkins (1963) pointed out that it is not socially acceptable for adults to express shame too fully, too intensely, or too frequently, and for that reason they often modify their expression of the emotion. One way of doing this is to quickly look downward. Others, however, may hold the head high, which can give the impression of contempt. Some people may constantly look humble so that a shame expression will not be noticeable.

Others may hold the head back, the chin out, but still have their eyes looking downward. Izard (1977) reported that Charles Darwin thought the same kind of capillary action that causes blushing to the face may also occur in the part of the brain that controls blushing, resulting in the mind becoming confused. This loss of "presence of mind" often results in inappropriate remarks by the person experiencing the effect. A feeling of being totally ineffective and incompetent can occur. This results in a temporary inability to think logically and efficiently. The person suffering the feeling is at a loss for either words or actions to deal with the occasion.

Shame Treatments

Lewis (1971) and Lowenfeld (1976) have asserted that the methods for dealing with shame are few or inefficient. Although shame is an important human affect (Gilligan, 1976; Tomkins, 1962, 1963) and has been a focus for analysis and psychotherapy (Kaufman, 1980, 1985; Lewis, 1971; Mollon, 1984; Nathanson, 1987; O'Leary & Wright, 1986), it has not been frequently examined in terms of treatment (Lewis, 1971) or it has been incorporated into and not differentiated from guilt (Thrane, 1979; Hartman & Lowenstein, 1962). Morrison (1984) believes this lack of attention toward treatment is due in part to therapists' own shame experiences and their failure to deal with their own defects of the ideal self, inhibiting them from dealing empathically with their clients' shame feelings. Wurmser (1981) also pointed out that sometimes therapists' own defenses when working with a patient can hinder therapy. These defenses can range from denial of the patient's pain, to anger at the patient that may even result in labeling the client as "psychotic" in order to put distance between the therapist and the

client, to outright fright on the part of the therapist at what is being uncovered as they fail to explore in depth the shame feelings of their client.

On the other hand, there are a number of defenses that can be used to mask shame and for this reason shame is often difficult to detect in people (Lewis, 1971; Morrison, 1983). Lewis (1984) also notes that shame can be relieved by an encouraging glance from the disapproving person. However, she is also quick to point out that this type of treatment does not always alleviate shame. Kinston (1983) suggests that one way to overcome a negative evaluation of the self is to "obtain frequent, and often public, acclamation and admiration" (p. 218). Saltzman (1983) presents a method for treating shame which he calls "paracatastasis." In this approach the client imagines the person(s) who created the emotion as being present. The client then experiences whatever feelings he/she wishes from assertion to rage toward the significant figure. Morrison emphasizes that the antidote for shame is the acceptance of self in spite of personal flaws, mistakes, imperfections, failings, and blunders and that this step forward should occur within the framework of psychoanalytic therapy.

Treatment for shame has usually been directed from a psychoanalytic point of view, exploring shame as either a major narcissistic pathology or as a neurosis (Lewis, 1971; Morrison, 1983, 1984). Psychoanalytic treatment consists of the patient mastering shame, first through acknowledgement and acceptance of the shame experience and underlying failure, then moving on to genetic origins and reconstruction. According to Wurmser (1981), infinite patience is required when dealing with shame in analysis as the layers hiding shame are uncovered and as clients are helped not to hate and devalue what they are learning about themselves. Talking and getting one's shame out into the open appears to be a first step in treatment. By getting it out into the

open the person no longer has to hide or cover up. Kaufman (1981) writes of examples of Einstein and Freud openly revealing shameful parts of themselves, illustrating the power of talking about the experience to free oneself of shame.

Other ways of dealing with shame have been proposed. Helen Lewis (1971), from clinical observations, also considered laughter an important antidote for shame, noting that "laughter is also a corrective or release for the feeling of shame. When the patient can laugh about it, she is free of shame. When she cannot, it is a *very, very, very sensitive sore spot*" (p. 203). Paradoxically, Lewis noted, "although shame involves images and ideas about what other people are thinking, only one's own laughter can dispel it" (p. 318). Retzinger's (1985) empirical study supports Lewis' hypothesis. Her experimental studies revealed that laughter does indeed reduce shame. Much earlier, Freud (1905) discovered that jokes dissolve humiliation. One of the difficulties in using humor to deal with shame is that people are ashamed of being ashamed and thus are unable to see a solution in gentle humor (Lewis, 1971).

Edwards (1976) held that because shame is experienced as pain felt because of a personal defect, the use of anger is an effective balance. A somewhat perverse method of dealing with shame has been noted by Kaufman (1981), who reports that some who experience shame try to humiliate others to rid themselves of their own disabling feeling of humiliation. This is often done with sarcasm or cynicism, accompanied by an attitude of scorn and arrogance.

Although the various schools of therapy differ in their methods of dealing with feelings of shame, there is a general agreement that identification, diagnosis, and treatment is essential (Edwards, 1976). The intervention

for dealing with shame, regardless of the approach, is directed toward restoring the self to its former condition (Mohl & Burstein, 1982).

Shame and Self-Concept

How people feel about themselves affects virtually every aspect of their lives. The way people respond to experiences in life is dependent in part on their self-concept. In an interview study of college students, Miller (1985) found that the core of shame is the sense of self as diminished or "less than." Shame is a response relating to a person's self-concept and self-integrity. Modigliani (1971) defined shame as a loss of situational self-esteem.

It is important that people feel that they are in charge of their lives, that they are in control. This is one of the bases of self-esteem. In interacting with individuals, people must open themselves to others in order to satisfy human needs. It is important that the degree and direction of self-exposure be controlled by individuals in order that in reaching out to others they do not extend themselves indiscriminately, finding themselves unnecessarily subjected to rejection. This rejection can be communicated through many different means, including criticism, ridicule, scorn, or abandonment.

Kohut (1971, 1977) associated empathy as the core to developing self-esteem, a feeling of personal worth and a tolerance and respect of others. When this does not occur, feelings of shame, humiliation, anger, and loneliness may develop. Shame usually brings a feeling of self-hate and regulates the individual's basic sense of self as less than worthy or as having little worth. It is most often experienced as embarrassment or humiliation. The danger with shame is that it can distort the idea of who one is, or how

worthy one is. A sense of shame drives some people to build an inflated self-image through the pursuit of fame or material rewards in the belief that their worth will be testified to by these accomplishments (Scheff, 1984). Kaufman (1985) emphasizes that

our identity is that vital sense of who we are as individuals, embracing our worth, our adequacy, and our very dignity as human beings. All these can be obliterated through protracted shame, leaving us feeling naked, defeated as a person and intolerably alone. (p. 7)

Kriegman (1983) supports that children who know they have certain rights appropriate to their age and maturation, develop strong self-esteem and shame is not noted in these children. However, shame is noted in children who are not given appropriate rights by their principal caregiver(s). Lewis (1971) hypothesized, following a review of self-concept studies, that normal persons with a low self-image and those with a high need for approval may also be prone to shame. Skorina and Kovach (1986) suggest that the trauma of childhood incest often creates shame and poor self-esteem in adult women, influencing their interpersonal relationships, while Rosenthal (1987) addressed the consequences of abuse and neglect for children in foster care, among them vulnerability to shame and helplessness.

Wurmser (1981) contends that when people see a discrepancy between what they are and what parents' expectations are of them (i.e., a discrepancy between the self and the ideal self), people will see themselves as weak and defective: they do not measure up. These people, Wurmser reports, often turn to drugs and alcohol to relieve the shame of being "less than." Lindsay-Hartz (1984) contends that with shame the image that people have of themselves is that they are not good enough. They see themselves in the negative way that others see them. The shaming event takes over the

whole of who they are, making them forget about the other positive aspects of themselves (e.g., if fat, they disregard their pretty face and warm personality). It leaves one feeling exposed. Campbell (1984) believes people who feel engulfed by feelings of shame perceive themselves as powerless. They believe their lives will not get better and suicide becomes a possibility as a way out.

How people feel about themselves affects virtually every aspect of their lives. The way people respond to experiences in life is dependent in part on their self-concept. Mollon (1984) believes that for people whose self-esteem is fragile, shame is very important emotion. He goes even further and suggests that shame has a role in depression, which often occurs as "an attempt to protect the sense of self" (p. 213). Several other authorities agree with Mollon that shame has a role in depression (Kaufman, 1981; Kohut, 1971; Miller, 1985). Wurmser (1981), in a clinical setting, reported severe states of depression in clients with a competition-envy-shame configuration.

Individuals see depression as an escape from a perceived weakness or helplessness. Most everyone has heard the expression that "depression is the common cold of mental health." If this is true, then the behavioral influence that the feelings of shame can exercise on a college or university campus may be very easily perceived. Mohl and Burstein (1982) conclude that "as self-esteem is maintained, other stresses in life will be more manageable" (p. 115). When self-esteem is challenged, a person's feeling of being vulnerable is increased.

A number of emotion theorists describe shame as a painful emotion experienced when self-esteem is lost or damaged (Aristotle, 1941; Isenberg,

1949; Kaufman, 1974, 1985; Lynd, 1958; Piers & Singer, 1953). Erik Erikson (1963) agreed with this theory, believing that shame developed from parental disapproval when the disapproval caused the child to be uncertain of his or her self-worth. Carl Rogers (1951) also tied parental disapproval, shame, and self-concept together. Parental approval is essential to the child's feeling of self-worth. Rogers preferred approach was to exercise "unconditional positive regard," disapproving of a behavior without giving the impression of disapproving of the individual or child as a person.

The emotion of shame is inseparable from a person's journey in the search for him or herself. The desire or need for an approving perception of one's characteristics, abilities, and positive attitude about oneself is important. These internal beliefs provide a continuity and meaning in life and determine in part what a person can do and become. It is the true potential, the power to be inside each of us. It is a judgement we make of ourselves.

Effects of Shame

Suicide is now the third leading cause of death among 15 to 24 year olds, with an annual rate of 12.9/100,000 (U.S. Department of Commerce, 1988). For every successful suicide, it is estimated that there are 50 to 100 attempts (Arbetter, 1987). Several studies on suicide have found shame a major feeling experienced by this population. Karl Menninger (1985), from his experience with suicides, describes feelings of shame as being one of the prevalent motives leading to suicide. Wandrei (1985) compared data on females who had attempted suicide and who then subsequently succeeded in killing themselves within five years after hospitalization, finding, among

other differences, that successful suicides were more likely to have experienced severe feelings of shame.

Drugs and alcohol are problems of major proportion on college campuses (Maultsby, 1978). Viney, Westbrook, and Preston (1985) found that drug addicts had a pattern of shame (feelings of inferiority and inadequacy). The addicts were most concerned about their deficiencies being exposed to others. These authors believe that an overpowering sense of shame may be the predominant reason why so many addicts do not follow through with their treatment programs. Le Pantois (1986) reports in her group work with 6 to 12-year old children of alcohol and cocaine-dependent parents that one of the major issues the children faced related to their parents' addictions was the feeling of shame. These children grow up and go to college, bringing with them their parent scripts of childhood (Harris, 1982). It is estimated that there are five million adult children of alcoholics (U.S. Department of Health & Welfare, 1987). Brown and Sunshine (1982) suggest that children of alcoholics experience shame, but that they do not let others know their feelings. Awareness of shame and the magnitude in which people are affected by it is important for student development personnel specialists on college campuses to know because their primary function is to promote and improve the quality of student life in colleges.

Eating disorders are another concern on college campuses. This problem, which has been especially noted among young women, is mushrooming. Chenez, Varhely, and Hipple (1983) found that bulimic individuals have a sense of shame and embarrassment about their manifestations that causes isolation and extreme carefulness toward others. This created loneliness, which in turn reinforced their already low self-concept.

Violence on college campuses can be seen in the increased number of reported acquaintance rapes. Studies have shown increased acts of interpersonal violence among college students (Cate, Henton, Koval, Christopher, & Lloyd, 1982). Coleman (1985) presents an interesting explanation regarding violence and its correlation with war. The author proposes that war is evoked from a need to address suffering and distress over the issue of power and shame which were established in infancy. She further suggests that a person's ability to endure shaming is a major element that determines the amount of violence in a person. In his studies of violent men in a Veterans' Administration hospital, Lansky (1984) found that shame played a major role in family violence among the subjects. Where there is a discrepancy in perceived power between people, there appears to be an opportunity for shame to occur.

It is possible to conceive of shyness at the opposite end of the spectrum from violence. Some researchers (Crozier, 1982; Kopp, 1977; Tomkins, 1987) have proposed that shyness is an emotion related to shame. It could be suggested that as people become more assertive and stand up for those things that are important to them that shyness might recede.

Perfectionism has also been linked with shame. Sorotzkin (1985) describes two forms of perfectionism, one of which is to avoid shame. This occurs when an individual fails to live up to an exaggerated belief about him or herself. With unemployment in some parts of the country on the rise, colleges and universities are finding more unemployed seeking retraining for a new career. Studies have found this group also expressed feelings of shame. Viney (1985) analyzed unemployed 15 to 40 year olds, comparing them with low and high stress groups, and found the unemployed subjects ex-

pressed more shame than those in the comparison groups and that young unemployed females experienced shame which was not found in older males.

Assertiveness

Assertion training has a long history, described in its earliest form by Salter (1949). However, credit for the current development of assertion training is generally given to Wolpe (1958) and Lazarus (Wolpe & Lazarus, 1966), who more clearly differentiated assertion from aggression and used various role play procedures as part of their assertion training.

