ASSERITIVE SOCIAL SKILLS
TRAINING FOR THE ELDERLY

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Abstract
Given the current context of social concern regarding the rights of senior citizens, this study describes and evaluates a program of assertive social skills training (ASST) for elderly people. The participants (2 men and 13 women) were distributed into two groups: the experimental group (EG, which received the ASST) and the placebo group (PG, which was exposed to interactive presentations on several topics). Pre-test and post-test evaluations with IHSI-Del-Prette and the monitoring of the scores indicated the acquisition and maintenance of a repertoire of especially assertive social skills by the EG, but not by the PG. The authors discuss the reliability and importance of the study with a placebo design for assessing the internal validity of the intervention programs in, their critical features and also the importance of this kind of intervention for the elderly in today’s world.

Key words: elderly, assertive social skills training, placebo, effectiveness evaluation.

Resumen
Dado el contexto actual de preocupación social cuanto a los derechos de los ancianos, este estudio describe y evalúa un programa de entrenamiento de habilidades sociales asertivas (ASST, assertive social-skills training) para personas de edad avanzada. La muestra (2 hombres y 13 mujeres) participaron de uno de dos grupos: experimental (GE, que recibió el ASST) y placebo (GP, con presentaciones interactivas de temas diversos). Las evaluaciones con IHSI-Del-Prette pre, post-test y el seguimiento de las medidas indicaran adquisición y mantenimiento de repertorio de habilidades sociales, especialmente asertivas, para EG, pero no para PG. Los autores discuten la viabilidad y la importancia de los estudios con diseño

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placebo para evaluar la validez interna de los programas de intervención, sus características esenciales sino también la importancia de este tipo de intervención para los ancianos en la realidad contemporánea.

Palabras clave: ancianos, programa de entrenamiento de habilidades sociales asertivas, placebo, evaluación de la eficacia.

Introduction

Healthy aging depends on various factors, including interpersonal relationships (Caballo, Z. Del Prette, Casares, & Carrillo, 2006; Carneiro, 2005; Carneiro & Falcone, 2004; Carneiro, Falcone, Clark, Z. Del Prette, & A. Del Prette, 2007; Z. Del Prette & A. Del Prette, 1999) and, more specifically, the quality of social interactions. In the case of the elderly, interpersonal relationships can contribute to good health, since engagement in social interactions and activities facilitates the development of attachments to others and the expansion of the social support network. These interpersonal relationships can help when coping with various interpersonal demands and the improvement of self-esteem, personal effectiveness and positive identity.

Moreover, access by this specific group to the resources in the social environment may require a repertoire of effective social skills, especially assertive ones. Jakubowski and Lange (1978) consider assertiveness as the expression of a person’s rights, thoughts, feelings and beliefs directly, honestly and adequately in a way that does not violate the rights of others. For Z. Del Prette and A. Del Prette (2005), assertiveness is based on the notion of equal rights and duties, and legitimate behaviors for the establishment and defense of these rights, as well as of the conditions of respect and dignity.

Socially competent assertiveness involves the performance of social skills such as refusing unreasonable requests, expressing dislike or anger, making requests, expressing opinions on various issues, expressing disagreement, making compliments, requesting a change in behavior, and dealing with criticism (Z. Del Prette & A. Del Prette, 2003).

According to Caballo (1993a), Assertiveness training (AT) was studied extensively in the 70’s and 80’s and constitutes an important intervention technique, especially when combined with other therapies (Lega, Caballo, & Ellis, 1997). A. Del Prette, Z. Del Prette, and Barreto (1999), and A. Del Prette & Z. Del Prette (2003) point to cultural changes in societies that currently value a broader set of skills than those specified by Alberti and Emmons (1986) in the 70’s, and include other kinds of social skills. Thus, A. Prette Del and Z. Del Prette (2001) suggest the teaching of self-control as an important ingredient in the exercise of assertiveness. A similar perspective is adopted by Falcone (2000), who considers the effectiveness of an assertive response to be greater when it is combined with empathy, affirming that this combination of social skills minimizes the negative effects of an assertive performance.

Certain segments of the population, such as women and children, may, for various reasons, need greater protection from society to prevent the violation of their rights. The development of assertive skills can provide an additional resource
to help these populations stand up for their rights. This seems to be the case for the elderly as well, and constitutes the focus of this study.

