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Efficacy of Assertiveness Training in Enhancing Interpersonal Skills among Selected Nurses Attending MCPDP at Osun State School of Nursing, Osogbo: Osun State, Nigeria

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Abstract
Introduction: Assertiveness is an important behaviour for today's professional nurse. As nurses move away from traditional subservient roles and perceived stereotypes, it is increasingly being recognized that a nurse needs to behave in an assertive way. The study investigated the influence of Assertiveness Training in enhancing interpersonal skills among selected nurses attending mandatory continuing professional development programme (MCPDP).**Methodology: -** The sample consisted of one hundred and twenty nurses randomly selected, from the clustered population of nurses attending MCPDP in Osun State, Nigeria. A. 3 x 2 factorial design was adopted. The analysis of covariance was used to test two null hypotheses at 0.05 level of significance using SPSS version window 17.**Results: -** Results indicated that subjects exposed to treatments performed significantly better than the control group on the measures of interpersonal skills i.e. Assertiveness Behaviour inventory; social skill inventory, F (15,304) = 103.41, P<0.0. **Conclusion: -** It was concluded that the therapeutic technique was effective in enhancing interpersonal skills of the subjects.
Keywords: Efficacy, Assertiveness Training, Interpersonal Skills, MCPDP, Low intelligence, High Intelligence, Osogbo.

INTRODUCTION

Assertiveness is a key attribute for nurses without which true autonomy (Keenan, 1999), Professional Status (Parking, 1995) or empowerment (Fulton, 1997), cannot be achieved (Esin, Nazan & Murvivvet, 2013). Traditionally, nurses have been taught to be acquiescent and submissive helpers of doctor (Slator, 1990; Poroch & Mclntosh, 1995). Assertive behaviour has been an essential communication skill within the nursing profession which is a predominantly female, nurses working on wards retain a submissive role and do not assert themselves well (Poroch & Mclntosh, 1995). Poroch and Mclntosh (1995), identified barriers that prevent nurses from being assertive. These included a lack of knowledge about personal/professional rights, concern about what others will think about their behaviour and anxiety due to the lack of confidence and poor self – esteem (Esin et al. 2013). This belief may stem from nurse burying into the stereotypical sex roles as described by Kantor (1979). But Farrel (2001), argued that feeling oppressed is not the sole prerogative of female nurses as men in nursing also feel oppressed. Farrel (2001), was anxious to move beyond the oppression debate and recognized that these effects are not confined to oppressed groups, stating that men in nursing also feel oppressed and that "doctors eat their young too" (Farrel, 2001, p79). Assertiveness is considered health behaviour for all people that, when present, mitigates against personal powerlessness and results in personal empowerment (Esin et al, 2013). They went further to state that Nursing has determined that assertive behaviour among its practitioners is an invaluable component for successful professional practice. According to Russel (1990), Assertive nurses, including managers, will stand up for their rights while recognizing those of others. They are straightforward, being freed to be themselves. Assertive nurses should know they are responsible only for their own thoughts, feelings, and actions. They can help others deal with their anger thus prevent conflicts. They know their strengths and limitations. Rather than attack or defend assertive nurses, the nurse manager should assess, collaborate, and support, remaining neutral and non threatening. They can accept, challenges. Researches have shown – that for organizations to survive in the face of complexities facing the world of work, it needs people with destructive interpersonal characteristics. It needs workers who will be responsible for their own lives, those who can subordinate than feelings to values, and those who have the initiative and the responsibility to make things happen (Hammed, 1999). One of the problems militating against the effectiveness and efficiency of a nurse leader could be attributed to deficient interpersonal skills in terms of communication, conflict resolutions, physician, authority and lack of skills for managing conflicts (Russel, 1990), Senior nurses should be able to develop others staff by enabling them to apply theory to practice and encouraging them to test new skills in a safe and supportive environment. This, again, as an example of where leadership activities combine with developmental ones to create competent practitioners through practice based learning. These nurses should adopt a supportive leadership style, interpersonal skills with mentorship, coaching and supervision as the core values (Skill you need, www.skillsyouneed.com, 14/06/15).

