ASSERTIVE BEHAVIOR AND DEPRESSION AMONG NATIVE AMERICAN NURSING STUDENTS AND NATIVE AMERICAN NURSES

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

BY

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DENTON, TEXAS

MAY 1982

ACKNOWLEDGMENTS

The undertaking of this study has been a life-long dream. But I could not have accomplished this endeavor without the assistance and contributions of many, in particular, those dear to me.

I would like to extend my gratitude to the faculty at Texas Woman's University who have assisted me with my work. My thanks goes especially to Dr. David Marshall, who has served as consultant/advisor responding to my aid above and beyond the call of duty. A special thanks goes to my chairperson, Dr. Margie Johnson, who has guided and supported me during my years in the graduate program.

I wish to extend my appreciation to those who have assisted me with the development of this work. Particularly Dr. Robert Ryan, Director of the Society of American Indian Psychologists and Whitecloud Center, Portland, Oregon, and Dr. Teresa LaFromboise, secretary of the Society of American Indian Psychologists whose critiques of my work have been most helpful.

My sincere appreciation is also extended to Lydia Pourier, Director of the Nursing Education Center for Indians, Albuquerque, New Mexico who has made it possible for my research to become a reality. Still a very special

thanks to Laurie Freeman Rowell, who not only has read and critiqued my work but has proven to be a friend as well. A special word of thanks to Elaine Cudd for the typing.

But most of all I am indebted to the inspiration and stamina of my dearest friend, Juan O. Atencio, who has taught me to love and appreciate the Navajo. Also my dearest friend and sister, Marcine Leah Cassadore from the San Carlos Apache reservation, who has taught me to truly appreciate even more the richness of my own heritage. Still many thanks to those too numerous to mention, who have inspired me all the way.

Last, but not least, I wish to thank my mother who has provided me with courage when everything else seemed to go wrong. Her strength and guidance have served to instill confidence in my ability. My son Joey, with his love, courage, and patience with a mother in school, has added that extra spark to my life. Thank you, Joey, because without your love and encouragement, I could never have made it.

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CHAPTER 1

INTRODUCTION

For many, America has been a land of great wealth and opportunity. However, for others, life continues to be a struggle against the forces of opposition, oppression, alienation, and frustration. Currently, as in the past, members of such groups--minorities and poor--have had difficulty obtaining the benefits and services that society has to offer. As a result, members of these groups are beginning to examine and question their present status within society while they seek more effective ways to improve their standard of living.

To aid such groups in achieving these goals (i.e., receiving benefits and services), this study has focused attention on health care treatment modalities. Recently within the mental health milieu, the concept of assertiveness has gained widespread popularity. Assertiveness refers to one's ability to act or speak on his own behalf without undue anxiety (Alberti, 1977, p. 22). The study of assertiveness has had wide implications in terms of addressing the needs of those who wish to enhance personal effectiveness particularly among women and children; and,

until recently, the issue of its relevance to members of minority groups has been brought forth.

It is within this context that a desire to increase the efficacy of existing health care delivery systems, particularly for minorities and poor, has emerged. Previously, health care delivery systems have been designed to address the concerns of the members of the society as a whole while little has been done to address the unique problems and concerns of the indigent population. But, first in order to improve or address the efficacy of the health care delivery systems, it is imperative to examine the adequacy of the preparation of those health care professionals who are to directly provide such health care. However, often it is the professional who is rendered helpless by either being unfamiliar with, or being unprepared to deal with, the unique problems of the clients that he is to serve.

Literature has alluded to the dearth of adequately prepared health care professionals capable of addressing concerns and answering questions about their clients. Hence, it is the belief of this investigator that the problem can best be dealt with by those who know best, the social and cultural milieu of minority groups, that is, the minority group members themselves.

Problem of Study

The preparation of minority health care workers has been inadequate due to high attrition among minority students within academic institutions. Hence, to safeguard the preparation of minority health care workers, it is crucial to help them to develop a built-in mechanism to insure their success within the system.

In order to devise more effective ways to improve mental health care delivery systems for Native Americans and lower socioeconomic clients, this study then attempts to address the following objectives:

1. Levels of depression among Native American nursing students and nurses

2. Levels of assertiveness among Native American nursing students and nurses

3. Establishment of a relationship between levels of depression and levels of assertiveness among Native American nursing students and nurses

4. Establishment of the efficacy of assertiveness training programs in alleviating reactive or neurotic depression which stems from long term exposure of feelings of helplessness, hopelessness, and despair.

Seligman (1973), through a cognitive model of depression as learned helplessness, observed that depression

has aspects of human helplessness. Helplessness is a phenomenon whereby one learns that his outcomes are futile. In other words, the person believes himself to be powerless and hopeless and his future to be bleak. Seligman's theory has relevance to those individuals who are forced to live within the political and social entrapment caused by poverty, ghettoes, and the like. Resultant feelings of helplessness and hopelessness are likely when one experiences that he has little impact on his environment.

Although 6.2% of registered nurses are members of ethnic/racial minority groups (Roth, Graham, & Schmitting, 1979), they have been disproportionately neglected in the literature. In addition, certain ethnic groups have been omitted almost entirely, particularly Native Americans, Chicanos, Asians, Filipinos, Puerto Ricans, and others (Claerbaut, 1978, p. 46). Claerbaut's research cites the concerns and problems of minority students within academic settings, such as feelings of frustration and conflict, especially when dealing with white majority culture members. John Byrd, in his book Modern Indian Psychology (1971), has written about the problems among modern Indians. He contrasts and compares Indians' and non-Indians' values and cultures. Bryde explains the reasons for feelings of isolation, frustration, conflict, and other problems facing

Indians. He relates historical events that have been communicated to him from many Indian and non-Indian people, as well as presenting his theories from an Indian perspective.

Justification of the Problem

Because shifts in population tend to increase ethnic isolation, deficiencies in health care services tend to exist among ethnic minorities. These differences are best handled by those people whose lives are most intimately affected by the problem--members of the minority group themselves, individuals who must meet problems peculiar to their cultural milieu and socioeconomic status.

These problems are effectively addressed by Seligman (1973) who discusses the relationships between helplessness and those problems associated with race and poverty. But it should be recognized that depression and learned helplessness can be treated effectively.

This study will examine one form of behavior therapy, assertiveness training, as a method for treating and preventing depression among minority group nurses. However, there is an important factor to consider in terms of implications. While many minority group members can benefit from such training programs, existing frameworks may need to be modified in order to fit the communication

patterns of the particular cultural group. Therefore, existing therapies must be assessed for their effectiveness. Donald Cheek addresses this issue in his book, Assertive Black...Puzzled White (1976), when he discusses instances of professionals having limited experience and/or knowledge of client's cultural and/or racial background. He feels that it is important to stress cultural variables in any type of therapy (Cheek, 1976).

Indians, just as any other cultural or ethnic group, face problems while dealing with friends, relatives, work settings, educational institutions, or any situation. Many of the problems and concerns of this minority group parallel those problems addressed by the women's movement. Discrimination, underemployment, exploitation and denial from full participation in society, are just a few of the conflicts that have arisen. But, even more pronounced is the problem unique to the Indian woman, her double minority status. When such conflicts are coupled with feminist issues which affect nurses in particular, the situation of the American Indian woman presents a unique and complex series of problems.

Indians feel because they have different values that society will reject them, and as a result, often harbor negative feelings about themselves when interacting with the dominant culture. If a person does not believe that

he will do well, or if he feels helpless, he will not try as hard. This affects intellectual achievement and produces intellectual deficits (Seligman, 1973). To compound the problem, the Indian, who feels he cannot ever be accepted, will not try as hard as members of the dominant culture. He is caught in the position of being unable to move either backward or forward. As Seligman observes "intelligence no matter how high cannot manifest itself if one believes his own actions have no effect" (1973). Thus, minority groups will not likely perservere equally with non-minority groups in the face of academic difficulties. Hence, repeated experience with success accompanied by real changes in opportunity will be necessary to break this cycle of helplessness and hopelessness.

It has been estimated that there has been minimal success with existing treatment modalities particularly for minorities and poor and subsequently there has been a need to address the inadequacies of such treatments (Lorion, 1971). It has long been recognized that communication patterns and lifestyles do differ significantly from those of the white middle class value orientations. The importance of clarifying these value orientations within cultural context is crucial. Thus, any study which attempts to analyze and remedy the problems of American Indian nursing

students and nurses may shed light on difficulties faced by minority groups in general.

Conceptual Framework

Sources used to create the theoretical framework include behavior therapy that was characterized initially (Salter, 1949; Wolpe, 1958; Wolpe & Lazarus, 1966) as a counter-conditioning procedure for anxiety. In addition, assertiveness training stems from "social learning theory (Bandura, 1969), as well as a combination of 'Gestalt' theory (Perls, 1969) and humanistic-existential theory (Rogers, 1961), incorporating concepts of universal human rights" (Alberti & Emmons, 1977).

Alberti and Emmons (1977) define assertive behavior as "behavior which enables a person to act in his or her own best interests, to stand up for herself or himself without undue anxiety, to express honest feelings comfortably, or to exercise personal rights without denying the rights of others." Even though Wolpe (1958) first used the word "assertive," in his book on reciprocal inhibition, Andrew Salter (1949) was the first originator of assertion training.

Research has demonstrated that people who are assertive are happier and exhibit less anxiety (Alberti & Emmons, 1977). They are free to express their wants and desires

without undue fear. Through the expression of such needs, they tend to view themselves more positively. As a result, they experience increased personal satisfaction, which leads to increased feelings of self-worth and self-esteem. Assertiveness training has been proved most useful and has been applied most successfully to persons who experience difficulty in expressing themselves because of fear of rejection and feelings of hostility and worthlessness. It has been especially beneficial to those who are dealing with interpersonal situations such as conflict.

Through widespread popularity of its appropriateness in a wide variety of situations, assertiveness training has become more extensive in its use and application. Assertive training has been developed and tailored to the needs of women, children, marital couples, and more recently to members of particular ethnic groups. However, in spite of its increased popularity, it must be cautioned that its appropriateness cannot be assumed to be applicable to all people for all situations. It is not a "cure all" nor does it provide solutions to all problems. Yet, despite its limitations, assertiveness training can be used appropriately in training, education, or therapy.

Through the effective use and enjoyment of personal power and personal rights, one can become an integral member of society. Until one is able to become fully

actualized, he cannot truly appreciate the feelings and concerns of others. Hence, self-esteem is an essential component of self-assertion.

In similar sense, Indians are forced to deal with those forces external to their culture, and if they are to co-exist mutually in a satisfactory relationship with the non-Indian society, they must first continue to appreciate and accept their own values while appreciating values different from their own. In essence, it is the attitude of feeling good about oneself that leaves one free to move in and out of different relationships without the loss of identity, integrity, or loss of self. However, learning how to deal effectively with members of the non-Indian society has not been accomplished without pain and suffering for the Indians who often continue to face rejection or hostility in their expanding social and academic milieu. Such responses have led to flight or escape on the part of the Indian in an attempt to return to the familiar. This has often led to personal failure while similtaneously inhibiting growth. Such problems are compounded for the Indian woman, who has been traditionally bound by culture to deny or negate her own feelings and aspirations.

The culture problems faced by the Indian woman suggest that the depression she faces may be linked to a lack of

assertiveness. In this regard, a careful analysis of the benefits of assertiveness training may be in order.

Such a view provides a useful framework for analysis of the Indian perspective. As victims of poverty and social entrapment, the Indian is often rendered helpless and cannot go back to a lifestyle that no longer exists, at least not in its original form, nor can he advance. As a result, he becomes anxious because he lacks the repertoire of behavior appropriate to solve his problems. This leads to increased frustration which in turn is replaced by depression when he learns that he has little or no impact upon his environment.

If it is true that depression can be brought about by social and cultural entrapment, then an appropriate intervention for depression would be to provide opportunities for success. Once a person learns that he does have an impact upon his environment and that he can effect change, then he will alleviate his depression. Assertiveness training may be an appropriate intervention because it provides the skills that are necessary in order to increase personal effectiveness. It can enable one to master his environment by learning how to tap into the various resources and opportunities that are available.

Assumptions

The study assumes that

1. Depression and learned helplessness are prevalent among the college and general populations.

2. Native American college students and nurses are equally subjected to depression as well.

3. It is further assumed that an assertiveness training program may be useful in assisting Native American nursing students and Native American nurses in improving their communication skills and interpersonal relationships.

Hypotheses

The hypothesis for this study was as follows: There is no statistically significant difference in the level of depression and assertiveness of Native American nursing students and nurses following four sessions of assertiveness training.

The subhypotheses for this study include:

1. There is no statistically significant difference in assertiveness and depression scores of the Native American nursing students and nurses between groups which have received modified assertiveness training and those who have had traditional assertiveness training.

2. There is no statistically significant difference in assertiveness and depression scores of Native American nursing students and nurses between groups which have received traditional assertiveness training and those who have had bibliotherapy (attention control).

3. There is no statistically significant difference in assertiveness and depression scores of Native American nursing students and nurses between groups which have received bibliotherapy and those which have had no treatment (control).

Dependent and Independent Variables

The dependent variables are the levels of depression and assertiveness.

The independent variables are assertion training: modified, traditional, bibliotherapy, and control.

Definition of Terms

The definitions of terms for the purpose of this research are:

1. Assertiveness:

Theoretical Definition. This concept describes

> relative characteristic behavior which enables a person to act in his or her own best interests; to stand up for himself/herself without undue anxiety; to express honest feelings comfortably; or to exercise personal rights without denying the rights of others (Alberti & Emmons, 1977, p. 27).

Operational Definition. Assertiveness as measured by the Gambrill and Richey Assertion Inventory and the Assertiveness Example-Anchored Rating Scale developed according to the Taylor method.

2. Depressive Reaction:

Theoretical Definition. This reaction is "marked by excessive sadness that has had its beginnings in a specific environmental event" (Davison et al., 1978).

Operational Definition. Depression as measured by the Beck Depression Inventory and the Depression Example-Anchored Scale developed according to the Taylor method.

3. Native American/Alaska Native:

Theoretical Definition. A person having origins in any of the original peoples of North America, and who maintain cultural identification or community recognition (U. S. Government Printing Office, 1980, 620-231/4226).

4. Native American/Alaska Native Nurses and Student Nurses:

Theoretical Definition. A person who has origins in any of the tribes among the "first people" of the United States who either enrolled in a program that prepares him/her to enter into the practice of nursing or who has graduated from a basic nurses' training program and possesses a license to practice nursing within the Southwestern portion of the United States.

Operational Definition. An individual who is of American Indian/Alaska Native descent currently enrolled in a nursing program within the Southwestern part of the United States or who has graduated from a nursing program and is currently in practice.

Limitations

The assessment of assertiveness is done with the Gambrill and Richey Assertion Inventory, which has not been developed specifically for a Native American population. The reported validity and reliability that has been reported for non-Indian populations may not be accurate for Native American participants. Equally, the Beck Depression Inventory has been developed initially from a psychiatric population, and its reported reliability and validity may not be accurate for Native American participants.

The geographical area is limited to Native American/Alaska Natives located within the Southwestern part of the United States. Therefore, the interpretation arrived at in this study may not be appropriate to other parts of the United States.

Summary

The needs and problems of the minorities and the poor have traditionally been multi-faceted. For the Native American, in particular, problems continue to be virtually

insurmountable. Although there are numerous treatment modalities to deal with such problems, they have not effectively addressed the problems, conflicts, and frustrations of the indigent and ethnic people of color.

Assertiveness training, through recent popularity, has benefited a number of people within a variety of situations; however, it has not been tailored to address the needs of these ethnic groups. The present study attempts to address the tailoring of such treatment or training procedures so that it will deal with those concerns specific to minority group members. Prevailing problems of discrimination, poverty, poor health, etc. have contributed to the plight of minorities, making their problems unique to those of other members of society.

CHAPTER 2

REVIEW OF LITERATURE

Review of the Literature Related to the Problem

Assertiveness has been a popular topic through recent years. However, papers considering assertiveness in conjunction with ethnicity have not been widely published. Nonetheless, some recent works do explore the problem. A recent publication by Donald Cheek (1977), Assertive Black . . .Puzzled White, discusses assertiveness behavior and Black lifestyles. Dr. Cheek points out that psychological theories have built-in cultural biases, but assertive training within itself is free of bias and is, therefore, beneficial to the Black clients. Dr. Cheek maintains that the way assertive training is practiced does not benefit Blacks because of problems in communication. Subsequently, the author delineates ten steps that are requisite in order to apply assertiveness techniques to the Black client, steps that explore and emphasize sensitivity to the feelings and communication pattern of the Black client that white therapists need to know. Language is broken down into "white talk and Black talk". For Cheek points out that although English is spoken in both groups, certain words have

different meanings and usages when applied to the Black lifestyle. The author concludes that in order for assertive training to be most effective, the facilitator or therapist must be Black-oriented and already familiar with the Black reality and Black language styles (p. 49).

"Group Assertion Training for Spanish Speaking, Mexican-American Mothers" (Landau & Paulson, 1977) revolves around assertion training for Spanish-speaking Mexican-American mothers. Authors Landau and Paulson cite the Mexican-American as the second largest disadvantaged minority group in the United States (p. 119). Assertive training could prove most beneficial to a population that has been forced into an existence along the periphery of American society.

The authors focused their study on the effectiveness of assertiveness training with young Mexican-American mothers. The program emphasized improvement of interpersonal relationships through appropriate communication. Learning to make requests, denying requests within concrete situations, and learning how to seek employment, were some of the skills enhanced by the study of assertiveness techniques. This program attempted to teach persons of the ethnic group to enhance the communication skills derived from their own cultural influence so that the therapist could in turn help them make their needs known.

Still another concern for minority groups is the breaking of myths and stereotypes held by one group when describing another. Hwang (1977) describes in his work "Assertion Training for Asian-American" the problems of being an Asian in the American culture. Hwang advocates assertive training to remedy the ill of self-denial, passive and submissiveness toward authority that is prevalent among the members of Oriental culture. He identifies myths that most Orientals hold about themselves so that they may react to each stereotype. However, Hwang observes that the method to achieve this is through better communication, in order to assist an individual to communicate freely with his or her sincere and honest feelings.

Report of Previous Research Findings Related to the Problem

In scanning the present literature, an observer will find that rather limited research has been focused in this area although the broad, general topic "assertiveness" is very popular. In 1973, the Minnesota Project on the Ethnic American sponsored an experimental program through a workshop in an effort to make American education more responsive to the cultural needs and new assertiveness of minority groups in Ameican society (Montalto, 1973). The title of the project was Modifying the Small Group Experience for Multi-Cultural America. The project had identified and

assumed that the importance of ethnicity as well as other related variables, contribute towards differences in attitude and outlook among Americans.

This project has emphasized group participation based on the premise that once an individual becomes a part of a group, his behavior is altered by the group; however, at the same time, one is warned that the group's action does not necessarily reflect the actions of the individual and warns against such generalizations since "it is not assumed that a presumed group pattern is inevitably expressed in a person's actions. The range of variations within particular groups is so great that generalizations are extremely difficult" (Montalto, 1973, p. 3). Overall, the project's goals were to assess individual communication styles within the cultural context.

