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Evaluations of Older Adult Assertiveness in Problematic Clinical Encounters

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Within a communication predicament of aging framework, this study examined assertiveness as an option for older adults confronted with a problematic health care conversation. Older and younger participants evaluated scenarios in which senior client targets with or without hearing loss employed either assertive, passive, or aggressive responses. As predicted, assertive seniors were evaluated as most competent and likely to be satisfied with future encounters. Compared to older adults, young adults gave equivalent ratings for assertiveness but viewed the senior's passive response especially positively and the aggressive response especially negatively. Hearing loss made no difference in evaluations of the three response styles. Findings are discussed in terms of the benefits for older adults of developing skills in selective assertiveness, with emphasis on their successful management of health care encounters.

Keywords: *aging; communication; assertiveness; person perception*

Problematic Communication in Later Life

Communication dilemmas frequently arise for older adults in health care encounters. How should they respond to infantilization, premature interruptions, comments about them in their presence, inadequate explanations due to the assumption they wish to rely on authority for decisions, being kept waiting due to the assumption they have nothing better to do, and the "what can you expect at your age" messages?

Such conversational dilemmas can be conceptualized within the Communication Predicament of Aging Model (Coupland, Coupland, & Giles, 1991; Hummert & Ryan, 1996; Ryan, Giles, Bartolucci, & Henwood, 1986). Conversations based on

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negative stereotypes of aging such as dependence, poor health, and incompetence tend to incorporate modifications that limit the older person's opportunity for satisfying communication. The negative cycle of age-adapted communication implicitly constrains opportunities for older adults to behave assertively. Frequent exposure to stereotype-based communication can undermine older adults' opportunities for rewarding social participation and lead to helplessness, lowered self-esteem, and becoming older in appearance and behavior (Coupland et al., 1991; Levy, 2003; Nelson, 2002; Rodin & Langer, 1980; Whitbourne & Wills, 1993). The long-term impact on older recipients can be reflected in their own stereotype-reinforcing communication behaviors: painful self-disclosure (Bonnesen & Hummert, 2002; Coupland et al., 1991), age excuses (Ryan, Bieman-Copland, Kwong See, Ellis, & Anas, 2002), repetitive verbal behavior (Bieman-Copland & Ryan, 2001), and off-topic verbosity (Pushkar et al., 2000).

Within a health care encounter, unsatisfactory communication can result in inadequate diagnosis, inappropriate treatment, and reduced compliance with life style, exercise, and medication prescriptions (Adelman, Greene, & Ory, 2000; Street, 2001). Compared to younger adults, problematic health communication has special implications for seniors because they are passive seekers of health information, they do not use nontraditional sources (e.g., Internet), and they rely heavily on their health care professionals for medical advice and decision making (Bilodeau & Degner, 1996; Cassileth, Zupkis, Sutton-Smith, & March, 1980). If their physician or other health professional does not communicate effectively, then older patients or clients may lose their main opportunity to obtain essential information. For example, women under the age of 60 ask more questions about their cancer diagnosis and participate actively in their health care decisions compared to women aged 60 and older (Cameron & Horsburgh, 1998). In turn, physicians and oncologists often do not communicate in as much detail as they would with younger patients who are more likely to be involved in their treatment decisions (Greene, Adelman, & Rizzo, 1996; Meyer, Russo, & Talbot, 1995).

Here, the term *patronizing communication* is used for stereotype-based talk targeting older persons (Caporael, 1981; Coupland et al., 1991; Hummert & Ryan, 1996, 2001; Ryan, Hummert, & Boich, 1995). Patronizing communication involves verbal alterations such as simplified vocabulary and grammar, repetition, overfamiliarity, disapproval, nonlistening, and altered topic management. Ignoring the older individual when accompanied by a third party is also typical. Within health care encounters, these communication modifications often function as a dependency-support script whether they are based on nurturing or efficiency intentions (Baltes, Neumann, & Zank, 1994; Hummert & Ryan, 1996). Such problematic, dependency-inducing communication reduces older adult opportunities to gain the information, motivation, and support they need in health care encounters.

