CLINICAL PSYCHOLOGY
SCIENCE AND PRACTICE

Assertiveness Training: A Forgotten Evidence-Based Treatment

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The current article discusses assertiveness training, a once highly popular area of investigation that has been neglected in recent years by the field of psychotherapy. A substantial body of research indicates that assertiveness is a relevant factor associated with a variety of clinical problems, populations, and contexts, and that assertiveness training is a valuable transdiagnostic intervention. Despite its demonstrated importance, research on assertiveness and assertiveness training as a stand-alone treatment within clinical psychology has diminished drastically. We review the history of assertiveness training, revisit early research evidence for assertiveness training in treating various clinical problems, discuss the current status of assertiveness training, consider issues of clinical implementation, and comment on how the variables accounting for unassertiveness map onto the NIMH RDoC funding priorities.

Key words: **anxiety, assertiveness training, depression, RDoC, self-esteem.** ***[Clin Psychol Sci Prac, 2017]***

Although psychotherapy has been in existence for over a century, the field has struggled to build upon research findings with consistent, accumulating evidence. As has been stated elsewhere, one reason for this problem is because the field of psychotherapy has the tendency to place greater emphasis on what is new at the expense of what has been done in the past (Goldfried, 2000). This is exemplified by increased focus on "third wave" cognitive behavioral therapies (CBTs) at the expense of the "first" and "second" waves. The third wave of CBT is a term that includes only more recent therapies that emphasize acceptance and mindfulness (e.g., acceptance and commitment therapy, dialectical behavior therapy), whereas the first wave of CBT—actually behavior therapy—reflected an emphasis on classical and operant conditioning, and the second wave involved the incorporation of cognitive interventions into behavior therapy. Although acknowledging the contributions of the "third wave" in cognitive behavioral therapy, Dimidjian et al. (2016) have suggested that a "potential problem … with the 'third wave' metaphor is that it not only communicates a chronological categorical structure, but also one in which the future 'washes away' the past" (p. 16). The tendency to overlook past research, coupled with several paradigm shifts in research aims and methodology, is problematic because it ultimately results in a rediscovery of past findings, which undermines progress. To exemplify and rectify this issue, the current article aims to recover a stand-alone transdiagnostic treatment that largely disappeared from the literature when research shifted away from focal, dimensional, and clinically relevant factors to using treatment packages to treat *DSM* disorders (Hershenberg & Goldfried, 2015).

During the 1970s and 1980s, assertiveness training occupied a prominent role within clinical behavior therapy (Goldfried & Davison, 1976; Rimm & Masters, 1979). Assertive behavior is defined as any action that reflects an individual's own best interest, including standing up for oneself without significant anxiety, expressing one's feelings comfortably, or exercising

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doi:10.1111/cpsp.12216

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one's own rights without denying the rights of others (Alberti & Emmons, 1970). Therefore, unassertive behavior, as seen both within clinical settings and from research findings, reflects individuals' difficulties in standing up for themselves—expressing their wants or needs, thoughts, and feelings. Assertiveness is considered along a continuum, whereby assertiveness problems can manifest as excessive agreeableness (i.e., submissive/unassertive) or excessive hostility (i.e., aggressive). Thus, rather than being submissive or aggressive, the goal of assertiveness training is to help clients become better able to openly verbalize what they want in various life situations. Assertiveness training, which uses a variety of cognitive behavioral techniques, can be conceptualized as a component of social skills training, which broadly aims to help individuals reduce any anxiety-based inhibitions and learn specific skills to develop more competent social functioning.

Within this framework, unassertiveness may result from a genuine skills deficit (e.g., inability to understand and effectively communicate wants/needs), performance deficits, possibly due to anxiety, or both (Heimberg & Becker, 1981). Therefore, assertiveness training may involve behavioral skill training that targets skill deficits (e.g., behavioral rehearsal, modeling) or cognitive restructuring, which targets anxious thoughts that lead to avoidance behavior. Notably, behavioral skill training may also be viewed as a form of exposure that may function to reduce anxiety in addition to increasing skill. Although a core intervention at one time, assertiveness training has experienced a dramatic decrease in the clinical and therapy research literature (Peneva & Mavrodiev, 2013). Specifically, between the years 1967 and 1999 a PsycINFO search of "assertiveness training" yielded 762 articles, approximately 23 publications per year, and from 2000 to the present the same search yielded 181 articles, or roughly 11 publications per year (see Figure 1). This decrease is particularly noteworthy, as it occurred while growth rates in publication across scientific fields increased at an estimated rate of 8–9% since World War II (Bornmann & Mutz, 2015). This decline may also reflect the fact that assertiveness training has become embedded within larger treatment packages and/or has been described in recent years with different terminology. The goal of the current article is to discuss why this has happened and why it is important to have assertiveness training recognized again as a stand-alone, transdiagnostic intervention.

We begin by presenting an overview of the history of assertiveness training in clinical psychology, followed by a brief review of the research evidence linking the lack of assertiveness and assertiveness treatment to several clinical problems, including anxiety, depression, serious mental illness, self-esteem, and relationship satisfaction. The current status of assertiveness training is then discussed, including arenas in nonclinical domains where assertiveness has remained an important factor in contributing to community welfare. We provide concrete suggestions regarding the clinical implementation of assertiveness techniques and include illustrations from our clinical observations. Lastly, we highlight how this somewhat forgotten evidence-based intervention for increasing assertiveness may have significant relevance to the National Institute of Mental Health Research Domain Criteria (NIMH RDoC) funding priorities.