During the 1960s two rather important cultural changes seem to have occurred. First, a new level of value was placed on personal relationships, which began to be valued as a major source of self-worth and satisfaction in life. Perhaps it was because it became more difficult to achieve self-worth through traditional sources, such as career and marriage, that people began to look for other ways of improving the quality of their personal lives. Second, the scope of socially acceptable behavior was expanded appreciably. Many people found themselves lacking the skills to deal with these new societal changes. Individuals discovered they lacked the skills to make decisions about how to behave, and also lacked the cognitive and behavioral skills to act on their decisions and to stand up for these decisions when attacked or impeded by others (Lange & Jakubowski, 1976).

The term "assertive" has provided a field day for would-be semanticists. It is only recently that the word has come to mean anything different than "aggressive." Indeed, it may still be a relatively small proportion of the population which differentiates the two concepts. The term "assertiveness" as used by professionals is actually the opposite of "aggressive" and

yet many people use the terms interchangeably. Assertion is not something people are born with, nor is it something that people either possess or do not possess. It is a skill or a way of behaving that one learns, and can therefore be taught (Galassi & Galassi, 1977). It is important to recognize that assertive behavior is typically situational. An individual may have difficulty in expressing disagreement with his/her parents, yet have no difficulty expressing disagreement with friends. In the two situations, the person has learned to behave differently.

While it is true that assertive behavior is learned, it is also true that nonassertive behavior is learned. Maddi (1972) identified a number of factors, including punishment, reinforcement, modeling, lack of opportunity, cultural standards, personal beliefs, and uncertainty about one's rights, which may have contributed to this process. People often do not assert themselves in a particular situation because they were previously punished either physically or verbally for expressing themselves in that situation. Years later, these same situations engender a feeling of discomfort and anxiety. These individuals learned that one way to feel less anxious in like situations is to keep their opinions to themselves, i.e., to be nonassertive.

In some instances, punishment of assertive behavior and reinforcement of nonassertive behavior occur simultaneously. For example, research in education has shown that much of the interpersonal behavior that children learn in school involves being passive, silent, and not rocking the boat. The obedient, quiet child often tends to be valued and praised (reinforced) by teachers, whereas the inquisitive, opinion-giving child may be seen as disruptive or unruly and may be punished more often than his/her less assertive peers. These children sometimes learn from formal education that it is better or perhaps safer to be seen and not heard (Coopersmith, 1968).

Shame and Assertiveness

The ability to affirm oneself, especially when confronted with defeat, failure, or rejection, permits the individual to feel important, valued, and worthwhile inside. The development of a belief system that one is important, even if you "blow it" (a goal of assertiveness training), can help people to affirm themselves when criticized by significant others or when messages are conveyed that they are not quite good enough as a person.

Brousek (1979) suggests that the basis for a person's feelings about who they are (their sense of self) is the feeling of efficacy. Mollon (1986) discusses the reactions associated with shame of people who have been ignored or hurt by their principal caretaker (often parents) and proposes that their vulnerability is due to the person's inability to obtain a meaningful emotional response from the caretaker, resulting in injury to the self. With shame we feel small and worthless; we are a bad person; we are unable to speak up, assert ourselves, to affirm ourselves from within; we are unable to be assertive.

Kopp (1976) emphasized that a child who is constantly shamed, ridiculed, disapproved of, threatened with abandonment, or shown contempt is forced into feeling inferior, unworthy and powerless. This can often lead to a life spent in looking for and needing the approval of others so that one can be confirmed as being O.K. This can create a professional people-pleaser, a nonassertive person in a sense. In trying to meet everyone's approval, they really are not able to do those things that they really want and need to do.

Kopp (1976) also believed that shame is a learned experience. If this is true, then that which is learned can be unlearned and new beliefs and feelings can be developed to replace the old shame. Assertiveness training teaches replacement of old belief systems with rational, factual beliefs (Lange & Jakubowski, 1976; Maultsby, 1984; Rathus, 1973). Kaufman (1974) writes, "Only when we can stop trying to be all things do we become free to be who we are and only as we move beyond shame and toward self-affirmation can we begin to relinquish this striving for perfection" (p. 573). One possible barrier, as postulated by Miller (1985), is that there are those individuals in a constant state of shame because they "fear the . . . consequences of competitive self-assertion" (p. 33).

Rabin, Amir, Nardi, and Ovadia (1986) found in diabetics that assertiveness increased self-confidence and compliance with medical directives and that patients' feelings of shame and inadequacy were mitigated when hospital staff and social workers took steps to increase assertiveness and cognitive skills.

Behavioral and cognitive skills are preventive tools that can be used in a wide variety of stressful situations and can give a sense of competence to demoralized patients. Sometimes a small success in one significant area can strengthen the patient to the extent that other more far-reaching progress will subsequently follow. (p. 150)

Braum (1985) hypothesized an interesting argument that the structure of organizational authority in the work place creates shame anxiety that discourages assertiveness and interferes with work. Assertiveness training can help people go after what they want out of life. They learn to develop a style of communicating which results in being accepted and treated equally by others (Alberti & Emmons, 1970; Lange & Jakubowski, 1976). Assertive

communication deals directly and immediately with a situation. Doing this could help the shamed person, who has learned to avoid direct and immediate confrontation, discover that avoidance does not ease the pain of personal mistakes. Kopp (1976) believes that excessive shyness can result from being overly shamed as a child. This often causes people to become apologetic, hesitant, and afraid of people (unassertive). These individuals believe there is some defect in their character.

Kinston (1983) reported that self-assertion on the part of the child is often seen as an attack on the parent. A loss of love, approval, and well-being (emotional abandonment) is often the punishment that follows such assertion. Edwards (1976) stated that "fear of abandonment and the shame of defeat are the earliest traumatic experiences of humans" (p. 7). Other studies (Coopersmith, 1968; Cotle, 1975; Maddi, 1972) have shown that early negative reinforcement of self-assertion often results in people failing to try to assert themselves in other situations. It could be hypothesized that if children receive disapproval for their self-assertions early in life, they will not be able to stand up for themselves later in life, bring out into the open and talk about, laugh, joke, or feel rage about their feelings of shame.

When feelings of shame have been experienced by individuals who are unable to restore good feelings with those who are important in their lives, symptoms of shame develop as hysteria, phobias, and depression (Lewis, 1984). Lewis looked at behavior modification as one way to deal with these symptoms. Assertiveness training is rooted in behavior modification and would appear to be a logical means to help deal with shame and its symptoms. This study proposes assertiveness training as a treatment for these feelings of shame.

There are many reasons why assertion is important. First, the ability to express oneself is a desirable and, at times, necessary skill for human survival. In addition, the ability to express oneself has been an important component of definitions of mental health for many years (Dollard & Miller, 1950). Research has shown that individuals who have difficulty expressing themselves across a wide variety of behaviors with other individuals, report feelings of depression and undue anxiety in interpersonal situations. These individuals report feeling unappreciated and taken for granted and were also found to have a high incidence of somatic or psychosomatic complaints, such as headaches and stomach problems (Ludwig & Lazarus, 1972). In contrast, individuals who have participated in responsible assertion training programs frequently report increased feelings of confidence, positive reactions from others, reduced anxiety in social situations, improved interpersonal communication, and decreased somatic complaints. In summary, the ability to assert oneself when one chooses is a desirable skill to master.

Summary

A survey of the literature turned up some theoretical disagreement on the definition of shame. There are conflicting ideas and postulates in the literature regarding shame. Some regard it as indistinguishable from guilt (Hartmann & Lowenstein, 1963), others as similar and dependent on ego-superego relations (Jacobson, 1964; Piers & Singer, 1953; Sandler, Holder, & Meers, 1963), and still others associated shame with identity, narcissism, and the sense of the self (Broucek, 1982; Erikson, 1950; Lichtenstein, 1963, 1964; Moller, 1984, 1986; Morrison, 1983; Winston, 1983). It is not the goal of this study to define shame so that it could be applied to every person in

every situation. There are a variety of ideas, thoughts, and theories on this topic. A number of them have been presented to enable the reader to develop an idea of the many ways shame can be felt and expressed.

Investigations have begun to focus on shame as an important factor of human behavior. This examination of a long-neglected affect could reflect a shift from a mechanistic to a developmental approach when explaining psychological disorders. Perhaps shame would have had more attention paid to it had it been perceived as occurring from the infancy stage, as some investigations have observed (Brousek, 1982; Nathanson, 1987; Spritz, 1965; Tomkins, 1963).

III. METHODOLOGY

Included in this section is a description of the population of the study, the course content, reading and laboratory assignments and physical facilities, the instruments used to collect the data, the procedures taken to execute the research project, and the statistics used to analyze the data.

Design of the Study

This study was an empirical investigation of a treatment for the emotion of shame. The purpose of the study was to determine if a course in assertiveness training had an effect on internalized shame in college undergraduate students. A design to evaluate the effect of assertiveness training on internalized shame is explicit in the hypotheses of this study.

Sample

Experimental Group

The sample for this study was composed of college students enrolled in three classes of Psychology 479-570, Assertive Training Procedures, at the University of Wisconsin-Stout during fall semester of the 1987-1988 academic year.

The enrollment for the three sections ranged from 28 to 30 students per class. Students selected the section in which they wished to enroll and were assigned to that section on a first come, first served basis or fit of

schedule. At the beginning of the fall semester, 1987, 86 students were asked to participate in a research thesis project. Of this number, 5 students declined, 1 did not complete the post-test instruments, and 4 were graduate students who were not used in the study to keep the experimental and control subjects as comparable as possible. The subjects were administered two standardized tests: the Rathus Assertiveness Schedule and the Internalized Shame Scale. For nine consecutive weeks of the fall semester (one quarter), the experimental group received 36 hours of assertiveness training: Psychology 479-570, Assertive Training Procedures.

The classes met for nine weeks, two hours per day, on Tuesdays and Thursdays, for a total of 36 hours. On the last day of the class, the subjects were again administered the Rathus Assertiveness Schedule and the Internalized Shame Scale.

Control Group

This group consisted of 128 students enrolled in 5 classes of Speech 391-100, Fundamentals of Speech, fall semester, 1987. Speech was selected as the control group in order to provide a sample as close as possible to the subjects in the Assertive Training Procedures classes. There were no graduate students in this group. Of the number asked to participate, 123 students agreed, 7 did not complete the pretest instruments completely, and 19 students did not take the posttest measurements. The subjects were administered the Rathus Assertiveness Schedule and the Internalized Shame Scale. The control group did not receive the cognitive-behavioral assertiveness training: Psych 479-570, Assertive Training Procedures. The subjects in the control group were again administered the Rathus Assertiveness Schedule and the Internalized Shame Scale at the end of nine weeks. These

tests coincided with the completion of the treatment (Psychology 479-570, Assertive Training Procedures) by the experimental group and 97 subjects completed the pre and posttest instruments.

All of the participants in the experimental and control groups were presented with a consent form, as required by the University of Wisconsin-Stout Human Subjects Committee. These forms described the rights of the subjects participating in the study (see Appendix A). This study was reviewed and approved by the University of Wisconsin-Stout Committee for the Protection of Human Subjects. This was done in accordance with the policy on protection of human subjects by the United States Department of Education. Table 1 is a summary of both the experimental and control groups who participated in this study.

Table 1. Sample Size, Number of Participants, Fall Semester, 1987.

Population	Experimental	Control
Freshmen:		
pretest	10	6
posttest	9	5
Sophomores:		
pretest	23	71
posttest	22	56
Juniors:		
pretest	17	37
posttest	20	27
Seniors:		
pretest	27	14
posttest	31	9
TOTALS:		
Sample Size	82	112
Number of cases	76	97

Note: The increase in post cases was due to instructor administration of the post instruments to everyone in the class, not just those who had taken the instruments prior to taking the class. Data from subjects who did not take the instruments on both occasions were not included in the study results.

Treatment

The treatment for the experimental group consisted of 36 hours of assertiveness training over a 9-week period (one quarter). The classes met for two hours per day, two days per week (Tuesdays and Thursdays). The major objective of the class was to increase assertive skills in order to enhance the student's chances to achieve greater self-fulfillment in their personal lives and professional work. The specific objectives of the class were:

- 1) The student would be able to differentiate between the concepts of assertive, nonassertive, and aggressive behavior.
- 2) The student would be able to identify his or her behavior as assertive, nonassertive, or aggressive in interpersonal relationships.
- 3) The student would be able to recognize assertion, nonassertion, and aggression in others.
- 4) The student would be able to describe the step-by-step process of assertive behavior.
- 5) The student would be able to apply assertive procedures in life situations in order to reduce the guilt and anxiety which often result from nonassertive behavior.
- 6) The student would be able to support the value of standing up for one's rights and honoring the same right in others.
- 7) The student would be able to defend the importance of the right to freedom of expression without violating the rights of others.

Course Content of the Experimental Group

The content of Psych 479-570, Assertive Training Procedures, was developed in 1974, based on the work of Arnold Lazarus (1966, 1968, 1973), Andrew Salter ((1949, 1961), Robert McFall (1970, 1971, 1973), Albert Ellis (1961), Thomas Gordon (1970), Spencer Rathus (1973), and Joseph Wolpe (1966, 1969, 1970, 1973). The textbooks used were *Your Perfect Right: A Guide to Assertive Behavior* (4th ed.) (Alberti & Emmons, 1982) and *People Skills: How to Assert Yourself, Listen to Others, and Resolve Conflicts* (Boltan, 1979). The course content was not altered for purposes of this investigation.

