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AUTOGENIC TECHNIQUES AND POSITIVE SUGGESTIONS  
AS TREATMENTS FOR COMMUNICATION APPREHENSION  
IN THE PUBLIC SPEAKING CONTEXT

by

Diane Baxter Foley

B.S., The University of the State of New York, 1980

Presented in partial fulfillment of the requirements

for the degree of

Master of Arts

UNIVERSITY OF MONTANA

1984

Approved by:

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Chair, Board of Examiners

*[Signature]*  
Dean, Graduate School

*September 10, 1984*  
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Foley, Diane Baxter, M.A., Summer 1984 Interpersonal  
Communication

Autogenic Techniques and Positive Suggestions as  
Treatments for Communication Apprehension in the  
Public Speaking Context (70 pp.)

Director: William W. Wilmot *W. Wilmot*

The negative effects of communication apprehension (CA) have been well documented. Nevertheless, treatments to reduce CA in its four contexts (group apprehension, meeting apprehension, speaker apprehension and apprehension in dyadic interaction) remain less than satisfactory since the available treatments are time-consuming, require various degrees of trainer preparation and have been given to only small groups of subjects at one time.

To address these problems, this study utilized two forms of treatment: three five-minute sessions of autogenic techniques to one group, and three five-minute sessions of positive suggestions to a second group to reduce CA in the public speaking context. Sixty-six students in Public Speaking classes with high speaker apprehension were subjects for the study. Reduction of speaker apprehension was measured by self-report pre- and post-tests with the PRCA-24, final grades in subjects' classes and dropout rates from the classes. Treatment groups were compared on these measures with a non-treatment control group; students who only attended classes.

All three groups reported a significant reduction in speaker apprehension on posttests. No significant difference was found in final grades of the three groups. Twenty-three percent of subjects in autogenic techniques and control groups dropped the class as compared to thirteen percent of the group who received positive suggestions. This showed that the independent variables (autogenic techniques and positive suggestions) had no larger effect on the dependent variables than just enrolling in the class.

## ACKNOWLEDGMENTS

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## CHAPTER I

### INTRODUCTION

#### Purpose of Study

The purpose of this research was to study the effects of the separate treatments of Autogenic Techniques and Positive Suggestions on communication apprehension in the public speaking context. The research question for this study was: Do Autogenic Techniques and/or Positive Suggestions reduce communication apprehension in the public speaking context as measured by self-reports, final grades in Introduction to Public Speaking classes and dropout rates from Introduction to Public Speaking classes?

For the past thirty years, scholarly attention has centered on anxiety experienced by individuals about oral communication performance (Daly & Friedrich, 1981). In addition, the negative effects of communication apprehension have been documented in more than two-hundred studies in the decade from 1970 to 1980 (McCroskey, 1981). Stage fright is the oldest of the conceptualizations of communication apprehension (CA) and empirical research has been directed toward stage fright for almost half a century (McCroskey, 1981). As McCroskey says, "From our contemporary

vantage point we can view the construct of stage fright as representing CA in the public speaking context" (1981, p. 3). Nevertheless, treatment to reduce CA in all its contexts is still less than satisfactory since it is time consuming, requires varying degrees of trainer preparation and has been given to only small groups of subjects at one time.

In this study, college students in a freshman Introduction to Public Speaking class received Autogenic Techniques (ATs) and Positive Suggestions (PSs) in an attempt to reduce their communication apprehension in a public speaking context, demonstrated by self-reports of speaker apprehension on the Personal Report of Communication Apprehension (PRCA-24) instrument. Also, subjects' final grades and dropout rates in their public speaking classes were assessed.

Autogenic Techniques and Positive Suggestions were used because of their potential as an economical treatment for CA. The techniques could be presented in a short time and required no prior preparation of the trainer. Both techniques are based on procedures that have been shown to reduce speaker and generalized anxiety. A more specific description of these treatments and the rationale for their use can be found in the following chapter. To test the effects of ATs and PSs on speaker apprehension, a third group of Ss who reported similar amounts of CA in the

public speaking context received no treatment, and the same dependent measures were measured to determine whether or not there was empirical evidence of reduction of speaker apprehension.

#### Conceptual and Operational Definitions of Variables

Communication apprehension (CA) is an individual's level of fear or anxiety associated with either real or anticipated communication with another person or persons (McCroskey, 1977, p. 1; 1981, p. 1).

Speaker apprehension is defined as CA in the public speaking context and is one of the four contexts contributing to overall CA (McCroskey, 1981). The other three components of CA are apprehension in meetings or classes, in small groups, and in dyadic interactions (McCroskey, 1981). Speaker apprehension is measured by items 19-24 of the PRCA-24 (see table 1).

TABLE 1

#### PRCA-24 SUBSCALES MEASURING SPEAKER APPREHENSION

19. I have no fear of giving a speech.
20. Certain parts of my body feel very tense and rigid while giving a speech.
21. I feel relaxed while giving a speech.
22. My thoughts become confused and jumbled when I am giving a speech.
23. I face the prospect of giving a speech with confidence.
24. While giving a speech I get so nervous, I forget facts I really know.

Autogenic Training is a term devised by J. H. Schultz of Germany in 1959 and, in this study, it is used interchangeably with the terms Autogenic Techniques and Autogenic Exercises. Autogenic Techniques (ATs) consist of a series of mental exercises to produce relaxation (Heron, 1977), and their basic component is that the subject is helped to relax: ATs work "in exact opposition to . . . stress and are useful to people under emotional strain" (Schultz & Luthe, 1959).

In Autogenic Techniques, the subject is told in a calm slow manner that each of his/her limbs and extremities are warm and heavy, his/her heartbeat is calm and regular, his/her respirations are slow and deep, his/her solar plexus is warm and that his/her forehead is cool. This therapy allows the mind and body to self-regulate toward a more harmonious state (Pelletier, 1980). Although ATs can be self-administered by the subject, they were read verbatim to subjects in this research. According to Wolfgang Luthe:

The decisive difference between the usual type of "active concentration" and "passive concentration" used during autogenic exercises lies in the person's attitude toward the functional result to be achieved. "Passive" concentration implies a casual attitude and functional passivity toward the intended outcome of his concentrated activity, whereas "active" concentration is characterized by the person's concern, interest, attention, and goal-directed active efforts during the performance of the task and in respect to the final functional result (Luthe, 1969, p. 132).



In other words, with Autogenic Exercises, the sensations of being deeply relaxed should come to the subject and take over, rather than the subject striving actively for them since striving will only interfere with the process (Pelletier, 1980). For optimal relaxation, therefore, the subjects in this research were asked to sit and listen to the ATs (see Appendix A for complete, specific wording of ATs). Positive Suggestions are suggestions stated in a positive manner; e.g., "Please sit down" versus "Please do not stand" (Heron, 1977) and all suggestions used in this research were positively, rather than negatively worded, and also worded simply. As Heron (1977) states "Suggestive Therapy is . . . useful . . . in functional difficulties." (See Appendix B for complete, specific wording of PSs.)

## CHAPTER II

### REVIEW OF LITERATURE

#### Rationale

In 1970 J. C. McCroskey found that approximately 20% of major university populations were afflicted with CA and McCroskey, Daly, Richmond & Cox (1975) reported that student apprehensives were perceived less positively by others than students who did not have CA. Student apprehensives were also perceived as less socially and sexually attractive (McCroskey, Daly, Richmond & Cox, 1975; McCroskey and Richmond, 1975; Quiggens, 1972; Fenton & Hopf, 1976, Wissmiller & Merker, 1976).

Students with CA have difficulties in other areas as well. Although apprehensives are equally as intelligent as the rest of the population (Bashore, 1971; Davis, 1977; McCroskey, Daly & Sorenson, 1976), one study indicated that between 50 and 70% of apprehensives at two major universities dropped public speaking classes in spite of the fact that public speaking was a required course (McCroskey, 1970). In this study, McCroskey reported that this compared with an attrition rate of 5 to 10% for students with low or moderate CA. Two simulation studies

have shown that the apprehensive person who interacts at a job interview may be perceived by the screener as potentially less competent and less successful (Daly & Leth, 1976; Richmond, 1977). When the apprehensive gets a job s/he is apt to refuse a promotion with higher pay and more status because that promotion would require him/her to increase his/her communication (Scott, McCroskey, & Sheehan, in press).