Interpersonal skills interpersonal skills are the life skills we use everyday to communicate and interact with others, both individually and in groups, people who have worked on developing strong interpersonal skills are usually more successful in both their professional and personal lives (skills you need, www.skillsyouneed.com, 14/06/15). It went further to state that interpersonal skills are not just important in the work place, our personal and social lives can also benefit from better interpersonal skills. People with good interpersonal skills are usually perceived as optimistic, calm, confident and charismatic-qualities, that are often enduring or appealing to others (www.skillyneed.com, 14/06/15). Assertiveness is a key attribute for nurses without which true autonomy (Keenan, 1999), professional status (Parkin, 1995) or empowerment (Futton, 1997) cannot be achieved. Traditionally, nurses have been taught to acquiescent and submissive helpers of doctors (Slater, 1990, Poroch & Mclntosh, 1995). Assertive behaviour has been an essential communication. Strategy for women in pursuing equality, however within the nursing profession which is a predominantly female, nurses working on wards retain a submissive role and do not assert themselves well (Poroch & Mclntosh, 1995).

The need to be assertive exists when situations arise involve contact with other people. The assertive styles, rather than the passive or non assertive one, is advocated to minimize feelings of anger or fear associated with stressful encounter and to work toward a peaceful resolution (Seaward, 1997). Some nurses may be learned to express their needs honestly, to use anger constructively, to improve personal and work relationship and to develop self confidence through assertive behaviour. But others still struggle with being assertive, perhaps because they don't believe they have the right to be assertive, they have the right to be assertive, they are anxious about asserting themselves or they don't know how to be assertive (Chauvards, 1991). According to Johnson (1993), Learning assertive techniques are considered as tools for coping. skills with a variety of life stressors. Increasing assertive behaviour become an expression of person's feelings. The need to integrate assertiveness skills into nursing practice was emphasize by (Carpencitry Shaban, 1992). Who thought that care for another human being involves becoming a certain kind of person, and not merely doing certain kind of things. Every nurse must know the importance of becoming that kind of assertive person. Health care providers, professional nurse, must be able and willing to speak up for personal, professional and welfare of their patients who are active participants in their own health care (Elshiny, Abd-Alla & Aly, 1995). Many authors and researchers have confirmed the efficacy of Assertiveness Training package in enhancing the social styles and / or social skills of different categories of people (Lazarus, 1971; Galassi et al(1981; Stefanek & Eisler, 1983; Lawrence, 1987; Akinade, 1987). Galassi, et al (1981) however cautioned that for assertiveness training as a behaviour change technique to be effective, the concept of assertion has to be critically looked at from either the anxiety inhibition model, skill deficit model or cognitive difference model which will guide the research and practice in order to identify factors controlling and maintaining assertion. The anxiety inhibition or response model emphasized that assertive behaviour are primarily the result of anxiety conditioned in social situations. To effect a change with patients or client who had assertion deficit, it was upheld that, there must be an inducement through behavioural rehearsal, i.e. to behave assertively in a succession of situations in which their tendency towards assertion was always more potent them the anxiety they experienced. If this relationship is to be maintained, the bond between the social stimuli, and the anxiety and non-assertiveness that they elicited will be weakened (reciprocally inhibited) and ultimately reconditioned (Wolpe, 1958). The principle of operant conditioning and modeling were also viewed as playing a role in Wolpe's theory but anxiety assumed the causal role in-non assertive behaviour because the presence of anxiety inhibited the expression of assertive behaviour. Mcfull and Marson (1970), proved that overt behavioural rehearsal was effective in increasing assertive behaviour among the college students. Eisler et al (1973, 1978), discovered that overt modeling practice was more effective in increasing assertive behaviour. While Gleuckauf and Quitner (1992), reported that group assertiveness helped wheelchair bound adults to handle the socially awkward situations in which they often find themselves. Kenku (1984) and Akinade (1987) reported that Assertiveness Training produced statistically significant improvement over hypertensiveness and the reduction of shyness among shy subjects over the control subjects.

It is thus observed that the success of any organization depends on highly qualified human resources, who must posses some behavioural characteristic such as good interpersonal skills, participatory abilities, sense of commitment, social competence, dedication and loyalty to the organization. All these qualities are expected of a professional nurse for him/her to carryout the professional functions.

The Assertiveness Training technique which has been adopted in this study is a cognitive behaviour modification approach designed to increase a person's competence in dealing with other human beings. Workers exposed to these packages will make use of identification personal rights, assertiveness training needs, and role plays in training sessions, transfer behaviour and evaluation of behaviour. The learner is encouraged to explore socially desirable behaviours by using assertiveness training within the hospital settings.

