EVALUATING THE EFFECTIVENESS OF AN INSERVICE PROGRAM ON ASSERTIVE TRAINING

BY

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ABSTRACT OF THE THESIS

Evaluating The Effectiveness Of An

Inservice Program On Assertive Training

by

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Master of Science in Nursing

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Professor Julie Hover, Chairman

Much has been written concerning communication difficulties within the nurse-physician relationship. Hazards to patient care exist which could be eliminated if these communication difficulties could be reduced. A study done by Hofling et al. revealed that nurses accepted unethical medical orders. Specifically, when a telephone order for an unknown drug in twice the maximum dose was given, 21 of the 22 nurses set out to give the medication. The nurses' responses could be described as nonassertive behavior. Assertive behavior enables a person to express his feelings without undue anxiety and to exercise his rights without denying the rights of others.

The purpose of this study was to provide and evaluate an inservice program on assertive training for staff nurses. The hypothesis was that nurses who received the assertive training would be more assertive on the job than those who had not received

the training. The subjects included 12 volunteer female nurses who worked on medical-surgical units. They were randomly assigned to the experimental or the control condition. Subjects in the experimental condition received the assertive training inservice program consisting of three highly structured sessions, including behavioral rehearsal of specific job-related situations.

Two measures of assertiveness were obtained: a behavioral measure and an attitudinal measure. The behavioral measure consisted of an on-the-job observation of responses to the experimental phone call used in the Hofling study. Neither measure supported the hypothesis.

In both studies nurses accepted the unethical medical order. In Hofling's study the modal response to the phone call was described as chagrin, mild anxiety, and hint of guilt. However, in this study a majority of the subjects responded with anger and unjustified use of situational rationalizations.

Chapter 1

INTRODUCTION AND LITERATURE REVIEW

A fascinating study has been done which revealed that most nurses accepted unethical medical orders. When a telephone order for an unknown drug in twice the maximum dose was given to each of 22 nurses by an unknown voice identifying itself as a doctor, 21 of the nurses set out to give the medication. Significantly, 11 of the subjects expressed having had an awareness of the dosage discrepancy. In addition, phenomena falling into the category of "psychopathology of everyday living" were observed in 17 cases. These include such behaviors as mishearing, not being able to locate the medication on first attempt, and beginning to say "twenty capsules" instead of milligrams when repeating the medication order (Hofling, Brotzman, Dalrymple, Graves and Pierce, 1966). This may be an indication that some of the other subjects had at least a sub-conscious awareness of the dosage discrepancy. If all the nurses had denied an awareness of the dosage discrepancy, one might postulate that their educational programs had failed to teach them principles of medication administration. It might be suggested that the nurses were functioning in an automatic manner; thus, failing to use the intellectual capabilities they possess. However, this is not the case. At least half of the nurses were aware of the dosage discrepancy. Upon disclosure of the experiment,

most subjects responded with chagrin, mild anxiety, and a hint of guilt. All subjects could recall similar naturally occurring experiences. A majority of the subjects referred to the displeasure of doctors on occasions when nursing resistance had been offered to instructions which had been considered improper (Hofling et al., 1966).

The nurses' responses could appropriately be described as non-assertive behavior. Could it be that the thought of an unpleasant confrontation with a doctor inhibits the nurse's ability to respond assertively?

The purpose of this study was to provide an inservice program on assertive training to staff nurses and to evaluate the effectiveness of this training through replication of the previously cited study.

The word "assertive" is applied to the outward expression of practically all feelings except anxiety (Wolpe, 1958). Joseph Wolpe, a noted South African psychiatrist, has shown that assertive responses inhibit or weaken anxiety previously experienced in interpersonal relationships (Wolpe, 1958).

Assertiveness is a heterogeneous concept with a variety of behavioral components (Brockway et al., 1972). These include loudness of voice, facial expression, eye contact, word choice, body expression, and distance from person with whom one is interacting (Brockway et al., 1972; Serber, 1972; Eisler et al., 1973).