The aging of the population is one of the great triumphs of humanity, although it also constitutes one of the greatest challenges of modern society (World Health Organization, 2007). According to a review by the United Nations (UN, 2009), there are currently 6.8 billion people in the world, and of these, 865 million (12.3%) are elderly. Additionally, the UN estimates that in 2050 there will be nine billion people worldwide, and 2.4 billion (26.2%) will be senior citizens. For Brazil, this review indicated a population of more than 193 million in 2009, 21 million (11.3%) of them being 60 or more.

The growing number of elderly individuals has been the object of legislation and public policies (Huenchua, 2006), as well as the focus of increasing investment in research and services for this clientele, including the field of psychology (Carneiro, 2005; Cupertino, Rosa, & Ribeiro, 2007; Schneider & Irigaray, 2008; Tortosa & Motte, 2006). The quality of life of the elderly has clearly been included in the agenda for public policies and the production of socially relevant knowledge. In Brazil, the recent adoption of the Brazilian Statute for Elderly, i.e. a legal instrument establishing the rights of this segment of the population, is an example. The existence of legislation protecting the rights of senior citizens is important, but it is not sufficient to guarantee the effective exercise of these rights, especially in contexts of dyadic interaction in everyday life.

In this context, it can be argued that the development of assertive social skills is an effective and feasible strategy to enable elderly people to assert and exercise their full rights in everyday interpersonal relations. For A. Del Prette and Z. Del Prette (2001), the exercise of individual rights implies: (a) the recognition of these rights as the established norm, (b) the identification of situations in which these rights have been disrespected, (c) the mobilization of feelings of justice, (d) standards of performance to ensure the restitution of a balance in the relationships between people and / or groups.

Exploratory studies in Brazil (Carneiro, 2005; Carneiro & Falcone, 2004; Carneiro et al., 2007) have found that elderly people in general reveal a considerable deficit in their repertoire of assertive social skills, and that this can compromise the quality of their relationships with individuals of younger generations (Lima, 2000). Such results suggest the need for assertive social-skills training (ASST) directed to Brazilian senior citizens, although no study has yet evaluated the effectiveness of such an ASST program.

In a study investigating the relationship between social skills and recognition of the rights of the elderly, Braz (2007) evaluated two groups of elderly individuals, one of them attended classes specifically focusing on their rights under the Brazilian Statute for the Elderly (G1) and the other (G2) of individuals not attending such classes, but that had initiated a program at the “Senior University”. The results showed that instructional intervention did not result in significant changes for the G1 group in relation to their understanding of their rights, nor in their repertoire of assertive social skills. The results also indicated that the members of the G2 group had improved in their recognition of their rights and their repertoire for
certain social skills. However, neither group showed any identifiable increase in assertive social skills. It was thus concluded that instructional interventions in relation to rights may not be sufficient to produce changes in the development of a repertoire of assertive social skills, which would suggest the need for assertive social-skills training programs for this population. Moreover, it was hypothesized that interaction and social exchange with peers may lead to the improvement of various kinds of social skills. These data therefore suggest a need to control the factors common to any group intervention in order to verify the internal validity of assertive social-skills programs.

Based on such a hypothesis, one of the various alternatives which could be used to control the internal validity of an intervention program would be the use of a placebo group as a control, although this has seldom been explored (Rocha, Z. Del Prette, & A. Del Prette, 2008). These authors discuss the conceptual, methodological and ethical issues involved in the use of placebos in psychology, as well as the practical challenges in implementing this type of design. They highlight the three possibilities outlined by Baskin, Tierney, Minami, & Wampold (2003) for “placebo intervention”: (1) the replacement of all active ingredients, (2) the systematical removal of some of the active ingredients of effective treatment (a dismantling placebo), and (3) the maintenance of specific ingredients common to any type of therapy (such as social support, placebo attention, etc.).

In summary, the present study is based on the above considerations that (a) the attention received by an elderly person may result in a possible weakness, especially in the exercise of their rights, (b) assertive skills are important for the defense of interpersonal human rights, as claimed by a vast literature from the 70's, and (c) it is important for interventions in psychology to seek new designs for control; placebo procedures may be a possible alternative, assisting in the identification of the critical components of a program, or at least the possible impact of common factors.

