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Assertiveness Levels among Nurses in a Hospital Setting in Banepa, Kavre District

Neha Shrestha[1], Kushum Kunwar[2], Rachita Neupaney[3] Sastika Shrestha[4]
College of Nursing, College of Nursing, College of Nursing, Day care ward, Kathmandu University, Kathmandu University, Kathmandu University, Bhaktapur Cancer Hospital

Abstract: ***Assertiveness, the honest and direct expression of one's beliefs, needs, and opinions while respecting others' rights, is a crucial skill in nursing. It fosters strong inter-professional relationships, mitigates workplace violence, reduces stress, minimizes negligence, and enhances leadership, job satisfaction, autonomy, and efficacy. This study aimed to evaluate nurses' assertiveness levels in a hospital Setting in Banepa, Kavre District. Using a descriptive cross-sectional design, 88 nurses were sampled through disproportionate stratified random sampling. A structured questionnaire collected socio-demographic data, while the Begley and Glacken Assertiveness Behavior Questionnaire (α= 0.65) measured assertiveness levels. Data were analyzed using SPSS version 16, employing descriptive (percentage, frequency, mean, and standard deviation) and inferential statistics (chi-square test). Results revealed that 80.7% of respondents exhibited a moderate level of assertiveness, while 19.3% demonstrated high assertiveness. Significant associations were found between assertiveness levels and age (p=0.001), marital status (p=0.005), number of siblings (p=0.011), work experience (p=0.0001), job nature (p=0.001), and assertiveness training (p=0.027). The findings highlight a predominant moderate assertiveness level among nurses. Therefore, implementing assertiveness training programs could effectively enhance assertiveness levels among nursing staff.***

Keywords: Assertiveness, Assertiveness Training, Begley and Glacken Assertiveness Behavior Questionnaire, Hospital, Nurses

I. INTRODUCTION

A. Background of the Study

Assertiveness, as defined by Dorland's Medical Dictionary, is characterized by confidently affirming one's stance without aggressive dominance or submissive acquiescence [1]. The American Psychological Association (APA) describes it as a communication style that allows individuals to express feelings and needs directly while respecting others [2,3]. This psychological concept encompasses behavior, cognition, and emotion, enabling individuals to freely express themselves without unnecessary anxiety or anger [4].

Andrew Salter introduced the term assertiveness in 1949, emphasizing its role in peacefully managing confrontations. Arnold Lazarus later redefined it as the expression of personal rights and feelings, focusing on reducing stress-related behaviors [5].

In nursing, assertiveness plays a pivotal role in enhancing leadership, job satisfaction, and patient safety [6]. Despite its importance, studies indicate a prevalence of limited assertiveness among nurses, impacting their learning and efficacy [7]. Nurses are ethically obligated to question incorrect orders and advocate for patient rights [8,9]. Nurses, being the largest workforce in hospitals, are uniquely positioned to advocate for patient care changes, thereby strengthening inter-professional relationships and preventing workplace violence [10].

Studies have shown varying levels of assertiveness among nurses, with a significant proportion exhibiting limited assertiveness [11,12]. For instance, a study at Minia University Hospital revealed low assertiveness among head nurses [13], while another study at Shoahday-e Qaen Hospital in Iran found a majority with limited assertiveness [14]. Similarly, research on nurse entrepreneurs reported a high prevalence of unassertive behaviors [9].

Analyzing assertive behaviors among nurses at Sir Ganga Ram Hospital, Lahore, revealed differences between charge nurses and head nurses in utilizing assertive communication techniques [15].

Given the importance of assertiveness in nursing practice, this study aims to assess assertiveness levels among nurses in a hospital setting in Banepa, Kavre district.

By understanding assertiveness levels and their correlates, this research seeks to identify opportunities for enhancing assertiveness skills among nursing staff, ultimately improving patient care outcomes.

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B. Rationale of the Study

Assertive communication is essential in nursing practice to ensure patient safety, effective teamwork, and quality care delivery. However, research has highlighted a recurring issue of a lack of assertiveness among healthcare professionals, leading to communication errors and potentially compromising patient outcomes [16].