Assertive behavior is described as behavior which enables a person to act in his own best interests, to stand up for himself without undue anxiety, and to exercise his rights without denying the rights of others (Alberti and Emmons, 1970).

In non-assertive behavior, the individual typically denies himself and is inhibited from expressing his actual feelings (Alberti and Emmons, 1970). He may be constantly placating other people because he fears to offend them or because he feels a moral obligation to place the interests of others before his own. He may allow people to maneuver him into situations he does not desire (Wolpe, 1970). He often feels hurt and anxious as a result of his inadequate behavior (Alberti and Emmons, 1970).

Situational non-assertiveness concerns those individuals whose behavior is usually adequate and self-enhancing. However, certain situations stimulate a great deal of anxiety, which prevents fully adequate responses to that particular situation.

Much has been written concerning the nurse-physician relationship and the communication difficulties within this relationship. Stein (1967) states that when this relationship is observed in an interactional framework it has a special quality which fits the game model. He suggests that the attitudes which demand the game be played create serious obstacles in the path of meaningful communications. Christman (1965) points out that many hazards to patient care exist which could be eliminated if the communication difficulties could be reduced both qualitatively and quantitatively. The study cited by Hofling et al. documents that, indeed, a hazard to patient care does exist. In an article by Bates (1970) it is stated that in examining the nature of the nurse-physician relationship there is considerable evidence to indicate that it is characterized by medical authoritarianism on the one hand and nursing's acceptance of dependence or even deference on the other.

This blocks realization of the full potential of the doctor-nurse team and consequently, patient care suffers.

Most authors are quick to point out factors which contribute to the difficulties in effective communication. Stein discusses aspects of the medical and nursing students' education which shape the attitudes necessary for the game referred to earlier. The physician's role as healer requires not only that he be highly competent but also that he be "decisive, authoritative, and assertive". Therefore, to recognize a need for others is to acknowledge his limitations and may be difficult for him to do (Magraw, 1966).

Stein (1967) states that nursing students are taught how to relate to physicians. They are told that he has infinitely more knowledge than they and thus should be shown the utmost in respect.

Other sociocultural factors which contribute are summarized by Bates (1970) and elaborated on by various authors. These include: 1) sex (doctors are usually male; nurses are most often female, and the pattern of male dominance prevails), 2) age (doctors are often older than the nurses with whom they work), 3) socio-economic class (doctors tend to come from a higher socioeconomic class) and 4) social status (society accords greater rewards and higher prestige to the position of doctors).

The organizational hierarchy in nursing may also be a factor which contributes to nurse-physician communication difficulties. Nurses who may be the best clinicians (and communicate the most effectively with physicians) are being drained away from direct patient care through promotion (Christman, 1965).

In summary, much has been written concerning the nature of the nurse-physician relationship, communication difficulties within this relationship and their consequences. Factors which contribute to these difficulties have been identified. Little research has been done on methods which would effectively improve the nurse-physician relationship. It would seem that increasing nurses' ability to be assertive in situations which are currently inhibiting to assertive responses would effectively improve nurse-physician communication.

Chapter 2

METHOD

The purpose of this study was to provide an inservice program on assertive training to staff nurses and to evaluate the effectiveness of this training.

The hypothesis was that nurses who receive the assertive training inservice program would be more assertive on the job than those nurses who have not received the training.

Two measures of assertiveness were obtained: a behavioral measure and a situation-specific attitudinal measure.

Subjects and Setting

The setting was St. Mary's Hospital Medical Center in Madison, Wisconsin. The subjects included 12 female nurses* on medical-surgical units who (1) had held their current job not less than three months, (2) were under 35 years of age, (3) had had either three- or four-year nursing programs and (4) had volunteered to participate in the inservice program and this study.

Procedure

Subjects were recruited for voluntary participation in an experimental inservice program on assertive training. The investigator introduced herself as a graduate student in nursing interested in inservice education and evaluation of inservice programs.

*Fourteen subjects were recruited initially. Two withdrew before becoming involved due to personal problems.

