

Effectiveness of Assertive Therapy for Parents in Managing Adolescent Emotions

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ABSTRACT

Background. Adolescents experienced significant psychosocial stressors during the COVID-19 pandemic due to movement restrictions, social isolation, and disruptions in routine, which adversely affected emotional regulation. As primary caregivers, parents play a critical role in supporting adolescents' emotional well-being, particularly during prolonged home confinement. Assertiveness training may enhance parents' ability to manage adolescents' emotional responses by improving communication, emotional control, and problem-solving skills.

Objective. To determine the effectiveness of assertiveness training for parents in improving their ability to manage adolescents' emotional regulation.

Methods. This study employed a quantitative quasi-experimental design with a control group. A total of 92 parents were recruited and allocated to either the intervention group (n = 46) or the control group (n = 46) using simple random sampling. The intervention consisted of assertiveness training delivered over six structured sessions, focusing on enhancing parents' assertive communication and emotional management strategies in addressing adolescent problems. Outcome measures assessed parents' ability to manage adolescent emotions before and after the intervention.

Results. Participants ranged in age from 22 to 65 years, with the largest proportion aged 43–45 years. Most respondents were married (82.6%), had adolescent daughters (43.4%), and had attained a low educational level (80.4%). Post-intervention analysis demonstrated a statistically significant improvement in parents' ability to manage adolescent emotions in the intervention group compared with the control group ($p < 0.05$). An associated increase in adolescents' emotional understanding, as perceived by parents, was also observed following the intervention.

Conclusion. Assertiveness training is effective in enhancing parents' capacity to manage adolescents' emotional regulation. Collaboration between the Department of Health and psychiatric nursing specialists is recommended to integrate assertiveness training into community-based mental health programs. Incorporating this intervention as a core competency for psychiatric nursing specialists in community health settings may strengthen family-centered mental health services, particularly during public health emergencies.

Keywords: adolescent, assertive, emotion, parents



Paper presentation – International Conference on Health Development, October 30, 2021, Jakarta, Indonesia.

eISSN 2094-9278 (Online)
Published: June 30, 2026
<https://doi.org/10.47895/amp.v60i12.4600>
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INTRODUCTION

Adolescence is a critical stage of human growth and development, typically occurring between the ages of 13 and 20 years, and is characterized by rapid changes in self-concept, cognitive capacity, emotional regulation, sexuality, moral reasoning, and religious understanding.¹ During this developmental period, adolescents are particularly sensitive to environmental and interpersonal influences. Exposure to adverse experiences such as bullying, anxiety in social relationships, peer rejection, and ineffective communication with parents may significantly disrupt psychosocial development, rendering adolescents vulnerable to mental health problems.²

Assertiveness training was first introduced in 1966 by Wolpe as a promotive therapeutic approach aimed at improving interpersonal relationships and communication skills.³ This intervention was initially developed to benefit individuals who experience difficulty expressing thoughts, emotions, and needs appropriately. Subsequent studies have demonstrated the effectiveness of assertiveness training in enhancing assertive behaviors among school-aged children, particularly those exposed to bullying, by equipping them with skills to communicate needs and set boundaries effectively.⁴ Assertiveness-based interventions have also been applied to children experiencing academic-related anxiety, such as examination stress, highlighting that anxiety commonly emerges during early developmental stages and may persist if not adequately addressed.⁵

Beyond childhood, assertiveness training has been applied among individuals transitioning into early adulthood, a period marked by increasing personal, academic, and occupational responsibilities. Effective assertive communication is particularly essential in professions requiring high levels of interpersonal interaction, such as nursing. Training nursing students in assertiveness has been shown to reduce communication errors that may compromise patient safety and service satisfaction.⁶ Individuals faced with extensive responsibilities are also prone to psychological stress, which may inhibit assertive behavior and lead to maladaptive coping strategies.⁷ Conversely, inadequate development of assertive behavior during childhood and adolescence has been associated with shame, social withdrawal, low self-confidence, emotional dysregulation, and social isolation during the teenage years.⁸ These findings underscore the importance of early interventions that promote assertive behavior and emotional competence.

Assertiveness interventions have also been tested in youth populations with promising outcomes.⁹ Previous research on assertiveness training emphasized distinguishing assertive from non-assertive behaviors and identifying maladaptive thought patterns, with training sessions typically consisting of structured learning, skill practice, and group discussion.¹⁰ Previous studies have demonstrated that assertiveness training significantly reduces depressive symptoms among adolescent and enhances their ability to regulate emotions and

communicate effectively in social contexts.^{11,12} Adolescents have been described as a “second golden age” of development, during which targeted psychosocial interventions may yield long-term benefits.¹³

Given the importance of this developmental stage, the family environment, particularly parenting style, plays a crucial role in shaping adolescents’ assertiveness. Parenting style has been shown to influence the development of assertiveness in adolescents.¹⁴ Parents play a pivotal role in shaping adolescents’ emotional development and coping strategies. Effective parent–adolescent communication allows emotional insecurity, anxiety, and stress to be identified and addressed constructively.

