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A study of the effectiveness of an assertiveness training program on a group of elderly serious and persistent mentally ill

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A STUDY OF THE EFFECTIVENESS OF AN ASSERTIVENESS TRAINING PROGRAM ON A GROUP OF ELDERLY SERIOUS AND PERSISTENT MENTALLY ILL

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ABSTRACT

A STUDY OF THE EFFECTIVENESS OF AN ASSERTIVENESS TRAINING PROGRAM ON A GROUP OF ELDERLY SERIOUS AND PERSISTENT MENTALLY ILL

by Normandy Lynn Blazek Jencks

The impairments of serious and persistent mentally ill elderly manifest in decreased functioning in three or more primary living skills and prevent their economic self-sufficiency (Goldman, 1983). The purpose of this study was to measure the effect of an eight week assertiveness training program on this population to aid clinicians in selecting appropriate therapies.

The quasiexperimental design used the Modified Rathus Assertiveness Schedule as a pretest and posttest with an intervening eight week educational program of assertiveness training. The once a week program was conducted by a registered nurse with eleven elderly serious and persistent mentally ill living in the community. A dependent t - test was applied to the difference in the mean scores of the pretests and posttests. The participants developed more assertiveness but not to a significant degree on the written test; they developed observable improvements in their assertiveness skills.

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Chapter 1

INTRODUCTION

Serious and persistent mentally ill elderly people of our communities continue to function only marginally within our society. They may interact superficially and inappropriately in many situations. Their psychiatric impairments can include thought disorder, speech incoherence, delusions, hallucinations, anxiety, depression, loss of concentration or memory, distractibility, apathy and anhedonia (Anthony & Liberman, 1986).

These impairments can lead to significant disability. Unemployment is as high as 70 percent in the serious and persistent mentally ill (Goldstrom & Manderscheid, 1982). They have difficulties in work tolerance, endurance, following instruction, cooperating with co-workers and supervisors, problem solving, task orientation, sustained concentration, and the ability to accept criticism and ask for assistance (Anthony & Liberman, 1986).

While employment may not be a great concern of the elderly, illness can have severe consequences for their daily activities. Anthony and Liberman (1986) state, "Disabilities include poor self-care skill (e.g., cooking, cleaning, grooming, and teeth care), social withdrawal and seclusiveness, abandonment of family responsibilities, and work incapacity" (p. 548). Arthur (1989) states, "The fact is that many chronic mental patients are unable to perform some of the most simple tasks of living. These lacunae can include an absolute or relative inability to initiate conversations, to carry out self-care and grooming, to develop and maintain friendships, to look for a job, and myriad other skills" (p. ix).

Krauss and Slavinsky (1982) identify two needs of the serious and persistent mentally ill as (a) a need for social interaction and (b) a need for hope. The lack of social interaction results in a lack of social skills in serious and persistent mentally ill people. According to Liberman, DeRisi and Mueser (1989), their difficulties are attributed to four factors which are, (a) mentally ill people never learned to express their emotions because they were not exposed to appropriate role models, (b) the onset of psychiatric illness is often accompanied by and reflected in a severe deterioration in the patients' social functioning, (c) environmental stressors such as personal traumas and losses often impair cognitive processing which, in turn, interferes with patients' reactivity, preventing them from being socially effective, and (d) a patients' social environment can change so that previously used social skills are ineffective, rendering the person powerless to employ these behaviors. This constellation of deficits degrades the entire life of a serious and persistent mentally ill person. Their lack of social skills isolates them more and prevents the social interaction which they need in order to develop social skills.

These disabilities affect a significant portion of the population of the United States. According to Graves, in the National Center for Health Statistics, psychiatric hospitals and community mental health centers treated over 2,000 people per 100,000 population on an outpatient basis in 1986. The inpatients of all state, county, private, general and Veterans Administration hospitals in 1986 were 111.8 per 100,000 population according to the National Center for Health Statistics, 1988. These figures reflect all ages and psychiatric conditions.

Older Americans have a higher rate of diagnosis of mental disorders than younger people. When only the population of 65 years and older is considered, in 1987 mental disorders constituted 883 diagnoses per 100,000 population. The days of care for inpatients 65 years and older with mental disorders were 11,451 for 100,000 population in 1987 in comparison to the average of 9,056. The average length of stay for inpatients 65 years and older in 1987 was 13 days vs. the average of 12.3 days. These disabilities affect a significant portion of the population of the United States (Graves, 1989).

The President's Commission on Mental Health (1978) estimated that approximately 2,000,000 people in the U.S. can be diagnosed as schizophenic. Psychotic illness in the elderly is estimated to affect a total that ranges between 600,000 and 1,250,000 people (Goldman, Gattozzi, & Taube, 1981). The results are, according to Goldman (1983), "We estimated the population of the chronically mentally ill to range in size from 1,700,000 to 2,400,000 Americans, including 900,000 who are uninstitutionalized" (p. 37).

Problem

The treatment of the serious and persistent mentally ill has had little success. Mosher and Keith (1980) report, "Unfortunately, there is as yet relatively little research evidence documenting the efficacy of specific psychosocial treatments with schizophrenic patients" (p. 127). Arthur (1989) supports this position, "When one turns to the actual care of seriously disabled patients with mental disorders - exemplified, above all, by those suffering with schizophrenia - we encounter a paucity of methods for helping them acquire social and living skills" (p. ix).

The mental health professions have been treating this population of serious and persistent mentally ill with a variety of techniques. With drug

therapy and appropriate social support, the persistent mentally ill can be maintained outside of a hospital environment (Stein & Test, 1985). Their needs for food, shelter, and clothing can be provided along with medical and psychiatric treatment. Often the treatments are minimal because of the lack of funds and the policy and philosophy of deinstitutionalization.

The pressures to find more appropriate treatments for serious and persistent mentally ill people has changed psychotherapy techniques. Traditional psychotherapy within a hospital setting has given way to therapies based more on social support in the community: group therapy, behavior modification, and family therapy. Mosher and Keith (1980) outline six wide categories of social support treatment for people with schizophrenia as individual, group, family psychotherapy, community support systems, milieu therapy and social skills training. They explain that each of these therapies are used with some success when applied to a very tightly defined population. Consequently, professionals continue to test therapies for appropriate application to a set of patients with a specific diagnosis.

New ideas in this area directed researchers and clinicians to treatment modalities based more on behavior therapy and social skills training. O'Neill and Gardner (1983) define behavior therapy as "interventions based on principles of learning, including those derived from operant conditioning, classical conditioning, and social learning theory" (p. 709). Kasdin and Wilson (1978) further define behavior therapy as "the application of principles derived from experimental psychology for the alleviation of human suffering and the enhancement of human functioning" (p. 46). Behavior therapy and social skills training are not

theoretical frameworks. They do define a practice of changing patients' actions through retraining without a detailed analysis of the patients history or pathologic state.

The program of behavior therapy or social skills training must contain certain elements to be successful. O'Neill and Gardner (1983) outline characteristics of successful behavior therapy such as: therapeutic experiences which provide opportunities to learn adaptive or prosocial behavior, treatment which is clearly defined and monitored and the development of overt patient behavior. Additional elements are conformity to the age and functioning of the subjects in language and mental state, a long period of time (18 months) in which the mentally ill are involved with the program on a weekly basis, and active involvement by the participants with the therapist and other members of the group.

One of the techniques of behavior therapy or social skills training is assertiveness training. Assertiveness training attempts to improve a mentally ill person's functioning by increasing their appropriate social skills. The treatment emphasizes gaining communication skills through education. Liberman, et al. (1989) state, "As a broad-spectrum behavioral therapy, social skills training is an effective means of teaching patients from varied walks of life and educational backgrounds the emotionally expressive and interpersonal skills necessary for community adaptation" (p. xiii). O'Neill and Gardner (1983) agree by concluding, "Behavior therapy can be an effective therapy and ... is particularly useful in the treatment of definable conditions" (p. 714).

Liberman, DeRisi and Mueser (1989) have developed a program that utilizes roleplaying in assertiveness training. Their work, Social Skills

Training for Psychiatric Patients, clearly and specifically guides a therapist through steps in the process of assertiveness training. Emphasizing the use of skills, the authors focus on the behavior of the patient, allowing him/her ample practice in changing his/her behavior. The social skills therapist in this program provides information, demands performance from the patient, gives feedback on the performance, redirects the performance and reinforces successful assertive behavior. The program is divided into clear lessons with procedures that are highly structured and concrete yet they apply to many different patients, therapists, and treatment areas. The study under consideration will utilize a program of assertiveness training following the program outlined by Liberman, DeRisi, and Mueser.

Purpose

The purpose of this study is to measure the effect of an eight week assertiveness training program on a group of elderly serious and persistent mentally ill. The results can aid clinicians in selecting an appropriate therapy for their clients. The proposition of this study is that an increase in assertiveness training will increase the patients' social skills, their functioning in society and the quality of their lives. Additionally, the subjects will benefit because the increased assertiveness skills are congruent with Jeger and Slotnick's (1982) behavioral-ecological interventions for mental health. That is, the training seeks to optimize human development by enhancing the individuals' coping and mastery skills which increase self-efficacy and self-esteem thus, the quality of life is improved.

Most of the clients live in board and care homes throughout the city of San Jose, California and are in need of outside activities which provide socialization or the potential to increase socialization. One of the effects of the assertiveness training (social skills training) is an increase in socialization; therefore, these clients will receive direct personal benefits.