THE HISTORY OF ASSERTIVENESS TRAINING

Assertiveness training has a long history, dating back to Salter's book *Conditioned Reflex Therapy*, published in 1949. Although Salter did not use the terminology "assertiveness training" at the time, he placed an emphasis on the need for certain individuals—especially those he called "inhibitory personalities"—to learn how to express themselves more openly. For example, Salter encouraged individuals to make use of "I"

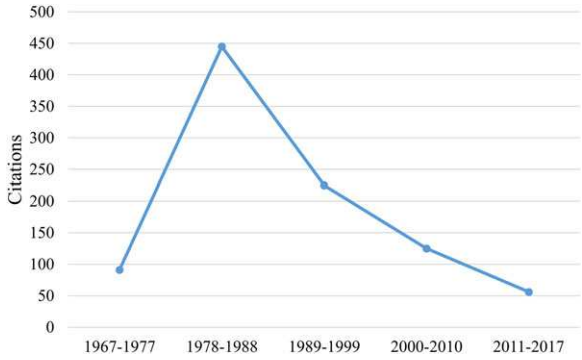


Figure 1. The number of citations published per year, in 10-year increments, from 1967 to the present. Citations were obtained from PsycINFO using the search term "assertiveness training."

statements, as a way of expressing what they thought and felt. At the time, Salter's writings had relatively little impact on the field. However, Wolpe, who is often given credit as a prime innovator in the creation of behavior therapy in the United States, found the use of such open and honest self-expressiveness as nicely fitting into this new approach to therapy (Wolpe, 1958). Wolpe conceptualized assertiveness training as a way of reducing anxiety. Although a primary method for anxiety reduction according to Wolpe was the use of relaxation, he thought of self-assertiveness as an additional intervention that could achieve the same goal. Assertiveness was differentiated from aggressiveness, in that the former was a way of putting oneself up without putting another person down. Assertiveness training made a widespread impact at that time because it was presented within the context of the larger behavioral movement (Rimm & Masters, 1979).

In the mid-1960s, Wolpe collaborated with Lazarus to develop the first questionnaire for assessing assertiveness (Wolpe & Lazarus, 1966). Lazarus (1971) broadly defined assertive behavior as "social competence," and unassertive behavior was deemed a "social deficit," whereby individuals lacked the behavioral strategies and skills necessary to adapt to their social reality. Specifically, Lazarus identified four abilities that were possessed by the assertive individual: (a) the ability to openly communicate about own desires and needs; (b) the ability to say no; (c) the ability to openly communicate about one's own positive and negative feelings; and (d) the ability to establish contacts and to begin, maintain, and end conversations (Lazarus, 1973). During this period, assertiveness as an area of intervention and study thrived, as the field was focused on identifying and addressing dimensional transdiagnostic factors as opposed to treatments that targeted specific disorders, or disorder-specific symptoms.

Although lack of assertive behavior was originally conceptualized as reflecting a deficit in behavior, whereby individuals did not know how or when to be appropriately assertive, Goldfried and Davison (1976) raised the possibility that because of concerns about the interpersonal consequences, unassertive individuals might also be inhibited from expressing themselves. This cognitive conceptualization reflected the introduction of cognition into behavior therapy, marking the beginning of a shift from behavior therapy to cognitive behavioral therapy. Subsequent research findings by Linehan, Goldfried, and Goldfried (1979) indicated that both behavioral skill training and cognitive restructuring were able to increase assertiveness. Cognitive restructuring increased assertiveness by targeting the anxiety that contributed to avoidance behavior, whereas behavioral rehearsal focused on learning to effectively express oneself, both verbally and nonverbally (e.g., appropriate eye contact, voice volume, affect, and physical posture).

In much the same way that the behavior therapy movement created greater attention to assertiveness training on the part of therapists, the co-occurring civil rights and feminist movements similarly gave impetus to the importance of being self-assertive in traditionally marginalized populations (e.g., women, ethnic and racial minorities). Starting in the late 1970s when the civil rights movement was rising in the United States, several psychologists utilized assertiveness as a means of protecting individual rights without prejudice to the rights of others, emphasizing that all people had equal rights, regardless of social status (Alberti & Emmons, 1970; Fensterheim & Baer, 1975; Jakubowski & Lange, 1976, 1978; Lazarus & Fay, 1975; Smith, 1975). Alberti and Emmons (1970) developed the first assertiveness training book intended for public consumption, which argued that all individuals have a right to be the master of their own life and to act in accordance with their own interests, beliefs, and feelings. Several years later, Fensterheim and Baer (1975), Lazarus and Fay (1975), and Smith (1975) each published self-help books for increasing assertiveness across all domains of functioning. In his book, Smith (1975) included a list of 10 assertive rights for all people and was one of the first psychologists to advocate for the importance of assertiveness in intimate relationships. Similarly, Jakubowski and Lange (1978) published a list of 11 basic assertive rights for all human beings (but with a special emphasis on women's rights), which included the right to be treated with respect.

Assertiveness training, both within the clinical setting and in the community, thrived within this social and historical context. Despite Salter's (1949) and Wolpe's (1958) early identification of assertiveness training as an important component in treating clinical

problems, research on assertiveness training has dramatically decreased in recent years. As indicated earlier, this change was likely driven by alterations in research funding priorities and a focus on large treatment packages and "third wave" CBT, consistent with the biomedical model that emphasized specific treatments for specific *DSM*-diagnosed disorders (Hershenberg & Goldfried, 2015).

RESEARCH EVIDENCE

There exists considerable basic research evidence linking unassertiveness to specific clinical problems, as well as findings from outcome research indicating that assertiveness training can improve various clinical symptoms above and beyond assertive behavior. Research investigating the role of assertiveness in psychopathology, as well as the impact of assertiveness training interventions, has been applied to diverse samples and clinical problems. Overall results for the efficacy of assertiveness training are positive. Meta-analyses comparing psychotherapy outcomes for depression and social anxiety have found that social skills training involving assertiveness was similarly effective compared to other CBT interventions (Barth et al., 2013; Cuijpers, van Straten, Andersson, & van Oppen, 2008; Fedoroff & Taylor, 2001; Taylor, 1996). In addition, a meta-analysis evaluating social skills training in schizophrenic inpatients found that social skills training, which primarily involved assertiveness training, had a strong positive impact on behavioral measures of social skill, self-rated assertiveness, and hospital discharge rate (Benton & Schroeder, 1990).