Monte Kagan, Ph.D., out of the University of California, Los Angeles, 1973, developed a dissertation titled Adaptation Mode and Behavior of Urban Anglo American and Rural Mexican Children. The study sought to test the hypothesis that. . . "in response to a conflict with their environment, urban Anglo American children attempt to adjust the environment to fit their own needs more than rural Mexican children who more often adjust themselves to meet the press of the environment" (p. 2900). The study contrasted the value orientations of Mexicans and Anglo Americans developed

from seven sources. Seven different experiments were devised. Among these were an "assertiveness pull scale" which was used to assess assertiveness of rural Mexican and semi-rural Anglo American and Mexican-American children. The result, according to the study, were as follows" the semi-rural United States children were more assertive than the rural Mexican children (p. 2900). Although there were no significant differences between Anglo American and Mexican children, the author concludes that there is a tendency for the Mexican-American children to be somewhat less assertive than the Anglo American children (p. 2900).

In 1975, Brian Grodner, out of the University of New Mexico, studied "Assertiveness and Anxiety among Anglo and Chicano Psychiatric Patients". Grodner sought to study the effects of cultural differences and socio-economic class on levels of assertiveness, and the relationship between assertiveness and anxiety. Grodner emphasizes the importance of identifying and understanding the psychological as well as the sociological characteristics of minority groups before applying or implementing any type of assertiveness training. His population was psychiatric patients in a Veteran's Administration Albuquerque, New Mexico hospital. His findings had suggested "partial correlations between assertiveness and ethnicity (socio-economic class held constant) and assertiveness and socio-economic class (ethnicity held

constant) showed that assertiveness was significantly correlated to socio-economic class but not to ethnicity" (p. 135). Also, "ethnicity, not socio-economic class, however, appears to have the strongest relationship with the correlation between assertiveness and anxiety" (p. 135).

In the final analysis, Grodner does proposes that assertiveness behavior training could be an appropriate intervention in assisting minority group members to take better advantage of the goods and services that society has to offer because a lack of assertiveness behavior results in or leads to losing opportunities (Grodner, p. 135).

In still another study, Maria Milagros Lopez-Garriga, in 1976, investigated Strategies of Self-Assertion: The Puerto Rican Woman at the City University of New York. Her study had attempted to define and understand the use of manipulative strategies in the woman's effort to circumvent patriarchal authority in the family. In an attempt to deal with certain issues regarding female oppression, the author analyzed manipulative behavior among women within different social classes. Her findings suggest a higher degree of manipulative strategies in middle class or middle strata women while dealing with their husbands as opposed to a lesser degree of manipulative strategies with those in the lower class women in dealing with their husbands.

Teresa D. LaFromboise, Ph.D., from the University of Oklahoma at Norman, 1979, has completed a dissertation titled Assertion Training with the American Indian. LaFromboise discusses assertiveness training as appropriate for the Indian people; however, as with other ethnic groups, the training must be tailored to the specific cultural, behavioral and values that are unique to them.

LaFromboise (1979) delineates a specific format geared to the Native American population as well as providing information and instructions for trainers. Hence, such a tool should provide a significant influence on assisting the Indian on the road towards a better life through assertion training.

Still another timely article (Minor, 1978) entitled "A Perspective for Assertiveness Training for Blacks" addresses the central theme discussed by Cheek and others that have recently come about, but he raises the question of "assuming common socialization when using assertiveness training's approach with Blacks" (p. 63), by stressing the importance of Black-white responses. Minor reminds us that historically Blacks in the United States have had to cope with racism within a predominately white society. Therefore, one must take into account that assertive responses can be misinterpreted during Black-white encounters.

To summarize, present research as well as current literature in varying degrees suggests the influence of culture, socio-economic class, and psychological factors over levels of assertiveness among minority group members. The intent of this study was to test the effectiveness of an assertion training format tailored to the cultural needs of Native American nursing students.

Several theories of depression have been provided (psychoanalytic, cognitive, learning, and physiological), however, Seligman's theory proves to be most helpful in discussing the plight of those of the disadvantaged society, the minorities and the poor. Seligman (1975) has offered a cognitive view of the Learned-Helplessness Model of Depression. His theory suggests that one learns that he is helpless when he learns that outcomes become independent of response.

For most of us, reinforcement is obtained when we receive rewards from the environment. This boosts self-esteem and provides further incentives towards increasing one's productiveness and capacity towards personal enhancement. Conversely, when one does not receive such rewards, then it is likely that he begins to harbor negative feelings about himself. If this present state is allowed to continue, then one becomes more cognizant of his failures and thus begins to see himself in an unfavorable light. Even

more pronounced is the painful existence of those among us who experience extreme personal failure daily. In such individuals life too often becomes unbearable, often leading to a state of deterioration not only of mental abilities, but physical activities as well. Such individuals are forced to exist along the periphery of society, denying themselves the prospects and rewards of living a real and fulfilling life. In extreme cases, these individuals may be so paralyzed by their own ineffectiveness that they are forced to live in the confines of institutions.

But, still there are those among us whose fate does not lie within that category, but who are equally trapped by their environment because their ineffectiveness results in their having no influence on it. They are the socially entrapped, forced to live in an existence against their will.

The usefullness of Seligman's theory provides a framework in which to analyze such a phenomenon because of its broad applicability to the human struggle to justify its existence.

Commencing with his notorious animal studies on learned helplessness, Seligman has been able to prove that the faulty responses of such animals (in this case, dogs) were brought about by the contrived situation of uncontrollable events. Through such experiments within the laboratory,

Seligman et al. has been able to replicate motivational, cognitive, and emotional disturbances that would not under normal conditions have otherwise been present. Similarly, the results of these experiments when compared to human experiments (college population), the phenomenon of helplessness has proven equally applicable (Seligman, 1975).

The effect of the environment has offered a possible explanation of helplessness. What this refers to, Seligman suggests, is the arrangement of controllable and uncontrollable events. In the same manner, poverty restricts choices. Individuals who feel trapped become anxious, and this anxiety is replaced over a long period of time by depression. Seligman argues that the limited success of Blacks, which can be generalized to other minority groups, can be explained in terms of helplessness (p. 163) rather than solely as a deficit in intelligence. He states, "Blacks do not persist equally with whites in the face of academic difficulty" (p. 164).

Another timely article regarding depression deals specifically with the etiology of depression among American Indians. Authors Townsley and Goldstein (1977) discuss the cause in terms of the parent-child relationship that promotes dependency of the American Indian on the Federal government. This pervasive condition has inadvertently supplied the incentive for the Indian to remain dependent.

This type of situation according to Seligman, only eliminates one's control or mastery over his environment. As a result, the Indian harbors a negative self-image. In addition, as Townsley and Goldstein (1977) have indicated also, economic factors play an important role in creating depression through the existence of low education and underemployment. Such factors have led to an increased alcohol intake, suicide, homocide (p. 460) and the like among the Native American people.

Difficulties within bureaucracy's settings have served not only to alienate the American Indian from his culture, but also to contribute significantly to the feelings of rejection, depression, and anxiety. The Minnesota Multiphasic Personality Inventory test which compares responses of American Indians with those of white students (Townsley & Goldstein, 1977, p. 461) reveals a greater personality disruption among the Indian students including a tendency to withdraw accompanied by social and emotional alienation.

In conclusion, the authors express that dependency depression has contributed to the lack of self-respect and a "lack of control over one's daily life" (p. 46) for the American Indian. The right to self determination is crucial for the American Indian to obtain control over his life, and, in turn, to regain his dignity and his independence.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The research design employed in this study was the experimental two-dimensional Factorial MANOVA. Figure 1 is an illustration of the Factorial MANOVA. There were four levels of the treatment category (Factor A)--Modified, Traditional, Attention Control (Bibliotherapy), and Control (See Appendices A, B, and C, respectively, for complete description)--and two trainers (Factor B). The dependent

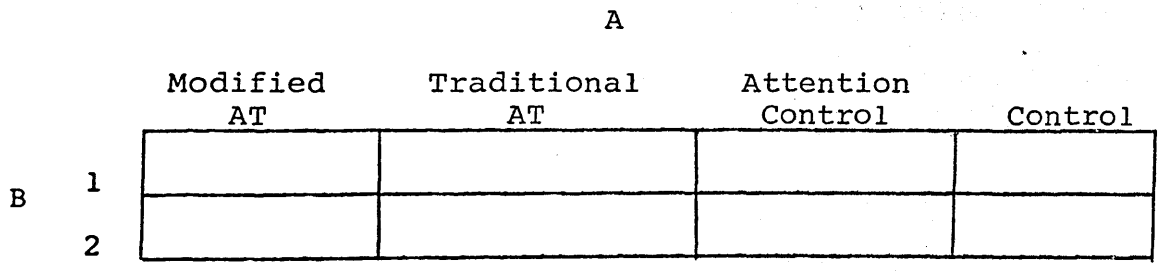


Figure 1. Factorial MANOVA.

variables were post-test depression scores and post-test assertiveness scores.

Two organizations had been contacted--Society of American Indian Psychologists and American Indian/Alaska Native Nurses Association--to serve as a panel of experts (ten members from each organization), for the development of the Modified Assertiveness Training Format.

Subjects were randomly assigned to the treatment and control groups. Each subject received one of the four levels of the treatment-control factor (i.e., Modified, Traditional, Attention Control, Control). Similarly, each trainer administered one of each of the two levels of the treatment factor, Modified and Traditional, to two separate groups of subjects.

To check for the trainer's effect on and interaction with the treatment, the design is illustrated in Figure 1.

There was no significant main trainer effect or interaction, and the design was collapsed into a one-way multivariate analysis of variance. Randomly selected recordings in lieu of records of each treatment was made for "core conditions" to check fidelity of treatment conditions.

The data in the completely randomized design are represented in the following dummy table (Figure 2). For the

Factor-Assertiveness Procedure Treatment Levels

Group 1*	Group 2**	Attention Control***	Control****

N = 5-12 Subjects per cell
* = Modified geared towards Indian AT Group
** = Traditional AT Group
*** = Attention Control Group
**** = Control Group

Figure 2. One-way MANOVA.

One-way MANOVA, the following hypothesis had been delineated: There was no significant difference in the effectiveness of the four levels of the treatment-control factor and the means were equal.

According to Dayton, the Factorial design has two major advantages: (a) there is economy of time and money because the same subjects are used to estimate the effects of both treatments, and (b) subjects receive both treatments at the same time. As a result, the interaction effects are brought out or made available for analysis or the application of one treatment can increase or decrease the effects of the other treatment. In addition, more sophisticated designs can control for small error variance or yield smaller experimental error (Dayton, p. 66).

Some disadvantages, however, are that external generalization is limited due to randomization to obtain the experimental subjects. A more sophisticated design may not be applicable for practical reasons because of time and money or the experimental situation may not lend itself to such a design.

Setting

The setting for this study was in Albuquerque, New Mexico, a Southwestern city. There are two major

universities, one state and one private, and a technical vocational school within the City.

Nursing students were enrolled in one of these programs that offer nurses' training. It was expected that the students were normally present on or near the campus for their regular classes during that time.

Population and Sample

The research population was taken from Native American nursing students from collegiate nursing-based programs and Native American nurses located within the Southwest. Subjects were selected to participate in the study because of their Native American background. The criteria for selection were (a) the student's current enrollment within a nursing program, (b) the student's having designated nursing as a major, and (c) the student's interest and consent in participating in the study. A remuneration of #3.35 per hour for each student who attended four sessions was paid to provide some service compensation for the time and inconvenience the student incurred while attending the sessions.

Protection of Human Subjects

Upon receiving permission from the Human Subjects Review Committee of the Texas Woman's University, the study

began. Permission forms (Appendix D) were used to obtain permission from participants.

There were no physical risks to the subjects. Possible risks, however, were identified as follows:

1. The exposure of the subject's identity may occur during and after the study.

2. The subject may find the study lengthy and fatiguing.

3. The information obtained could be used for purposes of exploiting the Indian population.

Assurances against the described risks were as follows:

1. Code numbers insured confidentiality as well as a thorough explanation of the nature and purpose of the questionnaires and an assurance to the subject that his prior consent would be required. The data collected was used solely for the purpose of the study. Subjects were advised that they may withdraw from the study at any time. All actual or potential risks were made known to each subject. Ample time was allotted to answer additional questions and/or concerns.

2. Their participation provided information that may contribute to the retention of Native American/Alaska Native nursing students and nurses within the nursing curriculum.

3. The training provided should enhance communication skills by increasing or adding to the repertoire of behavior and it gives the individual an option to choose or not to choose.

Moreover, subjects were treated with dignity and respect regardless of circumstances. All measures were taken to insure the subject's comfort and safety.

Ethical Considerations

Upon termination of the investigation, the benefits of the treatment were disclosed to the subject, with particular attention to the control groups. The benefits of the treatment procedure were made available to the subjects with follow-up referral and counseling if necessary. The subjects were warned that the results of assertiveness training may affect their relationships with significant others (i.e., spouses, friends, children) and that they should be prepared for these changes.

Instruments

The questionnaires were self-administered. There were two scales: (a) Beck's Depression Inventory, to assess levels of depression; and (b) Gambrill and Richey's Assertion Inventory, to assess levels of assertiveness.

The present Assertion Inventory (Gambrill and Richey) is a useful tool which has been used to assess levels of assertiveness among non-Indian populations. Individuals are assessed for assertiveness within certain social situations. It not only elicits the response probability, but how often the subject is likely to respond in such a situation. The subject completed the first scale, Degree of Discomfort, for the 40 items before answering the second scale, Response Probability.

For the Degree of Discomfort Scale each subject indicated his degree of discomfort next to each item. The scale is from one to five (1-5), a one response would indicate the degree of least discomfort, and a five would be the degree of most discomfort. Similarly, for the Response Probability Scale, the subject indicated the number of times he engaged in such behavior if found in a similar situation; a one response would indicate most often while a five response least often. The anticipated time it took for the subject to respond to the questionnaire ranged from 15 minutes to 45 minutes. This correlated with degrees of discomfort so that one obtained a composite picture of the response probability as well as the degree of anxiety accompanying. Authors Gambrill and Richey (1975) report a reliability of 0.87 for the discomfort score and 0.81 for

response probability (Pearson correlations between pre- and post-test scores). Additional validation research is recommended (McReynolds, 1977). (Appendix F)

Beck's Depression Inventory Scale establishes validity and reliability as it measures the levels of depression. It has been developed by Beck, Ward, Mendelson, Mock, and Erbaugh (1961). The instrument has been selected because it provides a scale that is designed to quantify the concept of depression. The BDI consists of 21 multiple choice items wherein the individual must select the response in each category which best fits him. The scores are then added to provide a total BDI score. Since 1961, two revisions of the instrument have been published (1967 & 1978).

The reliability coefficient based on a psychiatric sample has been reported as 0.93 by Beck and others (1961) although Weckowicz, Muir, and Cropley (1967), as well as Miller and Seligman (1973) report a lower figure. Considerable discussion provides evidence for substantial validity while the instrument has been reported to rate high when correlated with others that are self-rated (McReynolds, 1977). (Appendix G)

Two scales of measurement in addition to the Beck Depression Inventory and the Gambrill and Richey Assertion Inventory had been developed according to the Taylor method to assess depressive content and assertiveness content,

respectively (Appendices H & I contain a copy of each instrument). Kendall's coefficient of confidence for the Taylor Assertive Scale is $\underline{W}$ = .88, and for the Depressive Scale is $\underline{W}$ = .893.

Data Collection

Native American/Alaska Native nursing students were contacted through the cooperation and efforts of Lydia Pourier, Director, Nursing Education Center for Indians. Subjects also responded to a local campus newspaper advertisement (Appendix E). A mailing list obtained from the New Mexico Board of Nursing made it possible to contact approximately 140 nurses licensed to practice in the State of New Mexico, particularly those residing in the Albuquerque, Santa Fe area. Mrs. Louise Kiger, Nurse Educator, Santa Fe Indian Hospital, was responsible for contacting nursing staff within that institution.

The present investigation evaluated the effects of different assertiveness training procedures on levels of assertiveness and on levels of depression among Native American nursing students. The initial design, Factorial MANOVA, had four levels of the treatment factors--modified, traditional, attention control, and control. The levels of the second factor were two trainers. The experiment contrasted groups which received both training procedures,

modified and traditional, with trainer one and groups that received the same training procedures with trainer two.

Randomization of subjects to various groups was done without regard to pre-test scores on depression and assertiveness, to "equalize" the variability on depression and assertiveness. This was to make the groups comparable.

First, subjects were randomly assigned to four groups. Next, each of the two trainers administered two types of training to two separate groups. This apparent repitition allowed a control for trainer bias. Since there was no significant main trainer effect or interaction, the design was collapsed into a one-way analysis of variance. The other half of this design consisted of subjects who had received either bibliotherapy or no therapy at all (attention control and control groups, respectively). All subjects were interviewed before and after treatment by a third party who used two instruments (Assertiveness and Depression Scales) developed by the Taylor method. In addition, the Gambrill and Richey and the Beck's Depression Inventory were administered as pre- and post-tests, and the results of these tests were correlated with the results of the interview.

Pilot Study

A pilot study was conducted in order to examine the responses of Native American subjects on the Gambrill and Richey (1973) Assertion Inventory. The overall assertiveness scores for the Indian population when compared to the non-Indian population were not significantly different (See Appendix J).

A few of the subjects had experienced difficulty with following directions. However, additional clarification had been provided with specific examples that illustrated how the questionnaires were to be completed.

Treatment of Data

In order to test for the effect of the trainer on the study and his degree of interaction with the treatment, the multivariate analysis of variance was applied. The necessary sums of squares were computed and the appropriate *F* ratio of each hypothesis was calculated. The computed *F* ratios were tested for significance at the .05 level against the critical value. Thus, main effects and interaction effects were determined. Since there was no significant main trainer effect or interaction, the design was collapsed into a one-way analysis of multivariance which tested the differential treatments of the assertiveness training procedures.

Similarly, for the one-way multivariate analysis of variance, the sums of squares were computed with the use of a MANOVA Summary Table. The appropriate F ratios were tested for significance against the critical value. The null hypothesis was not rejected, the research hypothesis was then accepted at the .05 level of significance. An analysis of covariance, covarying pre-test with post-test scores, was applied to "equate" the groups for pre-test and then examine the post-test differences.

CHAPTER 4

ANALYSIS OF DATA

The present investigation sought to test the effectiveness of a modified assertiveness training program developed for a Native American nurse and student nurse population. It is anticipated that the reported results shall provide useful information to those professionals; nurses in particular, who wish to design strategies to enhance the recruitment, retention, and advancement of minority nurses within the nursing profession. With this aim in mind, the results of the study are presented throughout this section. A description of the sample presents a narrative of the sample characteristics followed by a report of the findings. The findings are addressed in order of the stated hypotheses which are summarized at the end of the chapter.