The benefits beyond this group lie in the need for specific outcome research tied to specific strategies for teaching assertiveness to this population. The review of the literature in this area (Wallace, Nelson, Liberman, Aitchison, Lukoff, Elder, & Ferris, 1980) indicates the need for operational definitions and measurable outcomes.

Hypothesis

An eight week program of assertiveness training for serious and persistent mentally ill elderly clients will significantly increase their assertiveness as measured by the Modified Rathus Assertiveness Schedule (Appendix A).

Definitions

For the purpose of this study, the following definitions apply:

1. Assertiveness is the total raw score on the Modified Rathus Assertiveness Schedule (Appendix A).

2. Assertiveness training is a program of social skills training used to increase assertiveness designed by the researcher (Appendix B). The training is based on the program by Liberman, DeRisi, and Mueser in Social Skills Training for Psychiatric Patients.

3. Behavior therapy has been defined as interventions for the alleviation of suffering and the enhancement of functioning which are

based on learning principles, operant conditioning, classical conditioning and social learning theory.

4. Elderly describes any person in this study 55 years of age or older.

5. Serious and persistent mentally ill includes those persons with organic brain syndrome, depressive and manic-depressive disorders, paranoid and other chronic psychoses. This includes patients who suffer organic brain syndrome, schizophrenia, recurrent depressive, or manic-depressive disorders that prevent function in three or more primary living skills and that prevent their economic self-sufficiency (Goldman, 1983). The primary skills of daily life are, personal hygiene and self care, self direction, interpersonal relationships, social transactions, learning, and recreation (Goldman, 1983).

6. Social skills are a variety of communication skills which are used in any successful social encounter to communicate our emotions and needs accurately. Individuals who appropriately use social skills can receive information, process it and successfully use verbal and nonverbal expressions to achieve interpersonal goals.

Design

The quasiexperimental design using a pretest and posttest format commenced by selecting a group of elderly serious and persistent mentally ill people. The participant's consents were obtained along with demographic information. A pretest using the Modified Rathus Assertiveness Schedule (Appendix A) was administered during an interview. An eight week program of assertiveness training (Appendix B) was administered and the participants were posttested after the training was finished. The difference in the measures of the pretest and posttests

was computed and a t - test was applied to the difference in the mean scores of the pretest and the posttest. The researcher also gathered observational data of participants' behavior during the training sessions.

The purpose of the design was to determine if the manipulation of the independent variable (the program of instruction) had an effect on the dependent variable (the participants' responses on the Modified Rathus Assertiveness Schedule). The advantages of this design are its appropriate application to the hypothesis, and its feasibility of implementation. The disadvantages of this particular design are (a) selection of the population based on their association with a club rather than a random sample, (b) possible improvement in test scores as the participants learn from the pretesting, (c) attrition of the participants or their refusal to participate in the study based upon their usual reticence, (d) lack of sufficient time to measure the effect of the training, and (e) the interactive effects of the group processes and specific training.

The research participants were a group of elderly community-based serious and persistent mentally ill. Most participants were maintained with medications and lived in board and care homes. The sample size consisted of three men and eight women over 54 years of age. One man and five women were aged 55 to 64, two men and three women were 65 years and older. The study was conducted with these elderly serious and persistent mentally ill when they gathered at their usual meeting place, a friendship club, which met once a week at a non-profit facility.

The facility is run by volunteers who are mental health professionals. The setting is unique as it is a voluntary club of community-based elderly serious and persistent mentally ill most of whom have continued to meet

after their release from the state hospital in the 1960's. The strength of using these club members is their familiarity in this setting and their accessability for study. The limitation of this setting is the selection of the subjects for the study based on their association with the club, previous exposure to assertiveness training, and lack of randomization.

Assumptions

In undertaking this research, the following assumptions have been made:

1. The subjects have a deficit in assertive behavior before the pretest.
2. The assertiveness deficit can be remedied with instruction.
3. The learned assertiveness is evident immediately upon completion of the program.

Furthermore, this study assumes that chronic mental illness, as with chronic physical illness, requires care because there is no cure. Moreover, this study assumes that long-term care may not achieve high levels of rehabilitation and social functioning but may increase the quality of life by focusing on a holistic perspective of physical, mental, and social well-being. Lastly, there is an assumption that psychosocial interventions which emphasize continuing education efforts that build on the person's personal capacities are a benefit.

The social skills training outlined by Liberman, et al. (1989) and the tool, the Modified Rathus Assertiveness Schedule provide both the implementation and measurement tool for the proposed project. The results, while limited to a small group, will add to the body of knowledge. Improving the social skills of this population through assertiveness

training has the potential of conserving their social integrity through improved relationships with others.

Chapter 2

CONCEPTUAL FRAMEWORK AND RELATED LITERATURE

Behavioral Ecology and Community Mental Health

Jeger and Slotnick (1982) present a perspective of community mental health that emphasizes the interdependence of people, behavior, and their sociophysical environments. The behavioral approach derives from the psychology of learning of individuals, and the ecological approach encompasses the studies of social systems and the individual's environment. This combined approach focuses on individual behavior while taking into account the larger society. Certain values are promoted by the behavioral-ecological perspective: promoting individual competence, enhancing the psychological sense of community, and supporting cultural diversity. These values are a natural consequence of the dual foci of behavioral-ecology.

Behavioral-ecology attributes mental health problems to maladaptive transactions between individuals and their settings, rather than to causes exclusively within individuals or environments. Both the social and physical aspects of the environment are considered. The focus is on natural settings, and the reciprocal processes between people and their environments. Behavioral-ecology links individuals and their environments as an integrated whole, with all parts interdependent. A change in any part of the transactional unit influences change in other parts. The idea of a person and environmental congruence is more appropriate than a "good-bad" person or environment. Behavioral-ecology is concerned with maximizing fit and reducing discord between people and their environments. This integration of behavior and ecology emphasizes

the capacities of individuals to design their environments. Individual behavior becomes a dynamic interplay of person and environment.

The behavioral-ecology conceptual framework is an evolving orientation that utilizes a set of assumptions, principles and values, rather than a single theory or set of methods. It represents a perspective on people and their environment to guide the development of community mental health interventions. Behavioral-ecology focuses on the individual in the broader social context by drawing from both approaches which developed independently of each other and merge in this framework to advance community mental health theory, research and practice. The behavioral-ecological perspective holds much promise to overcome some of the problems in community mental health practice.

The behavioral-ecological perspective of community mental health is appropriate for the research under discussion because it includes the need for a congruence of person and environment, its goals are stated in behavioral terms and it is useful in planning implementation of future educational programs. The specific educational program applied in this research used the behavioral-ecological model in its consideration of the patients' needs within their social and physical environments.

A major feature of behavioral-ecology is its focus on overt behavior. Behavior is learned through experience with the environment and one of the ways that it occurs is through modeling or imitation (Krasner, 1971). Behavioral therapy approaches view mental health problems as maladaptive behaviors acquired through learning. The learning processes which create both normal and maladaptive behavior are behavioral - conditioning, observational learning (modeling and imitation), and

cognitive learning. The educational strategy of behavior modification uses the situation or environment as a tool in teaching new behaviors. The continuing focus on overt behavior incorporates the evaluation of behaviors while the instruction proceeds. This emphasis demands that the mental health goals be defined in measurable, i.e. behavioral, terms.

The goal in a behavioral framework is to unlearn maladaptive habits and acquire adaptive responses. Anthony and Liberman (1986) define the desired results of psychiatric rehabilitation, "The overall goal of psychiatric rehabilitation is to assure that the person with a psychiatric disability can perform those physical, emotional, social, and intellectual skills needed to live, learn, and work in the community, with the least amount of support necessary from agents of the helping professions" (p. 542). The goal is educational, and is implemented with the same learning principles that created the maladaptive responses. The focus is to change the behavior through training to develop social skills so that the individual becomes more competent in exchanges with other people and the environment.

Adaptation is the way people cope with the environmental stressors that they encounter and create. Behavioral-ecology considers individual competence (behavioral skills), which may be required to engage in adaptive responses to environmental stress. Jeger and Slotnick (1982) base the learning of these skills in an individual's process of adaptation to the environment, "Thus a concern with effective adaptation, rather than just maladjustment or pathology, is a defining attribute of behavioral-ecology" (p. 11).

Nursing Conceptual Framework

Adaptation was addressed in 1969 by M.E. Levine when she published her defining work, Introduction to Clinical Nursing. While writing an introductory nursing text, she also created a conceptual framework based upon an individual's adaptation to an environment and conservation of that individual's integrity. Levine (1969) states:

> Adaptation is the process of change whereby the individual retains his integrity within the realities of his environments. Adaptation is basic to survival, and it is an expression of the integration of the entire organism. The measure of effective adaptation is compatibility with life (pp. 9-10).

Levine sees the nurse using the nursing process as a critical component in a patient's adaptation to his environment. She asserts that, "The nurse participates actively in every patient's environment, and much of what she does supports his adaptations as he struggles in the predicament of illness. Nursing intervention means that the nurse interposes her skill and knowledge into the course of events that affects the patient" (p. 10). Thus, the nursing process must be founded on recognition of the individual's response which indicates the nature of the adaptation taking place. The nurse must learn to read the message from the patient first, interpret it correctly, decide on an intervention which is designed so that it fosters successful adaptation, and implement the intervention. This application of the nursing process is designed to support the patient's ongoing process of adaptation.

