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The effects of a group assertiveness training program on self-esteem, assertiveness, and health locus-of-control for female veterans in a VA domiciliary

Baily, Susan Jane, Ph.D.

The Ohio State University, 1991
THE EFFECTS OF A GROUP ASSERTIVENESS TRAINING PROGRAM ON
SELF-ESTEEM, ASSERTIVENESS, AND HEALTH LOCUS OF CONTROL
FOR FEMALE VETERANS IN A VA DOMICILIARY

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of The Ohio State University

By

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* * * * *

The Ohio State University
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Health, Physical Education, and Recreation
DEDICATION

To My Parents

To Alison and Jennifer

To Emmor

To the Female Veterans

- ii -
ACKNOWLEDGEMENTS

I wish to acknowledge Mr. Milton M. Solomon, RN (Chief, Nursing Service) and Dr. Linda Hedden (Chief, Domiciliary Service). Their administrative support at the Dayton, Ohio Veterans Affairs Medical Center made it possible for this study to be conducted. I sincerely thank the staff of the VA Medical Library, Lendell Beverly (Chief, Library Service), and in particular Margaret Metcalf, Nola Petit, and Ellen Proctor. I am grateful to my advisor, Dr. R. Cory Bates, for his guidance during my studies. To my committee members, Dr. Grayce Sills and Dr. Jennie Nickel, I acknowledge their valuable input and support. I wish to thank the female veterans residing at the domiciliary, Dayton, Ohio Veterans Affairs Medical Center, who willingly participated in this study; their sharing made a difference. I acknowledge with immeasurable gratitude Dr. Joan Padgett; without her, this would not have been possible.
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CHAPTER I
ORIENTATION TO THE STUDY

RATIONALE FOR THE STUDY

The self begins with birth and develops over one's lifetime. George H. Mead (1934) expressed this development in the following way:

There are two general stages in the full development of the self. At the first of these stages, the individual's self is constituted simply by an organization of the particular attitudes of other individuals toward himself and toward one another in the specific social acts in which he participates with them. But at the second stage in the full development of the individual's self, that self is constituted not only by an organization of these particular individual attitudes, but also by an organization of the social attitudes of the generalized other or the social group as a whole to which he belongs" (p. 158).

According to McKay and Janning (1987), self-esteem is essential for psychological survival. One of the main differences between humans and other animals is the human awareness of self. It is the ability to form some identity and attach a value to it.

Theories of the self are essentially definitions of what it is to be human. These theories allow society to be aware of what the individual can or cannot do, what
limitations may be present for functioning as humans, and what hopes may be nurtured for future change.

Self-esteem is one dimension in the development of the self. It has been defined as the degree to which one values one's self (Mead, 1934). The significance of one's personal worth is also addressed in Coopersmith's (1967) definition which states, "self-esteem is the evaluation an individual makes, and usually maintains, with regard to himself" (p. 45). In other words, self-esteem is the personal judgment of worthiness an individual expresses in the attitudes one holds towards one's self.

One factor which influences self-esteem is gender. Negative attitudes toward women continue to be highly evident in today's society. Feminine characteristics of passivity, submissiveness, dependence, and emotionality are negatively valued when compared to characteristics attributed to men (McKee & Sherriffs, 1957; McKee & Sherriffs, 1959; Rosenkrantz, Vogel, Bee, Broverman, &Broverman, 1968; Sherriffs & McKee, 1957). It is not surprising that female self-esteem tends to be more negative than male self-esteem. The symptoms of low self-esteem, depression, and anxiety reflect women's powerlessness, role conflicts, and the cultural devaluation of female traits (Kravitz, 1976).

One segment of the female population is veterans of military service. Historically, service in the armed forc-
es has provided a path for upward mobility for individuals as well as groups (Rothman, 1984). While participation in the armed forces has often been the forerunner of social advances in equality, many female veterans find themselves to be highly visible as "token minorities".

The term "token minority" describes the scarcity of women entering male dominated fields. This term highlights special characteristics, usually sex, race, religion, ethnic group, age, etc. Tokens represent their categories, whether they choose to or not, for example woman engineer, male nurse, black physician or female veteran (Kanter, 1977).

There are two typical ways "token minorities" respond to performance pressures. The first is overachievement and involves extra effort and promotion of themselves and their work at every opportunity. The second response is more common and involves underachievement. This can mean limiting visibility, including social visibility. Many underachievers deliberately keep a low profile to avoid conflict, risks, and controversial situations. Such situations are often the source of mental stress and can reinforce low self-esteem (Kanter, 1977; Spangler, Gordon, & Pipkin, 1978).

One response to the mental stress and low self-esteem that accompanies underachievement can be the inability to
function in the community, thereby necessitating a structured living environment. Female veterans have available from the Department of Veterans Affairs (hereafter to be known as the VA) the Domiciliary Program, which is a rehabilitation program in an institutional setting.

For this study, institutions are defined as "residential facilities providing one or more central services that meet some particular need of the client and/or society" (Lieberman, 1969, p. 330). It is a common belief that most institutions have negative effects on their residents caused by the "dehumanizing" and "depersonalizing" characteristics of institutional environments. Some characteristics that residents of institutions often share include: depression and unhappiness, intellectual ineffectiveness (not necessarily intellectual incompetence), feelings of personal insignificance and impotency, and negative self-image.

Aitken (1982) compared levels of self-esteem in residents of acute care, nursing home care, and rehabilitation centers. Results indicated that residents in the rehabilitation centers had the lowest scores in self-esteem. She concluded that higher scores of self-esteem are associated with a strong sense of self-worth as well as being adjusted, happy, and competent.
Goffman (1961) explicitly interprets living in an institution as a series of "self-mortifications", which suggests that the more total the institution, the greater its depersonalizing effect on residents. Additionally, he describes the stigma that is often associated with institutionalization as an attribute that is deeply discrediting. He applies this term, stigma, to "tainted, discounted persons often found in residential communities" (Goffman, 1963).

While living in institutional settings, people frequently behave in ways that prevent further deterioration of self-esteem (Tittle, 1972). One adaptive response to this threat is being a "good patient" and "not making waves." In institutional settings, this adaptive and protective behavior can be accompanied by failure to stand up for one's own rights and the possibility of permitting one's rights to be violated by others. Jakubowski-Spector (1973) described these responses as passive or non-assertive behaviors. While these behaviors are accepted and even encouraged in institutional settings, aggressive behaviors are not condoned and are usually accompanied by negative sanctions or dismissal from the setting.

For the most part researchers, theorists, and clinicians agree that assertiveness is desirable and healthy behavior, yet its societal value is many times related to
gender. "Strong, assertive, powerful women are accepted less readily by both men and other women" (Osborne & Harris, 1975).

Mental health professionals have concepts of mental health similar to society in general. Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970) described the impact of this orientation:

Clinicians were more likely to suggest that healthy women differ from healthy men by being more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises...more emotional, more conceited...(and) less objective (pg. 5).

What it means to be female inevitably suggests some type of submissive or passive role (Osborne, 1978). Since assertiveness often is not valued for women, they tend to be less assertive than men, resulting in their needs not being met. This frequently leads to feelings of lowered self-esteem. Assertiveness training may be an effective method to elevate self-esteem.

Assertiveness training that focuses on self-esteem is a health education intervention. Health education activities can potentially: 1) promote health-related learning; 2) produce changes in understanding or ways of thinking; 3) generate changes in behavior and life style; or 4) bring about changes in belief or attitude and facilitate the acquisition of skills (Tones, 1986).
Educational efforts that are directed at altering beliefs about personal control of health are also directed at altering perceptions about individual control over life events (Strickland, 1978). Rotter (1954) defined the locus of control concept as the extent to which individuals have a choice in how they behave. People who believe they have some control over their destinies are called "internals." "Externals", on the other hand, believe their outcomes are determined by factors outside themselves, i.e., fate, luck, chance, powerful others, or the unpredictable (MacDonald, 1973).

Further studies led to the development of the Health Locus of Control Scale (HLC) that assesses locus of control as it directly relates to health behaviors (Wallston, Wallston, Kaplan, & Maides, 1976) and to the development of the Multidimensional Health Locus of Control Scale (MHLC) (Levenson, 1974; Wallston, Wallston, & DeVellis, 1978). The plausibility of altering health locus of control for female veterans by an assertiveness training program has not been reported in the literature.

STATEMENT OF THE PROBLEM
Female veterans remain a "token minority" of the veteran population. Those who have found it necessary to reside in a domiciliary are an even more isolated group. There is no
published research that gives evidence to the value of assertiveness training as a health education intervention for domiciled female veterans. Therefore, the problem to be investigated in this study is to determine what effect an assertiveness training program will have on self-esteem, assertiveness, and health locus of control for a sample of female veterans residing at the domiciliary, Veterans Affairs Medical Center, Dayton, Ohio.

OBJECTIVES OF THE STUDY

The objectives for this study are:

1. To determine the effects of a group assertiveness training program on self-esteem, assertiveness, and health locus of control for a sample of female veterans residing in the domiciliary at the Dayton, Ohio Veterans Affairs Medical Center during August and September, 1987.

2. To analyze differences in mean aggregate scores for the dependent variables before and after an assertiveness training program is presented.

3. To examine relationships between the dependent variables and relevant demographic characteristics.

4. To determine the effects of a group assertiveness training program one month after program completion.
RESEARCH HYPOTHESES

1. There will be a difference in levels of self-esteem for female veterans who complete an assertiveness training program as measured by scores on the Rosenberg Self-Esteem Scale (Rosenberg, 1965).

2. There will be a difference in levels of assertiveness for female veterans who complete an assertiveness training program as measured by scores on the Adult Self-Expression Scale (ASES) (Gay, Hollandsworth, and Galassi, 1975).

3. There will be a difference in internality for female veterans who complete an assertiveness training program as measured by scores on the IHLC subscale of the MHLC.

4. There will be a difference in externality perceived to be due to luck, fate, or chance for female veterans who complete an assertiveness training program as measured by scores on the CHLC subscale of the MHLC.

5. There will be a difference in externality perceived to be due to the influence of powerful others for female veterans who complete an assertiveness training program as measured by scores on the PHLC subscale of the MHLC.
NULL HYPOTHESES

1. There will be no difference in levels of self-esteem for female veterans who complete an assertiveness training program as measured by scores on the Rosenberg Self-Esteem Scale.

2. There will be no difference in levels of assertiveness for female veterans who complete an assertiveness training program as measured by scores on the ASES.

3. There will be no difference in internality for female veterans who complete an assertiveness training program as measured by scores on the IHLC subscale of the MHLC.

4. There will be no difference in externality perceived to be due to luck, fate, or chance for female veterans who complete an assertiveness training program as measured by scores on the CHLC subscale of the MHLC.

5. There will be no difference in externality perceived to be due to the influence of powerful others for female veterans who complete an assertiveness training program as measured by scores on the PHLC subscale of the MHLC.
PROCEDURES

A modified one-group pretest-posttest design was used for this study (Campbell & Stanley, 1966). A meeting was held and female veterans were invited to participate in the study with assurances that participation refusal would not affect their care at the Medical Center. Female veterans (N=20) residing at the Dayton, Ohio Veterans Affairs Medical Center domiciliary between July and September, 1987 volunteered for this study.

Subjects signed consent forms and completed a demographic questionnaire, the Rosenberg Self-Esteem Scale, the ASES, and the MHLC Scale. Participation in a five day assertiveness training program was followed by repeated measures of the Rosenberg Self-Esteem Scale, the ASES, and the MHLC Scale immediately following the last session. A follow-up measurement was obtained four weeks after the last group session.

DEFINITIONS

Assertiveness

For this study, assertiveness is defined as the expression of wants, needs, and opinions clearly without violating the rights of others (Alberti & Emmons, 1983; Jakubowski-Spector, 1973; Zucher, 1983). Assertiveness is operationally defined for this study as the score an individual
receives on the Adult Self-Expression Scale (ASES).

**Assertiveness Training**
For this study, assertiveness training is defined as a semi-structured training approach which is characterized by its emphasis on acquiring assertive skills through practice and refers to the program outlined in Appendix J. Assertiveness training incorporates four basic procedures:
1. differentiating assertiveness from aggressive and nonassertive or passive behaviors;
2. identifying and accepting personal rights as well as the rights of others;
3. reducing cognitive and affective obstacles; and
4. developing assertive skills (Lange & Jaku-bowski, 1976).

**Domiciliary**
For this study, domiciliary is defined as a structured living environment for veterans who are not capable of complete independent living, but do not require the skilled care provided in acute care hospitals or nursing homes. The domiciliary is an institutional setting with the following mission: (1) maintaining the veteran's current health status, or (2) rehabilitation with
the goal of returning the veteran to community living (H. A. Siegal, personal communication, March 3, 1990).

Female Veteran
For this study, female veteran is defined as any female who has served in any branch of the military service of this country for the necessary period of time that entitles her to the use of VA services.

Health Locus of Control
For this study, health locus of control is defined as the degree to which individuals perceive health as a consequence of their own actions or unrelated to their own behavior (Wallston et al., 1976). For this study, health locus of control is defined in three dimensions and is based on the work of Wallston, et al. (1978). The three dimensions of the MHLC are as follows:

1. Internal health locus of control (IHLC) is defined as the extent to which personal behavior is perceived to directly affect health.

2. Chance health locus of control (CHLC) is defined as the extent to which health is perceived to be due to luck, fate, or chance.
3. Powerful others health locus of control (PHLC) is defined as the extent to which health is perceived to be due to the influence of powerful others. Health locus of control is operationally defined for this study as the scores an individual receives on the IHLC, CHLC, and PHLC subscales of the MHLC.

Self-Esteem For this study, self-esteem is defined as a positive or negative attitude toward a particular object, namely, the self (Rosenberg, 1965). Self-esteem is operationally defined for this study as the score an individual receives on the Rosenberg Self-Esteem Scale.

ASSUMPTIONS
1. Subjects will accurately report perceptions on measuring instruments used in this study.
2. Subjects will respond honestly on the measuring instruments.
3. Subjects will be motivated to learn assertiveness skills.
LIMITATIONS

1. Other variables (eg. socioeconomic status, anxiety, health-related behaviors) that may be related to self-esteem, assertiveness, or health locus of control were not controlled for or examined in this study.

2. For this study, gender was held constant: only female veterans residing at the domiciliary, VA Medical Center, Dayton, Ohio will be in this study.

3. Female veterans participating in this study were volunteers.

SUMMARY

Female veterans are one segment of the population that frequently experience low self-esteem. As a highly visible "token minority", some female veterans have adopted the survival strategy of underachievement leading to negative consequences which can necessitate a structured living environment. One negative effect for the female veteran resulting from institutional living is a further decrease in self-esteem.

While assertiveness is considered to be desirable and healthy behavior, its value frequently depends on gender in our society. Since assertiveness is often not valued for females, women tend to be less assertive than men. Many times this leads to feelings of lowered self-esteem. A
health education program for assertiveness training may be one method of increasing assertive behaviors and self-esteem.