The present study was therefore designed to find out if Assertiveness Training therapeutic package would effect significant the improvement of interpersonal skills of high and low intelligence subjects as well as the experimental group and the control group. The research was to test these two null hypotheses.

1. There is no significant difference in the improvement of interpersonal skills of high and low intelligence

respondents treated with Assertiveness Training.

2. There is no significant difference in the imp0rovement of interpersonal skills of respondents exposed to Assertiveness Training on the one hand and the control on the other hand.

Methodology

Design: A 3 by 2 factorial design was sued for the study. The experimental groups and the control constituted the row and the intelligence levels varying at two levels (B1, Low intelligence) and (B2, high intelligence) formed the column.

Sample size determination: In determining the sampling size, Araoye (2004) formula was employed. It was assumed that the total population of Nurses that will attend MCPDP could not be up to 10,000 therefore, the population was assumed to be about 1000. If N (the entire population is less than 10,000, the require sample size would be calculated thus)

$$nf = \frac{n}{1 + \frac{(n)}{N}}$$

Where: - nf = the desired sample size when population is less than 10,000.
n = the desired sample size when the population is more than 10,000 =400
N = the estimate of the population size = 1000

$$nf = \frac{400}{1 + \frac{400}{1000}}$$

$$= \frac{400}{1.4}$$

$$= 286$$

The sample size was 286

Sampling Technique: Considering the number of nurses that attended the MCPDP, only one hundred and twenty (120) were selected randomly from the cluster that turned up for MCDP. The Nurses were from different parts of Osun State who have come for the mandatory continuing professional development program which is a must requirement before the renewal of the professional licenses.

Inclusion Criteria: - All nurses that have attended the MCPDP and would have used for years and above irrespective of age, sex, unit where working and the health institution where employed.

Exclusive Criteria: - All nurses that were not attending the MCPDP.

Instrumentation: Four (4) instruments were used in carrying out the research, these included:

i. Rathus Assertiveness invention: - A 30 items self report inventory which was developed by Rathus (1973) was used in order to determine the assertiveness levels of nurses. The reliability and validation were made by Rathus and Navid (1977), Vall and McCullagh in the United States of America and by Voltan (1980) and yielded reliability coefficient of 0.92 using Cronbach's alpha.

ii. Novotnil social check list: Is a Likert type of scale divided into seven (7) divisions as Social Play and Emotional development, intermediate play Behaviour, Advanced play Behaviour, Understanding Emotions, Self Regulation Flexibility, Problem Solving, Conversational Skills, Non-verbal Conversational skills and compliments. It consist of 50 items.

iii. T-A Behavioural Inventory (Akinboye, 1996) is a 28 item self completed instrument designed to determine the personality type (A,B,D,C). It has Correlation Coefficient of 0.72.

iv. Philip Center Intelligence Test is an IQ and Apptitude test consisting of 30 items.

Treatment Programmes: Assertiveness training therapeutic approach was employed to improve the interpersonal skills of the nurses. Active directive strategies were employed to enhance the acquisition of the skills. These included:

- setting of behavioural Objectives.
- giving systematic instructions on topic being considered.
- demonstrating or modeling aspects of interpersonal relationships.
- giving the participants opportunity to think and perform the observed knowledge which they have already rehearsed.
- giving participants appropriate contingent behavioural feedbacks that are not average.
- giving the participants behavioural home-work to be able to demonstrate the effectiveness of the interpersonal skills.

The treatment programme lasted for seven (7) weeks. The first week was deviled to the subjects selection, while the remaining weeks were deviled to treatment as well as post-test administration.

The session in brief entailed the following:

i. Pre-test administration
ii. General orientation to the programme.
iii. Providing factorial information to the participants in Assertiveness.
3. Consideration to all aspects of a situation- emotion, environmental considerations, verbal and non-verbal messages.
4. Develop basic skills of:
   4.1. Reality orientation by direct involvement and acceptance of responsibility in resolving conflict.
   4.2. Physical and emotional composure.
   4.3. Having positive expectations that generate positive responses.
   4.4. Active listening.
   4.5. Giving and receiving information
5. Respond constructively with eye contact
6. Focus on data and issue when offering construct criticism to the boss.
7. Ability to accept responsibility rather than blaming others.
8. Post test administration and formal closing of the programme of the programme.

The subjects in the control group were not given any treatment at all, they ere however subjected to both the pre-treatment and post-treatments. However, they continued to received lectures on the MCPDP (they were selected at another venue in Wesley Guild Hospital, Ilesha. The treatment groups were based in OAUTHC, Ile-Ife and the State School of Nursing, Asubiaro, Osogbo).