One of the most pernicious consequences of stereotype-based communication is the "blame the recipient" phenomenon. Recipients of patronizing talk in both institutional and non-institutional settings are often perceived as dependent, incompetent, and unsatisfied (Giles, Fox, & Smith, 1993; Harwood, Ryan, Giles, & Tysoski, 1997;

Ryan, Meredith, & Shantz, 1994). In addition, Kemper and Harden (1999) have demonstrated that older recipients of age-adapted speech exhibit lower confidence in their own communication skills. Observers generally evaluate patronizing communication negatively, but older participants, especially residents in nursing homes, are more tolerant than younger adults (Ryan, Hamilton, & Kwong See, 1994; Ryan, Kennaley, Pratt, & Shumovich, 2000).

The negative feedback cycle of the Communication Predicament of Aging is likely to have more devastating consequences for vulnerable older adults, such as those with disabilities. Among older targets, more negative stereotypes are elicited by characteristics associated with the oldest old (Hummert, Garstka, & Shaner, 1997; Mulac & Giles, 1996). For example, memory and hearing problems are associated with older age (Gomez & Madey, 2001; Levy, 2003; Ryan, Kwong See, Meneer & Trovato, 1992). The stigma associated with hearing problems holds older people back from acquiring hearing aids and from using them once acquired (Hickson & Worrall, 2003; Pichora-Fuller & Carson, 2001). Similarly, negative prototypes of old age (e.g., despondent) elicit unfavorable beliefs about communication competence as compared to positive prototypes (e.g., golden ager) (Hummert, Garstka, & Shaner, 1995). Negatively stereotyped older adults also elicit more patronizing communication (Hummert, Shaner, Garstka, & Henry, 1998; Thimm, Rademacher, & Kruse, 1998). Furthermore, patronizing speech is also more likely to be addressed to older individuals in an institutional versus community setting and for topics reflecting dependency (Hummert et al., 1998).

As the literature on doctor-patient communication suggests (Adelman et al., 2000), older adults are vulnerable to problematic communication in health care settings because of age stereotypes, stereotypes related to dependency in health care, the likely presence of a companion as well as the narrow focus on health losses, impairment, and disability (Greene et al., 1996). The hierarchical nature of health encounters further jeopardizes older adult participation and outcomes (Bell, Kravitz, Thom, Krupat, & Azari, 2001; Hummert, Garstka, Ryan, & Bonnesen, 2004). Hence, it seems likely that a health care context may especially disadvantage older adults with an age-related disability (Pichora-Fuller & Carson, 2001).

Assertive Communication as a Response Option

Assertiveness involves a proactive response in difficult situations to contrast with passive or aggressive reactions (Rakos, 1991). Although meanings of assertiveness vary considerably, a core definition entails calm, direct, honest expression of feelings and needs (Rakos, 1991; Wilson & Gallois, 1993). Assertive behavior can lead to positive self-concept and greater likelihood of meeting personal needs (Doty, 1987). Assertiveness training has been extended to groups such as women, people with disabilities, and older adults (Doty, 1987; Engels, 1991; Franzke, 1987; Northrop & Edelstein, 1998; Rakos, 1991).

Because assertive behavior can be interpreted as aggressive or selfish, it is associated with risks. Wilson and Gallois (1993) indicate that assertiveness is often associated with lower ratings of friendliness and appropriateness. They interpret this typical finding in terms of confusion between aggression and assertiveness and restrictive role expectations for members of particular social groups (e.g., women, medical patients). Whether assertiveness is effective depends on its appropriateness in the specific situation. Lack of attention to contextual specificity is one reason for limited transfer to real life situations after assertiveness training (Rakos, 1991; Wilson & Gallois, 1993).

Assertiveness is strongly associated with masculinity and with younger cohorts (Gallois, 2004; Rakos, 1991; Twenge, 2001; Wilson & Gallois, 1993). Older people are less assertive than younger peers because they never were as assertive and also because they may have lost the confidence to use assertiveness skills (Furnham & Pendleton, 1983). Given that nonassertive behavior is encouraged in hierarchical societal institutions such as health care, assertive behavior in health care encounters may be labeled as aggression (Adler, McGraw, & McKinlay, 1998). Yet, older patients with disabilities may have much to gain from learning assertiveness skills adapted for specific contexts (see Hickson & Worrall, 2003; Orr & Rogers, 2003). To illustrate, members of disadvantaged groups have been found to receive more careful medical diagnostic investigation when they behave assertively (Krupat et al., 1999).