Studies conducted in various settings have shown moderate levels of assertiveness among nursing students [17] and relatively low assertiveness levels among nursing staff [18,19]. Furthermore, research has indicated demographic variations in assertive behavior among nurses, with factors such as gender, age, education, and type of employment influencing assertiveness levels [20,21].

With the evolving landscape of nursing education and practice, there is a growing need to reassess assertiveness levels among nurses, particularly in light of increasing academic qualifications among nursing professionals [22]. Assertiveness is integral to nursing practice, reflecting principles of equality, respect, responsibility, and accountability. It not only promotes patient rights and fairness but also enhances the efficiency and effectiveness of nursing care delivery. By assessing assertiveness levels and identifying demographic correlates, this research seeks to shed light on the role of assertiveness in nursing practice and its implications for patient care outcomes.

C. Objectives of the study

1) General Objective

To assess the assertiveness level among nurses at hospital setting in Banepa, Kavre District.

2) Specific Objectives

To determine the level of assertiveness among nurses at hospital setting in Banepa, Kavre District

To find out the association between the level of assertiveness and selected socio-demographic variables**.**

3) Research Question

What is the assertiveness level among nurses in a hospital setting of Banepa, Kavre District?

II. RESEARCH METHODOLOGY

1) *Research design*: Descriptive cross-sectional research design was used.
2) *Research Setting:* The research study was carried out at Scheer Memorial Adventist Hospital, a Seventh Day Adventist Hospital founded in 1960 A.D. Situated in Banepa Municipality, Kavrepalanchowk district, Nepal, the hospital boasts 150 licensed beds and employs approximately 400 part-time and full-time staff members. The nursing staff comprises a total of 150 individuals.
3) *Target population*: The study included nurses from various wards at Scheer Memorial Adventist Hospital in Banepa, Kavre Distict. These wards encompassed the medical ward, surgical ward, orthopedic ward, pediatric ward, Neonatal Intensive Care Unit (NICU), obstetrics and gynecology ward, Intensive Care Unit (ICU), emergency Outpatient Department (OPD), and the operation theatre.
4) *Sample size:* Sample size was calculated by using formula

$n=N.Z\alpha/2^2.\ P\ (1-P)/\ [(N-1)\ e^2 + Z\alpha/2^2.\ P\ (1-P)]$

Where,

- n = minimum sample size of the study subject
- N = Total study population (150)
- Z = standard normal distribution curve /value at α/2 for the 95% confidence interval (1.96)
- P = proportion of population (50% = 0.5)
- e = the margin of error (0.05)

So, $n= 101*(1.96)^2*0.5*(1-0.5)/\ [(101-1)\ *(0.05)^2+ (1.96)^2*\ 0.5*(1-0.5)]$

n = 80.13= 80

Adjusting sample size by adding Non response rate i.e. 10%

Now, n = 80+10% of 80 = 88

So, minimum sample size of subject body (n) = **88**

5) *Sampling Technique:* Probability, stratified random sampling was used based on working area of nurses.
6) *Inclusion Criteria:* Nurses employed in Scheer Memorial Hospital and willing to participate in the study
7) *Exclusion criteria:* Nurses who were on long leave and not available during the data collection period

8) Instrumentation: Self-administered structured questionnaire was developed consisting of structured and semi- structured questions. The research instrument is divided into 2 parts:

Part I: Information related to socio demographic information: Self-administered structured questionnaire to collect information on socio- demographic profile and information related to nursing profession.

PART II: Begley and Glacken Assertiveness Behavior Questionnaire: It is an open access standard developed by Begley and Glacken (2004) which had been based on a number of other accepted questionnaires, including the Assertion Inventory (Gambrill and Richey, 1975), a 30 item assertiveness schedule (Rathus, 1973) and the College Self Expression Scale (23). The questionnaire incorporates three dimensions of assertiveness: positive assertion, negative assertion and self-denial. Furthermore, three other areas were deemed to be of importance: the ability to deal with criticism, confronting others and the spontaneous expression of feelings. The instrument includes 28 questions in the Likert four-point format type, with the options 'always', 'often', 'rarely' and 'never'.

