Chapter Six

SUMMARY & CONCLUSIONS

6.0.0 SUMMARY AND CONCLUSIONS

6.1.0 Introduction

Today many of our adolescents are suffering from withdrawn disorder or overanxious disorder. This may be attributed to the present society which is a fast growing and highly competitive one. This fast growth and high competition is on the rise in every field, be it academic or social. The adolescent is expected to excel in all the fields and be called an "all round achiever". But since only a handful are actually able to achieve the title, the rest are forced to suffer the pangs of anxiety of being called 'Loser' in all or some fields. The investigator believes that this anxiety is most of the time caused by the nonassertiveness of the adolescents. The adolescents under the parental and environmental pressures are not able to speak up their desires and wishes or even limits. This further increases their sufferings. To keep oneself away from such sufferings many of the adolescents develop some kinds of undesirable behavioural patterns or disorders. Withdrawn Disorder and Overanxious Disorder are two such disorders.

Overanxious Disorder

According to DSM-III-R, a child can be diagnosed as overanxious if he shows;

Excessive or unrealistic anxiety or worry for a period of six months or longer, as indicated by the frequent occurrence of atleast four of the following:-

i) excessive or unrealistic worry about future events.

ii) excessive or unrealistic concern about the appropriateness of past behaviour.

iii) excessive or unrealistic concern about competence in one or more areas, i.e., athletics, academics, social.

iv) somatic complaints, such as headaches or stomachaches, for which no physical basis can be established.

v) marked self-consciousness.

vi) excessive need for reassurance about a variety of concerns.

vii) marked feelings of tension or inability to relax.

Withdrawn Disorder

According to DSM-III-R, the diagnostic criteria for withdrawn disorder is;

a) excessive shrinking from contact with unfamiliar people, for a period of six months or longer, sufficiently severe to interfere with social functioning in peer relationships.

b) desire for social involvement with familiar people (family members and peers the person knows well) and generally warm and satisfying relations with family members and other familiar figures.

c) age of onset is atleast two and a half years.

d) the disturbance is not sufficiently pervasive and persistent to warrant the diagnosis of avoidant personality disorder.

To reduce the above two disorders in the adolescents by making them more assertive, the investigator in the present study made use of two assertive training techniques namely, role playing and covert modeling.

Assertive Behaviour

Wolpe & Lazarus (1966) define the term Assertive Behaviour as one which is used quite broadly to cover all socially acceptable expressions of personal rights and feelings. They also explain that teaching clients to express their feelings decreases the client's level of anxiety, i.e., the expression of assertiveness results in a reciprocal inhibition of anxiety. However, care must be exercised in helping a person to become assertive, for assertiveness that invites retaliation will diminish attempts to be assertive.

Thus, the Central Theme of Assertive Behaviour revolves around being able to present and express oneself comfortably in social situations and to engage, without undue anxiety, in positive interaction. Therefore, proper assertion enables people to exert more control over their lives, develop more self-respect and self-confidence, effectively ensure that their needs are met, and they receive respect from those around them.

Assertive Training

Assertive Training, in psychology, is used as a method of developing more effective coping techniques. These techniques are useful with persons who have difficulty in interpersonal situations due to conditioned anxiety responses as they can't speak up what they think is right and appropriate. Thus, it is clear that assertive training is used to teach a person reasonable, appropriate and effective behaviour.

According to Corey (1977) Assertive Training can be particularly helpful for the following people:

1) Those who cannot express anger or irritations.
2) Those who are overly polite and who allow others to take advantage of them.
3) Those who have difficulty saying 'No'.
4) Those who find it difficult to express affection and other positive responses.
5) Those who feel they do not have a right to have their own feelings or thoughts.

Assertive Training can be given in various forms. The present study consisted of two forms namely, role playing and covert modeling.