Selective assertiveness. Selective assertiveness has been proposed as the main strategy for recipients to interrupt the Communication Predicament cycle (Ryan, Bajorek, Beaman, & Anas, 2005; see also Doty, 1987; Paterson, 2000; Taylor & Epstein, 1999). Assertive speakers communicate clearly while taking responsible control over meeting their goals without passively deferring to others or aggressively imposing on them (e.g., an older adult firmly requesting a follow-up doctor's appointment). In line with Socioemotional Selectivity Theory, speakers make choices about important, realistic goals to fit the circumstances (Carstensen, Isaacowitz, & Charles, 1999). Selectively assertive communication is characterized by straightforward messages, relaxed gestures, and calm and confident emotional responses. The assertive speaker is tactful: aware of the social context and the other person's perspective, knows when to be direct or indirect, and acknowledges the communication partner's positive behaviors when appropriate (Ryan et al., 2005; Wilson & Gallois, 1993). Older adults with age-related impairments can use these skills selectively for self-advocacy and group advocacy (Gallois, 2004; Hickson & Worrall, 2003; Orr & Rogers, 2003).

A series of person-perception studies have evaluated assertive responses in problematic situations by older adults (Hummert et al., 2004). Overall, assertive responses are rated as less polite than passive responses, but they succeed in increasing the perceptions of the inappropriateness of the patronizing conversational partner (Harwood & Giles, 1996; Harwood, Giles, Fox, Ryan, & Williams, 1993; Harwood et al., 1997). Resisting the "blame the recipient" tendency, assertive speakers are evaluated as more competent than non-assertive peers in community settings (Harwood et al., 1997;

Hummert & Mazloff, 2001). Qualitative analysis showed that assertive responders were expected to have the most positive thoughts about themselves and the most negative thoughts about the patronizer (Harwood et al., 1997). Even though direct assertiveness was not considered competent behavior in the Ryan et al. (2000) nursing home context, the assertive resident was successful in refusing a request with minimal consequences. Older adults using assertiveness have been consistently viewed as less satisfied than those using the passive response.

Despite this mix of negative and positive effects, assertiveness has emerged from these initial studies as a promising response option for older adults. Assertive responders appear more competent, meet their goals, and can communicate dissatisfaction with patronizing behavior. As well, an additional measure would help to clarify whether the low satisfaction scores are seen as a cause or a consequence of assertive behavior. These studies of older adult targets have not yet examined the group-dependent boundaries between assertive and aggressive responses.

The Present Study

This study was conducted to learn more about the potential of assertiveness, especially in terms of its frequent confusion with aggressiveness, and to examine how it might benefit older adults with and without hearing loss in problematic clinical encounters. To determine intergenerational views on older-adult assertiveness, young and older participants evaluated conversational scripts involving a health care professional talking with an older adult, with or without hearing loss. Conversations centered on each of three communication difficulties typical of problematic health care encounters experienced by older adults and by those with hearing loss: being ignored, a message delivered too quickly, and misunderstanding a message (Morrow, 1997; Ryan, Meredith, MacLean, & Orange, 1995). Each conversational script ended with either a passive, assertive, or aggressive response by the older adult.

We employed a mixed $2 \times 2 \times 2 \times 3$ design with participant age (young or older), hearing impairment of the target (present or absent), and target gender as the between-participants independent variables and response style (passive, assertive, or aggressive) as the within-participants independent variable. As in earlier studies, the target senior client and health care professional in each conversation were rated on competence, benevolence, politeness, and satisfaction. Because lower satisfaction ratings for assertive targets may have been due to inferences about their initial motivation, we added an item to gauge satisfaction in a future encounter.

Hypotheses

Hypothesis 1: The assertive client will be rated more positively than the passive client on competence and future satisfaction. This prediction is based on general "blame the recipient" effects for acquiescent recipients of patronizing speech (see Hummert et al., 2004) and the specific finding by Harwood et al. (1997) that assertiveness was viewed to be significantly more competent than passiveness. In distinguishing future from current satis-

faction, we anticipated demonstrating a positive benefit when the client maintains a sense of control.

Hypothesis 2: The assertive client will be rated more positively than the aggressive client on all measures.