Given these considerations, the present study was designed to describe and evaluate the effects of an assertive social-skills training program for senior citizens. This was done by comparing these results with those obtained for a placebo group in which only those elements common to group interventions of this kind (especially social coexistence and peer and therapist attention) were maintained (Baskin et al., 2003). The project was approved by the Ethics Committee (Protocol no. 090 dated 28/02/2008), and the research team respected and followed all the instructions established by Resolution 196/96, October 10, 1996, which regulates research involving human beings in Brazil.

**Method**

**Participants**

The participants attended a senior group that gathered at a private school in a medium-sized city located in the State of Sao Paulo (Brazil). Twice a week, the
Assertive social skills training for the elderly group participated in organized activities (games, music lessons, dance and physical education, travel planning, etc.). The criteria for the inclusion of the participants in the project were as follows: (a) being 60 or more, (b) not having previously attended classes about the rights of the elderly, and (c) having signed an Informed Consent form.

The two groups were statistically equivalent (Mann Whitney test) in relation to: (1) age (EG: \(M = 67.5, SD = 5.77\); PG: \(M = 65.5, SD = 3.59\), \(U = 14.00, p = 0.733\)), (2) gender (EG: seven women and one man PG: six women and one man, \(U = 27.50, p = 0.922\)), (3) socioeconomic level (EG: groups from A2 and D, PG: B1 and C2; \(U = 19.00, p = 0.496\)), (4) education (EG: one illiterate, six with elementary education, and one with high school education; PG: six with elementary education, and one with a high school education; \(U = 27.50, p = 0.941\)).

**Instruments and materials**

1. Social Skills Inventory for the Elderly (Inventário de Habilidades Sociais para Idosos, IHSI). This consists of a version of the Social Skills Inventory (IHS-Del-Prette, Z. Del Prette & A. Del Prette, 2001) with the adaptation of the wording for the population over 60 years (Carneiro et al., 2007) which is in the process of normalization in Brazil. The IHSI-Del-Prette consists of 38 self-report items, each one describing a specific situation which requires the use of a certain social skill involving interpersonal relationships. The respondent is asked to estimate the relative frequency with which he/she acts or reacts as suggested for each item, using a five-point Likert scale ranging from zero (never or rarely) to five (always or almost always). An assessment of the difficulty involved in the performance of these social skills, is made by using a similar scale from zero (very easy) to four points (extremely difficult). Since there is not any factor analytic structure available for this instrument yet\(^3\), the structure of the IHS-Del-Prette was adopted, as in the previous study of Carneiro et al. (2007); this produces an overall score as well as scores on five subscales: (F1) Self-affirmation when coping with risk; (F2) Self-affirmation in the expression of positive feelings; (F3) Fluency in social conversation; (F4) Exposure of self with strangers and in new situations; (F5) Self-control of aggressiveness.

2. Evaluation of User Satisfaction. The instrument adopted, based on the instruments developed by Rocha (2009), and by Kohr, Parrish, Neef, Driessen, & Hallinan (1988), consists of 30 self report items on a five-point Likert scale (zero to four), assessing the (a) quality of treatment and satisfaction with

\(^2\) The socioeconomic classification was assessed by the “Critério Brasil” Questionnaire, which is based on durable goods and educational level. It locates the respondent in one of five levels: three for higher income, each divided into two sub-levels (A1, A2, B1, B, C1 and C2) and two for lower incomes (D and E). For further information, view: http://www.abep.org/codigosguias/Critério_Brasil_2008.pdf

\(^3\) It is in the process of undergoing confirmatory factor analysis and the development of a normative reference set.
the program as a whole (nine items, a score from zero to thirty-six); (b) procedures used by the therapist (seven items, a score from zero to twenty-eight); (c) self-assessment of readiness to perform those skills which were the program objectives (12 items, score from zero to forty-eight); (d) self-assessment of the performance in sessions (two items, score from zero to eight; and (e) three open questions related to what they had liked the best in the training, what they liked the least, and which could be improved); the questions were answered either orally or in written mode.

Procedure

The repertoire of assertive social skills of the participants was assessed before the intervention (pretest), immediately after the intervention (posttest) and four months after the end of the intervention (follow-up). The Evaluation of User Satisfaction was administered during the closing session.