At least eighteen treatments and approaches are used to reduce CA in colleges and universities (Foss, 1982) (See Appendix C), but a recent survey showed that only six percent of respondents from colleges and universities that teach various categories of speech also offer programs to reduce communication apprehension (Hoffman & Sprague, 1982). Fifty-seven percent of these respondents agree that there is a need for such programs. McCroskey (1977) makes this point well:

A major thrust in the future . . . should be in the developments of treatments . . . it is vital that we learn . . . what we can do to eliminate what is clearly the most pervasive communication problem in our contemporary society (p. 31).

In the Hoffman and Sprague survey (1982), the most frequent reasons given by the respondents for not having programs to treat CA were lack of faculty and lack of money.

The most frequently reported successful treatment for CA is Systematic Desensitization: A search of the literature shows thirty-two instances of Systematic Desensitization

being used for the treatment of CA (McCroskey, 1970; McCroskey, 1972; Goss, Thompson & Olds, 1978; Berger & McCroskey, 1982; Freemouw & Scott, 1979; Weissburg & Lamb, 1977; Foss, 1982; Hoffman & Sprague, 1982; Neer, 1982). Systematic Desensitization has been used more frequently than the other 17 treatments mentioned above.

Systematic Desensitization is well described by Glasser (1981), O'Hair & Goss (1982) and Foss (1982) and relaxation is one of the main components. Systematic Desensitization, however, requires the presence of a previously prepared trainer with the exception of one article that deals with self-administered desensitization (Clark, 1973). Helping to reduce anxiety behaviorally (O'Hair & Goss, 1982), Systematic Desensitization is a relaxation technique in which "anxiety is reduced through the paired association of deep muscle relaxation with specific anxiety-arousing situations" (Beatty & Behnke, 1980).

Deep muscle relaxation is reported to have been used in the foregoing instances of Systematic Desensitization, and Shealy (1977) states that the physiological improvement with ATs is similar to that obtained in deep muscle relaxation. In one study, low imagery Ss with anxiety-based disorders showed the same response to both Autogenic Training and to progressive muscle relaxation (Hartman, 1982).

There are five main reasons why ATs and PSs may be appropriate as treatments. The first is that ATs are based on a main component of Systematic Desensitization and, according to Phillips (1982), most teachers use techniques based on Systematic Desensitization to reduce CA in students.

The second reason is that the entire treatment of ATs can easily be administered by non-faculty who have no prior training. All reported treatments of Systematic Desensitization have utilized a trainer who had varying degrees of previous preparation although one exception in the literature (Clark, 1973) is mentioned above. An extra potential advantage is that ATs can easily be learned and self-administered by the subject.

Autogenic Techniques can be used for much larger groups of subjects; the third reason why they may be appropriate. A trainer need not watch to see his subjects raise a finger or otherwise indicate anxiety as subjects sometimes do in Systematic Desensitization. Academic departments are frequently short of personnel to administer treatment programs (Neer, 1982), and ATs can be delivered to large groups of subjects with minimal staffing.

The amount of time required to treat CA may be shortened with the use of Autogenic Therapy; in this research, three five-minute sessions of ATs were administered to Ss who reported CA in the public speaking context.

Up to the present, the amounts of time reported to treat CA range from over a seven-year period (Phillips & Metzger, 1973) to five sessions reported by Watson (1982) (Garrison, 1979; Harris & Brown, 1982; McCroskey, 1972; O'Hair & Goss, 1982).

As with ATs, Positive Suggestions can be read by non-faculty who have no previous training; can be given to much larger groups of subjects, and will therefore require fewer personnel and may require a shorter amount of time to treat CA in the context of public speaking: in this research three five-minute sessions of PSs were administered to Ss who reported high CA in the context of public speaking.

- Finally, since ATs are an appropriate treatment of CA (Hoffman & Sprague, 1982) a department that teaches public speaking would profit from such a program that assists apprehensives in preparing for public speaking.

### Hypotheses

The hypotheses concerning the effects of ATs and PSs on CA in the public speaking context are:

H<sub>1</sub>: Students enrolled in a public speaking course who report speaker apprehension and receive three sessions of autogenic techniques or who receive three sessions of positive suggestions will show significantly lower degrees of

speaker apprehension on posttest than will students who report speaker apprehension and receive no treatment.

H<sub>2</sub>: Students who report speaker apprehension and receive three sessions of autogenic techniques or who receive three sessions of positive suggestions will show significantly higher final grades than will students in Introduction to Public Speaking classes who report speaker apprehension and who do not receive treatment.

H<sub>3</sub>: Students who report speaker apprehension and receive three sessions of autogenic techniques or who receive three sessions of positive suggestions will show lower dropout rates than will students in Introduction to Public Speaking classes who report speaker apprehension and do not receive treatment.

## CHAPTER III

### METHOD

#### Subjects

Sixty-six students enrolled in Introduction to Public Speaking classes were the subjects. Of the two-hundred and sixteen students in the classes, these sixty-six scored in the highest 30% on the PRCA-24 (communication apprehension for public speaking). Although normally participants who score in the highest 20% of CA are considered to be candidates for treatment, the 30% cutoff point was used in this research to obtain a sufficient sample size.

#### Design

The experiment implemented a randomized group design with three groups:

- A. AT treatment of 22 Ss
- B. PS treatment of 22 Ss
- C. and a no-treatment control group of 22 Ss.

The subjects were randomly assigned to the three groups, with each having an equal chance of being in any one of the three groups.

#### Dependent Variables

Dependent variables were measures of the PRCA-24, final



grades of the Ss, and dropout rates from Introduction to Public Speaking classes.

The PRCA-24 measure was developed by J. C. McCroskey in 1981; it is a Likert-type, self-report, 24-item instrument with six items for each of the four CA contexts, three positively worded and three negatively worded to avoid response bias. The instrument can be used to generate both a general score and four sub-scores representing generalized context CA in the areas of group apprehension, meeting apprehension, dyadic apprehension and speaker apprehension (McCroskey, 1981). Whatever form of the PRCA is used, it has been shown more valid for measuring CA in public speaking situations than in all other environments (McCroskey, 1981). More studies have been reported on measurement of CA in the public speaking context than on the other three contexts and Gilkinson (1942), Paul (1966), and McCroskey (1981) developed instruments with strong face validity (McCroskey, 1981). The PRCA-24 correlates significantly with speech anxiety as measured by the Spielberger State Anxiety Measure and results of this study (McCroskey & Beatty, 1984) are supportive of the PRCA-24 as a cross-situational predictive instrument. For public speaking anxiety, alpha reliability is .91 (McCroskey & Beatty, 1984).

The PRCA-24 was used in this research for the measurement of CA in the public speaking context, using items 19-24 of the scale (see Appendix D).

Even with significant changes pre- to post-test, the problem of concomitant behavior change in real life is still a real one (Herson & Bellack, 1976). Therefore, dependent variables also include final grades and dropout rates from Ss Introduction to Public Speaking classes.

#### Independent Variables

The independent variables were the types of treatment each group received: ATs, PSs and non-treatment of Ss who continued to attend Introduction to Public Speaking classes.

Autogenic Techniques are described in the introduction and complete and specific wording is found in Appendices A and B: the instructions were read verbatim to the Ss to help them relax about speaking apprehension.

Positive Suggestions are described in the introduction and complete and specific wording is found in Appendix C. These were also read verbatim for the Ss, the object being to help the Ss feel comfortable and relaxed in general areas of their lives as well as in speaking situations. Similar suggestions were used by Gibbons (1973) while emphasizing relaxation to alleviate anxiety over speaking in public. In summary, the three groups were:

Treatment 1: This group of 17 Ss received three five-minute sessions of ATs with pre- to post-tests.

