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Assertiveness by Older Adults with Visual Impairment: Context Matters

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ASSERTIVENESS BY OLDER ADULTS WITH VISUAL IMPAIRMENT: CONTEXT MATTERS

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Within a communication predicament of aging and disability framework, this study examined the impact of two types of contextual variation on perceptions of older adult assertiveness within problematic service encounters. Young (N = 66) and older (N = 66) participants evaluated conversational scenarios in which a visually-impaired older woman responded either passively or assertively to denial of requested assistance with reading needed information. Both older and young participants viewed the assertive older woman as more competent and as more likely to achieve her goals in future conversations than the passive older woman. The assertiveness advantage was greater in the community setting than in the hospital and for the more serious situations. Implications for education are discussed.

Older adults with vision loss face many challenges in maintaining their daily activities. The most common age-related causes of vision loss are macular degeneration, cataracts, glaucoma, and diabetic retinopathy. Age-related low vision is characterized by gradual, progressive losses with particular impact on reading and driving and indirect impact on social opportunities and mental health (Brennan & Silverstone, 2000; Heine & Browning, 2002; Ryan, Anas, Beamer, & Bajorek, 2003; Wahl, Becker, Burmedi, & Schilling, 2004). Rehabilitation services and

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assistive devices can make a critical difference in older adults' adaptation to decreasing vision (Mann, 2005; Mann, Hurren, Tomita, & Charvat, 1997). Yet all too many older adults experience a "nothing to be done about it" message from their eye specialists (Canadian National Institute for the Blind, 2004; Sussman-Skalka, Cimarolli, & Stuen, 2006).

In their personal narratives about blindness, Kleege (1999) and Poulson (2002) identified the many ways in which the stigma of blindness is made evident to visually impaired individuals. People with visual impairment are expected to be dependent, less capable, and all alike (Goffman, 1963; Smith & Kandath, 2000). Encounters with older adults with vision loss exacerbate the already prevalent fears associated with aging within our society. People unfamiliar with visual impairment exhibit uncertainty about how to interact with a person with visual impairment—what accommodations would be useful, when and how to offer help, and feeling constrained to avoid the many vision-related words and metaphors in everyday speech (Kleege, 1999; Smith & Kandath, 2000). As summarized in Braithwaite and Thompson (2000) and in Goffman (1963), particular communication challenges experienced by individuals with disability include the social pressure and risks of disclosing information about one's impairments, managing help (avoiding overhelp while recruiting needed help), and gaining access to required information.

The Communication Predicament of Aging Model (Ryan, Meredith, MacLean, & Orange, 1995) and Communication Predicament of Disability Model (Ryan, Bajorek, Beaman, & Anas, 2005) provide a framework for examining how communication dilemmas can shape excess social disability. These models feature a negative feedback loop whereby modified communication addressed to older adults with disability tends to constrain opportunities for satisfaction, goal attainment, and exhibiting competence. Patronizing communication is characterized by high pitch, exaggerated intonation, simplified language, limited topic selection, avoidance of talk, and exaggerated praise. Such talk often conveys dismissive, nonlistening, controlling, and overnurturing attitudes. Patronizing talk shapes either passive or aggressive responses which further contribute to the cycle which, in turn, eventually leads to withdrawal from activities, reduces a sense of control, and diminishes self-esteem (Fox, Giles, Orbe, & Bourhis, 2000; Hummert, Garstka, Ryan, & Bonnesen, 2004). Furthermore, a recent well-controlled longitudinal study (Levy, Slade, & Gill, 2006) showed that elders' stereotypes about inevitable aging losses predicted their hearing decline after three years. This and similar studies demonstrate how self-fulfilling stereotypes supported by communication

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predicaments contribute to premature decline in mental and physical health in older adults.

From both the visual rehabilitation and aging communication literatures, researchers and educators are led to consider possible communication training for older adults with visual impairments. Orr and Rogers (2003) have developed a communication skills manual for older adults with visual impairment. It is based on the following premise: "The way individuals communicate with others has a lot to do with whether or not their needs will be met" (p. 96). The Ryan et al. (2005) model presents selective assertiveness as the main strategy for interrupting the communication predicament of disability cycle. Assertiveness involves the calm, confident presentation of clear messages which are neither passive nor aggressive. Research on assertiveness and assertiveness training has demonstrated that acquired communication skills are often limited in their effectiveness and maintenance because of lack of attention to the importance of context (Northrop & Edelstein, 1998; Rakos, 1991; Wilson & Gallois, 1993). As introduced by Doty (1987) and elaborated by Savundranayagam, Ryan, and Hummert (2007), selective assertiveness involves choosing one's battles, using assertiveness to meet particular goals in particular situations. Assertive behaviors support choice and control for older adults, especially those with disability, but effective assertiveness training would educate participants about how social context influences their range of choices. Hence, assertiveness and self-advocacy training programs can benefit from increased knowledge about how assertive behaviors by older adults with visual impairments are perceived in different contexts.