The major units included in the course were: Discrimination between assertive, nonassertive, and aggressive behavior; the relationship of assertive skills to other social skills, e.g., initiating, maintaining, terminating conversations; rationale for assertiveness; components of assertiveness; the assertive process; I-messages vs. you-messages; effective feedback; cognitive restructuring; modeling procedures, behavioral rehearsal (role playing) procedures.

Reading and Laboratory Assignments

Reading assignments were closely correlated with the instructional presentations. The readings were to be completed prior to the discussion of the topic during lecture or laboratory demonstration. Assignments were distributed between the textbook and a personal journal identifying assertive, nonassertive, or aggressive behavior in personal, social, business, or consumer situations, which was handed in every two weeks to the instructor.

Laboratory assignments (behavior rehearsals) were developed to practice each specific unit and to supplement and reinforce the information presented during lectures and demonstration. The laboratory assignments (behavior rehearsal situations) were based on the students' personal experiences. Students worked in triads (groups of three) in the laboratory. The structure of the laboratory portion of the course allowed the students to work at their own pace on the activity assignments.

Physical Facilities

All students had access to the same facilities. An effort was made to maintain the room as constant as possible in regard to lighting, heating, and ventilation. All students had access to videotape equipment during certain class periods.

Instrumentation

The degree of confidence placed in the results of a research study depends significantly upon the strength of the instruments selected as measures of the dependent variables. The tests employed must exhibit the traits that assure validity and reliability. For this reason the following measures were used.

Rathus Assertiveness Schedule

The Rathus Assertiveness Schedule (RAS) (Rathus, 1973) is judged to be a valid method of assessing assertiveness and was used for the pre and posttest measurement of assertiveness. The RAS is a 30-item schedule for measuring assertiveness. Respondents rate items describing assertive or

nonassertive behaviors as self-descriptive on a 6-point (no neutral) modified Likert scale, ranging from "very characteristic of me" to "very uncharacteristic of me" or "extremely descriptive" to "extremely nondescriptive." The respondents were asked to rate items such as (1) I enjoy starting conversations with new acquaintances, and (2) I find it embarrassing to return merchandise. The RAS can yield scores ranging from +90 to -90, with positive scores indicating a higher level of assertiveness.

Test-Retest Reliability

The schedule has a moderate to high test-retest reliability. A Pearson product-moment correlation comparing odd and even scores yielded a r of .78 ($p < .01$) (Rathus, 1973).

Split-Half Reliability

Internal consistency as a self-report instrument was determined by a Pearson product-moment correlation comparing total odd and total even item scores, which yielded an r of .77 ($p < .01$), suggesting that the qualities measured by the RAS possess moderate to high homogeneity (Rathus, 1973).

Validity

The validity of the RAS was originally established by Spencer Rathus (1973) with two different measures of assertiveness.

Study 1: Judgements of a person who had knowledge of the respondent's assertiveness, rated the respondent who had also taken the RAS on semantic differential scales which have been found to define a general assertiveness factor. Rathus (1973) found a significant correlation ($p < .01$) of RAS scores with the five scales containing assertiveness factors on the semantic differential scale.

Study 2: RAS scores were compared with independent ratings of audiotaped responses of college women to five questions dealing with situations where assertiveness would be advantageous. A Pearson product-moment correlation coefficient was used, comparing the RAS scores and scores from the audiotaped study. The correlation yielded a r of .71 ($p < .01$). These external raters were unaware of the respondent's self-reported responses.

Since 1973, a third study investigated the validity of the RAS. Rathus and Nerid (1977) conducted a validity study of therapists' ratings of psychiatric patients' assertiveness on the same semantic differential scales used by Rathus (1973) in his validation. These researchers also verified the validity of the Rathus scale in their investigation. In addition, a study by Mann and Flowers (1978) demonstrated significant internal consistency. Their subjects were 71 nonpsychiatric adults, ranging in age from 19 to 56. The results of these studies support the use of the RAS as a standardized instrument for assessing assertiveness.

Internalized Shame Scale

The second instrument used was the Internalized Shame Scale (ISS). The ISS is a 28-item standardized instrument for measuring the intensity of internalized shame and was used for the pre and posttest measurement of internalized shame. The items are statements of experiences or feelings that the respondent rates as self-descriptive on a 5-point scale. For example, the respondent was asked to rate items such as (1) I replay painful events over and over in my mind until I am overwhelmed and (2) I would like to shrink away when I make a mistake. The experiences and feeling statements on the scale are all painful or negative in some way. The ISS

scale utilizes a modified (five positions, no neutral) Likert format, from "never" to "almost always." The ISS scoring can range from 0 (zero) to 112. The higher the score, the higher the level of shame.

Development of the Scale

The scale items are based on the descriptions of shame in the psychological literature of Lynd (1958), Tomkins (1963), Lewis (1971), Wurmser (1981), and Kaufman (1974). Ninety statements were written that took into account different aspects of the shame experience and were put on 3 × 5 cards. The pilot subjects were a group of people in an inpatient alcoholism treatment program presumed to have high levels of internalized shame. The subjects were asked to identify those statements that described experiences or feelings that were common and recurring and those experiences or feelings that were not common or rarely occurred. Each of the 90 items could be selected from 0 (zero) to 10 times by the pilot group. The items most frequently selected by the pilot group formed the basis for the items used to develop a pilot scale.

The pilot scale consisted of two kinds of statements: (1) childhood experiences dealing with parents that were assumed to be shame inducing and (2) experiences or feelings of shame, e.g., "I feel like I am never quite good enough" (Cook, in press). An adult scale and a childhood scale were developed from the original items and were administered to 30 subjects in inpatient alcoholism treatment programs.

From this group it was decided to develop a single scale doing away with most all items relating to childhood because the childhood scale items did not correlate as highly with the total score as did the adult scale items.

However, both the childhood and adult scales had high internal reliability (Cook, in press).

A second construction of the scale was developed with 39 items. The criteria used to select the items were twofold: (1) The items selected each correlated highly with the total score for the 30 pilot subjects and (2) the other criterion for items to be selected was the basis of how well any item corresponded to or was nearly alike another item. This 39-item scale included 7 items dealing with childhood experiences with parents.

The 39-item scale was given to 367 college undergraduates. In this sample there were an equal number of males and females. The average age was 21. Also given to this sample population was a survey to establish a contrast, nonclinical sample to be used to establish controls for further experimentation against which comparisons of other clinical samples could be made.

A third construction of the scale was then developed with 35 items. This version eliminated all items which related to childhood experiences with parents. A few items were edited to make them clearer and three new items were added to the scale. This third version of the ISS was administered to three different samples: (1) College undergraduates, including 55 percent males and 45 percent females ranging in age from 18 to 62; (2) An adult sample with 38 percent males and 62 percent females ranging in age from 21 to 63; and (3) A clinical sample of subjects ranging in age from 14 to 51 with an equal percentage of males and females. These clinical and nonclinical subjects formed a data base of 1,108 subjects. Seven items continued to show low correlation and did not contribute to the reliability of the scale. A factor analysis was done on the 414 cross-validation cases with these seven items removed. This was used as the basis for establishing a

final 28-item scale with four subscales and a single total score. Initial reliability and validity were developed from this data (Cook, in press).

Reliability

The internal reliability coefficient was .95 for the undergraduate sample. Test-retest reliability was established for 157 college women and men by retesting them over intervals ranging from 4 to 9 weeks. The reliability coefficient for the adult sample was .95 and for the clinical sample, .93 (significance level = .01), indicating substantial internal consistency (Cook, in press). Table 2 shows the test-retest correlations for the ISS scales. These coefficients indicate that the ISS has considerable stability over time and therefore provides a good measure for pre and posttesting of clinical subjects in studies used to investigate the effectiveness of therapy to reduce the intensity of internalized shame.

Table 2. Alpha Reliability Coefficients and Test-Retest Correlations for ISS Scales (Cook, in press, p. 31).

Sample	Total 28 Items	Scale 1 10 Items	Scale 2 4 Items	Scale 3 8 Items	Scale 4 6 Items
Non-Clinical (n=452)	.95	.92	.89	.85	.84
Clinical (n=183)	.97	.94	.89	.89	.89
Non-Clinical (n=60)	.85	.86	.75	.76	.71

Validity

The ISS has external validity for the present study (tested on a college population). The investigation of predictive validity of the ISS was done by the completion of two other measures by every subject in the three

samples. The scales were the Problem History Questionnaire and the Family of Origin Questionnaire. A hierarchical multiple regression revealed strong correlation of the Internalized Shame Scale with all items of both these scales ($r = .765$ to $.404$).

A cross-validation factor analysis used to develop the final 28-item ISS is shown in Table 3 (Cook, in press, pp. 28-30).

Table 3. Factor Analysis and Item Statistics for ISS Subscales.

	Factor ^a Loading	Item ^b Mean	Item ^c Total Corr.	Alpha ^c if Item Deleted
<u>Factor 1: Inadequate and Deficient</u> (scale alpha = .919; 10 items)				
Compared to other people I feel like I somehow never measure up	.783	1.4	.76	.907
I feel like I am never quite good enough	.751	1.8	.72	.909
I see myself as being very small and insignificant	.696	1.2	.80	.905
I feel insecure about others' opinion of me	.629	1.9	.67	.912
I feel somehow left out	.607	1.7	.59	.916
When I compare myself to others I am just not as important	.598	1.2	.68	.912
I feel as if I am somehow defective as a person, like there is something basically wrong with me	.571	0.9	.72	.909
I think that people look down on me	.569	1.3	.66	.913
I scold myself and put myself down	.555	1.9	.62	.915
<u>Factor 2: Empty and Lonely</u> (scale alpha = .889; 4 items)				
My loneliness is more like emptiness	.753	1.3	.75	.861
I have this painful gap within me that I have not been able to fill	.745	1.3	.75	.860
I always feel like there is something missing	.734	1.4	.79	.845
I feel empty and unfulfilled	.713	1.2	.75	.862
<u>Factor 3: Exposed and Self-Critical</u> (scale alpha = .848; 8 items)				
I could beat myself over the head with a club when I make a mistake	.680	1.3	.57	.831

(continued on following page)

Table 3. Factor Analysis and Item Statistics for ISS Subscales (continued).

	Factor ^a Loading	Item ^b Mean	Item ^c Total Corr.	Alpha ^c if Item Deleted
When I feel embarrassed, I wish I could go back in time and avoid that event	.664	2.0	.57	.831
I think others are able to see my defects	.663	1.8	.65	.822
I would like to shrink away when I make a mistake	.614	1.2	.58	.830
I seem always to be either watching myself or watching others watch me	.526	1.4	.56	.833
I see myself striving for perfection only to continually fall short	.513	1.7	.59	.829
I have an overpowering fear that my faults will be revealed in front of others	.508	1.3	.61	.826
I become confused when my guilt is overwhelming because I am not sure why I feel guilty	.445	1.1	.55	.833
Factor 4: Insignificant and Fragile (scale alpha = .844; 6 items)				
Sometimes I feel no bigger than a pea	.753	0.6	.63	.820
I feel as if I have lost control over my body functions and my feelings	.733	0.8	.68	.808
At times I feel so exposed that I wish the earth would open up and swallow me	.692	0.7	.63	.818
At times I feel like I will break into a thousand pieces	.677	1.0	.68	.806
I really do not know who I am	.453	1.1	.57	.830
I replay painful events over and over in my mind until I am overwhelmed	.434	1.4	.59	.827
^a Factor loadings based on 414 non-clinical cases.				
^b Item scale scores could range from 0 to 4. Item statistics based on 452 non-clinical cases.				
^c Based on the total subscale scores.				

Novak (1986) used the Cook ISS and administered it to a college population, along with two other measures (Beall Shame-Guilt Test, Perlman Attitude Anxiety Survey). His data supported three of the four subscales in the ISS. Items from the fourth subscale, "empty and lonely," were not used.

Intercorrelation of the shame subscales reported by Novak (1986) and Cook (in press) were high. Novak reported a range from .64 to .77 and Cook's intercorrelation ranged from .61 to .75 for the non-clinical sample and .77 to .82 for the clinical sample.

Administration

Every student in the control and experimental groups were given a letter of explanation of the research being conducted (Appendix A). The consent letter described the study and let the students know that their participation was completely voluntary and in no way would participation or non-participation affect their assignments or grade in the class.

Those who agreed to participate signed their name at the bottom of the letter and dated it. Each participant was asked to tear off their signature at the dotted line and to give the permission slips to the administrator of the instruments.

Confidentiality of scores was maintained and test scores were identified by asking the participants to write their names inside the diagonal mark in the upper left corner of both the ISS and the RAS. These procedures were repeated again for the posttesting.

After the participants completed the testing, the instruments were collected, placed in alphabetical order, and then given to the instructor who assigned a number, starting with number 1, to each student. This number was recorded in the instructor's grade book beside the students' names so that posttest matching would be possible. The names were then cut off the instruments.

