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SOCIAL SKILLS TRAINING IN A DEPRESSED, VISUALLY IMPAIRED OLDER ADULT

BRAD DONOHUE, RON ACIERNO, VINCENT B. VAN HASSELT and MICHEL HERSEN

Center for Psychological Studies, Nova Southeastern University

Summary — A multiple baseline design was used to assess the effects of social skills training (SST) in a 65-year-old woman suffering from major depression and severe macular degeneration. Responses to role-played scenarios requiring assertiveness, *in vivo* requests for assistance and social involvement, self-reported assertiveness, depression, and happiness were repeatedly recorded during baseline, treatment, and follow-up phases. Results showed progressive improvement in targeted social skills with SST in both clinic and home settings. Concurrent with enhanced levels of social skill were dramatic decreases of depression to a nonclinical level. Improved skill levels and diminished Geriatric Depression Scale scores were maintained during the 7-month follow-up period, except at the 6 month assessment after which booster treatment was applied to reinstate maximum improvement.

Applications of behavioral techniques to the evaluation and remediation of mental health problems in older adults have proliferated in recent years (see Hersen & Van Hasselt, in press; Wisocki, 1991). This growing interest is in part attributable to a convergence of data documenting an exceedingly high level of psychiatric disorders (e.g., anxiety, depression) in this population. For example, community-based surveys have demonstrated that prevalence of significant depressive symptoms in noninstitutionalized older adults ranged from 11 to 44%, with a mean of approximately 20% (Blazer, 1982). Moreover, cross-sectional epidemiological studies have shown that suicide rates in older adults are significantly greater than in younger individuals (Murphy & Wetzel, 1980; Templer & Cappelletty, 1986).

More recently, data have been accrued which suggest that such difficulties may be compounded in older adults who are afflicted with severe visual impairment. Indeed, progression of visual disorders (e.g., macular degeneration, glaucoma, diabetic retinopathy) in the elderly has been associated with loss of self-esteem, independence, ability to participate in recreational activities, meaningful interpersonal relationships, and a social support network (Cherry, Keller, & Dudley, 1991). And loss of a close social support system in those with progressive visual impairment is especially correlated with depression (Hersen, Kabacoff, Van Hasselt, Null, Ryan, & Melton, in press).

In order to enhance the social and emotional adjustment of older psychiatrically impaired adults, several social skill training protocols have been carried out (e.g., Berger, 1979; Franzke, 1987; Fisher & Carstensen, 1990). However, relatively few reports have specifically examined the effects of such programs with depressed older adults, who are ambulatory. In one of these efforts, Hussain and Lawrence (1981) compared the

efficacy of problem solving training (i.e., problem definition, generating solutions, decision-making, verification), social reinforcement of activity, and a waiting-list control condition in depressed nursing home patients. Patients receiving problem-solving training showed the most significant reduction of scores on the Beck Depression Inventory post-treatment and at 2-week and 3-month follow-up evaluations.

Fernandez-Ballesteros, Izal, Diaz, Gonzalez and Souto (1988) applied conversational skills training to elderly patients in a residential care home. Individuals receiving the 18-session behavioral intervention (i.e., modeling, discriminative and verbal reinforcement, discussion, behavioral rehearsal, homework assignments) displayed significant increases in conversational skills (e.g., "speaking up," "giving information") and decreases in scores on the Zung Self-Rating Scale of Depression relative to placebo and waiting list controls. Gains were maintained at a 3-month follow-up probe.

While the above findings suggest the potential value of skill interventions for depressed older adults, we were not able to find any single-case or group controlled studies with this population who also suffer from severe visual impairment. Indeed, the critical importance of teaching older visually impaired individuals to assertively obtain social support from their environment is bolstered by Hersen et al.'s (in press) recent data documenting significant negative correlations between depression and social support and depression and assertiveness in a cohort of 100 older visually impaired individuals. Moreover, in that study there was a significant positive correlation between assertiveness and the ability to obtain social support from the environment when needed. The present single-case analysis, theoretically and clinically relevant to the aforementioned findings (Hersen et al., in press), involved the successive application of a multiple component social skill program to a 65-year-old depressed female suffering from macular degeneration. Using a multiple baseline design across behaviors, the effects of our intervention were assessed with respect to social skill level, *in vivo* propensity to

make requests for assistance and social involvement, assertiveness, depression, and overall happiness.