Person perception studies of communication with older adults have already offered important information upon which the current study builds. Across many studies, health and other service providers communicating with older adults in a patronizing manner have been evaluated negatively, and sometimes the older recipients have been blamed for being addressed in this manner with lower competence ratings (Hummert et al., 2004). In studies comparing assertive and passive responses to patronizing speech, assertive older adults have been viewed as more competent in community settings, but not in long term care where resident roles are restricted by the hierarchical setting (Harwood & Giles, 1996; Harwood, Giles, Fox, Ryan, & Williams, 1993; Harwood, Ryan, Giles, & Tysoski, 1997; Ryan, Kennaley, Pratt, & Shumovich, 2000). Ryan, Anas, and Friedman (2006) have shown that older adult targets with or without hearing impairment are rated most competent when assertive as compared to both passive and aggressive responses. There is a price associated

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with assertiveness in these studies. The assertive older targets are evaluated as less polite and benevolent and less satisfied. However, Ryan et al. (2006) confirmed the prediction that future satisfaction was expected to be higher after an assertive encounter. The original satisfaction measure seems to reflect the presumption that the speaker must have been dissatisfied in order to be moved to use an assertive response.

We can expect that assertiveness will be evaluated differently across physical settings and across conversational situations. The person perception paradigm offers an excellent method for assessing these effects. Patronizing speech has been evaluated differently in community settings as compared to the hospital or long term care setting (Hummert et al., 2004). In the one relevant assertiveness study, more assertive responses were offered to patronizing advice given in a community setting than in the hospital (Hummert & Mazloff, 2001). The greater hierarchical structure in the institutional environment can be expected to limit the opportunities for assertiveness. Furthermore, one would expect that serious situations create a context where assertiveness is more acceptable. From the point of view of politeness theory, the weight of an assertive request is increased by a hierarchical environment and moderated by situational features indicating specific reasons for the request (Brown & Levinson, 1987).

THE PRESENT STUDY

The study reported in this paper assessed the impact of two contextual manipulations on evaluations of disability-related assertive responses by older adults with visual impairment. Young and older adults evaluated visually impaired older women targets presented in brief written conversational scenarios where they responded either passively or assertively to the lack of requested assistance with reading needed information.

The design included two between-participant factors [Participant Age (young vs. old), Seriousness (moderate vs. serious situation)] and two within factors [Setting (community vs. hospital), Response (passive vs. assertive)]. The target person was evaluated for competence, benevolence, satisfaction, how well she handled the situation, and probable success in future conversational encounters. Participants also wrote what they thought the conversational partner would say next.

Hypotheses

H1 The assertive target person will be rated more positively than the passive target on competence, handling of the conversation,

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and future conversational success. This prediction is based on reversing the general "blame the recipient" effects for acquiescent recipients of patronizing speech (see Hummert et al., 2004) and specific assertiveness findings by Harwood et al. (1997) and Ryan et al. (2006) in a community setting. These positive findings are expected to occur in spite of less favorable ratings for benevolence.

H2 The advantage of assertive responding over passive responding (i.e., the assertiveness advantage) will be greater in the community setting than in the hospital setting. This prediction is based on the relatively negative evaluation of assertiveness in a long term care setting (Ryan et al., 2000) as well as the lower expectation of assertiveness in the hospital setting than the community (Hummert & Mazloff, 2001).

H3 The assertiveness advantage will be greater in situations which have serious consequences versus more moderate consequences associated with the lack of help. Politeness theory supports upgrading when an assertive target makes clear the serious consequences associated with the request for help (Brown & Levinson, 1987).

Research Questions

R1 Do Setting and Seriousness interact jointly with Response type to influence evaluations of assertiveness through three-way interactions?

R2 How will the younger and older participants differ in their ratings of the target's assertiveness? Young people are more assertive today (Twenge, 2001); however, they may prefer the older target to act passively, in keeping with age stereotypes. Assertive responses by older adults were rated equally by the two age groups in Ryan et al. (2006), but the young were more appreciative of passive behaviors and less tolerant of aggressive responses.