Hypotheses

During the course of this study the follow null hypotheses were tested for retention or rejection:

- Ho₁: There is no significant difference between control and experimental groups with respect to level of shame scores as measured by the Internalized Shame Scale;
- Ho₂: There is no significant difference between pre and post scores with respect to shame as measured by the Internalized Shame Scale;
- Ho₃: There is no interaction between pre vs post and control vs experimental groups with respect to shame;
- Ho₄: There is no significant difference between control and experimental groups with respect to level of assertiveness as measured by the Rathus Assertiveness Schedule;
- Ho₅: There is no significant difference between pre and post scores with respect to assertiveness as measured by the Rathus Assertiveness Schedule; and
- Ho₆: There is no interaction between pre vs post and control vs experimental groups with respect to assertiveness.

The RAS and the ISS were each measured on the basis of total score.

Analysis of Data

Two statistical tools were used to analyze the data in this study: a analysis of variance with repeated measures (ANOVA[R]) and the Newman-Keuls Multiple Range test, also referred to as Student Newman-Keuls Comparison test.

The inferential statistical tool used to test the hypotheses was the analysis of variance with repeated measures (ANOVA[R]), or the correlated groups design (Pagano, 1981). This tool analyzes the differences between paired scores or subjects that are matched in some way. This study employed the basic form of this design, employing two factors: a treatment and a time factor. The factors each had two levels. The treatment levels were control and experimental and the time levels were pre and posttest.

The ANOVA with repeated measures is one of the most common statistical analytical tools used in behavioral research. It involves the application of an analysis of variance testing the null hypothesis that the means of the control and experimental groups sampled come from populations with equal means, differing only because of sampling error. This is a different procedure from one in which data from a single dependent variable is measured more than once on the same subjects (Winer, 1971). There were two dependent variables: shame and assertiveness.

Repeated measures analysis requires the assumption of homogeneity between repeated assessments. A repeated measures ANOVA is not robust with respect to violations of covariance (correlational) assumptions. Violations of these assumptions can result in too many rejections of null hypotheses for the stated significance level (Winer, 1971). The data for this

study were correlated as the two sets of data (pre and posttests) were collected from the same individual. Thus, there was no concern about violating the homogeneity of within-cell variances in the ANOVA.

Ball, McHenry, and Bonham (1983) stated that repeated measures designs are generally more statistically efficient (i.e., more powerful) in detecting differences between groups and interactions between groups. The ANOVA[R] test is preferred when violations of homogeneity are small, as they were in this study because of the use of paired samples.

The experimental design utilized for this study was a repeated measures design with treatment as the grouping factor and time as the within-subjects factor. Two distinct groups were utilized: control and experimental. The repeated measures factor was time, which was the pre and post-test (Table 4). The statistical tool used to explore the design was a two-way ANOVA with repeated measures, using the "F" statistic and the Newman-Keuls Multiple Range test to make multiple comparisons between means. The independent variables were treatment and time and the dependent variables were shame and assertiveness. All of the dependent variables originated from standardized test scores.

Table 4. Data Matrix for Repeated Measures Design.

	<u>Control</u>		<u>Experimental</u>	
	Pre	Post	Pre	Post
	Y1,1,1	Y1,2,1	Y2,1,1	Y2,2,1
Grouping Factor (Treatment)	•	•	•	•
	•	•	•	•
Repeated Measures Factor (Time)	•	•	•	•
	•	•	Y2176	Y2276
	Y1,1,97	Y1,2,97		

The mathematical model for the statistical treatment used in this study was:

$$Y_{ijk} = \mu + t_i + \beta_j + (t\beta)_{ij} + \pi_k + \epsilon_{ik} + \epsilon_{ijk} ,$$

where Y_{ijk} = measurement in i^{th} treatment group for the j^{th} time on the k^{th} subject,

μ = a constant,

t_i = main effect of i^{th} level of treatment factor,

β_j = main effect of the j^{th} level of time factor,

π_k = effect of k^{th} subject,

ϵ_{ik} = the error associated with the i^{th} treatment for the k^{th} subject, and

ϵ_{ijk} = the error associated with the i^{th} treatment and the j^{th} time for the k^{th} subject.

Possible interaction effects were examined using the Newman-Keuls Multiple Range test. The "F" test was used to reject the null hypotheses of the ANOVA. In order to determine where the differences were which caused the rejection of the null hypotheses, a multiple comparison between all possible pairs of means was performed, using the Newman-Keuls Multiple Range test, which employs a layered method for making multiple comparisons. Pairwise comparisons were made in a prescribed sequence from most extreme to least extreme pairs of means. The Newman-Keuls Multiple Range test is a more stringent approach for making multiple comparisons than other options (e.g., Duncan's test), particularly with respect to the tabular values that determine the critical ranges. Many statisticians argue that the mathematical bases for the Newman-Keuls tables are more defensible than for the Duncan's (Bruning & Kintz, 1977).

Summary

The sample in this study was composed of 173 undergraduate students from the University of Wisconsin-Stout, enrolled in Psych 479-570, Assertive Training Procedures, fall semester 1987, which were the experimental group, and students in 5 classes of Speech 391-100, Fundamentals of Speech, which were the control group. The students were assigned to the sections based on a "first come, first served" basis and fit of schedule. Both the control and experimental groups had freshmen, sophomores, juniors and seniors in the group. There was a fairly even distribution of freshmen and juniors in both groups. The control group, however, had proportionately more sophomores and the experimental group had proportionately more seniors. The average age for the control group was 20.21 and for the experimental group the average age was 21.37. The experimental group received 1 quarter equal to 9 weeks or 36 hours of assertiveness training. The control group did not receive any assertiveness training. All participants were administered pre and posttests on two measures, the ISS and the RAS. Both instruments are standardized tests and the subjects were measured on total scores. The statistical tools used were the analysis of variance with repeated measures, utilizing the "F" statistic, and the Newman-Keuls Multiple Range test, used to pinpoint specific pairwise differences among the treatments.

IV. PRESENTATION AND ANALYSIS OF THE DATA

A description of the procedure involved in preparing for and conducting the investigation was provided in Chapter III. This chapter includes the following: (1) A description of the statistical analyses performed for this study; (2) Procedures for testing the hypotheses are explained and the rationale for accepting or rejecting the hypotheses is presented; (3) The results of the analyses of the data are presented in the order that the null hypotheses were considered; and (4) Tables are presented to clarify the findings.

The purpose of this study was to determine the effect of assertiveness training on the emotion of shame in college students. The sample was drawn from three courses in assertive training procedures taught at the University of Wisconsin-Stout, Menomonie, Wisconsin. The control group was drawn from five "Introduction to Speech" classes at the same university. A total of 173 subjects, 76 in the experimental group and 97 in the control group, agreed to take part in the study. The data for the research were derived from standardized instruments and the findings were derived from a two-way ANOVA with repeated measures (ANOVA[R]) to test the null hypotheses. The "F" statistic was used to determine if differences existed between treatment (control and experimental groups) and time (pre and post-test) with respect to shame and to assertiveness. The Newman-Keuls Multiple Range test was applied where the ANOVA[R] showed there was a significant interaction effect. The purpose of the test was to determine where

the interaction occurred. The dependent variables were shame and assertiveness. The independent variables were treatment (control and experimental groups) and time (pre and posttest scores). The repeated measures factor was time.

The .01 level of significance was used as the standard to accept or reject the null hypotheses. A conservative level of significance was chosen to minimize the error of concluding falsely that a difference existed in the data if in fact it did not. If the computed value was less than the value indicated in the statistical tables (tabular value) at the .01 level of significance, the null hypothesis was retained. If the computed value of the "F" was equal to or greater than the tabular value of "F", the null hypothesis was rejected. If the null hypothesis was rejected at the .01 level of significance, it was concluded that the difference between the sample means was larger than what could be expected from sampling errors and that a real difference existed between the populations from which the samples were drawn. Using the .01 level of significance there was less risk of making a Type I error; that is, concluding falsely that a difference existed in the data that was not in reality present. However, it increased the risk of a Type II error, i.e., retaining the null hypothesis when it should have been rejected (concluding falsely that a difference did not exist in the data when in fact it did).

Hypotheses

Ho₁: There is no significant difference between control and experimental groups with respect to level of shame scores as measured by the Internalized Shame Scale.

This hypothesis proposed that the treatment groups were not different in levels of shame. It was anticipated that the two groups would be comparable with respect to total shame scores.

The Internalized Shame Scale (ISS) was administered to the participants in this study to determine if there were differences in the levels of shame between the control and experimental groups. An ANOVA[R] was utilized on the 28-item ISS score (pretest to posttest) to compare control and experimental groups. The calculated F-ratio for this hypothesis was .03, with a corresponding p-value of .870. Since the tabular value (6.785) exceeded the computed value of F (.03), the hypothesis was retained. The main effect mean shame scores averaged over pre and posttests between control and experimental groups were very close. This may be seen in Table 5. It can be concluded that averaged together there was no significant difference between the control and experimental groups.

Table 5. Main Effect Means:
Shame.

Control	33.433
Experimental	33.835

Ho₂: There is no significant difference between pre and post scores with respect to shame as measured by the Internalized Shame Scale.

The purpose of this hypothesis was to see if there was a difference in levels of shame between the two levels of the independent variable time (pre and post). This hypothesis tested the main effect of time on level of shame.

An ANOVA[R] was utilized on the 28-item ISS score to compare pretest to posttest mean scores. The combined pretest means of the control and experimental groups differed from the combined posttest mean scores. The pretest mean was 36.185 and the posttest mean was 31.035. See Table 6. The calculated F-ratio was 51.51 and the p-value was .001. Since the F value was larger than the tabular value of F (6.785), hypothesis two was rejected. There was a difference between the pre and posttest means. The level of shame at the beginning of the experiment was different than the level of shame at the end. There was a difference between the two levels of the independent variable, time (pre and post), with respect to the dependent variable, shame.

Table 6. Total Sample Mean
Scores: Shame.

Pretest	36.185
Posttest	31.035

H₀₃: There is no interaction between pre vs. post and control vs. experimental groups with respect to shame.

The primary purpose of this research was to investigate the effect of an assertiveness training course on shame. The purpose of this hypothesis was to see if the difference between pre and posttest mean scores in the control group was the same as the difference between pre and posttest mean scores in the experimental group with respect to the dependent variable, shame. This hypothesis tested to see if there was an interaction between time (pre and post) and treatment (experimental and control).

An ANOVA[R] was utilized to test the interaction between treatment and time with respect to the dependent variable, shame. The calculated F-ratio for hypothesis three was 37.46, which was larger than the tabular value of F, which was 6.785. The generated F-value was significant at the .001 level. Thus, hypothesis three was rejected. There was a significant interaction between time and treatment with respect to the ISS. A Newman-Keuls Multiple Range test was employed to make pairwise comparisons among the four interaction means (Table 7).

The shame pretest mean score for the control group was 33.856 and the posttest mean score was 33.010. The Newman-Keuls Multiple Range test did not find a difference between pre and posttest means for the control group. The pretest mean score for the experimental group was 39.158, but the posttest mean score dropped to 28.513. See Table 8. The Newman-Keuls Multiple Range test did, however, indicate a significant difference between the pre and posttest means for the experimental group. See Table 7. This change was statistically significant. There was a significant difference between pre and posttest scores for the experimental group. There was no significant difference between the pre and posttest scores for the control group with respect to shame. The change in the experimental group's pre and posttest shame scores was much greater than the change between pre and posttest scores in the control group. See Table 8. There was basically no change in the control group's pre and posttest scores with respect to shame.

Table 7. Results of Newman-Keuls Multiple Comparison Among Interaction Means.

Time	Treatment	Mean	N
1. Post	Experimental	28.513	76
2. Post	Control	33.010*	97
3. Pre	Control	33.856*	97
4. Pre	Experimental	39.158	76

*Mean is not statistically distinct.			

Table 8. Interaction Means: Shame.

	Pre	Post
Control	33.856	33.010
Experimental	39.158	28.513

Figure 1 graphically displays the interaction between time (pre and posttest) and treatment (control and experimental) with respect to shame. It is quite apparent that the difference between the control pre and posttest shame scores was not the same as the difference between the experimental pre and posttest shame scores. The change between pre and posttests was much greater in the experimental group than in the control group. It does appear that there was a significant difference between those who took the assertiveness training classes and those who were in the speech classes. It was therefore concluded that there was a difference in shame between subjects who received the cognitive-behavioral assertiveness training procedures and those subjects who did not receive the training.

See Table 9 for a summary of hypotheses one through three.

