

Assertiveness and caring: are they compatible?

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Background. Findings from numerous assertion studies suggest that nurses are generally non-assertive. This study examines the role of caring as an important determinant of adaptive assertive behaviour.

Aim and objectives. The aim of the investigation was to explore the relationship between assertion and caring skills. Two study objectives sought to determine whether both positive and negative assertive behaviours were related to caring skills.

Design. Correlational and cross-sectional study.

Method. The Caring Assessment Instrument (Care Q – Questionnaire Version) and the assertion inventory were used to collect self-report data from a convenience sample of 94 subjects. Behavioural data were obtained by directly sampling 50 nurses' responses within role-play situations.

Results. One significant result between the various assertion measurements and caring skill scores was noted, highlighting a relationship between negative assertion and the caring 'accessible' subscale.

Conclusion. Overall the findings of the study suggest that positive and negative assertive behaviours are not related to caring skills.

Relevance to clinical practice. The current findings suggest that the presence of caring attributes cannot be offered as a possible reason for non-assertion in nurses.

Key words: assertion, Care Q, caring, negative assertion, non-assertion, positive assertion

Introduction

The contribution of assertiveness to communication competence is now widely recognized (Hargie & Dickson, 2004). Yet, findings from numerous assertion studies suggest that nurses are generally non-assertive (e.g. Burnard, 1991; Porocho & McIntosh, 1995; Hernandez Gonzalez *et al.*, 1997; Jaime *et al.*, 1998; Holbrook & Freeman Adams, 1999; Martín *et al.*, 2000). Because assertiveness is viewed as a valued behaviour within nursing, resulting in positive outcomes such as the enhancement of leadership skills (Milstead, 1996), an increase in job satisfaction (Creech & Boyle, 1985), an avoidance of compromising patient care

(Porocho & McIntosh, 1995), alleviation of job stress (Bower, 1999), the heightening of nurses' effectiveness in bringing about change (Benton, 1999), and a greater insight into the factors that influence the responding style is necessary. While previous studies have focused on the assessment of assertiveness and the effectiveness of assertiveness training programmes, few studies have attempted to determine the possible reasons for non-assertion within the nursing profession. This study examines the role of caring as an important determinant of adaptive negative and positive assertive behaviours.

Positive assertion entails *other-centred* caring type behaviours such as expressing positive feelings, initiating and

maintaining interactions, giving and receiving compliments, and conveying empathy (Schroeder *et al.*, 1983; Lefevre & West, 1984). As many of these behaviours are perceived as 'caring' type responses their acquisition and promotion may also be considered important to, and valued in, nursing. In contrast to positive assertion, standard (conflict) negative assertive responses are often viewed as more *self-centred skills* and perceived as less likeable, less desirable and sometimes even less competent (e.g. Kern *et al.*, 1985; Wildman & Clementz, 1986; Cook & St. Lawrence, 1990; Rakos, 1997). Such behaviours may be perceived as 'uncaring' and considered to be undesirable attributes in nursing. The relationship between positive and negative assertion and caring skills is therefore of considerable interest. In situations where assertion measurements examine constructs similar to those within caring (e.g. initiating and maintaining interactions, conveying empathy) or conversely, negatively related to caring type behaviours (e.g. conflict assertive behaviours), the predictive utility of assertion instruments in recruitment may prove useful. The two objectives of the study were to:

- 1 determine whether positive assertion is related to caring skills;
- 2 determine whether negative assertion is related to caring skills.

Method

Ethical considerations

When seeking approval, particular consideration was given to gaining subjects' consent and ensuring confidentiality throughout the data collection phase. The investigation was approved by both The National Board for Nursing, Midwifery and Health Visiting for Northern Ireland and Queen's University Belfast's Research Ethical Committee.

Subjects

Subjects were recruited from a large School of Nursing and Midwifery from within a University in Northern Ireland. They were all trained nurses undertaking part-time programmes leading to either an Advanced Diploma or a BSc (Hons) Degree. Several factors were taken into consideration when determining the size of the sample, namely the homogeneity of the target population in terms of background and gender, and the practicalities of the data collection exercise. Convenience sampling was used initially to select a pool of female subjects ($n = 94$) for the main psychometric part of the study. From this pool 50 were then randomly

selected to participate further in behavioural tests. Recognizing the potential weaknesses of 'convenience sampling' (Polit *et al.*, 2000) steps were taken to enhance the representativeness of the initial sample of 94. Potential sources of variation including the culture, experience and gender of subjects were taken into consideration when deciding the final eligibility criteria.