Locus of control may be a key factor when viewing self-esteem as an individual intrapsychic phenomenon (Crouch & Straub, 1983). The concept of locus of control implies that individuals have a choice in how they behave with "internals", believing they have control over their own destinies, and "externals", believing their outcomes are determined by factors outside themselves. Underlying characteristics of "internals" are assertiveness and positive self-esteem with the underlying characteristics of "externals" being non-assertive and having low self-esteem (Appelbaum, Tuma, & Johnson, 1975; Joe, 1971; Replogle, O'Bannon, McCullough, & Cashion, 1980).

Health locus of control assesses locus of control as it directly relates to health behaviors. Locus of control may be alterable by internality training, therefore health educators need to involve themselves in programs promoting internal beliefs (Hallal, 1982). Internality programs focus on promoting and teaching "internal" behavior (Hobson & Scally, 1981; Tones, 1982; Tones, 1986). A group assertiveness training program is an example of an internality health education program.
This program has been designed for VA domiciled female veterans. Research is needed to determine the effectiveness of a group assertiveness training program on self-esteem, assertiveness, and health locus of control.
CHAPTER II
REVIEW OF THE LITERATURE

This chapter will include a discussion of the theoretical framework for this research study. Following the theoretical framework discussion, a review of the literature will address the major variables related to adult females and female patients in three sections which include: (1) self-esteem, (2) assertiveness and assertiveness training, and (3) multidimensional health locus of control (MHLC).

A review of the research on self-esteem and adult females and female patients will include an overview of self-esteem as well as descriptive and quasi-experimental studies reported in the literature. Assertiveness and assertiveness training will include discussions of definitions, related terms, and the various models of assertiveness training. Assertiveness or assertiveness training research conducted on adult females and female patients will be reported. Discussion of the MHLC scale and related terms will be presented. Research studies on MHLC and adult females and female patients will be reviewed.
THEORETICAL FRAMEWORK

The idea that one's environment affects one's behavior has been long-standing in psychology. Kurt Lewin (1934) proposed that behavior is a function of the interaction of the person and the environment. Coopersmith (1967) wrote that people who view themselves negatively will be less active and assertive in their responses to environmental demands than people who view themselves in a positive manner.

The perspective of Rudolph Moos (1987) is based on the general principle that the way one perceives the environment tends to influence the way one will behave in that environment. He focused on the social climate (the personality of the environment) by suggesting that environments, like people, have unique personalities.

One challenge when looking at self-esteem is that behavior cannot be adequately understood except in relation to the person-environment interaction (Schwartz, 1975). Based on the increasingly recognized importance of the person and environment relationship, Person-Environment fit theory (hereafter known as P-E fit theory) will be the theoretical framework for this study.

P-E fit theory deals with the manner in which characteristics of the person and the environment affect well-being (Caplan, 1983). Harrison (1978) depicted a P-E fit model that presents the interaction of person and
environment factors in relation to health strains and illness. (See Figure I)

Figure 1: Person-Environment Fit

In the model, the basic concepts of P-E fit theory (objective environment, subjective environment, objective person, subjective person) are located within squares. The circles contain concepts which are discrepancies between the two adjoining concepts. Relationships between the theoretical concepts are represented thusly: (1) the solid lines indicate causal effects, and (2) broken lines indicate contributions to interaction effects.
The objective environment refers to the environment as it exists independently of the person's perception of it. This environment includes objects which do not come into contact with the individual as well as those which do: the physical environment, the family environment, and other aspects of the physical and social worlds which exist independently of the person's perception of them. The objective environment is causally related to the person's subjective environment. The subjective environment represents the person's perception of the objective environment, i.e. it is the person's psychological construction of the world.

The objective person refers to the person as one really is and includes one's needs, values, abilities, and other attributes which are more or less enduring. The subjective person represents the individual's perception of the objective self, i.e. the self-concept or self-identity of the person. Thus the subjective person includes the individual's perceptions of needs, values, abilities, and other attributes.

Subjective P-E fit refers to the fit between the subjective person and the subjective environment, i.e. the individual's perceptions of P-E fit. Subjective P-E fit is critical in the model as it links the subjective environment, the subjective person, and strain, which can lead to illness (Harrison, 1978).
The importance of the relationship between the individual and the environment is studied in terms of their fit or "congruence" with each other (Harrison, 1978). A misfit or incongruence in P-E fit can result in health strains. Health strain refers to the deviation from normal responses in the person. These deviated responses include behavioral responses, such as heavy smoking, physiological responses, such as high blood pressure, and psychological responses, such as low self-esteem (Caplan, Cobb, French, Harrison, & Pinneau, 1975).

As the experience of poor P-E fit results in strain leading to illness, the individual may seek to improve the fit between one's self and the environment through coping or defenses. Coping refers to activities directed toward changing the objective environment (ie. environmental mastery) or objective person (ie. adaptation) in ways to improve the fit between the two (French, Rogers, & Cobbs, 1974).

Defenses are unconscious mental processes which distort the person's perception of the subjective P-E fit. Although defenses do not improve the objective fit between the individual and the environment, distorted perceptions of the individual result in improved subjective P-E fit (Harrison, 1978). While this improvement in subjective P-E fit lowers the level of strain which is experienced,
defenses decrease the individual's contact with reality and accuracy of self-assessment (Binder, Mayman, & Doehrman, 1974).

P-E fit theory predicts only that some form of strain occurs with P-E misfit and that the magnitude of the strain will be proportional to the degree of misfit. This framework supports the development of health education programs that are designed to address individual needs in unique environmental settings.

Female veterans residing in a VA domiciliary represent one population of unique individuals in a unique environment for whom the P-E fit theoretical framework has applicability. Female veterans, a token minority, can experience health strains resulting from a P-E misfit. In addition to physiological and behavioral responses to health strains, female veterans can experience low self-esteem as a psychological response to P-E misfit.

**SELF-ESTEEM**

In 1890, William James wrote that a person's self is the sum total of everything an individual can call one's own. Meisenhelder (1985) describes self-esteem as a positive regard for one's self, a universal need for every human being, and a key component in restoring and maintaining mental and physical health. While self-esteem is often
defined as a global concept, there are some who believe self-esteem is multidimensional and should be studied as such. Hamachek (1987) defines self-esteem as the affective component of the self-system and self-concept as the cognitive component.

Crouch and Straub (1983) divide self-esteem into two sections. Basic self-esteem refers to the self-esteem base developed during early life experiences. Functional self-esteem is that which is derived from an ongoing evaluation of interactions with other people and things. They maintain that this functional level of self-esteem, unlike basic self-esteem, can change noticeably.

Although basic and functional self-esteem are popular distinctions with non-specialists in this area, evaluation of the process of determining self-esteem suggests that these two components are not so easily separable. Stanwyck (1983) maintains that self-esteem is really a matter of "how I feel about how I see myself."

Self-esteem is developed through a lifelong learning process which is incorporated in the development of the self. This process revolves around the interaction of the social environment and the individual. Self-esteem is influenced by individual and societal factors in one's environment (Cooley, 1922; Peplau, 1952; Rogers, 1961; Sullivan, 1953).
A variety of terms are used interchangeably with self-esteem. Some of these include: self-concept, self-worth, self-acceptance, self-regard, and self-image. Self-esteem will be the term used in this study.

In addition to the lack of consensus on terminology, there is also a lack of consensus on a definition of self-esteem. For this study, Rosenberg's (1965) definition of self-esteem will be used. He simply defined self-esteem as "a positive or negative attitude toward a particular object, namely, the self" (p. 30).

Rosenberg elaborated on his definition of self-esteem by stating that high self-esteem means that individuals respect themselves and consider themselves worthy. Additionally, the individual does not believe the self is perfect but recognizes personal limitations and expects to grow and improve. Low self-esteem implies self-rejection and dissatisfaction. The individual lacks respect for the observed self, is unhappy with this self-picture, and wishes it were otherwise.

Some influencing factors on self-esteem that have been identified are: age (Larson, Boyle, & Boaz, 1984; Swartz, 1975), institutionalization (Larson, et al., 1984; Stanwyck, 1983; Tittle, 1972), relationships (Mead, 1934; Meisenhelder, 1985) and gender (Fodor, 1978; Jakubowski-Spector, 1973).
While there has been research on self-esteem using female subjects (e.g., Dougherty, 1985; Langemo, Volden, Oechsle, & Adamson, 1990) specific data analysis for gender was not done. The self-esteem research that has been done frequently focuses on the effect an intervention has had on self-esteem; the comparison of self-esteem between groups; or the relationships between self-esteem and health practices. There is a paucity of research on adult females and female patients and self-esteem.

Stake and Pearlman (1980) studied female volunteers to determine if assertiveness training was one solution to the problem of low self-esteem among women. Ninety-six women paid to attend an assertiveness training group at a community college and self-selected to attend one of twelve assertiveness training groups that consisted of six two and one-half hour sessions.

The Performance Self-Esteem Scale (PSES) (Stake, 1979) was given during the first group session. The PSES requires self-ratings of 40 traits related to performance and ability that reflect self-evaluation of one's self-esteem. Subjects again completed the PSES at the last assertiveness training session. After nine months, subjects completed a third PSES survey.

Changes in PSES following assertiveness training were tested in a series of two-way ANOVAs. The overall mean
PSES score increased at the end of the training and continued to increase on the follow-up test. Results suggested that increased ratings of performance and ability continued nine months after attending the assertiveness training program.

A strong positive correlation was found between PSES scores at follow-up and subjects' ratings of their use of assertiveness skills gained in the groups. According to the researchers, this correlation suggested that the practice of assertive behaviors leads to increased PSES scores. This increase in PSES scores may in turn lead to additional increases in assertive behavior.

Breast self-exam (BSE) practices in relationship to health beliefs, health locus of control and self-esteem were studied for 207 female volunteers recruited from social, recreational, service, and religious groups (Hlla, 1982). Four self-administered questionnaires were used to collect data, including the Health Beliefs Instrument (Stillman, 1977), MHLC (Wallston, et al., 1978), Tennessee Self Concept Scale-TSCS (Fitts, 1965), and a background information form modified from an instrument developed by Stillman (1977).

The research hypothesis that self-esteem scores would be higher for adult women who practiced BSE was supported in this study. Practicing BSE was significantly correlated
with higher scores on all nine subscales of the TSCS. The researchers concluded that the "Total P", which was a measure of overall self-esteem, was the strongest predictor of BSE.

Weitz (1982) examined the effects of feminist consciousness-raising (CR) groups on self-esteem and depression for 73 female volunteers recruited from Connecticut women's organizations. Data were obtained from the following: (1) participant observations of ten to sixteen week CR groups, (2) semi-structured interviews before and after group participation, and (3) pretest and posttest self-report scales. The scales used were the Eagley revision of the Janis-Field Self-Esteem Scale (Eagley, 1967) and the Center for Epidemiologic Study-Depression (CES-D) Scale (Radloff, 1977).

The author concluded that self-esteem is one major aspect of depression and that the mean of self-esteem increased significantly after CR group participation. Additionally, the number of CR group meetings attended correlated positively with the increase in self-esteem. Ongoing group members continued to show a higher increase in self-esteem over time than did dropouts.

Data taken from a 1976 national survey conducted by the Survey Research Center (Institute for Social Research) at the University of Michigan were analyzed to see if there
was a clear causal relationship between physical health and self-esteem (Antonucci & Jackson, 1983). The national sample of 2,264 adults (57% female) was selected by probability sampling procedures. The survey included measures of health, self-esteem, and demographics of respondents.

Three health predictors were used as independent variables and were determined by responses to questions identifying physical problems. A variable called ill health was derived from factor analysis of a 20-item questionnaire. Responses were grouped into four categories: no health problems, minor health problems, major health problems, and physical disability. Psychological problems were excluded.

The Rosenberg Self-Esteem Scale was used. Sociodemographic measures included sex, employment status, marital status, income, age, education, and race. Because of previous consistent findings of gender differences, models were examined first for the combined sample and then for gender.

Women with health problems were more likely to report lower self-esteem than women with no health problems. A largely linear effect of decreasing self-esteem for women was identified with increasing severity of health problems and remained so for severe health problems.

The introduction of sociodemographic controls for women did not significantly change the results. The
authors concluded that the largely linear inverse relationship between severity of health problem and self-esteem in this study were generally not dependent on the sociodemographic variables.

Muhlenkamp & Sayles (1986) investigated the relationship of self-esteem, social support, and health practices. A convenience sample of 98 volunteers (43 women) from an apartment complex completed a four-questionnaire packet.

The instruments used were: (1) Self-Esteem Inventory (SEI) (Coopersmith, 1967), (2) Personal Resources Questionnaire (PRQ) (Brandt and Weinert, 1981) to measure social support, (3) Personal Lifestyle Questionnaire (Brown, Muhlenkamp, Fox, & Osborne, 1983) to measure positive health practices in six areas (nutrition, exercise, relaxation, safety, substance abuse, health promotion), and (4) a demographic questionnaire. Respondents with high self-esteem perceived their social support to be adequate and they maintained more positive health practices than those with lower self-esteem and social support.

The influences of employment and husband's appraisal on self-esteem in married women were examined by Meisenhelder (1986). The sample of 192 women living with their spouses and children was selected from a yearly city listing. The subjects were divided into six groups of thirty-two women.
One hundred sixty-three (85%) women completed the Rosenberg Self-Esteem Scale and a modified Barrett-Lennard Relationship Inventory (RI) (Barrett-Lennard, 1962). The strongest predictor of self-esteem in women (total sample) was the perceived reflected appraisals of the husband.

Homemakers were three times more dependent on the attitudes of their husbands for their self-worth while employed women showed less dependency on the approval of their spouses. The researcher concluded that the most plausible explanation for the difference between employed women and homemakers, as predictors of self-esteem, was the difference in social environments. If the woman was employed, her co-workers provided feedback to her self-esteem. If she was a full time homemaker, her contacts through community or family activities reinforced her self-value.

Explaining health promoting lifestyle activities for a sample of women in midlife was undertaken by the investigation of relationships among perceived health locus of control, self-esteem, and perceived health status (Duffy, 1988). The sample for the study included 262 (44%) women from a mailing list of 600 university women employees.

In addition to a demographic form, four instruments were mailed to volunteers. The package included: (1) MHLC, (2) the Rosenberg Self Esteem Scale, and (3) The
Health Perceptions Questionnaire (Ware, 1976) which measures six perceptual dimensions of health. The fourth instrument was the Health Promoting Lifestyle Profile (Walker, Sechrist, & Pender, 1987) which was modified from the Lifestyle and Health Habits Assessment (Pender, 1982). Subjects who scored high on self-esteem and IHLC and low on CHLC, and who reported their current health status as high (good), were those who had high scores on the self-actualization, nutrition, exercise, and interpersonal support subscales.