The level of significance was set at the 0.05 level. An initial test of the interaction hypothesis was applied in order to test the effects of treatment by trainer before proceeding to test for general effects. Two questions were posed: (a) did the effect of trainer make an overall difference on assertiveness and depression scores? and (b) did the different training techniques make a difference on

assertiveness and depression scores? After failure to reject the hypothesis of interaction, the global multivariate null hypothesis was tested for the differential treatment effects. An analysis of covariance was applied to the pretests with post tests in order to "equate" the groups for pretest and then examine post test differences.

Description of Sample

Forty subjects were recruited for the research project. Subjects were assigned to the four treatment categories through a randomization procedure (using a table of random numbers). The four treatment categories were: Modified, Traditional, Attention Control, and Control. All subjects completed pretests that consisted of two self-administered inventories and an interview using two rating scales. A third party conducted all pre and post interviews. Subjects in the experimental group were notified by telephone of the date, place, and time the sessions were to begin. Two trainers simultaneously administered the training. The principal investigator did not participate in the collection of data in order to control for experimenter bias.

Several subjects (n = 6) did not continue in the study after completing the pretests because of conflicts in their time and disappointment with the delays in starting the

sessions. Some subjects had promised to attend the sessions but did not return; however, all subjects remained in the control group. The number of subjects completing the study was reduced to a total of 34 (n = 7 Modified; n = 7 Traditional; n = 10 Attention Control; n = 10 Control).

Subjects ranged in age from 17 to 52 years. Of the total number of subjects, 7.5% (3) were males while 92.5% (37) were females. Thirty-five percent were single, 40% were married, while 25% were divorced. Forty-five percent were employed full-time within local hospitals, 12.5% (5) inactive/unemployed, and 42.5% (17) were full time students. Thirty-seven and one-half percent (15) were registered nurses, 15% were LPN's, and 47.5% (19) were nursing students from baccalaureate and associate degree programs.

The training was done on the campus of the University of New Mexico while the control groups remained at various locations. The population was composed of subjects who had either lived or studied in New Mexico, Texas, or Oklahoma.

Findings

Prior to testing for general effects of assertiveness training on Native American nurses and nursing students, it was necessary to determine the existence, if any, of interaction effects of treatment by trainers. Subsequently, a two way analysis of multivariance was applied to test for

the interaction between treatment and trainer. This phase of the analysis had demonstrated that the presence of therapists did not effect the differential effects of the treatment factor. The computed F-statistic for 1 and 5 degrees of freedom is reported as F (1, 5) = 0.233253. Since this value did not exceed the critical/tabled value at the .05 level of significance, the hypothesis of no interaction was accepted. In addition, there was no significant differences between trainers, F (1, 5) = 2.907070.

Several hypotheses related to the intervention that was designed to increase scores on assertiveness while decreasing scores on depression are discussed as follows: The major hypothesis and three subhypotheses related to the intervention designed to increase assertiveness scores and decrease scores on depression among the four treatment groups was stated as:

There is no statistically significant difference in the level of depression and assertiveness of Native American nurses and nursing students following four sessions of assertiveness training. The subhypotheses for this study include:

1. There is no statistically significant differences in assertiveness and depression scores of the Native American nurses and nursing students between groups which have

received modified assertiveness training and those who have had traditional assertiveness training.

2. There is no statistically significant difference in assertiveness and depression scores of Native American nurses and nursing students between groups which have received traditional assertiveness training and those who have had bibliotherapy (attention control).

3. There is no statistically significant difference in assertiveness and depression scores of Native American nurses and nursing students between groups which have received bibliotherapy and those which have had no treatment (control).

The analysis of the data for the effects of the intervention failed to reject the overall multivariate null. For the differential treatment effects, the calculated value for the F-statistic for 1 and 5 degrees of freedom, was F = 0.72 (0.717393). There was no significant differences among the four groups. Therefore, in the comparisons required for each of the three subhypotheses, no significant differences were found (a) between modified assertiveness training and traditional assertiveness training, (b) between traditional assertiveness training and attention control, and (c) between attention control and control.

Additional Findings

Additional findings related to this investigation incorporates the multivariate analysis of covariance and univariate analysis of covariance, discriminant function tests and Pearson correlation coefficients. The findings are presented for:

1. the relationship between trainers,
2. the relationship among dependent variables,
3. the prediction of group membership,
4. correlations between rating scales developed by the researcher and self-administered inventories, and
5. multiple regression correlations for pre and post behaviors.

The multivariate analysis of covariance (MANCOVA) performed on covariates and post test scores showed no significant differences, F (5, 25) = 2.025972.

A univariate analysis of covariance was performed on the data in order to increase the precision of the design by further reducing experimental error. This analysis is capable of detecting even small differences among the treatment groups. The results showed some differences due to the trainer. A multivariate analysis of variance (MANOVA) was used to test for differences in the treatment by trainer effects (Table 1).

Table 1

Tests of Significance for Post Beck Using Sequential Sums of Squares

Source of Variance	Sum of Squares	DF	Mean Square	F	Significance of F
Treatment within Trainer 1	28.19212	1	28.19212	2.65232	.138
Treatment within Trainer 2	151.76187	1	151.76187	14.27780	.004*

*F (1, 9) = 5.12, $p < .05$, $\omega^2 = .65$.

The simple main effect indicated no treatment differences between the modified versus traditional assertiveness training for trainer 1. However, there was a significant difference for trainer 2. For example, one trainer did better than the other delivering the training sessions and consistently the traditional group did better than the modified group on the Gambrill and Richey with two components degree of discomfort, response probability assertiveness scale, Beck, and depression rating scores. There was no significant differences between trainers for the assertive and depression rating scales. When comparing

the univariate ancovas for the five variables, a significant difference was found on the Beck depression scores (Figure 3).

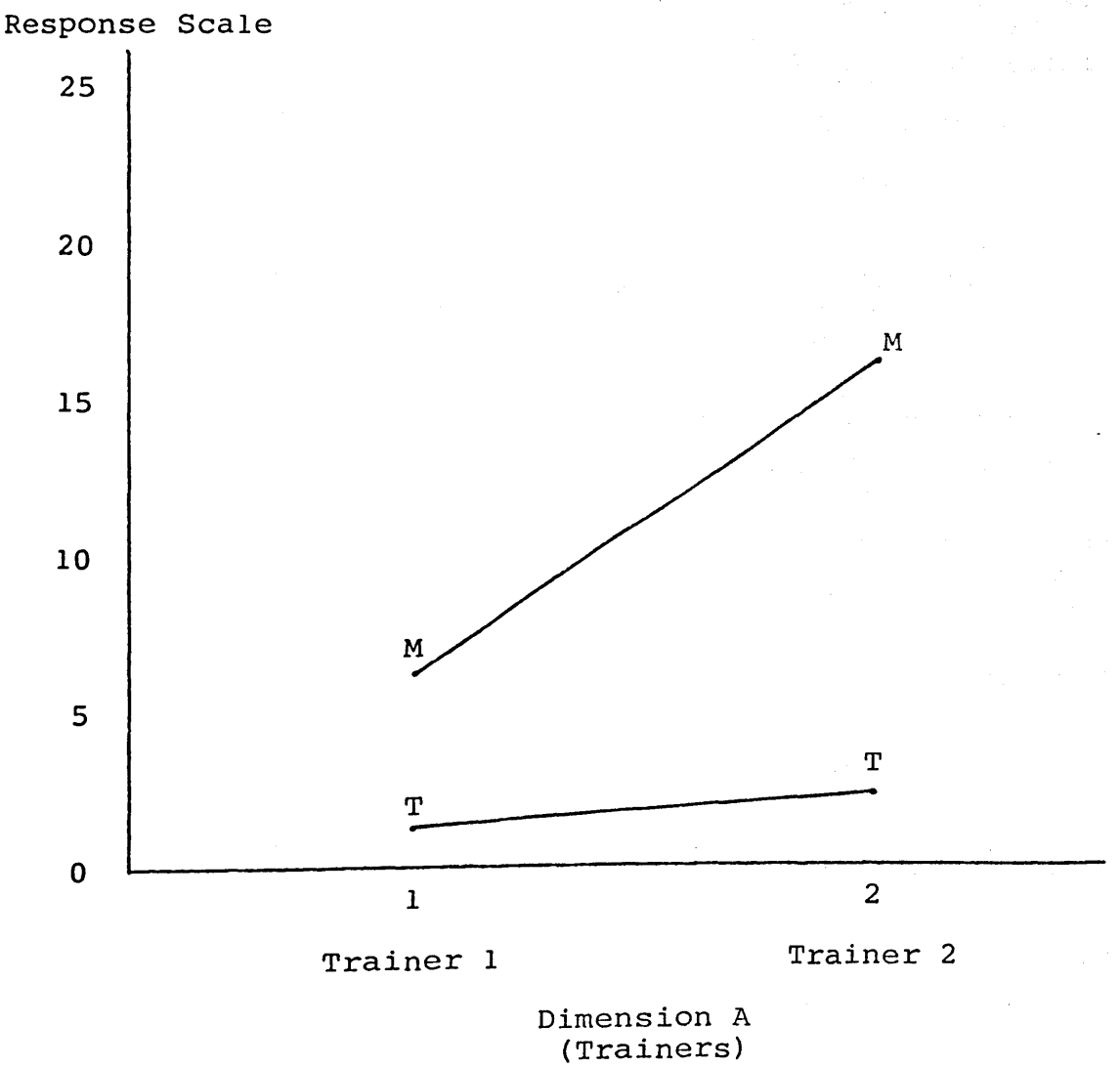


Figure 3. Illustration of population relationships between treatment by trainer interaction for Beck.

A discriminant analysis was performed on the data. When combining the pooled within-group correlations between canonical discriminant functions and discriminating variables the pattern is shown for three dependent variables: post Beck, post response probability, and post depression rating scores (Table 2). For the first function the

Table 2

Pooled Within-Groups Correlations Between Canonical Discriminant Functions and Discriminating Variables

Dependent Variables	Function 1	Function 2	Function 3
Post Beck	0.69319*	0.34057	-0.58911
Post Response Probability	0.28594*	0.15370	0.20117
Post Depression Rating	0.24517	0.59294*	0.50420
Post Assertiveness Rating	0.17434	0.06708	0.60294*
Post Discomfort Rating	0.13539	-0.01263	0.33950*

canonical discriminant coefficients show a larger coefficient for the Post Beck and the Post Response probability. The depression rating scale showed the next largest value (Table 3).

Table 3

Standardized Canonical Discriminant Function Coefficients

Dependent Variables	Function 1	Function 2	Function 3
Post Response Probability	0.62038	0.36163	0.66250
Post Beck	0.68954	0.52731	-0.50412
Post Assertiveness Rating	1.02983	-0.75557	0.93485
Post Depression Rating	-0.67337	1.37536	0.01207

The group means illustrate that the discriminant pattern showed a significant improvement for the Post Beck scores in the following order: traditional, modified, and attention control groups. For the post response probability the degree of improvement was shown for the traditional, attention control, and modified groups, and the post depression rating, the attention control, modified, control, and traditional groups (Table 4).

In addition, the discriminant analysis demonstrated that there were no significant differences in performance among the modified, traditional, and attention control groups. However, those groups did better than the no treatment/control groups (Table 5 & Figure 4).

Table 4

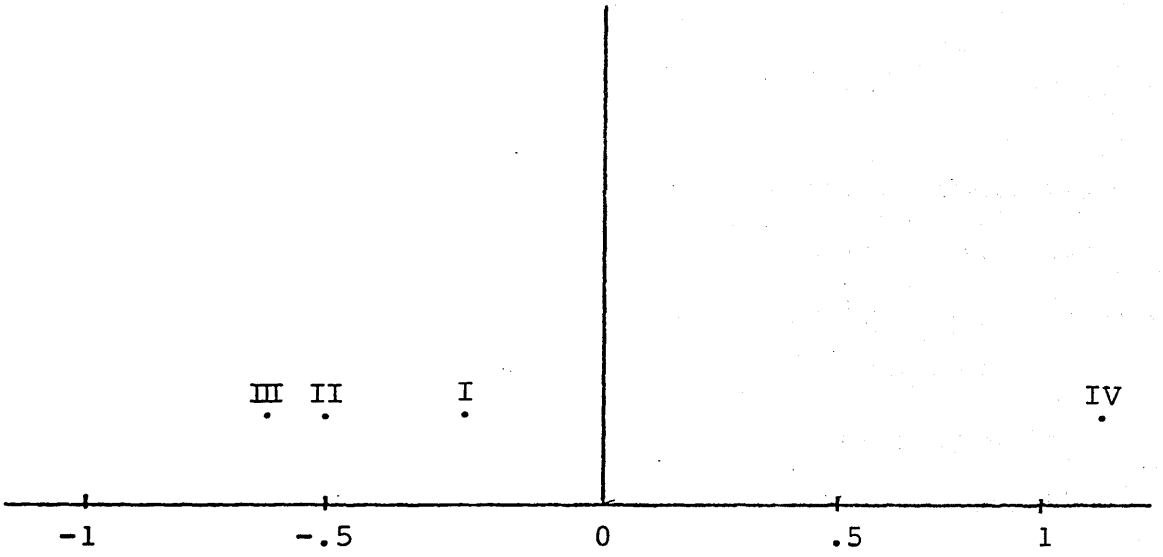
Discriminant Analysis
Group Means

Treatment	Post Discomfort	Post Response Probability	Post Beck	Post Assertiveness Rating Scale	Post Depression
Modified	88.28571	100.71429	7.42857	78.57143	76.42857
Traditional	93.85714	94.00000	3.14286	74.28571	65.71429
Attention Control	93.40000	97.20000	7.90000	74.50000	78.00000
Control	85.90000	108.70000	22.60000	79.50000	67.50000
Total	90.23529	100.64706	11.14706	76.76471	72.05882

Table 5

Canonical Discriminant Functions
Evaluated at Group Means

	Function 1	Function 2	Function 3
Modified	-0.25660	0.14647	0.26715
Traditional	-0.50073	-0.86432	-0.04617
Attention Control	-0.68690	0.46650	-0.11558
Control	1.21703	0.03599	-0.03910



I = Group I (Modified)
II = Group II (Traditional)
III - Group III (Attention Control)
IV = Group IV (Control)

Figure 4. Canonical discriminant functions evaluated at group means.

Correlations between Beck Depression, Assertion Inventory and Assertiveness, and Depression Rating Scales

Pearson product-moment correlation coefficients were computed for pre and post assertion and depression inventories and pre and post assertiveness and depression rating scales. The following table summarizes the results (Table 6). Moderate to high correlations were found for the following: pre and post discomfort scores; post discomfort and post response probability; pre assertiveness rating and pre depression rating scales; pre and post assertiveness rating scales; pre and post depression rating scales; pre assertiveness rating and post depression rating scales; and post assertiveness rating and post depression rating scales. Moderate to low correlations were found for the following: pre and post Beck; pre response probability and pre discomfort; pre discomfort and post response probability; pre discomfort and pre response probability; post response probability and pre discomfort; and pre depression rating with post assertiveness rating.

When correlating the rating scales with the self-administered inventories for depression and assertiveness, the results were as follows:

Table 6

Correlations between Beck Depression, Assertion Inventory and Assertiveness, and Depression Rating Scales

Variable	Pearson's r	R^2	p
Moderate to High:			
Pre with post discomfort	0.676	0.457	0.000
Post discomfort with post response	0.686	0.471	0.000
Pre assertiveness with pre depression	0.765	0.585	0.000
Pre with post assertiveness rating	0.636	0.404	0.000
Pre with post depression rating	0.670	0.449	0.000
Pre assertiveness rating with post depression rating	0.542	0.294	0.000
Post assertiveness with post depression rating	0.679	0.461	0.000
Moderate to Low:			
Pre Beck with post Beck	0.286	0.081	0.005
Pre response probability with pre discomfort	0.425	0.181	0.006
Pre discomfort with post response	0.433	0.187	0.005
Pre discomfort with pre response	0.425	0.181	0.006
Post response with pre discomfort	0.433	0.187	0.005
Pre depression with post assertiveness rating	0.452	0.204	0.004

*Significant at the .05 level
n = 34 subjects.

The correlation between the pre depression rating scale and pre Beck depression inventory was low, $\underline{r} = -0.3292$ ($\underline{R}^2 = 0.108$), $\underline{p} = .029$.

For the post depression rating scale and post Beck, no significant correlation was found. The pre assertiveness rating scale correlated moderately with the pre discomfort and pre response probability scores, $\underline{r} = -0.537$ ($\underline{R}^2 = 0.289$), $\underline{p} = .001$ and $\underline{r} = -0.500$ ($\underline{R}^2 = 0.25$), $\underline{p} = .001$. For the post assertiveness rating scales and the post discomfort and post response probability, the respective correlations were moderate to low, $\underline{r} = -0.31$ ($\underline{R}^2 = 0.096$), $\underline{p} = .034$ and $\underline{r} = -0.471$ ($\underline{R}^2 = 0.221$), $\underline{p} = .002$.

The pre assertiveness rating scales indicated a high ($\underline{R}^2 = 0.58$) degree of association with the pre depression rating scales. Subjects who scored high on assertiveness (who were more assertive) scored high on depression (who were less depressed). This also held true for the pre assertiveness rating scales and post depression rating scales. Subjects scoring high on assertion before receiving the training also scored low on depression after the training.

A moderate (i.e., $\underline{R}^2 = 0.204$) to low relationship existed between the pre depression rating scale and the post assertiveness rating scale. Those subjects scoring high

on depression before treatment were also more assertive after treatment.

Pre Beck self-administered inventory slightly (R^2 = 0.108) correlated with the pre depressive rating scale. No significant correlations were found between the post Beck and post depressive rating scale. The pre assertiveness rating scale and pre discomfort and pre response probability scores showed moderate association. The post assertiveness rating scale and post discomfort and post response probability scores showed a moderate to low correlation.

In the final phase of the analysis, a multiple regression was performed on the pre and post behaviors 1 through 5. Behavior 1 was eye contact; behavior 2, body posture; behavior 3, mood; behavior 4, appearance; and behavior 5, tone of voice (Table 7). An analysis of

Table 7

Behavioral Responses

Behavior	Range of Response	
Eye Contact	1 Direct	0 Indirect
Body posture	1 Erect	0 Slouchy
Mood	1 Energetic	0 Listless
Appearance	1 Well-dressed	0 Disheveled
Tone of voice	1 Audible	0 Inaudible

Direct through Audible received a value of 1.
Indirect through Inaudible received a value of 0.

covariance was performed on the dichotomous data. Tables 8 and 9 summarize the results. Significant values were found between pre and post behavior 1 (eye contact) and pre and post behavior 3 (mood). These differences were, however, distributed among all three treatment groups, and there were consequently no group differences in behaviors.

Table 8

Analysis of Pre and Post Behavior 1

Analysis of Variance	Df	Sum of Squares	Mean Square	F
Regression	1.	1.30719	1.30719	18.82353*
Residual	32.	2.22222	0.06944	

*F (1, 32) = 4.17, alpha = .05, ω^2 = .34.