Measurements

A systematic review of the literature was undertaken to identify suitable assertive and caring instruments (see McCartan, 2001). Measurements from both the verbal/cognitive modality and the motoric modality were used in the collection of data. In relation to the former, two different types of self-report instruments were employed, namely the Assertion Inventory (AI) (Gambrill & Richey, 1975) and the Caring Assessment Instrument – Questionnaire Version (von Essen & Sjoden, 1991). With regard to the motoric modality, data were obtained by directly sampling the subjects' responses through behavioural observations from role-play interactions.

The AI was used because of its unique ability to elicit two different types of information from each situation, namely (i) the degree of discomfort a subject experiences in specific situations, and (ii) the judged probability of the subject engaging in a behaviour. By using the average discomfort and response probability scores as cut-off points, different interpersonal assertion profiles can be identified. The AI was also chosen because it contains a relatively large proportion of positive as well as conflict (negative) social situations. By analysing the discomfort scores for both the positive and negative response classes it is possible to identify areas where respondents have the least or greatest difficulty. The psychometric support for the AI comes from several sources. Initial testing by Gambrill and Richey (1975) yielded high test-retest reliability with 0.87 for discomfort and 0.81 for response probability. They also claimed a degree of validity for the discomfort dimension, when scores discriminated an unassertive group of students from students enrolled in social science classes. In two other studies Rock (1977) reported significant correlations with two other assertion measures, and Pitcher and Meikle (1980) noted that the AI correlated significantly with the self-statements reported in negative assertive situations.

The caring assessment instrument (Care Q) – questionnaire version was used to measure the subjects' caring skills. von Essen and Sjoden's (1991) questionnaire version of the caring assessment instrument (Care Q) emerged as a methodological extension of Larson's (1981) initial study. Using the same

50 behavioural items and subscales of caring (see Table 1) both approaches differ only in the method used to collect the data. Larson's original caring assessment instrument uses Q-methodology as a means of scoring. Q-methodology entails a specific method of scaling which forces the subject to sort statements into a number of different categories according to a particular bipolar dimension. The subject is required to sort cards, each containing a statement item, into categories that range from 'most important' to 'least important'. Keane McDermot *et al.* (1987) however questioned the overall reliability of instruments based on Q-methodology. They concluded that by using Q-methodology, subjects were forced to make decisions which could be misinterpreted. Subjects, for example, may consider all items as important but are forced to categorize some items as less important. Such items may even be interpreted during analysis as being unimportant. von Essen and Sjoden (1991) agreed with Keane McDermot *et al.* and pointed out that the subject is required to rate the caring assessment instrument items so that 80% of them receive values of 3, 4 or 5. This they suggest 'results in very low variance which invariably leads to low inter-item correlations and complicates the computation of internal consistency values' (p. 270). In an effort to overcome the anomaly von Essen and Sjoden (1991) designed a questionnaire version of the Care Q, using the same 50 behavioural items. Rather than sorting cards into different categories, subjects were requested to assign scores to each item and were free to allocate anything from 1 to 7 points to all items. In a comparative study using both approaches von Essen and Sjoden (1991) found no discernible difference between results obtained from the original Care Q method and the questionnaire format. It was noted, however, that the questionnaire approach afforded the subjects more freedom when scoring, resulting in nurses scoring 30 items higher than the Care Q approach. In addition, the questionnaire was found to be easier to administer and both quicker and simpler to complete.

Psychometric support for the questionnaire version of the caring assessment instrument was provided by von Essen and Sjoden (1991) who found that a majority of items were given

very high values, denoting content validity. In addition they also produced evidence of acceptable reliability with an overall Cronbach's alpha of 0.95, and subscale values of 0.59 (explains and facilitates); 0.86 (comforts); 0.86 (trusting relationship); 0.72 (anticipates); 0.79 (monitors and follows through), and 0.76 (accessible).