Treatment 2: This group of 17 Ss received three five-minute sessions of PSs with pre- and post-tests.

Treatment 3: This group of 17 Ss received no treatment. Members of this group received only pre- and post-tests.

### Procedures

All students in ten Introduction to Public Speaking classes were pretested and Ss reporting the highest 30% in the CA context of speaker apprehension were recruited by two personal contacts at the end of their regular classes. Subjects were assigned to one of the three groups by random division. Those in the AT and PS groups received the treatments specified above. Approximately three weeks later all Ss took the posttest in their regular classes.

Before data was collected, permission was obtained from the Institutional Review Board For Use of Human Subjects in Research (see Appendix E). Permission was also secured from the Coordinator for the Basic Course and from the Graduate Teaching Assistants (GTAs) who taught the Introduction to Public Speaking classes, to collect data for this study (see Appendix F), and data collection began on the first day of classes.

The PRCA-24 was administered to all students in ten Introduction to Public Speaking classes within the first two weeks of the quarter (see Appendix G for researcher's instructions to students on how to take the test). Students answered on scantron forms at both pre- and post-test (see Appendix H for scantron form used).

All scantron forms from the pretests were read into the scantron processor and data was deposited immediately in the computer disk area. After SPSS was used to calculate scores of the 216 students on speaker apprehension, scores of 23 and above qualified for the highest 30% of speaker apprehension on the PRCA-24 (items 19-24). ID numbers were then matched with students' corresponding names and randomly divided into three groups with 22 subjects in each group.

The researcher taped multiple copies of ATs and PSs separately, and pretested the tapes for possible bias in vocal tone and emphasis. These tapes; first the ATs and second the PSs, were played for 37 students in a Relational Development class and students were asked which statement (treatment) the speaker (researcher) believed in the most. By raising hands after the tapes were played, 23 students indicated that they thought the researcher believed most strongly in the ATs; 10 believed the researcher believed most strongly in the PSs, and four students did not vote. In order to check the students' beliefs that the researcher was biased in favor of the ATs, the tapes were played for a second class: the same day, the tapes were played in reverse order; first the PSs and second the ATs, for 20 students in an Introduction to Communication Relationships class. All students in this class were asked to anonymously evaluate the speaker on a five-point, graduated

scale of involvement to non-involvement; being interesting to being uninteresting; being enthusiastic to unenthusiastic; being believable to unbelievable; being calm to excited; being slow to fast and being loud to soft on each treatment (see Table 2 for anonymous evaluation sheet with results of evaluations. Results of voting after the evaluation was completed are found in Table 3).

TABLE 2

ANONYMOUS EVALUATION SHEET TO DETERMINE POSSIBLE  
RESEARCHER (SPEAKER) BIAS TOWARD EITHER OF TWO  
TREATMENTS WITH RESULTS OF EVALUATIONS

- 1.) For Introduction to Communication Relationships  
Class--(Positive Suggestions)

Do not sign your name. This is an anonymous evaluation.  
PLEASE LISTEN TO THE FIRST FIVE-MINUTE RECORDED STATEMENT  
AND THEN FILL OUT THE FOLLOWING EVALUATION OF THE SPEAKER.  
IS SHE:

						TOTAL RESULTS OF EVALUATIONS	
INVOLVED	1	2	3	4	5	UNINVOLVED	65
INTERESTING	1	2	3	4	5	UNINTERESTING	84
ENTHUSIASTIC	1	2	3	4	5	UNENTHUSIASTIC	92
BELIEVABLE	1	2	3	4	5	UNBELIEVABLE	76
CALM	1	2	3	4	5	EXCITED	26
SLOW	1	2	3	4	5	FAST	27
LOUD	1	2	3	4	5	SOFT	92

TABLE 2, continued

2.) For Introduction to Communication Relationships

Class--(Autogenic Techniques)

PLEASE LISTEN TO THE SECOND FIVE-MINUTE RECORDED STATEMENT  
AND THEN FILL OUT THE FOLLOWING EVALUATION OF THE SPEAKER.  
IS SHE:

						TOTAL RESULTS OF EVALUATIONS	
INVOLVED	1	2	3	4	5	UNINVOLVED	58
INTERESTING	1	2	3	4	5	UNINTERESTING	82
ENTHUSIASTIC	1	2	3	4	5	UNENTHUSIASTIC	83
BELIEVABLE	1	2	3	4	5	UNBELIEVABLE	68
CALM	1	2	3	4	5	EXCITED	36
SLOW	1	2	3	4	5	FAST	39
LOUD	1	2	3	4	5	SOFT	84

TABLE 3

RESULTS OF STUDENTS IN INTRODUCTION TO COMMUNICATION  
RELATIONSHIPS CLASS VOTING BY HAND AFTER THEY WERE ASKED,  
"WHAT DOES THE SPEAKER THINK OF EACH STATEMENT: WHICH  
STATEMENT DOES THE SPEAKER BELIEVE IN THE MOST?"

1. Positive Suggestions	3
2. Autogenic Techniques	16
3. Did not vote	1

As presented on pages 16-18, student evaluators and voters thought the speaker believed more strongly in Autogenic Techniques than in Positive Suggestions. To eliminate bias, and because of the high scores on unenthusiastic and uninteresting, a male with a pleasant speaking voice was asked to record the treatments. He was blind to the purpose of the two treatments, and he read the printed instructions for the ATs and PSs into a tape recorder. To insure that students did not inform friends of the experiment's purpose, students in neither class were told the names of the treatments, nor were the names of the treatments recorded on the tapes. In addition, students who voted and evaluated were not told of the purpose of the two statements.

For the next step in the procedures, Ss for the two treatment groups were contacted at the end of their Introduction to Public Speaking classes throughout the next two weeks of the quarter; told that their scores indicated that they had reported some degree of speech anxiety, and informed about the treatment program (see Appendix 1 for researcher's exact statement to Ss in the two treatment groups). Each S was given a copy of the researcher's statement with the times and places that the next three treatments would be offered. Different times and places were offered for Ss who were to receive ATs than were offered for Ss who were to receive PSs, and empty

classrooms were reserved throughout the treatment period for these purposes. In addition, Ss were told about lists that were posted outside the main office room of their teachers (the GTAs) and the lists stated extra, continuing times and places where treatments would be offered. New lists were posted at least weekly throughout the five weeks when treatments were offered. At times, students were free right after the class during which they were contacted about their treatments, and they chose to receive treatments at that time.

When Ss were ready to hear their tapes, this statement was made to them:

Thank you for coming. As you see in this paper I've given you, I've listed three times that this treatment will be offered. I also keep an ongoing list of these and other times the program will be offered by the door outside 339. I appreciate you coming because it will help with my research and thesis and I'd like to give these treatments (have you hear the tape) three times at times that are convenient for you. If you'd prefer, you can also hear the tape twice now and once at one of the later times that is listed--whatever combination is best for you. You also have the option of hearing the tape three times now if you have a full schedule of classes and are not sure when you'll be able to get to a later session.

After hearing the tape once, all Ss opted to finish the program at that time. At this treatment session, each S signed a release form (see Appendix J) if they had not done so before: in addition, each S signed a separate paper indicating the number of times the treatment was heard.



Since more Ss were needed after the fourth week, the researcher contacted all untreated candidates for ATs and PSs a second time at the end of their regular Introduction to Public Speaking classes and presented the same statement plus a request to help with the research. At this time, the GTAs encouraged Ss with self-reported speaker apprehension to make an appointment with the researcher and receive treatment.

By the seventh week of the quarter, 17 Ss had received the AT treatment and 17 Ss had received the PS treatment. Two of the group scheduled for PSs chose not to take their treatments. At posttest, during the eighth and ninth week of the quarter, several of the Ss in three groups were absent so the researcher sought them out individually rather than contacting them in a class a fifth time.