Role Playing

A role is a pattern of behaviour that a person develops from his life experience in order to cope up with the situation he faces. He develops or perceives his role in terms of the anticipatory roles of other persons. The number and kind of roles a person takes, vary, as do the intensity and completeness with which the roles are executed. Hence, role playing is a technique in which the therapist and the client act out the relevant interpersonal interactions. In the process, the client takes up the role of himself as he is and the therapist takes up the role of "Significant Others" from the client's life.

Role Rehearsal

While role playing the therapist helps the client to bring out changes in postural and vocal expressions, contents of expressions from less assertive to more of assertive modes. As the client learns to shift his stance, more assertive verbalizations come from the therapist, so that, the client also takes up more assertive modes.

Role Reversal

Here the client takes up the role of "significant other" and the therapist takes up the role of the client. This helps the client to better predict the behaviour and reactions of others and hence adjust his behaviour accordingly. Thus, the

therapist constantly helps the client to learn to become more and more assertive with every new session.

Covert Modeling

Cautela (1971) has suggested that modeling stimuli can also be presented in imagination by means of instructions. The client imagines a model performing a particular behaviour rather than viewing a live or filmed model's performance. This procedure, therefore, is called covert modeling. Here it is assumed that the representational processes operative in live modeling are altered through imagination of a model's performance.

Thus, there are two basic ingredients needed for covert modeling. One is description of the situation or the context in which the assertive response is appropriate and the other an assertive response by the person (covert model) in the scene.

It is also used to initiate particular behaviour pattern which is not in the patient's current behavioural repertoire. It may also be employed to shape or improve a behavioural pattern which the patient currently performs. In the process, a patient's behaviour is guided towards greater effectiveness and efficiency.

6.2.0 Related Research

1972 O'Connor, R.D. selected thirty three social isolates from four nursery schools population according to teacher ratings and behavioural samples obtained by trained observers. In a 2 x 2 factorial design, half of the children viewed a twenty three minutes modeling film depicting appropriate social behaviour,while the other half viewed a control film. Half of the subjects in each film condition then received social reinforcement contingent upon the performance of peer interaction behaviour. Modeling was shown to be a more rapid modification procedure than was shaping, and the interaction levels produced through modeling, with or without the addition of shaping were more stable over time. In the follow up assessment,modeling subjects remained at the levels of non-isolates, while shaping and control subjects returned to isolate level.

1974 Kazdin, A.E. in the present study investigated the effect of covert modeling in developing assertive behaviour. Non-assertive subjects received covert modeling (imagined scenes in which a model performed assertively), covert model and reinforcement (imagined scenes in which a model performed assertively and favourable consequences followed model performance), no modeling (imagined scenes with neither an assertive model nor favourable consequences),

or delayed treatment (no-treatment controls who subsequently received either covert modeling or modeling reinforcement). In four treatment sessions, both model and model reinforcement conditions improved significantly on self-report inventories and a role-playing test of assertiveness. The modeling reinforcement group tended to show greater assertiveness at post treatment assessment and followup. The effects of covert modeling were maintained upto a three month followup assessment.

1975 **Field, G.D. and Test, M.A.** described an assertive training procedure for use with groups of severely disturbed adult patients. Five experimental subjects, who had received several group sessions of assertive training, were pretested, trained and post tested on role playing proficiency in three difficult situations. Five control subjects who had also received several group sessions of assertive training, were pretested and post tested but not trained in role-playing these three difficult situations. Dependent variables consisted of compliance content, and latency of response plus disruptive pause time. When post-tested, the experimental subjects responded less compliantly and more quickly with less disruption. The control subjects showed no significant change. 4 of 5 experimental subjects were retested at a 10 month followup and all had maintained their gains.

6.3.0 Methodology

Topic

"An experimental study to analyze the impact of assertive training on non-assertive overanxious and withdrawn adolescents".