Table 9

Analysis for Pre and Post Behavior 3

Analysis of Variance	Df	Sum of Squares	Mean Square	F
Regression	1.	2.23908	2.23908	16.36388*
Residual	32.	4.37857	0.13683	

*F (1, 32) = 4.17, alpha = .05, ω^2 = .31.

Summary of Findings

The results of the data supported the hypothesis that there would be no significant differences in the level of depression and assertiveness of Native American nurses and student nurses following four sessions of assertiveness training. A two way multivariate analysis of variance was applied to test for interaction effects of treatment by trainer. Upon failure to reject the hypothesis of no interaction, the analysis proceeded to test for the general effects of the treatment variable. The overall multivariate analysis of variance was applied to the results and the null hypothesis was accepted at the 0.05 significance level.

An analysis of covariance was later applied to detect and control for the effects of pretests (covariates) on

post test differences. The univariate analysis of covariance showed no differences among the four groups except for the Beck depression scores where significant differences were found. Differences due to trainer by treatment had indicated that trainer 1 delivered the treatments more effectively than trainer 2. An analysis of variance showed a significant difference between treatment by trainer for trainer 2 while no significance was found for trainer 1.

Additional findings through discriminant function analysis showed a pattern of significant discriminant coefficients for the post Beck, post response probability, and post depression rating scores. However, there were no significant differences among Modified, Traditional, and Attention Control groups. Overall, subjects in these groups did better than the no treatment (Control) group.

Pearson product-moment correlation coefficients were computed for pre tests and post tests on Beck depression and Gambrill and Richey Assertion inventories, as well as the assertiveness and depression rating scales. Moderate to high correlations were found on the pre and post Beck and depression and assertion rating scales. When the Beck depression was correlated with the depression rating scale, no significant relationship was established. Moderate to

low correlations were established between assertiveness rating scale and the Gambrill and Richey Assertion inventory.

A multiple regression analysis determined the results of pre and post behaviors. There was no significant differences among groups, however, there was significant differences between pre and post behaviors, 1 and 3.

The chapter that follows will interpret the findings presented. Conclusions will be discussed as well as implications for further research and nursing practice.

CHAPTER 5

SUMMARY OF THE STUDY

The results of this study will be discussed as they relate to the phenomenon of assertiveness with regard to one cultural minority in the health care field. In so doing, the study's aim was to address the following objectives: (a) to determine levels of depression among Native American nurses and nursing students; (b) to determine levels of assertiveness among Native American nurses and nursing students; (c) to establish the relationship between levels of depression and levels of assertiveness among Native American nurses and nursing students; and (d) to establish the efficacy of varied assertiveness training programs in order to alleviate reactive or neurotic depression which stems from long-term exposure of feelings of helplessness, hopelessness, and despair. The theoretical framework provided an empirical basis on which to test the effectiveness of an assertiveness training program stemming from several sources, Social Learning theory, Gestalt, Human-existential theory, and others. However, the central aim of this investigation was to further test the effectiveness of a modified format designed to fit the communication patterns

of a particular cultural group. Similarly, the theory of learned helplessness and depression provided a useful theoretical framework which effectively addresses the cultural and social entrapment experienced by minorities and poor. The Long-term exposure to helplessness and hopeless situations can lead to depression. Hence, an appropriate intervention is needed to provide opportunities for success which could in turn provide a person with the opportunity to have an impact on his or her environment. Assertiveness training is an appropriate intervention since it can provide those skills necessary for increasing personal effectiveness.

The specific research hypothesis that was tested is stated as follows:

There is no statistically significant difference in the level of depression and assertiveness of Native American nurses and nursing students following four sessions of assertiveness training. In addition, the research hypothesis of no interaction was evaluated to test the effects of trainer on treatment. As a result two research questions were proposed:

1. Did the difference in trainer make a difference in the amount of improvement on assertiveness and depression scores?

2. Did the differential treatment effects make a difference in the amount of improvement on assertiveness and depression scores?

The research hypothesis was further delineated as the following subhypotheses:

1. Subjects under modified treatment will score higher on assertiveness and lower on depression than subjects under the traditional treatment.

2. Subjects under traditional treatment will score higher on assertiveness and lower on depression than subjects under the attention control treatment.

3. Subjects under attention control treatment will score higher on assertiveness and lower on depression than subjects under (no treatment) control.

The results of this study are presented throughout this section. Conclusions and implications for nursing research and nursing practice shall be addressed in the final phase of this chapter.

Summary

Subjects were randomly assigned to four treatment categories. Each subject completed two self-administered inventories and submitted to pre and post interviews. Two trainers delivered the modified and traditional

assertiveness training. The variables tested were pretest and post test scores on assertiveness and depression.

A two way multivariate analysis of variance did not reveal any significant differences between the trainer and treatment factor, thus supporting the hypothesis of no interaction which was retained at the significant level of .05. The global multivariate null hypothesis was not rejected. Subsequently, there were no significant differences among the varied assertiveness training techniques.

A univariate analysis of covariance showed differences due to trainer. The analysis of covariance can detect even smaller differences in treatment effects. Consequently, the results showed trainer 1 more effective in delivering the treatments than trainer 2. An analysis of variance showed a significant difference between treatment and trainer for the second trainer and no significant differences for the first trainer. Additionally, univariate analysis of covariance revealed no significant differences among dependent variables, except for the Beck depression.

Discriminant function analysis showed improvement on scores for the Beck, response probability, and depression rating scores. However, there were no significant diffences attributed to group membership. The results of dependent variables did indicate, however, that subjects

under the modified, traditional, or attention control treatments did better on above post test scores than subjects in the control group.

Correlations between the rating scales (researcher developed) and self-administered inventories established some validity. Pearson-product moment correlations revealed moderate to low relationships.

A multiple regression analysis was performed on pre and post behaviors. Dummy variables defined group membership. Pre tests were forced in on group membership and an analysis of covariance was done on the dichotomous data. There were no significant differences in behaviors. Pre and post correlations were significant for behaviors 1 and 3 only.

Discussion of Findings

The null hypotheses tested in this study, under the multivariate analysis of variance, failed to be rejected. There were no reported significant differences in trainer or treatment effect. Although research tends to support the dramatic effects of assertiveness training (Alberta & Emmons, 1977), some controversial issues that have been raised may have some applicability in this study. Assertiveness has not been well defined in terms of being a trait or situation, nor is it a universal characteristic. Some people

exhibit assertive behavior in some situations and not in others. The concept of assertiveness may better lend itself to a more fluid or dynamic concept than to a static one. Unfortunately, experimental designs impose restrictions due to larger controls (internal validity) limiting generalizability (external validity). Therefore the findings of the experimental situation may not apply to real life situations.

It is also difficult to obtain exact measurements when changes due to experimental conditions induce changes in subject performance. Although some subjects expressed interest in attending the sessions, many subjects became less motivated to receive the training because the sessions moved into the holiday period. Measurement of those behaviors in this research were also limited to the moderate to low validity of the assessment tools as well, tools which were developed for different samples. The Beck Depression and Gambrill and Richey Assertion Inventories (pencil-and paper tests) were developed from a non-Indian population. The rating scales were developed by the researcher and were administered by an interviewer. Differences may have been due to changes inherent in the interviewer. This difference could have produced a shift in scores. (Campbell & Stanley, 1963, p. 9)

The univariate analysis of covariance however, did establish some differences between results obtained by different trainers. One trainer delivered the treatments more effectively than the other. This difference was substantiated by the fact that there was an experience differential. Although both trainers had prior experience with assertiveness training, one trainer had considerable background in dealing with the particular subjects examined in this study. The analysis for trainer by treatment showed one trainer did deliver the training more effectively than the other. Surprisingly, an examination of the dependent variables for differences reveals that the traditional format showed improvement consistently over the modified format. This did not support the hypothesis that the modified rather than the traditional format would be more effective. In particular, the results showed differences in the Beck inventory depression scores. In other words, subjects were less depressed, but not necessarily more assertive. The discriminant analysis, however, showed three discriminating variables when correlated with discriminant functions. The Beck had showed the largest correlation, the post response probability followed, and the post depression rating scale next. It was found in examining group membership that for modified, traditional, attention control, and control, there were no significant

differences for any but the control groups. This implies that subjects who received some treatment did better than those who had received no treatment at all. The means were higher for subjects in the (no treatment) control group for the depression and response probability scores. Higher means in this case indicate poorer performance. This supports impart the hypothesis that subjects in the attention control will perform better than the subjects in the control group. Jakubowski cites in her article "Clinical Problems of Women" that assertiveness training can be extremely beneficial in treating depression. The present research seems to support such claims. Subjects performed significantly better in the Beck (i.e., lower depression scores). It is reasonable to expect that depression is lowered but no statement can be made about interpersonal relationships.

Further analysis addressed the following question: how well did the depression and assertiveness rating scales (researcher developed) correlate with the self-administered pencil-and-paper tests? There were no significant correlations between the depression rating scale and the Beck for pretest and post tests. This could be expected considering that the rating scales were designed more specifically for the sample rather than the Beck, which was developed originally from psychiatric non-Indian population. The

assertion inventory and the assertiveness rating scales showed moderate to low correlations for pretests and post tests. The inverse relationship reported merely reflects the difference in interpretation of the instruments. For example, a higher score on the assertion inventory indicates poorer performance while a higher score on the rating scale indicates improved performance. Some differences were anticipated by the investigator. But while the assertion inventory was not developed specifically for an Indian population, there was some correlation as both samples represented college populations.

In the final analysis, behaviors 1 through 5 were analyzed for differences. The behaviors were dichotomous (i.e., the behavior was either present or absent). Eye contact was either direct or indirect. No significant differences in the behaviors were reported among any of the groups. However, two behaviors, eye contact and mood, did show significant pretest and post test changes. It would be reasonable to expect that subjects who were least assertive and more depressed would exhibit more non-coping behaviors before treatment than after treatment.

Conclusions and Implications

The ultimate goal of this study was to design an assertiveness training format that would encourage an

assertive lifestyle for one particular ethnic group. Research has shown that assertiveness training can be effective in increasing one's interpersonal effectiveness. Native Americans often find themselves having to exist simultaneously within two cultures. This can be particularly stressful, forcing many to "give up" or just remove themselves from uncomfortable situations. The problems for the American Indian nurse becomes even more pronounced when he or she attempts to function within a complex health care system, forced to deal with issues that are alien to his or her culture. The degree to which this researcher had addressed such concerns are discussed below.

Although overall significance was not obtained between and among varied assertiveness treatments, the following conclusions have been derived:

1. There was significant improvement in depression and response probability scores. The univariate analysis of covariance, in particular, had demonstrated significant differences for the Beck depression scores. Members of the traditional group were found less depressed. Research has shown that assertiveness training can be effective in treating depression because assertiveness provides one with a sense of control (Jakubowski, 1973, p. 165). Increased

scores on the response probability supported earlier research that assertive people will probably behave or exhibit more assertive behavior.

2. Subjects who had received either one of the following treatments: Modified, traditional, or attention control (Bibliotherapy) were less depressed and exhibited more assertive behavior. These findings support other findings throughout the literature, that providing "attention" or "some kind" of treatment can produce a change in behavior. Results indicate that the trainer may well influence treatment. The implications are that persons who engage in directing assertiveness training should have adequate knowledge of theory and research relevant to assertive principles. Each facilitator should have sufficient background when dealing with anxiety and its effects on behavior (Alberta & Emmons, 1977, p. 369).

Significant results from the treatment examined in this study may not have been obtained due to trainers' preorientation to assertive training techniques that have been geared toward non-Indian populations. Although correlations established some validity for the assessment procedures utilized in the study, this may have indicated a lack of the instruments' sensitivity to minor changes

in these behaviors. Perhaps further post testing at a later date (i.e., 1 month or 3 months) may show significantly different results.

It has been recognized within the last several years that assertiveness training can benefit most people. In a time when people are questioning their rights and reaffirming their beliefs, assertiveness training has become increasingly popular. Numerous situations arise in nursing practice that demonstrate the applicability of assertiveness training. The nursing profession is presently undergoing change, and old myths and stereotypes are being displaced for more suitable images that are capable of reflecting a more appropriate role for the nurse. It is an established fact that the more successful the nurse is when enacting her role, the more effective she is when dealing within interpersonal situations and the more likely she will be to deliver effective nursing care. Literature abounds with nursing's problems and conflicts while dealing with complex health care issues.

For the Native American nurse and nursing student the problems have been compounded because of cultural backgrounds complicated by the expectations of their professions. Although further research is imperative in order to continue to test the effectiveness of such psychotherapeutic interventions, the need to address such concerns continues.

Problems of student attrition and staff nurses dealing within bureaucratic non-traditional settings have long been a major concern for Indian people. Native American nurses and nursing students continue to be grossly under-represented in academics, particularly at the baccalaureate and higher degree levels. While this study did not reveal significant results, appropriate interventions such as those this research project has attempted to undertake may yet serve to improve this situation. It is therefore essential to continue to assess the welfare of Native Americans within the health care system as well as within educational settings and to introduce strategies that will aid them in their attempt to make an impact on the environment.

Finally not only nurses, but everyone else must recognize that the ultimate aim is the improvement of health care for all people. With the quality of health care for Indian people still lagging far behind that provided the general population, it is imperative to prepare significant numbers of those who can most sensitively address the health care problems of this ethnic group.

Recommendations for Further Study

It is anticipated that the continued use and refinement of innovative treatment modalities would establish significance. Therefore, according to the findings of

this research project, the following recommendations within this area are delineated:

1. Continued refinement and development of assertiveness training techniques tailored to specific cultural groups. Different lifestyles and communication patterns unique to a culture still carry over to other situations in life, even for those functioning in professional roles.

2. Replication of this study would be useful to establish more reliable data. A larger sample size extended over time would increase the generalizability of the research.

3. Additional studies need to be conducted within varied geographical locations since cultural differences exist among different Indian tribes.

4. It is recommended that existing assessment tools be refined in order to account for cultural differences. The use of existing techniques have often contributed to misinterpretations and mismanagement of treatment for persons who come from a different local or cultural background.

5. Additional outcome criterion may be used to evaluate the effectiveness of assertion training such as academic performance, attrition rates, coping strategies, standing, and ratings in class.

APPENDIX A

An Assertiveness Training Format for American Indian/Alaska Native Student Nurses and Nurses

AN ASSERTIVENESS TRAINING FORMAT FOR AMERICAN INDIAN/ALASKA NATIVE STUDENT NURSES AND NURSES

TABLE OF CONTENTS

Session 1 Overview

Key assertive principles to be discussed:

1. Administering inventories

2. Definitions

   Assertive behavior
   Aggressive behavior
   Non-assertive behavior

3. Role play assertive, aggressive and non-assertive behaviors examining the choices and consequences of each action

4. Roles and responsibilities in giving honest and clear feedback. The leader is to demonstrate how to give feedback

5. Homework assignment

Time schedule:

Topics	1 and 2	- 45	minutes
Topic	3	- 30	"
"	4	- 30	"
"	5	- 15	"

SESSION 1

Modified Format

Objectives

-to measure levels of assertion for each participant
-to define assertive, aggressive, and non-assertive behavior
-to inform participants about expectations as a result of being in the group
-to compare and contrast values between Indian/non-Indian cultures
-to inform participants how to give and receive positive and negative feedback via role play
-to provide time for review and assignment of homework
-to monitor and record personal assertive, aggressive, and passive behaviors and to observe the same behaviors in others

A. Introduction

1. The leader introduces herself to the group and explains who she is and what she has done in terms of her own experience with assertiveness training and being assertive. If Indian, she gives the tribal affiliation, if not Indian, her experience with Indian people and workshops.

2. The trainer is to give testimony to the times she has been assertive, or if non-Indian, then of individuals who are Indian who have been successful using assertiveness skills.

3. The leader administers pretests (assertion and depression inventories) and explains rationale for their use.

4. The leader gives an overview of the group's format and how the group is to be structured. She also includes assertiveness training and how it can benefit most people. She explains specific procedures, i.e., lectures, role playing, homework assignments, etc. and how they are utilized. She then prepares the group for a change in behavior

that will affect family, friends, peers, etc. Finally, the leader informs participants that they are to keep daily logs of their progress as homework assignments.

For example, a format for the daily log might be (leader is to provide the following for an example):

Date	Time	Event	Response	Evaluation

5. Leaders address any questions participants raise about being in the group.

B. Ice Breaker Exercises

The leader instructs participants to introduce themselves to each other. Participants are to pair off (in even numbers if possible) allowing participants to share expectations about being in the workshop with each other.

C. Leader Distributes Session 1 Outline

The outline summarizes key assertive principles to be discussed during the first session.

D. Definition of Assertive Behavior

Assertive behavior is "behavior which enables a person to act in his or her own best interests, to stand up for herself or himself without undue anxiety, to express honest feelings comfortably, or to exercise personal rights without denying the rights of others" (Alberti & Emmons, 1978). Consequence: The person making an assertive response would be expressive, feel good about himself/herself, and the person receiving the message/response would feel self-enchancing, may achieve desired goal.

Aggressive behavior, on the other hand, is to state or enforce one's rights at the expense of another. It usually involves "putting down" the other person. Consequence: The person making an aggressive response would feel self-enchancing at the expense of another and the person receiving the message/response would feel hurt, defensive.

Non-assertive behavior involves not speaking up or acting on one's behalf and thus pleasing others at the expense of one's own wishes and rights. Consequences: The person making a non-assertive response would feel self-denying, inhibited while the person receiving the message/response would feel guilty or angry.

Note. Because of cultural influence, Indians may tend to view such behavior as speaking up, initiating a request, etc. as being aggressive, i.e., it may not be appropriate to request or ask a favor from an elder.

E. Role Play

The leader requests participants to role play the following situations:

Situation 1

You are in a large lecture hall with a group of 100 nursing students. The teacher is lecturing on some material pertinent to your culture. You are aware that some of the facts are conflicting with your understanding of the material. Select one response from the following:

1. You say nothing, leave, but remain confused over the matter.

2. You raise your hand and tell the teacher that he/she has made an error.

3. You ask the teacher to further clarify his/her point but indicate your confusion and your source of information.

Situation 2

You are enrolled in a class that has content that you find extremely difficult even though you have spent a great deal of time preparing (studying) for it. Within the next three weeks an examination concerning the content will be given.

1. You close the books, resigning yourself to your fate of feeling that you will not pass anyway.

2. You denounce the class and express the opinion that the content required is meaningless.

3. You make an appointment to see the instructor to discuss your concerns about specific areas that you are having problems with.

Situation 3

You are sitting in a large classroom. Because you are sitting close to an air conditioning vent, your seat is extremely cold.

1. You do not complain but remain quietly in your seat (knowing that the conference that you are attending is about to end within a short time).

2. You stand up, hastily and conspicuously leave the room, stating that classrooms are always too uncomfortable.

3. You firmly but politely ask to change your seat because the area around the seat where you are sitting is too cold for you.