The nurses were told that the inservice program would be offered within the next twelve weeks and that it would meet one hour per week for four weeks.

The nurses who agreed to participate were asked to indicate this by signing the consent form (see Appendix A). Then subjects were randomly assigned to either the experimental or the control condition. Subjects in the control condition were told that due to the number of volunteers it would be necessary to run the program twice and they would be notified of the starting date.

The assertive training program consisted of three highly structured sessions. Behavioral rehearsal of specific job-related situations was used in each session. A brief treatment rationale based on learning principles was given: a person can become more assertive by learning what constitutes an effective response and practicing such behavior under non-threatening circumstances. Subjects were asked to imagine themselves in a given hypothetical situation which called for an assertive response. Research Assistant I, a graduate student in social work, participated in the behavioral rehearsal. Subjects were asked to respond assertively to statements made by Research Assistant I in the given situation. Coaching and modeling of appropriate assertive responses were provided by the investigator. The teaching plan and practice situations are presented in Appendix B.

Behavioral Measure

The behavioral measure of assertiveness consisted of an on-the-job observation of the subjects' response to a phone call.

This phone call created a situation requiring assertive behavior. This was done through replication of the situation described in the previously cited study, in which 21 out of 22 nurses accepted an unethical medical order. Although some modifications were required, the study was replicated as nearly as possible. Quoting from the study, the situation was as follows:

> . . . /Medication bottles/ bearing hospital labels were marked:
>
> ASTROTEN
> 5 mg. capsules
> Maximum daily dose: 10 mg.
>
> /These were labeled with a patient's name and placed in that patient's medication box./ Each /bottle/ contained . . . placebo capsules filled with glucose. To standardize the telephone order, a written script was prepared for the caller. In order to standardize the stimulus call as much as possible, a set of standardized replies of the likeliest responses of the nurse was composed and closely adhered to.
>
> It was decided that the emotional tone conveyed by the caller would be one of courteous but self-confident firmness. As a precaution against unintentional departures from this tone, it was arranged to have the calls monitored by . . . /the investigator/, whose function it would be to signal to the caller if he started to vary from the prescribed tone . . .
>
> Termination points for the telephone conversation were as follows: 1) compliance upon the part of the subject; 2) a clear-cut, sustained refusal; 3) insistence upon calling or talking to any third party of equal or superior rank in the hospital hierarchy; 4) the subject's becoming emotionally upset; and 5) prolongation of the telephone call - by any means - to ten minutes.
>
> To study the subjects' environment and their non-verbal behavior as well as to halt the experiment before the involvement of any patient, an observer /a graduate student in psychiatric nursing/ was placed on each unit selected. It was . . . /her/ function to terminate the situation by disclosing its true nature when: 1) the nurse had "poured" the medication and started for the patient's bed; 2) she had ended the telephone conversation with a refusal to accept the order; 3) she began to telephone or otherwise contact another professional person; 4) she began to write the order; or 5) at the expiration of ten minutes following the end of the phone call if none of the foregoing alternatives had been adopted.

> It was anticipated that a post-incident conversation between observer and subject would allow the observer to assume two additional functions . . . /she/ could obtain some further material from the subject (as to her inner responses to the experience), and . . . /she/ could offer psychiatric "first-aid" if indicated, to allay any disquieting feelings which might be mobilized by the experiment.
>
> The experiment was conducted during the period from . . . 7:00-9:00 p.m. . . . /and between 1:15 and 2:30 p.m./.

Attitudinal Measure

The situation-specific attitudinal measure of assertiveness (see Appendix C) was derived from the Rathus Assertiveness Schedule (Rathus, 1973). It was shortened and revised to make it applicable to specific work-related nursing situations. It was given to subjects by the head nurse on their unit. They were asked to return it to Nursing Service. They were aware it was a part of the study.

Debriefing Session

After both measures of assertiveness were obtained, a session in which all subjects were asked to be present was held. It was the final session for the subjects in the experimental condition; the first for those in the control condition.