Objectives

1. To study the relationship between overanxious disorder and nonassertive behaviour as well as between withdrawn disorder and nonassertive behaviour.
2. To study the impact of role-playing as an assertive therapeutic technique on nonassertive overanxious and withdrawn adolescents.
3. To study the impact of covert modeling as an assertive therapeutic technique on nonassertive overanxious & withdrawn adolescents.
4. To study the impact of the two techniques combined on nonassertive overanxious & withdrawn adolescents.
5. To assess the differential impact of the intervention techniques with respect to each behaviour disorder.
6. To compare the experimental & control groups to understand the effectiveness of the intervention techniques on the experimental groups.
7. To study the difference between the girls and boys on the impact of the intervention techniques applied for both disorders.

Hypotheses

1. There will be a correlation between the overanxious disorder & nonassertive behaviour. So the null hypothesis to be tested would be: There will be no correlation between the overanxious disorder and nonassertive behaviour.
2. There will be a correlation between the withdrawn disorder and nonassertive behaviour. So the null hypothesis to be tested would be: There will be no correlation between the withdrawn disorder and nonassertive behaviour.
3. There will be an impact of role-playing on nonassertive overanxious adolescents. So the null hypothesis to be tested would be: There will be no impact of role playing on nonassertive overanxious adolescents.
4. There will be an impact of role-playing on nonassertive withdrawn adolescents. So the null hypothesis to be tested would be: There will be no impact of role-playing on nonassertive withdrawn adolescents.
5. There will be an impact of covert modeling on nonassertive overanxious adolescents. So the null hypothesis to be tested would be: There will be no impact of covert modeling on nonassertive overanxious adolescents.
6. There will be an impact of covert modeling on nonassertive withdrawn adolescents.So the null hypothesis to be tested would be: There will be no impact of covert modeling on nonassertive withdrawn adolescents.

7. There will be an impact of the two techniques combined on nonassertive overanxious adolescents. So the null hypothesis to be tested would be: There will be no impact of the two techniques combined on nonassertive overanxious adolescents.

8. There will be an impact of the two techniques combined on nonassertive withdrawn adolescents. So the null hypothesis to be tested would be: There will be no impact of the two techniques combined on nonassertive withdrawn adolescents.

9. There will be a reduction in nonassertive overanxious disorder of adolescents belonging to the control group. So the null hypothesis to be tested would be: There will be no reduction in the nonassertive overanxious disorder of adolescents belonging to the control group.

10. There will be a reduction in the nonassertive withdrawn disorder of the adolescents belonging to the control group. So the null hypothesis to be tested would be: There will be no reduction in nonassertive withdrawn disorder of adolescents belonging to the control group

11. There will be a differential impact of the intervention techniques on nonassertive overanxious disorder. So the null hypothesis to be tested would be: There will be no differential impact of the intervention techniques on nonassertive overanxious disorder.

12. There will be a differential impact of the intervention techniques on nonassertive withdrawn disorder. So the null hypothesis to be tested would be: There will be no differential impact of the intervention techniques on nonassertive withdrawn disorder.

13. There will be a difference between each experimental group (ie,groups 1,2 & 3) and the control group (ie, group 4) for nonassertive overanxious disorder. So the null hypothesis to be tested would be: There will be no difference between each experimental group (ie, groups 1, 2 & 3) and the control group (ie, group 4) for nonassertive overanxious disorder.

14. There will be a difference between each experimental group (ie.groups 1,2 & 3) and the control group (ie, group 4) for nonassertive withdrawn disorder. So the null hypothesis to be tested would be: There will be no difference between each experimental group (ie, groups 1, 2 & 3) and the control group (ie, group 4) for nonassertive withdrawn disorder.

15. There will be a difference between nonassertive overanxious girls & boys on the impact of intervention techniques applied. So the null hypothesis to be tested would be: There will be no difference between nonassertive overanxious girls & boys on the impact of intervention techniques applied.

16. There will be difference between nonassertive withdrawn girls and boys on the impact of intervention techniques applied. So the null hypothesis to be tested would be: There will be no difference between nonassertive withdrawn girls and boys on the impact of intervention techniques applied.