## CHAPTER IV

### RESULTS

One-way analyses of variance (ANOVAS) using SPSS were performed on the three groups for change of scores from pre- to post-test on three groups and final grades for three groups. A multiple range test with LSD procedures was done on all tests significant at  $<.05$ . Percentages and chi-square tests were calculated on student dropout rates from Introduction to Public Speaking classes. In addition, pre- to post-test changes for communication apprehension within each group were assessed with correlated t-tests. For chi-square tests the level of significance was set at .01. For all other statistical tests the .05 level was used.

#### Discussion of Hypotheses

Three hypotheses were formulated with regard to the effect of ATs and PSs on speaker apprehension. Results of each hypothesis will be discussed below.

Since this study was concerned with change, the pretest ANOVAS will be reported before the discussion of hypothesis number one. A one-way ANOVA on the pretests showed a significant difference between the group receiving ATs ( $\bar{x} = 25.8824$ ), the group receiving PSs ( $\bar{x} = 23.7647$ )

and the control group ( $\bar{x} = 25.2941$ ) ( $F = 4.680$ , 2.48 df,  $p = .0139$ ). Since the ANOVA indicated a significant difference, a multiple range test was performed with the LSD procedure. This showed that the AT group was different from the PS group, that the PS group was different than the control group, and that there was no difference between the AT group and the control group on the pretest ANOVA.

The first hypothesis specified that when students who report speaker apprehension and receive three sessions of ATs, or receive three sessions of PSs, they will report significantly lower degrees of speaker apprehension on post-treatment measures than will students who report speaker apprehension and who do not receive ATs or who do not receive PSs.

Correlated t-tests pre- to post-test show that there was a significant change within each group. Both the group receiving ATs and the control group showed a significant change from pre- to post-test. Correlated t-tests pre- to post-test for the AT group showed a pretest mean of 25.8824 and a posttest mean of 20.5294 ( $t = 5.93$ , 16 df,  $p = 0.000$ ). Correlated t-tests pre- to post-test for the control group showed a pretest mean of 25.2941 and a posttest mean of 21.2353 ( $t = 6.19$ , 16 df,  $p = 0.000$ ). Also, both the groups receiving PSs and the control group showed a significant change from pre- to post-test. Correlated t-tests pre- to post-test for the PS group showed a pretest mean of

23.7647 and a posttest mean of 20.1765 ( $t = 2.94$ , 16 df,  $p = 0.010$ ). Correlated  $t$ -tests pre- to post-test for the control group showed a pretest mean of 25.2941 and a posttest mean of 21.2353 ( $t = 6.19$ , 16 df,  $p = 0.000$ ).

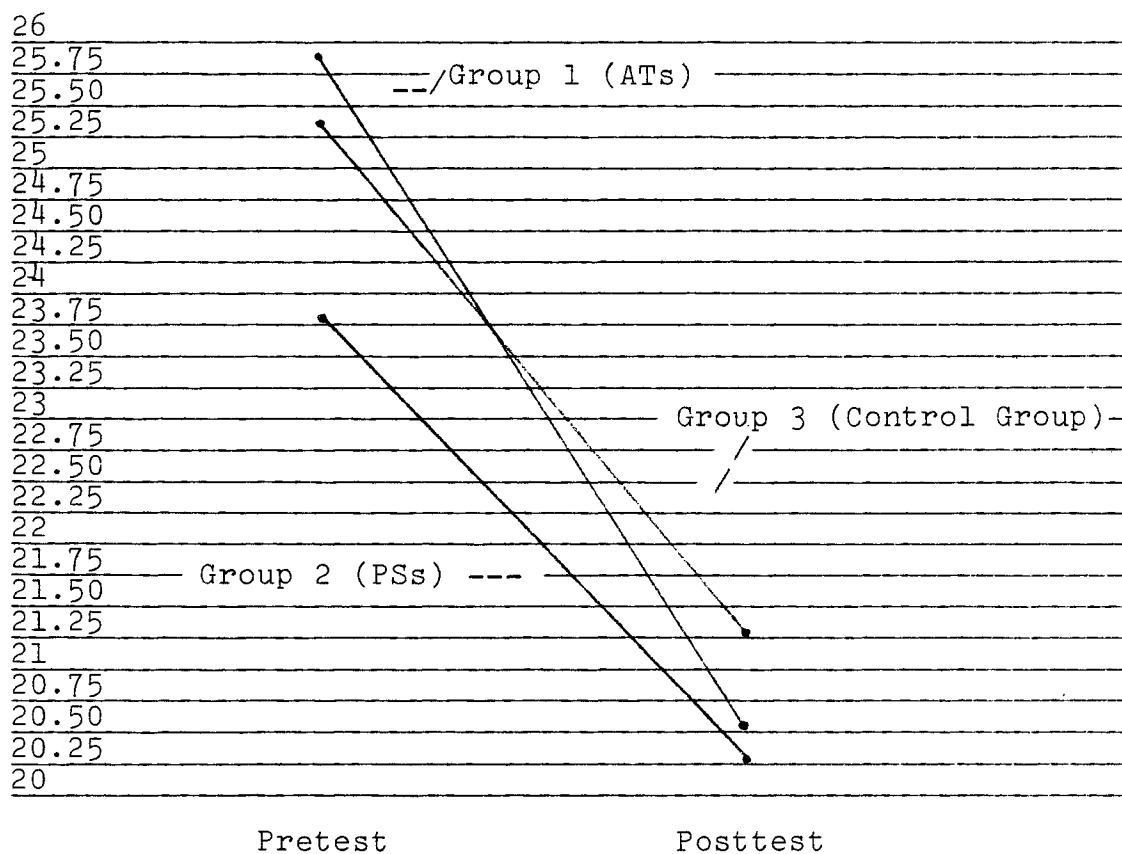
For comparison of the amount of change across groups, an ANOVA was performed on pre- to post-test change scores for three groups. An ANOVA on pre- to post-test change scores showed a mean of 5.3529 for change of scores for the AT group and a mean of 4.0588 for change of scores for the control group ( $F = 0.915$ ,  $p = 0.4075$ ) showing no significant difference in degrees of change across the groups. The ANOVA on pre- to post-test change scores showed a mean of 3.5882 for change of score for the PS group and a mean of 4.0588 for change of score for the control group ( $F = 0.915$ ,  $p = 0.4075$ ) illustrating no significant difference in degree of change across the groups.

A one-way ANOVA on the posttests showed no significant difference of the means across groups. The one-way ANOVA on the posttests showed a mean of 20.5294 for the AT group and a mean of 21.2353 for the control group ( $F = 0.308$ , 2.48 df,  $p = 0.7363$ ), showing no difference of the means on the posttests. The one-way ANOVA on the posttests showed a mean of 20.1765 for the PS group and a mean of 21.2353 for the control group ( $F = 0.308$ , 2.48 df,  $p = 0.763$ ) showing no significant difference on the means of the posttests.

Results of the above tests show that the first hypothesis was not supported. All groups changed significantly pre- to post-test but there were no differences between them in the degree of change (see Figure 1).

FIGURE 1

PRETEST, POSTTEST AND PRE- TO POST-TEST CHANGE SCORES  
(ANOVAS) WITH PRE- TO POST-TESTS (CORRELATED T-TESTS)



All three groups in experimental conditions in this research (all Ss who reported speaker apprehension on

pretest) reported a large reduction in speech anxiety, down toward the overall mean. The mean score for 216 students for speaker apprehension on pretest was 19.463. The mean for speaker apprehension for 66 Ss (three groups) on pretest was 24.9804. Mean score for speaker apprehension for three groups on posttest was 20.6471. The mean score of speaker apprehension in three groups in this study changed 4.333 score points from pretest to posttest. The difference between the mean score of all 216 students in ten classes (19.463) on pretest and the final mean score of three groups (20.6471) was 1.1841 score points. Therefore, the final mean score for three groups approached, but did not equal, the pretest average of speaker apprehension for all students.