As indicated earlier, most of the basic and clinical work in this area was published in the 1970s, 1980s, and 1990s (see Figure 1). The review that follows is intended to illustrate the degree to which this early evidence supports the clinical efficacy of assertiveness training as a stand-alone intervention in treating various clinical problems that are frequently encountered by practitioners. Although procedures might vary from study to study, the core of assertiveness training involves cognitive and behavioral techniques aimed at increasing client expressiveness, including cognitive restructuring of negative thoughts about asserting oneself, and behavioral rehearsal, role play, and modeling to reduce anxiety (i.e., exposure), improve assertive communication skills, and enhance self-efficacy. Therefore, for this review, studies that described techniques that are often associated with assertiveness training (e.g., behavioral rehearsal, modeling, cognitive restructuring), and have goals that are consistent with increasing assertiveness (e.g., direct communication of needs), have been included. To more easily summarize assertiveness-related research, we classify studies into subsections based on the clinical problems investigated —anxiety, depression, serious mental illness, self-esteem, and relationship satisfaction. For each clinical problem, we review basic research on associations with assertiveness and provide a summary of outcome research indicating how assertiveness training has had an impact on these clinical problems.

Anxiety

Basic Psychopathology Research. As we have indicated, Wolpe (1958) first conceptualized assertiveness as a treatment target for anxiety. Several studies have confirmed that difficulties with assertiveness are associated with anxiety, particularly social anxiety (Hollandsworth, 1976; Morgan, 1974; Orenstein, Orenstein, & Carr, 1975; Percell, Berwick, & Beigel, 1974; Sturgis, Calhoun, & Best, 1979). For instance, in a large sample of adolescents, unassertiveness was associated with increased social anxiety, lower self-esteem, and poorer social performance (Bijstra, Bosma, & Jackson, 1994). Another study with a sample of inpatient male alcoholics found a strong inverse correlation between assertiveness and anxiety (Pachman & Foy, 1978). Although a socially anxious individual may often display difficulties in assertiveness through submissiveness or avoidance (Hofmann, Gerlach, Wender, & Roth, 1997; Walters & Hope, 1998), there is also evidence that social anxiety is positively associated with anger and hostility, therefore indicating that assertiveness may be beneficial in reducing anger in these individuals (Allan & Gilbert, 2002; Novaco, 1976). In an investigation of potential mechanisms linking unassertiveness to clinical problems, Heimberg and colleagues found that across students, normal adults, and psychiatric inpatients, participants who were unassertive reported a higher frequency of negative self-statements than assertive participants (Heimberg, Chiauzzi, Becker, & Madrazo-Peterson, 1983). This and previous

research suggest an association between assertiveness problems and anxiety, particularly in the social domain.

Treatment Outcome Research. In addition to basic research on the relationships between unassertiveness and anxiety, there is evidence that assertiveness training is an effective treatment in reducing anxiety symptoms (Hedquist & Weinhold, 1970; Hoffmann, Kalkstein, & Volger, 1977; Percell et al., 1974; Warren, 1977; Workman, Bloland, Grafton, & Kester, 1986). In one of the first empirical evaluations of assertiveness training, Lomont, Gilner, Spector, and Skinner (1969) found that assertiveness group therapy, compared to insight-oriented group therapy, significantly reduced depression and anxiety symptoms, as well as overall clinical symptomatology in nonpsychotic psychiatric inpatients with social anxiety. Individual studies with all-male or all-female samples have similarly found that assertiveness training, compared to no treatment of placebo control, increases assertive behavior and decreases social anxiety (Rathus, 1972, 1973; Twentyman & McFall, 1975), suggesting that assertiveness training can be beneficial in reducing anxiety in both men and women.

To explore the relative effectiveness of cognitive versus behavioral techniques of assertiveness training on a variety of clinical symptoms, Hammen and colleagues conducted a randomized-controlled outcome study comparing cognitive restructuring, behavioral rehearsal, or wait-list control in unassertive adults. Consistent with findings from Linehan et al. (1979), results revealed that cognitive restructuring and behavioral rehearsal were equally effective in improving self-reported assertiveness and reducing fear of negative evaluation (Hammen, Jacobs, Mayol, & Cochran, 1980). Thus, it appears that assertiveness training, which may be implemented with such techniques as modeling, behavior rehearsal, and cognitive restructuring, can be beneficial in alleviating a variety of psychological symptoms, such as social anxiety, and improving functioning across diverse populations **(**Heimberg, Montgomery, Madsen, & Heimberg, 1977**)**.

A variety of different CBT treatment procedures—including assertiveness—appear to be similarly effective in treating anxiety (e.g., Emmelkamp, Mersch, Vissia, & Van der Helm, 1985; for a review, see Heimberg, 2002). An evaluation of the efficacy of cognitive restructuring and relaxation treatment compared to assertiveness training (behavioral rehearsal and modeling) for the treatment of speech anxiety revealed that both interventions were equally effective and were superior to wait-list and placebo control groups (Fremouw & Zitter, 1978). Similarly, a study comparing assertiveness training, rational therapy, and combined treatment for social anxiety found that all treatments were equally effective in promoting assertive behavior and reducing social anxiety symptoms (Tiegerman & Kassinove, 1977). Taken together, the research evidence indicates that anxiety, particularly social anxiety, is associated with unassertiveness issues, and that these symptoms may be ameliorated following assertiveness training.

Depression

Basic Psychopathology Research. Several early theories of depression have supported the notion that through either behavioral or cognitive pathways, depressed individuals are likely to have difficulty behaving assertively. Specifically, behavioral and interpersonal conceptualizations of depression have argued that depressed individuals have social skill deficits, resulting in interactions that are unlikely to be reinforcing, and perceived deficits in social support (Coyne, 1976; Lewinsohn, Hoberman, Teri, & Hautzinger, 1985; Segrin & Abramson, 1994; Windle, 1992). Consistent with this view, a large body of basic research supports the notion that assertiveness is inversely correlated with depressive symptoms (Barbaree & Davis, 1984; Bouhuys, Geerts, & Gordijn, 1999; Chan, 1993; Culkin & Perrotto, 1985; Haley, 1985; Heiby, 1989; Langone, 1979; Pachman & Foy, 1978; Robbins & Tanck, 1984; Sarkova et al., 2013; Sturgis et al., 1979).