METHOD

Participants

The participants were 66 older adults ($M = 74.5$ years; $SD = 6.8$; 61% women) and 66 young adults ($M = 18.7$ years; $SD = 1.2$; 62%

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women). Older adults were community residents recruited from the general community and a McMaster University volunteer research group. Young adults were first-year psychology students participating for course credit.

Materials and Procedure

Four conversational vignettes were created, depicting a visually impaired woman in her mid-70s engaged in a problematic exchange with a conversational partner. Each scenario included a brief introduction and a conversation in which the woman requested but did not receive help with reading needed information. The conversation took place in either a community or a hospital setting. In the community, help was requested with reading a petition at the hairdresser's protesting the construction of an apartment building or with reading the ingredients on a food package in the grocery store. In the hospital, the target requested help from a pharmacist to read product information or help from a nurse to complete a visitor information form. Care was taken to create hospital situations not involving direct health care. In all conversations, the partner had two turns and the target three. The conversations ended with the target responding passively or assertively to the lack of forthcoming help from the conversational partner. Two versions of each vignette were created by varying the seriousness of the request. Examples of the settings and conversations are shown in the Appendix. All questionnaires contained four conversations, one from each of the four contexts so that two were in community and two in hospital settings, with two ending in passive, and two in assertive responses. Two versions of the four-scenario questionnaire were prepared, one with moderate situations and one with serious situations.

Based on previous studies (see Hummert et al., 2004), participants evaluated the older target in each scenario on the following adjectives using 7-point Likert scales: capable, confident, incompetent, independent, unintelligent (Competence), likeable, polite, trustworthy, unkind (Benevolence), pleased, frustrated, dissatisfied, contented (Satisfaction). In addition, participants rated how well the target handled the situation, how important it was for her to obtain the help she needed, how likely she would get what she wanted in the future, and how likely she would have reacted that way. Participants also wrote what they thought the partner would have said next. The final question asked for the age range of the

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four women in the vignettes to ensure that the participants had the appropriate age of the target in mind while completing the questionnaire.

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.

Cronbach alpha reliability coefficients were at least .70 for 10 of the 12 setting by response evaluations of the older target's competence, benevolence, and satisfaction, with two values for the passive conditions slightly lower (.63, .65). Composite measures were formed by averaging the ratings of the relevant items.

The design comprised two between factors, participant age (young vs. old) and seriousness of the situation (serious vs. moderate) and two within factors, setting (community vs. hospital) and response type (passive vs. assertive). A multivariate analysis of variance was conducted to assess the personality traits of competence and benevolence. Otherwise the data were submitted to parallel univariate analyses. Given the focus on the meanings of assertiveness, we report only the main effects and interactions involving response type. Where Mauchly'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.

RESULTS

Manipulation Checks

All of the means of the response likelihood ratings were above the midpoint of the scale, except for the passive response in a serious community situation ($M = 3.75$). The ANOVA showed greater likelihood for the assertive response than the passive response, especially in a serious situation.

The ANOVA for importance of the target's need showed the anticipated main effect of seriousness, $F(1, 128) = 19.77$, $p < .001$, $\eta^2 = .13$. The needs of the target were viewed as more important in the serious situation ($M = 5.67$) than in the moderate ($M = 5.00$). In addition, the situation was viewed as more important by the older participants, as more important when an assertive response was employed, and as more important for the moderate situation in the hospital setting as compared to the community setting.

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Evaluations of the Target

The MANOVA for competence and benevolence yielded a significant multivariate main effect of response type (Wilks' $\Lambda = .51$, $F(2, 127) = 60.87$, $p < .001$) with significant univariate effects for both competence ($F(1, 128) = 72.66$, $p < .001$, $\eta^2 = .36$) and benevolence ($F(1, 128) = 9.89$, $p < .01$, $\eta^2 = .07$). The assertive target was viewed as more competent, but less benevolent than the passive target. The response main effect was qualified by multivariate interactions with each of the other independent variables. For the interaction with participant age (Wilks' $\Lambda = .94$, $F(2, 127) = 4.03$, $p < .05$), there was a significant univariate effect for benevolence ($F(1, 128) = 4.24$, $p < .05$, $\eta^2 = .03$). The assertive target was viewed as equally benevolent as the passive target by the older adults but as less benevolent by young participants ($M = 4.83$ vs. $M = 5.18$).