Hypothesis number two states that students who report speaker apprehension and receive three sessions of ATs or receive three sessions of PSs will show significantly higher final grades than will students who report speaker apprehension and do not receive ATs or PSs. A one-way ANOVA was performed on final grades in Introduction to Public Speaking classes on all three groups, converted to the following scale: A = 4

B = 3

C = 2

D = 1

F = 0

The mean of the AT group was 3.1176, the mean of the PS group was 3.3529 and the mean of the control group was 3.000 ( $F = 2.263$ , 2.48 df,  $p = 0.1151$ ). The null hypothesis was not rejected indicating that the independent variables (ATs and PSs treatments) did not affect the grades more than mere presence in the public speaking class.

Hypothesis number three predicts that students who report speaker apprehension and receive three sessions of ATs or receive three sessions of PSs will show lower dropout rates from Introduction to Public Speaking than will students who report speaker apprehension and do not receive ATs or PSs. This hypothesis was not supported in the case of ATs because five of the total of 22 Ss (23% of the Ss in the AT group) dropped the class as well as five of the total of 22 Ss in the control group (23%). Hypothesis number three was supported in the case of the PS group because three of the total number of 22 Ss in the PS group (13%) dropped the class, whereas five of the total number of 22 Ss in the control group (23%) dropped the class. A chi-square ( $x^2$ ) test was performed between the percentage of dropout rates of the PS group and the percentage of dropout rates of the PS group and the percentage of dropout rates of the control group. It was found that  $x^2 = 9.38$ , 1 df, a significant difference at the .01 level.

Unfortunately, there is no way to test hypothesis number three since all Ss who dropped the class either did

so before the third week of class when treatment was offered or opted to forego the treatment and left the class before the end of the quarter. Of the 8 Ss in the AT group and the PS group who dropped Introduction to Public Speaking class, none received treatment before leaving. Of the total number of 66 Ss in three groups, 13 Ss or 19.24% dropped the class after the pretest.



## CHAPTER V

### DISCUSSION

This chapter will discuss the results reported in Chapter IV, and provide suggestions for future research on the treatment of CA in its various contexts.

#### Quantitative Issues

One-way ANOVAS and correlated t-tests showed significant changes in PRCA-24 scores pre- to post-test for the two treatment groups and the control group. Autogenic Technique group participants with speaker apprehension showed significant reductions. The group receiving Positive Suggestions showed significant reductions in speaker apprehension, and control group participants with speaker apprehension showed significant reductions. In light of findings in the literature, these results were not expected.

Although Ss were recruited from freshman Introduction to Public Speaking classes, ages varied from 18 years of age to middle age. In this context McCroskey (1977) states that most adults with high CA are adjusted to their lives and he adds later that generalized context CA about public speaking is relatively enduring although a trait-like,

personality-like variable such as CA, though highly resistant to change, can be and often is changed during adulthood (McCroskey, 1981).

A second reason why results in this study were unexpected is that students in traditionally taught public speaking classes report high rates of CA after taking the course (Buerkel-Rothfuss & Yerby, 1982). Other studies have also shown that students in public speaking classes who are identified as having high CA show a significant increase in CA (Brooks & Platz, 1968; Phillips & Metzger, 1973; Taylor & Hamilton, 1974): in fact, as McCroskey (1977) states, those students most in need of help are actually hurt. In light of these studies it was not expected that the control group participants with speaker apprehension would show significant reductions. A possible reason why all three groups showed reductions in self-reported speaker apprehension is that all Ss were students in Introduction to Public Speaking classes in the same system. All these students took other PRCAs at intervals throughout the quarter; therefore, Ss may have perceived an expectation of improvement from their teachers.

Most studies show that higher grades are not to be expected in the context of this study. In 1976, McCroskey and Anderson reported that students with high CA as compared to those with low CA have been found to have lower overall college grade point averages and Seiler (1978) stated that

CA negatively affects academic achievement. One study (Hurt & Preiss, 1978) found CA was significantly negatively related to students' final grades and McCroskey (1981) said high CA is projected as a barrier to the formal study of communication, and discomfort may inhibit learning. In 1982, Boohar & Seiler found that college students with speech anxiety did not achieve as well as the non-anxious. However, the one-way ANOVA performed on final grades yielded no significant difference among groups. Based on this, it appears that treatment group assignment had little effect on final grades. One possible explanation for the equivalent final grades in three groups is the teaching process encountered in this study and described below. Perhaps some academically inhibiting speech anxiety was alleviated early in the course by classroom teaching methods which will be discussed later. Another possibility is the distribution of grades. There was little variation in grades in the groups. Twenty-one and a half percent of the total number of subjects got As; 72.5% got Bs and only 6% got C or lower. With the modal grade of "B" and little variance, it is possible that the lack of discrimination in grading masked any potential differences.

A final issue in this research covers attrition rates for three groups. Twenty-three percent of Ss in Autogenic Technique and non-treatment control groups dropped the class in comparison to 13% of Ss who were in the PS group

which indicates that treatments had no effect on attrition rates. Of the total 66 Ss in three groups, 19.24% dropped the course. This total compares favorably to a study reported by McCroskey in 1977 wherein 600 students were enrolled in a public speaking course: "over half" the students who were identified as having high CA in this study dropped the course before the end of term. A reason for the difference in these rates could be the sample size: the McCroskey study began with over 600 students whereas this study began with only 216 students. In this context, larger samples tend to be more representative of the general population (Bruning & Kinz, 1977). Another report by McCroskey (1970), mentioned earlier, found that an even higher rate of apprehensives (50 and 70%) dropped public speaking classes. As McCroskey said in 1981, people try to avoid studying things which cause them discomfort. A second possible explanation for the discrepancy in dropout rates is the time lapse between studies: more research is presently available regarding the management of CA in the public speaking context than was known in 1970-1977, and it is the opinion of the researcher that such knowledge is implemented in Introduction to Public Speaking classes in this university.

Daly and Friedrich (1977) found that classroom characteristics of the course and instructor can contribute to a reduction in CA. In the light of the studies mentioned in

the preceding paragraphs, it was not expected that the control group participants with speaker apprehension would show significant reductions. Obviously, the control group in the current study experienced reduced CA due to some factor. It is probable that the structure of this particular course produced the reduction in apprehension. The Coordinator for Introduction to Public Speaking reported that classes are structured in a non-threatening manner. For example, the first assignment is critiqued but not graded; the second speech is given sitting down to a group of four or five peers; visual aids are soon assigned and may be used, the Coordinator said, as a support; no impromptu speeches are requested from the students, and the Graduate Teaching Assistants who teach the sections concentrate more on content than on delivery.

This type of program for the Introduction to Public Speaking course receives some support in the literature; Kougler (1980) recommends an ungraded experience or two at the beginning of a basic university speech course, and she also recommends placing quiet students in small groups at first so they can become comfortable in the class. A third statement of Kougler (1980) is that impromptu speeches are the most difficult for the quiet student to face. A fourth support for the program that was designed for teaching the Introduction to Public Speaking classes that was utilized in this research is the statement by DeBoer (1980)

that students at the beginning of a speech class worry that delivery will be considered by the teacher to be more important to final grades than will content.

### Implications

Some considerations for a more effective treatment program will be discussed. A problematic issue in this study was relaxation of Ss. If a similar study were to be conducted in the future, changes would be made in timing and treatment areas: for example, an increase in number and length of treatment sessions and a designated treatment area where sessions would not be interrupted.

In this study it was hoped that three five-minute sessions of suggestive therapy would produce a significant change in reported and behavioral manifestations of CA in the public speaking context but this was not realized. A similar study would utilize four separate sessions, increased in length: this would still require less treatment time than the shortest five-session program of SD reported earlier by Watson (1982).