There were two studies that looked at specific illness populations. In the first study, thirty-six female chronic hospitalized psychiatric patients were selected to participate in a study comparing two appearance programs at the Austin State Hospital (Callis, 1982). The purpose of the study was to validate the therapeutic value of the program and to compare effectiveness of six and nine-week treatment programs. Each program consisted of 75 minute sessions twice each week.

The subjects were assigned to one of two programs. They lived as intact groups and were not involved in other programs while participating in the study. Of the original 36 subjects, nine completed the six-week program while seven completed the nine-week program.
Instruments used in this study were the TSCS and the Body Cathexis Measure (Secord and Jourard, 1953) to measure body satisfaction. Two subjective instruments were used to evaluate the appearance of subjects. Color photographs of each subject before and after treatment were rated and evaluated by three judges. Additionally, a subjective questionnaire developed by Goebel (1971) was the second measure of appearance. This was done by three mental health workers before and after the treatment program.

One week before treatment, TSCS and Body Cathexis measures were obtained. During the final session photographs were taken again. One week after completing the programs, the measure of appearance questionnaire was completed. Two weeks after the program the TSCS and Body Cathexis measures were repeated.

Results of analysis indicated that there was no significant difference in group scores for self-esteem. Analysis of individual cases indicated that 10 of the 16 women showed positive improvements in self-esteem. Three of the six patients who showed no improvement had very noticeable physical problems, so an improvement in appearance might have been unobtainable.

The second study that included an illness population investigated the differences in perceived health status, self-esteem, and body image among women with rheumatoid
arthritis (RA), systemic lupus erythematosi (SLE), and a group of healthy women (HLT) (Cornwell & Schmitt, 1990). A convenience sample of 26 RA women and 23 SLE women were obtained from physicians specializing in these disorders. The group of HLT women volunteers were obtained through a randomized computer selection of female university alumnae.

Outcome measures were obtained using the: (1) Sickness Impact Profile (SIP) (Bergner, Bobbitt, Carter, & Gibson, 1981), (2) Self Rating of Health Scale developed by the investigator, (3) Form B of Coopersmith's Self-Esteem Inventory (SEI), (4) Body Cathexis Scale, and (5) a general questionnaire addressing demographic characteristics and disease-related issues. RA and SLE subjects rated themselves as having lower self-esteem than HLT, but the differences were not significant. The researchers suggested that this may be due to a greater variability in self-esteem scores among ill subjects.

Research on self-esteem and adult females and female patients was reviewed. Results from descriptive studies identified that there were personal, employment, and health-related factors which influenced self-esteem. Some studies suggested that self-esteem can be changed as a result of interventions. Other studies examined the relationship between self-esteem and physical health as well as its relationship with other variables to specified health
practices. Two studies suggested that changes in self-esteem as a result of interventions may be evident only through analysis of individual rather than aggregate data. No studies on domiciled female veterans and self-esteem were found in the literature.

ASSERTIVENESS AND ASSERTIVENESS TRAINING

Many definitions of assertiveness are reported in the literature along with the interchangeable use of assertion, assertiveness, and assertive behavior. The term assertion was first used in 1958 by Wolpe while developing an intervention for individuals with passive or limited lifestyles. Assertive behavior was defined as "all socially acceptable expressions of rights and feelings" (Wolpe & Lazarus, 1966, p.39). Clark (1978) defined assertive behavior as "setting goals, acting on these goals in a clear and consistent manner, and taking responsibility for the consequences of these actions" (p. 11).

Alberti and Emmons (1983) defined assertiveness as "behavior which enables a person to act in his own best interest, stand up for himself without undue anxiety, to express his rights without destroying the rights of others" (p.3). Additionally, Lange and Jakubowski (1976) proposed that assertiveness is a direct and honest expression of personal feelings, opinions, and beliefs in proportion to the situation at hand.
Aggression and non-assertiveness or passiveness are both defined in the literature. The purpose of aggressive behavior is to humiliate, dominate, or put the other person down rather than to simply express one's honest emotions or thoughts. It is an attack on the person rather than on the person's behavior (Jakubowski-Spector, 1973). This aggressive behavior is used to manipulate, dominate, humiliate and infringe on the rights of others (Alberti & Emmons, 1983).

Non-assertive or passive behavior is that type of interpersonal behavior that results in a person's rights being violated by another (Jakubowski-Spector, 1973). Non-assertive or passive behavior invites others to infringe upon and take advantage of the non-assertive individual. The non-assertive person typically denies self and is inhibited from expressing actual feelings. Continued non-assertion and frequently accompanying acts of chronic self-apology decrease the sense of self-esteem and can lead to feelings of worthlessness and depression (Jakubowski & Lange, 1979).

Assertiveness training materialized and reached its peak during the 1970s in concert with the development of the National Organization for Women (NOW). This organization focused on assertive rights along with the common goal of equal rights for women. Yet, assertiveness training
continues to develop and evolve with no all-inclusive accepted procedures or definitions. Because of this non-specificity, most individuals integrate varying viewpoints and individualize assertiveness approaches.

Assertiveness training was defined by Alberti and Emmons (1983) as "a systematic approach to more effective self-expression, based on a balance between achieving one's own goals and respecting the needs of theirs." Lange and Jakubowski (1976) characterized assertiveness training by four distinct features: (1) teaching of the differences between aggressive, non-assertive (passive) and assertive behaviors; (2) helping with identification of individual rights; (3) assistance in reducing cognitive and affective obstacles to assertive behavior; and (4) active practice methods to develop specific assertive skills.

Much of the early research on assertiveness and assertiveness training included college students as subjects. A review of the literature showed that there were no research studies on assertiveness and assertiveness training and female veterans. In fact, there is a paucity of research on assertiveness and assertiveness training and adult females and female patients. While there have been studies on assertiveness (eg. Clark, Corbisiero, Procidano, & Grossman, 1984; Zappe, & Epstein, 1987), the data analyses were not specific for gender even though females were included in the studies.
Hollandsworth and Wall (1977) reported a descriptive study in which they attempted to identify gender differences in assertive behavior. A total of 702 subjects (294 men and 408 women) were drawn from community college and state files and were divided into four groups. The ASES was administered to all subjects to compare differences between males and females in terms of how they report themselves as behaving in a variety of assertiveness-evoking situations.

Gender differences were compared by computing t-tests for each of the 48 items on the ASES. If the t-test for an item was significant at the .05 level for two or more samples, a consistent sex difference was said to exist for that item. Twelve items out of the 48 met that criteria. Of these twelve items, males were significantly more assertive on nine items while females were significantly more assertive on three items. Men were more assertive with their bosses or supervisors while women were more assertive in expressing anger to parents, love to significant others and complementing and praising others.

The results suggested that women may be somewhat less assertive than men and that men and women are significantly different from each other in terms of specific assertive behaviors in some areas. The researchers questioned the widespread use of same-sex assertiveness training groups, even though women and men have uniquely different assertive
problems. They maintained that it limits the opportunity for role-playing and modeling.

Wolfe and Fodor (1977) compared three approaches to reducing anxiety which can accompany assertive behavior. Behavioral (BT), behavioral/cognitive restructuring (RBT), and consciousness raising (CR) were the three approaches studied.

The subjects included 64 women who were recruited through notices at an outpatient psychotherapy clinic calling for women who had problems in asserting themselves. Subjects were selected if they had a rating of four or less on a Global Self-Rating of Assertiveness which was based on the Rathus Assertiveness Schedule (Rathus, 1973).

Following preassessment, the 64 subjects were assigned to matched treatment or control groups. The groups were randomly assigned to one of three treatment conditions and to one of the two therapists or to the waiting list control group. Two treatment groups for BT, RBT, and CR each met for two, 2-hour sessions, one week apart. Sixteen waiting list (WL) subjects were told that the treatment would be delayed three weeks.

Behavioral and self-report data were obtained. For behavioral measures, audiotapes recorded responses to eleven situations presented on videotapes. Self-report measures obtained before and after treatment consisted of the

The behavioral measures pretest was individually administered approximately 10 days before treatment and again as a posttest one week after the treatment. Following each of their responses to the 11 behavioral situations, subjects rated the amount of anxiety on a 4-point scale similar to Walk's (1956) fear thermometer.

Tape recordings from pretest and post-treatment behavioral assessments revealed significant differences between treatment groups on the Assertive Content Scale (McFall & Lillesand, 1970). No change was indicated on the Rathus Assertiveness Scale. This study offered support for BT and RBT in the treatment of assertiveness difficulties for women, as BT and RBT improved significantly on the major measure—the ratings of responses to a lab behavioral test.

Models of assertiveness training were compared by Linehan, Goldfried, and Goldfried (1979). The purpose of the study was to compare a therapy designed by Goldfried, Decanteco, & Weinberg (1974) to modify cognitive appraisals by directly controlling for covert behavior rehearsal with a program designed to teach overt assertion skills. Both treatments were also compared to a treatment combining skill training with cognitive restructuring. Subjects
included 79 women volunteers with a score below "0" on the Rathus Assertiveness inventory and a score of 3 or above on the Assertion Difficulty Inventory, which was developed by the investigators.

The Rathus Assertiveness Inventory, the Assertion Difficulty Inventory, the S-R Inventory of Anxiousness (Endler, Hunt & Rosenstein, 1962), and the S-R Inventory of Hostility (Endler & Hunt, 1968) were administered at pretest, posttest, and at follow-up. A peer questionnaire was given to someone who knew the subject. An extended interaction behavioral role-playing test was administered at pretest and posttest. A contrived situational test was also done at posttest.

Subjects were assigned to one of three treatment groups (behavior rehearsal, systematic cognitive restructuring and behavior/rational restructuring), or a waiting list. A fourth group was a relationship control group which was designed to control for the effects of being in individual treatment for assertion problems and therapist approval and "permission" to behave assertively. Treatment was conducted in eight sessions over an eight week period. Follow-up sessions were conducted eight to ten weeks after termination.

Analyses of covariance were conducted on data. Results indicated that a combined intervention procedure,
employing both behavioral rehearsal and systematic rational restructuring, was most effective in increasing assertive behavior and reducing the emotional discomfort associated with such interactions. The researchers did report that this superiority was a function of the combined group relative to the control groups.

Pitcher and Meikle (1980) examined assertive responses in positive and negative assertion situations. The sample of 48 male and female subjects was randomly selected from the available pool of 65 volunteers, obtained from advertisements in the local newspaper. Participants were assigned to high, moderate, and low assertion levels based on their total scores on the Assertion Inventory (Gambrill & Richey, 1975) which was completed at the beginning of the experimental session.

Subjects completed the Assertion Inventory and the Conflict Resolution Inventory (CRI) (McFall & Lillesand, 1971) followed by role-play situations. Revised versions of the Assertion Self-Statement Test (Schwartz & Gottman, 1976) were included. Observational measures and observational procedures were completed.

Women obtained higher assertiveness scores than men. Women offered more expressions of appreciation while men used more aggression on the two verbal content measures that showed significant sex differences. Women
nonsignificantly offered more praise, spontaneous positive behavior, and requests for new behavior. Both men and women complied more with individuals of the same sex, but not at significant levels.

Stake and Pearlman (1980) investigated the use of assertiveness training as an intervention for low performance self-esteem women. Ninety-six of the 121 women volunteers completed one of twelve assertiveness training groups.

The assertiveness training program was divided into six sessions of two and one-half hours each. During the first and last group sessions, subjects completed the PSES and an 8-item questionnaire. Nine months to one year following the training, subjects were mailed a third copy of the PSES and a second questionnaire.

Changes in performance self-esteem following training were analyzed using ANOVA. The overall mean PSES score increased between the pretest and posttest and continued to increase at the follow-up measurement.

The increase in PSES scores was linked to the practice of assertive skills learned in the group. A strong positive correlation was found between PSES scores at follow-up and subjects ratings of their use of assertive skills gained in the groups. This correlation suggested that the practice of assertive behaviors leads to increases in PSES
scores. Regression analysis revealed greater PSES improvement among low PSES women which further suggested that women with lower PSES may be particularly attracted to assertiveness training.

Responses to cognitive self-control therapy and to behavioral assertion training as a function of depressed clients' relative strengths in the corresponding skill areas were reported in a study by Rude (1986). For the thirty-two volunteers recruited from newspaper advertisements, a within-subjects crossover design was used. Four subjects were assigned to each of eight treatment groups while sixteen subjects were assigned to a waiting list control group.

All subjects completed the MMPI (Hathaway & McKinley, 1967), Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1962), the Rathus Assertiveness Schedule, Self-Control Schedule (Rosenbaum, 1980), the Self-Control Questionnaire (Rehm, Fuchs, Roth, Karnblith, & Romano, 1979), and the Cognitive Self-Management Test developed by the researcher.

Treatment subjects met twice weekly for six weeks. They were readministered the depression, self control, and assertiveness scales during the sixth and twelfth sessions. Approximately three months following the treatment, the depression scale was mailed to treatment subjects, but not to the control group.
The study supported effectiveness of combined assertion skill and cognitive treatment for depression. There was a tendency for assertive participants to have benefited more from the assertion treatment than from the cognitive self-control treatment. An opposite tendency was evident for less assertive participants. The researcher concluded that participation in a treatment that focuses on and builds on one's relative strengths may decrease depression by enhancing perceptions of personal efficacy. An alternative explanation may be that the assertiveness deficits of the low assertiveness subjects were so profound that these individuals were unable to benefit from the brief treatment.

The research on assertiveness and assertiveness training and adult females and female patients was reviewed. One study looked at assertiveness training as an intervention while other studies compared gender differences in assertiveness responses to various situations. Models of assertiveness training were reviewed with recommendations for maximum effectiveness. No studies on female veterans and assertiveness and assertiveness training were found in the literature.
MULTIDIMENSIONAL HEALTH LOCUS OF CONTROL

Within the framework of social learning theory, behavior is determined by: (1) the individual's expectancy that a specific behavior will lead to a reinforcement and (2) the value of that reinforcement. The concept of internal vs. external control of reinforcement had its origin in social learning theory (Rotter, 1954) and has been defined as follows:

When a reinforcement is perceived by the subject as following some action of his own but not being entirely contingent upon his action, then, in our culture, it is typically perceived as the result of luck, chance, fate, as under the control of powerful others, or as unpredictable because of the great complexity of the forces surrounding him. When the event is interpreted in this way by an individual, we have labeled this belief in (under) external control. If the person perceives that the event is contingent upon his own behavior or his own relatively permanent characteristics, we have termed this a belief in (under) internal control (Rotter, 1966, p.1).

Strickland (1978) defined locus of control as "the degree to which an individual perceives the events that happen to him/her as dependent on his/her own behavior or as a result of luck, chance, fate, or powers beyond one's personal control and understanding" (p. 1192). While theoretically locus of control is a concept that exists on a continuum, it remains a concept that deals with individual interpretations of the causality of behavioral outcomes or reinforcements (Arakelian, 1980).
Use of the locus of control concept in health-related situations is not without problems. One of the more obvious difficulties is that many health behaviors are inordinately complex. In most health-related situations, locus of control is a mediating variable (Arakelian, 1980). These difficulties led to the development of the health locus of control scale (Wallston, et al., 1976) as a unidimensional measure of peoples' beliefs that their health is or is not determined by their behavior.