Relatively few studies have investigated the potential moderating role of important demographic variables, such as gender and race, in the association between assertiveness and depression. Notably, depression is more common in women and disadvantaged minorities (González, Tarraf, Whitfield, & Vega, 2010; Ikram et al., 2015; Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993), and therefore, it is important to determine how assertiveness may impact these populations. Integrative models of depression suggest that individuals

at increased risk for developing depression may experience higher rates of depression in part due to an interaction between experiencing more negative events and engaging in dysfunctional cognitive styles (Hankin & Abramson, 2001). Perhaps differences in assertiveness, either via behavioral or cognitive determinants (or both), might contribute to this disparity. More recent findings suggest that the type of assertiveness problems may differ across gender, such that depression is positively associated with hostility in men and agreeableness in women (Maier et al., 2009). Regarding possible gender differences in treatment efficacy, past research indicated that depressed women, but not depressed men, who reported low assertiveness were less likely to show improvements in symptoms at a six-week follow-up assessment, suggesting that low assertiveness may be an indicator of poor prognosis for women if unaddressed (Bouhuys et al., 1999). However, Robbins and Tanck (1984) found that elevated self-reported depression symptoms were associated with assertiveness problems in undergraduate men, but not women. Studies that have considered the moderating effect of ethnicity and/or culture have shown that Asians report low levels of assertiveness and high levels of depression (Chan, 1993). Lastly, there is evidence that low assertiveness is predictive of increases in depression symptoms or disorder onset, suggesting that assertiveness may be a component of the etiological pathways to depression (e.g., Ball, Otto, Pollack, & Rosenbaum, 1994; Sanchez, Lewinsohn, & Larson, 1980), although more research evaluating the directionality of this association is necessary. Thus, basic research offers evidence that assertiveness may be an especially important variable in populations at the greatest risk for depression.

Treatment Outcome Research. Given the number of studies that have found associations between assertiveness and depression, it is not surprising that the majority of the research evidence examining the efficacy of assertiveness training as an intervention has focused on its ability to increase assertive behavior and alleviate symptoms of depression (e.g., Lomont et al., 1969). Hayman and Cope (1980) found that depressed women in group assertiveness training, compared to a wait-list control, became significantly more assertive, and that these gains were maintained at an eight-week follow-up. Another outcome study examining the efficacy of group assertiveness training compared to traditional group psychotherapy in treating depression found that at one-month follow-up, the assertiveness group displayed increased self-reported comfort with assertiveness and greater likeliness to engage in assertive behaviors compared to a traditional psychotherapy group (Sanchez et al., 1980). Furthermore, those who received assertiveness training, compared to traditional group psychotherapy, experienced a significant reduction in depressive symptoms, suggesting that the benefits of assertiveness training can be superior to group therapy in treating depression (Sanchez et al., 1980). In addition to improvement in depressive symptoms and increased assertive behavior, LaPointe and Rimm (1980) found that depressed women assigned to assertiveness training, compared to cognitive or insight-oriented treatment, displayed more rational thinking and acceptance, and were significantly less likely to seek out further treatment at follow-up.

Overall, studies comparing the efficacy of assertiveness training to other evidence-based treatments have found that although assertiveness training is generally effective in increasing assertive behaviors and decreasing depressive symptoms, its efficacy is essentially equivalent to other forms of treatment for depression (Rehm, Fuchs, Roth, Kornblith, & Romano, 1979; Rude, 1986; Zeiss, Lewinsohn, & Muñoz, 1979). Two meta-analyses of past research comparing psychotherapy outcomes for depression in adults (Barth et al., 2013; Cuijpers et al., 2008) and a review of the social skills literature (Jackson, Moss, & Solinski, 1985) have come to largely the same conclusion, finding that social skills training, which primarily involved assertiveness training, was more effective than wait-list control and largely no different in effectiveness compared to other psychotherapeutic interventions, such as cognitive therapy or behavioral activation. An important issue that was indicated from these meta-analyses and the reviews that have been conducted on the efficacy of assertiveness training for depression is the paucity of empirical studies relative to other evidence-based treatments (Heimberg et al., 1977). For example, Cuijpers et al. (2008) found only five studies of assertiveness that were suitable for inclusion in the meta-analysis, and Barth et al. (2013) found only seven. Therefore, more

treatment outcome studies of assertiveness training are needed to better be able to evaluate its effectiveness using meta-analytic techniques.

Serious Mental Illness

Basic Psychopathology Research. Inpatient populations suffering from serious mental illness and comorbid psychiatric conditions may display deficits across a broad range of functioning. Indeed, prior research has found that individuals diagnosed with chronic schizophrenia, particularly those who experience negative symptoms, show deficits in emotion recognition, cognitive ability, and social skill, including assertiveness (Bellack, Morrison, Wixted, & Mueser, 1990; Douglas & Mueser, 1990; Kerr & Neale, 1993; Mueser et al., 1996). In addition to the potential lack of social skill, social withdrawal has been considered to be a core feature of chronic schizophrenia (Gleser & Gottschalk, 1967; McClelland & Watt, 1968; Weinman, 1967). One study found that patients with schizophrenia who had highly critical relatives (also referred to as expressed emotion) were more unassertive than patients with less critical relatives, suggesting that assertiveness may interact with environmental factors; however, it remains unclear whether lack of assertiveness was due to a skill deficit, anxiety, or both (Mueser et al., 1993). Therefore, individuals with chronic and seriously impairing psychiatric conditions, such as schizophrenia, may display unassertive behavior due to lack of social skill, decreased motivation, or increased social anxiety; more research is needed to further elucidate how these mechanisms may interact to produce unassertiveness.