Assertiveness development is a multidimensional process influenced by cognitive, behavioral, and environmental factors. Increased understanding can lead to changes in attitudes, beliefs, and communication skills, while external influences such as social environment and leadership also contribute to the formation of assertive behavior.^{15,16} Moreover, assertiveness-based interventions have been shown to strengthen adolescents’ ability to resist negative influences, including substance abuse and maladaptive behaviors.¹⁷

In West Java, specifically in Kelurahan Limo, Indonesia, increased emotional reactivity among adolescents was observed during the COVID-19 lockdown period. Movement restrictions and prolonged home confinement limited adolescents’ opportunities for peer interaction, resulting in heightened emotional distress. Parents reported difficulty managing adolescents’ emotional outbursts, particularly as adolescents spent significantly more time at home. These conditions underscore the importance of developing community-based interventions that enhance parental assertiveness and emotional coaching skills. Therefore, this study aims to determine the effectiveness of assertiveness training for parents in improving their ability to manage adolescents’ emotional regulation.

METHODS

Research Design

This study was conducted in Limo Village, Depok City, West Java Province, Indonesia, an area characterized by diverse population demographics, socioeconomic conditions, and educational backgrounds. A quantitative quasi-experimental design with a control group was employed between August and December 2021. The study consisted of a pre-test assessment, implementation of assertiveness training for the intervention group, and a post-test assessment.

The intervention aimed to improve parents’ ability to manage adolescents’ emotional regulation through assertiveness training during the COVID-19 pandemic. The independent variable was the provision of assertiveness training to parents in the intervention group, while the dependent variable was parents’ assertive ability in managing adolescent emotions before and after the intervention.

Selection of Participants

The study population consisted of parents who had adolescents aged 11–21 years. Adolescents were required to be unmarried and without a diagnosis of depression. Inclusion criteria for parents were willingness to participate throughout the research process and the ability to read and write. Purposive sampling was used to recruit participants for both the intervention and control groups.

A total of 46 parents were enrolled in the study, with 23 parents allocated to the intervention group and 23 parents to the control group. Parents in the intervention group received assertiveness training, while those in the control group did not receive any intervention during the study period. Due to restrictions imposed during the COVID-19 pandemic, participant recruitment was conducted with the assistance of trained data collectors in the field to ensure adherence to inclusion criteria.

Prior to the intervention, homogeneity testing was conducted to confirm that the intervention and control groups were comparable. The results indicated no significant differences between groups, demonstrating homogeneity of variance ($p > 0.05$).

Administrative permissions were obtained from the Head of Limo Village, the Head of the Limo District Health Center, and the Depok City Research and Development Agency (Balitbang). Data collection was carried out by a trained research team with undergraduate nursing (S1 Nursing) backgrounds. Training was provided to data collectors on the use of research instruments to minimize data collection bias.

Due to ongoing community activity restrictions during the pandemic, the intervention and data collection processes were conducted online using the Zoom platform. Mental health cadres assisted researchers in identifying eligible participants who met the inclusion criteria. Both groups consisted of 23 mothers and their respective adolescents.

Research Instruments and Data Collection

Data were collected using two instruments: a demographic questionnaire and a parental assertiveness questionnaire. The demographic questionnaire captured participants' background characteristics. The assertiveness questionnaire assessed parents' communication abilities in managing adolescent emotions, encompassing cognitive, psychomotor, and attitudinal domains.

Parents completed the assertiveness questionnaire twice: prior to the assertiveness training intervention (pre-test) and after completion of the intervention (post-test). Parental assertiveness was measured using a 36-item assertive behavior questionnaire previously tested in related research, demonstrating high reliability ($r = 0.92$).² The questionnaire consisted of both favorable (positive) and unfavorable (negative) statements to minimize response bias. Scores for unfavorable items were reverse-coded.

For the cognitive domain, responses were scored using a four-point Likert scale: strongly agree (1), agree (2), disagree less (3), and disagree (4). Psychomotor aspects of assertive communication were assessed using structured observation sheets completed by researchers during each intervention session as documentation of participants' engagement in assertiveness training.⁶ The instrument had been tested for validity and reliability in a pilot study involving 30 respondents, yielding an r value of 0.92.

Data Analysis

Baseline data were collected from both groups prior to the intervention using the assertiveness questionnaire. Following data collection, data were checked, coded, entered, and cleaned to minimize bias and ensure accuracy.

