IOSR Journal of Nursing and Health Science (IOSR-JNHS)
e-ISSN: 2320–1959.p- ISSN: 2320–1940 Volume 6, Issue 4 Ver. IV. (Jul. -Aug .2017), PP 24-30
www.iosrjournals.org

Effectiveness of Assertiveness Training on Assertiveness skills among Alcoholic Patients of selected De-addiction centers in Chennai

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Abstract: *In the present study, we evaluated the effectiveness of participation in assertiveness training programme upon the assertiveness skills of alcoholic patients. 60 alcoholic patients (30 in control group and 30 in experimental group) completed the Rathus Assertiveness Schedule. The alcoholic patients in the control group were allowed to participate in all alcoholism unit treatment and activities except those involving assertiveness training. Post test was done on the 15th day. Data were analyzed using descriptive and inferential statistics. Participants in the intervention group were associated with a statistically-significant increase in level of overall assertiveness skills between the pretest and post test data ($p<0.001$). The results also demonstrated that alcoholic patients over the age of 20 years are more likely to report a higher level of assertiveness skills in both the pre- and post-results. The assertiveness skills of alcoholic patients improved through participation in assertiveness training programme. Majority of alcoholic patients (93.33%) had a high level of satisfaction on training program.*

Keywords: *Alcoholic Patients, Assertiveness Skills, Assertiveness training, De-addiction centers*

Date of Submission: 24-07-2017 Date of acceptance: 05-08-2017

I. Introduction

Addiction is a disease that is unlike any other. While most diseases are physical, mental or emotional in nature, addiction and alcoholism affect every aspect of the afflicted individual's life, resulting in severe, life-altering consequences.[1]

Harmful use of alcohol is one of the world's leading risk factors for morbidity, disability and mortality. It is a component cause of more than 200 disease and injury conditions as described in the International Statistical Classification of Diseases and Related Health Problems (ICD) 10th Revision (WHO, 1992). Globally, alcohol consumption results in approximately 3.3 million deaths each year, and this number has already been adjusted to take into account the beneficial impact of low risk patterns of alcohol consumption on some diseases. Of all deaths worldwide, 5.9% are attributable to alcohol consumption; this is greater than, for example, the proportion of deaths from HIV/AIDS (2.8%), violence (0.9%) or tuberculosis (1.7%). Also, 5.1% of the global burden of disease and injury is attributable to alcohol, as measured in Disability Adjusted Life Years (DALYs).[2] The only incidence study on alcohol use in India has been reported by Mohan et al (2002) from Delhi. In the total cohort of 2,937 households, the annual incidence of nondependent alcohol use and dependent alcohol use among men was found to be 3 and 2 per 1000 persons. The incidence of alcohol use was significantly higher among men, in the age group of 41–50 years, among those with lower levels of education and who were self-employed. The consumption of alcohol was also in direct relation to the consumption of tobacco in both phases of the study.[3] The use of alcohol has increased phenomenally in India during the last two decades. It has permeated all sections of society. Alcohol consumption is not just detrimental to health, but is also associated with impoverishment and adverse socio-economic impact. Despite the recognition of the range of problems associated with alcohol, efforts to prevent and address alcohol problems in India have to date been adhoc, patchy and fragmented.[4] Forms of behavior therapy in the treatment of alcoholism were reported as early as 1928. One of the most recent trends in behavior therapy with alcoholics is assertiveness training. Specifically, this involves teaching interpersonal, emotional and cognitive skills that can serve as alternatives to abusive drinking. A basic assumption underlying this treatment approach is that alcoholics have a limited repertoire of non drinking skills required to cope with specific social, emotional and cognitive precipitants of heavy drinking. For example, the alcoholic may drink excessively when confronted with marital or interpersonal problems. He is deficient in other, more appropriate, responses to these situations such as assertiveness or problem solving skills. Indeed assertiveness deficits appear to be a major factor in drinking alcoholics.[5]

It is this modality of treatment which is the subject of the present research. The therapeutic objective of assertive training with alcoholics is to provide clients with direct training in precisely those interpersonal and social skills deficient. Very little attention is given to eliminating existing maladaptive behaviour; instead, it is assumed that as skilful, adaptive responses are acquired, rehearsed and reinforced, the previous maladaptive responses will be displaced and will disappear. As positive rewarding behaviours are practiced and developed, they will compete with and eventually replace alcoholic avoidance and escape.