Levenson (1974) challenged the conceptualization that locus of control was unidimensional and proposed that understanding and prediction could be improved by studying externality as fate and chance separately from externality as powerful others. Although her new scales did not include specific health-related issues, she demonstrated the advantage of measuring three distinct dimensions of locus of control. This work led to the development of the multidimensional health locus of control scale (Wallston, et al., 1978) to measure three dimensions of health beliefs: (1) internal health locus of control (IHLC), (2) chance health locus of control (CHLC), and (3) powerful others health locus of control (PHLC).

Internal health locus of control (IHLC) was defined as the extent to which personal behavior is perceived to directly affect health. External health locus of control
included two separate dimensions. Chance health locus of control (CHLC) was defined as the degree to which health is perceived to be due to luck, fate, or chance. Powerful others health locus of control (PHLC) was defined as the degree to which health is perceived to be due to powerful others, such as physicians, other health professionals, or family members (Wallston, et al., 1978).

There have been studies on MHLC and lifestyle changes described in the literature such as weight loss and smoking cessation programs, described in the literature. Research has been conducted on the MHLC scale itself. Health locus of control and its relationship to preventive health behavior was studied (Zindler-Wernet & Weiss, 1987), but the data were not analyzed for gender. Implications of health locus of control for the health professional were examined extensively by Kist-Kline and Lipneckey (1989). There is no research reported in the literature on MHLC and female veterans. Therefore, this literature review will focus on MHLC and adult females and female patients.

A descriptive-correlational study of 207 women volunteers was conducted to determine if there were differences in the health beliefs, health locus of control, and self-esteem for adult women who practiced breast self-examination (BSE) compared with women who did not practice BSE (Hallal, 1982). Four self-administered questionnaires
were used: (1) Health Beliefs Instrument, (2) MHLC, (3) TSCS, and (4) a background information form.

A correlation between internality and BSE was not supported in this study. Practicing BSE was negatively correlated with obtaining a higher score on the PHLC. The researchers suggested that the lack of significant correlation between internality and the practice of BSE could be that BSE is not viewed as an important behavior in promoting a specific outcome.

The relationship between weight loss, locus of control, and social support among 46 women volunteers was examined by Gierszenski (1983). This convenience sample was taken from employee participants in a company's nutrition and weight control program.

Instruments used in this study included the MHLC scale, a modified form of the Weight Locus of Control (WLOC) Scale (Saltzer, 1978), and a social support scale developed by the investigator. Measurements were taken after the program and in six months. Weight change was assessed by the Reduction Index (RI) developed by Feinstein (1959).

With both the MHLC and the WLOC, the means were opposite to what was expected, that is, IHLC subjects showed less weight loss/more weight gain than either PHLC or CHLC. These results might be accounted for by the use of a
modified scoring procedure in this test. Another suggestion regarding weight loss, in particular, is that it might be most desirable for dieters to be sufficiently internal to believe that they are capable of bringing their weight under control, yet sufficiently external that they are open to the assistance of health professionals.

Duffy (1988) investigated the impact on health promoting lifestyle activities with the relationships between perceived health locus of control, self esteem, and perceived health status. Two hundred sixty-two women were obtained from a mailing list of 600 and represented a 44% response rate.

In addition to the MHLC scale, the ten-item Rosenberg Self-Esteem Scale measured the self-acceptance component of self-esteem. The Health Perceptions Questionnaire measured perceptual dimensions about health-related factors. The 48 item Health-Promoting Lifestyle Profile also measured six health related dimensions. A demographic information sheet was developed by the investigators.

Correlation and multiple regression analyses were conducted. Subjects who scored high on IHLC, low on CHLC and reported their current health status as good were those who were more likely to participate in health promotion behaviors. The researcher noted that this supported earlier findings (Muhlenkamp & Sayles, 1986; Pender & Pender, 1980)
which suggested that individual perceptions of health locus of control, self esteem and health status influence health promotion behavior.

The relationships between health locus of control, health values, and self-care for faculty women was examined by Lakin (1988). The 104 volunteer subjects were mailed self administered instruments and data questionnaires.

The instruments were: (1) Exercise of Self-Care Agency (ESCA) Scale (Kearney & Fleischer, 1979) to measure self-care practices; (2) MHLC; (3) a health values scale modeled after Rokeach's (1973) value survey; and (4) a demographic and background information scale constructed by the investigator. The last instrument instructed subjects to rate their current health status, identify existence of current health problem and, if present, to describe the health problem.

A significant positive relationship was found between ESCA and internality and a significant negative correlation between ESCA and CHLC. ESCA and PHLC were not significantly related. Both of these results support the theoretical basis of the MHLC scale.

The roles of certain psychological constructs in determining both patient satisfaction and the level of pain with the use of patient-controlled analgesia (PCA) were studied (Johnson, Magnani, Chan, & Ferrante, 1989).
Seventy-six female subjects scheduled for elective abdominal gynecologic surgical procedures voluntarily participated in the study. The subjects were given a battery of psychological tests that included the Activities of Daily Living Scale (ADL) adapted from the West Haven-Yale Multidimensional Pain Inventory (Kerns, Turk, & Rudy, 1985), the MHLC, and the Hypochondriasis, Hysteria, and Depression scales of the MMPI.

Prior to surgery, patients were instructed in the use of the Abbott Life Care PCA infuser (Abbott Laboratories, North Chicago, IL). All patients except one received general anesthesia. Patients received IV opiates in recovery room until comfortable. PCA was begun immediately upon arrival at the ward.

On completion of PCA, patients were given a Patient Overall Evaluation (POE) to retrospectively assess the level of pain and the degree of satisfaction with postoperative pain relief while on PCA. For the purpose of analysis, patients were divided into chronic (n=42) and acute (n=33) pain subpopulations. A chronic pain patient was defined as having had continuous or intermittent pain for at least six months.

A Pearson product-moment correlation was performed to compare pain ratings and degree of patient satisfaction with the results of the psychological tests. Multiple
regression analysis was done to examine relationships among the dependent variable, usual pain score, and independent variables.

Correlation analysis revealed that the level of pain while using PCA was positively correlated with CHLC and the Hysteria scale of the MMPI, and inversely correlated with the IHLC. Patient satisfaction was found to be inversely correlated with the Hysteria Scale of the MMPI and CHLC and positively correlated with IHLC. Chronic pain patients showed the level of pain inversely correlated with IHLC and positively correlated with CHLC.

The higher level of pain and greater dissatisfaction seen in patients with higher CHLC suggested that these patients used PCA less effectively. Increased pain scores and less satisfaction with PCA were also observed in the chronic pain subpopulation with an external locus of control.

The results of this study indicated that patients who were considered "internals" were able to control their pain medications more effectively and had lower pain scores and increased satisfaction while using PCA. Chronic pain " internals" showed the same rates. The researchers suggested that an internal locus of control might be predictive of satisfactory analgesia and less discomfort with PCA usage.
Multidimensional health locus of control is a rapidly expanding area for research, although there is a paucity of research reported in the area with female adults and female patients in the literature. Newer studies are suggesting that the importance of MHLC studies are not only to label patients as internal or external but to see how this information can be used in planning health care (Shillinger, 1983).

SUMMARY
The literature discussed in this chapter included results of studies on self-esteem, assertiveness, and multidimensional health locus of control as they related to adult females and female patients. Research on self-esteem and adult females and female patients was reviewed in nine studies. One study evaluated self-esteem following an assertiveness training intervention showing an increase in self-esteem scores while another investigated the influence of variables on women's self-esteem. Another study reported the effects of consciousness-raising groups on self-esteem with an increase in self-esteem positive correlated with the number of sessions attended. Four of the studies examined the relationships of self-esteem and health beliefs and health practices with high self-esteem scores being positively correlated with health beliefs and health practices.
Two studies investigated illness population subjects. One study focused on chronic psychiatric patients and the effect an appearance program had on their self-esteem with no difference shown in self-esteem scores following the program. The other study examined differences in perceived health status and self-esteem between women with rheumatoid arthritis, women with systemic lupus erythematosis, and healthy women with no significant differences noted. The effects of interventions designed to change self-esteem remain inconclusive.

Differences between females and males in assertiveness and assertive responses were examined in two studies in the literature review on assertiveness and assertiveness training and adult females and female patients. Results from one of these studies, involving assertive responses, showed women obtaining higher assertiveness scores in contrast to most other literature regarding gender differences in assertiveness. Three approaches to decreasing anxiety that may accompany assertive behavior were investigated in another study. Another researcher compared three models of assertiveness training groups looking for the most effective model to increase assertiveness. Three models of assertiveness training groups were compared for effectiveness with women suffering from depression. Assertiveness training for women with low self-esteem resulted in an increase in self-esteem scores.
The final section of the literature review focused on MHLC and adult females and female patients. Results of the five studies examined were divided regarding importance and impact of internality. Three of the studies examined the correlation between MHLC and health beliefs and health practices. Two studies reported an increase in IHLC and a decrease in CHLC scores in relation to health practices while another showed no correlation between IHLC and BSE. A study examining the relationships between weight loss, social support, and locus of control had results that were completely opposite to what was expected. In this study, participants with high IHLC showed less weight loss and more weight gain than either high PHLC or CHLC subjects. A final study investigated the correlation between MHLC and pain control with PCA and patient satisfaction. The level of pain was positively correlated with CHLC and inversely correlated with IHLC while patient satisfaction was inversely correlated with CHLC and positively correlated with IHLC.

This research study is directed at evaluating effects of an assertiveness training program on self-esteem, assertiveness, and health locus of control for volunteer female veterans at the VA domiciliary in Dayton, Ohio. While there are several studies on female veterans (e.g. Block, 1982; Dvoredsky & Cooley, 1985; Gurney, 1987; Hammer, 1979;
McVicker, 1985), a review of the literature indicated that there was no research on the variables investigated in this study using a female veteran population as subjects. With the increasing number of females entering the military services, it is evident that this is a population that will continue to grow. This paucity of reported research with the increasing number of females in the military services supports the need for this study.
The purpose of this study was to determine what effect an assertiveness training program had on self-esteem, assertiveness and health locus of control for a sample of female veterans residing at the domiciliary, Veterans Affairs Medical Center, Dayton, Ohio. This chapter will describe the procedures that were used in this study to achieve this purpose. The procedures will be divided into the following sections: (1) study design, (2) subject selection, (3) outcome measures, (4) conditions of testing, (5) treatment, and (6) data analysis.

STUDY DESIGN

For this study, a modified one-group pretest-posttest design was used (Campbell & Stanley, 1966). (See Figure 2.)

0X00

0= dependent variables: self-esteem, assertiveness, and multidimensional health locus of control

X= treatment: group assertiveness training workshop

Figure 2: Modified One-Group Pretest-Posttest Design
The original one-group pretest-posttest design involves one group which is pretested (0), exposed to a treatment (X) and posttested (0). For this design, a follow-up posttest four weeks after treatment was utilized.

The pretest-posttest control group design, a true experimental design, was the original design of choice for this study. Because of a decrease in the available population it was necessary to change the study design. (See "Subject Selection.")

SUBJECT SELECTION

The population for this study was female veterans who resided at the Dayton, Ohio Veterans Affairs Medical Center domiciliary. There were 58 female veterans residing in the domiciliary at the time the study was planned.

The sampling process was conducted with the support of Linda Hedden, Ph.D., Chief, Domiciliary Service (Appendix A). A meeting of all the female veterans was scheduled by the Chief, Domiciliary Service. Because of discharges to the community and re-hospitalizations, there were 38 females residing in the domiciliary by the time of the meeting. The Chief of the Domiciliary Service introduced the investigator and then left the meeting so as to insure the privacy of the potential participants. The purpose of the study, in addition to an overview of the assertiveness
training workshop, was explained to the potential participants (Appendix B). This form reflected the modified plan for the study design.

Female veterans who indicated an interest in the workshop remained \( N=31 \), and an explanation of informed consent was then given. One consent form stated that study subjects understood the purpose of the study and had the right to refuse to participate in the study (Appendix C). The other consent form was for participation in social and behavioral research from The Ohio State University (Appendix D). Eleven additional veterans left the meeting.

Twenty female veterans who were interested in participating in the study signed the consent form. A demographic questionnaire developed by the investigator (Appendix E) as well as the Rosenberg Self-Esteem Scale (Appendix F), the Adult Self Expression Scale (ASES) (Appendix G), and the Multidimensional Health Locus of Control (MHLC) Scale (Appendix H) were completed during this meeting. Following completion of these self-report instruments, the subjects were randomly divided into two subgroups and were given appointment cards to attend one of two group sessions.
OUTCOME MEASURES

The instruments used to measure the dependent variables in this study were: (1) the Rosenberg Self-Esteem Scale, (2) Adult Self-Expression Scale (ASES), and the Multidimensional Health Locus of Control Scale (MHLC). Each instrument will be described in this section.

_**Rosenberg Self-Esteem Scale**_ Rosenberg (1965) developed the Self-Esteem Scale for a study of 5,024 high school students who were randomly selected from 10 public schools in New York City. Self-esteem scores were correlated with a variety of variables including family characteristics, interpersonal patterns, psychological states, occupational orientation, and participation and leadership in high school activities.

In terms of internal consistency, Rosenberg (1965) reported a reproducibility coefficient of .92 and a scalability coefficient of .72. Ward (1977) reported a coefficient alpha of .74 for 323 noninstitutionalized adults. Silber and Tippett (1965) reported a two week test-retest correlation of .85 for twenty-eight adults. Crandall (1974) reported an inter-scale correlation of .60 with Coopersmith's Self-Esteem Inventory. Factor analysis conducted by Kaplan and Pokary (1969) reported correlations ranging from .37 to .77 which supported the unidimensionality of the scale.
Evidence of convergent validity is provided by Silber and Tippett (1965), who reported correlations ranging from .56 to .83 between the Self-Esteem Scale and other measures of self-esteem. Rosenberg reported considerable evidence of predictive validity using a criterion group design.

The Rosenberg Self-Esteem Scale consists of ten items with responses reported along a four-point continuum ranging from "strongly agree" to "strongly disagree." Although originally designed as a Guttman Scale, it has been used frequently as a Likert Scale (Miller, 1973; Goldsmith, 1986). A low to high numerical ranking is used for the scoring of positive items, and the opposite for negative items. A resulting low score indicates a higher level of self-esteem while a high score indicates a low level of self-esteem. This scale was intended to be brief (for ease of administration), global, and unidimensional, although some studies suggest it is a multidimensional scale (Hensley & Roberts, 1976; Dobson, Goudy, Keith, & Powers, 1979).