Behavioural data were obtained by directly sampling the subjects' responses through observations from role-play interactions. This entailed the use of stimulus materials. The stimulus materials consisted of prerecorded audiotaped situations, developed using a standardized production format. Each tape contained a narrator's description of a given situation followed by a model delivering a prompt designed to elicit a particular response (i.e. non-assertion, empathic assertion, standard negative assertion, positive assertion, assertion with obligations). Audiotaped models as opposed to 'live' models were used in order to ensure greater control and because they were less anxiety provoking for the subject (Galassi & Galassi, 1977; Hersen *et al.*, 1978). In an effort to ensure consistency the same narrator was used throughout all behavioural tests. Each situation, introduced by a narrated description, offered the background and context to the ensuing interaction. As suggested by Ammerman and Hersen (1986), the situational descriptions were designed to be sufficiently specific and detailed in order to enable subjects to define the situations more adequately. The models delivered five different prompts in total, each designed to elicit a specific response. Subjects were required to reply out loud to each situation, and their responses were videotaped. They were afforded whatever time they needed to respond.

Data collection

Administration of self-report measures

Both self-report measurements were placed within a booklet and administered to the 94 subjects at the same time. Throughout data collection, procedures were put in place to ensure anonymity. By using randomly allocated identification numbers, subjects were able to obtain feedback on their scores and the authors were able to use the data for comparative purposes without the subject being identified.

Administration of behavioural test

While it was possible to ensure total anonymity during the administration of the self-report measurements, anonymity during the behavioural tests was not possible. In order to ensure strict confidentiality, subjects were reassured that only the researcher would have access to the behavioural

Table 1 The 50 behavioural items and subscales of the caring assessment instrument

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1. Accessible (six behavioural items)
 2. Explains and facilitates (six behavioural items)
 3. Comforts (nine behavioural items)
 4. Anticipates (five behavioural items)
 5. Trusting relationship (16 behavioural items)
 6. Monitors and follows through (eight behavioural items)
-

test data. In designing the behavioural test, several steps were taken to minimize possible reactivity when employing video recordings. One week prior to the test the format was explained to subjects and informed consent obtained. Because assertive responses may vary across settings containing different stimuli, care was taken to ensure that all behavioural tests were conducted within a similar environment (i.e. the setting was the same for everyone). In an attempt to minimize possible reactivity further, the camera was positioned unobtrusively and appropriately focused before role-plays, and furniture was kept to a minimum. The recording procedures were identical for all subjects. Apart from the subject, only one other person (i.e. the researcher) was present during the behavioural test. To fulfil this role, cognisance was given to the need for consistency across all subjects and the importance of not introducing ‘potentially contaminating variables’ that might affect the overall control of the testing. To ensure standardization a procedural checklist was employed.

Determination of the type of responses

Five lecturers with considerable experience in communication skills training participated as judges within the study. In order to ensure the reliability of their ratings judges participated in a training session similar to that advocated by Bellack (1983). Following this training and prior to the behavioural tests, the judges tested the predetermined behavioural checklists to ensure that the role-play descriptors and prompts were appropriately designed to elicit a specific response. The same checklists were then employed to categorize subjects’ responses into different types of functional behaviours (i.e. non-assertion, standard assertion, positive assertion, etc.).

Determination of interpersonal qualities of subject

Judges, using a predetermined Semantic Differential Scale, viewed videotaped responses to rate the interpersonal qualities of subjects (i.e. likeability, sympathy, consideration, respect and competence). All judges were required to sign confidentiality forms to ensure that information observed during behavioural tests would remain confidential.

Results

The chi-square test of independence was employed to test the hypotheses derived to investigate the objectives of the study. From a review of relevant literature it was decided that two-tailed tests would be used as the direction of the relationship could not be predicted.

Objective 1 – to determine whether positive assertion is related to caring skills

Hypotheses

Two main hypotheses were formulated to test this objective, namely that:

- H1 – a positive and significant relationship will exist between positive assertion (self-reported) and caring skills;
- H2 – a positive and significant relationship will exist between positive assertion (behavioural test) and caring skills.

Table 2 summarizes the chi-square values obtained when testing for the significance of the relationship between self-report and behavioural test positive assertion and caring skills. From the chi-square values obtained all comparisons were found to be non-significant at the 0.05 level of probability. It is concluded therefore that there are no significant relationships between positive assertion measurements (self report and behavioural test) and the caring assessment instrument scores. H1 and H2 are therefore rejected.