Levine (1969) further explains her adaptation model and conceptual framework by describing the principles upon which it is based:

> Nursing principles are all "conservation" principles. Conservation means "to keep together"....to maintain a proper balance between active nursing intervention coupled with patient participation on the

> one hand and the safe limits of the patient's ability to participate on the other (pp. 10-11).

Levine outlines four conservation principles which have as a postulate the unity and integrity of the individual, recognizing that every response to every environmental stimulus results from the integrated and unified nature of the human organism. Levine asserts that the four conservation principles of nursing are the conservation of patient energy, structural integrity, personal integrity, and social integrity (p. 10).

The fourth conservation principle of nursing (the conservation of social integrity) is most relevant to this study as it bases nursing intervention on the patient's social needs. The educational process is, foremost, a social one in which the participants are absorbing information, changing their attitudes, and, in this assertiveness training program, testing new behaviors. Their newly modified behaviors will enable the subjects to maintain and enhance their social relationships and conserve their social integrity.

The implementation of the principle of conservation of social integrity is supported by the behavioral-ecological framework of community mental health. The behavioral-ecological mental health interventions seek to improve the quality of life through social means. Jeger and Slotnick (1982) state, "...behavioral-ecological interventions seek to optimize human development by enhancing individuals' coping and mastery skills to increase self-efficacy and self-esteem and/or by enhancing organizational and community strengths" (p. 12). They explain that interventions can be directed toward changing individuals, changing environments, or system wide changes. Individual-level interventions include behavioral skill

training and personal problem-solving training which includes assertiveness training.

A major goal of individual interventions in the behavioral-ecological model is the enhancement of personal competence. Behavioral-ecological interventions seek to strengthen an individual's coping skills through training in social skills, assertiveness, problem solving, and anxiety reduction. Jeger and Slotnick state (1982):

> Individual-level community mental health interventions should aim to provide learning opportunities to consumers that will increase their ability to influence their environments (i.e., promote competence). Behavioral training to facilitate coping with stress, developing social skills, and improving general problem-solving capacities are compatible with this value (p. 11).

Literature Review

Behavioral Approaches

The mental health literature contains many studies of behavioral modification or social skills training with a geriatric population. The literature narrows considerably when the focus includes serious and persistent mentally ill elderly. Johnson and Fredericksen (1983) studied 250 elderly residents of a state mental institution. They conducted "reality orientation groups" which increased the rate of process behavior but had no effect on intended outcomes. Geriatric patients suffering from organic brain syndrome participated in a behavioral training program to improve self-care skills by McEvoy and Patterson (1984). The patients were divided into three groups from mild to severe dementia which stratified the results. The study suggests that patients with mild to moderate dementia are capable of modest rehabilitation of self-care skills. In a study on an adult chronic schizophrenic with an additional diagnosis of mild to moderate

retardation, Jackson and Martin (1983) found that the patient gained functional control over behaviors after social skills training. Teri (1983) reviewed five studies which had in common the emphasis on social learning and a skills building approach to treating depression in a variety of different age groups. The conclusions of the studies were that these treatments have a wide range of applications for both the elderly and patients with mild mood disorders and severe depression. Socially isolated, impaired elderly residents of nursing homes improved their conversational skills after a comprehensive program by Praderas and MacDonald (1986). The findings of all the studies of serious and persistent mentally ill are that regardless of the treatment nomenclature (behavior modification, social skills training, or communication skills training) the therapy has some positive effect. A few of the studies such as Jackson and Martin, (1983), McEvoy and Patterson, (1984), and Nirenberg, (1983), seem to reflect weak positive results, but all reported that they were effective.

Several studies have compared the efficiency of different modes of behavior modification in older, impaired adults. Marin and Azrin (1988) successfully treated 27 elderly insomniacs with behavioral and cognitive techniques which were equally effective in improving sleep times. Steuer (1984) tested cognitive behavioral versus psychodynamic modes of treatment on depressed geriatric patients and found significant reductions in depression and anxiety using both modes. In a behavioral skills program and coping skills program for nursing home residents, aged 37 - 88 years, Nirenberg (1983) found positive changes with the behavioral but not the coping skills program. While these behavior modification studies use

different names for the therapies such as social skills training or coping skills training, they all contain elements of assertiveness training.

Research on assertiveness training alone contains reports of successes in changing behavior with assertiveness training. One study (McFall & Twentymen, 1973) reported unequivocal transfer of assertiveness while Valario and Stone (1982) concluded that assertiveness training results in long term changes in behavior.

Researchers and clinicians have not been able to decide on a single procedure for assertiveness training but use a wide variety of treatment techniques. Many studies are being done on the effect of training without producing a structure of training. This situation leaves a therapist freedom to choose a technique that may not be identified for use with the population. A second focus of change involves the difficulty in determining the specific behaviors involved in being assertive. The definition of the concept of assertiveness is a key issue limiting teaching and research. The third focus is the difficulty in finding laboratory measures of assertive behavior. There are many measures of assertiveness being used, possibly measuring different aspects of assertiveness.

Research studies have indicated positive effects of assertiveness training for a variety of psychiatric populations, however, few studies researched only assertiveness training alone on elderly subjects. A study (Franzke, 1987) of 84 normal adults aged over 65 years tested the effects of a six week course on assertiveness training. Experimental and control subjects were administered an assertiveness scale and self-acceptance scale before and after the program of training. Findings show that the teaching of assertion was effective but did not change self-concept. In the

only other study of assertiveness training in the elderly (Gendron, Paitras, Engels, & Dastoor, 1986), the program consisted of not only assertiveness but problem solving and stress reduction techniques. The twelve subjects were, ironically, the family supporters or caretakers of elderly demented patients, and therefore, normal subjects. The caretakers (aged 45 to 83 years) received eight weekly sessions of "supporter endurance training" which allowed them to increase the amount of time they were able to cope with problems in caring for their disabled relative.

Both the Franzke (1987) and Gendron et al. (1986) studies of assertiveness training in the elderly contain normal research subjects, leaving a gap in the studies of assertiveness training in serious and persistent mentally ill elderly. Research studies have indicated positive effects of assertiveness training for a variety of psychiatric populations, which creates a demand for a study employing uncontaminated assertiveness training on elderly persons with serious and persistent mental illness.

The behavioral-ecological perspective of community mental health provided the framework for a pilot project for a nurse-managed health center in conjunction with a state-run university (Connolly, 1991). One of the components of the program included assertiveness training sessions. Eight weekly assertiveness training groups were held each semester at varying sites. Approximately eight to fifteen clients and two to four students attended. Positive change was evident and reported by the clients and the staff. Because of limited resources and rapid client turnover, no pre- or posttesting of assertiveness was done. The research under discussion attempts to further this useful work by demonstrating the

effectiveness of assertiveness training with a stable population exposed to weekly assertiveness training sessions.

Assertiveness Training

History

Assertiveness training was founded within the general framework of behavior therapy. Assertiveness was defined by Chittenden (1942) as any overt attempt to influence the behavior of another. The first to consider the concept of assertiveness as a worthwhile therapeutic technique was Salter (1949). Many of the theories and procedures of assertiveness training are based on his book, Conditioned Reflex Therapy. His six "excitatory reflexes" were early descriptions of assertive behavior which he advocated use of for virtually every psychiatric disorder. Salter's model involved a relearning process which changes excitatory behavior resulting in freedom of excitatory feelings and a corresponding decrease in inhibitory actions and feelings.

The early work of Wolpe (1958) opened up new areas of research correlating nonassertive behavior with anxiety. Assertiveness training, according to Wolpe, is a protection for anxiety. Wolpe added to the definition of assertive behaviors as the expression of friendly, affectionate, and other non-anxious feelings.

Literature in the 1940's and 1950's continued to group assertive behaviors in the general category of socially aggressive behaviors. The failure of Salter to distinguish between assertion and aggression is evident in his statement, "The basis of life is excitation. The creatures that survive in the jungle are those that slink and jump and kill" (p. 100). Alberti and Emmons (1970) differentiated assertive behavior from aggressive behavior

by declaring it, "Behavior which enables a person to act in his (her) own best interests, to stand up for himself (herself) without undue anxiety, to express his (her) own rights without denying the rights of others" (p. 22).

Assertiveness training today is based on many theories including behavioral theory and social learning theory. It has integrated popular movements in the last few decades such as the changing role of women and the thrust for universal human rights. Because of the diversity of contributions to assertiveness training, the development of training techniques and the practice of assertiveness training has outdistanced the growth of theory. Wolpe (1969) characterized assertiveness training as a counterconditioning for anxiety in the process of creating techniques of training. He developed, along with Lazarus (1971), therapies involving role-playing or rehearsing of various responses in therapy to explore insufficient behavior. While calling it "behavior therapy," both men specified procedures to modify nonassertive behavior. Wolpe suggested that psychodrama, later to be called behavior rehearsal, would help patients who find the practice of assertive behavior in their everyday interactions to be unusually difficult. Alberti and Emmons (1970) popularized the procedures of assertiveness training as a technique which aids people in gaining their "human rights."

Many other clinicians have contributed training techniques. The practices and procedures of assertiveness training have broadened, according to Shoemaker and Satterfield (1977), to include, "role-playing, psychodrama, behavior rehearsal, guided practice, role-reversal, mirroring, modeling, audio-video or verbal feedback, token feedback, flooding, desensitization, covert practice, coaching, self-management,

homework, contracting, non-verbal exercises, value clarification exercises, self-disclosure, small group discussion, group assignments, field trips, films and selected readings" (p. 50). Behavior rehearsal has also been called behavioristic psychodrama, role playing, and playacting.