A quasi-experimental design with two groups was used: experimental group (EG) consisting of individuals who participated in the assertive social-skills training program (ASST) and placebo control group (PG), who had participated in a program of educational dialogued presentation (EDP) involving elements which were supposed not to be the essential to ASST (attention, socialization with peers, contact with the therapist, etc.). The activities of ASST and EDP programs were distributed over 10 weekly sessions of one hour each. The sessions for both groups were conducted in a classroom located in centre or senior citizens. The same staff (both therapist and assistant) conducted the two programs.

The ASST sessions were based on the literature of assertive training and social-skills training programs (Alberti & Emmons, 1986; S. Bower & G. Bower, 1977; Caballo, 1993a; A. Del Prette & Z. Del Prette, 2001; Z. Del Prette & A. Del Prette, 1999, 2005; Jakubowski & Lange, 1978), but using the experiential method associated with cognitive-behavioral techniques (reinforcement, shaping, modeling, feedback, role play and behavior rehearsal), as proposed by A. Del Prette & Z. Del Prette (2001) and Z. Del Prette & A. Del Prette (1999, 2005). The ASST was based on the types of assertive social skills listed as items in the subscale of Self-affirmation in Coping with risk of the Del-Prette IHS (Z. Del Prette & A. Del Prette, 2001), as these had been found to be inadequate in the repertoire of the participants. Some examples of skills that compose this subscale are: expressing disagreement with the group, dealing with unfair criticism, asking questions to unknown people, expressing disagreement with the authority, speaking to known people, collecting

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4 In order to respond to the ethical and practical issues recommended by Rocha et al. (2008) for the placebo design, after the collection of the data for this study, the participants of PG were offered a program similar to the ASST.

5 This centre was a place where a group of senior citizens attended different leisure activities such as choral classes, volleyball matches, dancing classes and bingo. At the time this research was conducted, it was not offered, for those elderly, any kind of psychological intervention neither assertive training nor social-skills programs.
payment from a friend, maintaining a conversation with strangers, introducing
themselves to someone else, etc. (Z. Del Prette & A. Del Prette, 2001).

The initial sessions of ASST sought to (1) maximize the frequency and the
acquisition of process skills such as: asking and answering questions, giving and
receiving feedback, observing behavior, and describing the behavior identifying
antecedents, responses and consequences (A. Del Prette & Z. Del Prette, 2001; Z. Del
Prette & A. Del Prette, 2005); and (2) promote the development and performance
of two complementary social skills, i.e. empathy (Falcone, 2000) and self-control (A.

Each session was divided into three phases: (a) an initial phase of warm-up
activities, reports on homework and other activities designed to introduce the
theme of the session, (b) a central phase consisting of experiential procedures
designed to develop the specific objectives of the session, with structured situations
requiring the performance of the requisite skills focused on during the session, and
(c) a final phase consisting of assessment and feedback to / from participants and
the assignment of homework. A summary of the themes and objectives established
for each session is presented in table 1.

<table>
<thead>
<tr>
<th>Session</th>
<th>Theme</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Rapport</td>
<td>• To establish contract with participants</td>
</tr>
<tr>
<td>02</td>
<td>Processing skills 1</td>
<td>• To teach skills necessary to perform in session (giving and receiving feedback, observing behavior, describing behavior in terms of previous and consequent responses; participation in class by asking questions and listening to peers)</td>
</tr>
<tr>
<td>03</td>
<td>Emotional expressiveness</td>
<td>• To teach complementary skills involved in the performance of assertive social skills</td>
</tr>
<tr>
<td>04</td>
<td>Empathy</td>
<td>• To teach complementary skills involved in the performance of assertive social skills</td>
</tr>
<tr>
<td>05</td>
<td>Self-control</td>
<td>• To teach complementary skills involved in the performance of assertive social skills</td>
</tr>
<tr>
<td>06</td>
<td>Thinking assertively</td>
<td>• To teach a specific type of assertive social skills</td>
</tr>
</tbody>
</table>

6 The adjective experiential is an English translation for a Portuguese word (“vivencial”), which
does not correspond to any English word. It refers to the use of direct experience (“vivência”) activities,
which are defined by A. Del Prette and Z. Del Prette (2001) and Z. Del Prette and A. Del Prette (2005) as
analogue or symbolic situations developed in order to produce social skills demands (specially the inter-
personal ones) during the training sessions.
The educational dialogued presentations (EDP) focused on a variety of topics of interest to participants, established by a brief previous survey of the participants of the PG. The topics selected did not involve the issue of assertive social skills nor items from the Brazilian Statute for the Elderly. These selected topics were presented by the therapist in the form of a dialogue with the whole group or with subgroups, including questions such as myths and truths about aging, aging today, the biological aspects of aging, social issues of aging, comparisons between the body at present and in the past.