The literature indicates that alcoholic patients experience problems related to being non-assertive. However within the Indian context, research has not focused on assertiveness and formulation of specific strategies in order to deal with the non-assertive behavior of alcoholic patients. Thus there is a need to develop a comprehensive program to train the alcoholic patients in assertiveness and related skills. Hence, the present study is an attempt to fulfill these goals by developing an all-inclusive assertiveness training program and judging its usefulness among alcoholic patients.

II. Methods

2.1 Design

A quasi experimental design was used in this study. Two settings (Freedom Care Foundation and Wisdom Hospitals, Chennai) were chosen for the study. These settings were randomly assigned to the control and experimental group.

2.2 Intervention

It is a planned one hour interventional program for a period of ten days by using pre-designed module. The researcher utilised all the components of assertiveness training such as modelling, coaching, role playing, instructions, behaviour rehearsal, feedback and graded-structured exercises. Techniques like fogging, broken–record and negative assertion were employed. Activities like practice sessions with detailed exercises, worksheets, video shows, games and innovative methods with lecture cum discussion using power point presentation were held. It mainly focused on assertiveness skills and the core factors of assertiveness. The program was conducted mainly in the mornings between 11 am to 12 pm.

The intervention was designed to help the alcoholic patients handle difficult interpersonal situations by asserting themselves and letting others know what they want through turning down a request, asking a favour, expressing disapproval and giving someone a compliment. Hence it emphasized both on the task of becoming more self-expressive and retaining good relationships with those around the patient. It also helped to break old, unhealthy patterns of communication and replace them with more powerful and effective ways of thinking, feeling, behaving and relating to others.

Each patient was asked to discuss situations in his or her own life which were proving problematic. Much of the focus of this group was to develop skills in precisely those aspects of unassertiveness in which the client was having difficulty. The alcoholic patients were given a theoretical rationale for their treatment and they were strongly encouraged to begin behaving assertively. Ice breaking sessions was also conducted between the sessions to prevent monotony of the program.

2.3 Instrument

Data for this study were collected through completion of a demographic variable proforma, clinical variable proforma, level of satisfaction scale and Rathus Assertiveness Schedule. This scale was developed by Rathus and Nevid. This is a standardised tool consisting of thirty (30) items self report test on assertiveness. It has been shown to be valid with both normal and psychiatric populations. This scale may be used to estimate or assess whether or not the assertiveness training program has lead to a gain in the individual's assertive behavior. The individual is asked to place himself in the particular situation each item describes, think how descriptive is it of him and mark the degree of response on a six point scale. The scale is a 6 point Likert rating scale to measure the level of assertiveness. It consists of positive and negative items. Scoring was based on the responses of the participants. Scores of the individual items are summed and total scores are obtained. Scores for each item ranged from -3 to +3. The obtainable score ranges from -90 to +90. Higher the score, better the assertiveness skills.

2.4 Sample

By purposive sampling technique, a sample of 60 alcoholic patients who met the inclusion criteria were selected (30 patients in control group were from Freedom care foundation and 30 patients in experimental group from Wisdom hospitals, Chennai).

2.5 Data collection

After initial introduction, the researcher obtained informed consent from the alcoholic patients to participate in the study. Questionnaires were administered to all the inpatients. The alcoholic patients in the experimental group received, in addition to the treatment program, ten hours of assertiveness training over a period of two weeks. The data collection was done as one hour session per day. The alcoholic patients in the control group were allowed to participate in all alcoholism unit treatment and activities except those involving assertiveness training. On the 15th day, the scores for assertiveness skills were reassessed both in the control and experimental group. Then level of satisfaction regarding administration of assertiveness training was assessed using rating scale for level of satisfaction in the experimental group. Assertiveness training was given to the alcoholic patients in the control group after termination of the study.

2.6 Data analysis

Analysis and interpretation of data were carried out with descriptive statistics such as frequency, percentage, mean and standard deviation and inferential statistics such as independent't' test and chi-square test.

III. Results

Table (1): Frequency and Percentage Distribution of Demographic Variables in the Control and Experimental Group of Alcoholic Patients **(N=60)**

Demographic Variables	Control Group (n=30)		Experimental Group (n=30)	
	n	p	n	p
Age (in years)				
≤ 20	3	10	5	16.67
20-40	17	56.67	20	66.66
> 41	10	33.33	5	16.67
Mean age in years	**36.97**		**37.4**	
Educational status				
Non literate	-	-	-	-
Primary education	2	6.67	7	23.33
Secondary education	5	16.67	5	16.67
Higher secondary	9	30	7	23.33
Graduate and above	14	46.67	11	36.67
Occupational status				
Unemployed	4	13.33	1	3.33
Student	0	0	1	3.33
Business	6	20	9	30
Laborers	8	26.67	13	43.33
Employed in some organization	7	23.33	1	3.33
Retired	5	16.67	5	16.67
Marital status				
Unmarried	16	53.13	4	13.33
Married	13	43.33	20	66.67
Separated	0	0	2	6.67
Divorce	1	3.33	2	6.67
Widow/widower	0	0	2	6.67
Monthly family income				
≤ ₹20,000	22	73.34	25	80
> ₹20,001	8	26.66	5	16.67
Average monthly family income	**₹ 20,823**		**₹ 14, 077**	
Family history of alcohol abuse/ dependence				
Yes	19	63.33	20	66.67
No	11	36.67	10	33.33