Level of Assertiveness is categorized as:

Low assertiveness: Score range= 28-54

Moderate assertiveness: Score range= 55-83

High assertiveness: Score range= 84-112

9) Validity

The validity of the instrument was ensured through a thorough review of relevant literature. Content validity for Part I of the questionnaire was established by consulting with faculty members and experts in the field. Questionnaires were then adjusted based on their suggestions.

10) Reliability

The test for internal consistency (Cronbach's Alpha) yielded a score of 0.65, indicating a satisfactory reliability coefficient, and thus confirming the appropriateness of the instrument [23].

Prior to actual data collection, a pretest was conducted among 10% of nurses at Sumeru City Hospital, Lalitpur, to assess the feasibility, completeness, comprehensiveness, and appropriateness of the questionnaire.

11) Ethical Considerations

Ethical clearance was acquired from the Institutional Review Committee (IRC) of Scheer Memorial Adventist Hospital Medical Institute.

Permission was sought from the nursing director and respective ward in-charges.

Informed written consent was obtained from all participants before data collection, ensuring their understanding and agreement to participate.

Strict confidentiality and anonymity were upheld throughout the study.

The information gathered was solely utilized for research purposes.

Voluntary participation was ensured, and participants were given the option to withdraw from the study at any point without consequence.

12) Data Collection Procedure

Formal permission was obtained from Scheer Memorial Adventist Hospital (SMAH) and the College of Nursing, along with approval from the Institutional Review Committee (IRC) of SMAH.

Permission was also secured from the Nursing Director of SMAH in Banepa.

Additionally, permission was sought from the respective ward in-charges at SMAH.

Informed consent was obtained from all participating nurses, both verbally and through written documentation.

Data collection involved the distribution of self-administered questionnaires to nurses during appropriate times.

Data collection took place over a period of four weeks, from the 15th September to the 15th October, 2022.

13) Data Analysis Procedure

After the completion of data collection, the questionnaires were meticulously reviewed for completeness and handled with care. They were then stored, organized, and coded for subsequent analysis.

To minimize errors, data entry was conducted on the same day as collection. Sequential coding was applied, and the data were entered into Microsoft Excel under the supervision of the research guide.

Following data entry, the information was cross-checked for accuracy and analyzed using the Statistical Package for Social Sciences (SPSS) version 16.

All collected data were tabulated, analyzed, and categorized based on the research objectives. Descriptive statistics such as frequency, percentage, mean, and standard deviation were employed to characterize demographic and related variables.

Inferential statistics, including the chi-square test and Fischer exact test, were utilized to ascertain the relationship between selected socio-demographic characteristics and assertiveness levels.

III. FINDINGS

TABLE I
RESPONDENTS' SOCIO-DEMOGRAPHIC INFORMATION

n = 88

Variables	Frequency	Percentage (%)
Age (completed years)		
19-30	60	68.2
31-42	19	21.6
43-54	9	10.2
Mean±SD=29.78±8.52	Maximum: 52	Minimum: 19
Family Type		
Joint	32	36.4
Nuclear	56	63.6
Marital Status		
Married	43	48.9
Unmarried	45	51.1
Number of Siblings		
≤2	34	38.6
>2	54	61.4
Birth Order n= 81		
≤2	65	73.8
>2	16	18.2
Family Income (per month in NRs.)		
≥ 97451	12	13.6
48751-97450	27	30.7
36551-48750	27	30.7
24351-36550	19	21.6
14551-24350	3	3.4

Table I illustrates the demographic characteristics of the respondents. The majority (68.2%) fall within the age group of 19-30 years, followed by 21.6% in the 31-42 age group, and 10.2% in the 43-54 age group. The mean age is 29.78 with a standard deviation of ±8.52. In terms of family structure, 63.6% belong to Nuclear families, while 36.4% belong to Joint families. Regarding marital status, 51.1% of the respondents are married, whereas 48.9% are unmarried. Furthermore, 61.4% have more than 2 siblings, whereas 38.6% have 2 or fewer siblings. The majority (73.8%) have a birth order of 2 or fewer, while 18.2% have a birth order of more than 2. In terms of family income, 30.7% fall within the range of 48751-97450, followed by 30.7% in the range of 36551-48750, 21.3% in the range of 24351-36550, 13.6% with income greater than 97451, and 3.4% in the range of 14551-24350.