Available evidence suggests that the self-esteem scale is appropriate for use with older respondents (George & Bearon, 1980; Nelson, 1989).

Adult Self-Expression Scale (ASES) The ASES (Gay, et al., 1975) was developed because no easily administered, reliable, and validated instrument was available that was specifically designed to measure assertiveness for adults.
in general. Until the development of the ASES, existing assertiveness measuring instruments were either unstandardized or standardized on relatively homogeneous college populations. Only the College Self-Expression Scale (CSES) (Galassi, DeLo, Galassi, & Bastion, 1974) appears to have been developed systematically to cover a broad range of assertive situations and behaviors.

A two dimensional descriptive model of assertiveness was designed to serve as a two-way specification table for item selection. One dimension specified interpersonal situations in which assertive behavior might occur. A sixth global situation was added to this dimension. The second dimension specified assertive behaviors that might occur in these interpersonal situations.

Items from the CSES were analyzed, using available data, to determine their suitability for inclusion in the ASES. Items were selected on the basis of discriminative power, correlation with total score, and test-retest reliability. Selected items, rewritten when necessary for use with adults in general, and sixteen new items were placed in the 42-cell model.

A final 106 item pool, including all 50 original CSES items, were administered to 194 subjects. Item analysis was conducted in terms of item discrimination, item-total correlation, and original vs. rewritten item correlation. From the item pool, 48 items were selected for the ASES.
The ASES uses a five-point Likert format with scores ranging from 0 (almost always) to 4 (never or rarely). There are twenty-five positively worded and twenty-three negatively worded items. Four original CSES items, fifteen new items, and twenty-nine rewritten items make up the forty-eight item scale. A Pearson product-moment correlation for the ASES with the CSES results in .88 using all subjects and .79 for married subjects who are thirty years of age or older.

Two-week and five-week test-retest reliability data were collected and were .88 and .91 respectively. To establish construct validity, a discriminant analysis procedure was used for three variables hypothesized to differentiate between high and low assertive individuals. The two dimensional model used in the construction of the ASES was analyzed in terms of the resulting factor structure. Scores from 464 subjects were used. The two dimensional, descriptive model was generally supported.

Seven counselors administered the ASES to a group of thirty-two subjects seeking personal adjustment counseling in an effort to establish concurrent validity. It was hypothesized that these subjects would be less assertive as measured by the ASES than those not seeking counseling. A t-test was conducted to compare the mean ASES of these subjects with a control group. The mean for these subjects was significantly lower.
Scores for the ASES range from 0 to 192. The mean score is 115 with a standard deviation of approximately 20. ASES scores of 135 or higher are considered high and scores below 95 are considered low (Joiner, Lovett, & Goodwin, 1989).

**Multidimensional Health Locus of Control (MHLC)** The original Health Locus of Control (HLC) scale was developed by Wallston, Wallston, Kaplan, & Maides (1976) as a unidimensional measure of people's beliefs that health is or is not determined by their behavior. Starting with the eleven items of the original health locus of control scale, new items were written which reflected three dimensions of health locus of control beliefs: internality (IHLC), powerful others (PHLC), and chance (CHLC). The total item pool consisted of twenty-five IHLC items, thirty PHLC items, and twenty-six CHLC items.

Eighty-one health locus of control items were mixed with Levenson's I, P, and C scale items, a shortened ten-item version of the Marlowe-Crowne Social Desirability Scale, and two items tapping health status.

Item selection for the MHLC was based on analysis of results obtained from 125 respondents. The final MHLC scale had two equivalent forms of eighteen items selected from predetermined criteria. Alpha reliabilities for the two forms (Form A and Form B) were lower (.67-.77) when
used separately than when both forms were administered in combination (.83-.86). The three dimensions did not intercorrelate significantly. Normative values for the combined forms were: (1) IHLC (50.42), (2) CHLC (31.04), and (3) PHLC (40.97). MHLC subscales were tested for concurrent and discriminate reliability with the internal, powerful others, and chance locus of control scales developed by Levenson (1974). Each MHLC subscale correlated highly with its theoretical counterpart on Levenson's I, P, and C scales.

The two equivalent forms of the MHLC were constructed for research designs that required repeated measures. Equivalent forms used for repeated measures decrease the possibility that respondents may remember previous responses. Additionally, this equivalency increases the sensitivity of the MHLC to measure change.

During instrument development, test items were paired and assigned to Forms A or B in such a way as to have nearly identical scores. This was done by comparing mean scores of both forms. Each form consists of six items that reflect each of the subscales. The items are scored on a six-point scale ranging from one (strongly agree) to six (strongly disagree). When forms are completed, subjects receive three scores, one for each subscale. Higher subscale scores indicate a greater belief that: (1) personal
behavior affects one's own health (HLC), (2) health results from luck, fate, or chance (CHLC), and (3) powerful others influence health status (PHLC).

The MHLC scale is recommended for use with adults having at least an eighth grade reading level. Respondents should be able to understand and respond to the items on the questionnaire. This scale and its multidimensional approach allows researchers to determine what specific beliefs are affected when an individual has received an intervention.

CONDITIONS OF TESTING

After consent forms were signed by participants (Appendices C and D), pretest data were collected on August 14, 1987. These included the demographic questionnaire, the Rosenberg Self-Esteem Scale, the ASES, and the MHLC Scale. Pretest data were collected from all of the subjects (N=20) at the same time, although there was a week's difference in the time of the programs. Posttest data were collected immediately following the last group and four weeks later. Each group followed this posttest time framework with Group 2 being one week later than the first group.

Specific characteristics in the demographic questionnaire included: (1) age, (2) race, (3) religion, (4) marital status, (5) nurses training, (6) high school education,
(7) college, (8) employment history, (9) length of employment, and (10) years in the domiciliary (Appendix E). Diagnoses were obtained from the subjects' medical records (Appendix I).

TREATMENT
This section will include a summary of treatment procedures. An outline of the workshop is presented in Appendix J. Materials distributed to workshop participants are shown in Appendix K.

This assertiveness training program was developed for the female veterans residing in the domiciliary at the Dayton, Ohio VA Medical Center. From interacting with many of these residents over the years, this investigator became aware of their problems resulting from living in the domiciliary and their perceived inability to get along with other male and female domiciliary residents. Many of these difficulties appeared to be related to limited assertiveness skills.

This investigator had extensive psychiatric/mental health nursing experiences in leading assertiveness training and self-esteem building workshops for patients and health professionals. As an integral part of nursing practice, assertiveness training groups were conducted on the inpatient psychiatric nursing unit as well as in the
outpatient clinic. In addition to inservice programs for staff nurses in a large midwest medical center, assertiveness training and self-esteem building were also integrated into the curriculum of nursing courses offered at several community college nursing programs.

Exploration of the relevant factors for designing an assertiveness training program, including structure, time, and numbers, led to the selection of a group setting. Learning experience can be enhanced through relationships that evolve through the group process (Meisenhelder, 1985). To facilitate group interaction with this population, each group was limited to ten participants with each training session lasting one and one-half hours (Goldberg and Stanton, 1977; Callis, 1982).

Various assertiveness programs were investigated (Bower & Bower, 1978; Galassi & Galassi 1977; Lange & Jakubowski, 1976; Osborne & Harris, 1975). It was determined that a specific program would be designed for this particular population.

Assertiveness programs are usually designed from one of three models: (1) behavioral, (2) cognitive, and (3) behavioral-cognitive. This assertiveness training program was primarily behavioral in orientation with minimal focus on cognitive processes. Each session included a warm-up activity at the beginning of the session, assertiveness-related content and activities, and a homework assignment.
Because of age and potential visual problems as a result of long term psychotropic drug use, most of the handouts were prepared in large type. The self-report questionnaires were also reproduced in large type.

The first day of the program began with an explanation of expectations for the participants as well as issues about confidentiality, privacy, and disclosure. The concept of warm-up exercises was an integral part of the workshop. Warm-up exercises can be done individually, in dyads, or triads to assist the participants in becoming a part of the group. The exercises begin with non-threatening topics and increased in personal focus with each exercise. After the warm-up exercise was completed, content for the first session centered on self-esteem and feeling good about one's self (Bower & Bower, 1978) with a focus on self-esteem builders and self-esteem destroyers (Osborne & Harris, 1975). The homework assignment for the first session was for participants to bring a list of positive and negative self statements to the second session.

The second session began with a warm-up exercise which was followed by a homework review with each participant agreeing to share one positive self statement. Review of a hand-out of positive descriptors was followed by a didactic presentation that focused on the toll of negative self-esteem (Bower & Bower, 1978). A handout on the benefits of
positive self-esteem and the cost of negative self-esteem was distributed and discussed.

Handouts with examples of negative to positive shifts in self-statements were distributed for the homework assignments. Each participant was assigned to convert one negative statement from the previous night's homework to a positive statement.

The warm-up exercises for the third day were conducted in dyads. The converted statements from the previous night's homework were reviewed. Participants received feedback from their partners. The importance of positive self-statements and their relationships to assertiveness were emphasized.

Content for this session included an introduction to assertiveness. Definitions of assertiveness (Zucher, 1983) and differentiations between assertiveness, aggressiveness, and non-assertiveness or passiveness were presented (Jakubowski-Spector, 1973). "I-messages" were discussed as an important component of assertive communication (Cooley & Hollandsworth, 1977). The homework assignment was to bring three "I-messages" to the next session.

The warm-up exercise for the fourth day included sharing one I-statement with the group. The didactic presentation addressed verbal and non-verbal communication skill development (Galassi & Galassi, 1977; Osborne & Harris,
This included refusing requests, which was especially important for participants in this assertiveness training program. Refusal situations were role-played.

The homework assignment was for each participant to refuse a request if the situation occurred naturally or to write how they would refuse a specific request. The situation, as well as their responses, were to be written on a 5x8 card and brought to the last session.

The warm-up exercise for the fifth day consisted of each participant telling one new thing learned or one different thing done as a result of participating in the workshop. While it was not planned to devote extensive time to the review of the homework assignments, participants engaged in a prolonged discussion and received feedback about their practiced refusals.

The didactic presentation focused on the importance of the match between verbal and nonverbal behaviors with role-play activities (Jette & Logan, 1981). Participants freely described feelings and insights that accompanied role-playing experiences.

A review was given on the relationship between self-esteem and assertiveness. The importance of "I-messages", expressing opinions, and refusing requests as beginning assertiveness skills was reiterated. A list of reading materials on assertiveness requested by the workshop
participants was included with the handouts. Closure for
the group was marked by each group member sharing a posi­
tive I-statement.

The Rosenberg Self-Esteem Scale, ASES, and MHLC Scale
were administered immediately following the final session.
Upon completion of the questionnaires, an appointment card
was given for follow-up testing in four weeks. All of the
participants (N=20) completed the five day workshop and the
one month follow-up test.

DATA ANALYSIS
Data analyses on the Rosenberg Self-Esteem Scale, ASES, and
MHLC Scale were conducted using SPSSX subprograms. T-tests
were conducted to determine if there were statistically
significant differences in mean aggregate scores for the
two intervention subgroups on the pretest and posttest.
Because there was no statistically significant difference
between the two subgroups, subsequent analyses were con­
ducted on pooled data. T-tests were conducted to determine
if there were statistically significant changes in combined
aggregate mean scores between the pretest and posttest.
One month following the workshop a follow-up test was done
and t- tests were conducted to determine if there were sta­
tistically significant changes in mean aggregate scores
between the pretest and the posttest, between the pretest
and the follow-up test, and between the posttest and the follow-up test. Relationships between demographic data and the outcome measures were analyzed.

SUMMARY
This chapter included a discussion of the procedures that were used to determine the effects of a group assertiveness training workshop on self esteem, assertiveness, and health locus of control for a sample of female veterans in a VA domiciliary. The research design for this study was described. Procedures used to select the study sample were explained. Psychometric properties of the outcome measures which were used in this study were presented. Testing and treatment procedures were described. Data analysis techniques that are discussed in chapter 4 were summarized.
CHAPTER IV
DATA ANALYSIS

The purpose of this study was to determine the effects of a group assertiveness training program on self esteem, assertiveness, and health locus of control for a sample of female veterans in a VA domiciliary. Data for the study were analyzed using SPSSX computer subprograms.

This chapter will present the results of data analyses. Descriptive analyses will be reported for the study sample and outcome measures. Because t-tests demonstrated that there was no statistically significant difference between the two intervention subgroups, data were pooled for each outcome measure. Results of these analyses will be reported for each instrument that was used in this study.

Results of t-test analyses for hypothesized changes in test scores for the Rosenberg Self Esteem Scale, the Adult Self Expression Scale (ASES), and the Multidimensional Health Locus of Control Scale (MHLC) will be reported. The purpose of the research was to measure changes in self esteem, assertiveness, and the three dimensions of health
locus of control. All statistical tests were two-tailed with an alpha level set at .05 a priori.

STUDY SAMPLE
The study sample included twenty female residents from the domiciliary at the Dayton, Ohio Veterans Affairs Medical Center (DVAMC). All of the subjects were white and ranged in age from twenty-eight years to eighty-six years with a mean of sixty years of age. Their reported residency in the domiciliary ranged from less than one year to twenty-four years with a mean of ten years. Diagnoses retrieved from medical records revealed that the participants (N=20) had psychiatric diagnoses.

Thirteen women (65%) were protestant, five (25%) were Catholic and two (10%) did not specify a religious preference. An analysis of marital status indicated that eight women (40%) were divorced, four (20%) were never married, four (20%) were widowed, and three (15%) were married. One woman did not report her marital status.

Of the seventeen women (85%) who completed high school, four (20%) completed less than two years of college and three (15%) indicated that they had completed college. Additionally, four women (20%) indicated that they completed nurses training.
The women were asked to indicate if they had ever been employed outside the home. Fourteen women (70%) had been employed prior to or after their military experiences. The length of overall employment ranged from less than one year to thirty years with a mean of eleven years. Five women (25%) had never held jobs and one woman did not respond to this question.

**ROSENBERG SELF-ESTEEM SCALE**

The null hypotheses for this study related to self-esteem is as follows:

There will be no difference in levels of self-esteem for female veterans who complete an assertiveness training program as measured by scores on the Rosenberg Self-Esteem Scale.