Components of Assertiveness Training

The diversity of techniques has generated need for clarity. Rich and Schroeder (1976) have separated the procedures into five categories: (a) response acquisition, (modeling, instruction); (b) response reproduction (behavior rehearsal, role playing); (c) response shaping (audio-visual playback, coaching, group reinforcement); (d) cognitive restructuring (providing rationale of the process of assertiveness); and (e) response transfer (homework, diary). The findings of Rich and Schroeder suggest that all five techniques can be successfully used in a program of assertiveness training. The key elements of technique are identified by Alberti (1977) as (a) skills training (behaviors are taught, practiced, and integrated into behavior), (b) anxiety reduction (desensitization or counter-conditioning), or (c) cognitive restructuring (values, beliefs and attitudes changed by insight, exhortation or behavioral achievements). Each of these systems include all of the techniques of assertiveness training.

In 1966 Lazarus introduced the term behavioral rehearsal to describe a combination of modeling and role playing aimed at increasing patients' assertive behavior. The prototype for role playing was developed by McFall and Marston (1970) who had their subjects respond to taped interpersonal situations in which an assertive response could be appropriate. Verbal and nonverbal behaviors could be assessed, changed, and replayed. Roleplaying

aims to replace inadequate social responses with adapted behavior through practice in safe and comfortable situations.

The interrelationship of behavior and self-acceptance is explained by Alberti and Emmons in their 1970 publication, Your Perfect Right: A Guide to Assertive Behavior. The authors clearly differentiate nonassertive, assertive and aggressive behavior with excellent case studies. Their work provides a rationale and motivation for using assertive behaviors, particularly in the descriptions of the results of nonassertive and aggressive behaviors. The emphasis, as explained by the authors, is on the humanistic and holistic approach to behavior modification through assertiveness training.

The methods that Alberti and Emmons describe to enhance assertiveness are generated by Salter's linkage of a person's feelings and actions. Salter (1949) states, "To change the way a person feels and thinks about himself, we must change the way he acts toward others" (p. 100). His relearning process involves repeated "excitatory" behavior which results in a new freedom of thinking and feeling which creates further behavior change in the subject. This linkage of action and feelings continues in Wolpe and Lazarus' correlation of anxiety, a feeling, with nonassertive behavior. Their concept of "reciprocal inhibition" is that an individual can unlearn anxiety through pairing of anxiety-evoking and anxiety-inhibiting responses. Repeated confrontations of responses such as assertion paired with an anxiety-inducing stimulus can reduce anxiety and stimulate further assertions. "....for the conquest of anxiety depends on the occurrence of overt acts of assertion; and the development of the assertive

patterns is determined by the consequences of individual acts of assertion", (Wolpe & Lazarus, 1966, p. 43).

Alberti and Emmons rely heavily on Salter's and on Wolpe's theories while expanding them with a behavioral-humanistic value system. The concept of assertiveness as a contributor to self-esteem and, therefore, feelings is an integral part of their contribution. They hypothesize that the assertive individual is more likely to achieve desired goals since he is more expressive and able to make choices. Alberti and Emmons (1978) explain, "In the case of a non-assertive response in a given situation, the actor is typically denying self, and is inhibited from expressing actual feelings. Often allowing others to choose for him or her, this person seldom achieves his or her own desired goals" (p. 11). With success in achievements, the assertive person feels good about himself which reinforces the assertive behavior. The focus of this process is that the change in behavior occurs first through a process of education, then the individual's feelings change in response to the successes in attaining goals which reinforces the behavior. Wolpe and Lazarus add (1966), "....an additional consequence of assertive training is a changed self concept" (p.47). Alberti and Emmons concur with Wolpe and Lazarus, stating, "Developing the ability to stand up for yourself and do things on your own initiative, can reduce appreciably anxiety or tenseness in key situations, and increase your sense of worth as a person" (1978, p. 2).

A colleague of Alberti and Emmons, Lawrence Percell (1977) follows the Alberti-Emmons theory with, "A corollary to the assumption under discussion is that it is relatively easier to help someone act him or herself into a new way of thinking or feeling than it is to think or feel him or herself

into a new way of acting. Hence, the behavior therapist focuses on changing behavior, expecting the change in attitudes, beliefs and affect to follow" (p. 61).

The Alberti and Emmons model differs in four aspects from the Salter and Wolpe concepts. The major Alberti-Emmons contributions have been (1) to add a humanistic approach to the behavioral treatment approach of assertiveness training, (2) to develop more systematic assertiveness training procedures, (3) to expand the boundaries of human rights by including the expression of positive and caring feelings, and (4) to advocate ethical responsibility and standards for professional assertiveness training facilitators (p. 355). The Alberti-Emmons model gives great impetus to the function of teaching or training a client to change his life.

The Alberti-Emmons model (1978) rests on three assumptions: (a) an individual's feelings relate to his behavior, (b) behavior is learned, and (c) behavior can be changed. The study under consideration fits this model in two important aspects (a) the congruence of assumptions, and (b) using education to change behavior first which results in positive feeling to reinforce further behavior change.

Implementing Assertiveness Training

The implementation of assertiveness training is very complex because it is not a single procedure, but rather numerous techniques used in a variety of combinations. Liberman, DeRisi, and Mueser (1989) outline the roleplaying technique of assertiveness training. They explain that roleplaying uses the same methods to learn skills that individuals naturally use to learn skills for dealing effectively with new situations. Roleplaying methods are (1) observing another person competently use the

skill (modeling), (2) practicing the skill in a simulated situation (behavioral rehearsal), and (3) obtaining feedback and suggestions for improvement from others (social reinforcement). Modeling, behavioral rehearsal, and social reinforcement are the learning ingredients that form the backbone of the roleplaying technique of assertiveness training.

Liberman (1972) details the implementation of the educational program as: the therapist points out the dysfunctional consequences of failure to assert oneself, instructs the patient in roleplaying, and prompts and encourages the patient in appropriate self-assertion to improve his expressions of affect during the roleplay session. Additionally Liberman coaches trainers in appropriate methods of teaching by saying "You correctly understand that assertiveness training proceeds by (1) differential positive reinforcement of self-assertion, (2) the extinction of anxiety previously associated with self-assertion, and (3) learning by identifying with (imitating) the therapist's assertiveness" (p. 165). The third focus of imitation or roleplaying was used in the assertiveness training program in this study.

Liberman (1982) explains the learning process as an emotional change within the individual brought about by focusing on the teachable and demonstrable expression of emotion. Assertiveness training assumes that changes in emotion follow, rather than precede, changes in overt behavior. The acquisition of the skill of expressing an emotion is followed by the subjective experience of that emotion. With this assumption, the main goal of assertiveness training is to first help the patient change his or her behavior in visible and audible ways with the expectation that emotional changes will follow. Self-reinforcement and favorable reaction from others

strengthen these new behaviors, ensuring that they will remain in the patient's behavioral repertoire after training has ceased.

Measuring Assertiveness

There are two categories of measurement instruments used in assertiveness training: self-report measures and behavioral measures. The widely used self-report, pen and paper tests have been changing through time as researchers correct problems with them. As mentioned previously, one problem concerns the lack of a commonly accepted definition of assertive behavior. With a multitude of definitions, each researcher must determine a definition, and may be measuring different behaviors. There is also a concern that assertiveness is not one trait but a group of independent situation specific responses which defeats any generalization of the behavior from one situation to another. A measure of assertiveness must take into account these complications.

A study assessing five self-report assertiveness instruments reported significant differences in the items presented to the subjects (Furnham & Henderson, 1984). The results indicated that, despite differences in definitions of assertiveness, the five tools did distinguish between high-assertive and low-assertive subjects.

One measure that has been used successfully to measure assertive behavior was designed by Rathus (1973). The Rathus Assertiveness Schedule is a published instrument used by researchers. According to Alberti and Emmons (1978), the schedule is shown to have moderate to high test-retest reliability which fits the design of the study under consideration. Furthermore, the validity is satisfactory in indicating potential use of assertiveness by the subjects in the future. The item analysis shows good

correlation with the total scale score and with external criteria. Norms are available with males scoring higher than females. Alberti and Emmons (1978) reported, "This is one of the few scales which has been experimentally tested for validity and reliability and should be considered if one is doing assertiveness research" (p. 167). They continue, "The items are general enough to be useful for pre-post testing with non-college or college populations if assertiveness trainers wish to test the effectiveness of their groups" (p. 168). Vaal and McCullagh (1975) found that a modified version (Appendix A) of the Rathus Assertiveness Schedule had a lower readability level than the original schedule. More importantly, the researchers accepted the reliability of the instrument in a test-retest format. Liberman, et al. (1989) say of the Rathus Schedule, "... one of the best validated" (p. 52). They continue, "This schedule, and others like it, taps such domains as avoiding social confrontation, being reluctant to express feelings and opinions, experiencing social anxiety and discomfort, making reasonable requests of others, refusing unreasonable requests of others, having problems in asserting one's rights, and expressing affection" (p. 52).

Chapter 3

METHODOLOGY

This chapter describes the research design of the study including (a) setting, (b) sample, (c) instrument, (d) protection of human subjects, (e) procedures, (f) data collection, (g) description of the assertiveness training program with (h) outline of weekly sessions.

Research Design

The study used a quasi-experimental methodology, employing a pretest-posttest design with an intervening eight weeks of training. This hypothesis testing design is a single factor experiment with one variable being tested. The effect of the independent variable (an assertiveness training program) on the dependent variable (the measurement of assertiveness of the subjects) was assessed by the Modified Rathus Assertiveness Schedule. The Schedule was given before and after the assertiveness training program. Results from the before and after scores were compared. The purpose of the design is to determine if the manipulation of the independent variable has a positive effect on the dependent variable.