Objective 2 – to determine whether standard negative assertion is related to caring skills

Hypotheses

Two main hypotheses were formulated to test this second objective, namely that:

- H3 – a positive and significant relationship will exist between negative assertion (self-reported) and caring skills;
- H4 – a positive and significant relationship will exist between negative assertion (behavioural test) and caring skills.

The chi-square values obtained for the testing of objective no. 2 are presented in Table 3. These values indicate the degree of association between self-reported and behavioural

Table 2 Relationship between positive assertion ratings and caring skills ratings (using the chi-square test of independence)

Description	Positive assertion (χ^2)	
	Self-report	Behavioural test
Accessible (caring skills)	3.296	0.129
Explains and facilitates (caring skills)	3.729	3.324
Comforts (caring skills)	6.739	3.719
Anticipates (caring skills)	1.725	2.652
Trusting relationship (caring skills)	2.471	0.140
Monitors and follows through (caring skills)	1.779	0.092

*P < 0.05; **P < 0.01; ***P < 0.001; ****P < 0.0001.

Table 3 Relationship between standard (negative) assertion ratings and caring skills ratings (using the chi-square test of independence)

Description	Standard (negative) assertion (χ^2)	
	Self-report	Behavioural test
Accessible (caring skills)	5.022	10.045*
Explains and facilitates (caring skills)	2.804	2.988
Comforts (caring skills)	2.419	5.371
Anticipates (caring skills)	1.177	1.312
Trusting relationship (caring skills)	6.264	2.096
Monitors and follows through (caring skills)	2.419	2.270

* $P < 0.05$; ** $P < 0.01$; *** $P < 0.001$; **** $P < 0.0001$.

test ratings of standard (negative) assertion and the ratings of caring skills. No significant relationship was found between negative assertion (self-reported) and caring skills and so H3 is rejected. A significant relationship ($P < 0.05$) was found between the negative assertion (behavioural test) and accessible caring skills, and so H3 is accepted.

The chi-square value obtained (10.045) when d.f. = 4, is significant at the 0.05 level of probability. It is concluded that there is a significant relationship between the negative assertion behavioural test and accessible – caring skills. A descriptive insight into the nature of the relationship was obtained by examining the components contributing to the overall value of χ^2 . Analysis of contingency Table 4 highlights the three cell values that disproportionately make up the high χ^2 value:

- More standard negative assertive subjects scored ‘accessible’ caring skills as being of medium importance than would normally be expected.
- Fewer scored ‘accessible’ caring skills as being most important than would normally be expected.

Table 4 Standard negative assertion behavioural test and accessible – caring skills. Values of individual cells

Cell	Observed frequency	Expected frequency	Contribution to overall χ^2 value
Assertion with obligations (accessible no. 1)	9	5.8	1.8225*
Assertion with obligations (accessible no. 2)	3	5.4	1.0666
Assertion with obligations (accessible no. 3)	6	6.8	0.1031
Non-assertion (accessible no. 1)	5	5.1	0.0028
Non-assertion (accessible no. 2)	3	4.8	0.675
Non-assertion (accessible no. 3)	8	6.1	0.6063
Standard negative assertion (accessible no. 1)	2	5.1	1.9012*
Standard negative assertion (accessible no. 2)	9	4.8	3.675*
Standard negative assertion (accessible no. 3)	5	6.1	0.9184
Overall χ^2 value			10.045

*Disproportionate value

- Within the ‘assertion with obligations’ cells, more subjects scored accessible as being the most important than would normally be expected.

With regard to the other comparisons relating to the second study objective the chi-square values obtained demonstrated no significant relationships between negative assertion measurements (self report and behavioural test) and the caring assessment instrument subscale scores.

Discussion

One significant relationship emerged from the findings of this investigation into assertive and caring skills in nurses, namely that there was a positive relationship between the negative assertion behavioural test and accessible – caring skills. The remaining tests failed to reach significance at the 0.05 level. However, a number of important issues are apparent from these findings.