Method

Case History

The patient, a 65-year-old, Jewish, widowed, female diagnosed with macular degeneration was self-referred to the Nova Community Clinic for Older Adults (NCCOA) and complained of difficulties adjusting to her visual impairment, including decreased social activity, confrontations with people in the environment, and failure to perform daily living skills (e.g., cooking, cleaning). The Structured Clinical Interview for the DSM-III-Revised (SCID-R; Spitzer, Gibbon, & First, 1988), conducted during the initial evaluation, indicated a diagnosis of major depression. Onset of depression occurred shortly after the patient was diagnosed with macular degeneration, two years prior to her presentation for treatment at NCCOA. Macular degeneration, a progressive eye disease, resulted in complete blindness in her left eye and legal blindness in her right eye. She reported that her visual impairment caused her to feel "uncomfortable" when requesting "assistance and social support." Prior to the patient's impairment in vision, she reported no difficulties interacting with others. Moreover, she described her social life as "quite good," and actively attended social functions (e.g., luncheons, bingo, plays, movies).

The patient described several other episodes of major depression during the 20 years prior to receiving our social skills treatment. These episodes occurred subsequent to environmental stressors (e.g., death of a friend, death of husband), and each episode persisted for a year or more. Throughout these episodes she was maintained on a variety of psychotropic medications and dynamic psychotherapy, but reported that they were largely ineffective in ameliorating her depression.

During our social skills treatment the patient

attended the Fort Lauderdale Lighthouse for the Blind twice weekly for rehabilitative services. The Fort Lauderdale Lighthouse for the Blind is a comprehensive rehabilitation and social recreation program providing support and adjustment services (e.g., retraining in home appliance use) to visually impaired and blind individuals in Broward County, Florida. Throughout baseline, treatment, and follow-up phases, the patient received imipramine (30 mg daily), and clonazepam (0.25 mg daily).

Behavioral Assessment

Role-play test (RPT). Three components of social skill were assessed via a RPT consisting of three scenes in each area: (1) *negative assertion —* standing up for one's rights, requests for behavior change; (2) *request for assistance —* asking others for help; (3) *social involvement —* asking others for involvement in social activities. Performance on three training scenes and three generalization scenes (not rehearsed in training sessions) was evaluated on a weekly basis. In addition, responses on three novel scenes (to which the patient was not exposed during training) were only evaluated during the first baseline session and at the 6-month follow-up probe. Role played scenes were selected from an item pool of social situations generated by clients at the Fort Lauderdale Lighthouse for the Blind. Specifically, they were asked to construct interpersonal scenarios that they felt were relevant to their social situation. Using this strategy, 18 potential RPT items were developed. Of these, nine that were considered most common, difficult, and contributing to our patient's lack of social activity were selected for the present study. Examples of negative assertion and social involvement RPT scenes are presented below. Each scene involves narration and several prompts to facilitate patient responding.

Negative Assertion

Narrator: You are in line buying groceries. The man in front of you pays for his groceries and starts to walk toward the door. You don't notice that he has gone, so you don't move up. The man in back of you says:

Subject Response 1: "Hey, what's wrong with you? Hurry up!"

Subject Response 2: "You should have someone else buy your groceries."

Social Involvement

Narrator: You are walking to your apartment. You are bored and wish you could find someone that you could spend time with in the future, suddenly you hear an old friend say to you:

Subject Response 1: "Hi."

Subject Response 2: "I can't."

Subject Response 3: "I have to go now, I'm busy."

Specific multiple-criterion role-play tests for each skill area (i.e., Negative Assertion, Assistance Requests, and Social Involvement) included Training scenarios, which were rehearsed each treatment session and assessed each week; generalization scenarios, which were not rehearsed in treatment sessions but were assessed each week; and novel scenarios, which were assessed only during the first baseline session and the 6-month follow-up session. Detailed role-play criteria for each skill area are presented in the Appendix. Performance scores were derived by dividing the number of correctly performed role-play criteria by the total number of possible criteria to produce comparable weekly percentage scores across skill classes. These percentage scores were then averaged for each class of behavior during Baseline, Social Skills-Training, and Follow-Up periods to produce overall indices of change.