Table 1depicts that, a significant percentage of the alcoholic patients were aged 20-40 years (56.67%, 66.66%), were graduates and above. Less than half of them were laborers (26.67%, 43.33%). Nearly half of them were married (43.33%, 66.67%), had two children (46.15%, 43.75%) and belonged to joint family (43.33%, 50%). Majority of the samples earned a monthly family income of ≤ ₹20,000 (73.34%, 80%), followed Hinduism (70%, 86.67%) and had a family history of alcohol abuse/ dependence (63.33%, 66.67%) in the control and experimental group respectively.

Table (2): Frequency and Percentage Distribution of Selected Clinical Variables in the Control and Experimental Group of Alcoholic Patients **(N=60)**

Clinical variables	Control Group (n=30)		Experimental Group (n=30)	
	n	p	n	p
Age at which the alcohol consumption was started (in years)				
≤ 25	24	80	24	80
>26	6	20	6	20
Mean age of onset (in years)	**21.2**		**21.17**	
Duration of alcohol dependence (in years)				
≤ 20	24	80	20	66.67
>21	6	20	10	33.33
Average duration of alcohol dependence (in years)	**16.63**		**14.47**	
Amount of alcohol consumed per day (in ml)				
≤ 500	19	63.33	25	83.33
>501	11	36.67	5	36.67
Average amount of alcohol consumed per day	**400**		**438**	
History of associated complications				
Heart disease	-	-	5	16.67
Diabetes	1	3.33	2	6.67
Lung disease	2	6.67	1	3.33
Peripheral neuropathy	3	10	-	-
Liver disease	3	10	3	10
Cancers	9	30	5	16.67
Birth defects	4	13.33	-	-
Depression	8	26.67	12	40
Others	-	-	1	33.33
Hypertension	-	-	1	100
History of abstinence				
Yes	28	100	23	100
No	-	-	-	-
History of psychiatric hospitalization				
Yes	10	33.33	7	23.33
No	20	66.67	23	76.67
The reason for psychiatric hospitalization				
Depression	3	30	4	57.14
Fear	1	10	1	14.29
Conflicts in relationships	1	10	2	28.57
Difficulty in concentration	2	20	-	-
Epileptic psychosis	1	10	-	-
Insomnia	2	20	-	-

It can be inferred from table 2 that, most of the alcoholic patients in the control and experimental group started consuming alcohol at the age of ≤ 25 years (80%, 80%), with the duration of ≤ 15 years (80%, 66.67%). A significant percentage of them consumed an amount of ≤ 500 ml per day (63.33%, 83.33%), developed complications like depression (26.67%, 40%). All of them had a history of abstinence (100%, 100%) at least once for a brief period. Less than half of them had a history of psychiatric hospitalization (33.33%, 23.33%) and stated depression as the reason for psychiatric hospitalization (30%, 57.14%) in the control and experimental group respectively. Fig.(1) illustrates that, majority of the alcoholic patients predominantly used tobacco smoking along with alcohol (76.67%, 76.67%) in the control and experimental group respectively.