The purpose of this session was to further explain the study to the subjects and to answer any questions they may have had. It was also expected to provide an opportunity for expression and exploration of feelings.

Chapter 3

RESULTS AND DISCUSSION

Differences between the experimental and the control groups on the Assertiveness Schedule were examined using a t-test for independent samples. The mean score for the experimental group was 40.25: the control group was 47.25. The control group was found to be more assertive on this measure though not statistically significant at the 0.05 level of confidence ($t = 2.098$).

None of the subjects' responses to the phone call could be defined as a "clear-cut sustained refusal" to accept the medication order. There were, however, varying degrees of resistance both during and after the phone call.

On the surface the subjects' responses to the experimental phone call was similar to the responses reported by Hofling. In this study there were no "clear-cut sustained refusals" out of 12 subjects. In Hofling's study there was one refusal out of 22 subjects.

However, interesting differences in response to the phone call exist between the two studies. Hofling states the modal response of the subjects "could be said to involve chagrin, mild anxiety and a hint of guilt". The experimental phone call in this study must be viewed as quite disruptive. One subject contacted the evening supervisor and expressed feelings of having been unfairly tricked and deceived. The debriefer's report described her as appearing "very tense and upset". Another subject contacted the

Assistant Director of Nursing the following morning to express her displeasure about being deceived. One subject momentarily "looked like she might cry" during the debriefing explanation.

A possible explanation for the different subjects' reactions to the debriefing could be that differences existed between the debriefers in the two studies. In Hofling's study the debriefer was a male staff psychiatrist. In this study the debriefers were female nursing graduate students. One possibility may be that nurses would minimize their feelings when talking with the staff psychiatrist. He was a male, an authority figure, and a member of the hospital's psychiatric staff. They may have felt he was in a position to make evaluative interpretations of their response to the debriefing explanation. In contrast, in this study perhaps more anger was mobilized by the fact that the nurses felt "tricked and deceived" by another nurse.

The failure of some subjects to return the assertiveness schedules may be cited as further evidence of the disruptive effect of the experimental phone call. The intention was to have all the schedules returned before anyone received the phone call. However, four subjects did not return them. Three worked on the same unit, two were roommates, and one reportedly "tore up her questionnaire" after receiving the phone call.

Another difference between the two studies was that in Hofling's study phenomena falling into the category of "psychopathology of everyday life" were observed in a majority of cases. In this study, these phenomena were not observed. Situational rationalizations, however, were found in a majority of subjects' responses to

the debriefer's explanation and to the follow-up phone call by the investigator. Statements such as, "It was just such a busy night", and "If only it had been at another time", were common. The debriefer's perceptions were that none of the units seemed particularly busy or hectic at the time of the experimental phone call. In several cases, the subject denied that she was "really going to give the medication", even though it was retrieved by the debriefer in a medication cup.

The follow-up phone call by the investigator served to provide another opportunity for ventilation of feelings and to remind the subjects of the date, time and purpose of the follow-up session. Interestingly, eleven of the twelve subjects said they would be able to attend the follow-up session. However, only four subjects did attend this session; three were in the control condition and one was in the experimental condition.

A factor which made the data difficult to analyze was that in some instances the debriefer may have stopped the subject too soon. The debriefer was instructed to stop the subject before: 1) she wrote the order in the chart (although the caller stated he would write the order); 2) she consulted with a co-worker; and 3) she entered the patient's room. It was difficult for the debriefer to allow the subject to carry out all of her "intended" actions with these factors in mind. Thus, subjects report, "I wasn't really going to give it. I was just pouring it. Then I was planning to call Pharmacy". In one instance, a subject did confer with another subject before the debriefer could intervene. They decided that the second subject should pour the medication, "drag her feet on

the way to the patient's room and give the capsules slowly, one at a time", while the subject who had accepted the order paged the doctor to question the dosage. In the follow-up phone conversation with the investigator, this subject stated, "I should have been able to confront him directly, but we weren't going to give it until the doctor answered the page".