Hypothesis 3: The health professional will be rated less favorably when the client is either assertive or aggressive, than when passive. Past studies have suggested that raters infer that older clients would not shift from the expected nonassertive response without dissatisfaction with the conversational partner's behavior (Harwood et al., 1997; Ryan et al., 2000).

Research Questions

Research Question 1: How will the client's hearing loss affect the ratings of assertive and aggressive responses? On one hand, we might expect observers to afford greater latitude for conversational behavior to those with potential communication difficulties (Krupat et al., 1999). On the other hand, double jeopardy might lead observers to hold adults with a known disability to a higher standard of politeness (Palmore, 1999; Ryan et al., 2005).

Research Question 2: How will the younger and older participants differ in their ratings of the client's assertiveness? Young people are more assertive today; however, they may prefer the older client to act passively, in keeping with age stereotypes.

Method

Participants

The participants were 117 older ($M = 72.8$ years; $SD = 6.29$; 65% women) and 120 young ($M = 19.2$ years; $SD = 0.75$; 72% women) adults. Older adults were community residents recruited from a local seniors' center and a McMaster University volunteer research group. Young adults were first-year psychology students participating for course credit.

Materials and Procedure

On the basis of pilot work, three conversational scenarios depicted an older protagonist in a communication predicament in one of three health contexts selected to be non-age salient. One conversational scenario is given in the appendix with the three response options.

A pool of possible passive, assertive, and aggressive responses had been developed earlier with undergraduate students who generated one response of each type for four original health contexts. In the instructions to the participants, passive and aggressive responses were distinguished in terms of putting others first or one's self first, respectively. The assertive option was described as one where feelings are expressed openly without threatening others. The resulting responses were independently evaluated by two raters on the dimensions of aggressiveness and appropriate assertiveness, with modest but significant reliability between the two raters ($r = .5$ for both scales). Each response was also evaluated (Yes/No) as to whether it was deemed to be a "good"

response in terms of face validity and definition. Because we planned to manipulate the hearing ability of the target older client in the main study, one scenario was dropped when examination of the responses from that situation revealed many references to hearing loss. The wording of the best response candidates from the remaining three scenarios was adjusted so that their length was approximately equal across the different conditions.

Each scenario contained a brief narrative introduction followed by a conversation between a health professional and a senior client in his or her early 70s. The client was shown as being ignored by a physician, unable to follow a message delivered too quickly by a pharmacist, or misunderstanding a physiotherapist's message because of noise. In all conversations, both the professional and client had two turns to speak except for the "ignored" context where the client had only one turn. Within each context, the conversations in the contrasting response-style conditions were identical except for the final response of the client. All questionnaires contained conversations in the three health contexts, each with a different response style. Six versions of the questionnaire were formed using a modified Latin Square Design to counterbalance the three response styles across each of the contexts. In the introductory narrative, male or female targets were described either as having normal vision and hearing or as having normal vision but as having experienced some hearing loss and using a hearing aid.

Based on previous studies (see Hummert et al., 2004) participants evaluated both conversational partners in each scenario on the following adjectives using 7-point Likert scales: competence (*capable*, *unintelligent*, *confident*, *incompetent*), benevolence (*supportive*, *helpful*, *unkind*, *patronizing*, *rude*, *respectful*, *polite*), satisfaction (*pleased*, *frustrated*, *dissatisfied*, *contented*). Participants rated the client's final responses on 7-point passive-aggressive and assertiveness scales as manipulation checks. They also rated how well the client handled the situation, how satisfied the client would be in a future health encounter, and how realistic the conversation was.

Older participants received the questionnaire in person or by mail. They were instructed to complete the questionnaires individually and in one sitting. Young participants completed the questionnaire in supervised classroom-sized groups.

Results

The main analyses (mixed design MANOVA) were conducted using averaged ratings based on factor structures emerging from separate factor analyses (Pedhazur & Schmelkin, 1991) of the evaluations of the senior client and the health professional in the passive response condition. Where Mauchley's test of sphericity was significant, adjusted degrees of freedom are reported. Post-hoc comparisons were conducted using *t* tests with Bonferroni-type corrections for experiment-wise error.