Statistical analysis was conducted on data for the Rosenberg Self-Esteem Scale. As noted earlier, analysis was conducted to determine if there was a difference between the two intervention subgroups. A t-test was conducted on the mean difference of pretest and posttest scores for the subgroups. Results indicated that there was no difference between the two subgroups (t=1.6) and the intervention groups were combined.(Table 1)

Pretest scores for the combined sample ranged from 10 to 35 with a mean of 21.4 and a standard deviation of 6.5. Posttest scores ranged from 11 to 37 with a mean of 20.9 and a standard deviation of 6.3. Scores obtained on the
one-month follow-up test ranged from 10 to 33 with a mean of 20.4 and a standard deviation of 6.4. (Table 2)

Analyses of self-esteem scores indicated that the mean pretest score (21.4) was slightly higher than the mean posttest score (20.9) and follow-up test score (20.4). T-tests indicated that there was no statistically significant difference between scores on the pretest and posttest (t = .6), the pretest and follow-up test measurement (t = 1.3), or the posttest and follow-up test measurement (t = .8). (Table 3)
Table 1

SUBGROUP MEAN DIFFERENCE OF PRETEST AND POSTTEST SCORES AND T-TEST FOR SELF-ESTEEM SCORES FOR WOMEN IN THE STUDY

<table>
<thead>
<tr>
<th>SUBGROUP</th>
<th>N</th>
<th>MEAN DIFFERENCE</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10</td>
<td>1.7</td>
<td>1.6</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
<td>.7</td>
<td></td>
</tr>
</tbody>
</table>

Table 2

RANGE, MEAN, AND STANDARD DEVIATION FOR SELF-ESTEEM PRETEST, POSTTEST, AND FOLLOW-UP TEST SCORES FOR WOMEN IN THE STUDY

N=20

<table>
<thead>
<tr>
<th>TEST</th>
<th>RANGE</th>
<th>MEAN</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRETEST</td>
<td>10-35</td>
<td>21.4</td>
<td>6.5</td>
</tr>
<tr>
<td>POSTTEST</td>
<td>11-37</td>
<td>20.9</td>
<td>6.3</td>
</tr>
<tr>
<td>FOLLOW-UP</td>
<td>19-33</td>
<td>20.4</td>
<td>6.4</td>
</tr>
</tbody>
</table>
Table 3

MEAN SELF-ESTEEM SCORES AND T-TESTS FOR THE PRETEST, POSTTEST AND FOLLOW-UP TEST SCORES FOR WOMEN IN THE STUDY

N=20

<table>
<thead>
<tr>
<th>TEST</th>
<th>MEAN</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRETEST</td>
<td>21.4</td>
<td>.6</td>
</tr>
<tr>
<td>POSTTEST</td>
<td>20.9</td>
<td></td>
</tr>
<tr>
<td>PRETEST</td>
<td>21.4</td>
<td>1.3</td>
</tr>
<tr>
<td>FOLLOW-UP</td>
<td>20.4</td>
<td></td>
</tr>
<tr>
<td>POSTTEST</td>
<td>20.9</td>
<td>.8</td>
</tr>
<tr>
<td>FOLLOW-UP</td>
<td>20.4</td>
<td></td>
</tr>
</tbody>
</table>

Results of data analysis on the Rosenberg Self-Esteem Scale indicated that there was no statistically significant difference between pretest, posttest, and follow-up test measures. Therefore, the null hypothesis must be accepted.
ADULT SELF EXPRESSION SCALE (ASES)

The null hypothesis for this study related to assertiveness is as follows:

There will be no difference in levels of assertiveness for female veterans who complete an assertiveness training program as measured by scores on the ASES.

Again scores obtained on the ASES were first analyzed to determine if there was a difference between the two sub-groups. A t-test on mean difference scores indicated that there was no difference between the two subgroups (t=.9) and the groups were combined. (Table 4)

Scores on the pretest ranged from 64 to 171 with a mean of 93.9 and a standard deviation of 22.6. Posttest scores ranged from 46 to 171 with a mean of 92.1 and a standard deviation of 25. Scores obtained on the one-month follow-up test ranged from 53 to 120 with a mean of 85.6 and a standard deviation of 15.4. (Table 5)

Analyses of ASES scores indicated that the mean pretest score (93.9) was slightly higher than the mean posttest score (92.1) and follow-up test score (85.6). T-tests indicated that there was no statistically significant difference between scores on the pretest and posttest (t=.3), the pretest and follow-up test measurement (t=2), or the posttest and follow-up test measurement (t=1.5). (Table 6)
Table 4

SUBGROUP MEAN DIFFERENCE OF PRETEST AND POSTTEST SCORES AND T-TEST FOR ASES SCORES FOR WOMEN IN THE STUDY

<table>
<thead>
<tr>
<th>GROUP</th>
<th>N</th>
<th>MEAN DIFFERENCE</th>
<th>T</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>10</td>
<td>7.9</td>
<td>.9</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
<td>-4.3</td>
<td></td>
</tr>
</tbody>
</table>

Table 5

RANGE, MEAN, AND STANDARD DEVIATION FOR ASES PRETEST, POSTTEST, AND FOLLOW-UP TEST SCORES FOR WOMEN IN THE STUDY

N=20

<table>
<thead>
<tr>
<th>TEST</th>
<th>RANGE</th>
<th>MEAN</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRETEST</td>
<td>64-171</td>
<td>93.9</td>
<td>22.6</td>
</tr>
<tr>
<td>POSTTEST</td>
<td>46-171</td>
<td>92.1</td>
<td>25.0</td>
</tr>
<tr>
<td>FOLLOW-UP</td>
<td>53-120</td>
<td>85.6</td>
<td>15.4</td>
</tr>
</tbody>
</table>
Table 6

MEAN ASES SCORES AND T-TESTS FOR THE PRETEST, POSTTEST AND FOLLOW-UP TEST SCORES FOR WOMEN IN THE STUDY

N=20

<table>
<thead>
<tr>
<th>TEST</th>
<th>MEAN</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRETEST</td>
<td>93.9</td>
<td>.3</td>
</tr>
<tr>
<td>POSTTEST</td>
<td>92.1</td>
<td></td>
</tr>
<tr>
<td>PRETEST</td>
<td>93.6</td>
<td>2.0</td>
</tr>
<tr>
<td>FOLLOW-UP</td>
<td>85.6</td>
<td></td>
</tr>
<tr>
<td>POSTTEST</td>
<td>92.1</td>
<td>1.5</td>
</tr>
<tr>
<td>FOLLOW-UP</td>
<td>85.6</td>
<td></td>
</tr>
</tbody>
</table>

Results of data analysis on the ASES indicated that there was no statistically significant difference between pretest, posttest, and follow-up test measures. Therefore, the null hypothesis must be accepted.
MULTIDIMENSIONAL HEALTH LOCUS OF CONTROL SCALE (MHLC)

Each subscale of the MHLC scale was analyzed: (1) internal health locus of control (IHLC), (2) chance health locus of control (CHLC), and (3) powerful others health locus of control (PHLC). Data will be reported for each subscale.

The null hypothesis for this study related to IHLC is as follows:

There will be no difference in internality for female veterans who complete an assertiveness training program as measured by scores on the IHLC subscale of the MHLC.

Prior to analysis of pooled data, analysis was conducted to determine if there was a difference between the two subgroups. A t-test conducted on the mean difference scores indicated that there was no difference between the two subgroups on the IHLC \( (t=1.3) \), CHLC \( (t=.5) \), or PHLC \( (t=.2) \) subscales. (Table 7)

Combined group scores on the IHLC ranged from 11 to 36 with a mean of 18.7 and a standard deviation of 5.6. Post-test IHLC scores ranged from 6 to 27 with a mean of 17.3 and a standard deviation of 5.2. Follow-up test scores ranged from 8 to 35 with a mean of 17.8 and a standard deviation of 6.1. (Table 8)

Three t-tests were conducted on the IHLC subscale. Results indicated that there was no statistically significant difference between scores on the pretest and posttest \( (t=1.2) \), the pretest and follow-up test measurement
(t-1.1), or the posttest and follow-up test measurement (t=.4). (Table 9)

Table 7

SUBGROUP MEAN DIFFERENCE OF PRETEST AND POSTTEST SCORES AND T-TESTS FOR IHLC, CHLC, AND PHLC SUBSCALE SCORES FOR WOMEN IN THE STUDY

<table>
<thead>
<tr>
<th>GROUP</th>
<th>N</th>
<th>MEAN DIFFERENCE</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>IHLC</td>
<td>1</td>
<td>2.9</td>
<td>1.3</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>CHLC</td>
<td>1</td>
<td>2.1</td>
<td>.5</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>PHLC</td>
<td>1</td>
<td>0</td>
<td>.2</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>0.5</td>
<td></td>
</tr>
</tbody>
</table>
Table 8
RANGE, MEAN, AND STANDARD DEVIATION FOR PRETEST, POSTTEST, AND FOLLOW-UP IHLC TEST SCORES FOR WOMEN IN THE STUDY

N=20

<table>
<thead>
<tr>
<th>TEST</th>
<th>RANGE</th>
<th>MEAN</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRETEST</td>
<td>11-36</td>
<td>18.7</td>
<td>5.6</td>
</tr>
<tr>
<td>POSTTEST</td>
<td>6-27</td>
<td>17.3</td>
<td>5.2</td>
</tr>
<tr>
<td>FOLLOW-UP</td>
<td>8-35</td>
<td>17.8</td>
<td>6.1</td>
</tr>
</tbody>
</table>
Table 9

MEAN IHLC SCORES AND T-TESTS FOR THE PRETEST, POSTTEST AND FOLLOW-UP TEST SCORES FOR WOMEN IN THE STUDY

N=20

<table>
<thead>
<tr>
<th>TEST</th>
<th>MEAN</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRETEST</td>
<td>18.7</td>
<td>1.2</td>
</tr>
<tr>
<td>POSTTEST</td>
<td>17.3</td>
<td></td>
</tr>
<tr>
<td>PRETEST</td>
<td>18.7</td>
<td>1.1</td>
</tr>
<tr>
<td>FOLLOW-UP</td>
<td>17.8</td>
<td>.4</td>
</tr>
<tr>
<td>POSTTEST</td>
<td>17.3</td>
<td></td>
</tr>
<tr>
<td>FOLLOW-UP</td>
<td>17.8</td>
<td></td>
</tr>
</tbody>
</table>

Results of data analysis on the IHLC subscale of the MHLC indicated that there was no statistically significant difference between pretest, posttest, and follow-up test measures. Therefore, the null hypothesis must be accepted.
The null hypothesis for this study related to CHLC is as follows:

There will be no difference in externality perceived to be due to luck, fate, or chance for female veterans who complete an assertiveness training program as measured by scores on the CHLC subscale of the MHLC.

Pretest scores on the CHLC ranged from 10 to 31 with a mean of 20.2 and a standard deviation of 6.9. Mean posttest scores ranged from 7 to 31 with a mean of 18.7 and a standard deviation of 7.1. Follow-up scores ranged from 10 to 29 with a mean of 20.8 and a standard deviation of 5.7. (Table 10)

T-tests were conducted on CHLC subscale measurements. Results indicated that there was no statistically significant difference between scores on the pretest and posttest \((t=1.3)\), the pretest and follow-up test measurement \((t=-.8)\), or the posttest and follow-up test measurement \((t=2)\). (Table 11)
Table 10
RANGE, MEAN, AND STANDARD DEVIATION FOR PRETEST, POSTTEST, AND FOLLOW-UP CHLC TEST SCORES FOR WOMEN IN THE STUDY

<table>
<thead>
<tr>
<th></th>
<th>RANGE</th>
<th>MEAN</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRETEST</td>
<td>10-31</td>
<td>20.2</td>
<td>6.9</td>
</tr>
<tr>
<td>POSTTEST</td>
<td>7-31</td>
<td>18.7</td>
<td>7.1</td>
</tr>
<tr>
<td>FOLLOW-UP</td>
<td>10-29</td>
<td>20.8</td>
<td>5.7</td>
</tr>
</tbody>
</table>

Table 11
MEAN CHLC SCORES AND T-TESTS FOR THE PRETEST, POSTTEST AND FOLLOW-UP TEST SCORES FOR WOMEN IN THE STUDY

<table>
<thead>
<tr>
<th></th>
<th>MEAN</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRETEST</td>
<td>20.2</td>
<td>1.3</td>
</tr>
<tr>
<td>POSTTEST</td>
<td>18.7</td>
<td></td>
</tr>
<tr>
<td>PRETEST</td>
<td>20.2</td>
<td></td>
</tr>
<tr>
<td>FOLLOW-UP</td>
<td>20.8</td>
<td>.8</td>
</tr>
<tr>
<td>POSTTEST</td>
<td>18.7</td>
<td>2.0</td>
</tr>
<tr>
<td>FOLLOW-UP</td>
<td>20.8</td>
<td></td>
</tr>
</tbody>
</table>
Results of data analysis on the CHLC subscale of the MHLC indicated that there was no statistically significant difference between pretest, posttest, and follow-up test measures. Therefore, the null hypothesis must be accepted.
The null hypothesis for this study related to PHLC is as follows:

There will be no difference in externality perceived to be due to the influence of powerful others for female veterans who complete an assertiveness training program as measured by scores on the PHLC subscale of the MHLC.

Pretest scores on the PHLC ranged from 8 to 32 with a mean of 21.7 and a standard deviation of 6.3. Mean posttest scores ranged from 8 to 31 with a mean of 21.5 and a standard deviation of 6. Follow-up scores ranged from 6 to 32 with a mean of 22.3 and a standard deviation of 6.7. (Table 12)

T-tests were conducted on PHLC subscale measurements. Results indicated that there was no statistically significant difference between scores on the pretest and posttest (t=.2), the pretest and follow-up test measurement (t=.5), or the posttest and follow-up test measurement (t=.7). (Table 13)
### Table 12

RANGE, MEAN, AND STANDARD DEVIATION FOR PRETEST, POSTTEST, AND FOLLOW-UP PHLC TEST SCORES FOR WOMEN IN THE STUDY

N=20

<table>
<thead>
<tr>
<th>TEST</th>
<th>RANGE</th>
<th>MEAN</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRETEST</td>
<td>8-32</td>
<td>21.7</td>
<td>6.3</td>
</tr>
<tr>
<td>POSTTEST</td>
<td>8-31</td>
<td>21.5</td>
<td>6.0</td>
</tr>
<tr>
<td>FOLLOW-UP</td>
<td>6-32</td>
<td>22.3</td>
<td>6.7</td>
</tr>
</tbody>
</table>

### Table 13

MEAN PHLC SCORES AND T-TESTS FOR THE PRETEST, POSTTEST AND FOLLOW-UP TEST SCORES FOR WOMEN IN THE STUDY

N=20

<table>
<thead>
<tr>
<th>TEST</th>
<th>MEAN</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRETEST</td>
<td>21.7</td>
<td>.2</td>
</tr>
<tr>
<td>POSTTEST</td>
<td>21.5</td>
<td></td>
</tr>
<tr>
<td>PRETEST</td>
<td>21.7</td>
<td>.5</td>
</tr>
<tr>
<td>FOLLOW-UP</td>
<td>22.3</td>
<td>.7</td>
</tr>
<tr>
<td>POSTTEST</td>
<td>21.5</td>
<td></td>
</tr>
<tr>
<td>FOLLOW-UP</td>
<td>22.3</td>
<td></td>
</tr>
</tbody>
</table>
Results of data analysis on the PHLC subscale of the MHLC indicated that there was no statistically significant difference between pretest, posttest, and follow-up test measures. Therefore, the null hypothesis must be accepted.
CORRELATIONS BETWEEN DEMOGRAPHIC CHARACTERISTICS AND OUTCOME MEASURES