On one unit, the patient to whom the nurse was instructed to give the medication had been ordered NPO for the evening. The subject appropriately told the caller the patient was NPO and thereby did not have an opportunity to refuse the order on the basis of the dosage discrepancy.

Due to the limited number of volunteers for the study, it was necessary to include nurses who worked part-time in the sample. All of the subjects who worked part-time saw this as a factor in their inability to respond assertively to the caller. They felt that perhaps they should have known who the doctor was and what the medication was and its dosage range.

The data did not support the hypothesis that nurses who received the assertive training inservice program would be more assertive on the job than those nurses who had not received the training. It may be that three one-hour sessions is not enough time to effect a change in situation-specific nonassertive behavior. The literature indicates that significant change in an individual's ability to be assertive can occur during two to four one-hour sessions (McFall and Marston, 1970; McFall and Lillesand, 1971; Eisler et al., 1973; Serber, 1972). However, the subjects in these studies could be described as "generally nonassertive". No research has

been done with subjects described as "situationally nonassertive".

All of the subjects who attended the assertive training sessions were very enthusiastic about it. They felt that there was definitely a need for this type of training and could spontaneously recall many situations in which they lacked assertiveness in their interactions with doctors. One subject reported after the second session that she had practiced "in vivo" an assertive response with a resident, adding, "I'm not ready to try it with a doctor yet". The subjects who attended the follow-up session were hopeful that this training could be made available to more of the hospital staff. On their suggestion, two of the in-service education staff were invited and did attend the second assertive training program. They felt certain that assertive training principles could be incorporated into some of their future in-service programs.

The experimental phone call may have been a severe measure of whether or not there was an increase in the subjects' ability to be assertive. Most of the subjects reported having an increased awareness of what constitutes an assertive response. Many of them reported having practiced assertive responses "in vivo" with patients, peers and residents. Transfer of the assertive training to "real life" situations might have been facilitated if an actual physician had been involved in the behavioral rehearsal rather than a graduate student role-playing the physician.

Lack of assertiveness may be but one of several factors influencing the nurses' response to the experimental phone call. Nursing education programs may be a factor. A nurse begins developing a

professional identity early in her academic career. It is as a student that she is taught how to relate to physicians. It is often a time when she lacks confidence and is given little encouragement or reward for acting independently. Most of us as students have heard more than once, "Do not begin that procedure until your instructor is there to supervise you". She also learns very quickly that a doctor is a busy man and will not appreciate being approached about trivial matters. Unfortunately, she may feel she has little ability to discriminate between what is trivial and what is not. Thus, it may be safer not to approach the doctor at all.

Another factor may be that nurses lack a clear understanding of what their legal responsibilities in medication administration are. In a presentation of this research before a group of nursing faculty members, clinical nurse specialists and nursing graduate students, several individuals cited examples in which nurses gave medication against their judgment on the stipulation that the physician would be responsible (legally) for it. If a nurse fully internalized the belief that the legal responsibility for having given a medication was hers alone, would she be more critical before accepting orders?

Whether due to lack of assertiveness or some other factors, Hofling's study and this study both demonstrate nurses' willingness to accept unethical medical orders creating a hazard to patient safety. Further research is indicated to examine possible causes and explore and evaluate ways to minimize this danger to patients.

Chapter 4

SUMMARY

Much has been written concerning the nurse-physician relationship, communication difficulties within this relationship, and their consequences. Factors which contribute to these difficulties have been identified. Little research has been done on methods which would effectively improve this relationship. It would seem that increasing the nurse's ability to be assertive in situations which are currently inhibiting to assertive responses would effectively improve nurse-physician communication.