A second problematic issue in this study was the lack of a designated treatment room. Although empty classrooms were invariably reserved each time treatments were scheduled, ad hoc meetings of faculty were discovered twice during the study when researcher and Ss prepared to use the classrooms. Also, occasional students and faculty lingering after

preceding classes plus the occasional student from another class who entered the treatment classroom looking for misplaced books and articles were a possible distraction to Ss. In a future study, a single room with a more pleasant atmosphere might enhance the treatment effects. In summary, four lengthier treatment sessions would be provided in a designated treatment area with the hope of permitting more relaxation of Ss and increasing program effectiveness in a future study.

#### Future Research

Subsequent research might be directed toward suggestive therapy as treatment for CA and its various contexts. Suggestive therapy has received documentation by Schultz & Luthe (1959); Luthe (1969); Gibbons (1973); Heron (1977); Shealy (1977); and Pelletier (1980), all of which has been discussed earlier. It is the opinion of the researcher that suggestive therapy might be effective in a briefer time period than has been reported in previous studies. The advantages to this possibly less time consuming program are threefold: first, subject mortality may be less of a confounding issue when treatment time is shortened; for example, in this research, subject mortality was not a detriment to the study. The second reason why suggestive therapy might be tried is that no trainer preparation need be necessary: many variations of suggestive therapy may

have the potential to not need pre-learning or memorization by the trainer, and these forms would seem to have the potential to be read verbatim to subjects. Last of all, there is the possibility for treating larger groups of Ss than has formerly been reported. One hopes that suggestive therapy could, as mentioned earlier, be economical of time, people and money. Further, in situations where a public speaking class is structured differently, specified treatment programs might be warranted to mitigate the effects of speaker apprehension.

Finally, the finding of changes in the control group are suggestive of designs for public speaking courses. Rather than providing treatment programs, courses can be designed to take advantage of the effects found here. Public speaking courses can reduce CA by structuring classes in a non-threatening manner: for example, by having the first assignment critiqued but not graded; by letting students give their first speech sitting down, to a group of four or five peers; by not requesting impromptu speeches from students, and by concentrating more on the content of speeches than on the delivery.



## CHAPTER VI

### SUMMARY

Empirical research has been directed toward speaker apprehension in its various conceptualizations for over half a century, and the negative effects of communication apprehension have been documented throughout over two-hundred studies since 1970. Although CA is found in 20% of the population, treatment to reduce it and its four contexts (group apprehension, meeting apprehension, speaker apprehension and apprehension in dyadic interaction) remains less than satisfactory, since treatment is time-consuming, requires various degrees of trainer preparation, and has been given to only small groups of Ss at one time.

To address these treatment problems, 66 of 216 freshman students in 10 Introduction to Public Speaking classes at a Western university who reported speaker apprehension on the Personal Report of Communication Apprehension (PRCA-24) were Ss for this study.

The PRCA-24 is the most recently developed of several PRCAs whose reliability and validity has been found to compare favorably to other, similar instruments; one of the four subscores on the PRCA-24 can be used to generate measurement of CA in the public speaking context.

Subjects who reported the highest 30% of speaker apprehension were assigned to three treatment groups: three sessions of Autogenic Techniques in which a main purpose was to produce general relaxation of Ss; three sessions of Positive Suggestions in which main purposes were to increase confidence and relaxation in speaking situations as well as to reduce general anxieties, and a non-treatment control group in which Ss continued to attend Introduction to Public Speaking classes. Autogenic Techniques and Positive Suggestions as suggestive therapy require no prior trainer preparation, can be given to larger groups of Ss than has formerly been reported, and the three sessions of treatment in this study required less time than did Systematic Desensitization, the most frequently reported successful treatment for CA (five sessions to a seven-year period). In this way, three problems in the treatment of CA in the context of public speaking were addressed.

It was hypothesized that Ss who received ATs and PSs would report significantly less speaker apprehension on posttest than would Ss in the control group; that Ss who received ATs and PSs would show significantly higher grades than would Ss in the control group, and would show lower dropout rates from Introduction to Public speaking classes than would Ss in the control group. The hypotheses were not supported.

In view of overall documentation on CA, Ss in three groups may have done better on scores and behavioral manifestations than might have been expected. For instance, sources have indicated that public speaking classes can result in higher self-reports of CA but, in this case, all three groups with CA in the public speaking context reported a significant reduction. Research has also shown that final college grades of apprehensives tend to be lower than final grades of the non-anxious: however, there was no significant difference in final grades of three groups in this case. The third indication that Ss in this study may have experienced fewer problems than one might expect was the rates of attrition. Reported findings show that over half the students with high CA drop public speaking class before end of term, but only 19.24% of Ss who reported the highest degrees of CA in the public speaking context dropped the course in this study, all of which argues for the usefulness of the course design. One possible explanation of the unexpected findings is that the Introduction to Public Speaking course is structured to benefit the apprehensives. Apparently enrollment in this particular course is not harmful to apprehensives, and in fact reduces CA as much as additional treatments. The additional effort necessary to conduct PS and AT treatments is not warranted when public speaking classes are structured to ameliorate the negative effects of CA.

APPENDIX A  
AUTOGENIC TECHNIQUES

## AUTOGENIC TECHNIQUES

"Get comfortable and close your eyes if you wish.  
You have nothing to do and no place to go for ten minutes.  
Your left arm is warm and heavy.  
Your left hand is warm and heavy.  
The fingers on your left hand are warm and heavy.  
It's OK to move around and get comfortable while I talk.  
Your right arm is warm and heavy.  
Your right hand is warm and heavy.  
The fingers on your right hand are warm and heavy.  
You're centered in these instructions and nothing disturbs  
you.  
Your left leg is warm and heavy.  
Your left foot is warm and heavy.  
The toes on your left foot are warm and heavy.  
The only sound you want to pay attention to for the next  
five minutes is the sound of my voice.  
Your right leg is warm and heavy.  
Your right foot is warm and heavy.  
The toes on your right foot are warm and heavy.  
The muscles around your shoulders are comfortable and  
relaxed.  
The muscles around your neck are comfortable and relaxed.  
Your heartbeat is calm and regular.

Your respirations are slow and deep.

Your solar plexus is warm.

Your forehead is cool."

"Now I'd like you to shut your eyes for a moment while I count slowly to ten . . . when I say "ten," you will open your eyes feeling rested, comfortable and pleasantly refreshed.

One.

Two.

Three.

Four.

Five.

Six.

Seven.

Eight.

When I say "ten," you will open your eyes feeling rested, comfortable and pleasantly refreshed.

Nine.

Ten."

APPENDIX B

POSITIVE SUGGESTIONS

## POSITIVE SUGGESTIONS

"Get comfortable and close your eyes if you wish.

You have nothing to do and no place to go for ten minutes.

You will notice as you rest in your chair that there's a sense of relaxation pouring over you.

In general areas of your life, the following thoughts will be passing through your mind: you know that you can awaken each day and make a fresh start. You are glad to be alive and you know that you can enjoy a healthy and beneficial soothing of deep stress. You are beginning to feel great all of the time, and you realize that distress and non-serious physical discomforts can be alleviated for you. Automatically, you will notice that you can enjoy the things that are good for you, and you will notice that you can have less and less desire for things that are not good for you.

The only sound you want to pay attention to for the next five minutes is the sound of my voice.

When talking to people, the following thoughts will be passing through your mind: you notice that you feel calm and relaxed, and you notice that anxiety and apprehension are alleviated for you. You also notice that you are feeling more confident and that you are perceiving a lot of social support when you are in speaking situations as well as in other areas of your life."



"In all areas of your life as well as in speaking situations, you know that you can enjoy a very healthy soothing of deep stress. Later on, when you feel anxious or when you begin to feel apprehensive, you will be able to realize these things you are hearing now. You are beginning to know that you have a peaceable sanctuary within your own mind and that you can go, however briefly, to this retreat where healing and soothing of deep troubles can take place. If your eyes are closed, you may open them now."