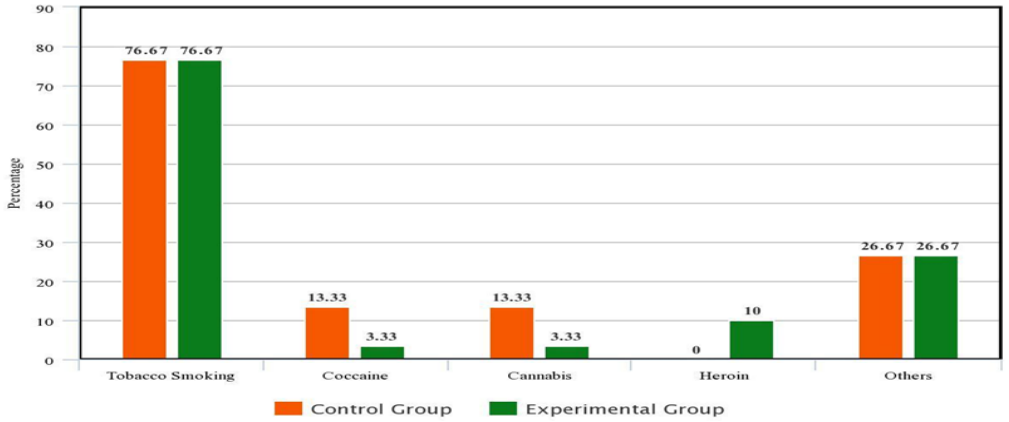

Figure 1: Percentage Distribution of History of Usage of Other Addictive Agents in the Control and Experimental Group of Alcoholic Patients

Table (3): Frequency and Percentage Distribution of Level of Assertiveness Skills in the Control and Experimental Group of Alcoholic Patients Before and After AST **(N=60)**

Variables	Control Group (n=30)				Experimental Group (n=30)			
	Before AST		After AST		Before AST		After AST	
	n	p	n	p	n	p	n	p
Assertiveness skills								
Non-assertive	29	96.7	29	96.7	28	93.3	11	36.7
Assertive	1	3.3	1	3.3	2	6.7	19	63.3

AST- Assertiveness training

It can be inferred from table 3 that majority of the alcoholic patients in the control group were non-assertive before and after (96.7%, 96.7%) AST. Conversely, majority of the alcoholic patients in the experimental group, were non-assertive before AST (93.3%). However, after the administration of AST, most of them became assertive (63.3%). This can be ascribed to the effectiveness of AST.

Table (4): Domain Wise Frequency and Percentage Distribution of Level of Satisfaction Scores of Assertiveness Training in the Experimental Group of Alcoholic Patients **(N=60)**

Domain	Experimental group (n=30)							
	Highly satisfied		Satisfied		Dissatisfied		Highly dissatisfied	
	n	p	n	p	n	p	n	p
Overall satisfaction	28	93.33	2	6.67	-	-	-	-
Related to the researcher	4	13.33	17	56.67	9	30	-	-
Related to assertiveness training	28	93.33	2	6.67	-	-	-	-

Table 4 shows that majority of the alcoholic patients (93.33%) were highly satisfied with all the aspects of assertiveness training.

Table (5): Comparison of Mean and Standard Deviation of Assertiveness Skills Scores Before AST between Control and Experimental Group of Alcoholic Patients and After AST between Control and Experimental Group of Alcoholic Patients **(N=60)**

Groups	n	Before AST			After AST		
		Mean	S.D.	't' value	Mean	S.D.	't' value
Assertiveness Skill							
Global score							
Control group	30	-2.47	12.78	0.26^{NS}	-2.60	13.34	**9.16*** **
Experimental group	30	-3.30	12.25		24.83	9.56	
Interpersonal communication							
Control group	30	-4.27	6.02	0.66^{NS}	-4.40	5.98	**5.52*** **
Experimental group	30	-5.30	6.17		4.40	6.36	
Self-concept							
Control group	30	-2.53	7.28	0.44^{NS}	-1.37	7.61	**5.34*** **
Experimental group	30	-1.73	6.77		8.10	6.05	
Public speaking							
Control group	30	3.27	7.14	$0..27^{NS}$	3.17	7.20	**5.7*** **
Experimental group	30	3.73	6.04		12.33	4.92	

^{NS} - Not significant; ***p< 0.001

The data presented in table 5 revealed that the mean and standard deviation for scores of assertiveness skills (M=-2.47, SD=12.78), (M=-3.30, SD=12.25) among alcoholic patients before AST in the control and experimental group was not significant at p>0.05. On the other hand, after the administration of AST, the mean and standard deviation of assertiveness skills (M=2.60, SD=13.34) of control group were less in comparison with the assertiveness skills (M=24.83, SD=9.56) scores of experimental group. The difference was found to be statistically significant at p<0.001 level of confidence and it can be accredited to the effectiveness of AST.

The table also shows that the mean and standard deviation scores for dimensions interpersonal communication (M=-4.27, SD=6.02), (M=-5.30, SD=6.17), self-concept (M=-2.53, SD=7.28), (M=-1.73, SD=6.77), public speaking (M=3.27, SD=7.14), (M=3.73, SD=6.04) before AST for control and experimental group was not significant at p>0.05. However after the administration of AST the mean and standard deviation scores for dimensions interpersonal communication (M=-4.40, SD=5.98), (M=4.40, SD=6.36), self-concept (M=-1.37, SD=7.61), (M=8.01, SD=6.05), public speaking (M=3.17, SD=7.20), (M=12.33, SD=4.92) in the experimental group was significant at p<0.001 level of confidence. It can thus be inferred that the AST was effective.