According to Bush (1985), this design is quasi-experimental because it lacks randomization and a control group. The group of subjects at the mental health center is unique in its longevity of friendships. Membership in the group was not decided by the researcher but by the members themselves.

The design of the study takes advantage of the strengths of a quasi-experimental research which are (a) practicality, (b) feasibility, and (c) applicability to the population.

According to Bush (1985), the possible disadvantages of the quasi-experimental design are threats to the internal validity of the study. General factors of validity that apply to this study are:

1. History. The program of assertiveness extends over a period of eight weeks in which other events may occur to change the observed outcomes.

2. Maturation. Biologic or psychologic processes such as aging or psychologic growth may occur to change outcomes.

3. Testing. Repeated testing may create learning in the subjects which will improve performance.

Setting

The study was completed in a non-profit volunteer facility offering drop-in counseling, education and referral services to homeless and board and care home residents, and serious and persistent mentally ill. The facility includes a regularly attended social club. The club meets once a week for singing, a walk, lunch, education, and activities. The large meeting room is on the second floor of a building owned by the city of San Jose. The subjects all had places to sit which roughly approximated a circle and they were able to move about freely.

Sample

The subjects of the study were the club members who had been associated with the club for varying amounts of time ranging from four months to 22 years. Many of the members had been coming to the club since discharge from a state psychiatric hospital in the late 1960's. Six of the members lived together in a board and care home in the immediate area of the facility, four lived in private homes and one lived in an

apartment. The board and care operator managed the member's transportation to the club.

There were eight women and three men in the experimental group; the mean age was 63 years, the range of ages was from 56 to 73 years. Three members of the group attended elementary school, two attended high school, three graduated from high school, one attended college and two completed advanced degrees. One person was legally blind, two were hard of hearing, one had a deformed limb from polio and two had difficulty walking, especially on stairs.

It is assumed that many of the participants are on psychotropic medications during this study as almost all serious and persistent mentally ill individuals are treated with medications. Some are treated briefly, many are maintained on them for years. The information on the participants' medications was not made available to the researcher because of the nature of their diagnoses.

All of the club members had been participants in a previous assertiveness training class unrelated to the present study. They were all able to actively engage in training and, with help, fill out the Modified Rathus Assertiveness Schedule.

Instrument

The Modified Rathus Assertiveness Schedule (Appendix A) was applied in this study to measure assertiveness of the subjects. This test is designed for adults and is short enough to maintain their attention. In dealing with situations that occur in the lives of the participants, it generates interest in the program of classes. Feelings are addressed but in

a non-threatening format. The test measures a range of responses from aggressive to withdrawn which generates quantitative responses.

Rathus (1973) suggested the modifications of the Rathus Assertiveness Schedule utilized in creation of the Modified Rathus Assertiveness Schedule. The first modification was to shorten the number of questions from 30 to 20. The 20 items recommended by Rathus were indicated with italicized print on the 30-item schedule. The second modification involved a change in the language of the schedule. Although the schedule seemed appropriate for measuring assertive changes in the population under study, it was felt by Rathus that some age-related items needed minor revision. These changes were suggested to more accurately reflect the subjects' bases of experience. Selected words were substituted, such as "wronged" for "injured" and "trying" for "attempted." These substitutions neither change the intent nor the severity of the items involved. The changes in language were minimal but helpful in making the schedule congruent with the subject's lives and, therefore, relevant to them.

Protection of Human Subjects

Permission to carry out this study was obtained from the Board of Directors at the sponsoring agency (Appendix C). The proposal was reviewed and approved by the Human Subjects Institutional Review Board at San Jose State University (Appendix D). The participants' rights were further protected by obtaining their voluntary informed consent (Appendix E) to participate in the study.

None of the clients in the proposed study was legally conserved or under the protection of a guardian. The clients were legally competent to

give their consent to participate. They do, in fact, sign consents to be at the agency where the study took place, sign consents in the medical clinics where they receive medical treatment, and sign consents almost everywhere that a person with or without the label of "mentally ill" would be required to sign. No client who was overtly psychotic was included in this study.

There was a licensed social worker, the Executive Director of the agency, available on site during pretest and posttesting, and during the training sessions. Also, the research was supervised by a registered nurse who is certified by the American Nurses' Association as a clinical specialist in adult psychiatric nursing. She provided supervision on the actual sessions and after the sessions. This was both a training technique for the researcher and additional protection for the clients.

Procedures

The experimental group received an eight week program of assertiveness training. The training sessions (Appendix B) followed the outline described by Liberman, et al. (1989). Each session was held one morning per week in a free time during the usual meeting of the club and lasted about forty minutes each. The regular meeting room was used. The researcher stood in one side of the circle of participants and circulated about the room to augment any vision or hearing problems of the participants. Observational data were collected during each training session.

Data Collection

The pretest was administered during a private interview to each participant and was administered to all participants before the classes

began. The posttest was administered to the group one week after the last training session and will be given in the same manner as the pretest situation. The demographic data (Appendix A), consents (Appendix E), and pretest - and posttests remained with the researcher and were not copied. They were coded with numbers for confidentiality before being given to the statistician for analysis. The results of the tests were analyzed with a dependent t - test to determine if the posttest scores showed more assertiveness in the subjects than the pretest scores.

Assertiveness Training Program

Roleplaying is the specific approach to social skills training that was used to train the subjects in this study. The model for the program of roleplaying is provided in Social Skills Training for Psychiatric Patients (Liberman, DeRisi, & Mueser, 1989). The training was implemented by pairing and consolidating the questions of the Modified Rathus Assertiveness Schedule, which created eight sessions of Assertiveness Training Program designed by the researcher (Appendix B) and based on Liberman et al. (1989).

Previous assertiveness training classes were done with this population revealing that the particular subjects of this study only very infrequently did their homework and that they would only roleplay with the trainer and not with each other. These conditions prevail even in the face of a trusting relationship with the trainer and long friendly relationships among the subjects.

Weekly Sessions

Consents.

There were eleven consents signed. The researcher read the entire two pages in a loud voice and all the group members were listening. It was emphasized that study participation was voluntary and the club members would still be included in the classes even if they didn't sign the consent. Some had questions, some refused to sign and class began.

The lesson plan was one used previously, which was defining assertion vs. aggression and using the example of a panhandler. Three people in the group gave good assertive responses. They needed coaching to frame them in "I" statements. We could do this same lesson again with voice tone, body language and eye contact. The class ended with a discussion of aggression and examples of how to feed it or counteract it with assertion. There is a considerable degree of knowledge generated by life experiences in this group which is not shown by the demographic data.

The researcher extended a personal invitation to the missing couple to join the group but they declined.

Pretests and session one.

The pretests required a personal interview with every person. They couldn't understand the scale from +3 to -3. The pretests were not called "tests" but "survey of their feelings." Thirteen people were requested to do the pretest, one refused and one person was too young to be part of the study leaving 11 useable tests.

Much of the group had wandered off so they were collected for lesson one. We talked about shyness as an excuse to withdraw and assertiveness as a tool to get results. Everyone stated, "I am not shy, I am assertive" with

good eye contact and voice tone. One man did the first roleplay. He made an appointment for the dentist and talked too fast and looked around the room but did complete it. A woman was not able to do the roleplay as her mind was wandering more than usual.

Session two.

Everyone was there including people not participating in the study. We reviewed the first lesson and generated much response. Question two discussed the concept of shyness. One woman told the group that her roommate with a shoulder problem had not received the medical care she needs because of lack of assertiveness. She roleplayed her roommate with the doctor and she explained what "her" medical problems really were and what "she" wanted. She was quite appropriate and assertive.

Question 11 was a classic. No one wanted to roleplay with an attractive person of the opposite sex but one man was doing a lot of talking so he was challenged. He walked right up, with good eye contact, said, "Hi, I'm X, and I think you are attractive." We all had a good laugh but it was also an excellent demonstration of assertiveness.

Then we went on to lesson two which was related to restaurant service. There were lots of complaints about restaurant service which were turned into roleplays. Three people were all able to state what was wrong (cold food, not what was ordered) and ask for a change. Once they had vented their complaints then they were able to appropriately roleplay. One man followed through even though he didn't usually talk much. We discussed the non-assertion of not eating the food and walking out of the restaurant. This was the best session ever. We had humor and people were anxious to talk and share.

Session three.

The questions were four and 22 which are about hurt feelings and dealing with the hurtful person to make them stop. One woman was able to roleplay with "Helen" who harasses her about speaking Spanish. She was able to say "I need to speak Spanish, please stop bothering me." We ran through it twice. Two other people came up with interesting situations but could not use the annoying person's name in the roleplay. A usually quiet man was the most interesting as he wanted to participate but couldn't come up with a situation and, after some discussion said, "I need a more positive situation. Can we talk about me being assertive with a friend?" That was a perfect example of assertiveness.

We reviewed the two items they needed to use: an "I" statement of need or lack, and a request for change. All were listening.

One man had some interesting observations about rights. "Women have the same rights as men" and "You have a right to be listened to."

A woman got lost in the group complaint about an annoying person. She was finally able, with coaching, to say "My feelings are hurt when you do ..." Then she stated, as her own, the group request for change in the annoying person.

Session four.