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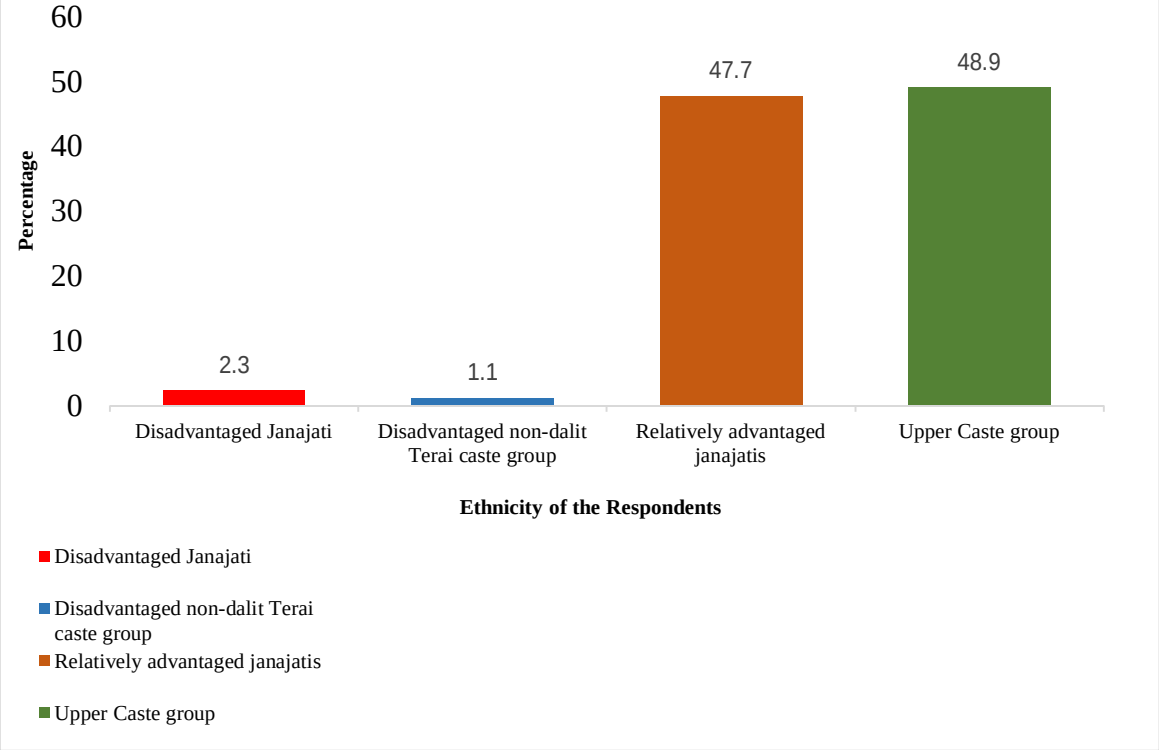


Fig 2. Respondents' Ethnicity

In Figure 2, it is depicted that nearly half (48.9%) of the respondents belong to Upper caste groups. The minimum number of respondents belong to the Disadvantaged non-dalit Terai Caste group, constituting only 1.1% of the total. Similarly, Relatively advantaged Janajatis account for 47.7% of the respondents, while Disadvantaged Janajatis comprise 2.3% of the total respondents.