Factor Analyses

For the items evaluating the client, an SPSS Principal Component factor analysis with Varimax Rotation gave a four-factor solution (58% variance): Competence—*capable*, *unintelligent* (reversed–r), *confident*, *incompetent* (r) and the item evaluating how well the senior handled the situation; Satisfaction: *frustrated* (r), *dissatisfied* (r), *contented*, and *pleased*; Positive manner: *supportive*, *helpful*, *respectful*, and *polite*; Negative manner: *patronizing, rude* and *unkind*. The factor analysis for the professional yielded three factors (62% variance): Positive affect/Manner: *supportive*, *helpful*, *contented*, *respectful*, *pleased* and *polite*; Negative affect/Manner: *frustrated*, *dissatisfied*, *rude*, and *unkind*; Incompetence: *unintelligent* and *incompetent*. Only items that had loadings of .5 or higher loading uniquely on one factor (.15 criterion) were accepted. Cronbach reliability coefficients were generally over .7 for the three response conditions; however, the coefficient fell below this generally accepted level in three cases (senior satisfaction: assertive = .61; aggressive = .58; senior negative manner: passive = .42). Because the majority of the coefficients for each variable were at acceptable levels, composite variables were computed for the sake of consistency.

Realism of Targets' Behaviors and Manipulation Checks

The mean realism ratings of the behaviors of the client and professional in the scenarios were generally at or above the midpoint of the scale, suggesting that the participants viewed the interactions as realistic portrayals of everyday community encounters.

Examination of the passive-aggressive and assertiveness ratings of the target responses revealed a main effect of response (Wilks's $\Lambda = .20$, $F(4, 226) = 221.47$, $p < .001$). On the passive-aggressive scale, the ratings were all significantly different from each other: $M_{passive} = 2.26$, $M_{assertive} = 4.68$, and $M_{aggressive} = 5.85$. On the assertiveness scale, the passive response ($M = 2.56$,) was rated as less assertive than the assertive ($M = 5.12$) and aggressive ($M = 5.40$) responses. An interaction between participant age and response qualified the main effect, Wilks's $\Lambda = .81$, $F(4, 226) = 13.66$, $p < .001$ (see Table 1). Both measures significantly contributed (Passive-aggressive: $F(1.9, 443.7) = 29.31$, $p < .001$, $\eta^2 = .11$; Assertiveness: $F(1.8, 412.7) = 5.69$, $p < .01$, $\eta^2 = .02$). On the passive-aggressive scale, both young and old participants differentiated among the three response styles, with the slope of the young participant ratings steeper than that for the old. There was no difference between the age groups in their ratings of the assertive response. On the assertiveness scale, the older participants gave significantly different ratings for each of the three responses; the young participants showed a similar pattern but did not differentiate between assertive and aggressive responses and revealed a steeper slope in their ratings from the passive to the aggressive.

Table 1
Mean Evaluations of Passive-Aggressive and Assertive As a Function of Participant Age and Response (*SD*s are in parentheses)

		Response		
Scale	Participant Age	Passive	Assertive	Aggressive
Passive-Aggressive	Young	1.78[a] (1.14)	4.81[b] (1.35)	6.21[c] (0.98)
	Old	2.77[d] (1.37)	4.55[b] (1.40)	5.48[e] (1.59)
Assertive	Young	2.30[a] (1.58)	5.31[b] (1.38)	5.39[b] (1.50)
	Old	2.83[c] (1.71)	4.93[b*] (1.42)	5.40[b*] (1.36)

Note: Means with different superscripts are significantly different from each other.
* These means differ significantly

Evaluations of the Senior Client

A MANOVA was conducted with Competence, Positive manner, and Negative manner, and Satisfaction composite variables. There was a main effect of Participant Age, Wilks's $\Lambda = .94$, $F(4, 226) = 3.59$, $p < .01$. Univariate tests revealed that only Negative manner contributed to the effect, $F(1, 229) = 4.62$, $p < .05$, $\eta^2 = .02$. The younger participants gave the senior client higher ratings of Negative manner than did the older participants ($M_{Young} = 2.14$; $M_{Old} = 1.95$).