The purpose of this study was to provide an inservice program on assertive training to staff nurses and to evaluate the effectiveness of this training. The hypothesis was that nurses who received the assertive training would be more assertive on the job than those who had not received the training. The subjects included 12 female nurses who worked on medical-surgical units and volunteered to participate in the study. They were randomly assigned to either the experimental or the control condition. Subjects in the experimental condition received the assertive training inservice program which consisted of three one-hour, highly structured sessions. Behavioral rehearsal of specific job-related situations was used in each session. Two measures of assertiveness were obtained, a behavioral measure and an attitudinal measure. The behavioral measure consisted of an on-the-job observation of the subjects' responses to the phone call requesting that nurses give twice the

maximum daily dose of an unknown medication. The situation-specific attitudinal measure was derived from the Rathus Assertiveness Schedule. It was shortened and revised to make it applicable to specific work-related nursing situations. Neither measure supported the hypothesis.

The behavioral measure used in this study closely replicates the experimental phone call used in the 1966 study done by Hofling et al. In both studies nurses accepted the unethical medical order. In Hofling's study the modal response to the phone call was described as chagrin, mild anxiety, and a hint of guilt. However, in this study a majority of the subjects responded with anger and unjustified use of situational rationalizations.

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Appendix A

CONSENT FORM

I am volunteering to participate in a special inservice program that will meet one hour per week for three weeks. I understand that the effectiveness of this program will be evaluated through research and agree to participate in this research. It is also my understanding that (Associate Executive Director and Assistant Director of Nursing) have approved both the program and the research. I further understand that my participation in the research will involve on-the-job evaluation and completion of a short questionnaire which will take a total of no more than 20 minutes at a time which will not interfere with patient care. I understand that I will remain anonymous and that my individual evaluation will be known only to the researcher and will not be shared with hospital personnel. Finally, I realize that as a voluntary participant I may withdraw at any time.

Name _____

Date _____

Appendix B

TEACHING PLAN

Session I.

A. Getting acquainted

B. Overview of inservice program:

1. Explanation of rationale

It has been well documented in the literature that often communication difficulties exist between physicians and nurses. Often these difficulties create a hazard to patient safety. Through this inservice program we will be exploring ways to increase the effectiveness of our communication with physicians and with others as well. We will do this through what we call "assertive training".

2. Definition of terms

Let me begin by defining some terms. Assertive behavior is self-enhancing, and honest expression of the individual's feelings. It allows a person to act in his own best interests, to stand up for himself without undue anxiety and to exercise his rights without denying the rights of others. A good feeling about himself typically accompanies the assertive response.

In non-assertive behavior, the individual typically denies himself and is inhibited from expressing his actual feelings. He may be constantly placating other people because he fears to offend them or because he feels a moral obligation to place the interests of others before his own. He may allow people to maneuver him into situations he does not desire. He often feels hurt and anxious as a result of his inadequate behavior.

Situational non-assertiveness concerns those individuals whose behavior is usually adequate and self-enhancing. However, certain situations stimulate a great deal of anxiety which prevents fully adequate responses to that particular situation.

Assertive behavior should not be confused with aggressive behavior. Although a person may find aggressive behavior self-enhancing and expressive of his feelings in a situation, he usually hurts others in the process by making choices for them, and minimizing their worth as people. The recipient of aggressive behavior often feels "put down". His rights have been denied and he feels hurt, defensive and humiliated.

In certain situations that stimulate anxiety, I believe that we as nurses sometimes respond in a non-assertive manner. This occurs at times with doctors, supervisors, co-workers etc. In this inservice program, we will focus specifically on these types of problem situations.

3. Explanation of methods used

The primary method by which we will deal with these situations is called behavioral rehearsal (or role playing). Research has shown that a person can learn to become more assertive by learning what constitutes an effective response and practicing such behavior under non-threatening circumstances.

Initially we will give you a hypothetical situation. We will ask you to:

a. imagine what your response would be (covert rresponding).
b. I will then respond with what we feel is an appropriate response (modeling).
c. later you will be asked to give a response to a given situation (overt responding).
d. you will receive assistance from Jim and me and the group members in making an assertive response (coaching).