TABLE II
RESPONDENTS' PROFESSIONAL INFORMATION

n = 88

Variables	Frequency	Percentage(%)
Educational Qualification		
ANM	10	11.4
PCL Nursing	45	51.1
B.Sc. Nursing	20	22.7
Bachelor of Nursing (B.N.)	13	14.8
Clinical Specialty of B.N n=13		
Medical Surgical Nursing	8	61.5
Midwifery	4	30.8
Psychiatry	1	7.7
Working area		
Intensive Care Unit	10	11.4
Medical Ward	10	11.4
Obstetric Ward	19	21.6
Orthopedic Ward	8	9.1

Surgical Ward	8	9.1
Operation theatre	4	4.5
Emergency Ward	10	11.4
Neonatal Intensive Care Unit	5	5.7
Out Patient Department	4	4.5
Pediatric Ward	10	11.4
Working Experience (in years)		
≤10	66	75
>10	22	25
Designation		
In charge	2	2.3
Staff Nurse	86	97.7
Nature of Job		
Temporary	56	63.6
Permanent	32	36.4
Reason for Joining Nursing		
By their own will	77	87.5
By force of parents/friends	11	12.5
Training on assertive communication/behavior		
Yes	27	30.7
No	61	69.3

Table II outlines the educational backgrounds, clinical specialties, work departments, work experience, job positions, job nature, reasons for joining nursing, and training on assertive communication among the respondents. More than half (51.1%) of the respondents possess a PCL qualification, followed by 22.7% with a B. Sc. Nursing degree, 11.4% with an ANM qualification, and 14.8% with a B.N. degree. Of those with a B.N. qualification, the majority (61.5%) specialize in Medical Surgical Nursing. Work departments vary, with Obstetric ward (21.6%) being the most common, followed by Intensive Care Unit, Medical ward, Emergency ward, and Pediatric ward (each at 11.4%). Most respondents (75%) have ten years or less of working experience, and the majority (97.7%) hold the position of Staff Nurse. Additionally, the majority of respondents (63.6%) have temporary employment. A large portion (87.5%) voluntarily chose to pursue nursing, and the majority (69.3%) have not undergone any training on assertive communication/behavior.

TABLE III
RESPONDENTS' LEVEL OF ASSERTIVENESS

n = 88

Variables	Frequency	Percentage(%)
High Assertiveness	17	19.3
Moderate Assertiveness	71	80.7
Low Assertiveness	0	0

Table III presents the assertiveness levels among the respondents. The majority (80.7%) exhibit a Moderate level of Assertiveness, while 19.3% demonstrate a High level of Assertiveness. None of the respondents fall into the Low assertiveness category.

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TABLE IV
ASSOCIATION BETWEEN LEVEL OF ASSERTIVENESS AND SELECTED SOCIO-DEMOGRAPHIC VARIABLES

n = 88

Variables	Moderate Assertiveness	High Assertiveness	Total	χ^2	*p* value
Age group (completed years) 19-36 37-54	62(91.17%) 9(45%)	6(8.83%) 11(55%)	68 20	21.14	.0001
Family Type Joint Nuclear	26(81.25%) 45(80.35%)	6(18.75%) 11(19.65%)	32 56	.010	.919
Marital Status Married Unmarried	29(67.44%) 42(93.33%)	14(32.56%) 3(6.67%)	43 45	9.45	.003 *(f)*
Siblings ≤2 >2	32(94.11%) 39(72.22%)	2(5.89%) 15(27.78%)	34 54	6.417	.011*(f)*
Birth Order n=81 ≤2 >2	51(78.46%) 13(81.25%)	14(21.54%) 3(18.75%)	65 16	0.91	1*(f)*
Family Income (per month in NRs) <36550 >36551	34(80.95%) 37(80.43%)	8(19.05%) 9(19.57%)	42 46	.004	.951
Educational Qualification Graduate Level Undergraduate Level	26(78.78%) 45(81.81%)	7(21.22%) 10(18.19%)	33 55	.122	.727
Working Experience ≤10 >10	61(92.42%) 10(45.45%)	5(7.58%) 12(54.55%)	66 22	23.35	.0001
Nature of Job Temporary Permanent	51(91.07%) 20(62.5%)	5(8.93%) 12(37.5%)	56 32	10.66	.001
Training on Assertive communication/Behavior Yes No	18(66.66%) 53(86.88%)	9(33.34%) 8(13.12%)	27 61	4.90	.027