**Data processing**

The results of the data from IHSI-Del-Prette were organized using Statistical Package for Social Sciences, version 16.0 (SPSS); the overall and subscale scores were computed, as recommended by the IHS-Del-Prette manual (Z. Del Prette & A. Del Prette, 2001). For the evaluation of User Satisfaction, mean values for each item and for all the items were calculated. Then, descriptive statistics (average and frequency) and non-parametric statistics for independent samples (Mann Whitney's U Test) and for related samples (Wilcoxon test) were determined, adopting a significance level of 0.05.

**Results**

Tables 2 and 3 present the descriptive data of the pretest, posttest and follow-up scores for the EG and PG in relation to frequency and difficulty, both on a global scale and for the subscales of Self-affirmation in coping with risk (F1), Self-affirmation in the expression of positive feelings (F2), Fluency in Social conversation (F3), Exposure of self to strangers and new situations (F4) and Self-Control of Aggression (F5).

The nonparametric Mann Whitney test indicated statistically significant differences between the groups in relation to the scores of the pre-test for the factor Self-affirmation in coping with risk (F1): the EG scored lower than the PG ($U=10.500, p=0.043$). The comparison between the groups in the posttest, however, did not reveal such a difference, now there was any difference in the other factor scores ($U=20.50, p=0.384$).
Table 2
Averages for general score and subscores of IHSI for pretest, posttest and follow-up of experimental and placebo groups

<table>
<thead>
<tr>
<th>Score</th>
<th>Experimental group</th>
<th>Placebo group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest M (SD)</td>
<td>Posttest M (SD)</td>
</tr>
<tr>
<td>Total</td>
<td>72.75 (19.34)</td>
<td>89.62 (17.19)</td>
</tr>
<tr>
<td>F1</td>
<td>16.00 (6.27)</td>
<td>22.75 (8.45)</td>
</tr>
<tr>
<td>F2</td>
<td>20.25 (4.62)</td>
<td>22.62 (4.27)</td>
</tr>
<tr>
<td>F3</td>
<td>14.37 (4.24)</td>
<td>16.25 (5.59)</td>
</tr>
<tr>
<td>F4</td>
<td>3.62 (2.13)</td>
<td>5.50 (3.46)</td>
</tr>
<tr>
<td>F5</td>
<td>6.12 (1.45)</td>
<td>8.12 (2.47)</td>
</tr>
</tbody>
</table>

Note: The range of scores for each test was as follows: 0-152 (total score), 0-44 (F1), 0-28 (F2), 0-28 (F3), 0-16 (F4), 0-12 (F5).

Table 3
Assessed difficulty of prettest, posttest and follow up of IHSI (general score and subscores) for experimental and placebo groups

<table>
<thead>
<tr>
<th>Score</th>
<th>Experimental group</th>
<th>Placebo group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before M (SD)</td>
<td>After M (SD)</td>
</tr>
<tr>
<td>Total</td>
<td>44.75 (23.21)</td>
<td>52.87 (22.71)</td>
</tr>
<tr>
<td>F1</td>
<td>14.87 (5.91)</td>
<td>16.12 (9.38)</td>
</tr>
<tr>
<td>F2</td>
<td>5.37 (5.55)</td>
<td>6.12 (5.38)</td>
</tr>
<tr>
<td>F3</td>
<td>6.87 (3.52)</td>
<td>12.00 (5.12)</td>
</tr>
<tr>
<td>F4</td>
<td>8.12 (6.16)</td>
<td>6.87 (3.31)</td>
</tr>
<tr>
<td>F5</td>
<td>4.25 (4.06)</td>
<td>4.25 (2.37)</td>
</tr>
</tbody>
</table>

Note: The range of scores for each test was as follows: 0-152 (total score), 0-44 (F1), 0-28 (F2), 0-28 (F3), 0-16 (F4), 0-12 (F5).

The comparison between the groups in the subscales (Mann Whitney) indicated that the gains (the difference between pretest and posttest scores) for the EG were significantly greater than those for the PG for Self-affirmation in coping with risk (F1: U= 9.000, p= 0.027) and Self-affirmation in the expression of positive feelings (F2: U= 6.000, p= 0.011). As far as the other scores are concerned, no
statistically significant differences were found between the groups. The comparison between posttest and follow-up scores did not show any significant differences, thus confirming the maintenance of the acquisitions of the EG.