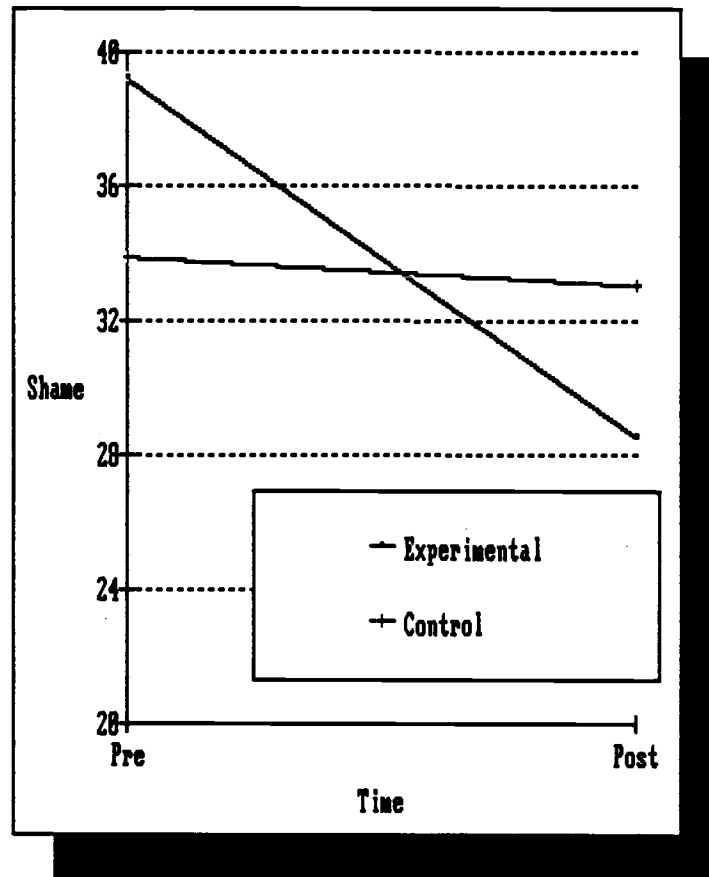


Figure 1. Interaction of Treatment and Time: Shame

Table 9. ANOVA With Repeated Measures For Shame.

Source of Variation	Df	SS	MS	F	F=.01 Tab	p	Decision
Treatment Group	1	13.81	13.81	.03	6.785	.870	Retain Ho ₁
Error ^a	171	87245	510.20				
Time	1	2812	2812	51.51	6.785	.001	Reject Ho ₂
Time × Treatment	1	2046	2046	37.46	6.785	.001	Reject Ho ₃
Error	171	9339.04	54.61				

^aAmong subjects, within each group.

Ho₄: There is no significant difference between control and experimental groups with respect to level of assertiveness as measured by the Rathus Assertiveness Schedule.

This hypothesis proposed that the treatment groups were not different in their level of assertiveness.

The Rathus Assertiveness Schedule (RAS) was administered to the participants in the study to determine if there were differences in assertiveness between the control and the experimental groups. An ANOVA[R] was used on the 30-item RAS score (pretest to posttest) to compare control and experimental groups.

The calculated F-ratio was .74, with a corresponding p value of .389. Because the calculated F-value was smaller than the tabular value (6.785), this hypothesis was retained. The mean for the control group was 126.15

and for the experimental group it was 128.96. See Table 10. It was concluded that there was no difference overall in assertiveness between the control and experimental groups.

Table 10. Main Effect Means:
Assertiveness.

Control	126.150
Experimental	128.960

H₀₅: There is no significant difference between pre and post scores with respect to assertiveness as measured by the Rathus Assertiveness Schedule.

The purpose of this hypothesis was to see if there was a difference in levels of assertiveness between the two levels of the independent variable, time (pre and post). This hypothesis tested the main effect of time on level of assertiveness.

An ANOVA[R] was employed to examine the difference between means on the 30-item RAS score to compare pretest to posttest mean scores. The combined pretest means of the control and experimental groups differed from the combined posttest mean scores. The pretest mean was 124.16 and the posttest mean was 130.653. See Table 11. The calculated F-ratio was 20.39 with a corresponding p-value of .001. Since the calculated F-value was greater than the tabular value (6.785), hypothesis five was rejected. It could be concluded that the level of assertiveness was higher for all subjects at the end of the experiment (posttest) than at the beginning. Some change could have been influenced by maturation or exposure to nine weeks of a speech class on the part of the control group and nine weeks of assertive-

ness training on the part of the subjects in the experimental group. It is not known which group increased more than the other. It can only be concluded that there was a significant difference in assertiveness between the two levels of the independent variable, time (pre and post).

Table 11. Total Sample Mean Scores: Assertiveness.

Pretest	124.116
Posttest	130.653

H₀₆: There is no interaction between pre vs. post and control vs. experimental groups with respect to assertiveness.

The goal of this hypothesis was to test to see if the difference between pre and post mean scores for the experimental group was the same as the difference between pre and post mean scores for the control group with respect to the dependent variable, assertiveness. This hypothesis tested to see if there was an interaction between time (pre and post) and treatment (experimental and control).

An ANOVA[R] was used to test the interaction between the independent variables, treatment and time, with respect to the dependent variable, assertiveness. The pre and posttest mean scores for the control group were, respectively, 123.814 and 128.485. The pre and posttest mean scores for the experimental group were, respectively, 124.500 and 133.421. See Table 12. The calculated F-ratio was 1.99, with a p-value of .160. Since the computed F-value was smaller than the tabular value of 6.785, hypothesis six was retained. The difference between the pre and posttest mean scores for the control group was the same as the difference between the pre and post-

test mean scores for the experimental group. Both groups were fairly low pretest with respect to assertiveness and both groups increased posttest with respect to assertiveness. See Figure 2, which suggests that the experimental group increased more than the control group and had higher assertiveness as measured by the RAS. Statistically, however, it could not be concluded that the experimental group increased more than the control group because there was no interaction.

Table 12. Interaction Means:
Assertiveness.

	Pre	Post
Control	123.814	128.485
Experimental	124.500	133.421

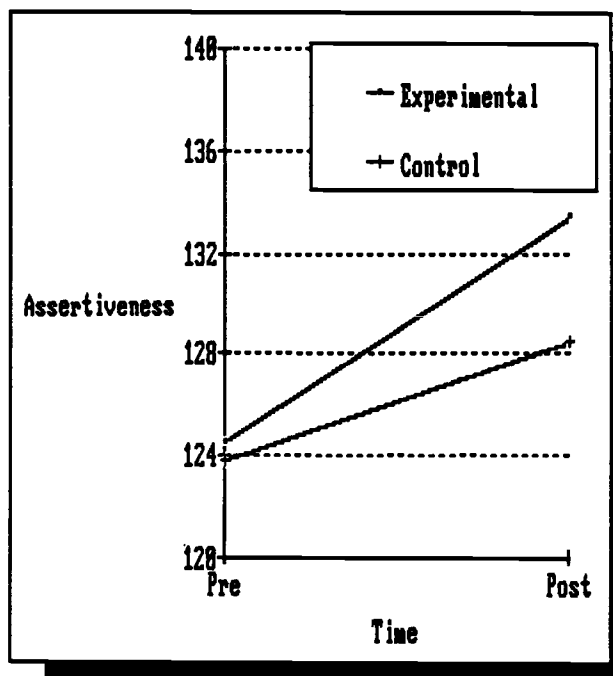


Figure 2. Interaction of Treatment
and Time: Assertiveness.

See Table 13 for a summary of hypotheses four through six.

Table 13. ANOVA With Repeated Measures For Assertiveness.

Source of Variation	Df	SS	MS	F	F=.01 Tab	p	Decision
Treatment Group	1	673.45	673.45	.74	6.785	.389	Retain Ho ₄
Error ^a	171	154581	154581				
Time	1	3935.70	3935.70	20.39	6.785	.001	Reject Ho ₅
Time × Treatment	1	385.02	385.02	1.99	6.785	.160	Retain Ho ₆
Error	171	33014	193.06				
^a Among subjects, within each group.							

Additional Findings

There were additional findings that need to be reported. Although it was not part of the hypotheses tested, the relationship among the different measures of the dependent variables were explored correlationally. A negative correlation was found between assertiveness and shame. A Pearson Product-Moment Correlation was calculated, comparing assertiveness and shame a posteriori. Table 14 indicates the correlation between internalized shame and assertiveness. As assertiveness increased, shame decreased.

Table 14. Estimated Sample Correlation Coefficients and Corresponding P-values for Dependent Variables.

	RAS-Pre	RAS-Post	ISS-Pre
RAS-Post	.6465**		
ISS-Pre	-.4938**	-.4186**	
ISS-Post	-.4571**	-.4648**	.7733**

** = $p \leq .001$

Summary

The ANOVA[R] was used to test the null hypotheses. The Newman-Kuels Multiple Range test was used to further explore Hypothesis Three where the ANOVA[R] showed there was a significant interaction effect between pre and posttest scores and shame. The purpose of the test was to seek out where the interaction had occurred. The results of the Newman-Kuels showed there was a significant difference between subjects who received the assertive training class and those who did not take the class with respect to shame. The change between pre and posttest scores was much greater in the experimental group with respect to shame than in the control group. The experimental group shame scores were lowered significantly, while there was only a miniscule change in the control group scores. It was therefore concluded that assertiveness training did indeed significantly affect the level of shame in undergraduate college students, as was shown statistically by their lower shame scores in relation to the change in shame scores for those subjects who did not take the assertiveness class. See Table 8. Overall results are summarized in Table 15.

Table 15. Summary of Results.

	Hypotheses	Effect Tested	Findings
Hypotheses for Dependent Variable Shame	Ho ₁	Main Effect of Treatment Comparison of Means	Retained
	Ho ₂	Main Effect of Time Comparison of Means	Rejected
	Ho ₃	Interaction of Treatment by Time	Rejected
Hypotheses for Dependent Variable Assertiveness	Ho ₄	Main Effect of Treatment Comparison of Means	Retained
	Ho ₅	Main Effect of Time Comparison of Means	Rejected
	Ho ₆	Interaction of Treatment by Time	Retained

V. SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

Summary

The purpose of this study was to examine the effect of a course in assertiveness training on internalized shame in college students to determine if assertiveness training was effective in decreasing the feeling of shame in undergraduate college students. Answers to the following questions were sought:

1. To what extent is the level of internalized shame and assertiveness different between the control group and experimental group?
2. To what extent does an assertiveness training course reduce internalized shame scores?
3. To what extent is there an interaction between pre vs post internalized shame and pre vs post assertiveness scores of the control group vs the experimental group?

It was hypothesized that students in the control and experimental groups would be comparable in level of internalized shame and assertiveness and that students in the experimental group would have lower internalized shame scores after taking a course in assertiveness training than those students in the control group who did not take assertiveness training. The subjects constituting the experimental group were students enrolled in assertiveness training classes at the University of Wisconsin-Stout, Menomonie, Wisconsin, during the 1987 fall semester. The control group was composed

of students in fundamentals of speech classes. The research questions were tested by examining six null hypotheses; null hypotheses three was further analyzed by multiple comparisons between all possible pairs of means (see Table 8, p. 62).

The design of the study was an empirical investigation of a treatment for the emotion of shame. The experimental design was a repeated measures design with one grouping factor (treatment) and one within subjects factor, which was time. The treatment grouping factor had two levels, control and experimental. The within subjects factor, time, had two levels, pre and post. There were two main effects, treatment and time, and one two-way interaction, which was the interaction of treatment \times time. The dependent variables were shame and assertiveness. The independent variables were treatment (control and experimental) and time (pre and post). The repeated measure was time.

Internalized shame was defined in this study as: (1) the painful emotional reaction of feeling inferior, of being defective or unworthy as a person; (2) the fear of exposure experienced with or without an audience by way of mental imagery or cognition; and (3) a reliving of the event or experience leading to the feeling of shame. Assertiveness was defined as a style of communication that is direct, honest, and appropriate to the situation, recognizing one's interpersonal rights while being respectful of the rights of others. It includes the expression of feelings, thoughts, and ideas that are self-focused and goal-directed.

The nature of the investigation required the assessment of the internalized shame and assertiveness variables. Recognized standardized tests were used as criterion measures of the dependent variables. The Rathus Assertiveness Schedule (RAS) was used as a measure of assessing students'

assertiveness. Students rated items describing assertive or nonassertive behavior as being self-descriptive. A measure of students' shame levels was obtained from the Internalized Shame Scale (ISS), which contains questions about experiences or feelings that are painful or negative.

The two-way analysis of variance (ANOVA[R]) with repeated measures was used to test the null hypotheses. The Newman-Keuls Multiple Range Test, also referred to as the Student Newman-Keuls Test, was applied where the analysis of variance revealed a significant interaction effect. A confidence level of .01 was used as the standard for rejecting the null hypotheses for all statistical tests.

Null hypothesis one stated there was no significant difference between control and experimental groups with respect to level of shame scores as measured by the ISS. On the basis of the ANOVA[R] on the ISS, average over pre and posttests and comparing between the control and experimental group scores for all subjects, null hypothesis one was retained. The two groups were comparable with respect to total shame scores.

Null hypothesis two stated there was no significant difference between pre and post scores with respect to shame as measured by the ISS. Based upon the results of the ANOVA[R] comparing pre and posttest ISS scores, null hypothesis two was rejected. The combined pretest means of the control and experimental groups were larger than the combined posttest means for these two groups.

Null hypothesis three stated there was no interaction between pre vs post and control vs experimental groups with respect to shame. However, the ANOVA[R] clearly showed there was a significant interaction between time and treatment. Therefore, null hypothesis three was rejected. An interaction is a condition where the means for the levels of one variable do

not move up and down with the same magnitude as the means for the second variable (Courtney, 1987). The difference between pre and posttest shame scores in the control group was not the same as the difference between pre and posttest shame scores in the experimental group.

In order to determine which group experienced the significant difference, the Newman-Keuls Multiple Range Test was performed, revealing no significant difference between the pre and posttest means for the control group. However, the Newman-Keuls Test did show a statistically significant difference between pre and posttest means for the experimental group. At the end of the experiment there was a significant difference between the control and experimental subjects with respect to shame. The experimental subjects had significantly lower shame scores than the control subjects.

Null hypothesis four postulated that there was no significant difference between control and experimental groups with respect to level of assertiveness as measured by the RAS. This hypothesis was retained. The control and experimental groups were evenly matched with respect to level of assertiveness.