This lesson was about the basics of saying "no" and "why" especially when confronted with outrageous behavior. The first was simple as one woman was not sitting in her usual comfortable chair but another group member was. With prompting, she requested her chair from him, giving him the opportunity to say "no." She did and he moved because the request

was not outrageous. This was much more assertive behavior than expected from her but the scene did not give him a chance to be assertive.

Another woman roleplayed the problem of her roommate who roams at night. The woman asked her "roommate" to stop roaming because she was disturbing her sleep. She showed good eye contact and voice tone.

Another woman wanted help with her son. She was quite scattered but, with coaching, she asked him to stop being so noisy in the house. She kept getting sidetracked into ultimatums like "Be quiet or get out!" so we talked about aggression vs. assertion and roleplayed again.

One man had a good problem with his mother in which he comes home in the middle of the night and knocks on her window. He had the outrageous behavior, not her. Assertiveness was demonstrated as she might display it, then he played "Mom" and he was quite assertive and appropriate. He may have gotten some insight into these 2AM confrontations.

Session five.

This session dealt with the inner turmoil of emotions and how to break through and express them properly. The man with the 2AM confrontations with his mother wanted to work again. He so enjoyed displaying his mother's outrageous behavior (when it is frequently his that is outrageous) that it takes a lot of coaching to get him to roleplay.

A woman worked on a problem with her husband in which each of them wake the other during the night. She negotiated a compromise while she was being assertive to "him." Because "he" stayed assertive, she was able to maintain her assertion. This was a very successful roleplay.

The man who deals more directly with the process of assertiveness wanted to work. He often feels overwhelmed by his brother and wanted to know how to tell him to "back off." It became obvious that he wanted to know how to convey a message without saying anything and without any visual or verbal clue to his brother. In other words, he was asking how to be non-assertive. The behavior was identified as withdrawn behavior and it was left open for him to talk about it again next week.

Another man told us a situation he had with the bus company in which he telephoned to complain. He performed perfectly the first time - stating a reasonable problem, expressing annoyance and asking for a change. It was a perfect demonstration.

Session six.

The bus company was the topic again today. A different man called them because his pass didn't work. He roleplayed the problem, and asked for a change.

A quite non-verbal man was set up to ask for a job on the telephone. There was a woman next to him and he asked her for a job and she responded appropriately and they discussed the job. This was the first roleplay between the participants. Then she asked him for a job and wanted every Friday off.

No one else wanted to apply for a job so we moved on to the complaint department. One of the men returned a toaster oven because it was broken. He could not invent a defect but he did have good eye contact and mumbled less than usual.

Another man argued over a cup of coffee for $1.50. He kept stating that he would walk out and not pay. After a lot of coaching, he finally stated

that the price was too high. He still couldn't ask for a change and wanted to walk out of the restaurant.

Session seven.

This lesson was very difficult to teach because it dealt with withdrawn behaviors which are the result of fear. The setup of the class with roleplaying involves much coaching with no serendipity involved. We started with a discussion of fear of people and places. The class members knew the format of the class and shaped it appropriately. One man wanted to roleplay a situation with a man who had physically attacked him. He showed classic avoidance behavior at first, and with coaching was able to ask to be left alone. He kept analyzing whether this was really a "tough guy" and if he could find a "weak spot." We roleplayed again so he could practice simply asking him to leave him alone, using an "I" statement.

One woman stated that she just doesn't have fear; it's not in her nature. She was typically avoiding any situation in which she might be in an argument. With questioning, she finally admitted that there is a situation in which she fears a particular person. She roleplayed that situation but she framed her assertive comments in such a playful, non-committed voice and manner that they could not be considered really assertive. We worked on voice tone and body posture. When asked to roleplay her previous assertive comments with the new mannerisms, she went back to saying that she doesn't fear anyone.

Another woman stated that she told her doctor about her fear of elevators and of going out. She roleplayed perfectly the basics of telling "him" the problem and asking for his help.

Another woman wanted to practice the basic problem of asking a person very close to her to talk about a very touchy subject. We went over it twice so she could use his name and bring up the subject and ask if they could arrange a time and place to talk about their problem. She was able to perform her roleplay well.

A man asked how to approach his ex-wife to talk about custody of their son. He approached his "wife" very well and we discussed the problems with the present arrangement and he asked for changes. He negotiated terms and suggested compromises.

Question 17 was about accepting a compliment. The scene was set up and then each person was given a compliment and they responded assertively. Some deviated into explanations which were identified and changed back to the basics of "thank you."

We talked about question 20 which is about being tongue tied. They were tired so we closed the session with an admonition to be thinking of topics for the last session next week.

Session eight, preparing for closure.

This lesson generated much conversation based on other people pushing into line ahead of the rest. These were easily turned into roleplays with many participants. A woman stated that she could make an observation of the problem but she had trouble asking for a change. We practiced that several times. One man was using aggressive statements which were gradually molded into assertive over several roleplays. Another man replayed a specific incident from years ago in which he wanted to practice being assertive even when the other party had become aggressive. The group defined exactly when the statements and behaviors

of the other party became aggressive, and that the participant had the option of withdrawing at that point. He roleplayed his assertive statements with the researcher while the group coached him with assertive comments. This was a fitting end to the class as the group members were able to assist each other in remaining assertive.

Posttests

The posttests were done as personal interviews with four members of the group. They answered quickly and confidently because they had been addressing these very questions in the class. The rest of the group members were posttested at their residence, again answering quickly and confidently. Certificates of Completion of the Assertiveness Training Program (Appendix F) were distributed to all members of the group, including the ones not participating in the study. Everyone recieved certificates because the original contract with the group had been that everyone could participate in the sessions even if they did not participate in the study.

Chapter 4

FINDINGS AND INTERPRETATION

Findings

The data were collected to support or reject the hypothesis: An eight week program of assertiveness training for serious and persistent mentally ill elderly clients will increase assertiveness as measured by the Modified Rathus Assertiveness Schedule.

In this study, conducted at a mental health clinic, there were eleven subjects in the experimental group. There were eight women and three men; the range of ages was from 56 to 73 years, and the mean age was 63 years. The subjects had been associated with the club from four months to 22 years. Six of the members lived together in a board and care home in the immediate area of the facility, four lived in private homes and one lived in an apartment. Three members of the group attended elementary school, two attended high school, three graduated from high school, one attended college and two completed advanced degrees. Because of the setting, a random selection of the sample was not possible and there was no control group. No analysis was performed on the demographic information in comparison to the assertiveness scores because of the small sample size and lack of randomization.

The experimental group received an eight week program of assertiveness training. The training sessions (Appendix B) followed the outline described by Liberman, et al. (1989). Each session was held one morning per week in a free time during the usual meeting of the club and lasted about forty minutes each. The regular meeting room was used. The researcher stood in one side of the circle of participants and circulated

about the room to augment any vision or hearing problems of the participants. Observational data were collected during each training session.

The roleplaying technique of training employed situations in which the participants could practice new behaviors. The participants had several opportunities to use the trainer as a safe person with which to try social interactions that allowed them to express their needs and wants without hurting other individuals. The trainer guided and prompted the participants to display assertive behaviors. The roleplaying was repeated until the participants felt comfortable with the new behavior.

The experimental group was tested with the Modified Rathus Assertiveness Schedule (Appendix A) before and after the training program. The pretests and posttests were scored by the researcher. The 20-item Schedule was shortened to 19 as one question was discarded as unusable. A statistical consultant was utilized to write a program utilizing the Statistical Package Social Sciences to analyze the data. The data were entered into the computer and means, standard deviations and t values were computed. The t - test was applied to the difference in the mean total scores on the pretest and posttest scores of the experimental group.

The experimental group which received an eight week group program of assertiveness training did not score significantly higher on the posttest of the Rathus Assertiveness Schedule than on the pretest ($t(10)= -1.66$, $p>.05$). Table 1 shows there were increases in assertiveness in the mean scores between the pretests and posttests for the experimental group; however, the differences were not at a significant level.

Table 1

Comparison of the Mean Scores of the Pretest and Posttest on the Rathus Assertiveness Schedule

M Pretest	M Posttest	t	DF	f
-4.727	6.636	-1.66	10	.127

Note. No significant difference between tests ($p > .05$).

The t - test did not support the hypothesis that the eight week program of assertiveness training for seriously and persistent mentally ill elderly clients will significantly increase assertiveness as measured by the Modified Rathus Assertiveness Schedule; therefore, the hypothesis was rejected.

The data did show an increase in assertiveness in the mean scores. The pretest mean score was -4.7, and the range of scores was -37 to 17. The posttest mean score was 6.6, and the range was -21 to 34. This was a 10 point increase in the mean assertiveness score of the participants. Individual raw scores of assertiveness did increase from the pretest to the posttest on 8 (73%) of the participants (Table 2).

Table 2

Comparison of the Pretest and Posttest Scores of the Assertiveness Training Group

Subject	Pretest	Posttest	Difference
1	-37	-21	16
2	7	34	27
3	11	1	-10
4	-13	18	41
5	-37	-4	33
6	0	2	2
7	-12	13	25
8	-1	33	34
9	17	-15	-32
10	1	18	19
11	12	-6	-18
M	-4.727	6.636	
SD	18.467	18.167	

Data Interpretation

The experimental group which received an eight week program of assertiveness training did not score significantly higher on the Modified Rathus Assertiveness Schedule posttest in comparison with the pretest. Although the t - test applied to the paired mean scores did not result in statistical significance, there was improvement in the scores of eight (73%) of the participants.