There was a main effect of Response Style, Wilks's $\Lambda = .20$, $F(8, 222) = 110.92$, $p < .001$ significant for all dependent measures: Competence: $F(2, 458) = 58.60$, $p < .001$, $\eta^2 = .20$; Positive manner: $F(1.9, 432.5) = 259.64$, $p < .001$, $\eta^2 = .53$; Negative manner: $F(1.7, 380.3) = 166.09$, $p < .001$, $\eta^2 = .42$; Satisfaction: $F(1.8, 400.7) = 356.34$, $p < .001$, $\eta^2 = .61$. The assertive response was viewed significantly more positively than the other responses for Competence. In addition, it was rated more positively than aggressive but more negatively than passive responses for Positive and Negative manner and Current Satisfaction (see Table 2). There was a significant Participant Age by Response-Style interaction, Wilks's $\Lambda = .81$, $F(8, 222) = 6.56$, $p < .001$, Positive manner: $F(1.9, 432.5) = 6.14$, $p < .01$, $\eta^2 = .03$; Negative manner: $F(1.7, 380.3) = 9.44$, $p < .001$, $\eta^2 = .04$; Satisfaction: $F(1.8, 400.7) = 15.69$, $p < .001$, $\eta^2 = .06$ (see Table 2). Compared to older participants, younger participants rated the passive client as being more satisfied, and the aggressive client as being less satisfied. The assertive client was rated similarly by both groups. Young and old also agreed on their ratings for the positive manner of the client who responded assertively or aggressively, but the ratings of the young group were significantly higher when the client responded passively. The young group also rated the client's manner as negative when passive, and more negative when aggressive. There were no effects of the client's hearing ability or gender, either as main effects or in interactions.

A $2 \times 2 \times 2 \times 3$ ANOVA was conducted with the separate item estimating the senior client's satisfaction in a future encounter with the health professional. There was a

Table 2
Mean Evaluations of the Senior Client As a Function of Participant Age and Response (*SD*s are in parentheses)

		Response		
Measure	Participant Age	Passive	Assertive	Aggressive
Competence	Young	—	—	—
	Old	—	—	—
	Marginal means	4.74^{a} (1.05)	5.57^{b} (1.03)	4.81^{a} (1.02)
Positive manner	Young	5.05^{a} (1.04)	4.21^{b} (1.22)	2.45^{c} (1.02)
	Old	4.57^{d} (1.13)	4.22^{b} (1.18)	2.67^{c} (1.39)
	Marginal means	4.82 (1.11)	4.21 (1.20)	2.56 (1.22)
Negative manner	Young	1.31^{a} (0.60)	1.85^{b} (1.08)	3.27^{c} (1.44)
	Old	1.56^{b} (0.75)	1.56^{b} (0.81)	2.74^{d} (1.43)
	Marginal means	1.43 (0.69)	1.71 (0.96)	3.01 (1.45)
Satisfaction	Young	4.49^{a} (1.28)	2.44^{b} (1.04)	1.64^{c} (0.77)
	Old	3.81^{d} (1.89)	2.36^{b} (1.04)	1.97^{c} (0.93)
	Marginal means	4.15 (1.28)	2.40 (1.04)	1.80 (0.87)
Future satisfaction	Young	—	—	—
	Old	—	—	—
	Marginal means	2.99^{a} (1.69)	4.16^{b} (1.77)	3.27^{a} (1.70)

Note: Means with different superscripts are significantly different from each other.

main effect of Response Style, $F(1.9, 437.7) = 35.79$, $p < .001$, $\eta^2 = .14$ (see Table 2). Compared to the passive and aggressive clients, the assertive senior was expected to enjoy the most satisfaction in a future conversation.

In addition to the Response Style main effect, there was a two-way interaction between Participant Age and Hearing Ability, $F(1, 236) = 4.56$, $p < .05$, $\eta^2 = .02$. The young participants did not differentiate on the basis of the client's hearing status for this dependent measure ($M_{\text{normal hearing}} = 3.60$, $M_{\text{hard of hearing}} = 3.56$, $t\,(115) = .23$, $p > .10$) whereas older participants did ($M_{\text{normal hearing}} = 3.08$, $M_{\text{hard of hearing}} = 3.67$, $t\,(115) = 2.59$, $p < .05$).