Null hypothesis five stated there was no significant difference between pre and posttest scores with respect to assertiveness as measured by the RAS. To determine if there was a difference an ANOVA[R] was utilized, resulting in the rejection of hypothesis five. The data indicated that the posttest level of assertiveness was higher for all subjects. The change for the control group could have been influenced by their participation in a speech class.

Null hypothesis six stated there was no interaction between pre vs posttest and control vs experimental groups with respect to assertiveness. This hypothesis examined the interaction between the control vs the experi-

mental and pre vs posttest scores with respect to the dependent variable, assertiveness. This hypothesis was retained. Control and experimental groups showed little difference on pretest scores; both groups were fairly low with respect to assertiveness. However, both groups increased their level of assertiveness on posttests. Figure 2 (p. 67) suggests that the experimental group increased its posttest assertiveness scores more than did the control group. However, the increase was not found to be statistically significant at the .01 level.

Conclusions

The research focused on finding a treatment for the emotion of shame in college students. Figure 1 (p. 63) shows that the experimental group which had assertiveness training experienced a statistically significant decrease in the level of shame in comparison to the control group, which did not receive assertiveness training. While there was a change in level of shame in the control group from pre to posttest, that change was very small and not significant.

The significant interaction in hypothesis three indicates that the difference between experimental and control groups' pretest scores was different than the difference between their posttest scores. The pretest scores difference was positive, while the posttest difference was negative. The margin of difference between pre and posttest scores was not the same. If there had been no interaction, the difference in the pretest score would have been the same as the difference in posttest scores for the control and experimental groups. At pretest, the experimental group was higher in level of shame than the control group. At the posttest, the experimental group was

more than 11 points lower in level of shame than the control group. The control group did not experience a significant difference between the level of shame at the beginning of the experiment and the end of the experiment. The change in level of shame was less than one point for the control group (see Table 8, p. 62). The results of the experiment provide evidence of a relationship between assertiveness training and shame. Subjects indicated lower feelings of shame after nine weeks of an assertiveness training class than those subjects who did not take the course.

Which group, experimental or control, increased more in posttest assertiveness was not entirely clear statistically, although Figure 2 (p. 67) indicates that the experimental group appeared to have higher levels of assertiveness over time than the control group. This may have been due to a weakness in the experimental design. The effects of the pretest may have influenced the score for the posttest (Courtney, 1986). This could have occurred when testing for this variable since the same tests were used for pre and posttests. Allowing more time between pre and posttests could eliminate the possibility that the pretests influenced the respondents' awareness of situations reflecting assertiveness. Extending the study over a longer period of time could possibly minimize this internal threat.

The results of the Pearson Product-Moment Correlation, which was calculated a posteriori, clearly showed the strong negative correlation between the two dependent variables, assertiveness and shame. As assertiveness increased, shame decreased. The strong negative correlation between assertiveness and shame supported the findings in hypothesis three, which found no significant difference in shame scores for the control group, but a statistically significant difference between pre and posttest scores for the experimental group. Thus, it would seem that this study suggests the value

of exploring other treatments for shame in addition to psychotherapy. This study revealed that an assertiveness training class did have a positive effect on lowering the level of shame in college students. Because of the lack of empirical research examining treatment for the emotion of shame, it was not possible to compare these findings with other research findings.

This was the first preliminary research that was done using assertiveness training as a proposed treatment for the emotion of internalized shame in college students. This was the first research which field-tested a method to examine the effects of assertiveness training on shame. The findings appear to support the hypothesis that assertiveness training does in fact lower the level of internalized shame in college students.

One question remains unanswered in this research. Why did both the control and experimental groups increase in assertiveness from pretest to posttest, while only the experimental group experienced a statistically significant decrease in shame from pretest to posttest? Perhaps one answer could be that the speech class also acted as a treatment. At the end of nine weeks when the posttest occurred, each student in the control group had given at least two speeches in front of the class. This experience could have increased their self-confidence and assertiveness. Further testing on a larger sample might provide some answers to this question. Since the subjects in the assertiveness training class experienced statistically significant lower shame scores, why both groups (control and experimental) did not decrease in shame just as both increased in assertiveness could be addressed. The experimental group did appear to increase more from pre to posttest in assertiveness. However, this observation was not proven statistically at the .01 level of significance.

Implications

One of the objectives of the study was to suggest programming for student affairs divisions in colleges and universities. People in all the functional areas of student affairs on college campuses might begin to incorporate assertiveness training into their departments. This is especially true in university counseling centers and residence life departments, but it is also true in student activities programming, financial aids, food service, student health, and even in the registrar and admission areas.

People who feel good about themselves tend to have better interpersonal relationships and report more satisfaction in the achievement of academic, career, and social goals (Rogers, 1951). These goals are also stated in many universities' mission and goal statements. As such, academic affairs and student affairs divisions might incorporate the findings from this research into their curricula.

In Chapter II, the theoretical link between assertiveness and positive self-concept was examined and established. Because shame affects the self-concept, it can interfere with development of individual abilities to the fullest potential. It has been stated that self-concept is the most important single factor affecting human behavior (Combs, Avila, & Purkey, 1971). Shame, on the other hand, diminishes self-concept, leaving individuals exposed as inadequate, defective and robbed of dignity (Fossum & Mason, 1986). This judgement of self as being of little worth, of being ineffective and incompetent, can be a prime determinant in the actions or inability to act in the achievement of educational, vocational, and personal goals by college students.

Expanding the range of treatment possibilities to deal with the emotion of shame can give people choices besides psychotherapy, which can involve lengthy as well as costly treatment. On most college campuses, short-term therapy is the practice imposed in counseling and mental health centers for reasons of personnel and budget restrictions. Assertiveness training, offered either as a class or in group settings, is a recognized short-term therapy that in view of the findings and conclusions drawn from this study appears to have possibilities as effective short-term therapy to reduce college students' levels of shame.

Recommendations

Based on the review of literature during the course of this study, it became apparent that the need existed to increase the body of knowledge relevant to the treatment of shame. This was seen as vital in order to deal with an emotion that is recognized as forming very early in life and which can affect a person over a lifetime, if the experience becomes internalized. In order to further expand this body of knowledge and to continue the effort to learn more about the emotion of shame and its effect on individual lives, and in order to minimize the effect shame can have, the following research is recommended:

1. Replicate the present study using samples from other populations so the results could be generalized to other groups besides college students.
2. Replicate the present study on several college campuses in different geographical locations in order to determine if the findings are applicable to large cross sections of student populations.

If should be determined if the findings are widely applicable or whether they are a result of specific conditions existing in a mid-sized midwestern university.

3. Investigate the association between shame and self-directed hostility which discharges itself as depression to ascertain the effect of assertiveness training on these variables.
4. Conduct a longitudinal study to assess the effect of assertiveness training on levels of shame over time. Develop a course to teach assertiveness training on campuses so that research of this nature could be carried out.
5. Conduct this same study over an 18-week period of time rather than 9 weeks. The effects of a pretest may influence the scores on a second or posttest. Allow more time between pretesting and posttesting to eliminate the possibility that the pretest was a learning experience for the respondent.
6. Replicate the present study to determine if the findings can be reproduced.

BIBLIOGRAPHY

- Adler, A. (1974). *The practice and theory of individual psychology* (2nd ed.). Totowa, NJ: Littlefield, Adams & Co.
- Alberti, R., & Emmons, M. (1970). *Your perfect right* (4th ed.). San Luis Obispo, CA: Impact.
- Alexander, F. (1938). Remarks about the relation of inferiority feelings to guilt feelings. *International Journal of Psychoanalysis*, 19, 41-48.
- Arbetter, S. (1987). By their own hand. *Current Health* 2, 14(1), 18-21.
- Aristotle. (1941). Nichomachean ethics. In R. McKeon (Ed.), *The basic works of Aristotle* (trans. by W. D. Ross), pp. 1317-1431. New York: Random House.
- Ausubel, D. P. (1955). Relationships between shame and guilt in the socializing process. *Psychological Review*, 62, 378-390.
- Ball, D., McKenry, P., & Price-Bonham, S. (1983). Use of repeated-measures designs in family research. *Journal of Marriage and the Family*, 45, 885-896.
- Bartlett, E. S., & Izard, C. E. (1972). A dimensional and discrete emotions investigation of the subjective experience of emotion. In C. E. Izard (Ed.), *Patterns of emotions: A new analysis of anxiety and depression*. New York: Academic Press.
- Baum, H. S. (1985). Predicaments of bureaucratic subordinancy: Dramatic escape and compensataion. *Political Psychology*, 6, 681-703.
- Beall, L. (1972). *The shame-guilt test*. Unpublished manuscript, Berkeley, CA: The Wright Institute.
- Berne, E. (1964). *Games people play: The psychology of human relationships*. New York: Grove.
- Bilmes, M. (1967). Shame and delinquency. *Contemporary Psychoanalysis*, 3, 113-133.
- Binder, J. L. (1970). *The relative proneness to shame or guilt as a dimension of character style*. Unpublished doctoral dissertation, The University of Michigan, Ann Arbor, MI.
- Bolten, R. (1979). *People skills: How to assert yourself, listen to others, and resolve conflicts*. Englewood Cliffs, NJ: Prentice-Hall.

- Branden, N. (1971). *Psychology of self-esteem*. New York: Bantam.
- Brandt, R. B. (1958). Blameworthiness and obligation. In Abraham Melden (Ed.), *Essays in moral philosophy*, pp. 3-39. Seattle, WA: University of Washington Press.
- Brousek, F. J. (1982). Shame and its relationship to early narcissistic developments. *International Journal of Psycho-Analysis*, 63, 369-378.
- Brown, K., & Sunshine, J. (1982). Group treatment of children from alcoholic families. *Social Work With Groups*, 5(1), 65-72.
- Bruniz, J. L., & Kintz, B. L. (1977). *Computational handbook of statistics* (2nd Ed.). Glenview, IL: Scott, Foresman & Co.
- Buchanon, E. III, & Oliaro, P. (1984). Law, alcohol, and higher education. In T. G. Goodale (Ed.), *New directions for student services series: Alcohol and the college student*, pp. 49-52. San Francisco, Jossey-Bass.
- Burns, D. (1980). *Feeling good: The new mood therapy*. New York: William Morrow.
- Cameron, P., & Bachmer, J. (1982). And coffee too. *The International Journal of the Addictions*, 17, 569-574.
- Campbell, F. A. (1984). The concept of shame. *Perspectives in Psychiatric Care*, 22, 62-64.
- Carroll, J. (1985). *Guilt*. London: Routledge and Kegan Paul.
- Cate, R., Koval, I., Christopher, F., & Lloyd, S. (1982). Premarital abuse: A social psychological perspective. *Journal of Family Issues*, 3(1), 79-90.
- Cheney, A., Varhely, S., & Hipple, J. (1983). Recruitment strategy in forming a counseling group for bulimic women. *Journal of College Student Personnel*, 24, 368-369.
- Cohen, J. (1969). *Statistical power analysis for the behavioral sciences*. Orlando, FL: Academic Press.
- Coleman, M. (1985). Shame: A powerful underlying factor in violence and war. *Journal of Psychoanalytic Anthropology*, 8(1), 67-79.
- Combs, A. W., Avila, D. L., & Purkey, W. W. (1971). *Helping relationships*. Boston: Allyn and Bacon.
- Cook, D. R. (in press). *Measuring shame: The internalized shame scale*. Unpublished manuscript submitted for publication.
- Coopersmith, S. (1968). Studies in self-esteem. *Scientific American*, 218, 96-107.

- Coopersmith, S. (1967). *The antecedents of self-esteem*. San Francisco: W. H. Freeman.
- Cotler, S. B. (1975). Assertion training: A road leading where? *Counseling Psychologist*, 5(4), 20-29.
- Courtney, E. W. (1986). *Design for research*. Corvallis, OR: Sanderling Press.
- Courtney, E. W. (1987). *Methods of analysis: The F statistic*. Corvallis, OR: Sanderling Press.
- Covington, M. V., & Omelich, C. L. (1985). Ability and effort valuation among failure-avoiding and failure-accepting students. *Journal of Educational Psychology*, 77, 446-459.
- Crozier, W. R. (1982). Explanations of social shyness. *Current Psychological Review*, 2(1), 47-59.
- Deigh, J. G. (1979). *Guilt and shame: Philosophical investigations in moral psychology*. Unpublished doctoral dissertation, University of California, Los Angeles, Los Angeles, CA.
- Deigh, J. G. (1983). Shame and self-esteem: A critique. *Ethics*, 93, 224-245.
- Dollard, J., & Miller, N. E. (1950). *Personality and psychotherapy*. New York: McGraw-Hill.
- Edwards, D. G. (1976). Shame and pain and shut up or I'll really give you something to cry about. *Clinical Social Work Journal*, 4(1), 3-12.
- Ellis, A., & Harper, R. A. (1961). *A guide to rational living*. Englewood Cliffs, NJ: Prentice-Hall.
- Elzey, F. (1967). *A first reader in statistics*. Belmont, CA: Brooks/Cole.
- Erikson, E. (1950). *Childhood and society*. New York: Norton.
- Feldman, S. S. (1962). Blushing, fear of blushing and shame. *Journal of the American Psychoanalytic Association*, 10, 368-385.
- Fisher, R. A. (1973). *Statistical methods for research workers* (14th ed.). New York: Hafner.
- Fisher, S. F. (1985). The phenomenology of shame in borderline development and treatment. *Psychotherapy*, 22, 101-109.
- Fossum, M. A., & Mason, M. J. (1986). *Facing shame: Families in recovery*. New York: W. W. Norton & Company.
- French, T. M. (1970). *Psychoanalytic interpretations*. Chicago: Quadrangle Books.