Treatment Outcome Research. In addition to the use of assertiveness training to target individuals with specific diagnostic presentations such as anxiety and depression, past research has explored whether assertiveness training could be used to influence comorbid conditions and increase general functioning in individuals with serious mental illness and hospitalized samples. Specifically, assertiveness group training compared to control groups (e.g., normal hospital milieu program) has been found to significantly improve both self-report and behavioral indices of anxiety and assertive behavior in inpatients with serious mental illness (Aschen, 1997; Booraem & Flowers, 1972; Lin et al., 2008). Similarly, assertiveness group training, compared to process-oriented group therapy, significantly increased assertiveness and tended to improve self-esteem and decrease hostility in adolescent and young adult inpatients (Fiedler, Orenstein, Chiles, & Breitt, 1979). A study by Hersen, Kazdit, Bellack, and Turner (1979) found that both live and covert modeling were effective techniques for increasing assertive behavior in unassertive psychiatric inpatients (Hersen et al., 1979). Although there is some evidence that assertiveness may have limited effectiveness in treating some conditions, such as comorbid anxiety and schizophrenia (Serber & Nelson, 1971), literature reviews have indicated that social skills training broadly can benefit individuals diagnosed with schizophrenia and serious mental illness in general (Brady, 1984; Gomes-Schwartz, 1979; Hersen & Bellack, 1976; Wallace et al., 1980).

Consistent with prior research, a recent study demonstrated that 12 sessions of group assertiveness training compared to group supportive therapy for individuals with chronic schizophrenia significantly improved assertive behavior, decreased social anxiety, and increased self-reported satisfaction with interpersonal communication immediately following treatment and at the three-month follow-up (Lee et al., 2013). In addition to inpatient settings, there is evidence that assertiveness training can improve assertiveness, decrease social anxiety, and improve self-esteem in psychiatric outpatients and day-care settings (Bloomfield, 1973; Brown & Carmichael, 1992; Clark, Corbisiero, Procidano, & Grossman, 1984; Perczel & Tringer, 1998; Pfost, Stevens, Parker, & McGowan, 1992; Weinhardt, Carey, Carey, & Verdecias, 1998).

Self-Esteem

Basic Psychopathology Research. Outside of studies focusing on disorder-specific symptoms, there is evidence that unassertiveness is associated with other transdiagnostic factors that are broadly related to psychopathology, such as lowered self-esteem and self-concept (Bijstra et al., 1994; Percell et al., 1974; Riggio, Throckmorton, & DePaola, 1990; Riggio, Watring, & Throckmorton, 1993; Tolor, Kelly, & Stebbins, 1976). For instance, in a large undergraduate sample, assertiveness was positively correlated with measures of self-esteem (Riggio et al., 1990) and unassertive adolescents

reported both lower self-esteem in social domains and lower quality of life (Bijstra et al., 1994). Research evidence suggests that a lack of assertiveness may negatively impact individuals' perceptions of their own self-worth; this association may be particularly strong in the social domain.

Treatment Outcome Research. Treatment outcome studies have found that assertiveness training improves general self-esteem, self-concept, and internal locus of control (Hammen et al., 1980; Meyer, 1991; Percell et al., 1974; Warren, 1977; Workman et al., 1986). In a sample of hospitalized adolescents and young adult patients, group assertiveness training, compared to process-oriented group therapy, significantly increased assertiveness and tended to improve self-esteem and decrease hostility (Fiedler et al., 1979). Notably, assertiveness training has been found to improve ratings of self-esteem and self-concept in a variety of populations, including professional women and nurses (Barr, 1989; Stake & Pearlman, 1980), adolescents (Waksman, 1984), and the physically disabled (Morgan & Leung, 1980). As individuals become less worried about the opinion of others and become more comfortable in asserting themselves, they seem to become more self-confident in the legitimacy of what they want, think, and feel.

Relationship Satisfaction

Basic Psychopathology Research. A small literature has also evaluated assertiveness in the context of couples' relationships. Hafner and Spence (1988) examined several consequences of assertiveness in men and women in a longitudinal study of married couples. Overall, women who had been married between 7 and 16 years rated themselves as having increased discomfort acting assertively compared to their husbands. Further, unassertiveness in either partner was associated with negative outcomes for the couple, including increased hostility in the husband and increased guilt and anxiety in the wife. In the same study, unassertive men in marriages lasting longer than 16 years reported higher levels of generalized anxiety and lower relationship satisfaction (Hafner & Spence, 1988). There is also evidence linking low assertiveness to husbands who are physically abusive (Rosenbaum & O'Leary, 1981). In fact, low assertiveness in abusive husbands appears to be a consistent finding (Hotaling & Sugarman, 1986). Broadly, this research suggests that assertiveness may be an important psychological factor influencing marital satisfaction and marital interactions.

Treatment Outcome Research. With regard to the impact of assertiveness training on relationship satisfaction, Gordon and Waldo (1984) found that when either individual men or women from a couple participated in assertiveness training, versus wait-list control, self-reported levels of trust and intimacy improved from pre- to post-training in both partners (i.e., those who received training and their nonparticipating partners). Assertiveness training in a small number of passive male patients was evaluated with respect to changes in interactions with their wives, finding that assertiveness training was associated with improvement in the husbands' assertiveness, characterized by their increased eye contact, longer dialogue, more frequent requests, and shorter speech delays in responding to their spouse (Eisler, Miller, Hersen, & Alford, 1974). Although several studies indicate that participation of a single member of a dyad is sufficient, there is some indication that participation of both partners is warranted (Muchowski & Valle, 1977). For example, a study of conjoint assertiveness training for couples, compared to placebo control, found that assertiveness training resulted in increased verbal assertion and decreased verbal aggression in couples (Fiedler et al., 1979). Furthermore, assertiveness training resulted in increased self-reported clarity and positive interactions with one's spouse (Fiedler et al., 1979). Overall, this research offers evidence that unassertive behavior is problematic in long-term relationships (e.g., marriages lasting over a decade), but that assertiveness training can be used to improve marital satisfaction.

Summary

In sum, early basic research supports the notion that assertiveness is inversely correlated with specific clinical problems, such as depression and anxiety, as well as comorbid diagnoses resulting in serious mental illness; assertion is also relevant to a variety of transdiagnostic factors, such as self-esteem, and relationship satisfaction. Taken together, the accumulated evidence suggests that

assertiveness problems are an important characteristic in internalizing psychopathology. Moreover, treatment outcome research indicates that targeting assertiveness through behavioral (e.g., behavior rehearsal) and/or cognitive means (e.g., cognitive restructuring) increases assertive behavior and decreases symptoms of depression and anxiety, and improves self-esteem and relationship satisfaction**,** supporting the utility of assertiveness training as a useful stand-alone treatment for targeting a variety of clinical problems. Although there is limited research available examining moderators of the relationship between assertiveness and these factors, it appears gender, culture, and ethnicity are important considerations for future research.