Evaluations of the Health Professional

A MANOVA was conducted with the composite scores from the factors Positive Affect/Manner, Negative Affect/Manner, and Incompetence. The only main effect was for Response (Wilks' $\Lambda = .91$, $F[6, 224] = 3.84$, $p < .01$). Both Positive and Negative Affect/Manner contributed to the effect (Positive: $F[1.9, 432.9] = 9.35$, $p < .001$, $\eta^2 = .04$; Negative: $F\,[2, 458] = 8.23$, $p < .001$, $\eta^2 = .04$). The professional was rated as having the same level of Positive and Negative Affect/Manner when the client responded assertively or aggressively but was rated as more positive and less negative when the client gave a passive response: The means for passive, assertive, and aggres-

sive, respectively are Positive Affect/Manner: 2.84, 2.39, 2.55; Negative Affect/Manner: 3.65, 4.04, 4.13.

Although there was a significant triple multivariate interaction between Participant Age, Target Gender, and Response Style (Wilks's $\Lambda = .94$, $F[6, 224] = 2.30$, $p < .05$), there were no significant univariate effects. There were no effects for participant age, target hearing ability, or target gender.

Discussion

Assertive Seniors

Overall, these findings demonstrate that older adult assertiveness can be a positive option for older adults in difficult conversational circumstances. As predicted (H1 and H2), assertive responses within the three problematic health care encounters were evaluated more positively than passive and aggressive responses for client competence and future satisfaction. Indeed, assertive responses were preferred to aggressiveness on all client evaluations. Compared to the passive response, the positive evaluations of assertiveness occurred in the expected context of unfavorable ratings on the positive and negative manner dimensions and client satisfaction with the current conversation. Previous community-based scenario studies have shown assertiveness to be viewed as competent behavior even if less polite (Harwood et al., 1993, 1997; Harwood & Giles, 1996). However, this is the first study to distinguish the positive effects of assertiveness on future satisfaction from the antecedent dissatisfaction presumed to necessitate assertiveness. Moreover, this study begins to address the boundaries between assertive and aggressive responding.

Assertiveness by older clients was deemed equally acceptable regardless of whether the client used a hearing aid (R1). We deliberately began our studies of hearing and assertiveness with a mild manipulation of hearing status. Clearly, more powerful manipulations are needed to provide a strong test of the predicted interaction between client-hearing status and response style. Because older adults with hearing loss are more likely to encounter problematic communication in health care, they have more to gain from assertiveness in the long run (see Krupat et al., 1999). Although this study focuses on linguistic features of assertiveness, assertiveness by persons with a disability can often be nonverbal (Ryan et al., 2005; Wilson & Gallois, 1993). For example, the Canadian Hearing Society offers people with hearing loss a CommuniCard, which provides its users with a nonverbal officially sanctioned method of letting their interlocutors know how best to communicate with them (e.g., "Face me and do not cover your mouth"). Other more spontaneous nonverbal gestures to manage conversations (e.g., a hand gesture indicating another's turn to speak in the ignoring situation) could be studied profitably in the future.

Assertive responses were equally acceptable to young and old participants (R2). Thus, older adult assertiveness is appropriate quite generally not just from an ingroup point of view. However, young participants did show a stronger relative preference for passive over aggressive responses. Presumably, this reflects a greater outgroup expec-

tation among the young that older adults should behave passively and especially avoid aggressive behavior (Hummert et al., 2004). The steeper slope of negative evaluations for aggressive behavior among young participants highlights a special risk for older adults if their attempts to be assertive shift toward the aggressive end of the passive-assertive-aggressive continuum (Wilson & Gallois, 1993).

Health Professionals Talking With Assertive Seniors

The health professional was evaluated more negatively when the client was assertive or aggressive than when the client was passive (H3). Other studies have found this pattern for recipients of assertive versus passive responses (Harwood et al., 1993, 1997; Ryan et al., 2000). On one hand, a passive response perpetuates the Communication Predicament by indicating acceptance of the health professional's behavior. On the other hand, the assertive response showed the same potential for threatening the face of the health professional as aggressive behavior. Humor, appreciation, and empathy have been found to attenuate the face threat to a powerful conversational partner and thus to offer some advantages to care recipients when direct assertiveness seems risky (Hummert et al., 2004; Ryan et al., 2000; Wilson & Gallois, 1993). Moreover, nonverbal features such as smiling or a gentle voice can tone down directly assertive verbal messages.