1. non-assertive 2. aggressive 3. assertive

F. Developing Assertive Skills

1. Leaders inform the trainers that the remaining group time will be devoted to developing and refining assertion skills.

2. They describe the trainees' roles and responsibilities in giving honest and clear feedback to each other. The leader is to demonstrate how to give feedback (i.e., start with positive feedback first, withhold criticizm, offer suggestions or alternate ways of responding, and stress the importance of positive as well as negative feedback).

The leader is then to hand out questions relating to feedback to the group.

G. Termination of Session 1 and Homework Assignments

Review key principles that have been discussed.

1. Monitor yourself in various situations (work, class, social and intimate relationships, etc.) and develop an awareness of how often you respond assertively, non-assertively, or aggressively.

2. Start recording in your daily log positive and negative observations.

3. Read the "Indian-White Language Comparison" for discussion in the next session.

Session 2 Overview

Key principles to be discussed:

1. Feedback from first session

2. Consciousness raising exercises

   a. Importance of recognizing the roles of men and women in modern day American society and the traditional Indian society

   b. Socialization of men and women in nursing

3, Developing assertion skills and understanding values/ value conflicts

   Important values among the traditional Indian culture and non-Indian culture are discussed and compared.

4. Indian Bill of Rights

   Understanding rights and responsibilities that underlie the right to be assertive

5. Components of verbal and non-verbal communication

6. Homework assignments

Time schedule:

Topic	1	- 15 minutes
Topics	2, 3, and 4	- 60 "
Topic	5	- 30 "
"	6	- 15 "

SESSION 2

Modified Format

Objectives

-to continue to build a sense of group cohesiveness
-to provide participants with insights into their own behavior through consciousness-raising exercises

a. by developing an awareness of the socialization process of men and women in modern American society and traditional Indian society

b. by discussing the effect the roles of men and women have upon nursing as a profession

-to provide an opportunity for participants to acquire and incorporate assertion skills into their own repertoire of behavior through role play and modeling
-to discuss and identify individual Indian and nursing human rights
-to incorporate verbal/non-verbal components of assertive communication

A. Introduction

1. Discussion of homework assignments and sharing of past week's experiences, including the positive and negative observations of other's behavior

2. Overview of the principles covered in session 1 and distribution of the handout for session 2

B. Socialization of Males and Females

1. Leaders initiate and facilitate discussion of the roles of females and males within non-Indian society, i.e., discuss roles of women as wives, mothers, sisters, daughters, and expectations that generally are ascribed to such roles. For example: Women are expected to please their husbands by tending to the home, caring for the

children, doing the laundry, and sexually serving their husbands, etc. Men are expected to go to work and attend to important matters such as financial decisions. Their roles are that of father, son, brother, breadwinner, authority figure within the family. The leader should initiate group discussion as to how various occupations perpetuate these roles such that social work, nursing, and teaching are extensions of women's roles in providing care outside the home. Men similarly attend to positions of prestige as lawyers, doctors, politicians, businessmen, etc.

2. Similarly the roles of women and men are discussed within the Indian culture. This may include discussion of Indian society by tribe. Also discussion may center around the woman's roles changing because of the changing role of the male. Again have the members of each group provide or list examples of traditional roles of women and traditional roles of men. The group may compare and verbalize its own feelings about its adaptation to traditional and non-Indian culture.

3. Similarly the roles of Indian women in health and healing can be explored. What has been the woman's role with disease and spiritual healing? roles of women within the medical context? social changes affecting roles? (i.e., advancement in technology, the role of the male changing and affecting the role of women).

4. Roles ascribed to those in nursing (middle class value orientation) should be covered. The leader again initiates discussion by requesting that the participants discuss the nature of nursing, i.e., 1) What is the behavior expected of a nurse? This may take place in terms of roles or responsibilities; for example, nurses are expected to carry out the doctor's orders, never question or disobey a superior, never be concerned with monetary gains. By remaining in passive roles nurses give power to those who represent authority. The consequence of giving power to others reduces the nurse's personal effectiveness and places her in a subservient position. The leader should allow time for discussion. Now the group is ready to try to come up with a list of expectations of nursing behaviors.

C. Development of Assertive Skills and Understanding Values and Value Conflicts

Bryde (1971) defines values as important things or actions we prefer over other things and actions. Provide comparison of traditional values over modern non-Indian values (instruct group to add to list).

Modern Middle Class Value	Traditional (Indian Cultural Value)
Individuality	Group cohesiveness
Competitiveness	Cooperativeness
Material possessions i.e., cars, houses, paintings, etc.	Material achievement not as important
Future orientation	Present orientation
Manipulating environment	Protecting environment

Allow the group to come up with additional examples.

D. Indian Bill of Rights

Have each member of the group with the leader as facilitator to come up with an Indian Bill of Rights - to be collected. Assign a person to record these.

Encourage participants to react and respond to principles in the Indian Bill of Rights; the group is to come up with its own Indian Bill of Rights.

Select rights that apply to Indian student nurses and nurses.

Next, distribute the Bill of Rights for Health Care Professionals (Chenovert) and compare those rights to those of the Indian Bill of Rights.

(Adapted from LaFromboise)

E. Assertion Skills - Behavioral Components

The leader explains and role plays examples of the non-verbal components of an assertive response.

1. Eye contact - discuss the use of eye contact to engage another person.

   Eye contact, looking at another person directly in the eyes, is an assertive non-verbal component.

For non-Indians avoiding eye contact implies recognition of the authority-subordinate relationship in a non-verbal way. For some Southwestern tribes, maintaining eye contact is an act of disrespect, hostility, or rudeness (Allen, 1973). Indian trainees must differentiate between cultural appropriateness of direct eye contact with Indians.

Practice - do assertion training with Indian adults (can do desensitization exercises). Gradually have the person look into another's eyes by instructing him/her to start at the feet (if no anxiety is experienced), then at the stomach, next at the chest, on to the left shoulder, right shoulder, then the neck, and finally to the face.

2. Facial expressions - the goal is to teach trainees to adapt the non-verbal messages to coincide with the verbal message. Facial expressions express the emotional tone of the communication, for example, anger, happiness, purpose. It is expected that one would utilize the facial expression appropriate to the situation, i.e., one does not laugh if he is uttering words of sorrow.

3. Gestures - these are kinetic movements that usually employ the hands along with the face. They may connote surprise, reference to objects or persons, or gestures of emphasis. Tactile gestures employ placing the hand on the person of another (usually the listener).

4. Voice - words in and of themselves do not communicate meaning. The tone of voice and rate of speech carry the message. The tone could be low pitched, high pitched, or medium. A deep steady voice can connote a position of authority while a soft meek voice can imply subservience or that one is being dominated by another.

5. Rate of speech - a fast rate of speech may imply anxiety or a state of excitability, while a slow rate of speech may mark uncertainty, boredom or disinterest, or apathy in what is being communicated at the time.

6. A nervous twitch or tick - such mannerisms may distract from the message that is being sent or received.

7. Space and distance - different ethnic groups will utilize different distances and space while engaging in conversation. For example, some people prefer to stand close (Jewish) and even touch while interacting while others prefer to remain further apart (white Middle Class). In addition, within all cultures, women, men, children, elderly have different forms of body posture.

   Practice - Have the participants form dyads and discuss any topic. When each begins discussion he/she is instructed not to make eye contact and to restrict all body language cues. After two minutes ask each slowly to make eye contact and begin to bring his/her body into use in communicating his/her message.

Verbal Communication Styles

The leader is to present Indian-White Language Comparison (LaFromboise) to trainees for discussion. Allow discussion to center around differences between Indian communication styles and non-Indian communication styles. Have the trainees use the outline for note taking. The trainer briefly discusses concepts of message matching. For Indians, words carry more meaning than just a message. Words alone do not express meaning. Also different tribes use language in different ways for children, elders, etc.

Parts of Communication

1. Context - situation surrounding the communication itself

2. Message - affected by role perceptions, role expectations

3. Sender - person sending the message

4. Receiver - person receiving the message

5. Consequence of message - the outcome or the effects of the message

Trainer is to discuss how assertiveness may be perceived as aggressiveness for the Indian because of non-interference and passivity factors due to the respect for the other's rights to his beliefs, so that to make a request may be perceived as a violation of that right.

Message Matching

Here the message matching and verbal communication styles should be incorporated into these practice sessions.

Developing Assertion Skills

This involves role play talking differently with Indians and non-Indians. Practice the following (adapted from Cheek, 1976).

Sender	Message	Target Person
Nurse		Physician
Nursing Student		Administrator
Male/Female		Supervisor/Instructor
		Peer
		Male/Female
		Indian/Non-Indian

"I" Messages

"I" message may be inappropriate for some tribes. To say I feel instead of I am, etc., may be helpful when constructing sentences with "I" messages (LaFromboise) (assuming response for one's own feelings and behavior).

F. Termination of Session 2

Summarize principles of this session. Discuss any questions or issues raised.

1. Daily logs are to be continued.

2. Review the concepts from the Indian Bill of Rights. Identify which, if any, of the Principles of the Indian Bill of Assertive Rights you find difficult or impossible to implement.

3. Mirror exercise - observe yourself in front of a mirror for ten minutes. While observing, be sure to talk in order to provide a clear impression of how you appear to others (verbal and non-verbal contexts).

Session 3 Overview

Key principles to be discussed:

1. Discussion time for Bill of Rights and homework for the mirror exercise

2. Refinement of skills

3. Role playing exercises

4. Homework assignment

   -Log
   -GAP profile
   -Questionnaire

Time schedule:

Topic 1	- 30	minutes
Topics 2 and 3	- 60	"
Topic 4	- 30	"

SESSION 3

Modified Format

Objectives

-to encourage (through role play and feedback) participants to continue refining assertive skills
-to reinforce the principles that underlie verbal and non-verbal communication
-to analyze responses to personal life situations through GAP (Group Awareness Profile) and questionnaire

A. Introduction

Summarizing of previous homework assignments.

Sharing of previous week's log

Overview of the principles covered in sessions 1 and 2

B. Indian Behavioral Scripts

The following scripts are designed to illustrate specific aspects of assertive behavior. Have trainees with the leader as facilitator, role play the following situations:

Making a request

You are asked to present to a class of nursing students childrearing practices among the Indian communities throughout the United States. You have limited knowledge about the subject matter, but would prefer to limit your discussion to the practices engaged by your own tribe.

You are having academic difficulty with a particular subject. Make an appointment to see your school counselor (who is Indian). You wish to drop a course and retake it at a later date, but your request is denied. In the meantime, you have learned that another student has been granted a similar request.

Refusing a request

You have recently worked two night shifts consecutively in the past week and have had only one day off. You are scheduled to be off the next day, but your supervisor approaches you and requests that you come in order to staff another unit that is short. You have already planned to attend important ceremonies with your family and friends.

The group may think of other situations besides the above examples. Encourage members of the group to give honest and clear feedback utilizing the principles covered in earlier sessions.

Practice - Allow the group to select pertinent aspects of the components of non-verbal and verbal behavior for practice and refinement, also, construct sentences with "I" messages, remembering to say I feel instead of I am.

Body language - have members monitor each other's body language, body posture, gestures, distancing, eye contact, etc.

Leader please note: Individual members may be assigned specific behaviors to monitor for giving feedback.

C. Termination of Session 3

Review key principles covered in this session, Leaders are to clarify points and/or answer questions raised relevant to the sessions.

D. Homework Assignment

1. Keep daily logs
2. Complete the GAP
3. Read and respond to the questionnaire for the last session
4. Bring personal life situations that you wish to demonstrate before the group for the next session
5. Practice giving feedback

Session 4 Overview

Key assertive principles to be discussed:

1. Discussion of previous homework assignments

2. Practice on personal life situations

3. Logs - as a wrap-up

4. How to continue assertive behavior

   Find a support person for practicing assertive behavior and feedback

   Read books on assertiveness

   Set up rewards for yourself for very successful assertive behavior.

5. Administration of post-tests

Time schedule: Topics 1, 2, 3, and 4 - 75 minutes
Topic 5 - 30-45 minutes

SESSION 4

Modified Format

Objectives

-to provide additional practice and opportunity for role playing
-to provide an opportunity to refine assertion skills and further assimilation of content
-to continue to enhance areas for additional assertiveness training

A. Introduction

1. Discussion of previous week's homework assignments, sharing successes and failures of the previous week

2. Assertion skills practice based on assessment (GAP Questionnaire) - personal life situations

3. Focusing upon message matching, communication styles

4. Wrap-up. Use of log. Behavioral hierarchy. How to continue assertive behavior

5. Administering post-tests

B. Group Awareness Test (adapted from Cheek)

This test adapted from Cheek and LaFromboise is designed to assist the trainees to gain insight into their own behavior while interacting with Indian and non-Indian people. The leader is to encourage discussion centered around the GAP test.

The interpretation of the test is as follows: ideally all questions the client would circle as assertive. If six or more responses are in the other categories i.e., not sure, passive, or aggressive, the client needs assistance in becoming more assertive.

QUESTIONNAIRE

INSTRUCTIONS: Read and respond to the following questions. Be honest and open with yourself. In answering the questions try to be specific; you may provide examples.

-Have you ever felt different from other people because
1. you have selected nursing as a career and
2. you are Indian?

-Have you ever felt that entering into the nursing profession has alienated you from your family, friends, tribe, etc.?

-How has your career choice to be in nursing been affected by you being Indian?

-Do you ever feel that you do not get enough support from other Indians?

-How do you feel about yourself as a person and as an Indian?

-Do you see some of the roles ascribed in nursing similar to the roles that are ascribed to you as being an Indian female/male?

-Are you satisfied with the direction of your life as you see the way it is going?

-What are some of the things that you would like to see change within your life?

-Can you identify attitudes that prevent you from becoming assertive?

A BILL OF RIGHTS FOR HEALTH CARE PROFESSIONALS

1. You have the right to be treated with respect.
2. You have the right to a reasonable work load.
3. You have the right to an equitable wage.
4. You have the right to determine your own priorities.
5. You have the right to ask for what you want.
6. You have the right to refuse without making excuses or feeling guilty.
7. You have the right to make mistakes and be responsible for them.
8. You have the right to give and receive information as a professional.
9. You have the right to act in the best interest of the patient.
10. You have the right to be human.

From M. Chenovert, Special Techniques in Assertiveness Training for Women in the Health Professions.

GROUP AWARENESS PROFILE (GAP TEST)

1. I think most whites would see me as	passive	assertive	aggressive	not sure
2. I think most Indians would see me as	passive	assertive	aggressive	not sure
3. I think most patients would see me as	passive	assertive	aggressive	not sure
4. I think most white people are	passive	assertive	aggressive	not sure
5. I think most Indians are	passive	assertive	aggressive	not sure
6. I think most physicians are	passive	assertive	aggressive	not sure
7. I would like most white people to see me as	passive	assertive	aggressive	not sure
8. I would like most Indians to see me as	passive	assertive	aggressive	not sure
9. I would like most patients to see me as	passive	assertive	aggressive	not sure
10. I think I usually look	passive	assertive	aggressive	not sure
11. I think I usually act	passive	assertive	aggressive	not sure
12. With an Indian it is easy for me to be	passive	assertive	aggressive	not sure
13. With a patient it is easy for me to be	passive	assertive	aggressive	not sure
14. With a physician it is easy for me to be	passive	assertive	aggressive	not sure
15. With a white person it is easy for me to be	passive	assertive	aggressive	not sure
16. With an Indian it is hard for me to be	passive	assertive	aggressive	not sure
17. With a white person it is hard for me to be	passive	assertive	aggressive	not sure
18. With a patient it is hard for me to be	passive	assertive	aggressive	not sure
19. With a physician it is hard for me to be	passive	assertive	aggressive	not sure

Adapted from Cheek, D. Assertive Black . . . Puzzled White. San Luis Obispo, CA: Impact Publishers, Inc., 1976 and LaFromboise, Teresa. Assertiveness Training with American Indians. Lincoln, Nebraska, 1979.

BEHAVIORAL HIERARCHY

Assertive Behaviors

Instructions: Below is an example of a behavioral hierarchy that is based upon the entries from your daily log.

Order of priority	Assertive Behaviors
9	Ask for raise.
7	Boss not to call Honey.
8	Ask mate to help more around house.
3	Say no to door-to-door salesmen.
1	Ask children to pick up after themselves.
6	Extra day off.
5	Send back food not prepared properly.
2	Spend 30 minutes alone each day - "me time".
4	Read a book.

GUIDE TO GIVING FEEDBACK

1. Did the person get to the point reasonably quickly?

2. Did they describe specific behavior that was objectionable or did they solely use global labels like "bad attitude"?

3. Did the person attack the other person, or act in a judgemental or accusatory fashion?

4. Did the person open up discussion to get the other person's reaction? Did they then listen to what that person said?

5. Did they assume a stance of "I must win" or was there any possibility of a reasonable compromise that did not violate the integrity of either individual?

6. Did they use a lot of "you's" or did they use a lot of "I's"?

7. Was their voice clear, appropriately loud, with words emphasized or was their voice hesitant, sing-song? How about eye contact?

INDIAN-WHITE LANGUAGE COMPARISON

Indian-Indian	Indian-White
Content (what you talk about)	
- Indian politics	- Indians
- About your family	- Weather
- About other Indians	- Activities of interest to whites (sports, hobbies, clubs)
- Being Indian today	- The news, politics, current events
- Past and future social and cultural events	- Mutual acquaintances
- Mutual friends, romantic and personal activities, gossip	- School or work
- School or work	- Rarely about social events, unless work-related
- Job opportunities	
- White people and their racist attitudes	
Style (how you talk about it)	
- If use abstract terms, they are in relation to the person it pertains to	- Use of generalized and abstract forms of expression
- Use of slang	- Little or occasional slang, humor
- Use of Indian words throughout, or use situational dialect as a restrictive code to designate the speaker as one who belongs	- Awareness of grammar and correct enunciation
	- Somewhat restrained
	- Don't understand the humor
- Usually in a joking, teasing, or hinting way	- Adherence to professional positions and title as a basis of authority on the topics
- Begins talk with a disclaimer of one's humility, yet displays logic and wisdom throughout the conversation	- A lot of questions and answers
	- Interject alternative opinions and interruptions
- Signifies the nature of his/her relatedness to an event	- Applies subtle pressure to reveal secret knowledge of traditional ways
- Assumed closeness and sharing	
- Person speaking has the floor for as long as he has something to say	
Function (why you talk about it)	
- Relaxation, enjoyment, and recreation	- To get or maintain a position
- Become better acquainted or maintain friendship	- To be seen as capable of getting along
	- To be seen as different
- Mutual interest and sharing	- Mutual interest
- Sometimes for selfish motives	- Obtain or keep business connection
	- Ulterior motives, little sharing

APPENDIX B

An Assertiveness Training Format for Student Nurses and Nurses

AN ASSERTIVENESS TRAINING FORMAT

FOR

STUDENT NURSES AND NURSES

TABLE OF CONTENTS

Session 1 Overview

Key assertive principles to be discussed:

1. Administering inventories

2. Definitions

   Assertive behavior
   Aggressive behavior
   Non-assertive behavior

3. Role play assertive, aggressive, and non-assertive behaviors examining the choices and consequences of each action

4. Roles and responsibilities in giving honest and clear feedback. The leader is to demonstrate how to give feedback

5. Homework assignment

Time schedule:

Topics	1 and 2	- 45	minutes
Topic	3	- 30	"
"	4	- 30	"
"	5	- 15	"

SESSION 1

Traditional Format

Objectives

-to measure levels of assertion for each participant
-to define assertive, aggressive, and non-assertive behavior
-to inform participants about expectations as a result of being in the group
-to inform participants how to give and receive positive and negative feedback via role play
-to provide time for review and assignment for homework
-to monitor and record personal assertive, aggressive, and passive behaviors and to observe the same behaviors in others

A. Introduction

1. The leader introduces herself to the group and explains who she is and what she has done in terms of her own experience with assertiveness training and being assertive.