For the interaction of response type with setting (Wilks' $\Lambda = .89$, $F(2, 127) = 7.75$, $p = .001$), there were again significant univariate effects for competence ($F(1, 128) = 13.80$, $p < .001$, $\eta^2 = .10$) and benevolence ($F(1, 128) = 7.79$, $p < .01$, $\eta^2 = .06$). Competence ratings of the assertive target showed a bigger advantage over the passive target in the community than in the hospital. The assertive target was rated as less benevolent than the passive target only in the hospital. See Table 1 for all means reported for assertive vs. passive responses in a community vs. hospital setting.

The multivariate interaction of response type with the seriousness of the situation (Wilks' $\Lambda = .91$, $F(2, 127) = 6.29$, $p < .01$) revealed significant univariate effects for both competence ($F(1, 128) = 6.03$, $p < .05$, $\eta^2 = .05$) and benevolence ($F(1, 128) = 11.13$, $p = .001$, $\eta^2 = .08$). For competence, the advantage of the assertive style was larger under serious conditions. The assertive response had a

Table 1. Mean evaluations of the target as a function of setting and response type

	Community		Hospital	
Measure/Item	Passive	Assertive	Passive	Assertive
Competence	3.96 (1.1)	4.87 (0.9)	4.09 (1.0)	4.51 (1.1)
Benevolence	5.16 (0.9)	5.12 (1.0)	5.26 (0.9)	4.89 (1.1)
Satisfaction	3.74 (1.1)	3.39 (1.2)	3.71 (1.0)	3.01 (1.2)
Handling of situation	3.23 (1.8)	5.02 (1.7)	4.09 (1.8)	4.70 (1.7)
Future success	2.98 (1.6)	4.53 (1.4)	3.68 (1.7)	4.33 (1.6)

Note: Standard deviations are in parentheses.

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Table 2. Mean evaluations of the target as a function of seriousness of request and response type

	Moderate		Serious	
Measure/Item	Passive	Assertive	Passive	Assertive
Competence	4.06 (0.9)	4.54 (0.9)	3.98 (1.0)	4.84 (0.8)
Benevolence	5.36 (0.7)	4.93 (0.9)	5.06 (0.8)	5.8 (0.8)
Satisfaction	3.84 (0.8)	3.20 (1.1)	3.61 (0.9)	3.20 (1.0)
Handling of situation	4.08 (1.4)	4.78 (1.4)	3.23 (1.6)	4.94 (1.5)
Future success	3.50 (1.5)	4.25 (1.4)	3.16 (1.3)	4.62 (1.1)

Note: Standard deviations are in parentheses.

disadvantage on benevolence only in the moderate situation. See Table 2 for all means reported for assertive vs. passive responses in moderate vs. serious situations.

Analysis of target satisfaction yielded a main effect of response type ($F(1, 128) = 32.14$, $p < .001$, $\eta^2 = .20$), with the assertive target viewed as less satisfied than the passive target. These effects were qualified by an interaction of response type with the setting ($F(1, 128) = 5.60$, $p < .05$, $\eta^2 = .04$). Participants saw the assertive target as especially dissatisfied in the hospital.

The univariate ANOVA on the ratings of how well the target handled the situation yielded a main effect of response type ($F(1, 128) = 65.39$, $p < .001$, $\eta^2 = .34$) with the assertive target receiving higher ratings than the passive target. The interaction between response type and setting ($F(1, 128) = 31.59$, $p < .001$, $\eta^2 = .20$) showed that the advantage for the assertive target was especially strong in the community. Furthermore, an interaction of response type with seriousness ($F(1, 128) = 11.51$, $p < .001$, $\eta^2 = .08$) revealed that assertiveness was viewed by the participants to be especially advantageous in a serious situation.

Analysis of ratings about expectations for success in future encounters yielded a main effect of response type ($F(1, 128) = 58.33$, $p < .001$, $\eta^2 = .31$) with participants expecting that the assertive target would be more successful than her passive counterpart. In addition, the participants indicated that encounters in the hospital would be met with more future success ($F(1, 128) = 6.46$, $p < .05$, $\eta^2 = .05$). These two main effects of response type and setting were qualified by an interaction between them ($F(1, 128) = 17.37$, $p < .001$, $\eta^2 = .12$). The advantage for assertive behavior over passive was bigger in the community than the hospital.

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There was also an interaction between response type and participant age ($F(1, 128) = 4.67$, $p < .05$, $\eta^2 = .04$), indicating that the young gave the bigger advantage to the assertive target (Young: $M_{\text{Assertive}} = 4.59$, $M_{\text{Passive}} = 3.17$; Old: $M_{\text{Assertive}} = 4.28$, $M_{\text{Passive}} = 3.49$). A response type by seriousness interaction ($F(1, 128) = 6.00$, $p < .05$, $\eta^2 = .05$) revealed a bigger advantage for the assertive versus passive target in terms of future success in the serious situation compared to the moderate.