Situation I:

Mr. Bower is a middle-aged terminally ill patient on your unit. He will be going home in a few days for what will probably be the last time. His doctor has not seen him for two days. Last evening he expressed concern about this. He made statements such as, "I wonder why Dr. Smits hasn't been in to see me. I guess I'm just not very interesting to him any more." Today Dr. Smits has just finished writing orders in the last of his patients' charts. He has not seen Mr. Bower.

He turns to you and states, "Well, good night, Ms. _____. I'll see you tomorrow."

Imagine as clearly as possible what you feel your response would be to this situation. (pause) Now I will respond with what we feel is an appropriate assertive response. (Research Assistant I repeats Dr. Smits' response.)

Assertive response:
"Dr. Smits, I think it would be helpful if you stopped in to see Mr. Bower. He was concerned yesterday about why you had not been in. He said he felt as though he just wasn't very interesting to you any more."

Discussion of response:

In the next situation, we will ask for volunteers to share their responses with the group. You will receive feedback and assistance from the group.

Situation II:

It is 2 days post-op. Mr. Morgan has had abdominal surgery; he is a 60 year old man on your unit. You know that he has smoked from two to three packs of cigarettes a day for the past thirty years. He is doing very little changing of position in bed. He will not cooperate with the coughing and deep breathing exercises. You are concerned that he is congested and feel that IPPB should be ordered. You inform Dr. Smits of his unwillingness to cooperate with the coughing and deep breathing exercises and that he is now very congested.

He responds, "Well, just keep trying and don't let that gruff attitude of his scare you. He needs those exercises."

Assertive response:
"I agree. He does need the exercises. But he is already congested. I think IPPB should be ordered."

4. Assignments

   a. Develop an assertive response to the following situation:

Mrs. Satrom is an elderly patient on your unit. You are making rounds with Dr. Smits. You enter Mrs. Satrom's room. Dr. Smits changes the dressing on her leg wound. You note that the wound is still draining. Dr. Smits has now finished changing the dressing. He bids Mrs. Satrom a good day and turns to leave the room. He has made no indication that he intends to wash his hands.

You enter the hallway and he turns to you and says, "Well, Ms. _____, let's go see how Miss Howards is getting along today."

   b. Come prepared with a "real life" work situation requiring an assertive response.

Session II.

A. Rehearse assertive response devised for the given situation.

B. Rehearse the "real life" work situations requiring an assertive response.

C. Assignments

   1. Come prepared to share a "real life" work situation in which you were not assertive.

2. Practice "in vivo" an assertive response and be prepared to rehearse it with the group.

Session III.

A. Develop an assertive response for the "real life" work situation in which subject had not been assertive.

B. Rehearse the responses developed with group giving feedback.

C. Rehearse situations in which subjects had practiced an assertive response "in vivo".

D. Assignment: Practice as many "in vivo" assertive responses as possible between this and the final session.

Appendix C

ASSERTIVENESS SCHEDULE

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

+3 very characteristic of me, extremely descriptive

+2 rather characteristic of me, quite descriptive

+1 somewhat characteristic of me, slightly descriptive

-1 somewhat uncharacteristic of me, slightly nondescriptive

-2 rather uncharacteristic of me, quite nondescriptive

-3 very uncharacteristic of me, extremely nondescriptive

____ 1. I am careful to avoid hurting my superior's feelings, even if I feel I have been injured.

____ 2. When a superior asks me to do something, I insist upon knowing why.

____ 3. I have avoided asking questions of certain doctors for fear of sounding stupid.

____ 4. When I have done something important or worthwhile, I manage to let my superiors know about it.

____ 5. I am quick to express an opinion to a superior.

____ 6. Rather than cause friction on the unit, I have avoided challenging certain doctors.

____ 7. I find it easier to conform rather than risk making a scene by challenging a superior.

____ 8. I feel it is my responsibility to challenge instructions which I do not understand.

____ 9. I feel it is more important to be seen as cooperative and easy to get along with, than to challenge everything I don't understand.

___ 10. I feel it is not my place to challenge those with more education and experience than myself.

___ 11. When I feel instructions from a superior are erroneous, I express my opinion without hesitation.