CURRENT STATUS OF ASSERTIVENESS TRAINING

As suggested earlier, references to assertiveness and assertiveness training are rarely found in current reviews of the research literature. For example, arguably one of the key references to current research on psychotherapy, *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (Lambert, 2013) contains no reference to assertiveness training. Similarly, in the fifth edition of Barlow's (2014) *Clinical Handbook of Psychological Disorders: A Step-by-Step Treatment Manual*, a reference source central to CBT, assertiveness training is not included as a primary treatment, although unassertiveness is identified as a key client characteristic in anxiety, depression, and alcohol/substance abuse disorders. Although there were several decades of a rich clinical and research literature on the therapeutic applications of assertiveness training starting in the 1960s, this began to change in the 1980s, when the NIMH moved away from a psychosocial model and adopted more of a medical model to treating psychological problems, construing psychological problems more as disorders. With this shift, funding priorities moved away from research on assertiveness and other transdiagnostic variables (e.g., perfection and procrastination) and required that research focuses on *DSM* disorders. Thus, there was a shift from conducting "outcome research" to carrying out "clinical trials," the model used in determining the efficacy of drugs. As a consequence, research on the clinical use of assertiveness training was no longer funded (Hershenberg & Goldfried, 2015), and the complex relationships between neurophysiological and psychosocial variables were largely ignored (Gabbard, 1992).

Although work on assertiveness training declined significantly in the literature, it continued to be present in the background, referred to with different names as a part of larger treatment packages, typically developed for the treatment of specific psychiatric disorders. For example, in Linehan's (2014) use of dialectical behavior therapy for patients with borderline personality disorder, the "interpersonal effectiveness" module focuses on situations where the objective is to change something (e.g., requesting that someone do something) or to resist changes someone else is trying to make (e.g., saying no). The skills taught are intended to maximize the chances that a person's goals in a specific situation will be met, while at the same time not damaging either the relationship or the person's self-respect. In the use of behavioral activation for the treatment of depression (Dimidjian, Martell, Herman-Dunn, & Dubley, 2014; Martell, Dimidjian, & Herman-Dunn, 2010), patients are encouraged to begin to behave in ways that will get them what they need and want. Although they refer to the importance of targeting depressed individuals' "avoidance behavior," they do not clearly specify that this would entail an increase in assertiveness. In addition, committed, value-based actions are a core component of acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 2003), which involves the person identifying and participating in behaviors that are consistent with his or her goals and values, despite fears of failure or negative evaluation. In the cognitive behavioral analysis system of psychotherapy (CBASP; McCullough, 1984), chronically depressed individuals are conceptualized as having little to no awareness of the interpersonal impact they have on others, which results in their perceived lack of control over their environment and feelings of helplessness and hopelessness. Therefore, a primary aim of CBASP is to foster identification of the actual (not feared) interpersonal consequences of one's behavior and increased ability to obtain desired outcomes through assertive action. Behavioral skills training to improve assertiveness is therefore a primary technique in CBASP (McCullough, 2003).

There are important issues to consider when assertiveness training exists as merely a part of a larger

treatment package, under a different name, and for the treatment of a specific *DSM* disorder. First, despite the evidence for its effectiveness, assertiveness training may be less recognizable as a stand-alone intervention because components are not intended to be used in isolation. In addition, the co-occurrence of clinical problems (e.g., anxiety and depression) is likely to be viewed simply as comorbidity, as opposed to being included in an individualized case formulation that deals with the functional relationship between multiple related variables (Hershenberg & Goldfried, 2015). Thus, when clinicians are encouraged to adhere strictly to manualized treatment packages, as opposed to developing an individualized case formulation, clinical judgment may be limited and adverse outcomes may occur (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). Further, when the name of a clinical problem (e.g., unassertiveness) or an intervention (e.g., assertiveness training) is changed, the consequences of the name change are that past clinical and research contributions are lost in literature searches.

There are some arenas in which assertiveness training continues to exist and be studied as a stand-alone intervention, but primarily outside traditional therapeutic contexts. For example, there is growing interest in the role of assertiveness in the workplace, particularly with women (e.g., Pfafman & McEwan, 2014). Although it has been previously suggested that assertiveness results in positive outcomes for women in the workplace (Josefowitz, 1982; Mathison & Tucker, 1982; Yamagishi et al., 2007), the actual impact of increased assertiveness may be more complex due to violations in gender-normed expectations and situational factors. There is some evidence that situational factors, such as whether an interaction is conflictual or commendatory, and gender can impact individuals' perceptions of assertive behavior, suggesting that assertiveness may not always be perceived positively (Delamater & Mcnamara, 1986; Hess, Bridgwater, Bornstein, & Sweeney, 1980; Kelly, Kern, Kirkley, Patterson, & Keane, 1980; St. Lawrence, Hansen, Cutts, Tisdelle, & Irish, 1985). For example, one study examined how assertive women managers were perceived by men and women observers, and found that although men reported positive perceptions of assertive communication in women, women reported negative perceptions of assertive women (Mathison, 1986). These findings suggest that women's assertive behavior in the workplace may be subject to a double bind, wherein they are perceived negatively for failing to conform to prescribed gender norms, yet are perceived negatively for failing to communicate effectively in a professional environment (Babcock, Laschever, Gelfand, & Small, 2003; Bowles, Babcock, & Lai, 2007). Recent studies conducted in Asia have focused on using assertiveness training for community well-being via assertive community treatment programs. These studies have found that assertive community treatment, compared to the usual hospital-based rehabilitation program or placebo control, resulted in decreased depressive symptoms, higher self-reported participant satisfaction, and reduced dropout rates for adolescent inpatients with serious mental illness and adolescents in nonclinical residential care (i.e., no legal guardian; Ito et al., 2011; Jung, 2014). Furthermore, assertive community treatment reduced hospital length of stay and readmission rate (Liem & Lee, 2013). Given these promising findings, assertive community treatment warrants further community use and empirical investigation. Finally, there is considerable evidence that unassertiveness is associated with risk for sexual assault victimization and that assertiveness training may be beneficial in preventing sexual assault. For example, research has found that women who have difficulty communicating assertively in sexual situations are at heightened risk for sexual assault victimization (Franz, DiLillo, & Gervais, 2016; Kearns & Calhoun, 2010; Kelley, Orchowski, & Gidycz, 2016; Livingston, Testa, & VanZile-Tamsen, 2007). Preventive intervention programs for undergraduate women aimed at increasing sexual assertiveness have found that assertiveness training was associated with reduced incidences of sexual assault (e.g., Simpson Rowe, Jouriles, McDonald, Platt, & Gomez, 2012).