An evaluation of the changes in the EG (Wilcoxon) confirmed the improvement in scores from pre to posttest for overall frequency for the Global Scale \((Z = -2.380, p = 0.017)\), and in the subscales of Self-affirmation in coping with risk \((F1: Z = -1.963, p = 0.050)\), and Self-affirmation in the expression of positive feelings \((F2: Z = -2.124, p = 0.034)\). Unexpectedly, there was also an increase from the pretest to the posttest for the EG in the difficulty of the Fluency and Social Conversation subscale \((F3: Z = -2.384, p = 0.017)\), as shown in Table 3.

Table 4 presents the data from the evaluation of user satisfaction. In the assessment of the participants’ satisfaction with the program, both groups showed means close to the maximum of 36 (EG: \(M = 30.88, SD = 1.55\), PG: \(M = 34.40, SD = 0.74\)) and these did not differ significantly. Only one of the items, related to the quality of care received, revealed a significant difference \((U = 2.50, p = 0.06)\), with the PG giving higher scores than the EG.

**Table 4**

*Satisfaction with intervention of experimental and placebo groups*

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
<th>EG (M (SD))</th>
<th>PG (M (SD))</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your overall evaluation of your satisfaction with the program?</td>
<td>0-36</td>
<td>30.88 (4.39)</td>
<td>33.33 (3.01)</td>
</tr>
<tr>
<td>How do you evaluate the quality of treatment you received?</td>
<td>0-4</td>
<td>3.13 (0.35)</td>
<td>4.00 (0.00)</td>
</tr>
<tr>
<td>Did you receive the desired training?</td>
<td>0-4</td>
<td>3.13 (0.35)</td>
<td>3.83 (0.40)</td>
</tr>
<tr>
<td>Did the training meet your needs?</td>
<td>0-4</td>
<td>3.38 (0.51)</td>
<td>4.00 (0.00)</td>
</tr>
<tr>
<td>Would you recommend this program to a friend?</td>
<td>0-4</td>
<td>3.38 (0.74)</td>
<td>3.83 (0.40)</td>
</tr>
<tr>
<td>How satisfied are you with the amount of help received?</td>
<td>0-4</td>
<td>3.50 (0.75)</td>
<td>3.67 (0.51)</td>
</tr>
<tr>
<td>Did the training help you relate more effectively with the people around you (such as friends, family, acquaintances, and strangers)?</td>
<td>0-4</td>
<td>3.13 (0.64)</td>
<td>3.83 (0.40)</td>
</tr>
<tr>
<td>How satisfied are you with the training you received?</td>
<td>0-4</td>
<td>3.62 (0.74)</td>
<td>3.50 (0.54)</td>
</tr>
<tr>
<td>Would you participate in this program again?</td>
<td>0-4</td>
<td>3.38 (0.74)</td>
<td>4.00 (0.00)</td>
</tr>
<tr>
<td>Was the psychologist able to relate the information provided to your interests and needs?</td>
<td>0-4</td>
<td>4.00 (0.00)</td>
<td>4.00 (0.00)</td>
</tr>
</tbody>
</table>

Note. EG= Experimental group, PG= Placebo group.


**Discussion**

The results indicate an improvement in the scores of social skills for the EG, but not the PG, especially in relation to the subscales of *Self-affirmation in coping with risk* (F1) and *Self-affirmation in the expression of positive feelings* (F2). These changes were found for the social skills targeted in this specific ASST program, i.e., the assertive social skills (included in F1), and some complementary social skills such as self-control (A. Del Prette & Z. Del Prette, 2001; Z. Del Prette & A. Del Prette, 2005) and empathy (Falcone, 2000). The follow-up assessments showed that the gains of the EG were maintained four months after the end of the intervention. The initial discrepancy had disappeared, suggesting that the positive impact on the scores of the EG could be attributed to the essential ingredients of ASST rather than to those elements also included in the intervention of the PG. It is important to mention that the self reports measures found in this study were coherent with data obtained through systematic observation during the sessions. This finding strengthens the correlations reported by Caballo (1993b).