Sample

The sample of the present study consisted of 80 adolescents, with 10 adolescents in each of the groups. It was controlled in terms of age, sex & educational background. Purposive Incidental Sampling was done as the subjects were included in the sample only if they were diagnosed as being overanxious or withdrawn amongst the one's diagnosed as nonassertive. The sample was collected from three schools in Delhi.

Tools Used

The adolescents were diagnosed as overanxious or withdrawn with nonassertive behaviour on the basis of three inventories. The inventories were developed by the investigator and were based on the Diagnostic criteria as given in DSM-III-R and some reference books and journals. The inventories were:

1) Inventory for overanxious disorder
2) Inventory for withdrawn disorder
3) Inventory for nonassertiveness

The same inventories were provided to the adolescents at pre, post and followup levels.

The adolescents were also rated by their parents and teachers on similar inventories at all the three levels.

Design

The main design was as under:

Table: Shows the distribution of the final sample according to the two disorders and the therapeutic techniques used in the present study.

		Assertive Techniques				Total
		Role playing	Covert Modeling	Two Techniques combined	Control	
Disorders	Nonassertive overanxious disorder	10	10	10	10	40
	Nonassertive withdrawn disorder	10	10	10	10	40
Total		20	20	20	20	80

The table above shows the distribution of the sample according to the two disorders and the therapeutic techniques taken in the present study.

The Variables

As in all experimental studies the present study too consisted of independent and dependent variables.

Independent Variable

It is the one which is manipulated by the investigator or experimenter. Therefore, the independent variable of the present study was nonassertiveness. To manipulate the independent variable the following techniques were used: Role playing, covert modeling and a combination of the first two.

Dependent Variable

It is the one which is dependent on other variable and consists of what is measured in an experiment. The dependent variable of the present study, therefore, were the disorders, i.e. overanxious disorder and withdrawn disorder.

Data Analysis

The data collected was quantitative in nature and hence, was subjected to statistical analysis. The statistics used were Analysis of Variance, Analysis of Covariance, Student's t-distribution and Product-Moment of Correlation.

6.4.0 Results

Table : Shows the correlation for Pre-data of adolescents between the nonassertive behaviour and the two disorders.

	Nonassertive behaviour
Overanxious disorder	0.40**
Withdrawn disorder	0.42**

** Significant at 0.01 level of significance.

Both the correlation values in the above table were found to be significant at 0.01 level, signifying a positive relationship between the nonassertive behaviour and the two disorders.

Table : **Shows, at a glance, the t-test results of adolescents, parents, and teachers at all the three levels for Nonassertive Overanxious Disorder, treatmentwise.**

		Nonassertive Overanxious Disorder		
		Adolescents' Scores	**Parents' Scores**	**Teachers' Scores**
Pre-Post level	t_1	7.5**	6.5**	4.8**
	t_2	6.3**	5.4**	2.8**
	t_3	5.1**	5.7**	1.1
	t_4	0.3	0.5	0.2
Post-Followup level	t_1	1.2	1.3	1.3
	t_2	1.2	1.3	0.3
	t_3	0.6	0.3	0.9
	t_4	0.3	0.1	1.0
Pre-Followup level	t_1	6.6**	6.2**	5.8**
	t_2	6.1**	6.4**	3.5**
	t_3	4.7**	6.8**	1.4
	t_4	0.0	0.7	0.8

Table : **Shows, at a glance, the t-test results of adolescents, parents, and teachers at all the three levels for Nonassertive Withdrawn Disorder, treatmentwise.**