2. Testimonials of assertive behavior - The trainer is to give testimony to the times she has been assertive.

3. The leader administers pretests (assertion and depression inventories) and explains rationale for their use.

4. The leader gives an overview of the group's format and how the group is to be structured. She also includes assertiveness training and how it can benefit most people. She explains specific procedures, i.e., lectures, role playing, homework assignments, etc. and how they are utilized. She then prepares the group for a change in behavior that will affect family, friends, peers, etc. Finally, she informs participants that they are to keep daily logs of their progress as homework assignments.

For example, a format for the daily log might be (leader is to provide the following for an example):

Date	Time	Event	Response	Evaluation

5. Leaders address any questions participants raise about being in the group.

B. Ice Breaker Exercises

The leader instructs participants to introduce themselves to each other. Participants are to pair off (in even numbers if possible) allowing participants to share expectations about being in the workshop with each other.

C. Leader Distributes Session 1 Outline

The outline summarizes key assertive principles to be discussed during the first session.

D. Definition of Assertive Behavior

Assertive behavior is "behavior which enables a person to act in his or her own best interests, to stand up for herself or himself without undue anxiety, to express honest feelings comfortably, or to exercise personal rights without denying the rights of others" (Alberti & Emmons, 1978). Consequence: The person making an assertive response is expressive, feels good about himself/herself and the person receiving the message/response feels self-enchancing and may achieve his/her desired goal.

Aggressive behavior is to state or enforce one's rights at the expense of the other. It usually involves "putting down" the other person. Consequence: The person making an aggressive response feels self-enchancing at the expense of another and the person receiving the message/response feels hurt, defensive.

Non-assertive behavior involves not speaking up or acting on one's own behalf and pleasing others at the expense of one's wishes and rights. Consequences: The person making a non-assertive response feels self-denying, inhibited and the person receiving the message/response feels guilty or angry.

E. Role Play

The leader requests participants to role play the following situations:

Situation 1

You are in a large lecture hall with a group of 100 nursing students. The teacher is lecturing on a topic of interest to you. You are aware that some of the facts are conflicting with your understanding of the material. Select one response from the following:

1. You say nothing, leave, but remain confused over the matter.

2. You raise your hand and tell the teacher that he/she has made an error.

3. You ask the teacher to further clarify his/her point but indicate your confusion and your source of information.

Situation 2

You are enrolled in a class that has content that you find extremely difficult even though you have spent a great deal of time preparing (studying) for it. Within the next three weeks an examination concerning the content will be given.

1. You close the books, resigning yourself to your fate of feeling that you will not pass anyway.

2. You denounce the class and express the opinion that the content required is meaningless.

3. You make an appointment to see the instructor to discuss your concerns about specific areas that you are having problems with.

Situation 3

You are sitting in a large classroom. Because you are sitting close to an air conditioning vent, your seat is extremely cold.

1. You do not complain but remain quietly in your seat (knowing that the conference that you are attending is about to end within a short time).

2. You stand up, hastily and conspicuously leave the room, stating that classrooms are always too uncomfortable.

3. You firmly but politely ask to change your seat because the area around the seat where you are sitting is too cold for you.

1. non-assertive 2. aggressive 3. assertive

F. Developing Assertive Skills

1. Leaders inform the trainers that the remaining group time will be devoted to developing and refining assertion skills.

2. They describe the trainees' roles and responsibilities in giving honest and clear feedback to each other. The leader is to demonstrate how to give feedback (i.e. start with positive feedback first, withhold criticizm, offer suggestions or alternate ways of responding, and stress the importance of positive as well as negative feedback).

The leader is then to hand out questions relating to feedback to the group.

G. Termination of Session 1 and Homework Assignments

Review key principles that have been discussed.

1. Monitor yourself in various situations (work, class, social and intimate relationships, etc.) and develop an awareness of how often you respond assertively, non-assertively, or aggressively.

2. Start recording in your daily log positive and negative observations.

3. Think of some specific behaviors or attitude that you wish to change about yourself before you end the last session.

Session 2 Overview

Key principles to be discussed:

1. Feedback from first session

2. Consciousness raising exercises

   a. Importance of recognizing the roles of men and women in modern day American society

   b. Socialization of men and women in nursing

3. Developing assertion skills and understanding values/ value conflicts

   Internal-external value conflicts and beliefs that inhibit one from being assertive.

4. Bill of Rights

   Understanding rights and responsibilities that underlie the right to be assertive

5. Components of verbal and non-verbal communication

6. Homework assignments

Time schedule:

Topic	1	- 15 minutes
Topics	2, 3, and 4	- 60 "
Topic	5	- 30 "
"	6	- 15 "

SESSION 2

Traditional Format

Objectives

-to continue to build a sense of group cohesiveness
-to provide participants with insights into their own behavior through consciousness-raising exercises

a. by developing an awareness of the socialization process of men and women in modern American society

b. by discussing the effect the roles of men and women have upon nursing as a profession

-to provide an opportunity for participants to acquire and incorporate assertion skills into their own repertoire of behavior through role play and modeling
-to discuss and identify individual nursing and human rights
-to incorporate verbal/non-verbal components of assertive communication

A. Introduction

1. Discussion of homework assignments and sharing of past week's experiences, including the positive and negative observations of other's behavior

2. Overview of the principles covered in session 1 and distribution of the handout for session 2

B. Socialization of Males and Females

1. Leaders initiate and facilitate discussion of the roles of females and males within American society, i.e. discuss roles of women as wives, mothers, sisters, daughters, and expectations that generally are ascribed to such roles. For example: Women are expected to please their husbands by tending to the home, caring for the children, doing the laundry, and sexually serving their husbands, etc. Men are expected to go to work and

attend to important matters such as financial decisions. Their roles are that of father, son, brother, breadwinner, authority figure within the family. The leader should initiate group discussion as to how various occupations perpetuate these roles such that social work, nursing, and teaching are extensions of women's roles in providing care outside the home. Men similarly attend to positions of prestige as lawyers, doctors, politicians, businessmen, etc.

2. Roles ascribed to those in nursing (middle class value orientation) should be examined. The leader again initiates discussion by requesting that the participants discuss the nature of nursing i.e. 1) What is the behavior expected of a nurse? This may take place in terms of roles or responsibilities; for example, nurses are expected to carry out the doctor's orders, never question or disobey her superior i.e. doctor, administrator, never be concerned with monetary gains. By remaining in passive roles nurses give power to those who represent authority. The consequence of giving power to others reduces the nurse's personal effectiveness and places her in a subservient position. Leaders should allow time for discussion. Now the group is ready to try to come up with a list of expectations of nursing behaviors.

C. Development of Assertive Skills and Understanding Values and Value Conflicts

Some internal/external beliefs (values) may prevent or inhibit one from being assertive. A leader should assist the members of the group to clarify such values. For example: One may wish to spend some time alone but fear that he/she may appear unconcerned about others, or one may wish to express a desire to share an activity with a spouse or a friend but is afraid that such a request is inappropriate because it places a demand on the other.

D. Bill of Rights

Have each member of the group with the leader as facilitator to come up with a Bill of Rights - to be collected. Assign a person to record these.

Encourage participants to react and respond to principles in the Bill of Rights - group is to come up with its own Bill of Rights.

Select those rights that apply to student nurses and nurses.

Next, distribute the Bill of Rights for Health Care Professionals (Chenovert) and compare those rights to those Bill of Rights developed by the group.

E. Assertion Skills - Behavioral Components

The leader explains and role plays examples of the non-verbal components of an assertive response.

1. Eye contact - discuss the use of eye contact to engage another person.

   Eye contact, looking at another person directly in the eyes, is an assertive non-verbal component. For many people avoiding eye contact implies recognition of the authority-subordinate relationship in a non-verbal way.

   Practice - do assertion training with adults (can do desensitization exercises). Gradually have the person look into another's eyes by instructing him/her to start at the feet (if no anxiety is experienced), then at the stomach, next at the chest, on to the left shoulder, right shoulder, then the neck, and finally to the face.

2. Facial expressions - the goal is to teach trainees to adapt the non-verbal messages to coincide with the verbal message. Facial expressions express the emotional tone of the communication, for example, anger, happiness, purpose. It is expected that one would utilize the facial expression appropriate to the situation, i.e. one does not laugh if he is uttering words of sorrow.

3. Gestures - these are kinetic movements that usually employ the hands along with the face. They may connote surprise, reference to objects or persons, or gestures of emphasis. Tactile gestures employ placing the hand on the person of another (usually the listener).

4. Voice - words in and of themselves do not communicate meaning. The tone of voice and rate of speech carry the message. The tone could be low pitched, high pitched, or medium. A deep steady voice can connote a position of authority while a soft meek voice can imply subservience or that one is being dominated.

5. Rate of speech - a fast rate of speech may imply anxiety or a state of excitability, while a slow rate of speech may mark uncertainty, boredom or disinterest, or apathy in what is being communicated at the time.

6. A nervous twitch or tick - such mannerisms may distract from the message that is being sent or received.

7. Space and distance - different ethnic groups will utilize different distances and space while engaging in conversation. For example, some people prefer to stand close (Jewish) and even touch while interacting while others prefer to remain further apart (white Middle Class). In addition, within all cultures, women, men, children, elderly have different forms of body posture.

   Practice - have the participants form dyads and discuss any topic. When each begins discussion he/she is instructed not to make eye contact and to restrict all body language cues. After two minutes ask each slowly to make eye contact and begin to bring his/her body into use in communicating his/her message.

Parts of Communication

1. Context - situation surrounding the communication itself

2. Message - affected by role perceptions, role expectations

3. Sender - person sending the message

4. Receiver - person receiving the message

5. Consequence of message - the outcome or the effects of the message

Developing Assertion Skills

This involves role play talking differently with the following individuals. i.e. Practice this by doing the Message matching exercise.

Sender	Message	Target Person
Nurse Nursing Student Male/Female		Physician Administrator Supervisor/Instructor Peer Male/Female

"I" Messages

"I" messages are appropriate for being assertive. You may say I feel, or I am, etc. It may be helpful to practice constructing sentences with "I" messages (assuming response for one's own feelings and behavior).

F. Termination of Session 2

Summarize principles of this session. Discuss any questions or issues raised.

Homework assignment

1. Daily logs are to be continued.

2. Review the concepts from the Bill of Rights. Identify which, if any, of the Principles of the Bill of Assertive Rights you find difficult or impossible to implement.

3. Mirror exercise - observe yourself in front of a mirror for ten minutes. While observing, be sure to talk in order to provide a clear impression of how you appear to others (in verbal and non-verbal contexts).

Session 3 Overview

Key principles to be discussed:

1. Discussion time for Bill of Rights and homework for the mirror exercise

2. Refinement of skills

3. Role playing exercises

4. Homework assignment

   -Log
   -GAP profile
   -Questionnaire

Time schedule:

Topic 1	- 30	minutes
Topics 2 and 3	- 60	"
Topic 4	- 30	"

SESSION 3

Traditional Format

Objectives

-to encourage (through role play and feedback) participants to continue refining assertive skills
-to reinforce the principles that underlie verbal and non-verbal communication
-to analyze responses to personal life situations through GAP (Group Awareness Profile) and questionnaire

A. Introduction

Summarizing of previous homework assignments

Sharing of previous week's log

Overview of the principles covered in sessions 1 and 2

B. Behavioral Scripts

The following scripts are designed to illustrate specific aspects of assertive behavior. Have trainees with the leader as facilitator, role play the following situations:

Making a request

You are having academic difficulty with a particular subject. You make an appointment to see your school counselor. You wish to drop a course and retake it at a later date, but your request is denied. In the meantime, you had learned that another student had been granted a similar request.

Refusing a request

You have recently worked two night shifts consecutively in the past week and have had only one day off. You are scheduled to be off the next day, but your supervisor approaches you and requests that you come in

order to staff another unit that is short. You have already planned to spend some time with your family and friends.

The group may think of other situations besides the above examples. Encourage members of the group to give honest and clear feedback utilizing the principles covered in earlier sessions.

Practice - Allow the group to select pertinent aspects of the components of non-verbal and verbal behavior for practice and refinement, also, construct sentences with "I" messages.

Body language - Have members monitor each other's body language, body posture, gestures, distancing, eye contact, etc.

Leader please note: Individual members may be assigned specific behaviors to monitor for giving feedback.

C. Termination of Session 3

Review key principles covered in this session. Leaders are to clarify points and/or answer questions raised relevant to the sessions.

D. Homework Assignment

1. Keep daily logs
2. Complete the GAP
3. Read and respond to the questionnaire for the last session
4. Bring personal life situations that you wish to demonstrate before the group for the next session
5. Practice giving feedback

Session 4 Overview

Key assertive principles to be discussed:

1. Discussion of previous homework assignments

2. Practice on personal life situations

3. Logs - as a wrap-up

4. How to continue assertive behavior

   Find a support person for practicing assertive behavior and feedback

   Read books on assertiveness

   Set up rewards for yourself for very successful assertive behavior

5. Administration of post-tests

Time schedule: Topics 1, 2, 3, and 4 - 75 minutes
Topic 5 - 30-45 minutes

SESSION 4

Traditional Format

Objectives

-to provide additional practice and opportunity for role playing
-to provide an opportunity to refine assertion skills and further assimilation of content
-to continue to enhance areas for additional assertiveness training

A. Introduction

1. Discussion of previous week's homework assignments, sharing successes and failures of the previous week

2. Assertion skills practice based on assessment (GAP Questionnaire) - personal life situations

3. Focusing upon message matching, communication styles

4. Wrap-up. Use of log. Behavioral hierarchy. How to continue assertive behavior

5. Administering post-tests

B. Group Awareness Test (adapted from Cheek)

This test adapted from Cheek is designed to assist trainees to gain insight into their own behavior while interacting with others. The leader is to encourage discussion centered around the GAP test.

The interpretation of the test is as follows: ideally all questions the client would circle as assertive. If six or more responses are in the other categories i.e., not sure, passive, or aggressive, the client needs assistance in becoming more assertive.

QUESTIONNAIRE

INSTRUCTIONS: Read and respond to the following questions. Be honest and open with yourself. In answering the questions try to be specific; you may provide examples.

-Have you ever felt different from other people because
1. you have selected nursing as a career and
2. you are male/female?

-Have you ever felt that entering into the nursing profession has alienated you from your family, friends?

-How do you feel about yourself as a person?

-Do you see some of the roles ascribed to nursing similar to the roles that are ascribed to you as being a female/male?

-Are you satisfied with the direction of your life as you see the way it is going?

-What are some of the things that you would like to see change within your life?

-Can you identify attitudes that prevent you from becoming assertive?

A BILL OF RIGHTS FOR HEALTH CARE PROFESSIONALS

1. You have the right to be treated with respect.
2. You have the right to a reasonable work load.
3. You have the right to an equitable wage.
4. You have the right to determine your own priorities.
5. You have the right to ask for what you want.
6. You have the right to refuse without making excuses or feeling guilty.
7. You have the right to make mistakes and be responsible for them.
8. You have the right to give and receive information as a professional.
9. You have the right to act in the best interest of the patient.
10. You have the right to be human.

From M. Chenovert, Special Techniques in Assertiveness Training for Woman in the Health Professions.

GROUP AWARENESS PROFILE (GAP TEST)

1.	I think most patients would see me as	passive	assertive	aggressive	not sure
2.	I think most nurses would see me as	passive	assertive	aggressive	not sure
3.	I think most physicians would see me as	passive	assertive	aggressive	not sure
4.	I think most nurses are	passive	assertive	aggressive	not sure
5.	I think most women are	passive	assertive	aggressive	not sure
6.	I think most physicians are	passive	assertive	aggressive	not sure
7.	I would like most people to see me as	passive	assertive	aggressive	not sure
8.	I would like most nurses to see me as	passive	assertive	aggressive	not sure
9.	I would like most patients to see me as	passive	assertive	aggressive	not sure
10.	I think I usually look	passive	assertive	aggressive	not sure
11.	I think I usually act	passive	assertive	aggressive	not sure
12.	With a nurse it is easy for me to be	passive	assertive	aggressive	not sure
13.	With a patient it is easy for me to be	passive	assertive	aggressive	not sure
14.	With a physician it is easy for me to be	passive	assertive	aggressive	not sure
15.	With a nurse it is hard for me to be	passive	assertive	aggressive	not sure
16.	With a patient it is hard for me to be	passive	assertive	aggressive	not sure
17.	With a physician it is hard for me to be	passive	assertive	aggressive	not sure

(Adapted from Cheek, D. Assertive Black . . . Puzzled White. San Luis Obispo, CA: Impact Publishers, Inc., 1976)

BEHAVIORAL HIERARCHY

Assertive Behaviors

Instructions: Below is an example of a behavioral hierarchy that would be based upon the entries from your daily log.

Order of priority	Assertive Behaviors
9	Ask for raise.
7	Boss not to call Honey.
8	Ask mate to help more around house.
3	Say no to door-to-door salesmen.
1	Ask children to pick up after themselves.
6	Extra day off.
5	Send back food not prepared properly.
2	Spend 30 minutes alone each day - "me time".
4	Read a book.

GUIDE TO GIVING FEEDBACK

1. Did the person get to the point reasonably quickly?

2. Did they describe specific behavior that was objectionable or did they solely use global labels like "bad attitude"?

3. Did the person attack the other person, or act in a judgemental or accusatory fashion?

4. Did the person open up discussion to get the other person's reaction? Did they then listen to what that person said?

5. Did they assume a stance of "I must win" or was there any possibility of a reasonable compromise that did not violate the integrity of either individual?

6. Did they use a lot of "you's" or did they use a lot of "I's"?

7. Was their voice clear, appropriately loud, with words emphasized or was their voice hesitant, sing-song? How about eye contact?