Skills were assessed through weekly probe sessions that were audiotaped and retrospectively rated. Ratings were made on a dichotomous occurrence/nonoccurrence basis. To establish inter-rater agreement, a second judge, blind to treatment phase and hypothesis, independently rated one-third of the RPT items (randomly selected). Inter-rater agreement was computed on each social skill across all scene categories. Percentage agreement was 98% for negative

assertion, 95% for request for assistance, and 96% for social involvement requests.

Wolpe–Lazarus assertiveness scale (WLAS; Wolpe & Lazarus, 1966). The WLAS is a 30-item self-report questionnaire developed to evaluate an individual's level of assertion. The respondent endorses yes or no to each item, which reflects either the positive, negative, or general expression of assertion. Representative items are: "Do you usually keep your opinions to yourself?" and "If a friend makes an unreasonable request, are you able to refuse?" In a study with psychiatric inpatients and day hospital patients, the WLAS was demonstrated to have moderately high internal consistency, with an overall split-half reliability of $r = .78$ (Hersen et al., 1979). A one-week test–retest study with 46 patients yielded an overall Pearson Product-Moment correlation of $r = .65$.

Geriatric depression scale (GDS; Yesavage et al., 1983). The GDS has been widely used in psychotherapeutic studies of depression in later adulthood. This measure consists of 30 yes/no items representing depressive symptomatology in the aged. On the basis of overall scores, subjects are classified as severely depressed (21–30), mildly depressed (11–20), or normal (0–10). Previous studies have demonstrated high degrees of internal consistency for the GDS (Yesavage et al., 1983; Parmelee, Katz, & Lawton, 1989). The GDS has high concurrent validity ($r = .83$) with the Zung Self-Rating Depression Scale (Yesavage et al., 1983). Hyer and Blount (1984) and Olin, Schneider, Eaton, Zemansku, and Pollock (1992) have shown, respectively, high concurrent validity between the GDS and the Beck Depression Inventory ($r = .73$ and .91).

Overall happiness ratings. Self-reported daily ratings of "Overall Happiness" (0 = completely unhappy, 100 = completely happy) were also obtained as an ongoing index of mood over the course of the study. Daily scores were averaged each week.

Requests for assistance and social activity. The client was asked to report the number of requests for assistance that she initiated since the last contact when called at home every two evenings. During these phone interviews, she also was asked about frequency of self-initiated social activities. These were added to yield weekly totals for each of these two measures.

Social Skills Training

Consistent with the multiple baseline design across behaviors, target skills were trained sequentially and cumulatively in a predetermined order. All treatment was provided by an advanced doctoral student of clinical psychology who had prior experience in social skill strategies. Training sessions were carried out once per week, with each session lasting for approximately 60 minutes.

During the initial session, the patient was informed that loss of vision was interfering with the ability to obtain adequate social reinforcement, and that skills training would improve both the quality and quantity of her social relationships. The patient was informed of the experimental nature of the treatment.

The first two baseline sessions consisted of nondirective therapy in which the therapist empathized with the patient about misfortunes that has resulted since her loss of vision. No feedback, advice, or skills training were provided during baseline sessions. For each of the 13 training sessions, each scene was read to the patient by the therapist and subsequently role-played. Positive feedback for skill performance was provided by the therapist at the end of each role-play. The patient received instructions, observed the therapist modeling appropriate responses, rehearsed the scenes, and was praised for improvements noted. Training of negative assertion occurred over a 3-week period (sessions 3–5); training in requests for assistance occurred over a 6-week period (sessions 6–11); and training in requests for social involvement occurred over a 4-week period (sessions 12–15).

Booster Sessions

Booster sessions were carried out over the telephone throughout the 7-month follow-up period to consolidate initial treatment gains. Most important, however, the patient was encouraged to practice newly-acquired skills when initiating social activities with her friends. A final booster session was carried out at the Fort Lauderdale Lighthouse for the Blind immediately after the 6-month follow-up. At that time, the patient experienced increased depression following opthamologic surgery that failed to restore her vision.