Association between the Selected Demographic Variables and the Level of Assertiveness Skills in the Control and Experimental Group of Alcoholic Patients Before and After AST

Chi square test was used to find out the association between selected demographic and level of assertiveness skills. It was found that there was a significant association between age of the alcoholic patients (χ^2=4.85, df=1) at p<0.05 and the level of assertiveness skills. However there is no significant association between other demographic variables and the level of assertiveness skills (p > 0.05).

Association between the Selected Clinical Variables and the Level of Assertiveness Skills in the Control and Experimental Group of Alcoholic Patients Before and After AST

There was no significant association between selected clinical variables and the level of assertiveness skills (p > 0.05).

IV. Discussion

The purpose of the study was to evaluate the effectiveness of Assertiveness Training upon the assertiveness skills of alcoholic patients. Majority of the alcoholic patients in the control group were non-assertive before and after (96.67%, 96.67%) AST respectively. In the experimental group, most of the alcoholic patients were non-assertive before AST (93.3%). However, after the administration of AST, most of them were assertive (63.3%) in the experimental group of alcoholic patients respectively.

Patock-Peckham, Cheong, Balhorn & Nagoshi in 2006, compared alcoholic and non-alcoholic psychiatric patients on self-reported assertiveness and behavioral assertiveness. Here, the relationship between the assertiveness of alcoholics and their alcohol drinking behavior was assessed. Results indicated that, while alcoholics reported themselves to be more assertive than non-alcoholic's, both groups were equally non-assertive on behavioral tests measuring negative assertion which is expression of anger or irritation.[6]

In the present study it was observed that the mean post test assertiveness skills score in the control group (2.60±13.34) was significantly lower than the mean post test score of the experimental group (24.83±9.56) which was significant at p<0.001 level. These findings are in line with a study conducted by Ferrell. W. L. & Galassi. J. P., (1981) who compared the effects of milieu therapy plus assertion training to milieu therapy plus human relations training in reducing drinking behavior and increasing interpersonal skills, of skill-deficient, chronic alcoholics in an alcoholic rehabilitation centre. Although both treatments led to comparable sobriety rates at a 6-week follow-up, the treatment group which contained assertion training demonstrated significant gains in interpersonal skills as compared to the treatment group which contained human relations training. A two year sobriety was achieved which was significantly longer than the human relations training group.

Chi- square test was done to find the association between selected demographic variables and the level of assertiveness skills. There was significant association between age and the level of assertiveness skills. The study finding indicated that as age increases assertiveness skills also increases. With increasing age, the individual learns interpersonal skills which in turn increases his/her feelings of confidence in interpersonal situations. The individual may feel more in control of their lives. With the feelings of self-efficacy the individual responds assertively in interaction with others. Older individuals may exhibit assertive behaviour as a result of coping with major social changes of life. This finding is consistent with a study conducted on five pivotal personality traits on pairs of twins: empathy, nurturance, aggressiveness, assertiveness and, of course, altruism. The author administered tests designed for evaluating each trait and scored them. Results of the study showed that all of the "positive" traits (empathy, nurturance, altruism, and assertiveness) increased with age, whereas aggressiveness decreased with age (Rushton et al., 1986).[8] It was found that there was no significant association between the selected clinical variables and the level of assertiveness skills in the control and experimental group of alcoholic patients.

V. Conclusion

The alcoholic patients felt and expressed that the training program provided was relevant and useful to their routine interactions and they were confident to apply these skills in day to day activities. Moreover, the participants were satisfied as their goals and expectations were met during the training program. It is worth noting that subjects felt the need to conduct such programs for all alcoholic patients. Thus the present assertiveness training program was found to be effective not only from a statistical point of view but also from the feed back and evaluation provided by the participants. Nurses can also use the exercises from the current study to help patients find more assertive and empowered ways to react and be proactive.

However the study findings could not be generalized due to small sample size. Random sampling was not possible due to practical difficulties. True experimental research could not be conducted as there are chances of contamination effects. There is a need for extensive research in this area. Assertiveness training which is a behavioural therapy intervention can be effectively utilised to help alcoholic clients achieve a greater degree of self-esteem and emotional freedom.

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Jyothi S.Sunandha. "Effectiveness of Assertiveness Training on Assertiveness skills among Alcoholic Patients of selected De-addiction centers in Chennai ." IOSR Journal of Nursing and Health Science (IOSR-JNHS) 6.4 (2017): 24-30.