Control of Extraneous Variables

The subjects for the study were selected through simple randomization. The control group subjects were selected from the Wesley Guild Hospital, Ilesha while the Experimental group subjects were selected from OAUTHC, Ile-Ife and SONO, Asubiaro Hospital Compound, Osogbo. In the administration of the treatments packages, the researcher and the trained research assistants (2) ensured that the treatment conditions were only administered to the experimental group.

Method of Data Analysis

The research questions were analyzed using table and percentage while the hypotheses were tested using a two way fixed Analysis of covariance to determine the relative effectiveness and improvement of the independent variable on the dependent variable (enhanced interpersonal skills). The hypotheses were tested at the 0.05 level of significance with SPSS window version 17.

Results

Hypotheses 1 states that there is no significant difference in the improvement of interpersonal skills of high and low intelligence subjects treated with Assertiveness Training.

Table 1: Pre and Post Treatment Comparison of subjects exposed to Assertiveness Training using ANCOVA.

Table 2: post Treatment Comparison of subject exposed to Assertiveness Training only using ANOVA.

Considering table 1 and 2 the hypothesis was rejected as a significant difference was noticed on the improvement of interpersonal skills of both low and high intelligence respondents. This analysis indicated that the levels of intelligence and the treatment group seemed to have interactive effect. It thus revealed that subjects on high intelligence treated with Assertiveness Training improved better in their display of interpersonal skills than those subjects with low intelligence.

Table 3: table of X-means and Adjusted Y-means of Assertiveness Training of different levels of Intelligence.

Table 4: Pre and Post Treatment Comparison of subjects exposed to Assertiveness Training and control group using only ANCOVA.

Table 4 showed that there was a significant difference between the means of the treatment group (Assertiveness Training) when compared with the control group.

Table 5: - Post Treatment Comparison of subjects exposed to the Assertiveness Training and control using only ANOVA.

Table 6: "t" test comparisons between subjects treated in Assertiveness Training and the control.

Table 6 showed the test comparison of the two groups which indicated that there was a statistical significant difference, since the treatment group experienced a pronounced improvement in their interpersonal skills, the hypothesis was therefore rejected.

Table 7: X-means and adjusted Y means of Assertiveness Training of low and high intelligence

respondents and the control.

Hypotheses 2; states that there is no significant difference in the improvement of interpersonal skills of high and low intelligence respondents exposed to Assertiveness Training on one hand and the respondents in the control group on the other hand. The results on the table 4,5,6,7 revealed that there was significant difference in the treated subjects when compared with the control. The hypotheses was therefore rejected.

Discussion of Findings

The first null hypotheses which stated that there is no significant difference in the improvement of interpersonal skill on high and low intelligence subjects treated with Assertiveness Training was rejected. The findings revealed that there was differential improvement in the interpersonal skill scores between the low and high intelligence subjects statistical comparison using the adjusted X means and Y means showed that subjects from the high intelligence background exhibited better and enhanced improved interpersonal skills than those in the intelligence group. The comparative ability of the response of low and high intelligence subjects to the assertiveness training corroborates the submission of Akinboye (1999) who posited that employees in modern organization require lots of learning, thinking and practical day to day problem solving , planning, and interpersonal skills in order to be able to function effectively. This finding has thus shown that the classification of subjects into either low or high intelligence levels greatly affected their performances during and after the infrastructural processes. Gardner (1983, 1993), however cautioned us not to under-rate individuals whose scores were low or any analytical intelligence tests because intelligence comes in different packages He argued further that we do not have an intelligence namely, analytic, creative or practical intelligence. A nurse is expected to possess the three as their profession involves the problem solving approach, us of Nursing diagnosis and application of finger dexterity in carrying out procedures for patients.

Stenberg and Wagner (1995) also supported Gardner's (1993) ideas of multiple intelligence but distinguishes more simply among three intelligence – the academic intelligence or problem solving skills which are assessed by intelligence tests, the practical intelligence often required for everyday tasks and the creative intelligence, demonstrated in reacting to novel situations. With these classifications, it is therefore interesting to note that subjects who are in high level intelligence classification performed better and gained tremendously who/are in the low level category. Mayer (1996) in his own submission was at variance with the findings of this study when he asserted that managerial success depends less on academic abilities to manage oneself, one's task and other people. He opined that people who demonstrate practical intelligence may or may not have distinguished themselves in academic activities. It was obvious from the above that personal competence in everyday living requires much more than what traditional intelligence do measure. In other words, we must ensure that all the multiple intelligentsia in workers are properly tapped to bring the best out of them.