Follow-Up Probes

Follow-up probes were performed at 1, 3, 6, and 7 months posttreatment. One, 3, and 6-month follow-ups included role-play assessment of the three targeted skills (negative assertion, assistance requests, social involvement). The 7-month assessment did not include role-play assessment. In addition, requests for assistance and social involvement, Wolpe–Lazarus Assertiveness Scale, Geriatric Depression Scale, and happiness ratings were obtained at each probe session.

Results

The results of training on role-play performance are presented in Figure 1. Sequential and cumulative introduction of social skill treatment to targeted behaviors resulted in improved average performance for both training and generalization scenes over specific skills training phases. Such improvement was maintained at follow-up. Also, improvement was evident on novel scenes for all skills at follow-up.

Figure 2 presents concurrent self-report measures of requests for assistance and requests for social involvement. Requests for assistance remained at a low level until this behavior was targeted in Session 6, at which time the frequency increased dramatically. Further increases in the number of requests for assistance occurred after social involvement requests were targeted in Session 12. Improvements were maintained at 1, 3, 6, and 7-month follow-ups, but at a somewhat lower level than when social involvement training was being implemented.

Number of requests for social involvement decreased initially during negative assertion training, remained at low levels during assistance request training, and then increased after social involvement training was implemented. Not only were improvements maintained during the 1, 3, 6, and 7-month follow-ups, but number of social involvement requests actually increased.

Figure 3 presents self-report measures of assertiveness, depression, and happiness throughout all phases of the study. Scores on the Wolpe–Lazarus Assertiveness Scale increased throughout treatment and were maintained during the 7-month follow-up period, with the exception of the minor decrease noted at the 6-month assessment. Similarly, depression decreased to nonclinical levels during treatment while happiness ratings increased dramatically. The slight deterioration of the patient's mood prior to initiation of assistance request training in Session 6 deserves comment. Shortly after negative assertion training was implemented in Session 3, she suffered a sudden and additional loss of vision. At that time the patient reported deterioration in her mood and, to a lesser extent, diminished overall assertion. With the exception of the 6-month follow-up assessment, depression remained at a nonclinical level throughout the follow-up. During the 5th month posttreatment opthalmologic surgery was performed in an attempt to restore the patient's vision. Surgery failed, and she then reported increased depression and diminution of overall assertiveness at the 6-month follow-up. At this point, an additional booster treatment session was carried out, yielding diminished depression and increased assertion at the 7-month follow-up assessment.