The greatest changes were the observable improvements in the interpersonal communication skills of the subjects as recorded by the researcher in the field notes. The group members took great risks in bringing their problems and real-life situations to the group. The level of commitment to the group process was very evident by the energy expended in the work. Two group members finally felt comfortable enough with the roleplay situations to practice with each other instead of with the researcher. The most noteworthy change was the last session in which the group members were coaching each other in assertiveness without assistance of the researcher. In coaching others, they showed a higher observed level of assertiveness in their own behavior.

Although the research hypothesis was not supported, this study does suggest that assertiveness training is a positive experience for the elderly serious and persistent mentally ill. Furthermore, there is never justification for interpreting the inability to reject the null hypothesis as proof of a lack of relationship among variables (Treece & Treece, 1977).

No analysis of the data based on demographic information was performed. The small sample size limited any meaningful analysis of demographics and the assertiveness scores.

Another possible explanation for the nonsignificant results may be the time frame in which the testing was done. According to Yalom (1975), the maximum effect of a group process training program may not be experienced by the clients for six to eighteen months after cessation of a program.

There is also a possibility that the tool, the Modified Rathus Assertiveness Schedule, was not a valid instrument with which to measure assertiveness of geriatric serious and persistent mentally ill clients. The Rathus Assertiveness Schedule is a tested and proven instrument. However, the use of the Modified Rathus Assertiveness Schedule may have changed the reliability of the schedule.

Chapter 5

DISCUSSION

Summary of Study

The purpose of this study was to measure the effect of an eight week assertiveness training program on a group of elderly serious and persistent mentally ill to aid clinicians in selecting appropriate therapies. The quasiexperimental design used the Modified Rathus Assertiveness Schedule as a pretest and posttest with an intervening educational program of assertiveness training. The training sessions were conducted with eleven members of a preexisting self-help group which met at a volunteer mental health agency at the same time and day each week. The researcher was a registered nurse. A dependent t - test was applied to the difference in the mean scores of the pretest and posttests. The group participants developed more assertiveness but not to a significant degree on the Modified Rathus Assertiveness Schedule. The participants developed observable improvements in their assertiveness skills during the assertiveness training program.

Conclusions

The analysis of the data indicates that the program of assertiveness training was effective in increasing assertiveness but not to a significant degree. The data demonstrate that positive changes in assertive behavior have been facilitated by assertiveness training sessions. Further research may enable clinicians to predict who may or may not benefit from assertiveness training.

This study suggests that use of the Assertiveness Training Program (Appendix B) is a positive experience for the serious and persistent

mentally ill elderly. The group members participated in a training program with enthusiasm, with many animated exchanges among these usually dejected individuals. They were able to practice behaviors new and exhilarating for them. They were given hope that they can improve their personal relationships without sacrifice or denial. The most startling change was their willingness to take risks.

The findings were congruent with the cited literature on behavior modification with elderly serious and persistent mentally ill (Johnson & Fredericksen, 1983; McEvoy & Patterson, 1984). The results also supported prior studies on social learning and skills building (Teri, 1983; Praderas & MacDonald, 1986; Jackson & Martin, 1983; Nirenberg, 1983). Specific research on assertiveness training on serious and persistent mentally ill elderly (McFall & Twentymen, 1973; Valario & Stone, 1982) reports successes such as were found in this study.

The training program of assertiveness utilized in this study also represents a nursing intervention based on Levine's (1969) principle of conservation of social integrity. The increased assertiveness scores can be viewed as conservation of social integrity. The participants' newly modified behavior enabled them to maintain and enhance their social relationships, gain social competence and conserve their social integrity.

The findings of this study demonstrate and support the behavioral-ecological model of community mental health as cited earlier in the conceptual framework (Jeger & Slotnick, 1982). The specific intervention, assertiveness training, enhanced the participants' coping and mastery skills in social situations. This increased competence changes the transactional unit of the individual and his environment. The balance of fit

between the individual and his environment may prevent worsening of symptoms, increase their ability to cope with daily stressors, and reduce their functional disabilities.

A final conclusion based on this study is that the elderly serious and persistent mentally ill can learn to be more assertive which may improve the quality of their lives.

Scope and Limitations

The study was limited to serious and persistent mentally ill elderly subjects. The possible limitations of this type of study are (a) insufficient exposure to the intervention, (b) limited outcome measures, (c) possible contamination of the subjects by previous assertiveness training unrelated to the program, (d) the sample size which is less than 30, (e) the lack of random selection of the subjects, and (f) the limited time frame of the study. Yalom (1975) indicated that the positive changes that result from group therapy may not be experienced by clients before six to eighteen months.

Recommendations

Based on this researcher's literature review and research, these recommendations are provided for future research based on a replication of the study with the following improvements in the design: add a control group; employ separate individuals to test and train the subjects; include multiple behavioral outcome measures; posttest at six and eighteen month intervals; and repeat the study with the same population and instrument.

Implications for Nursing Practice

The researcher recommends a coordinated program of social support services which includes assertiveness training designed to both strengthen the individual's skills and develop the environmental supports necessary to

sustain the individual in the community. The coordinated services could be provided by nurses in a supportive environment which emphasizes the uniqueness of the individual, recognizes and supports his responsibility for his wellness, and maximizes his feelings of control and self-worth. This program of services including assertiveness training is especially needed for the many clients who remain resistant to skills training and environmental support programs which contain the goal of independent living and full employment. These individuals can benefit from a program which improves their social adjustment and quality of life. The program is designed to both strengthen the individual's skills and develop the environmental supports necessary to sustain him in the community.

The profession of nursing is uniquely qualified to deliver this teaching intervention to clients. Nurses are trained to assess the gaps in a client's health care based upon lack of education, select an appropriate intervention based on the individual's abilities, deliver the intervention, and assess the effectiveness of the intervention. Assertiveness training fits this nursing process as an appropriate nursing intervention.

A fitting end to this discussion of nursing research is an example of the change in behavior and goodwill generated by the assertiveness training program. Each day one woman would greet the trainer with "I am assertive, are you?"

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APPENDIX A

Demographics Form and Modified Rathus Assertiveness Schedule

Demographics Form

The study, The Effectiveness of an Assertiveness Training Program, requires a minimum of information about you. Please answer the following questions. As you can see, you will not be personally identified in any way. Thank you for your participation.

Your age?

Your sex?

The last year of schooling that you completed?

Length of time in the Fireside Friendship Club?

Do you live in a private home, board and care home, or apartment?

Modified Rathus Assertiveness Schedule

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

+3 very much like me, extremely true of me

+2 rather like me, quite true of me

+1 somewhat like me, slightly true of me

-1 somewhat not like me, slightly different from me

-2 rather not like me, quite different from me

-3 very much not like me, extremely different from me

Mark the best answer for each question.

_____1. I hesitate to make or accept appointments because of "shyness".

_____2. When the food at a restaurant is not done right, I complain to the food servers.

_____3. I am careful to avoid hurting other people's feelings, even when I feel that I have been wronged.

_____4. When I am asked to do something, I insist upon knowing why.

_____5. To be honest, people often take advantage of me.

_____6. I often don't know what to say to attractive people of the opposite sex.

_____7. I hesitate to make phone calls to businesses.

_____8. I would rather apply for a job by writing letters than by doing personal interviews.

_____9. I find it embarrassing to return merchandise.

____10. I have avoided asking questions for fear of sounding stupid.

____11. During an argument I am afraid that I will shake all over.

____12. I avoid arguing over prices with clerks and salesmen.

____13. If someone has been spreading rumors about me, I see him(her) to "have a talk".

____14. I often have a hard time saying "No".

____15. I bottle up my emotions rather than make a scene.

____16. I complain about poor service in a restaurant.

____17. When I am given a compliment, I just don't know what to say.

____18. Anyone trying to push into line ahead of me is in for a good battle.

____19. I am quick to express an opinion.

____20. There are times when I just can't say anything.

APPENDIX B

Assertiveness Training Program

Assertiveness Training Program

The assertiveness training program is based upon the behaviors expected from the client when placed in the learning situation. The goals for the client have taken into consideration that they will not do homework and they will only roleplay with the trainer and not each other.

Session One

The two situations chosen for this session are related to each other and are based on #1 & #6 of Modified Rathus Assertiveness Schedule which are:

#1. I hesitate to make or accept appointments because of "shyness".

#6. I often don't know what to say to attractive people of the opposite sex.

The concepts of "shyness" or confusion with strangers reinforces nonassertive behavior by being an "excuse" to refrain from using assertive behaviors. The correct approach to statement #1 is to demand an alternate behavior of the patient that overrides "shyness". Examples are, "I am not shy, and I am assertive". The approach to #6 is a definition of the client as a worthy and interesting person first, then challenge the client with a situation which causes him to state that he can approach and talk to attractive people of the opposite sex. Appropriate responses might include, "I am not shy, I am assertive" and "I am a worthy and interesting person".

Session Two

The basis of this lesson is service in a restaurant and is expressed by #2 & #16 of Modified Rathus Assertiveness Schedule which are:

#2. When the food at a restaurant is not done right, I complain to the food servers.

#16. I complain about poor service in a restaurant.

The key word here is complain. No one wants to be seen as a complainer, however, the potential assertive behavior is appropriate in this situation and is addressed to the proper recipients. Both of these statements require from the client a statement of his rights in this situation such as, "I have a right to decent food" and "I have a right to good service".

Session Three

The difficult area of feelings is addressed here based on #3 & #13 of Modified Rathus Assertiveness Schedule which are:

#3. I am careful to avoid hurting other people's feelings, even when I feel that I have been wronged.