APPENDIX C

Bibliotherapy

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APPENDIX D

Human Subject Review Committee Permission Forms

TEXAS WOMAN'S UNIVERSITY
Box 23717 TWU Station
Denton, Texas 76204

HUMAN SUBJECTS REVIEW COMMITTEE

Name of Investigator: Janice M. Penn Center: ~~Denton~~

Address: ~~Twin Lakes, Route 5, Stuart Road Box 268~~ Date: June 8, 1981

~~Denton, Texas 76201~~

Dear Ms. Penn

Your study entitled Assertive Behavior and Depression Among Native American Nursing Students, and Native American Nurses

has been reviewed by a committee of the Human Subjects Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health, Education, and Welfare regulations typically require that signatures indicating informed consent be obtained from all human subjects in your studies. These are to be filed with the Human Subjects Review Committee. Any exception to this requirement is noted below. Furthermore, according to DHEW regulations, another review by the Committee is required if your project changes.

Any special provisions pertaining to your study are noted below:

_____ Add to informed consent form: No medical service or compensation is provided to subjects by the University as a result of injury from participation in research.

_____ Add to informed consent form: I UNDERSTAND THAT THE RETURN OF MY QUESTIONNAIRE CONSTITUTES MY INFORMED CONSENT TO ACT AS A SUBJECT IN THIS RESEARCH.

_____ The filing of signatures of subjects with the Human Subjects Review Committee is not required.

_____ Other:

✓ No special provisions apply.

cc: Graduate School
Project Director
Director of School or
Chairman of Department

Sincerely,

Marilyn Hinson

Chairman, Human Subjects
Review Committee

at Denton

APPLICATION TO HUMAN SUBJECTS REVIEW COMMITTEE

Subject: Research and Investigation Involving Humans

Statement by Program Director and Approved by Department Chairman

This abbreviated form is designed for describing proposed programs in which the investigators consider there will be justifiable minimal risk to human participants. If any member of the Human Subjects Review Committee should require additional information, the investigator will be so notified.

Five copies of this Statement and a specimen Statement of Informed Consent should be submitted at least two weeks before the planned starting date to the chairman or vice chairman on the appropriate campus.

Title of Study: Assertive Behavior and Depression Among Native American Nursing Students. And Native American Nurses

Program Director (s): Dr. Margie Johnson mj

Graduate Student: Janice M. Penn jmp

Estimated beginning date of study: May, 1981

Estimated duration: 4 weeks

Address where approval letter is to be sent:

Twin Lakes, Route 5, Stuart Road Box 268 , Denton, Texas 76201

Is this research being conducted for the thesis or professional paper? Y __ N ____; for the dissertation? Y __x__ N _____.

1. Brief description of the study (use additional pages or attachments, if desired, and include the approximate number and ages of participants, and where they will be obtained). This study will undertake to examine the psychological phenomenon of assertiveness with regard to one cultural minority (Native American Alaska Native Nursing Students), in the health care field. In so doing, it addresses the following objectives: 1. to assess levels of depression among Native American Nursing Students 2. to assess levels of assertiveness among Native American Nursing Students 3. to establish the relationship between levels of depression and levels of assertiveness among Native American Nursing Students; and 4. to establish the efficacy of varied assertiveness training programs in order to alleviate reactive or neurotic depression which stems from long term exposure of feelings of helplessness, hopelessness, and despair. Two instruments, Beck Depression Inventory and the Gambrill and Richey Assertiveness Inventory, will be administered to a sample of 40 to 64 subjects 18 years of age and older. They will be used as pre-and-post-tests. A third party, will serve as an interviewer to rate the subjects with two additional scales developed according to the Taylor method to assess assertive and depressive behavior. The subjects will be located in Albuquerque, New Mexico .

2. What are the potential risks to the human subjects involved in this research or investigation? "Risk" includes the possibility of public embarrassment and improper release of data. Even seemingly nonsignificant risks should be stated and the protective procedures described in #3 below. The potential risks are as follows:
   1. Confidentiality - the information obtained about the subjects could be exposed to others without the subjects awareness.
   2.. Inappropriate use of the data.
   3. Distaste for the topic--uncertainity as to the nature of the topic.
   4. Exploitation of the Indian Group
   5. Anxiety experienced related to a change in behavior as a result of the training procedures.

3. Outline the steps to be taken to protect the rights and welfare of the individuals involved.
   1. Students shall be informed that the information obtained shall be used for the sole purpose of the investigation, and all information will be retained by the investigator in compliance with the Human Subjects Review Committee, guidelines.
   2. Subjects will be informed prior to the investigation the nature and purpose of the research, and an assurance to the subject that his/her prior consent is required.
   3. Subjects will be told that they may withdraw from the study at anytime without penal
   4. Ample time will be allotted to answer any questions or concerns for clarification.

   Outline the method for obtaining informed consent from the subjects or from the person legally responsible for the subjects. Attach documents, i.e., a specimen informed consent form. These may be properly executed through completion of either (a) the written description form, or (b) the oral description form. Specimen copies are available from departmental offices. Other forms which provide the same information may be acceptable. Written description of what is orally told to the subject must accompany oral form in the application.

5. If the proposed study includes the administration of personality tests, inventories, or questionnaires, indicate how the subjects are given the opportunity to express their willingness to participate. If the subjects are less than the age of legal consent, or mentally incapacitated, indicate how consent of parents, guardians, other qualified representatives will be obtained.

Subjects shall be informed of the nature and procedure of the instruments that are being utilized in the study. Subjects would be advised of any actual or potential risks that are involved . The subject shall be informed that he/she may withdraw from the study at any time (without penalty) should the subject chooses not to continue in the study. The investigator will provide ample time to answer any questions or concerns as well as clarify further information as necessary. All subjects are of the legal age of consent and are not mentally incapacitated.

Dissertation/Theses signature page is here.

To protect individuals we have covered their signatures.

APPENDIX E

Newspaper Advertisement

XCELLENT location
35.00 plus. 256-7127,
7/30

bedroom furnished
square feet, storage,
ildren, 842-0925. tfn

artment: $180/month,
ared swimming pool,
information contact
d NE, 266-8392, 255-
tfn

DROOM furnished
month, utilities paid.
6131. 7/30

ation near UNM and
0 minutes. 1 bedroom
utilities paid.. Deluxe
disposal, recreation
m and laundry. Adult
ty NE. 243-2494. tfn

ENT, one half block
tfn

m houses. Fenced,
t bedroom apt. Close,
647. 7/30

ENT 1/2 block from
tfn

EDS 1-2BR house,
a, 8-15-81 to 5-30-82;
chael Hamilton, 918
end phone number.
7/30

room with swimming
rigerated air and cable
ncludes utilities. 209
7/30

bedroom townhouse
/NM area. Warehouse
. Parents buy this and
free. 247-8724, 842-
8/17

spacious, attractive,
$185. 116, number 2,
7/30

OCKS UNM. Large
, 242-3298. 8/25

lace SE- $170/mo. bot
1-2717 (days) or 266-
7/30

- $185, plus utilities, 1
7/3(

ARGE house with
place, washer, pets
1-81, $125/month.
8/17

6. Employment

MCAT TUTOR WANTED, references needed, part-time, excellent pay, 265-2524. tfn

WORK-STUDY STUDENTS! On campus employment with New Mexico Union Food Service. We are now accepting applications for the fall semester. We offer flexible scheduling and free meal benefits. Bring your fall class schedule and apply in the Food Service office in the NM Union. Ask for Jeanette or Betty, 8a.m.-4p.m. 8/25

JEWISH RELIGIOUS SCHOOL is looking for teachers who can teach Hebrew, prayer and Jewish Heritage, Call J. Goldman, 821-8270. 8/17

WORK-STUDY POSITION open at the Daily Lobo. Call 277-5656 or come to Marron Hall, room 131 to fill out an application. 7/30

NATIVE AMERICAN NURSES, Nursing students, or pre-nursing students wanted to fill out questionnaires and be interviewed for research for doctoral dissertation on assertiveness training. $3.35/hr., Mary Tenorio, 294-5616, or between 3 p.m.-11 p.m. 247-9501, ask for Medical Floor. 8/17

PERSONS TO MAKE anonymous meal, service and cleanliness evaluations of local restaurants in Albuquerque for National Research Co. Fees and Meals paid. Proficiency specialists, Box 20244, San Diego, CA 92120. 7/30

FALL SEMESTER EMPLOYMENT/S.U.B. shifts are 6 to 9 a.m.; 9 to 10:30 a.m.; 10:30 to 1:30 p.m. We offer on-campus employment and free meal benefits. If you are interested, apply at the New Mexico Union Food Service office and bring your fall class schedule. Ask for Jeanette or Betty, 8-4p.m. 8/23

PART TIME JOB afternoons and evenings. Must be able to work Friday and Saturday nights. Must be 21 years old. Apply in person, no phone calls, please. Saveway Liquor Stores at 5704 Lomas NE, 5516 Menaul NE. tfn

7. Travel

I NEED A ride to Nashville/Memphis area, leaving Albuquerque 8-10-81 - 8-13-81, Byron, work 268-5697; home 344-2618. 7/30

GOING SOMEWHERE? SAVE a little money-take someone along. Advertise your ride in the Daily Lobo. 7/16

8. Miscellaneous

PAINTER'S PANTS, MILITARY shorts, army pants, sun helmets, all at great prices, Kaufman's, a real Army-Navy store. 504 Yale SE. 256-0000. 8/24

HOT FEET? RELIEF with our 100 percent cotton men's dress socks. No sweat. 243-0338. 8/17

ARTISTS/WRITERS/PERFORMERS- Conceptions Southwest, UNM's publication of fine art, literature and performing art, is looking for responsible, creative students to fill staff positions for the 1982 issue. All positions are non-paying, but lots of practical experience and training are available. Call Leslie at 884-5123. 8/17

HAVE SOMETHING DIFFERENT to say? Say it in a better way. Class ads tell it all. 7/30

9. Las Noticias

ANYTHING EXCITING HAPPENING? Advertise your meeting, get-together or organization in Las Noticias for .10 per word. 7/30

SATURDAY NITE JAMS August 8th, Zozobra, and 15th Thumper From 9:00 p.m.-1:00 a.m. UNM S.U.B. Ballroom Admission $3.00 general, $2.00 UNM T.V.I. and U of A students for more information call 277-6492. 7/30

Janice M. Penn
Twin Lakes, Route 5, Stuart Road
Box 268
Denton, Texas 76201
(817)382-1898

July 27, 1981

Student Publications
The University of New Mexico
U.N.M. Box 20
Albuquerque, New Mexico 87131

Dear Becky Martinez:

Thank you for your most valuable assistance in making the announcement. Enclosed you will find the check for $20.35 covering the cost of the advertisement.

In the meantime, I shall look forward to reading the announcement in the newspaper. THANK YOU AGAIN.

Sincerely,

Dissertation/Theses signature page is here.

To protect individuals we have covered their signatures.

APPENDIX F

The Assertion Inventory

THE ASSERTION INVENTORY

Many people experience difficulty in handling interpersonal situations requiring them to assert themselves in some way, for example, turning down a request, asking a favor, giving someone a compliment, expressing disapproval or approval, etc. Please indicate your degree of discomfort or anxiety in the space provided before each situation listed below. Utilize the following scale to indicate degree of discomfort:

1 = none
2 = a little
3 = a fair amount
4 = much
5 = very much

Then, go over the list a second time and indicate after each item the probability or likelihood of your displaying the behavior if actually presented with the situation.* For example, if you rarely apologize when you are at fault, you would mark a "4" after that item. Utilize the following scale to indicate response probability:

1 = always do it
2 = usually do it
3 = do it about half the time
4 = rarely do it
5 = never do it

*Note. It is important to cover your discomfort ratings (located in front of the items) while indicating response probability. Otherwise, one rating may contaminate the other and a realistic assessment of your behavior is unlikely. To correct for this, place a piece of paper over your discomfort ratings while responding to the situations a second time for response probability.

Degree of discomfort	Situation	Response Probability
_____	1. Turn down a request to borrow your car	_____
_____	2. Compliment a friend	_____
_____	3. Ask a favor of someone	_____
_____	4. Resist sales pressure	_____

Degree of discomfort		Situation	Response Probability
_____	5.	Apologize when you are at fault.	_____
_____	6.	Turn down a request for a meeting or date.	_____
_____	7.	Admit fear and request consideration.	_____
_____	8.	Tell a person you are intimately involved with when he/she says or does something that bothers you.	_____
_____	9.	Ask for a raise.	_____
_____	10.	Admit ignorance in some area.	_____
_____	11.	Turn down a request to borrow money.	_____
_____	12.	Ask personal questions.	_____
_____	13.	Turn off a talkative friend.	_____
_____	14.	Ask for constructive criticism.	_____
_____	15.	Initiate a conversation with a stranger.	_____
_____	16.	Compliment a person you are romantically involved with or interested in.	_____
_____	17.	Request a meeting or a date with a person.	_____
_____	18.	Your initial request for a meeting is turned down and you ask the person again at a later time.	_____
_____	19.	Admit confusion about a point under discussion and ask for clarification.	_____
_____	20.	Apply for a job.	_____

Degree of discomfort		Situation	Response Probability
_____	21.	Ask whether you have offended someone.	_____
_____	22.	Tell someone that you like them.	_____
_____	23.	Request expected service when such is not forthcoming e.g., in a restaurant.	_____
_____	24.	Discuss openly with the person his/her criticism of your behavior.	_____
_____	25.	Return defective items, e.g., store or restaurant.	_____
_____	26.	Express an opinion that differs from that of the person you are talking to.	_____
_____	27.	Resist sexual overtures when you are not interested.	_____
_____	28.	Tell the person when you feel he/she has done something that is unfair to you.	_____
_____	29.	Accept a date.	_____
_____	30.	Tell someone good news about yourself.	_____
_____	31.	Resist pressure to drink.	_____
_____	32.	Resist a significant person's unfair demand.	_____
_____	33.	Quit a job.	_____
_____	34.	Resist pressure to "turn on".	_____
_____	35.	Discuss openly with the person his/her criticism of your work.	_____
_____	36.	Request the return of borrowed items.	_____

Degree of discomfort	Situation	Response Probability
_____	37. Receive compliments.	_____
_____	38. Continue to converse with someone who disagrees with you.	_____
_____	39. Tell a friend or someone with whom you work when he/she says or does something that bothers you.	_____
_____	40. Ask a person who is annoying you in a public situation to stop.	_____

APPENDIX G

Beck Inventory

BECK INVENTORY

Name _____ Date _____

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY! Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7.
0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8.
0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9.
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10.
0 I don't cry anymore than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11.
0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

12.
0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.
0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

14.
0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15. 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes _____ No _____

20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
2 I am very worried about physical problems and it's hard to think of much less.
3 I am so worried about my physical problems, that I cannot think about anything else.

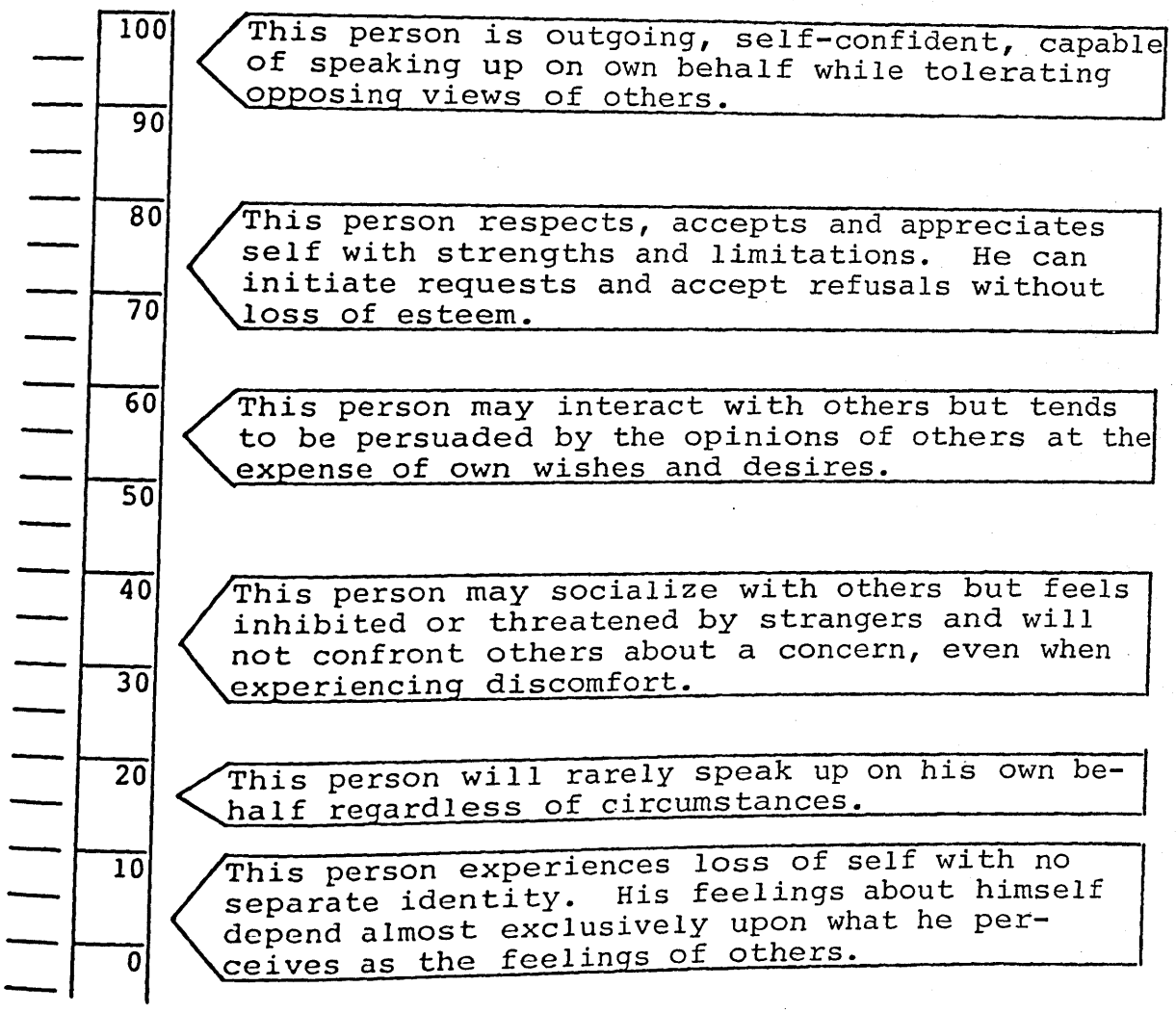
21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

APPENDIX H

Assertiveness Rating Scale

ASSERTIVENESS RATING SCALE

Instructions: This is an example-anchored scale that is designed to rate assertive traits. The scale is comprised of six anchor points ranging from least assertive to most assertive. Pick out the one (1) anchor point that best describes the subject and place a check (✓) beside the appropriate example.