Discussion
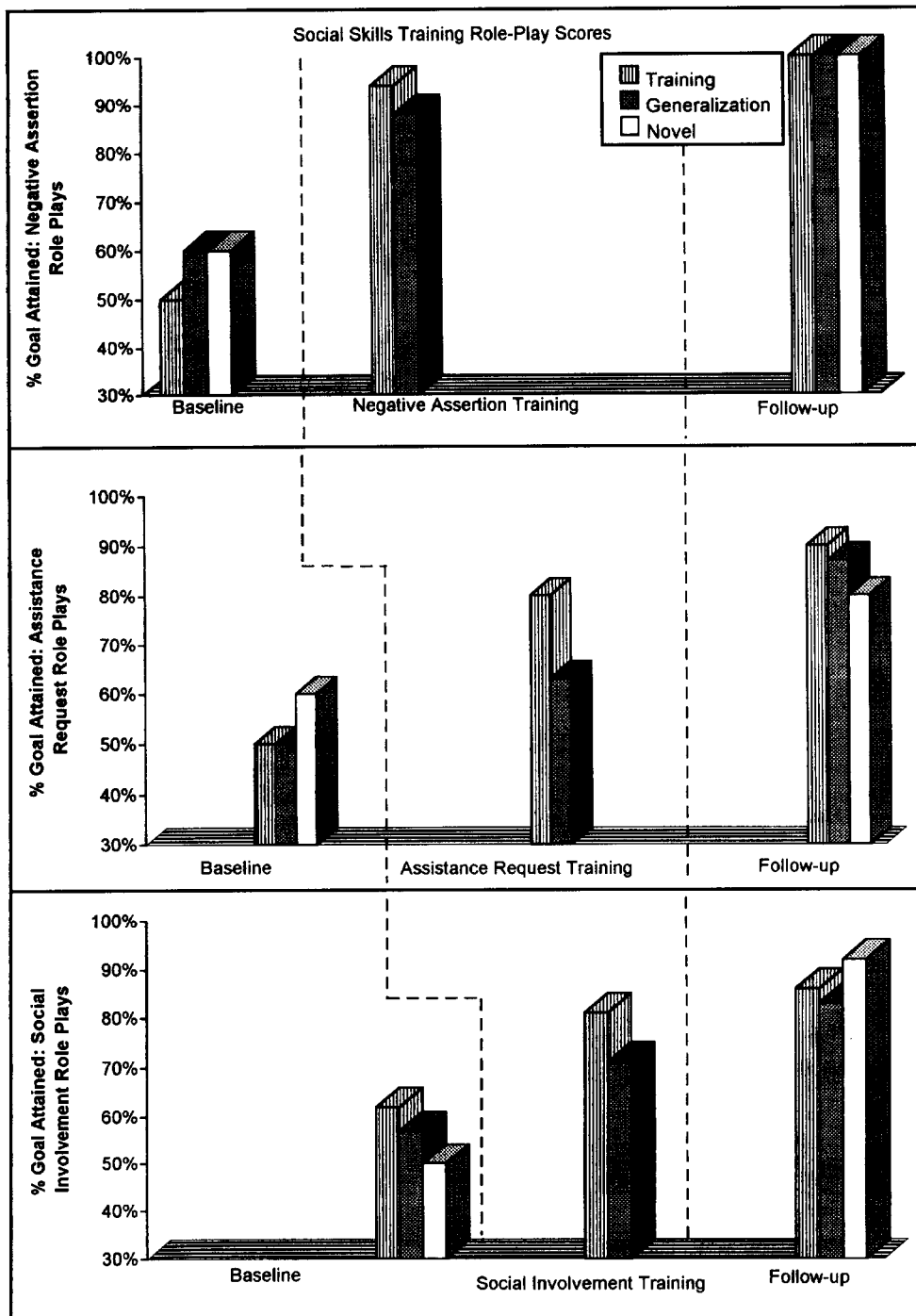
There were three major objectives in carrying