Considering the experimental design, these data provide evidence of the effectiveness of the active elements in the ASST, i.e., the experiential model associated with cognitive-behavioral techniques, as proposed by A. Del Prette & Z. Del Prette (2001) and Z. Del Prette & A. Del Prette (1999, 2005). These elements go beyond those which were considered common to any type of intervention, including that of the PG (therapist’s attention, social interaction among participants, social support, etc.) (Baskin et al., 2003; Rocha et al., 2008). The data also show that the results of the PG were no worse than they were before the treatment, which rules out possible ethical implications of randomized placebos, as used in this study.

The reported increase in difficulty from the pretest to the posttest of the skills of *Fluency in Social Conversation* (F3) for the EG may be related to several factors. These social skills were not specifically targeted by the ASST, although such skills are necessary in interactions related to conversation, and it is possible that the participants of the EG were exposed to more of these interpersonal demands and developed a more accurate discernment of their performance and their feelings when facing such situations. This hypothesis is supported by the participants’ reports during the sessions when they were asked to describe behaviors, talk about the themes of the session, interact with peers, and provide and receive specific feedback on an immediate performance. It is reasonable to assume that interactions in situations requiring assertiveness increase a person’s perception of one’s failings. This may then lead to the perception of such situations as aversive, as found in the study of Rocha (2009), in which mothers reported talking about their own difficulties and those of their children as aversive. In the present study, this difficulty was also associated with assertive demands in relation to affectively relevant people such as children, spouses and friends.

The EG and PG did not reveal equivalence in status prior to intervention in relation to social skills in general (Global Score) and in *Self-affirmation in coping with risk* (F1), with the EG showing lower scores in the pretest. According to Cozby
(2003), however, if, the results showed a greater change in the experimental group than in the control group despite differences in selection, this indicates that the independent variable was robust enough to overcome these differences. Thus, the results provide evidence for the internal validity of the ASST as an effective resource for overcoming inadequacies in the assertiveness of the population, thus contributing to the exercise of their daily rights, as specified in the Brazilian Statute for the Elderly.

The developed program proved to be feasible and economical, specially considering the positive impact it had on eight people (and could be extended to at least 15 people without reducing the quality of the treatment) in only ten sessions with two professionals and very few material resources needed. It is thus an alternative service which can be explored for the support to this clientele.

In the evaluation of User Satisfaction, both the EG and PG had high means, close to the upper limits of the scale, suggesting that the two programs played an important role when meeting the participants’ needs, even if it was only for affection and attention. Only one of the items revealed a statistically significant difference between the two groups. Although the EG showed higher scores, these were lower than those of the PG. The hypothesis is that the costs involved in dealing with assertive demands (as mentioned above) were greater for the EG, whereas the conditions perceived by the PG were less demanding.

The use of a placebo control group is unusual in psychology in Brazil, but the results of this study suggest the importance of such a design for the evaluation of programs of intervention, especially when these involve “packages” of procedures. Moreover, it has produced empirical evidence of potentially relevant programs for meeting current social demands, such as the effective exercise of the rights of the elderly.

Despite the encouraging results of this study, we recognize some of its limitations. One of these involves the small sample. Further studies with a larger number of participants should be conducted to obtain more generalizable results. Moreover, since the IHSI-Del-Prette is in the process of validation, the identification of early deficits based on the normative sample used for the IHSI-Del-Prette (in young adults) should be viewed with caution, as the norms for the IHSI-Del-Prette for the older sample are currently being established. Greater precision is needed to identify the clinical and social meanings of the acquisitions of the participants in the EG. These aspects should certainly be assessed again once a normative reference for the social skills of the elderly is available. However, the study has shown an improvement in the scores of social skills of the elderly, which strengthens the argument that social skills can be learned at any stage of life. A third recommendation is that, despite the evidence that the impact of the program lasted for at least four months after the end of the ASST program, a longer period of monitoring might be useful in future studies.

Another limitation of the study was the use of a quasi-experimental design, although this can be overcome in future studies by randomly selecting the participants of the groups. Moreover, given the potential of the placebo design, other aspects could be explored in a search for the active components of
ASST. These might suggest, for example, the exploration of the alternative of a dismantling placebo design (Baskin et al., 2003). Further studies could also assess the impact of ASST programs on the basis of direct indicators, such as the observation of the participants in actual interactions that require assertive social-skills, and the recognition of the protected by the Brazilian Statute for the Elderly.

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