No previous studies have attempted to investigate whether assertion skills are associated with caring skills. Although there appears to be an outward relationship, this surprisingly is not evident from both the self-report and behavioural test findings. Absences of significant results in all 12 tests indicate no relationship between assertion skills and caring skills. The findings suggest that the responding styles (i.e. positive assertion responses and caring response categories) are not related either in the degree or in the kind of skills employed. Where skills differ in terms of ‘degree’ the responses may be dissimilar in intensity only. This implies that the same skills are employed but they differ in the way that they are used. Conversely, differences in ‘kind’ may denote separate sets of skills being used, suggesting that they are specific only to a particular construct (Bolton, 1987). The absence of an association also suggests that the presence of caring behaviours does not necessarily hinder or facilitate the use of

positive assertion. The deployment of positive assertion skills may largely depend upon the circumstances within the situation rather than the presence of certain defining traits. For example, an individual may decide not to respond assertively because they are highly ego-involved. Consequently, they are likely to be very cautious in evaluating arguments against their own position (Littlejohn, 1999). Alternatively, caring behaviours may be 'trait' orientated whereby caring responses are seen as relatively static characteristics of the individual which hold constant across various situations (i.e. professional and private).

There are two possible explanations for the absence of significant results concerning positive assertion. The first involves the specific nature of the behavioural test. The skills required to give and receive compliments are quite different to those involved on other positive assertion responses. Having examined the association between caring and compliments it might be more productive for future research to focus on other response classes such as empathy and 'initiating and maintaining conversations'. The second explanation focuses on the categorization used within the self-report measurement. About 51.1% (48) of subjects reported that they use positive assertion 'about half the time'. The obvious implication is therefore that 51.1% also do not use positive assertion 'about half the time'. The usefulness of using a 'middle of the road' categorization is questionable.

While one significant association ($P < 0.05$) was found between the negative assertion behavioural test and 'accessible' caring skills, this must be treated cautiously. When interpreting a sizeable number of results consideration must be given to the possibility of some significant results occurring by 'chance' (Gardiner & Gettinby, 1998). This is sometimes referred to as the 'multiplicity problem'. Acknowledging this statistical possibility, a descriptive insight into the nature of the one significant relationship was obtained by examining the components contributing to the overall value of χ^2 (see Table 4). More standard negative assertive subjects scored 'accessible' caring skills as being of medium importance than would normally be expected. Conversely fewer scored 'accessible' caring skills as being most important than would normally be expected. Within the 'assertion with obligations' cells, more subjects scored accessible as being the most important than would normally be expected. However these findings appear not to be systematically related to other scores. No definite overall trends are noted either across all assertion cells, or involving other responding styles. Furthermore, as no other significant relationship was noted between standard negative assertion and caring skills the 'clinical' significance of the finding is equivocal.

Focusing on the care assessment profile scores, the findings of the present investigation partially support one previous Care Q study that found nurses to perceive 'trusting relationships' and 'accessibility' to be important (Mangold, 1991). However the findings conflict with several other studies that considered 'comforting' to be the most important group of caring behaviours (Larson, 1984; von Essen & Sjoden, 1991, 1993).

Implications

While there appears to be similarities between caring skills and positive assertion, surprisingly no significant relationships were found. Nevertheless, findings did indicate a moderately strong tendency for nurses to employ positive assertion skills. The implication is that these groups of skills appear to coexist without association. The lack of relationships tentatively suggests that the presence of positive assertion does not necessarily indicate that an individual will be strong or weak in particular caring skills. Equally, the presence of particular caring skills fails to denote the extent of a nurse's positive assertion competency. With regard to conflict situations, lack of discernible significant relationships suggests that caring skills appear neither to inhibit nor facilitate negative assertion. As a consequence, the current findings suggest that the presence of caring attributes cannot be offered as a reason for non-assertion in nurses.

Limitations

A number of factors have been identified as possible limitations which must be taken into consideration when interpreting the findings of the present investigation. Some concerns centre on the representativeness of the sample group, and in particular the difficulties and practicalities associated with the choice of both the sample size and sampling procedure. Although the target population was considered to be a fairly homogeneous group with respect to assertiveness behaviours, the likelihood that this was accurately reflected in the non-probability sample selected for the investigation cannot be fully ascertained. While a larger group may have helped to enhance the representativeness of the sample, thereby reducing sampling error, the administration and scoring practicalities associated with the behavioural test prohibited any increase in the sample size. Potential weaknesses were also noted with possible 'reactivity' due to video recording. While steps were taken to minimize reactivity during the behavioural tests, it is difficult to determine to what extent responses were affected by the use of video

recordings. It is possible that the camera might have provoked anxiety within the subjects, which may in turn have affected their responses to the prompts.

Contributions

Study design: PJM, ODWH; data analysis: PJM; manuscript preparation: PJM, ODWH.

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