Figure 1. A multiple baseline analysis of negative assertion training, assistance request training, and social involvement training. Mean data are presented for training, generalization, and novel scenes during baseline, social skills training, and follow-up.
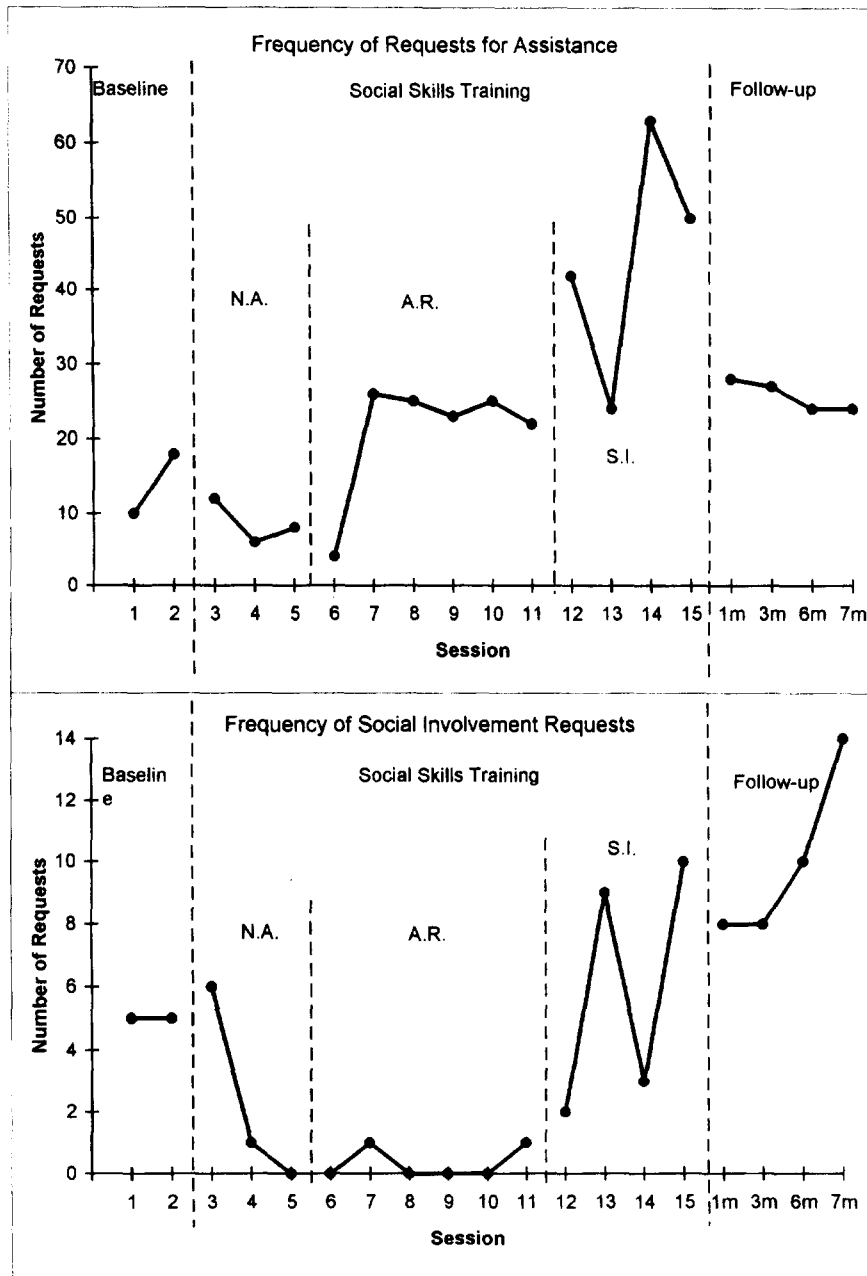
Figure 2. Self-reported weekly frequencies of requests for assistance and requests for social involvement, during baseline, negative assertion training (N.A. in the graph), assistance-request training (A.R. in the graph), social-involvement training (S.I. in the graph), and follow-up.

out our single case analysis: (1) to increase the frequency and quality of targeted social skills of a depressed and visually impaired older female