#13. If someone has been spreading rumors about me, I see him(her) to "have a talk".

Both of these statements involve a direct confrontation with another person who has hurt the client. An exploration of the alternatives may help such as letting resentment build up vs. being assertive vs. being aggressive. The role-play situation needs a response from the client that states that that his feelings are just as important as the other person's and that he would like to be listened to and considered by the other person. A proper response could be, "We need to talk about this".

Session Four

The problem of dealing with demands made by other people is handled by #4 & #14 of Modified Rathus Assertiveness Schedule which are:

#4. When I am asked to do something, I insist upon knowing why.

#14. I often have a hard time saying "No".

The focus is not upon the appropriateness of the other person's request or demand but on the behavior of the. The most direct method of

obtaining the new behavior is to present situations in which he can ask "Why" or state "No" to the demand by the trainer.

A simple rote answer of "Why" or "No" to trainer questions may bring out the most reticent of individuals.

Session Five

The Modified Rathus Assertiveness Schedule involves the inner turmoil of emotions that patients attempt to handle properly with questions #5 & #15:

#5. To be honest, people often take advantage of me.

#15. I bottle up my emotions rather than make a scene.

The clients often feel the need to speak but cannot. The trainer's recourse is to inform the client that he is allowed to feel bad or confused at times but that he can still choose to be assertive. Present a situation involving such outrageous behavior that even the most withdrawn patient will be compelled to speak, then guide his statements to expressions of feelings. The subject's expression of feelings may take the forms of statements of rights such as, "I am allowed to express my emotions appropriately" or, "I am allowed to feel bad at times".

Session Six

Asking for information or a job from a stranger is addressed by #7 & #8 of Modified Rathus Assertiveness Schedule which are:

#7. I hesitate to make phone calls to businesses.

#8. I would rather apply for a job by writing letters than by doing personal interviews.

The trainer needs to set up a very formal business situation in which the client can practice the basics of calling a business and talking to

professionals. Very good responses from the client would involve the rights to be dealt with fairly and courteously in business.

The business theme continues by addressing the issue of dealing with money. The difficulty in being assertive when money is involved is addressed by #9 & #12 of Modified Rathus Assertiveness Schedule which are:

#9. I find it embarrassing to return merchandise.

#12. I avoid arguing over prices with clerks and salesmen.

The trainer can help the client most by invoking a very business - like scene in which money is openly discussed. The client may be coached that he is allowed to change his mind and that he is entitled to pay a fair price for goods.

Proper responses from the client would include prices.

Session Seven

Based on #10 & #11 of Modified Rathus Assertiveness Schedule which are:

#10. I have avoided asking questions for fear of sounding stupid.

#11. During an argument I am afraid that I will shake all over.

These two items are testing assertive behavior with resultant fear. The cleint needs to know that he can be fearful and yet continue in his assertive behavior. Assertive responses would indicate that the client shows more intelligence by asking questions instead of remaining silent and that he is allowed to be angry and to express that anger.

The safety in withdrawal issue is again addressed by questions #17 & #20 of the Modified Rathus Assertiveness Schedule which are:

#17. When I am given a compliment, I just don't know what to say.

#20. There are times when I just can't say anything.

This may be the hardest behavior for a client to overcome because of the safety in being reticent. The trainer should give the compliment and coach a reply that incorporates recognition of the client and his accomplishments. In regards to #20, the trainer may coach the client, " I am not perfect, I am allowed to be human". Similarly, coaching for #20 may follow the form of "I am allowed to be recognized for myself and my accomplishments".

Session Eight

A last concept of assertiveness is based upon questions #18 & #19 of Modified Rathus Assertiveness Schedule which are:

#18. Anyone trying to push into line ahead of me is in for a good battle.

#19. I am quick to express an opinion.

These are potentially aggressive behaviors that clients can confuse with assertive behaviors. The trainer needs to differentiate between the two behaviors and ask the client for suggestions of alternate behaviors. Then the trainer can practice being slightly obnoxious with the client to see if he enunciates responses such as "I am entitled to equal respect" and "My opinions are important". This is a fitting end to the program as it limits the assertive behaviors at the level of aggression.

APPENDIX C

Consent of Mental Health Facility

ACT for mental health

Downtown Counseling Center

July 24, 1990

Mrs. Normandy Jencks, R.N.
Graduate Student, San Jose State University
1771 Warburton Avenue, #11
Santa Clara, CA 95050

Dear Normandy:

The Board of Directors of ACT is pleased to inform you that we unanimously approved your study to evaluate the effectiveness of an assertiveness training program, May 9, 1990, for the cleints in the Fireside Friendship Club at ACT.

The Board understands that this is part of your master's thesis study, to be conducted during the Fall 1990 semester under the supervision of Dr. Connolly and Dr. Stamper, in the Department of Nursing. Furthermore, it is understood that the group will be conducted during the usual Wednesday activities held at ACT, at 441 Park Avenue. The Board wishes to remind you that those clients who are under conservatorship will require additional permission from their individual conservators. You will need to determine which of the clients in the Wednesday Fireside Friendship Club have conservators. The Board also requires that each individual have and sign an informed consent (as you distributed to the Board on May 9th) with the understanding that all such signatures are completely voluntary.

The Board is looking forward to the results of your study and requests that a copy of the study be sent to the Board upon completion. Good luck in your endeavors.

Sincerely yours,

ACT FOR MENTAL HEALTH

Wanda Alexander, L.C.S.W., M.F.C.C.
President of the Board

cc: Board of Directors

APPENDIX D

Consent of Institutional Review Board

SJSU SAN JOSE STATE UNIVERSITY

A campus of The California State University

Office of the Academic Vice President • Associate Academic Vice President • Graduate Studies and Research
One Washington Square • San José, California 95192-0025 • 408/924-2480

To: Normandy Jencks
1771 Warburton Apt.11
Santa Clara, CA 95050

From: Charles R. Bolz
Office of Graduate Studies and Research

Date: January 4, 1991

Chas R Bolz

The Human Subjects Institutional Review Board has approved your request to use human subjects in the study entitled:

"A Study of the Effectiveness of an Assertiveness Training Program on a Group of Serious and Persistently Mentally Ill"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Dr. Serena Stanford immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have any questions, please contact Dr. Stanford or me at (408) 924-2480.

cc: Phyllis M. Connolly, Ph.D.

APPENDIX E

Consent Form

SJSU SAN JOSE STATE UNIVERSITY

A campus of The California State University

School of the Applied Arts and Sciences • ***Department of Nursing***
One Washington Square • San José, California 95192-0057 • 408/924-3130

AGREEMENT TO PARTICIPATE IN RESEARCH
SAN JOSE STATE UNIVERSITY

RESPONSIBLE INVESTIGATOR: Normandy Jencks R.N., C.C.R.N.

TITLE OF PROTOCOL: A Study of the Effectiveness of an Assertiveness Training Program.

I have been asked to participate in a research study investigating the effectiveness of an assertiveness training program. The results of this study can guide professionals in their choice of educational training methods for clients.

I understand that:

1) I will complete a Rathus Assertiveness Schedule, participate in an assertiveness training program, and again complete a Rathus Assertiveness Schedule one week after the program. All the activities will occur at the Fireside Friendship Club at ACT for Mental Health in San Jose. The Rathus Assertiveness Schedule will take twenty minutes or less to complete. The assertiveness training program will involve less than one hour once a week over ten weeks.

2) There are minimal risks as the study is an evaluation of the effectiveness of an educational training program. The questionnaire and program may be inconvenient in time and place. Because you will be interacting with the trainer, you may experience emotions generated by the experiences in class. As in any life experience, you may interpret these emotions positively or negatively. The assertiveness training program will be supervised by Dr. Phyllis M. Connolly, an American Nurses' Association Certified Clinical Specialist in Adult Psychiatric/Mental Health Nursing.

3) The benefit to me is participation in a program of assertiveness training that will assist me to respond assertively in social situations and may improve my quality of life.

4) There are no alternative procedures that are being withheld.

5) The results from this study may be published, but any information from this study that can be identified with me will remain confidential and will be disclosed only with my permission.

School of the Applied Arts and Sciences • ***Department of Nursing***
One Washington Square • San José, California 95192-0057 • 408/924-3130

6) There is no monetary compensation for participation.

7) Any questions about my participation in this study will be answered by Normandy Jencks, at (408) 248-7894. Complaints about the procedures may be presented to Dr. Phyllis M. Connolly, Department of Nursing, at (408) 924-3144. For questions or complaints about research subject's rights, or in the event of research-related injury, contact Serena Stanford, Ph.D. at 924-2480.

8) My consent is given voluntarily without being coerced; I may refuse to participate in this study or in any part of this study, and I may withdraw at any time, without prejudice to my relations with SJSU and ACT for Mental Health or the Fireside Club. My refusal to participate will not influence my rights to services, education, or socialization with ACT or the members of the Fireside Club.

9) I have received a copy of this consent form.

I HAVE MADE A DECISION WHETHER OR NOT TO PARTICIPATE. MY SIGNATURE INDICATES THAT I HAVE READ THE INFORMATION PROVIDED ABOVE AND THAT I HAVE DECIDED TO PARTICIPATE.

_____
SUBJECT'S SIGNATURE

_____ _____
DATE INVESTIGATOR'S SIGNATURE

APPENDIX F

Certificate of Completion

Completion Certificate

Has achieved all objectives in
the assertiveness training class

Normandy Jencks, RN

Phyllis Connolly, PhD

April 1991