- Freud, S. (1905). Jokes and their relation to the unconscious. *Standard Edition*, 8. London: Hogarth Press.
- Freud, S. (1905). Three essays on the theory of sexuality. *Standard Edition*, 7. London: Hogarth Press.
- Freud, S. (1963). *General psychological theory*. New York: Macmillan.
- Friesen, V. I. (1979). On shame and the family. *Family therapy*, 6, 39-56.
- Galassi, M. D., & Galassi, J. P. (1977). *Assert yourself*. New York: Hamon Sciences Press.
- Gambrill, E. D., & Richey, C. A. (1976). *It's up to you: Developing assertive social skills*. Millbrae, CA: Les Frommes.
- Gilligan, J. (1976). Beyond morality: Psychoanalytic reflections on shame, guilt and love. In T. Lickona, *Moral development and behavior: Theory, research and social issues*, pp. 144-158. New York: Holt, Rinehart & Winston.
- Gordon, T. (1970). *Parent effectiveness training*. New York: P. H. Wyden.
- Grinker, R. R. (1955). Growth, inertia and shame: Their therapeutic implications and dangers. *The International Journal of Psycho-Analysis*, 36, 242-253.
- Harris, T. A. (1982). *I'm O.K. You're O.K.* New York: Avon.
- Hartman, H., & Lowenstein, R. M. (1962). Notes on the superego. *Psychoanalytic Study of the Child*, 17, 42-81.
- Isenberg, A. (1949). Natural pride and natural shame. *Philosophy and Phenomenological Research*, 10, 1-24.
- Izard, C. (1977). *Human emotions*. New York: Plenum Press.
- Jacobson, E. (1964). *The self and the object world*. New York: International Universities Press.
- Kaufman, G. (1974). The meaning of shame: Toward a self-affirming identity. *Journal of Counseling Psychology*, 21, 568-574.
- Kaufman, G. (1985). *Shame: The power of caring*. Cambridge, MA: Schenkman.
- Kaufman, G. (1986). Dynamics and treatment of shame-based syndromes. In *Proceedings of the Ninth Annual Adult Psychiatric Day Treatment Forum*. Minneapolis, MI: University of Minnesota.

- Kinston, W. (1983). A theoretical context for shame. *International Journal of Psycho-analysis*, 64, 213-226.
- Knox, K. (1985). Women's identity: Self psychology's new promise. *Women and Therapy*, 4, 57-69.
- Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.
- Kohut, H. (1977). *The restoration of the self*. New York: International Universities Press.
- Kopp, S. (1976). *The naked therapist*. San Diego, CA: Edits.
- Kriegman, G. (1983). Entitlement attitudes: Psychosocial and therapeutic applications. *Journal of the American Academy of Psychoanalysis*, 11, 265-281.
- Lange, A. & Jakubowski, P. (1976). *Responsible assertive behavior: Cognitive/behavioral procedures for trainers*. Champaign, IL: Research Press.
- Lansky, M. R. (1984). Violence, shame, and the family. *International Journal of Family Psychiatry*, 5(1), 21-48.
- Lansky, M. R. (1987). Shame and domestic violence. In D. L. Nathanson (Ed.), *The many faces of shame*, pp. 335-362. New York: Guilford.
- Laughlin, H. P. (1979). *The ego and its defenses* (2nd ed.). New York: Jason Aronson.
- Lazarus, A. A. (1966). Behavior rehearsal versus nondirective therapy versus advice in effecting behavior change. *Behavior Research and Therapy*, 4, 209-212.
- Lazarus, A. A. (1968). Behavior therapy in groups. In G. M. Gazda (Ed.), *Basic approaches to group psychotherapy and group counseling* (pp. 149-175). Springfield, IL: Charles C. Thomas.
- Lazarus, A. A. (1973). On assertive behavior: A brief note. *Behavior Therapy*, 4, 697-699.
- Le Pantois, J. (1986). Group therapy for children of substance abuses. *Journal of Social Work*, 9(1), 39-51.
- Levin, S. (1967). Some metapsychological considerations on the differentiation between shame and guilt. *International Journal of Psycho-Analysis*, 48, 267-276.
- Levin, S. (1971). The psychoanalysis of same. *International Journal of Psycho-Analysis*, 52, 355-361.

- Levin, S. (1977). On shame. In C. W. Socarides (Ed.), *The psychoanalysis of shame*. New York: International Universities Press.
- Lewis, H. B. (1971). *Shame and guilt in neurosis*. New York: International Universities Press.
- Lewis, H. B. (1976). *Psychic war in men and women*. New York: New York University Press.
- Lewis, H. B. (1981). Shame and guilt in human nature. In S. Tuttmann, C. Kaye, & M. Zimmerman (Eds.), *Object and self: A developmental approach*. New York: International Universities Press.
- Lewis, H. B. (1984a). Freud and modern psychology: The social nature of humanity. *Psychoanalytic Review*, 71, 7-26.
- Lewis, H. B. (1984b). The role of shame in depression. In M. Rutter, C. Izard, & P. Read (Eds.), *Depression in young people: Developmental and clinical perspectives*. New York: Guilford.
- Lewis, H. B. (1985). Depression vs. paranoia: Why are there sex differences in mental illness? *Journal of Personality*, 53(2), 150-178.
- Lewis, H. B. (1987). Shame and the narcissistic personality. In D. L. Nathanson (Ed.), *The many faces of shame*, pp. 93-132. New York: Guilford.
- Lichtenstein, H. (1963). The dilemma of human identity: Notes on self-transformation, self-objectivation and metamorphosis. *Journal of the American Psychoanalytic Association*, 11, 173-225.
- Lichtenstein, H. (1964). The role of narcissism in the emergence and maintenance of a primary identity. *International Journal of Psycho-Analysis*, 45, 49-56.
- Lindsay-Hartz, J. (1984). Contrasting experiences of shame and guilt. *American Behavioral Scientist*, 27, 689-702.
- Lowenfeld, H. (1976). Notes on shamelessness. *The Psychoanalytic Quarterly*, 45, 62-71.
- Ludwig, L. D., & Lazarus, A. A. (1972). A cognitive and behavioral approach to the treatment of social inhibition. *Journal of Psychotherapy Theory, Research and Practice*, 9, 204-206.
- Lynd, H. M. (1958). *On shame and the search for identity*. New York: Harcourt, Brace.
- Maddi, S. R. (1972). *Personality theories: A comparative analysis*. Homewood, IL: The Dorsey Press.
- Mahoney, M. (1974). *Cognition and behavior modification*. Cambridge, MA: Ballinger Publishing.

- Malatesta, C., & Izard, C. (1964). *Emotion in adult development*. Beverly Hills, CA: Sage Publications.
- Mann, R. J. & Flowers, J. V. (1978). An investigation of the validity and reliability of the Rathus Assertion Schedule. *Psychological Reports*, 42, 632-634.
- Marsella, A. J., Murray, M. D., & Golden, C. (1974). Ethnic variation in the phenomenology of emotions. *Journal of Cross-Cultural Psychology*, 5, 312-321.
- Maultsby, M. Jr. (1984). *A million dollars for your hangover*. Lexington, KY: Rational Self-Help Books.
- McFall, R. M., & Lillesand, D. B. (1971). Behavior rehearsal with modeling and coaching in assertion training. *Journal of Abnormal Psychology*, 77, 313-323.
- McFall, R. M., & Marston, A. R. (1970). An experimental investigation of behavior rehearsal in assertive training. *Journal of Abnormal Psychology*, 76, 295-303.
- McFall, R. M., & Twentyman, C. J. (1973). Four experiments on the relative contributions to assertion training. *Journal of Abnormal Psychology*, 81, 199-218.
- Meichenbaum, D. (1977). *Cognitive-behavior modification: An integrative approach*. New York: Plenum Press.
- Miller, S. (1985). *The shame experience*. Hillsdale, NJ: The Analytic Press.
- Modigliani, A. (1971). Embarrassment, facework and eye contact: Testing a theory of embarrassment. *Journal of Personality and Social Psychology*, 17(1), 15-24.
- Mohl, P., & Burstein, A. (1982). The application of Kohutian self-psychology to consultation-liaison psychiatry. *General Hospital Psychiatry*, 4, 113-119.
- Mollon, P. (1984). Shame in relation to narcissistic disturbance. *The British Journal of Medical Psychology*, 57, 207-214.
- Mollon, P. (1985). The non-mirroring mother and the missing paternal dimension in a case of narcissistic disturbance. *Psychoanalytic Psychotherapy*, 1(2), 35-47.
- Mollon, P. (1986). Narcissistic vulnerability and the fragile self: A failure of mirroring. *British Journal of Medical Psychology*, 59, 317-324.
- Morris, H. (1971). *Guilt and shame*. Los Angeles: Wadsworth.

- Morrison, A. P. (1983). Shame, ideal self, and narcissism. *Contemporary Psychoanalysis*, 19, 295-318.
- Morrison, A. P. (1984). Working with shame in psychoanalytic treatment. *Journal of the American Psychoanalytic Association*, 32, 479-505.
- Morrison, A. P. (1987). The eye turned inward: Shame and the self. In D. L. Nathanson (Ed.), *The many faces of shame*, pp. 271-291. New York: Guilford.
- Mosher, D. L., & White, B. B. (1981). On differentiating shame and shyness. *Motivation and Emotions*, 5, 62-72.
- Nathanson, D. L. (1987). A timetable for shame. In D. L. Nathanson (Ed.), *The many faces of shame*, pp. vii-xiii, 1-63. New York: Guilford.
- O'Leary, J., & Wright, F. (1986). Shame and gender: Issues in pathological narcissism. *Psychoanalytic Psychology*, 3, 327-339.
- Pagano, R. (1981). *Understanding statistics in the behavioral sciences*. St. Paul, MI: West Publishing Co.
- Piers, G., & Singer, M. (1953). *Shame and guilt*. Springfield, IL: Charles C. Thomas.
- Rabin, C., Amir, S., Nardi, R., & Oradia, B. (1986). Compliance and control: Issues in group training for diabetics. *Journal of Health and Social Work*, 11(2), 141-151.
- Rabow, J. Platt, G. M., & Goldman, M. S. (1987). *Advances in psychoanalytical sociology*. Malabar, FL: Robert E. Krieger Publishing Company.
- Rathus, S. A. (1973). A 30-item schedule for assessing assertive behavior. *Behavior Therapy*, 4, 398-406.
- Rathus, S. A. (1975). Principles and practices of assertive training: An eclectic overview. *The Counseling Psychologist*, 5, 9-19.
- Rawls, J. (1971). *A theory of justice*. Cambridge, MA: Harvard University Press.
- Retzinger, S. (1985). The resentment process: Videotape studies. *Psychoanalytic Psychology*, 2(2), 129-151.
- Rogers, C. (1951). *Client centered therapy*. New York: Houghton-Mifflin.
- Rosenthal, K. (1987). Rituals of undoing in abused and neglected children: The foster care dilemma. *Child and Adolescent Social Work Journal*, 4, 226-236.
- Rotenstreich, N. (1965). On shame. *Review of Metaphysics*, 19, 55-86.

- Salter, A. (1949). *Conditioned reflex therapy*. New York: Capricorn.
- Salter, A. (1961). *Conditioned reflex therapy: The direct approach to the reconstruction of personality* (2nd ed.). New York: Putnam.
- Saltzman, N. (1983). Paracatastrophies and exorcism in biopsychotherapy: Treating shame, guilt and bad feelings about the self. *International Journal of Eclectic Psychotherapy*, 2(2), 14-30.
- Sandler, J., Holder, A., & Meers, D. (1963). The ego-ideal and the ideal self. *Psychoanalytic Study of the Child*, 18, 139-158.
- Scheft, T. J. (1985). Universal expressive needs: A critique and a theory. *Symbolic Interaction*, 8, 241-262.
- Schneider, C. D. (1977). *Shame, exposure and privacy*. Boston: Beacon Press.
- Sederer, L., & Seidenberg, R. (1976). Heiress to an empty throne. *Contemporary Psychoanalysis*, 12, 240-250.
- Shane, P. (1980). Shame and learning. *American Journal of Orthopsychiatry*, 50, 348-355.
- Sheff, T. J. (1984). The taboo on coarses emotions. *Review of Personality and Social Psychology*, 5, 146-169.
- Sheff, T. J. (1985). Universal expressive needs: A critique and a theory. *Symbolic interaction*, 8, 241-262.
- Shimanoff, S. B. (1984). Commonly named emotions in everyday conversations. *Perceptual and Motor Skills*, 58, 514.
- Sisson, C. (1977). *The effectiveness of cognitive-behavioral assertion training on the self-concept of college undergraduates*. Unpublished doctoral dissertation, Oregon State University, Corvallis, OR.
- Skorina, J. K., & Kovach, J. A. (1986). Treatment techniques for incest-related issues in alcoholic women. *Alcoholism Treatment Quarterly*, 3(1), 17-30.
- Smith, R. L. (1972). *The relative proneness to shame or guilt as an indicator of defensive style*. Unpublished doctoral dissertation, Northwestern University, Evanston, IL.
- Socarides, C. W. (Ed.). (1977). *The world of emotions: Clinical studies of affects and their expression*. New York: International Universities Press, Inc.
- Solomon, R. (1976). *The passions*. Garden City, NJ: Anchor-Doubleday.
- Spero, M. H. (1984). Shame: An object-relational formulation. *Psychoanalytic Study of a Child*, 39, 259-282.