Although assertiveness training as a stand-alone intervention has not been emphasized in many contemporary writings dealing with clinical practice, its use with women in the workplace, female nurses in Japan, community programs, and as a way for protecting women against sexual assault victimization is most salient and highlights that assertiveness training can be used successfully outside of a treatment package for

problems that are not disorder-specific. Like its use for women and racial minorities during the civil rights movement in the 1970s, assertiveness training continues to expand beyond clinical boundaries to contribute to the community welfare. At present, clinical research is transitioning away from the model that prioritized RCTs of manualized treatment packages for the treatment of *DSM*-diagnosed clinical disorders, toward a neurobiological model, which prioritizes basic neurobiological and behavioral research across multiple units of analysis to target underlying transdiagnostic mechanisms of disorders (http://nimh.nih.gov/research-priorities/rdoc/index.shtml). As we indicate in greater detail later in this article, it is our hope that with this transition, important psychological (e.g., assertiveness) and environmental factors that impact the development and maintenance of psychopathology are recognized and integrated into this framework, including clinical assessment and intervention.

CLINICAL IMPLEMENTATION AND OBSERVATIONS

In our review of the basic and applied research, evidence exists to support the use of assertiveness training for the treatment of various clinical problems. Although we have touched on the clinical procedures used to facilitate increased assertiveness, it is important to comment further on these interventions, as well as on some clinical observations of the impact that facilitating assertiveness can have for clients.

As noted earlier, there are a number of different ways in which assertiveness training may be implemented, depending on the nature of the determinants associated with the client's unassertiveness (e.g., anticipatory anxiety, skill deficits, or both). When anticipatory anxiety is the primary target, the general strategy used in facilitating assertive behavior most typically focuses on the cognitive mediators accounting for inhibiting anxiety (e.g., the fear and guilt of expressing one's own needs and desires [Linehan et al., 1979]). In the context of skill deficits, the actual behavioral components associated with more assertive interactions are the primary focus of treatment. In essence, research and clinical observation indicate that inhibitory emotional reactions and/or lack of interpersonal behavioral skills are associated with lack of assertiveness.

There are a variety of ways in which cognitive restructuring may be used to deal with inhibitory anxiety. Although there are an array of concerns clients may have about behaving assertively, such as fear of hurting someone, fear of being disapproved of or rejected, or fearing confrontation, the primary issue is the belief that an assertive response will have a negative impact on the way others think of them. This belief system undoubtedly has a number of different early social learning and cultural experiences associated with it. There is an irony here in that when asked their opinion of people who do not say what they really want, the unassertive individual will often say that this lack of assertiveness on the other person's part has a negative impact on him or her. Therefore, their perception of the contingencies associated with assertive behavior is often inaccurate, which allows for a cognitive intervention to help individuals become disabused of their anticipatory misperceptions on the potential reaction of others.

A certain amount of skill training is often required in helping the individual to learn an effective way to interact assertively. Providing information, modeling assertive behavior on the part of the therapist, and rehearsing an interpersonal assertive interaction with audio or video feedback can help clients learn not only what to say, but also how to say it. In addition, these behavioral techniques may function as a form of exposure to feared interpersonal situations, which may contribute to reductions in anxiety. Although it is beyond the scope of this article to go into any further detail about the implementation of assertiveness training in clinical practice, guidelines for doing so can be found elsewhere (e.g., Alberti & Emmons, 2008; Goldfried & Davison, 1994; Lange & Jakubowski, 1976; Smith, 1985).

Informal reports by practicing clinicians, either CBT or otherwise, indicate that the lack of assertive interactions with others occurs quite frequently in their clinical caseloads. Indeed, this is consistent with the research reviewed above, indicating that such clinical problems as anxiety, depression, lack of self-esteem, and relational problems are associated with unassertiveness. To further document how clinical observation parallels the research literature, we asked one of our clients (whose identity has been disguised) to indicate

the impact that increased assertiveness—facilitated clinically by means of cognitive restructuring, modeling, behavioral rehearsal, and between-session practice—had made in his life. The client is a male accountant in his late twenties, who wrote:

> A year ago, much of my interactions with others were fraught with anxiety and guilt. Things are thankfully different now. No apologies. No hesitation (well, very limited hesitation). No "I'm so sorry," no "my apologies," no fake smiling while I secretly resent what I've agreed to do, no guilt for having the courage, conviction, and strength to express my thoughts or say "no."
>
> A year ago, and many years before that, I would have spent min—and sometimes much longer—in internal conflict, overwhelming feelings of guilt, shame, and self-doubt. I'd say "yes" when inside I was screaming no. It was the right thing to do, after all. I'm a nice person. That means you just say yes, no matter what. And the apologizing. "Sorry" became a standard comment in my interactions with others.
>
> Assertiveness training, learning that it's okay to say no or acceptable to express my thoughts or feelings in a matter-of-fact fashion, has made me a better spouse and parent. I'm frustrated less often. I'm confident in my abilities. I've also established boundaries with my parents, a year-long process of standing up for my own family and what's best for us. It's still a process, but I'm far along the path to a healthy relationship with them.
>
> These benefits aren't limited to my personal life. I'm far less anxious at work. I am able to speak to my colleagues with conviction and confidence, including an aggressive boss who has in the past criticized and questioned my work and drove me to tears. I can speak with this aggressive boss in a firm, confident manner and assert my position. This year, the boss gave me an excellent review. Others in senior positions have told me how I've grown over the past year in taking on more responsibility and initiative, reporting that others have been saying and noticing the same.