APPENDIX C

TREATMENTS USED TO REDUCE COMMUNICATION  
APPREHENSION IN COLLEGES AND UNIVERSITIES

**APPROACHES BASED IN LEARNING THEORY**

1. *Biofeedback*. With biofeedback, students learn to control communication anxiety by controlling the physiological manifestations of it. By learning to control heart rate, for instance, students can reduce the overt motor and verbal manifestations of speech anxiety.
2. *Cognitive Restructuring*. With this technique, speech-anxious students are taught to identify anxiety-provoking negative self-statements they make in communication situations (i.e., "I'm going to sound stupid") and to substitute more adaptive, non-anxiety-producing coping statements ("I have done my homework on my topic").
3. *Group Counseling*. Various therapeutic opportunities for communication apprehensive individuals have been provided in the group setting. Such groups provide a supportive environment in which members can learn more effective interpersonal responses to situations that they find difficult to handle or anxiety-producing outside of the group.
4. *Hypnosis*. This approach has been used primarily as a treatment for stuttering, which can be a symptomatic manifestation of communication apprehension. It also has been used, however, as part of a systematic desensitization program. A major disadvantage of hypnosis is that it requires a considerable investment in terms of time and effort on the part of the would-be hypnotist to prepare for treatment, or considerable expense in utilizing the skills of a trained practitioner.
5. *Implosion/Flooding*. Implosion and flooding are designed to increase subjects' speech anxiety as much as possible by having them imagine anxiety-producing situations until extinction occurs. The premise here is that aversive cues in the imagined situation are secondary, and in the absence of a primary reinforcer (the actual condition), they lose their aversiveness, and the avoidance reaction decreases.
6. *Modeling*. This is a behavior modification technique in which students watch a model—either live or filmed—demonstrate the behavior they wish to develop. Often accompanied by rehearsal, coaching, and relaxation, the modeling procedure purportedly expedites behavior change through its vicarious extinction of fear. Some claim it is a less-dependable approach than others because it relies on comparison and not on direct personal accomplishments.
7. *Rational Restructuring*. This approach, similar to cognitive restructuring, differs in that it assumes the cognitive process often is stifled by high anxiety. Thus, rational restructuring incorporates progressive imagery training to deal with fear.
8. *Rational Emotive Therapy*. The primary assumption of this approach is that the recipient must learn to recognize and deal with basic irrational ideas acquired in the course of life. Thus this method is aimed at changing general life strategies rather than changing specific behaviors by asking the individual to interpret speech anxious situations in alternative ways.
9. *Reciprocal Inhibition*. This is a form of systematic desensitization that pairs imagining an anxiety-arousing situation (giving a speech) with an incompatible response (relaxation). A hierarchy of anxiety-arousing situations is used until the anxiety response for each level of the hierarchy no longer is elicited.
10. *Self-Efficacy*. With this approach, individuals anticipate their ability to perform

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\*Foss, K. A. Communication Apprehension: Resources for the Instructor. Communication Education, 31, (3), July, 1982, 196-199.

certain behaviors and imagine the consequent outcomes of such behaviors. Self-efficacy is based on the notion that persistence in activities that are subjectively threatening but in fact are relatively safe produces mastery, enhances self-confidence, and reduces defensive behaviors.

11. *Stress Inoculation*. With this approach, students first are taught that stress is a cycle of physical arousal, automatic appraisal of a communication situation as tense, and subsequent negative self-statements about it. Relaxation training, positive coping statements, and skills training are used to replace the negative self-statements.
12. *Systematic Desensitization*. This method is based on the premise that if fear-arousing events repeatedly are associated with positive experiences, they lose their aversive quality. The treatment itself involves training in relaxation as well as constructing anxiety hierarchies for communication situations. Relaxation then is paired with the anxiety-evoking stimuli until each is extinguished.

#### APPROACHES BASED IN SKILLS TRAINING

1. *Assertiveness*. This approach teaches new ways of responding to communication situations that enhance self-esteem and encourage self-confidence. It involves the simulation of problem situations so that clients can practice their new behaviors until comfortable and can do so without concern for the real-life consequences of such behavior.
2. *Oral Interpretation*. This is a relatively indirect approach to speech anxiety since it places the communication apprehensive in a situation in which s/he assumes the role of another person—i.e., a character in or narrator of a story. The premise is that successful experiences of this type can provide positive reinforcement of and transfer to communication situations generally. Because the student temporarily operates on a “not me” basis, this approach is most successful when low-esteem is the cause of communication anxiety.
3. *Reality Therapy/Goal Setting*. In reality therapy, students are taught to revise the way they perceive communication and to learn techniques for dealing with common communication situations. By monitoring and recognizing their own improvement, they become increasingly positive about their communication efforts and more realistic in evaluating them.
4. *Rhetoritherapy*. This approach is based on the notion that anxiety is not a primary cause of communication problems but is a reaction to not knowing how to communicate effectively in a particular situation. The individual is taught the needed skills so that the prospect of communicating is now more rewarding than was not doing so.
5. *Social/Conversational Skills Training*. This approach is a broad one used to treat not only lack of communication competence but social anxiety generally. The assumption here is that individuals are anxious either because (1) maladaptive anxiety inhibits the appropriate responses they have in their repertoire; or (2) they lack certain skills and simply do not know what to do or say in a particular social situation.

#### TREATMENT VIA THE BASIC COMMUNICATION COURSE

Communication apprehension traditionally has been dealt with in the regular classroom through progressive oral communication performances designed to teach

skills and increase self-confidence. Recent research suggests, however, that highly-anxious students may be hurt rather than helped by required oral presentations, the assignment of grades for class participation, and the like.

APPENDIX D

PERSONAL REPORT OF COMMUNICATION  
APPREHENSION-24 ITEMS (PRCA-24)

## Personal Report of Communication Apprehension (PRCA-24)\*

This instrument is composed of 24 statements concerning your feelings about communication with other people. Please indicate in the appropriate space on the scantron the degree to which each statement applies to you by marking whether you:

A	B	C	D	E
Strongly agree	Agree	Are undecided	Disagree	Strongly disagree

There are no right or wrong answers. Many of the statements are similar to other statements. Do not be concerned about this. Work quickly, just record your first impression. Use #2 lead pencil to mark your answers.

1. I dislike participating in group discussions.
2. Generally, I am comfortable while participating in a group discussion.
3. I am tense and nervous while participating in group discussions.
4. I like to get involved in group discussions.
5. Engaging in a group discussion with new people makes me tense and nervous.
6. I am calm and relaxed while participating in group discussions.
7. Generally, I am nervous when I have to participate in a meeting.
8. Usually I am calm and relaxed while participating in meetings.
9. I am very calm and relaxed when I am called upon to express an opinion at a meeting.
10. I am afraid to express myself at meetings.
11. Communicating at meetings usually makes me uncomfortable.
12. I am very relaxed when answering questions at a meeting.
13. While participating in a conversation with a new acquaintance, I feel very nervous.
14. I have no fear of speaking up in conversations.
15. Ordinarily, I am very tense and nervous in conversations.
16. Ordinarily, I am very calm and relaxed in conversations.
17. While conversing with a new acquaintance, I feel very relaxed.
18. I'm afraid to speak up in conversations.
19. I have no fear of giving a speech.
20. Certain parts of my body feel very tense and rigid while giving a speech.
21. I feel relaxed while giving a speech.
22. My thoughts become confused and jumbled when I am giving a speech.

(PRCA-24), continued

23. I face the prospect of giving a speech with confidence.
24. While giving a speech I get so nervous, I forget facts I really know.

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\*From: McCroskey, J. C. Oral communication apprehension: Reconceptualization and a new look at measurement. Paper presented at the Central States Speech Association convention, Chicago, 1981.

APPENDIX E

PERMISSION FROM THE INSTITUTIONAL REVIEW BOARD  
FOR USE OF HUMAN SUBJECTS FOR THIS STUDY



PERMISSION FROM THE INSTITUTIONAL REVIEW BOARD  
FOR USE OF HUMAN SUBJECTS FOR THIS STUDY

UNIVERSITY OF MONTANA

DATE: January 26, 1984

TO: Diane B. Foley, Department of Interpersonal Communication

FROM: University of Montana Institutional Review Board for Use of Human Subjects  
in Research

As a result of  administrative review of ~~the~~ the ~~University~~ of Montana Institutional Review Board your proposed research project, \_\_\_\_\_  
to treat sixty students who indicate that they have communication apprehension  
as measured by self-reports

has been approved and is considered

a "no risk" project not requiring the written informed consent of  
the participants.