Expected Help After Assertive versus Passive Responses

Two coders examined the written responses to the question "What would the (conversational partner) have said next?". Responses about the conversational partner were categorized as helpful, continuing to be unhelpful, or suggesting that someone else be asked ("redirect"). The Cohen's Kappa reliabilities for the four setting by response conditions were all at least .9.

Chi squares were calculated to compare the proportions of participant comments reflecting helping behavior from the conversational partner for the assertive versus passive response conditions, in the serious and moderate contexts, in the community and hospital settings and by the young and old participants. Collapsed over participant age, the assertive response was always associated with greater expected help than the passive response for both moderate and serious situations, in the community as well in the hospital setting. In addition, both young and old participants expected greater help from the conversational partner in both the community and hospital settings when the target was assertive than when she was passive ($X^2 > 4.6$, $p < .05$).

DISCUSSION

Summary of Findings

Assertiveness was positively evaluated on selected measures. Compared to passive speakers, assertive speakers were seen as more competent, more capable in handling their situation, and more likely to attain their goals in future encounters. This assertiveness benefit occurred even though satisfaction and benevolence ratings were predictably lower in some conditions. We did find that context matters for assertiveness. The assertiveness advantage (i.e., the difference between ratings for assertive and passive responses) was greater in the community setting than in the hospital. There was also a greater

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assertiveness advantage in situations with serious consequences. Even though the two hospital situations differed less in rated seriousness than those in the community, no triple interactions occurred for the evaluative data. The analysis of expected help confirmed the assertiveness advantage in meeting the needs of the visually impaired target speaker.

Future Research On Contextual Assertiveness

The person perception paradigm allows for the manipulation of many aspects of conversations with assertive versus passive responses. In the present study, the written format did not allow inclusion or comparison of vocal and other nonverbal aspects of assertive behavior. Yet, it did permit us to eliminate the possibly confounding effects of these characteristics.

Future studies could profitably use this paradigm to examine assertiveness in other settings and conversational situations. Given the reduced tolerance of assertiveness observed in the one nursing home study (Ryan et al., 2000), it would be useful to contrast the three settings (community, nursing home, hospital) directly. The contrast in settings here is all the more important given that the conversational situations in the hospital did not involve the older persons in the dependent role of patient but in active roles parallel to those in the community scenarios. Care recipient role could be manipulated orthogonally with setting to determine the predictable interaction. Other conversational situations could be compared along diverse dimensions. For example, the relative assertiveness advantage could be compared across conversational domains between older adults and their adult children (see Morgan & Hummert, 2000; Williams & Nussbaum, 2001). One could manipulate the importance of autonomy in the conversation by topic (e.g., decisions about driving versus banking arrangements). Other disability-related situations calling for assertiveness include dealing with unwanted advice or overly controlling behaviors, seeking to be talked to directly when with a younger companion, meeting new people, or making other types of requests. One could also contrast situations within both hospital and community settings that are more or less hierarchical (e.g., patient with a doctor versus person asking receptionist for directions to an office) in order to tease apart the influences of typical differences associated with setting.

From a communication perspective, one could also examine the impact of different assertive options (Doty, 1987; Kemper & Harden, 1999; Wilson & Gallois, 1993). For example, appreciative and humorous responses can be viewed more favorably than more direct

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assertiveness in terms of politeness and saving the face of a powerful communication partner (Hummert et al., 2004; Ryan et al., 2000). These less direct assertive strategies would likely be more effective in settings and situations less associated with the assertiveness advantage. Use of audiotapes and videotapes for presenting conversational scenarios would allow for assessments about strategies for minimizing the impact of a verbal request, for example, with vocal, facial, stance, and gestural choices (Brown & Levinson, 1987). One could also usefully compare assertive alternatives giving different degrees of information about the impairment in situations of visible (e.g., white cane) versus invisible disability (see Braithwaite & Thompson, 2000).