Descriptive statistics were used to summarize participant characteristics, presented as frequency distributions for categorical variables and as mean, median, standard deviation, minimum, and maximum values for numerical variables. Bivariate analysis was conducted using paired (dependent) t -tests to assess differences in assertive abilities before and after the intervention. Multivariate analysis was performed using multiple regression analysis to further examine factors associated with changes in parental assertiveness. Statistical analyses were conducted using SPSS version 25.

Ethical Clearance

Ethical approval was obtained on August 1, 2021, from the Health Research Ethics Committee of Universitas Pembangunan Nasional Veteran Jakarta (Ethical Approval No. 416/VIII/2021/KEPK). Additional permission was granted by the local Village Head.

Parents were not considered a vulnerable population and were deemed capable of making independent decisions regarding participation. Prior to enrollment, researchers provided a detailed explanation of the study objectives, procedures, potential benefits, voluntary participation, and participants' rights to withdraw at any time. No physical or psychological risks were identified during the research process. To support participation during online sessions, compensation was provided in the form of internet data allowances.

Prospective participants were given a 24-hour period to consider participation. Written informed consent was obtained from all participants before data collection commenced.

RESULTS

This study was conducted as a promotive and preventive effort to improve adolescent mental health by strengthening the role of parents as emotional coaches at home. The findings provide empirical data on psychosocial conditions experienced by adolescents and parental assertive abilities in managing adolescent emotions during the COVID-19 pandemic.

Baseline characteristics of parents and adolescents, including age and gender, were analyzed to assess group equivalence. Homogeneity testing of demographic characteristics and baseline parental assertiveness scores between the intervention and control groups was performed using an independent t-test.

Participant Characteristics

Table 1 presents the age distribution of parents and adolescents in both groups. The mean age of parents in the intervention group was 44.91 years (SD = 9.27), while that of the control group was 43.13 years (SD = 8.39). The median age for parents in both groups was 45 years. Adolescents had a mean age of 17.96 years (SD = 3.09) in the intervention group and 17.30 years (SD = 2.40) in the control group, with a median age of 18 years. These findings indicate comparable age distributions between groups. Although the parental age range was wide (22–65 years), no extreme values were observed among adolescents, consistent with the WHO-defined adolescent age range.

Table 2 summarizes the distribution of adolescents' sex, parents' marital status, and educational level. All participating parents were mothers in both groups. Slightly more

adolescents were male (56.2%) than female (43.4%). Most parents were married (82.6%), and the majority had a low level of formal education (80.4%), defined as elementary or junior high school education.

Effect of Assertiveness Training

Table 3 presents the comparison of parental assertiveness scores before and after the intervention. Baseline assertiveness scores were comparable between the intervention and control groups. The mean pre-test score was 105.0 (SD = 8.58) in the intervention group and 104.1 (SD = 7.85) in the control group.

Following assertiveness training, the mean assertiveness score in the intervention group increased significantly to 131.3 (SD = 4.43), representing a mean increase of 26.3 points. In contrast, the control group demonstrated a slight decrease in mean score to 103.1 (SD = 7.54). Paired t-test analysis revealed a statistically significant difference between pre- and post-test scores in the intervention group ($p = 0.001$), with a 95% confidence interval ranging from -28.51 to -24.09. Although a statistically significant difference was also observed in the control group ($p = 0.001$), the magnitude of change was minimal and not clinically meaningful.

Table 1. Distribution of Age of Parents and Adolescents (n=46)

Characteristic	Groups	Mean	Median	SD	Min-Max
Age of Parents	Intervention	44.91	45	9.273	23-65
	Control	43.13	45	8.385	22-60
Age of Adolescents	Intervention	17.96	18	3.090	12-21
	Control	17.30	18	2.400	13-20

Table 2. Distribution of Adolescents' Sex, and Parents' Marital Status and Educational Level (n=46)

Characteristic		Intervention group		Control group		Σ	
		n	%	n	%	n	%
Sex (adolescent)	Boy	11	47.8	15	65.2	26	56.2
	Girl	12	52.2	8	34.8	20	43.4
Marital status (parents)	Married	18	78.2	20	86.9	38	82.6
	Single	5	21.8	3	13.1	8	17.3
Educational Level (parents)	Low	19	82.6	18	78.2	37	80.4
	High	4	17.4	5	21.8	9	19.5

Table 3. Analysis of Differences in the Assertive Ability of Parents in the Intervention and Control Groups before and after Intervention (n=46)

Groups		n	Mean	SD	t	P-v	Mean different CI 95%
Intervention	Pre	23	105.0	8.58	-24.67	0.001	-28.51;-24.09
	Post	23	131.3	4.43			
	Difference		26.3	4.15			
Control	Pre	23	104.1	7.85	5.03	0.001	0.58;1.41
	Post	23	103.1	7.54			
	Difference		-1.0	318			