		Nonassertive Withdrawn Disorder		
		Adolescents' Scores	Parents' Scores	Teachers' Scores
Pre-Post level	t_1	14.6**	12.6**	2.2*
	t_2	6.1**	5.3**	3.0**
	t_3	8.9**	7.5**	5.6**
	t_4	0.2	0.2	0.9
Post-Followup level	t_1	2.3*	0.9	1.3
	t_2	0.5	1.3	0.6
	t_3	1.6	1.7	2.2*
	t_4	0.5	0.02	0.2
Pre-Followup level	t_1	11.6**	10.7**	6.9**
	t_2	5.4**	7.0**	4.7**
	t_3	8.5**	10.4**	8.5**
	t_4	0.2	0.3	0.6

Table : **Shows, at a glance, the t-test results of adolescents, parents, and teachers at all the three levels for Nonassertive Behaviour, treatmentwise**

		Nonassertive Behaviour	
		Adolescents' Scores	Parents' Scores
Pre-scores	t_1	16.8**	14.3**
	t_2	10.1**	8.8**
	t_3	10.1**	7.8**
	t_4	0.6	0.4
Post-scores	t_1	3.1**	0.9
	t_2	2.7**	1.4
	t_3	1.2	1.5
	t_4	0.4	0.3
Followup-scores	t_1	16.7**	14.7**
	t_2	10.6**	8.8**
	t_3	9.1**	8.0**
	t_4	0.4	0.7

* Significant at 0.05 level of significance
** Significant at 0.01 level of significance

The tables above show at a glance, impact of the intervention techniques used on the two disorders taken in the present study.

6.5.0 Conclusions

It can be safely concluded that nonassertiveness is directly related with both overanxiousness and withdrawn disorder as the correlation results obtained were positively significant for both the disorders.

It was also found that role-playing as an assertive therapeutic technique proved to be the most effective in reducing both nonassertive overanxious disorder and nonassertive withdrawn disorder, more so with the nonassertive withdrawn disorder.

Covert modeling was also found to be effective as an assertive therapeutic technique is reducing the nonassertive behaviour and the two disorders although it did not prove to be as effective as role-playing technique.

The combination of the above two techniques proved to be almost as effective as covert modeling in reducing nonassertive behaviour and the two disorders.

It was also found that those who received assertive training i.e. the experimental groups, were significantly benefitted by it as compared to those who did not receive the assertive training i.e. the control group.

Out of the two disorders it was found that nonassertive withdrawn disorder was reduced to a greater extent than the nonassertive overanxious disorder.

The nonassertive behaviour was also found to be significantly reduced which in turn could have caused the reduction in the two disorders.

Boys and girls seemed to be equally benefitted by the assertive training.

6.6.0 Limitations of the present study

1) Due to shortage of time provided by the schools the treatment was conducted only for three months and follow up only for one month.
2) The time was provided only during the working hours of the school.
3) Due to nonavailability of time and lack of interest on the part of the teachers only one inventory was provided to them.
4) Teachers were explained the procedure for filling up the inventory but were allowed to fill it up at their own convenience.
5) Investigator was not permitted to meet the parents in person and therefore, even they filled up the inventories at their own convenience.
6) Teachers showed a lot of disinterest and therefore, the sincerity of their responses is doubtful.
7) Measuring instruments were specially developed for this study because of lack of availability of the standardized tests for measuring the two disorders as well as the nonassertive behavior of adolescents. Inspite

of taking precautions to make it as error free as possible, there are bound to be a few limitations when an inventory is compared with a standardized test.

6.7.0 Suggestions for further research

Keeping the above mentioned limitations in mind, following suggestions if taken into account can show results with greater degree of certainity.

1) Sample size can be increased and more variables can be brought in like socio-economic backgrounds, different age groups, etc. in future research.

2) More number of interventions can be employed to test their effectiveness as assertive techniques.

3) Future research, if possible should be such which does not require teachers' ratings. Peer ratings could be used.

4) The time-period of the actual intervention could be increased by trying to conduct sessions at places where adolescents can be easily approached.

5) Before giving any intervention techniques, diagnosis of the problem is essential and for this standardized tool is necessary. If this could be made available, future research would be more meaningful.

6) Counselling to parents and siblings and even teachers could be tried out to help the child improve further.