Finally, future studies could compare evaluations of young and old assertive targets and also targets of both ages with or without visual disability. Both the current study of visual impairment and the Ryan et al. (2006) study of hearing impairment involved a number of manipulated factors and, hence, did not compare target ages. The lack of participant age effects may well be due to the fact that both age cohorts have similar expectations about assertiveness among older adults. However, both groups—or at least the young age group—may have much higher expectations for assertiveness among young targets (see Twenge, 2001). These expectations may or may not interact with setting and situational components of context. Although Ryan et al. (2006) did not find any differential tolerance for assertive or aggressive responses for targets with hearing impairment than without, impairment might matter when the communication problem is more clearly connected to the impairment itself as in the present study.

Educational Implications for Older Adults with Visual and Other Impairments

Assertiveness training can be incorporated into a variety of services for older adults. Lecture series or courses concerning successful aging might well address the role of communication in taking control for one's health. Most important would be to teach assertiveness and other communication skills within any health promotion or health literacy program, either for seniors in general or for those with specific disabilities (e.g., vision loss or mobility impairment) or specific diagnoses (e.g., osteoporosis or diabetes). Caregiver support groups or caregiver educational programs can provide older caregivers with information and the opportunity to practice skills for choosing appropriate words, tone of voice, and gestures for different contexts in which they need to advocate for their loved ones. One special

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benefit of teaching assertiveness within the caregiving context is that older adults are likely to be more receptive to the value of making their voices heard when advocating for others.

The findings here provide support for assisting older adults with visual and other impairments to be contextually sensitive in their use of assertiveness (Gambrill, 1995; Rakos, 1991; Wilson & Gallois, 1993). Given that assertiveness is more readily accepted in the community, one needs to be more particular in choosing one's battles in hospital settings and more careful with language and nonverbal cues. We have demonstrated here that the weight of a request can be mitigated by clearly stating the seriousness of the situation (Brown & Levinson, 1987). Assertiveness training has been shown to assist older adults in identifying alternative communication approaches (Doty, 1987; Orr & Rogers, 2003). Even though older adults are often led to believe that they should gracefully accept difficulties and give up desired activities, research on successful aging warns that the graceful relinquishment of rewarding activities can accelerate aging (Crowther, Parker, Achenbaum, Larimore, & Koenig, 2002). The specific information from this study about the communication challenges faced by older adults with disability in various settings and situations can contribute to greater effectiveness in assertiveness training for self-advocacy as well as for caregiver advocacy. Skills in contextually-appropriate assertiveness are not learned in a day or mainly through lectures. Opportunities to practice skills for different situations in a friendly environment, especially with peer feedback, would seem to be essential for increasing one's repertoire and sensitivity to contextual constraints.

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APPENDIX: CONVERSATIONAL SCENARIOS: EXAMPLES

A) Community Setting:

Carol Gibson, aged 72, is doing her weekly errands and is at the grocery store just before Easter when it is exceptionally busy. She is having trouble reading the small print on a cereal box. **She is watching her weight and wants to find out how many calories are in this product (Moderate)/She has an allergy to peanuts and wants to make sure that this product is peanut free (Serious)**. There is an employee nearby stocking the shelves.

Carol Gibson: Excuse me.
Employee: Yes? What can I do for you?
Carol Gibson: Well, I'm having trouble reading the dietary information on this cereal package. Could you read it to me?
Carol Gibson: I don't have time right now. Maybe you can go and look for someone else.
Carol Gibson: ***Passive***: Okay, I guess you do look pretty busy there. I'll try to find someone else to help me.
Assertive: I know you're busy.
(Moderate) I'm watching my weight so it's important to know how many calories are in this product.
(Serious) I have an allergy to nuts, so it's important to know if there are any nuts in this product.

B) Hospital Setting:

Margaret Jones, aged 75, is at the hospital to **talk to the volunteer coordinator about volunteering positions (Moderate)/visit her daughter who has just come out of knee surgery (Serious)**. As she enters the hospital, a nurse wearing a mask hands her a newly revised SARS screening form and asks her to fill it out before she can proceed. Margaret takes the form but cannot see what the print says.

Margaret Jones: Is this something new? Can you tell me what it's about?
Nurse: Didn't you see the signs on the front door? This is the revised version of the SARS screening form. It asks for your name and if you've had

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	contact with anyone with SARS and so on—the same questions it always asks.
Margaret Jones:	I'm sorry, but I can't see where I should put my answers. Could you fill it out for me?
Nurse:	Well, you'll have to wait over there until I finish with these people behind you.
Margaret Jones:	***Passive***: Okay, I guess I can wait until you have time. ***Assertive***: **(Moderate)** I'm here to talk to the volunteer coordinator. **(Serious)** My daughter has just come out of knee surgery and I'm anxious to see her. I'm sure it will only take a minute for you to help me.