As indicated by his testimonial, this client experienced assertiveness difficulties across several areas of his life—interactions with friends, family, and coworkers—that often led to chronic worry, intense feelings of anxiety, guilt and frustration, and functional impairment. Negative thoughts about expressing his wants/needs prevented him from learning that others often respond well to assertive communication. Thus, targeting these thoughts and practicing assertive communication allowed him to have corrective experiences, which facilitated continued assertiveness.

It is important to note that some clients may be unassertive in certain aspects of their lives but not others (Heimberg & Becker, 1981), typically when unassertiveness is primarily due to an anxiety-driven performance deficit (versus skill deficit). This was vividly demonstrated with the case of a professional woman in her mid-fifties, who was just promoted to an important position in finance. By all accounts, her high level of competence and interpersonal assertiveness clearly warranted this promotion. Her presenting problem consisted of panic attacks resulting from high levels of stress in the new position, where she had not been given the support staff that she had been promised. Although she had made inquiries about when this would happen, she was continually put off by her superiors. After dealing with the symptom reduction of panic attacks, we focused clinically on the cognitive and behavioral mediators associated with her high stress level. She reported that she found her male superiors to be very intimidating. Having been raised in the south, she learned early on that it was important for her to be be an accommodating female when interacting with men, which made it difficult for her to assertively request what she needed. Assertiveness training involving cognitive restructuring, behavioral rehearsal, modeling, and between-session application not only resulted in her getting what she needed, but also reduced her level of stress. Most importantly, however, this is a vivid illustration that unassertive behavior may occur in individuals who are otherwise most assertive.

HOW RESEARCH ON ASSERTIVENESS TRAINING RELATES TO RDOC FUNDING PRIORITIES

Given the limitations of treatment protocols designed to target discrete diagnostic categories, it has been argued that future research and treatment should focus on the client's individual characteristics that may contribute to his or her symptoms (Zinbarg, Uliaszek, & Adler, 2008). Consistent with this view, the NIMH Research Domain Criteria initiative (RDoC; Insel et al., 2010) has transitioned funding priorities away from research based on *DSM* diagnoses toward more basic psychological constructs. These constructs, which are believed to underlie both adaptive and abnormal behavior and interact with environmental factors across the lifespan, are to be measured across several levels of analysis (e.g., genes, neurology, behavior). In this context, assertiveness is a promising target for further study, as it is clearly a dimensional construct that ranges within healthy and disordered populations. In addition, as reviewed above, assertiveness training involves the assessment and modification of emotional, cognitive, behavioral, motivational, and social processes, all of which have been identified as key domains for further investigation under RDoC. For example, within the RDoC framework, problems of assertiveness may be investigated under the "Social Processes" domain, which focuses on the dynamic processes used in social interaction, including the motivation and ability to engage in effective social communication (Sanislow et al., 2010). In addition, the "Negative Valence" and "Cognitive" domains map onto the fear, anxiety, avoidance, and cognitive distortions that often accompany unassertiveness and that may be important to the development and maintenance of psychopathology.

Importantly, assertiveness problems are not disorder-specific. Therefore, assertiveness training may be a valuable intervention for addressing problems of comorbidity, a fundamental goal of the RDoC initiative. The shift in the current clinical research priority framework provides a most relevant arena for the continued study of assertiveness as a potential transdiagnostic factor for psychopathology.

Given its promise as a potential mediator/moderator of varying clinical symptoms, unassertiveness is clearly a variable warranting future research, including the investigation of how assertiveness difficulties in childhood and adolescence may indicate a vulnerability for the development of a variety of clinical symptoms, allowing for the improved identification of high-risk individuals. Furthermore, future research within this framework can investigate the efficacy of assertiveness training as a preventive or early intervention for individuals identified as high risk (e.g., individuals with familial history of depression) or individuals with subthreshold symptoms. Traditionally, treatment efficacy has been evaluated using self-report measures of symptom severity, clinical interviews, or, less frequently, behavioral observation, which reveals little about the mechanistic processes that lead to change. Future research may consider evaluating *how* assertiveness training works by utilizing a multimethod assessment across several units of analysis, such as self-report, behavior, genes, and psychophysiology, to determine the process of change across clinical problems (Goldfried, 2016; Hershenberg & Goldfried, 2015).

CONCLUDING COMMENTS

Despite its long history, assertiveness has been largely overlooked in the clinical and research literature in the 21st century. The current article highlights the role of assertiveness in a variety of clinical problems, as well as the benefits of assertiveness training in ameliorating psychological symptoms. Early basic research suggests that assertiveness problems are common among internalizing disorders, such as depression and anxiety, as well as nonclinical problems, such as self-esteem and relationship satisfaction, making assertiveness a construct that may play a central role in the maintenance of clinical problems. Importantly, a substantial body of early research supports the efficacy of assertiveness training in improving clinical symptoms, increasing self-esteem, relationship satisfaction, and assertiveness—both broadly and within specific contexts. However, assertiveness training has largely disappeared as a standalone treatment, and assertiveness training is rarely a focus of current empirical studies. As noted earlier, this decrease in prevalence was likely due, in part, to the transition in research funding priorities in the 1980s from dimensional constructs (i.e., "target problems") that impact coping, such as personality characteristics, assertiveness, and perfectionism, to *DSM* disorder-

specific investigations. This is also highlighted by the fact that assertiveness training techniques have been renamed and absorbed into treatment packages that are designed to be specific to particular *DSM* diagnoses (e.g., interpersonal effectiveness training in dialectical behavior therapy for borderline personality disorder). The proliferation of disorder-specific packages presents a problem for training that has been discussed at length elsewhere (Dimidjian et al., 2016; Goldfried, 2000). Notably, the recent NIMH RDoC initiative provides optimism for a revival of basic and applied research on transdiagnostic psychological constructs as mediators and moderators of psychopathology.

CONFLICT OF INTERESTS

The authors have no conflict of interests to disclose.

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Received January 24, 2017; revised August 2, 2017; accepted August 9, 2017.