adult, (2) concurrently to reduce this patient's level of depression and increase assertiveness, and (3) to document generalization and maintenance of
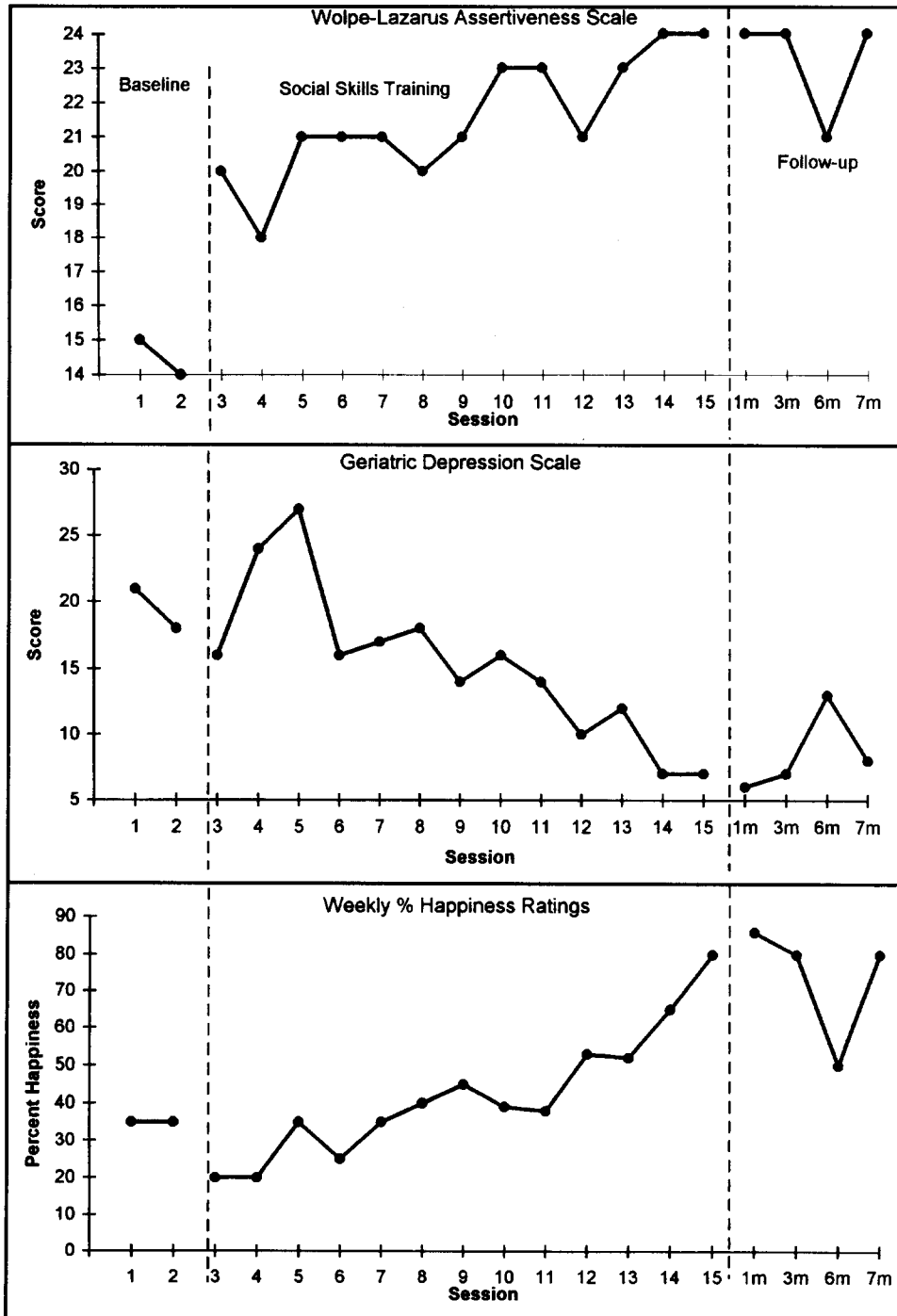
Figure 3. Wolpe–Lazarus assertiveness scale, geriatric depression scale, and ratings of overall happiness (0% = completely unhappy, 100% = completely happy) during baseline, social skills training, and follow-up.

treatment gains in the patient's natural environment. Outpatient social skills training targeted negative assertion, requests for assistance, and requests for social involvement. Treatment included a combination of instructions, modeling, role-playing, feedback, and praise to increase social interaction.

Behavioral observations indicated that targeted social skills improved with treatment and that these skills were found to generalize to novel situations in a behavioral task. In addition, skills were maintained at 1, 3, 6, and 7-month follow-ups. Moreover, this patient was able to implement these skills in her natural environment, as she reported an increased frequency in requests for assistance and social involvement following training in these areas. Interestingly, her frequency of requests for social involvement was maintained throughout follow-up, whereas frequency of requests for assistance decreased during follow-up, perhaps reflecting improved self-sufficiency (a stated goal of the Lighthouse for the Blind).

We found that it was particularly important to teach our patient how to reinforce others when gratification from her environment was received. For example, even though obviously she could not drive in reciprocation, she certainly was able to prepare a meal in return, tell a joke, or treat a friend to a restaurant meal.

Mood appeared to be more negatively influenced by environmental circumstances (e.g., loss of vision, failure of surgery to restore vision) than skill acquisition. Nevertheless, improvements in social skill roughly coincided with improvements in overall assertion, depression, and happiness. Improvement in mood was most striking after social involvement was targeted and notably, the patient increased the frequency of her requests for social involvement.

Although limited by the fact that we are only reporting a single case analysis, our data confirm the importance of teaching the older depressed adult suffering from visual impairment to obtain social gratification from the environment (see Hersen et al., in press). Indeed, in the absence of a strong social support network, the older visually impaired individual is likely to become isolated

and depressed. By teaching such an individual assertive responding strategies her basic and interpersonal needs will be met and depression will diminish or lift altogether. From a preventative standpoint, we believe that by teaching such a person to deal with negative life circumstances, to make appropriate requests for assistance, and to make effective requests for social involvement he or she will be inoculated against depression. However, a more comprehensive controlled clinical trial will be required to confirm this hypothesis.