- Spitz, R. (1965). *The first year of life*. New York: International Universities Press.
- Stein, E. V. (1968). *Guilt: Theory and therapy*. Philadelphia, PA: The Westminster Press.
- Stephenson, S. (1979). Assertiveness training. *Hyde Park Monograph*, 1(4), 4-7.
- Stephenson, S. (1982). *A study of the relationship between assertiveness and self-concept*. Unpublished education specialist field study, University of Wisconsin-Stout, Menomonie, WI.
- Stierlin, H. (1974). Shame and guilt in family relations. *General Psychiatry*, 30, 381-389.
- Stipek, D. J. (1983). A developmental analysis of pride and shame. *Human Development*, 26, 42-54.
- Thompson, G. G. (Ed.). (1971). *Social development and personality*. New York: John Wiley & Sons.
- Thrane, G. (1979). Shame. *Journal of the Theory of Social Behavior*, 9, 139-161.
- Tomkins, S. (1962). *Affect imagery-consciousness*, Vol. 1: *The positive affects*. New York: Springer.
- Tomkins, S. (1963). *Affect imagery-consciousness*, Vol. 2: *The negative affects*. New York: Springer.
- Tomkins, S., & Izard, C. (Eds.). (1965). *Affect, cognition, and personality: Empirical studies*. New York: Springer.
- Tuttman, S., Karje, C., & Zimmerman, M. (1981). *Object and self: A developmental approach*. New York: International Universities Press, Inc.
- U.S. Department of Commerce, Bureau of the Census. (1988). *Statistical abstract of the United States*. Washington, D.C.: U.S. Government Printing Office.
- Viney, L. L. (1985). "They call you a dole bludger": Some experiences of unemployment. *Journal of Community Psychology*, 13(1), 31-45.
- Viney, L. L., Westbrook, M. J., & Preston, C. (1985). Sources of anxiety in drug addiction. *Journal of Clinical Psychology*, 41, 121-129.
- Wallace, L. (1963). The mechanism of shame. *Archives of General Psychiatry*, 8, 80-85.
- Wandrei, K. E. (1985). Identifying potential suicides among high-risk women. *Social Work*, 30, 511-517.

- Ward, H. P. (1972). Aspects of shame in analysis. *American Journal of Psychotherapy*, 32, 62-73.
- Ward, H. P. (1972). Shame--A necessity for growth therapy. *American Journal of Psychotherapy*, 26, 232-243.
- Weiner, B., & Brown, J. (1984). Affective consequences of ability versus effort ascriptions. *Journal of Educational Psychology*, 76, 146-158.
- Wicker, F. W., Payne, G. C., & Morgan, R. D. (1983). Participant descriptions of guilt and shame. *Motivation and Emotion*, 7, 25-39.
- Winer, B. J. (1971). *Statistical principles in experimental design* (2nd Ed.). New York: McGraw-Hill.
- Witkin, H., Lewis, H. B., & Weil, E. (1968). Affective reactions and patient-therapist interactions among more and less differentiated patients early in therapy. *Journal of Nervous and Mental Disease*, 146, 193-208.
- Wolpe, J. (1966). *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford University Press.
- Wolpe, J. (1969). Assertive training. In *The practice of behavior therapy* (pp. 61-71). Elmsford, NY: Pergamon Press.
- Wolpe, J. (1970). The instigation of assertive behavior: Transcripts from two cases. *Journal of Behavior Therapy and Experimental Psychiatry*, 1, 145-151.
- Wolpe, J. (1973). Supervision transcript: V. Mainly about assertive training. *Journal of Behavior Therapy and Experimental Psychiatry*, 4, 141-148.
- Wolpe, J., & Lazarus, A. A. (1966). *Behavior therapy techniques*. New York: Pergamon Press.
- Wurmser, L. (1981). *The mask of shame*. Baltimore, MD: The John Hopkins University Press.
- Wurmser, L. (1987). Shame: The veiled companion of narcissism. In D. L. Nathanson (Ed.), *The many faces of shame*, pp. 64-92. New York: Guilford.
- Wylie, R. (1961). *The self-concept*. Lincoln, NE: University of Nebraska Press.
- Zimbardo, P., Pilkonis, P., & Norwood, R. (1974). *The silent prison of shyness*. Glenview, IL: Scott, Foresman College Division.

APPENDICES

Appendix A

Consent Forms

Control

September, 1987

Dear UW-Stout Student:

I am in need of your cooperation and help. I am in the process of conducting a study designed to gain information on the relationship of assertiveness training and internalized shame in college students. The overall goal is to see if a treatment or model can be developed to understand the relationship of assertiveness to internalized shame. You will not receive any formal assertiveness training and thus you will act as a control group for the research project.

Your participation in this study is on an entirely voluntary basis. If you choose to participate, your total commitment will be about 30 minutes at the beginning and at the end of the quarter to complete two standardized instruments designed to measure assertiveness and internalized shame plus some demographic questions. Your participation, or lack thereof, will in no way affect any grading or other assignment in this class.

No individual scores will be identified in the research findings and your answers will be completely confidential.

The questions on the Internalized Shame Scale are experiences and feeling statements that are painful or negative but which most everyone has had in some way.

Your name will be removed from the instrument by your instructor before being seen by the researcher. The forms are numbered only in order to compare pre and post results.

Your participation is very important to this research and to me. I hope you will be interested in joining me in this project.

Most sincerely,

Redacted for Privacy

Sue Stephenson
Counseling Center

I have read and understand the above and agree to participate in the study.

Signature _____ Date _____

Experimental

September, 1987

Dear Student in Psych 479-570:

I am in need of your cooperation and help. I am in the process of conducting a study designed to gain information on the relationship of assertiveness training and internalized shame in college students. The overall goal is to see if a treatment or model can be developed to understand the relationship of assertiveness to internalized shame. Your participation in this project will help in reaching this goal.

Your participation in this study is on an entirely voluntary basis. If you choose to participate, your total commitment will be about 30 minutes at the beginning and at the end of the quarter to complete two standardized instruments designed to measure assertiveness and internalized shame plus some demographic questions. Your participation, or lack thereof, will in no way affect any grading or other assignment in this class.

No individual scores will be identified in the research findings and your answers will be completely confidential.

The questions on the Internalized Shame Scale are experiences and feeling statements that are painful or negative but which most everyone has had in some way.

You will not be asked for your name. The forms are numbered only in order to compare pre and post results.

Your participation is very important to this research and to me. I hope you will be interested in joining me in this project.

Most sincerely,

Redacted for Privacy

Sue Stephenson
Counseling Center

I have read and understand the above and agree to participate in the study.

Signature _____ Date _____

Appendix B

Standardized Tests

Control

No. _____

INTERNALIZED SHAME SCALE

Copyright 1986 by David R. Cook

DIRECTIONS: Below is a list of statements describing feelings or experiences that you may have from time to time or that are familiar to you because you have had these feelings and experiences for a long time. These are all statements of feelings and experiences that are generally painful or negative in some way. Some people will seldom or never have had many of these feelings and experiences. Everyone has had some of these feelings at some time, but if you find that these statements describe the way you feel a good deal of the time, it can be painful just reading them. Try to be as honest as you can in responding.

Read each statement carefully and mark the number in the space to the left of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below. DO NOT OMIT ANY ITEM.

Year in school: Fr ____ Soph ____ Jr ____ Sr ____ Grad ____

Age: ____ (years) Sex: Male ____ Female ____ Major ____

Have you ever taken a class in assertiveness training? Yes ____ No ____

SCALE**NEVER- 0****SELDOM- 1****SOMETIMES- 2****FREQUENTLY- 3****ALMOST ALWAYS- 4**

____1. I feel like I am never quite good enough.

____2. I feel somehow left out.

____3. I think that people look down on me.

____4. Compared to other people I feel like I somehow never measure up.

____5. I scold myself and put myself down.

____6. I feel insecure about others' opinions of me.

____7. I see myself as being very small and insignificant.

____8. I feel intensely inadequate and full of self doubt.

____9. I feel as if I am somehow defective as a person, like there is something basically wrong with me.

____10. I have an overpowering fear that my faults will be revealed in front of others.

____11. I have this painful gap within me that I have not been able to fill.

____12. There are different parts of me that I try to keep secret from others.

____13. I feel empty and unfulfilled.

____14. When I compare myself to others I am just not as important.

____15. My loneliness is more like emptiness.

____16. I always feel like there is something missing.

SCALE

NEVER- 0 SELDOM- 1 SOMETIMES- 2 FREQUENTLY- 3 ALMOST ALWAYS- 4

- ____17. I really do not know who I am.
- ____18. I replay painful events over and over in my mind until I am overwhelmed.
- ____19. At times I feel like I will break into a thousand pieces.
- ____20. I feel as if I have lost control over my body functions and my feelings.
- ____21. Sometimes I feel no bigger than a pea.
- ____22. At times I feel so exposed that I wish the earth would open up and swallow me.
- ____23. I become confused when my guilt is overwhelming because I am not sure why I feel guilty.
- ____24. I seem always to be either watching myself or watching others watch me.
- ____25. I see myself striving for perfection only to continually fall short.
- ____26. I think others are able to see my defects.
- ____27. When bad things happen to me I feel like I deserve it.
- ____28. Watching other people feels dangerous to me, like I might be punished for that.
- ____29. I can't stand to have anyone look directly at me.
- ____30. It is difficult for me to accept a compliment.
- ____31. I could beat myself over the head with a club when I make a mistake.
- ____32. When I feel embarrassed, I wish I could go back in time and avoid that event.
- ____33. Suffering, degradation, and distress seems to fascinate and excite me.
- ____34. I feel dirty and messy and feel like no one should ever touch me or they'll be dirty too.
- ____35. I would like to shrink away when I make a mistake.

Experimental

Na. _____

INTERNALIZED SHAME SCALE

Copyright 1986 by David R. Cook

DIRECTIONS: Below is a list of statements describing feelings or experiences that you may have from time to time or that are familiar to you because you have had these feelings and experiences for a long time. These are all statements of feelings and experiences that are generally painful or negative in some way. Some people will seldom or never have had many of these feelings and experiences. Everyone has had some of these feelings at some time, but if you find that these statements describe the way you feel a good deal of the time, it can be painful just reading them. Try to be as honest as you can in responding.

Read each statement carefully and mark the number in the space to the left of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below. **DO NOT OMIT ANY ITEM.**

Year in school: Fr ____ Soph ____ Jr ____ Sr ____ Grad ____

Age: ____ (years) Sex: Male ____ Female ____ Major _____

SCALE**NEVER- 0****SELDOM- 1****SOMETIMES- 2****FREQUENTLY- 3****ALMOST ALWAYS- 4**

- ____1. I feel like I am never quite good enough.
- ____2. I feel somehow left out.
- ____3. I think that people look down on me.
- ____4. Compared to other people I feel like I somehow never measure up.
- ____5. I scold myself and put myself down.
- ____6. I feel insecure about others' opinions of me.
- ____7. I see myself as being very small and insignificant.
- ____8. I feel intensely inadequate and full of self doubt.
- ____9. I feel as if I am somehow defective as a person, like there is something basically wrong with me.
- ____10. I have an overpowering fear that my faults will be revealed in front of others.
- ____11. I have this painful gap within me that I have not been able to fill.
- ____12. There are different parts of me that I try to keep secret from others.
- ____13. I feel empty and unfulfilled.
- ____14. When I compare myself to others I am just not as important.
- ____15. My loneliness is more like emptiness.
- ____16. I always feel like there is something missing.

SCALE

NEVER- 0 SELDOM- 1 SOMETIMES- 2 FREQUENTLY- 3 ALMOST ALWAYS- 4

- _____17. I really do not know who I am.
- _____18. I replay painful events over and over in my mind until I am overwhelmed.
- _____19. At times I feel like I will break into a thousand pieces.
- _____20. I feel as if I have lost control over my body functions and my feelings.
- _____21. Sometimes I feel no bigger than a pea.
- _____22. At times I feel so exposed that I wish the earth would open up and swallow me.
- _____23. I become confused when my guilt is overwhelming because I am not sure why I feel guilty.
- _____24. I seem always to be either watching myself or watching others watch me.
- _____25. I see myself striving for perfection only to continually fall short.
- _____26. I think others are able to see my defects.
- _____27. When bad things happen to me I feel like I deserve it.
- _____28. Watching other people feels dangerous to me, like I might be punished for that.
- _____29. I can't stand to have anyone look directly at me.
- _____30. It is difficult for me to accept a compliment.
- _____31. I could beat myself over the head with a club when I make a mistake.
- _____32. When I feel embarrassed, I wish I could go back in time and avoid that event.
- _____33. Suffering, degradation, and distress seems to fascinate and excite me.
- _____34. I feel dirty and messy and feel like no one should ever touch me or they'll be dirty too.
- _____35. I would like to shrink away when I make a mistake.

Control & Experimental

No. _____

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 persons 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 by 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.