χ^2 =Pearson's Chi Square test, f = fischer's exact test, Level of significance, p = < 0.05

Table IV reveals significant associations between the level of assertiveness and various demographic variables. Specifically, there is a significant association observed between the level of assertiveness and the age of the respondents. However, no association is found between the type of family and the level of assertiveness. Furthermore, significant associations are identified between marital status and assertiveness level, as well as between the number of siblings and assertiveness level among the respondents. Conversely, no association is found between birth order and assertiveness level.

Additionally, the table illustrates no significant association between family income and assertiveness level, nor between educational qualification and assertiveness level among the respondents. However, significant associations are observed between assertiveness level and working experience, assertiveness level and nature of job, as well as assertiveness level and training on assertive communication/behavior.

IV. DISCSUSSION

A descriptive cross-sectional study on "Assertiveness Levels Among Nurses in Hospital Settings in Banepa, Kavre District" was conducted, utilizing Probability Stratified Random Sampling. The study comprised a sample size of 88 participants, and data were collected using the standard tool, the Begley and Glacken Assertiveness Behavior Questionnaire.

The study found that a majority (80.7%) of the respondents exhibited a moderate level of assertiveness, which aligns with similar findings in Nepal by Shrestha S. in 2019 [19]. However, this contrasts with findings from Sumathi et al. in 2020 in India and Larijani et al. in Iran in 2010, where differing levels of assertiveness were observed, possibly due to variations in sample size and assessment tools [6][3].

Additionally, 19.3% of respondents displayed high assertiveness, consistent with studies in Egypt by Abdel M. in 2017 and Augustine R. in 2019 in India [25][20]. Conversely, none of the respondents demonstrated low assertiveness, differing from findings in Slovenia, Iran, and Egypt, suggesting potential influences of sample size, sampling techniques, and data collection tools [17][8][12].

Significant associations were observed between assertiveness levels and demographic variables, including age, marital status, number of siblings, working experience, nature of job, and participation in assertiveness training. These findings corroborate with various studies across different countries, indicating the multifaceted nature of assertiveness and its correlates among nurses [25][26][3][18][20][17][27].

In conclusion, the study underscores the prevalence of moderate assertiveness among nurses in Banepa, Kavre District, with notable associations between assertiveness levels and various demographic factors. Understanding these associations can inform targeted interventions to enhance assertiveness skills among nurses, thereby potentially improving patient care and healthcare outcomes.

RECOMMENDATIONS

A. For The Study Area

Implement regular assertiveness training sessions for nurses at SMAH to enhance their communication skills and confidence in advocating for patient needs.

Integrate modules on assertiveness concepts and techniques into the undergraduate nursing curriculum to ensure that future nurses receive foundational training in assertive communication.

Utilize interactive role-play activities as part of assertiveness training programs to provide practical opportunities for nurses to apply assertiveness skills in simulated scenarios and reinforce learning.

B. For Further Study

Explore additional factors influencing assertiveness levels among nurses, such as personality traits, years of experience, and organizational culture.

Conduct a replicated study with a larger sample size to validate the findings and improve the generalizability of results.

Consider adopting a mixed-methods research approach to gain deeper insights into the qualitative aspects of assertive behavior among nurses and its impact on patient care outcomes.

V. LIMITATIONS

The study's sample size of 88 participants may be relatively small, potentially limiting the generalizability of the findings to a larger population of nurses.

The use of Probability Stratified Random Sampling may introduce bias if certain groups of nurses are overrepresented or underrepresented in the sample.

The reliance on self-reported data through the Begley and Glacken Assertiveness Behavior Questionnaire may introduce bias, as participants may provide socially desirable responses or inaccurately assess their own assertiveness levels.

The study's cross-sectional design provides a snapshot of assertiveness levels at a single point in time, limiting the ability to establish causality or track changes in assertiveness over time.