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Appendix

Scoring Role Play Performance

Role plays are scored according to the criteria specified below. One point is given for the fulfillment of each criterion. Note that several criteria require the presence of a specific verbal content response, while others require the absence of responses. Additional scoring parameters are provided with each criterion.

Negative Assertion Criteria are as Follows: (Possible 5-point Total)

1. Patient states interpersonal problem objectively, without argumentation.
   e.g. "I'm blind, and I could not see that it was my turn to go."
2. Patient states a possible reason for the other person's behavior and this reason is nonblaming.
   e.g. "Its not your fault. You just did not know that I'm blind."
3. Patient suggests a solution involving an action on the other person's part.
   e.g. "Why don't you help me pick up these letters and we'll both be on our way."
4. Patient politely terminates conversation irrespective of other's compliance with request.
   e.g. "Well, if your too busy to help, I guess that's o.k. So long."

5. Patient did not make any statements during role-play that were rude, unfriendly, caustic, sarcastic or malicious in tone or content.
   e.g. 0-point "If you weren't such a thoughtless jerk, this would not have happened."

Assistance Request Criteria are as Follows: (Possible 10-point Total)

1. Patient specifically states what behavior from the other person is desired.
2. Patient specifically states when the behavior is desired (if the temporal nature of the request is obvious, as in the example below, award this point).
3. Patient specifically states where or how the behavior is to be performed.
   e.g. (1–3) "Please take my arm and direct me over to my apartment in building A."
4. Patient states how meaningful the behavior would be, or how much it would be appreciated.
   e.g. "It would really be a great relief to me if you could help me out."
5. Patient offers some form of reciprocation for others assistance.
   e.g. "While you're taking me, I'll tell you a good joke."
6. When assessor resists request, patient specifically asks why.
   e.g. "Why can't you take me."
   e.g. 0-point "Don't you have a minute to help me?"
7. Patient makes a statement validating assessors resistance by either acknowledging the assessor's reason for resistance, or agreeing with it in some way.
   e.g. "Oh, I see. You can't because you're too busy."
8. Patient makes a specific alternate request that "handles" assessor's objection.
   e.g. "If you don't have the time to walk me over to Sears, perhaps you could guide me over to the information desk."
9. Patient terminates conversation politely, without rude or sarcastic comments or intonation.
   e.g. 0-point response "Oh alright. Just forget it then."
10. Patient did not make any statements during role-play that were rude, unfriendly, caustic, sarcastic or malicious in tone or content.

Social Involvement Criteria are as Follows: (Possible 12-point Total)

1. Patient states pleasant salutation to assessor.
   e.g. "Hello, Ida, very nice to see you today."
2. Patient makes a nonrequest statement about a common topic of interest (i.e., "small talk").
   e.g. "It's been terribly hot, hasn't it?"
3. Patient inquires about a current interest or activity of the assessor.
   e.g. "What are your plans for today?"
4. Patient comments in some way on what the assessor has just said.
   e.g. "Oh, you're going to visit you grandchildren, that's just wonderful."
5. Patient specifically states what social behavior from the other person is desired.

6. Patient specifically states when the social behavior is to take place (if the temporal nature of the request is obvious, as in the example below, award this point).
7. Patient specifically states where or how the social behavior is to be performed.
   e.g. (5–8) "Phyllis, why don't you come on into my house for some tea, I just brewed it."
8. When assessor resists social request, patient specifically asks why.
9. Patient makes a statement validating assessors resistance by either acknowledging the assessor's reason for resistance, or agreeing with it in some way.

e.g. "Oh, I see. You can't come in for tea because you're too tired."
10. Patient makes a specific alternate request that "handles" assessor's objection.
    e.g. "Maybe we can get together for a little talk when you feel a little bit more energetic."
11. Patient terminates conversation politely, without rude or sarcastic comments or intonation.
    e.g. 0-point response "Oh alright. Just forget it then."
12. Patient did not make any statements during social assertion role-play that were rude, unfriendly, caustic, sarcastic or malicious in tone or content.