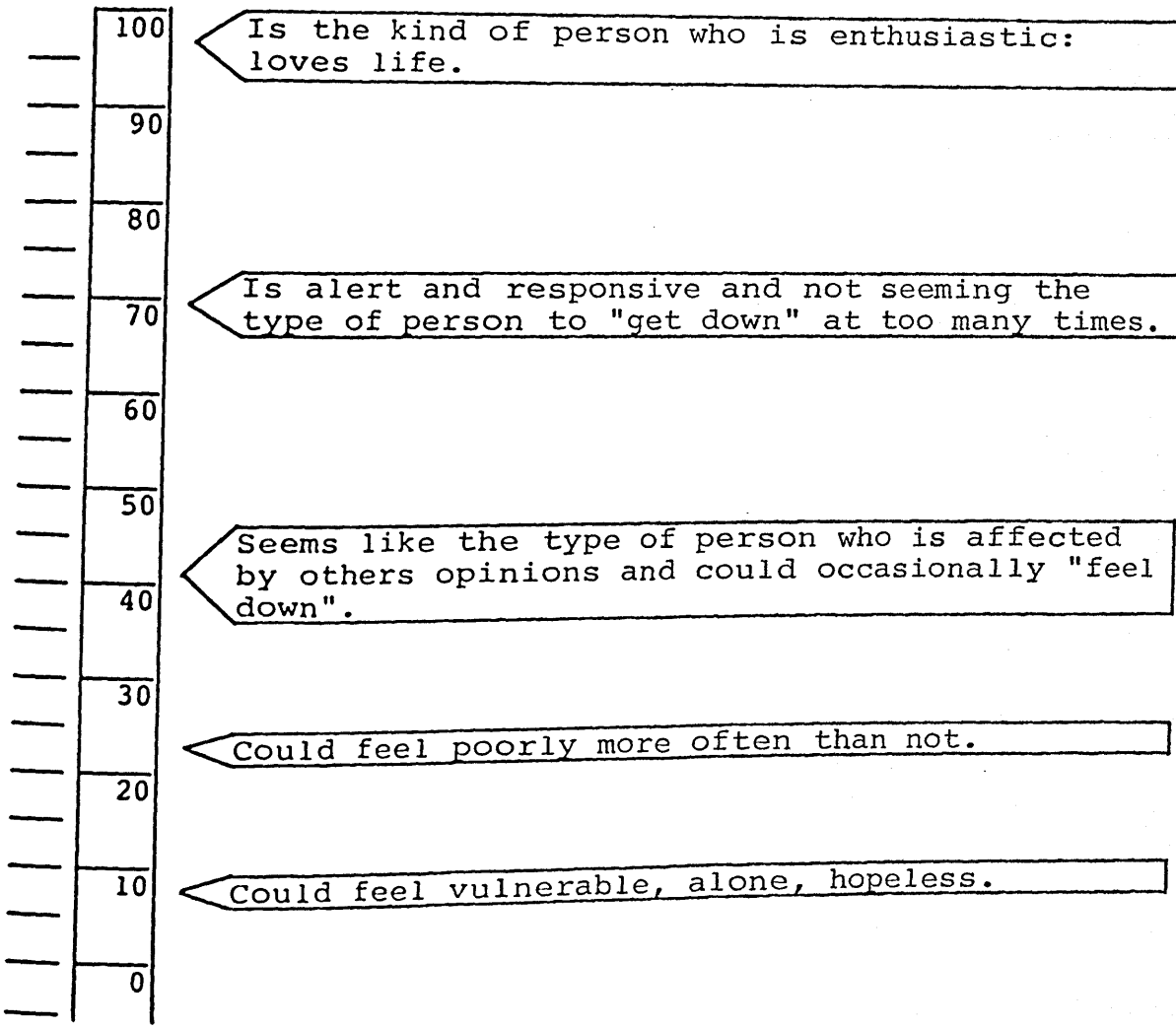


APPENDIX I

Depression Rating Scale

DEPRESSION RATING SCALE

Instructions: This is an example-anchored scale that is designed to rate depressive traits. The scale is comprised of five anchor points ranging from least depressive to most depressive. Pick out the one (1) anchor point that best describes the subject and place a check (✓) beside the appropriate example.



INSTRUCTIONS: Please place a check ( ) in the space provided below to rate the subject on the following behaviors:

Behavior	Range of Response	
Eye Contact	_____Direct	_____Indirect
Body Posture	_____Erect	_____Slouchy
Mood	_____Energetic	_____Listless
Appearance	_____Well-dressed	_____Disheveled
Tone of Voice	_____Audible	_____Inaudible

APPENDIX J

Pilot Study

A pilot study examined the responses of Native American subjects on the Gambrill and Richey (1973) Assertion Inventory. The assertion inventory was administered to an adult American Indian population, ages 18 years and above. Less than half, 34.8% (8 individuals) were males while 65.2% (15 individuals) were females. The total number of subjects was 23.

Upon receipt of the results, the data was analyzed and tabulated according to the following criteria. First, a frequency count on distribution was done to see how many people responded to each item. Then, a correlation matrix was determined on each of the two scales (Degree of Discomfort and Response Probability) to get the correlation coefficient. Next, a Pearson correlation coefficient was used item by item to determine the level of significance between the two scales. Finally, a point bicerial correlation was done to indicate the relationship between sex and the variable in the response.

The analysis began with a bivariate frequency distribution on each discomfort score ranging from 1 to 40 ($D_1 - D_{40}$) and a similar frequency distribution for response probability scores ranging from 1 to 40 ($R_1 - R_{40}$). The results for the discomfort scores indicated that the distribution over each variable was even or spread out

evenly over the different categories. The overall distribution of scores, since they did not indicate skewness, takes the shape of a bivariate normal distribution. An example of the distribution for a typical response is illustrated on the following table.

Discomfort Score 1	Category	Code	Absolute Frequency	Relative Frequency %
	None	1.	3	13.0
	A little	2.	7	30.4
	A fair amount	3.	4	17.4
	Much	4.	2	8.7
	Very much	5.	7	30.4
			23	100.00

Response Probability Score 1	Category	Code	Absolute Frequency	Relative Frequency %
	Always do it	1.	3	13.0
	Usually do it	2.	6	26.1
	Do half the time	3.	1	4.3
	Rarely do it	4.	5	21.7
	Never do it	5.	8	34.8
			23	100.00

Next, a reliability analysis for the discomfort scale for the 40 items was determined through the method of covariance matrix that analyzed covariance between each item. The discomfort reliability coefficient was 0.88544. Similarly, for the response probability scale, an item by item covariance matrix was done as well as a correlation matrix. The response probability correlation coefficients obtained represent a high degree of association. The response probability coefficient correlation was 0.92.

To proceed with the analysis, an item by item correlation between the Degree of Discomfort and Response Probability scale (i.e., $D_1 - R_1$, $D_2 - R_2$, etc.) was examined in order to determine the reliability coefficients. In a sense, this investigator sought to use this coefficient as a validity coefficient since it would be expected that a high degree of uneasiness or discomfort would lead to a decrease in response. For this purpose, the Pearson product-moment correlation was used to determine the coefficient. It was predetermined that anything .05 would be significant.

By definition, the correlation coefficient tests the null that there is no correlation between the variables. The results of the data indicate that approximately one-half of the data (17 correlations) were significant at the .05 level. Data were examined to determine whether

differences in responses could be attributed to male/female differences. The overall results indicated significant variation.

In the final analysis there did no appear to be any racial bias. Because of the high reliability scores and other supportive evidence mentioned above, the tool appeared to be strong enough for further use when developing the dissertation.

The time for completing the instrument appeared to be within a reasonable length of time--with 15 minutes the average. Moreover, in allowing someone besides the investigator to administer the tool, experimenter bias should have been eliminated.

APPENDIX K

Interview Questions Used for Rating Scales

Interview Questions for Assertiveness and Depression Rating Scales

Question: Tell me about yourself.
1. Interests
2. Dislikes
3. Goals

Question: How do you feel about your profession?

Question: What image do you have of yourself as
1. a person?
2. a nurse?

Question: Did you ever think of becoming a doctor instead of a nurse? Why or why not?

Question: Do you always agree with the doctor? Your supervisor? What do you do if you think he's/she's wrong?

Question: How do you feel around people?
1. people you know?
2. people you do not know?

Question: If you find yourself feeling unhappy (depressed) what do you do? Why? Do you feel/do this often?

APPENDIX L

Letter of Permission Granting Use of Assertion Inventory

UNIVERSITY OF WASHINGTON
SEATTLE, WASHINGTON 98105

School of Social Work
1417 N.E. 42nd Street

October 29, 1979

Janice Penn
Stuart Road, Route 5
Twin Lakes
Denton, Texas 76201

Dear Ms. Penn:

I hereby give my permission for you to reproduce the Assertion Inventory as is for use in your dissertation research. Please cite the reference as it appears in Behavior Therapy, 1975, 6, 550-561.

I have not had time to peruse my literature for further validation of the Inventory. I thought I better get this written letter of permission to you before delaying it any further. I will let you know the results of my mini-survey as soon as I can.

Good luck with your proposal development.

Sincerely,

Dissertation/Theses signature page is here.

To protect individuals we have covered their signatures.

APPENDIX M

Correspondence to Nursing Education Center for Indians

Janice Penn
Twin Lakes, Route 5, Stuart Road
Box 268
Denton, Texas 76201

October 22, 1980

Lydia Poirer, R.N., M.P.H.
Director
Nursing Education Center for Indians
Public Health Service, Indian Health Service
2601 12th Street, N.W.
Albuquerque, New Mexico 87102

Dear Ms. Poirer:

I am a nursing doctoral student at Texas Woman's University, Denton, Texas, and a Clinical Fellow sponsored by the American Nurses' Association. Currently I am preparing a proposal for the doctoral dissertation and I wish to pursue a study on Native American nursing students within collegiate nursing programs in the Southwest.

I am requesting your most valuable assistance in order to help me identify Native American nursing students located in such programs, who might be willing to participate in my study. I do believe that this research will ultimately address the concern that certain ethnic/racial minority groups including Native Americans, have been underrepresentated in the literature, and to increase the understanding of the Native American culture through the modification of existing assessment tools.

I would be most happy to share with you any additional information upon request as well as address any comments or concerns that you may have pertinent to this investigation. A copy of the "Problem Statement" is enclosed for your inspection. All necessary steps will be taken to protect the rights and privacy of all subjects who will be willing to participate.

In the meantime, I thank you for your kind attention in this matter, and I shall be anxiously waiting for your response.

Sincerely,

Janice Penn, R.N., M.A.

Enc.

APPENDIX N

Correspondence to American Indian/Alaska Native Nurses Association

November 27, 1980

Ms. Janice Kekahbah, R.N., M.A.
Executive Director
American Indian/Alaska Native
Nurses Association, Inc.
P. O. Box 1588
Norman, Oklahoma 73070

Dear Ms. Kekahbah:

I wish to thank you for letting me share with you some of my ideas about the dissertation that I am about to do. I enjoyed the recent telephone conversation we had.

Enclosed, please find, a preliminary draft of the proposal accompanied by the initial draft of the Modified Assertiveness Training procedure that I am developing for your review. I welcome your input as well as others who might be willing to participate as a panel of experts.

In the meantime, I shall be looking forward to hearing from you.

Sincerely,

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To protect individuals we have covered their signatures.

APPENDIX O

Correspondence to Whitecloud Center

November 27, 1980

Dr. Robert A. Ryan, Director
Whitecloud Center
University of Oregon
Health Science Center
840 SW Gaines Road
Portland, Oregon 97201

Dear Dr. Ryan:

I enjoyed our recent telephone conversation last Thursday, November 20th, and I am indeed happy to have the opportunity to share with you the nature of my study.

As we had discussed, I am requesting that you, as well as the members of the Society of Native American Psychologists, serve as the panel of experts for the Modified Assertiveness Training Procedure that I am developing.

Enclosed, please find, the preliminary draft of the proposal as well as the format for the assertiveness training procedure for your review. As soon as I receive the bibliography that is being forwarded to me by Ms. Diana Kelso, I will utilize the relevant materials. In the meantime, I shall be anxiously waiting for your response. I thank you for the kind attention that you have given this matter.

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APPENDIX P

Letter to Panelist

Janice Penn
Twin Lakes, Route 5, Stuart Road
Box 268
Denton, Texas 76201
(817) 382-1898

Dear Panelist:

Thank you for agreeing to participate as an expert in my study which is designed to test the effectiveness of a modified assertiveness training procedure for a Native American nursing student population.

As the panelist, I would like you to review, criticize and comment on the content for each session, in order to determine its appropriateness for such a population. My plans are to begin my study by early or mid spring, 1981.

For your convenience, I have enclosed a self-addressed envelope. In the meantime, I cannot thank you enough for your most valuable assistance.

Sincerely,

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To protect individuals we have covered their signatures.

APPENDIX Q

Permission Letter Granting Use of Beck Depression Inventory

CENTER FOR COGNITIVE THERAPY
AARON T. BECK, M. D., DIRECTOR
ROOM 602
133 SOUTH 36TH STREET
PHILADELPHIA, PA. 19104
TELEPHONE: (215) 243-4100

February 23, 1981

Janice Penn, R.N., M.A.
Twin Lakes, Route 5, Stuart Road
Box 268
Denton, Texas 76201

Dear Ms. Penn:

Thank you for your recent letter. As Coordinator for Continuing Education, I am responding to your interest in our scales and research on the behalf of Aaron T. Beck, M.D.

For your convenience I have enclosed a copy of the most recent version of the Beck Depression Inventory, as well as a list of suggested references containing validation information for the scale.

You have Dr. Beck's permission for use and reproduction of the Beck Depression Inventory - Copyright 1978 for your dissertation research. In return I would like to request that you send us copies of any reports or publications you prepare detailing the results of any research in which the scale was used. These reports will be catalogued in our library which serves as a central resource for other researchers and clinicians.

If you have any questions feel free to contact me. I will look forward to your results.

Sincerely

Dissertation/Theses signature page is here.

To protect individuals we have covered their signatures.

APPENDIX R

Correspondence from the New Mexico Board of Nursing

STATE OF NEW MEXICO

Board of Nursing

2340 Menaul, N.E. Suite 112
Albuquerque, New Mexico 87107
Telephone (505) 842-3026

Date: 7/29/81

Johnson Systems Associates
Post Office Box 4781
Albuquerque, New Mexico 87196

225 5777

Attn: Pete Johnson

Dear Pete:

This will authorize you to prepare the materials indicated below for Janice Penn.

It is understood that Johnson Systems Associates will charge the recipient:

$40.00 per 1,000 names for a list
$44.00 per 1,000 names for labels
$40.00 per 1,000 names for a tape plus a $25.00 deposit

These prices are in addition to the $50.00 programming fee.

INSTRUCTIONS:

_____ RN's only; _____ LPN's only; _x_ RN's and LPN's

_____ List; _x_ Labels; _____ Tape

Sorted: _____ Alphabetically; _____ Numerically; _x_ Zip code order

Geographical Distribution: _x_ All; _____ NM only

Counties: _____

Zip codes: _____

Other Instructions: please extract only on racial American Indian category (RAC,3)

Thank you for your cooperation.

Sincerely,

Teresa C. Sanora
Director of Administration

Enclosure: none

CC: Janice Penn, Twin Lake, Route 5, Stuart Road, Denton, TX 76201

APPENDIX S

Fliers to New Mexico Nurses

INDIAN STUDENT NURSES AND NURSES NEEDED

VOLUNTEER AS A SUBJECT FOR A DOCTORAL DISSERTATION RESEARCH PROJECT ON ASSERTIVE BEHAVIOR AND DEPRESSION AMONG AMERICAN INDIAN/ALASKA NATIVE NURSING STUDENTS AND NURSES

AS A SUBJECT YOU WILL RECEIVE A COMPENSATION OF $3.35 PER HOUR (MINIMUM WAGE) FOR A 4 WEEK STUDY, 2 HOURS PER WEEK IF YOU PARTICIPATE IN THE ASSERTIVENESS TRAINING SESSIONS OR IF YOU SERVE AS CONTROLS (NO TRAINING)

The study is to take place in Albuquerque, New Mexico for 4 weeks and your prior permission is required. There will be four groups of subjects, two of the groups shall receive Assertiveness Training while the remaining two groups of subjects shall serve as controls (no training). Subjects will be randomly assigned to each of the groups. A qualified trainer will administer the sessions. One person will interview you before the study begins using two scales that question your responses within certain social situations, for example, how you initiate requests, deny requests, seek information, etc. A second scale will rate your responses as to when and how often you feel sad or glad at certain times. In addition, you will be asked to rate yourself on the same responses by completing two questionnaires. Upon completion of the study you will be asked to complete the same scales and questionnaires as described above. For further information and details please contact the following person at the following locations:

Mary Francis Tenorio
Plaza Dorado Apts. -425 Western Skies S.E.
Apt. 625, Box 126
Albuquerque, New Mexico 87123
505-294-5616

OR

University Heights Hospital
Medical Floor, 3-11 Shift
1127 University Blvd. NE
Albuquerque, New Mexico
505-247-9501

OR

Santo Domingo Pueblo
505-465-2531

[illegible] it is a [illegible] fact that Indian people in particular have found the competitive American value system basically alien to Indian ways. There it is common knowledge by Indian and non-Indians alike that Indian people appear to have trouble effectively coping and communicating within the majority culture. As a result they often remove themselves from uncomfortable situations, and or refrain from expressing their ideas, feelings and opinions. (LaFrombaise, 1979). Assertiveness Training offers an alternative to whose who experience personal helplessness. It is not a "cure-all" but research has shown that people who make assertive responses are healthier, happier and experience less anxiety. (Alberti & Emmons, 1978).

Whether you work, attend school, face friends, deal with relatives or in any situation, you can benefit from Assertiveness Training. Until recently Assertiveness Training addressed mainly the needs and concerns of women, children, married and divorced couples, the elderly and nurses. But little has been done to address the unique needs of the American Indian people.

[illegible] parallel those problems addressed by the women's movement. Discrimination, underemployment, exploitation and denial from full participation in society are just a few of the conflicts that have arisen. But even more pronounced is the problem unique to the Indian woman, her double minority status. When such conflicts are coupled with feminist issues which affect nurses in particular, the situation of the American Indian woman presents a unique and complex series of problems.

Even though the health needs of American Indians are greater than any other population, the number of Indian nurses and nursing students are inadequate to meet those needs. This study is one attempt to address this problem through the development of theory. The attempt is to examine the effectiveness of a psychotherapeutic intervention that is applicable to American Indian nurses.

Therefore if you feel that you can benefit from this type of training by increasing your personal effectiveness and communication skills, you are urged to participate in this training. Your participation will not only contribute to nursing service and nursing education (which is sorely needed) but will increase knowledge about Indian culture. If you wish to make a choice and if you are interested please contact the following person on the accompanying announcement. or you may call or write as soon as possible to:

Janice M. Penn
Twin Lakes, Route 5. Stuart rd
Box 268
Denton. Texas 76201
or call collect
(817) 382-1898

RETURN FOR MORE INFORMATION

Name.....

Address.....

City.....

Tel. AC .....

Place of Empl .....

.....

Thank you for your cooperation.

****

Janice M. Penn, R.N.
Doctoral Canditate
Texas Woman's University
Full Member of the
American Indian Alaska Native
Nurses Association, Inc

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