The relationship between demographic characteristics and outcome measures for the study group were examined using mean difference scores between the pretest and posttest measurements. Gender (female), race (white), and religion (preference selected) were held constant for this study. The measures of association that were computed and which are specified on Table 14 include Kendall's tau, Cramer's V, and Pearson Product Moment Correlations. Coefficients that were statistically significant are identified in the table by an asterisk (*) after the coefficient. Negligible to relatively high correlation coefficients were obtained. Low to relatively high relationships will be reported in the following discussion and presented in the table (Table 14).
Table 14

RELATIONSHIP BETWEEN DEMOGRAPHIC CHARACTERISTICS AND OUTCOME MEASURES

N=20

<table>
<thead>
<tr>
<th>DEMOGRAPHIC CHARACTERISTICS</th>
<th>SELF ESTEEM</th>
<th>ASES</th>
<th>IHLC</th>
<th>CHLC</th>
<th>PHLC</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE&lt;sup&gt;c&lt;/sup&gt;</td>
<td>.01</td>
<td>-.1</td>
<td>.1</td>
<td>.03</td>
<td>.01</td>
</tr>
<tr>
<td>MARITAL STATUS&lt;sup&gt;b&lt;/sup&gt;</td>
<td>.4</td>
<td>.3</td>
<td>.2</td>
<td>.5</td>
<td>.3</td>
</tr>
<tr>
<td>HIGH SCHOOL EDUCATION&lt;sup&gt;b&lt;/sup&gt;</td>
<td>.03</td>
<td>.2</td>
<td>.03</td>
<td>.01</td>
<td>0</td>
</tr>
<tr>
<td>COLLEGE&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-.6&lt;sup&gt;*&lt;/sup&gt;</td>
<td>0</td>
<td>.04</td>
<td>.01</td>
<td>.5</td>
</tr>
<tr>
<td>NURSING EDUCATION&lt;sup&gt;b&lt;/sup&gt;</td>
<td>.1</td>
<td>.1</td>
<td>-.3</td>
<td>.3</td>
<td>.5&lt;sup&gt;*&lt;/sup&gt;</td>
</tr>
<tr>
<td>YEARS IN DOMICILIARY&lt;sup&gt;c&lt;/sup&gt;</td>
<td>.02</td>
<td>-.2</td>
<td>.2</td>
<td>.1</td>
<td>.03</td>
</tr>
<tr>
<td>EMPLOYMENT HISTORY&lt;sup&gt;d&lt;/sup&gt;</td>
<td>.3</td>
<td>.4</td>
<td>.4</td>
<td>.2</td>
<td>.3</td>
</tr>
<tr>
<td>LENGTH OF EMPLOYMENT&lt;sup&gt;c&lt;/sup&gt;</td>
<td>.1</td>
<td>-.3</td>
<td>.1</td>
<td>.2</td>
<td>.1</td>
</tr>
</tbody>
</table>

*<sup>p</sup>&lt;0.05

<sup>a</sup> Kendall's tau
<sup>b</sup> Cramer's V
<sup>c</sup> Pearson Product Moment Correlation
Relatively high relationships were obtained between specific characteristics and outcome measures. Nursing education was significantly correlated with PHLC ($r = .5$). There was a significant inverse relationship between college education and self esteem ($r = -.6$).

Moderate relationships were obtained for several characteristics, but were not statistically significant. Nursing education negatively correlated with IHLC ($r = -.3$) and positively correlated with CHLC ($r = .3$). There was a positive correlation between employment outside of the home and self-esteem ($r = .3$), IHLC ($r = .4$), and PHLC ($r = .3$). Correlations were obtained between marital status and self-esteem ($r = .4$) as well as PHLC ($r = .3$).

These moderate and relatively high correlations suggest interpretable relationships. Subjects who completed nurses training had a lower belief that behavior influences health, a greater belief that health resulted from chance and that powerful others significantly influenced health status. These findings may be explained by the ages of the nurses, all of whom were over 60 years of age. At the time these women received their nursing education, nurses were socialized to be handmaidens of the physician. This socialization, along with the actual nursing practice of the times, could attribute to the relatively high correlation that powerful others (ie. physicians) significantly influenced health status.
College graduates had significantly lower self-esteem. This result may be related to this group of women experiencing greater losses associated with institutional living. The loss of individuality, privacy, and control could lead to lower self-esteem for college educated women who may have an expanded awareness of the mismatch between independence and dependency that is fostered in institutions. Those who had an employment history had higher self-esteem, a greater belief that health is influenced by behavior, and that powerful others influence health status. Subjects who had an employment history were also more assertive than those who had never worked. Subjects who were employed for a longer period were more assertive.

Low correlations were computed between several characteristics and outcome measures that were not statistically significant. Age correlated with IHLC ($r=.1$). A low correlation was obtained between length of domiciliary residency and IHLC ($r=.2$) and CHLC ($r=.1$). An employment history positively correlated with CHLC ($r=.2$) and IHLC was correlated with marital status ($r=.2$). Additionally, a low correlation was obtained for years of employment outside the home and IHLC ($r=.1$), CHLC ($r=.2$), and PHLC ($r=.1$).

Analysis of relationships between demographic characteristics and outcome measures suggest that there are significant relationships. Self-esteem, assertiveness, and
health locus of control may be related to personal, educational, and employment characteristics for study subjects. However, these results must be interpreted with caution because of the small sample size (N=20) and because significance may result when multiple tests are computed.

**INTERPRETATION**

This section will include an interpretation of data analysis on the outcome measures as well as discussion of the relationship between demographic characteristics and the outcome measures. The null hypotheses for this study were:

1. There will be no difference in levels of self-esteem for female veterans who complete an assertiveness training program as measured by scores on the Rosenberg Self-Esteem Scale.

2. There will be no difference in levels of assertiveness for female veterans who complete an assertiveness training program as measured by scores on the ASES.

3. There will be no difference in internality for female veterans who complete an assertiveness training program as measured by scores on the IHLC subscale of the MHLC.

4. There will be no difference in externality perceived to be due to luck, fate, or chance for female veterans who complete an assertiveness training program as measured by scores on the CHLC subscale of the MHLC.
5. There will be no difference in externality perceived to be due to the influence of powerful others for female veterans who complete an assertiveness training program as measured by scores on the PHLC subscale of the MHLC.

Results of analyses on the Rosenberg Self-Esteem Scale, ASES, and MHLC Scale indicated that there was no statistically significant difference between pretest, posttest, and follow-up test measures. Therefore, the five null hypotheses must be accepted. If these null hypotheses are accepted as true, then additional issues need to be addressed.

The failure of this study to detect significant associations between variables may be as a result of inadequate numbers rather than a true absence of association. The discharge of twenty female veterans from the domiciliary between the time of the original planning and the time the study was done resulted in a small number of subjects (N=20). This necessitated a change in study design from an experimental design to a pre-experimental design. Because of the design change, there was less control over the study results due to internal validity threats (Campbell & Stanley, 1966). Since the potential study population was extremely stable there were not enough new incoming patients to repeat the intervention.
The investigator's concern that additional women might be discharged from the domiciliary contributed to the design for the workshop being held on five consecutive days. This design did not allow for assimilation of workshop teachings and drastically reduced the amount of time that could be used for practicing new skills. Another factor that may be related to the lack of significant findings is that posttests were administered immediately upon completion of the final workshop session. The posttests may not have adequately measured true treatment outcomes because the subjects did not have time to apply newly learned skills in real-life situations. Multiple t-tests were used to assess relationships between pre and posttest measures. While this practice raises the possibility of finding a significant association by chance, no significant associations were detected. If such associations had been found, further analysis with repeated measures ANOVA would have been indicated.

SUMMARY
In this chapter, data analyses using SPSSX subprograms and interpretation of results were included. T-tests using mean difference scores indicated that there was no significant difference between the two subgroups. Therefore, data analysis was conducted on pooled data for outcome measures.
Correlations between demographic data and mean scores for outcome measures were examined.

T-tests were used to test the null hypotheses. There were no statistically significant differences between pre-test, posttest, and follow-up test measures. The null hypotheses were accepted.
CHAPTER V
SUMMARY, CONCLUSIONS, IMPLICATIONS AND
RECOMMENDATIONS

This chapter will contain four components. The summary and results of the study will be presented. Implications of the findings and recommendations will be included.

SUMMARY
The purpose of this study was to determine the effects of a group assertiveness training program on self-esteem, assertiveness, and health locus of control for a sample of female veterans residing in a VA domiciliary. The null hypotheses for this study were:

1. There will be no difference in levels of self-esteem for female veterans who complete an assertiveness training program as measured by scores on the Rosenberg Self-Esteem Scale.

2. There will be no difference in levels of assertiveness for female veterans who complete an assertiveness training program as measured by scores on the ASES.
3. There will be no difference in internality for female veterans who complete an assertiveness training program as measured by scores on the IHLC subscale of the MHLC.

4. There will be no difference in externality perceived to be due to luck, fate, or chance for female veterans who complete an assertiveness training program as measured by scores on the CHLC subscale of the MHLC.

5. There will be no difference in externality perceived to be due to the influence of powerful others for female veterans who complete an assertiveness training program as measured by scores on the PHLC subscale of the MHLC.

From a population of female veterans residing in the domiciliary, 20 volunteers agreed to participate in a group assertiveness training program. The subjects were pretested using the Rosenberg Self-Esteem Scale, the Adult Self Expression Scale (ASES), and the Multidimensional Health Locus of Control (MHLC) Scale. Additionally, a demographic data questionnaire was administered during the pretest session.

Subjects were divided into two subgroups, each with ten members. Subjects (N=20) completed two similar, but separate workshops. Each workshop consisted of one and one-half hour group sessions for five consecutive days and
were held one week apart. Each subgroup completed the posttest immediately following the final workshop session. Four weeks after the final session, follow-up test measures were completed.

Study data were analyzed using SPSSX subprograms. T-tests conducted to determine if there were differences in mean aggregate scores for the two intervention subgroups indicated that there was no statistically significant difference between the two subgroups. Therefore, data analysis was conducted on pooled data for outcome measures.

T-tests were conducted to determine if there were statistically significant changes in combined mean scores between the pretest and posttest, between the posttest and follow-up measures, and between the pretest and follow-up test measures. A .05 level of significance was set a priori. Relationships between demographic data and outcome measures were analyzed.

Findings from data analysis indicated that the five null hypotheses must be accepted, as there was no statistically significant differences between pretest, posttest, and follow-up test measures. There were, however, relatively high relationships obtained between specific characteristics and outcome measures. These included: (1) nursing education and PHLC (r=.5), and (2) an inverse relationship between college education and self-esteem.
Additionally, there were low, moderate, and relatively high correlations that were not statistically significant.

CONCLUSIONS
Based on the results of this study, the conclusions are as follows:

1. The group assertiveness training program did not alter self-esteem, assertiveness, internal health locus of control, chance health locus of control, or powerful others health locus of control as tested using the five null hypotheses.

2. The results from this study were not consistent, for the most part, with those reported in the self-esteem literature review (Hallal, 1980; Stake & Pearlman, 1980; Weitz, 1982; Antonucci & Jackson, 1983; Muhlenkamp & Sayles, 1986; Meisenhelder, 1986; and Duffy, 1988). Results from this study were consistent with those reported by Callis (1982) and Cornell & Schmitt (1990) in which scores were measured for patient populations.

3. The results from this study were not consistent with those reported in the assertiveness and assertiveness training literature review (Hollander & Wall, 1977; Wolfe & Fodor, 1977; Linehan, et al., 1979;
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4. The results from this study were not consistent with those reported in the multidimensional health locus of control literature review (Hallal, 1980; Gierszenski, 1983; Duffy, 1988; Lakin, 1988; & Johnson, 1989).

5. There are some significant relationships between demographic characteristics and outcome measures. Self-esteem, assertiveness, and health locus of control may be related to educational characteristics for study subjects.

IMPLICATIONS

Implications from this study are:

1. Assertiveness training for female veterans at the time of admission to the domiciliary could expedite the return to community living. Ongoing assertiveness training could be offered to female veteran domiciliary residents to reinforce newly learned skills, to learn additional skills, and to offer a safe environment in which to practice these skills. Assertiveness skills can greatly enhance the female veteran's potential for successful community living.

2. Having assertive skills can be beneficial to hospitalized female veterans. A national study of all VA
facilities surveyed nurses and physicians about their perceptions of female veterans. One finding was that female veterans were perceived as being very nonassertive. Recommendations from this survey included assertiveness training for female veterans (Schuler, Barclay, Harrison, & Larson, 1986).

3. Many psychiatric patients, which includes a large number of female veterans in VA domiciliaries, present a special need for assertiveness training. Many years in an institutional setting often promote patient attitudes with accompanying attitudes of passivity. This can be self-defeating in normal, everyday living (Clark, et al., 1984).

4. Being assertive and getting one's needs met leads to feeling good about self and an increasing positive self-esteem. Positive self-esteem is necessary for maintaining a high quality of life. Schwartz (1975) maintains that self-esteem is the "linchpin to the quality of life." If self-esteem is important to psychological well-being, then assertiveness training programs should be an integral part of holistic treatment programs.

5. In this time of skyrocketing health care costs, there is increased attention being directed toward individual responsibility for health. Female veterans with a
high level of internality are more likely to practice health promotion behaviors (Duffy, 1988; Lakin, 1988), including assertiveness. One means of helping individuals to change to higher levels of internality, which results in higher levels of self-responsibility, health promoting behaviors, and higher self-esteem is assertiveness training.

6. There is a need for further research using other designs. Designs that use quantitative methods may be unable to show socially significant outcomes for patient populations.

RECOMMENDATIONS

The results of this study lead to the following recommendations for future research:

1. This study measured the effects of a group assertiveness program conducted for five consecutive days. It is recommended that further research be done in which the workshop is presented one or two days a week for a longer period of time— at least eight weeks but preferably for twelve weeks. This would present the opportunity for assimilation and practice of new skills in the community as well as in the residential institution.
2. Only quantitative measures were used in this study. Triangulation is recommended for future research. Triangulation is the use of more than one design in a research study (Babbie, 1979). Different varieties of data collection methods are selected because each examines a different aspect or dimension of the problem being studied (Knafe & Breitmayer, 1989). The use of qualitative data along with quantitative data would increase the robustness of the study results. Personal interviews with subjects one month after workshop completion is recommended to collect the qualitative data.

3. At the beginning of the workshop, study subjects had great difficulty differentiating between assertiveness and aggressiveness. It is recommended that future research include an instrument or instruments to either: (a) discriminate between assertiveness and aggressiveness, or (b) measure both assertiveness and aggressiveness. The investigator will have data that better reflects subjects' true understanding of both concepts.