To involve sufficient risk to require the written informed consent  
of the participants as defined in the UM Policy Statement for the  
Use of Human Subjects in Research as amended in the memorandum of  
December 28, 1978, to your department.

has been conditionally approved and the conditions imposed by the Board  
are:

has not been approved in its present form. The Board suggests that you:

cc: William W. Wilmot, Department of Interpersonal Communication

H. Richard Fevold, Chair  
H.R. Fevold, Chairman

NOTE: It is mandatory that you report immediately to the IRB:  
1. Changes in procedures,  
2. Unanticipated problems,  
3. Adverse reactions of, or effects on, subjects.

## APPENDIX F

REQUEST FOR PERMISSION FROM THE COORDINATOR  
OF THE BASIC COURSE AND FROM THE  
GRADUATE TEACHING ASSISTANTS TO COLLECE DATA

REQUEST FOR PERMISSION FROM THE COORDINATOR  
OF THE BASIC COURSE AND FROM THE  
GRADUATE TEACHING ASSISTANTS TO COLLECT DATA

TO COORDINATOR OF THE BASIC COURSE AND ALL GTAs:

I'd like to request your permission to be present on the first day of your Introduction to Public Speaking class and give the students a ten-minute test for my thesis research. I will explain the test to the students.

Thank you very much,

Diane B. Foley

APPENDIX G

RESEARCHER'S INSTRUCTIONS TO STUDENTS  
AT PRETEST ON HOW TO TAKE THE PRCA-24

RESEARCHER'S INSTRUCTIONS TO STUDENTS  
AT PRETEST ON HOW TO TAKE THE PRCA-24

"Hi. I'm Diane Foley and I'd appreciate it if you would answer how you feel on 24 different items about communication with other people. There are no right or wrong answers. In order to assure the usefulness of your answers you are asked to be totally honest. Do not ponder each item, but respond with your initial impression. Check to make certain you have answered each item.

This is voluntary on your part and will be used for my thesis. I'd certainly appreciate it if you would answer. Results will be available in the Communication department for those who are interested.

First I'm going to pass out pencils and scantrons to you. Some of you may be familiar with scantron answer sheets, and some of you may be new students and not familiar, so I'll review how to use scantrons. Don't use anything except the pencils I pass out to mark your answers, and I'll need to have these #2 pencils back . . . .

Does everyone have one of the pencils I handed out (hold one up) and a scantron (hold one up)? If you don't, raise your hands and I'll see that you get one . . . .  
Now write your name and the subject, Introduction to Public Speaking, the date and the hour of your class in the places

that are indicated.

Now notice the top of your scantron. (Hold one up and point as I explain.) There is a square box with numbers in it, and on the right side of the box there are ten little empty boxes up and down. This is where you write your student I. D. number, which is the same as your social security number. Starting at the top in the empty boxes, you write your number and do not leave any spaces . . . . After you write your number, you fill in the appropriate box to the left of the number until you've matched all the numbers in your student I. D. number. If a number is larger than five, fill in the five plus the digit needed to add up to the desired number. For instance, if your number starts with 516, when you come to "6," fill in the "five" and the "one" on the same line. Any questions?

When I pass out the scantrons, please indicate in the appropriate space on the scantron the degree to which each statement applies to you by marking whether you (also show them on the blackboard): A - strongly agree; B - agree; C - are undecided; D - disagree, or E - strongly disagree.

Now I'll pass out the questions . . . are there any questions? When you've finished, I'd like to have the questions, pencils and scantrons back." (Stay till they are all finished. Then collect and thank them.)

APPENDIX H

SCANTRON FORM USED FOR PRE- AND POST-TESTS

SCANTRON FORM USED FOR PRE- AND POST-TESTS

	c:1:	c:2:	c:3:	c:4:	c:5:	c:0:	
	c:1:	c:2:	c:3:	c:4:	c:5:	c:0:	
	c:1:	c:2:	c:3:	c:4:	c:5:	c:0:	
	c:1:	c:2:	c:3:	c:4:	c:5:	c:0:	
	c:1:	c:2:	c:3:	c:4:	c:5:	c:0:	
	c:1:	c:2:	c:3:	c:4:	c:5:	c:0:	
	c:1:	c:2:	c:3:	c:4:	c:5:	c:0:	
	c:1:	c:2:	c:3:	c:4:	c:5:	c:0:	
	c:1:	c:2:	c:3:	c:4:	c:5:	c:0:	

**PART I**

CODE I.D. NUMBER AT LEFT BY FILLING IN THE APPROPRIATE BOXES. IF A NUMBER IS LARGER THAN 9, FILL IN 6 PLUS THE DIGIT NEEDED TO ADD UP TO THE DESIRED NUMBER.

WRITE I.D. NUMBER HERE

**KEY**

EXAMPLE

IMPORTANT

- USE #2 PENCIL
- EXAMPLE: A B C D E
- ERASE COMPLETELY TO CHANGE

NAME \_\_\_\_\_

SUBJECT \_\_\_\_\_

DATE \_\_\_\_\_

HOUR \_\_\_\_\_

FEED THIS DIRECTION

WRONG

(T)	(F)	KEY
1	A B C D E	
2	A B C D E	
3	A B C D E	
4	A B C D E	
5	A B C D E	
6	A B C D E	
7	A B C D E	
8	A B C D E	
9	A B C D E	
10	A B C D E	
11	A B C D E	
12	A B C D E	
13	A B C D E	
14	A B C D E	
15	A B C D E	
16	A B C D E	
17	A B C D E	
18	A B C D E	
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24	A B C D E	
25	A B C D E	
26	A B C D E	
27	A B C D E	
28	A B C D E	
29	A B C D E	
30	A B C D E	
31	A B C D E	
32	A B C D E	
33	A B C D E	
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35	A B C D E	
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41	A B C D E	
42	A B C D E	
43	A B C D E	
44	A B C D E	
45	A B C D E	
46	A B C D E	
47	A B C D E	
48	A B C D E	
49	A B C D E	
50	A B C D E	



## APPENDIX I

RESEARCHER'S STATEMENT AT FIRST CONTACT WITH SUBJECTS  
IN AUTOGENIC TECHNIQUE AND POSITIVE SUGGESTIONS  
GROUPS INFORMING THEM OF TREATMENT PROGRAM

RESEARCHER'S STATEMENT AT FIRST CONTACT WITH SUBJECTS  
IN AUTOGENIC TECHNIQUE AND POSITIVE SUGGESTIONS  
GROUPS INFORMING THEM OF TREATMENT PROGRAM

With the advice of Dr. William Wilmot, Dr. Marshall Prisbell and Dr. John Watkins, I, Diane B. Foley, am offering a free treatment program for speech anxiety. Some people had scores on self-reports indicating that they could profit from the treatment which may help reduce anxiety about speaking.

Assignments consist of attending three 5-10 minute sessions which are based on extensive research in communication and stress, and there are no formal reading assignments or written work. Evaluations from previous research demonstrates that this program may be helpful in reducing anxiety.

Results will be used for my thesis to evaluate effectiveness of the program.

The treatment program is scheduled at the following times:

If you are interested, please sign the included sheet (release form) and return to me or your teacher.

Thank you,

Diane B. Foley

APPENDIX J  
RELEASE FORM

## RELEASE FORM

I hereby agree to participate in this research.  
I understand that the questionnaires I fill out will be used for research purposes only and will not be made available to anyone other than the researcher without my written consent.

I further understand that at no time will my name be directly associated to these questionnaires but will be identified only by a code number for the maintenance on my anonymity.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Volunteer's Signature

\_\_\_\_\_  
Researcher's Signature

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