The second hypotheses which states that there is no significant different in the improvement of interpersonal skills of high and low intelligence subjects exposed to assertiveness training on one hand and the subjects in the control group on the other hand was rejected. Rejecting the hypothesis is consistent with the finding of Galassi, and Vedicer (1981), Hemberg and Becker (1981), Stefanek and Eiser (1983), Lawrence (1987), Akinade (1987); and Hamed (1999) whose researches led credence to the effectiveness of assertiveness training techniques inn enhancing and promoting interpersonal skills amongst their various subjects. The control group on the other hand did not manifest such improvement on their interpersonal skills because they had not learnt other ways of managing their lifes. It is obvious that they reflected the current state of their behaviour without much difference. If was possible that while the groups in assertiveness training were participating actively in the various eight sessions, the control group was dissipating their energy on various other things not related to interpersonal skills enhancement programme.

CONCLUSION

Promoting assertive behaviour aims to improve nurse/patient communication, and personal confidence. These are essential ingredients in a health care environment struggling with oppressive cultures and stereotypical roles that create unhealthy work practices. They are also essential behaviours for many nurse with poor interpersonal skills and lacking confidence.

Teaching assertiveness skill in of particular interest to nurses as those barriers impertinent to being confident an assertive would have been removed through constant training on relationship assertiveness methods in order to develop good interpersonal.

Implication of the Study for Nursing Practice

Assertiveness training will allow nurses to develop good interpersonal relationship skill through which communication skill will evolve without with managing conflicts in the ward situation may be difficult.

Interpersonal skill in one of the qualities of a good leader, since Nursing is a rallying profession in the health care team, making divisions delegating appropriately and acting with integrity as a leader will not be

difficult.

Interpersonal skill will afford nurses to engage in a rang of leadership activities in their daily routine. Some will naturally adopt an effective leadership style, while others may find the concept of leadership or seeing themselves as leaders difficult to understand, hence assertiveness training comes in. effective interpersonal skill will lead to effective leadership which in critical in delivering high quality care, ensuring patients safety and facilitating positive staff development.

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TABLE 1 – Pre and Post treatment comparison of subjects exposed to assertiveness Training using ANCOVA

Source	DF	SS	MS	F ration observed	Fration critical	P
Between group	7	40371.70	5767.39	116.14	2.03	<.05
Within group	152	7548.20	49.66			
Total	159	49919.90	5817.05			

TABLE 2. Post treatment camparison of subjects exposed to Assertiveness Training only design ANOVA.

Source	DF	SS	MS	F ration observed	Fration critical	P
Between group	3	25992.74	8664.25			
Within group	76	3804.25	50.06	173.08	2.72	<.05
Total	79	29796.99	8714.31			

TABLE 3. Table of X means and Adjusted Y means of Assertiveness Training of different levels of intelligence

Treatment programme	Low intelligence			High intelligence		
	N	X – X	Y- X	N	X-X	Y-X
Assertiveness training	20	73.4000	96.714	20	87.800	96.422

TABLE 4: Pre and post treatment comparison of subjects exposed to Assertiveness Training control group using ANCOVA.

Source	DF	SS	MS	F ration observed	Fration critical	P
Between group	15	75993.25	5066.22	103.411	1.67	<0.005
Within group	304	14892.85	48.99			
Total	319	90886.10	5115.21			

TABEL 5: Post Treatment comparison of subject exposed to the Assertiveness Training and control using ANOVA

Source	DF	SS	MS	F ration observed	Fration critical	P
Between group	7	52900.94	7557.25	163.37	2.05	<0.05
Within group	152	7032.75	46.27			
Total	159	59933.39	7603.55			

TABLE 6: T Test Comparisons Between Subjects Treated In Assertiveness Training And The Control Group

Treatment	Adjusted post test scores Y means	Set	DF	T value	P
Assertiveness Training	193.136	0.319	78	151	<0.05
Control	144.935	0.319			

TABLE 7: X means and adjusted Y means of Assertive Training of low and intelligence subjects and the control group.

Treatment	N	Pretest	Adjusted posted means series
Assertiveness Training	40	161.2	193.136
Control	40	136	144.935