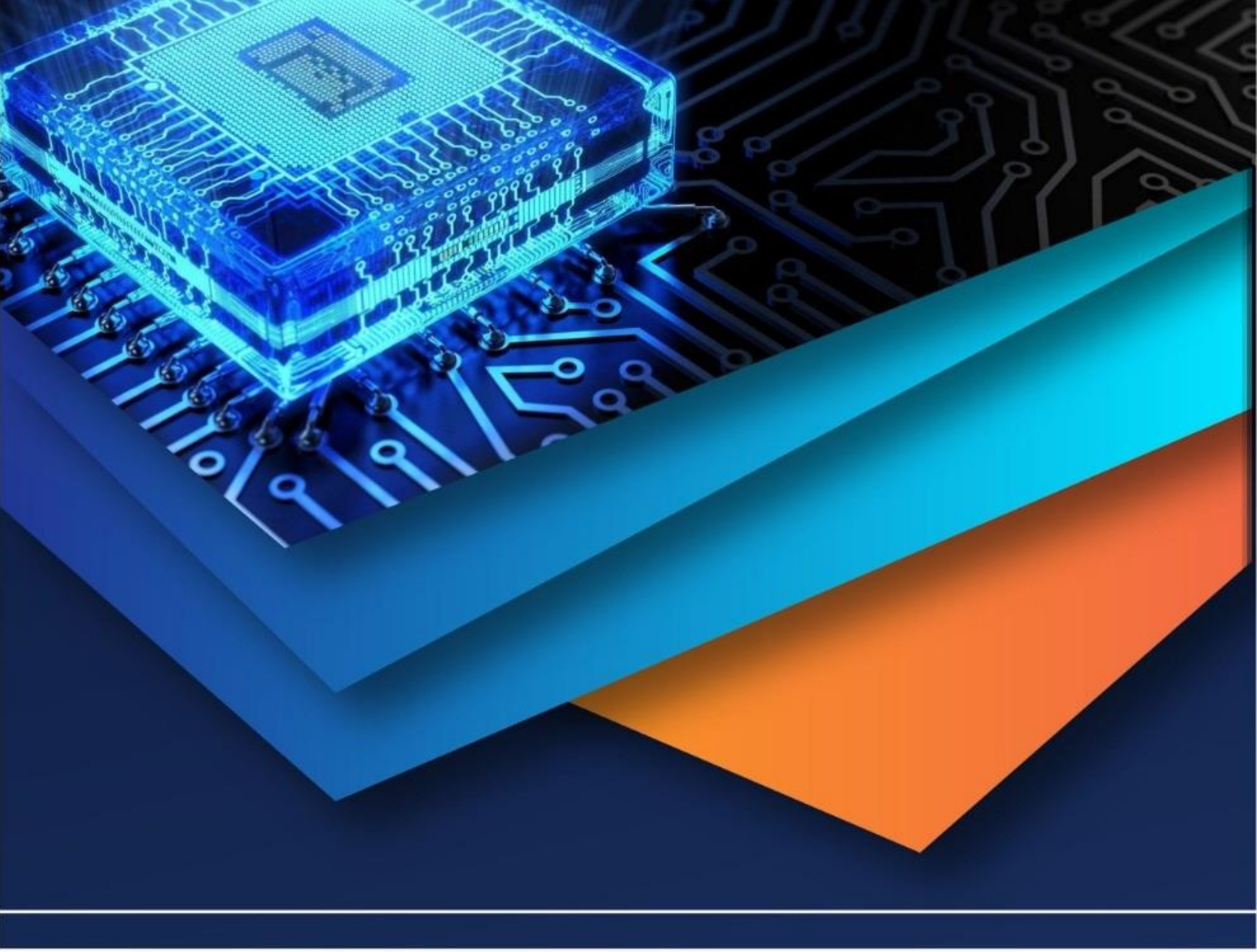
The study focuses solely on nurses in a hospital setting in Banepa, Kavre District, which may limit the generalizability of the findings to nurses in other healthcare settings or geographic locations.

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