The concept of selective assertiveness would encourage older adults to choose carefully when to voice their desires or concerns after assessing benefits and risks and to focus on fitting words and manner to the goals, speaker, and situation (Ryan et al., 2005). Research by Birditt and Fingerman (2005) on choosing one's battles shows that older adults favor passive, accepting responses as compared to young adults who are more likely to react aggressively in situations of interpersonal conflict. Through future research, we need to learn more about ingroup and outgroup boundaries between assertion and aggression and about ways of expanding the range for assertiveness when the battle is especially important to older adults.

Limitations and Future Studies

This study was limited in several ways that may affect the generality of the findings. The groups were convenience samples comprising relatively well-educated individuals whose views of assertiveness may not be representative of those in other socioeconomic circumstances. This was a scenario-based study with only three situations and accompanying exemplars of each conversational style. Written formats have demonstrated effectiveness and avoid the extra impact of amplifying or mitigating vocal and nonverbal cues, yet audio and videotape presentations could be useful to assess the impact of contrasting vocal and other nonverbal components of assertiveness (see Hummert et al., 2004). As in other speech-style evaluation studies, measuring the vocal and nonverbal associates of contrasting styles would be a useful addition (see

Ryan, MacLean, & Orange, 1994). The hearing impairment manipulation, deliberately chosen to be mild in this initial study, should be strengthened in future research to elicit between-participant effects and/or a within-design for the hearing factor employed.

Most likely, young participants' stronger preference for passive responding is specific to old, outgroup targets (Hummert et al., 2004). Contrasting evaluations of young and older target clients could directly confirm this assumption and also determine whether the equivalence of the two hearing conditions derives from a leveling effect in which hearing impairment is considered natural to old age (Pichora-Fuller & Carson, 2001). It might well be that higher approval of assertiveness in speakers with hearing impairment would occur only for young targets (Hummert et al., 2004).

Using similar written scenarios or videotapes of hypothetical situations, future research could examine the degree to which approval of older adult assertiveness differs in hierarchical contexts such as acute-care hospitals and nursing homes versus other less hierarchical community contexts (Hummert & Mazloff, 2001). For instance, one could focus upon the two key problematic situations identified in the disability and communication literature: unwanted advice and overly controlling behaviors (Braithwaite & Eckstein, 2003; Ryan et al., 2005). In addition, assertive responses can be contrasted with passive and aggressive responses to managing help within intergenerational family contexts (Hummert & Morgan, 2001). Another important variable to manipulate is the importance of the conversation to the older person's autonomy (e.g., resisting too-strong advice around driving or relocation versus less central issues).

A stronger test of the impact of hearing loss on the evaluation of assertiveness could involve increasing the salience of age and hearing in the scenarios. In addition, the forms of assertiveness could be manipulated in terms of whether hearing impairment and/or age are mentioned as an explicit justification for the assertive response (Ryan et al., 2002). To illustrate, Ryan, Anas, and Mays (forthcoming) examined the impact of assertiveness on the part of individuals with visual impairment in need of help with reading printed health messages. Finally, additional dependent measures might be useful in detecting the predicted interaction between hearing and response style. For example, objective items concerning whether the client is expected to engage in the intended activity (e.g., taking medication, doing exercises) and whether the client's health improves after the health care encounter might be more sensitive (Biernat, 2003).

Appendix
"At the Pharmacy"

Mr. Smith is a 74-year-old man who [has normal hearing / wears a hearing aid]. He is at the drugstore standing at the pharmacist's counter. Mr. Smith is there to get a prescription for his sinus headaches. There is one other person in line behind Mr. Smith waiting to talk to the pharmacist as well. The pharmacist approaches Mr. Smith and begins to explain to him how and when to take his medication.

Pharmacist: Okay, Mr. Smith. It's important that you remember to take 2 pills 3 times a day approximately 8 hours apart, never on an empty stomach. So, always make sure that you have a snack or meal beforehand. Also, the pills may cause you to feel drowsy within an hour or two of taking them.

Mr. Smith: Pardon?

Pharmacist: I guess you didn't catch all that. The instructions are in the bag!

Mr. Smith: *Passive*: Okay, I'll make sure that I read all of the instructions as soon as I get home.

Assertive: I would appreciate it if you could go over those instructions again so that I get everything right.

Aggressive: If you don't stop this rudeness now, I'm going to find another pharmacist who will treat me properly!

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