4. The sample size for this study was small (N=20). It is recommended that future research include larger samples for greater statistical power.
5. This study measured health locus of control using the Multidimensional Health Locus of Control Scale (MHLC). It is recommended that future research with subjects having a psychiatric diagnosis also use the Mental Health Locus of Control Scale (Hill, 1980). This scale was designed to measure expectancies concerning who will be in control and who is responsible for change in persons with psychiatric diagnoses. Since control is often the core of issues with psychiatric patients, this additional and specific scale can furnish vital data to researchers.
Appendix A

SUPPORT LETTER FROM CHIEF, DOMICILIARY SERVICE
June 2, 1987

Susan J. Owen, R.N., M.S.
Mental Hygiene Clinic
Dayton, Ohio VAMC

Dear Mrs. Owen:

I have reviewed your proposal and grant permission for you to conduct this research study with the available female veterans in the domiciliary.

I will schedule a meeting with the women to enable you to explain the study to them. I will notify you of the time for the meeting.

Thank you for your interest in providing an assertiveness program for this veteran population.

Sincerely,

Linda Hedden, Ph.D.
Chief, Domiciliary
Dayton, Ohio VAMC

"America is #1—Thanks to our Veterans"
EXPLANATION OF STUDY TO SUBJECTS

Hello. My name is Sue Oven and I have been a nurse at this VA for sixteen years. In addition to that, I am also working on my doctorate in Health Education from the Ohio State University. I am planning on doing my research here at the domiciliary with the female veteran residents.

My study will have to do with comparing the effects of an assertiveness training program on women's views of their self-esteem, assertiveness, and health locus of control. I am going to do this by inviting all the female residents to participate in this research. The participants will give their views on self-esteem, assertiveness, and health locus of control at three different times. They will attend classes on assertiveness after giving their views the first time. These classes will meet for one and one-half hours a day for five days. The participants' views on self-esteem, assertiveness, and health locus of control will be obtained immediately following the last class. I plan to wait a month after you have shared your views for the second time and ask you to share again, for the third time, your views about self-esteem, assertiveness, and health locus of control.

Those of you with IT assignments will be excused from your IT assignments, but this will NOT affect your IT pay. Your participation in this study is voluntary and if you choose not to participate, this will not affect your residency in the domiciliary or receiving treatment at this VA Medical Center.

All information you share in this research study will be strictly confidential. No information will be available to anyone other than myself. At the completion of my study, I will hold a brief meeting with all participants and discuss the results. Now I encourage you to ask me any questions you might have regarding the study.

Now that I have answered your questions, let me explain the consent forms to you. Because I am a student at the Ohio State University, the consent form from the Ohio State University has my advisor's name as the principal investigator. I am letting you know that I am the one that will be doing the study. The other consent form is required by the VA and is an additional protection for you.

It is important you sign and date both of these forms in order to participate in this study. Thank you for your participation. You will receive an appointment card giving you the date, time, and place of the first meeting to give your views on self-esteem, assertiveness, and health locus of control.
Appendix C

INFORMED CONSENT FORM
INFORMED CONSENT FORM

I agree to participate in the study being conducted by Susan J. Owen, R.N.,M.S.,C.S. The nature of the study has been explained to my satisfaction.

I understand that my participation is voluntary and that I am free to withdraw from the study at any time without any effect on my receiving treatment at the Veterans Administration Medical Center.

I am assured that any personal information that I contribute will be kept confidential.

Signature

Date

"America is #1—Thanks to our Veterans"
Appendix D

THE OHIO STATE UNIVERSITY CONSENT FORM
THE OHIO STATE UNIVERSITY

CONSENT FOR PARTICIPATION IN
SOCIAL AND BEHAVIORAL RESEARCH

I consent to participating in (or my child's participation in) research entitled:

EFFECTS OF A GROUP ASSERTIVENESS TRAINING PROGRAM ON SELF-ESTEEM,
ASSERTIVENESS, AND HEALTH LOCUS OF CONTROL FOR FEMALE VETERANS IN
A DOMICILIARY

R. Cory Bates (Principal Investigator) or his/her authorized representative has
explained the purpose of the study, the procedures to be followed, and the expect-
ded duration of my (my child's) participation. Possible benefits of the study have
been described as have alternative procedures, if such procedures are applicable
and available.

I acknowledge that I have had the opportunity to obtain additional information
regarding the study and that any questions I have raised have been answered to my
full satisfaction. Further, I understand that I am (my child is) free to with-
draw consent at any time and to discontinuance participation in the study without
prejudice to me (my child). The information obtained from me (my child) will
remain confidential unless I specifically agree otherwise by placing my initials
here .

Finally, I acknowledge that I have read and fully understand the consent form.
I sign it freely and voluntarily. A copy has been given to me.

Date: ___________________  Signed: ___________________

Signed: ___________________  Signed: ___________________

(Principal Investigator or his/
her Authorized Representative) (Person Authorized to Consent
for Participant - If Required)

Witness: ___________________

US-027 (Rev. 12-81) -- To be used only in connection with social and behavioral
research.
Appendix E

DEMOGRAPHIC QUESTIONNAIRE
GENERAL INFORMATION QUESTIONNAIRE

Please complete this questionnaire by circling the appropriate answer or giving the specific information requested.

AGE_____

EDUCATION- GRADE/HIGH SCHOOL
Highest Grade Completed  1  2  3  4  5  6  7  8  9  10  11  12

NURSING SCHOOL
Number of Years Completed  1  2  3  4  5  6  7  8  9  10  11  12

COLLEGE
Number of Years Completed  1  2  3  4  5  6  7  8  9  10  11  12

NUMBER OF YEARS IN THE DOMICILIARY_____

EMPLOYMENT HISTORY
Employed Outside the Home YES___NO___
If Yes, How Many Years?_____
Occupation_____________________

RACE
Black   White   Hispanic    Oriental    American Indian
Other (PLEASE SPECIFY)_____________________

RELIGION_____________________

MARITAL STATUS
Never Been Married    Married    Separated    Divorced    Widowed

STUDY CODE__________________
Appendix F

ROSENBERG SELF-ESTEEM SCALE
PLEASE NOTE

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Appendix G

ADULT SELF-EXPRESSIONS SCALE (ASES)
Appendix H

MULTIDIMENSIONAL HEALTH LOCUS OF CONTROL SCALE
(MHLC)
Appendix I

PERMISSION TO RETRIEVE DIAGNOSES FROM MEDICAL RECORDS
July 31, 1987

Behavioral and Social Sciences Human Subject Review Committee
The Ohio State University

Dear Committee Members:

Mrs. Susan J. Owen has permission to access the medical records of the female veterans in the domiciliary to obtain diagnoses for demographic purposes for her research project.

Sincerely,

Linda Haddon, Ph.D.
Chief, Domiciliary
Dayton, Ohio VAMC
GROUP ASSERTIVENESS TRAINING PROGRAM

I. DAY 1
   A. Introduction
      1. Introduction of facilitator
      2. Program description
      3. Warm-up exercises
   B. Feeling Good About Yourself
      1. Individual activities
      2. Group activities
   C. Homework

II. DAY 2
   A. Warm-up exercises
   B. Review homework
   C. Building self-esteem
      1. Individual activities
      2. Group activities
   D. Homework

III. DAY 3
   A. Warm-up exercises
   B. Review homework
   C. Assertiveness
      1. Definitions
      2. Differentiate
      3. Components
   D. Verbal skill development
      1. Group activities
      2. Modeling
   E. Homework
IV.  DAY 4
A.  Warm-up exercises
B.  Review homework
C.  Assertiveness
   1.  Verbal skill development
       a.  group activities
       b.  modeling
   2.  Non-verbal skill development
       a.  group activities
       b.  modeling
D.  Homework

V.  DAY 5
A.  Warm-up exercises
B.  Review homework
C.  Assertiveness
   1.  Skill development
   2.  Small group activities
D.  Summary and evaluation
Appendix K

WORKSHOP HANDOUTS
DEFINITION OF SELF-ESTEEM

SELF-ESTEEM IS DEFINED AS A PERSON'S EVALUATION OF THEMSELVES
PLEASE NOTE

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Definition of Self-Esteem
139-143

Definition of Assertiveness
145-148

University Microfilms International
DEFINITION OF ASSERTIVENESS

ASSERTIVENESS IS THE EXPRESSION OF WANTS, NEEDS, AND OPINIONS CLEARLY WITHOUT VIOLATING THE RIGHTS OF OTHERS
VERBAL COMPONENTS OF ASSERTIVE BEHAVIOR THAT AFFECT RESPONSE

1. **LATENCY** (Response Lag): The interval of silence between the termination of the speaker's statement and your response.
   - Short latencies or negative latencies (interruptions) are usually perceived as aggression.
   - Long latencies are perceived as nonassertive by the speaker and the listener.
   **ASSERTIVE TECHNIQUES**
   a. Moderate periods of latency
   b. Use "filler" statements within one or two seconds such as, "that surprises me" or "let me think about that."

2. **VOICE VOLUME**: The loudness of one's voice during an interaction.
   - Soft volume is perceived as nonassertive.
   - Loud volume is perceived as aggressive.
   **ASSERTIVE TECHNIQUES**
   a. Keep voice volume moderate
   b. Practice moderating volume and request feedback from others.

3. **AFFECT** (The Feeling Message): Feelings are transmitted with verbal messages.
   - A flattened affect that does not transmit any feeling is perceived as nonassertive.
   - An overly controlled affect is perceived as aggressive (such as clenching the jaw when speaking).
   - Overmodulation is perceived as aggressive or reflecting instability.
   **ASSERTIVE TECHNIQUES**
   a. Listen to a role model who appropriately modulates the voice during interactions.
   b. Practice projecting affect to and obtaining feedback from someone.

4. **FLUENCY**: A speaking pattern that is expressive, clear, and emphasizes key words.
   - Awkward hesitations, stammering, or frequent interjections are perceived as nonassertive.
   - A rapid pace and condescending tone are perceived as aggressive.
   **ASSERTIVE TECHNIQUES**
   a. Prepare for an interaction by rehearsing out loud or with someone.
   b. Maintain a steady voice tone that is not monotone.
   c. Role play anticipated situations with someone.
NONVERBAL COMPONENTS OF ASSERTIVE, NONASSERTIVE, AND AGGRESSIVE INTERACTIONS (defined for the American culture)

<table>
<thead>
<tr>
<th>BEHAVIOR</th>
<th>ASSERTIVE</th>
<th>NONASSERTIVE</th>
<th>AGGRESSIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Contact</td>
<td>Firm</td>
<td>Teary eyed, Avoids</td>
<td>Piercing, Staring</td>
</tr>
<tr>
<td>Distance (Proximity)</td>
<td>1½ to 3 feet</td>
<td>Steps back, Maximizes</td>
<td>Closes in quickly</td>
</tr>
<tr>
<td>Posture</td>
<td>Faces listener, Stands or sits straight</td>
<td>Turned away, Leans against support</td>
<td>&quot;Face on face&quot;</td>
</tr>
<tr>
<td></td>
<td>Asymmetrical posture of hands &amp; feet</td>
<td>Rigid, symmetrical</td>
<td>Feet apart, hands on hips</td>
</tr>
<tr>
<td>Gestures</td>
<td>Loose movement below the shoulder</td>
<td>Hands held in one rigid position</td>
<td>Abrupt, large gestures (especially above shoulders)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Demeaning finger pointing</td>
</tr>
<tr>
<td>Facial Expressions &amp; Head Movements</td>
<td>Fluctuate to match the message</td>
<td>Incongruent with verbal message</td>
<td>Snarl, raised eyebrow, etc.</td>
</tr>
<tr>
<td>Physical positioning &amp; personal space</td>
<td>Maintain same height</td>
<td>Lower height, Seated apart from others</td>
<td>Standing to seated person</td>
</tr>
<tr>
<td>Touch</td>
<td>Appropriate in time &amp; manner</td>
<td>Avoids or weak</td>
<td>Intrusive or overpowering</td>
</tr>
</tbody>
</table>
MODEL FOR EXPANDING INDIVIDUAL ASSERTIVENESS SKILLS

1. LIST THE NONASSERTIVE OR AGGRESSIVE BEHAVIORS THAT YOU WANT TO CHANGE.

2. CHOOSE ONE OF THE LISTED BEHAVIORS ON WHICH YOU WILL FOCUS.

3. DEVELOP YOUR PLAN FOR CHANGE USING ALL THE SUPPORTIVE TECHNIQUES THAT YOU HAVE LEARNED.

4. IMPLEMENT YOUR ASSERTIVE PLAN.

5. EVALUATE THE PROCESS AND OUTCOME OF YOUR ASSERTIVE INTERACTION.

6. UTILISE SELF OR GROUP REINFORCEMENT FOR YOUR ASSERTIVENESS.

7. DEVELOP YOUR PLAN TO REPEAT THE ASSERTIVE BEHAVIOR (WITH ANY NEEDED MODIFICATIONS).

8. CONTINUE TO EXPAND YOUR ASSERTIVE SUCCESSES BY SELECTING A NEW BEHAVIOR THAT YOU WANT TO CHANGE.
EXPANDING INDIVIDUAL EXPERTISE IN ASSERTIVENESS SKILLS

LIKE ANY OTHER SKILL, ASSERTIVE SKILLS ARE LOST IF NOT PRACTICED.
LEAVE THIS WORKSHOP WITH A COMMITMENT.
RECOGNIZE THE IMPORTANCE OF INDIVIDUAL CHOICE
GUIDELINES FOR EXPANDING EXPERTISE INCLUDE:

A. INCREASE SUCCESS WITH LOW-RISK ASSERTIONS
   1. ONE TIME CONTACTS
   2. OTHER ASSERTIVE PEOPLE
   3. SITUATIONS WITH GREATER CHANCE OF SUCCESS

B. USE SLOW INTRODUCTIONS VERSUS TOTAL IMMERSIONS.
   1. EXPRESS ONE OPINION AND GRADUALLY INCREASE THE NUMBERS

C. LEARN FROM OBSERVING A ROLE MODEL

D. REWARD YOURSELF
   1. SELF REINFORCEMENT
   2. GROUP REINFORCEMENT-SHARE EXPERIENCES

E. REMEMBER THAT NO ONE IS ALWAYS ASSERTIVE!

EXPECT THAT THIS BEHAVIOR CHANGE WILL GET POSITIVE AND NEGATIVE
REACTIONS FROM OTHER.
CONTINUE TO SHARPEN YOUR OBSERVATION SKILLS IN DIFFERENTIATING
ASSERTIVE, NONASSERTIVE, AND AGGRESSIVE BEHAVIORS DAILY.
READING MATERIAL ON ASSERTIVENESS


When I say no I feel guilty by Manual Smith
REFERENCES


35. Endler, N. S., & Hunt, J. V. (1968). S-R inventories of hostility and comparison of the proportion of variance from persons, responses, and situations for hos-