Table 4. Correlation and Regression Analysis of Assertive Behavior Scores in the Intervention Group before and after Training (n=46)

Variable	r	R ²	Equation of a line	P-value
Assertive behavior of parents	0.883	0.78	Y = a + bx Score post = 119.46 + 1.7*score pre	0.001

Table 5. Analysis of Factors that Contribute to the Ability of Parents in the Intervention Group to Behave Assertively

Characteristic of parents	Parental assertiveness				
	n	R	R ²	t	P-value
Assertiveness training	23	0.983	0.966	8.620	0.001
Age of parents	23	0.100	0.010	0.460	0.649
Level of education	23	0.023	0.001	-0.108	0.915
Sex of adolescents	23	0.350	0.127	1.740	0.095
Marital status	23	0.037	0.001	0.167	0.869

Correlation and Regression Analysis

Correlation and regression analyses were conducted to examine the relationship between parental assertiveness scores before and after training in the intervention group (Table 4). A strong positive correlation was observed between pre- and post-training scores (r = 0.883). The coefficient of determination (R² = 0.78) indicated that 78% of the variance in post-training assertiveness scores was explained by baseline assertiveness levels. The regression equation demonstrated that each one-point increase in pre-training assertiveness score was associated with a 1.7-point increase in post-training score.

Factors Influencing Parental Assertiveness

Simple linear regression analysis was used to identify factors contributing to parental assertiveness in the intervention group (Table 5). Assertiveness training was the only variable that demonstrated a statistically significant and strong association with parental assertiveness (r = 0.983, p = 0.001). Other variables, including parental age, educational level, adolescent sex, and marital status, showed weak and non-significant relationships with parental assertiveness.

Based on established correlation strength classifications, the relationship between assertiveness training and parental assertiveness was categorized as very strong, whereas other demographic factors demonstrated weak or negligible associations.¹⁸

DISCUSSION

This study demonstrates that assertiveness training for parents significantly improves their ability to manage adolescents’ emotional regulation during a period of heightened psychosocial stress, such as the COVID-19 pandemic. Adolescence is characterized by rapid physical, emotional, and social changes that may precipitate anxiety, emotional dysregulation, and behavioral difficulties, particularly when

adolescents lack adequate coping skills and social support.¹³ During the pandemic, restrictions on mobility and peer interaction increased adolescents’ reliance on family support, positioning parents as primary emotional coaches within the home.

Assertive therapy is grounded in several key principles:

- (1) consistent communication without anger, emotional reactivity, or ridicule, while maintaining focus on desired goals for adolescents;
- (2) provision of clear, direct, and respectful information, supported by appropriate non-verbal communication such as eye contact, open body posture, and a calm, firm tone;
- (3) honest and direct expression of parental thoughts and emotions without intermediaries; and
- (4) the use of “fogging,” a technique in which parents acknowledge the truth or validity of adolescents’ criticisms without defensiveness or emotional escalation.¹⁹

These principles encourage emotional acceptance, mutual respect, and constructive problem-solving between parents and adolescents.

The findings of this study underscore the importance of differentiating assertive parenting from passive and aggressive parenting styles. Passive parents tend to avoid adolescents’ emotional expressions, minimize emotional distress, and lack clear boundaries or guidance. Such patterns may impair adolescents’ ability to recognize and regulate emotions, leading to withdrawal, low self-confidence, emotional suppression, and social insecurity. In contrast, aggressive parenting is characterized by irritability, emotional volatility, coercion, and suppression of adolescents’ emotional expression. Adolescents exposed to aggressive parenting may internalize anger, develop maladaptive coping strategies, and externalize distress through harmful behaviors such as aggression or delinquency.

Assertive parenting represents a balanced approach that promotes emotional validation, clear communication, and

respectful boundary-setting. Parents who adopt assertive communication acknowledge adolescents' emotions without denying or exaggerating them, express expectations calmly, and encourage adolescents' autonomy while maintaining guidance.⁶ The results of this study demonstrate that parents who received assertiveness training showed a substantial increase in assertive behavior, with a mean improvement of 26.3 points, while the control group showed a slight decline over time. These findings suggest that assertive skills are not static and may deteriorate without reinforcement, highlighting the need for continuous parental support and education.

Although most parents in this study had low formal educational attainment, assertiveness training was effective in improving parental knowledge, attitudes, and psychomotor communication skills. Previous studies have shown that parental knowledge, attitudes, and practices play a crucial role in shaping how parents respond to children's health and emotional needs.²⁰ This finding supports the assertion that educational level does not preclude parents' capacity to acquire effective communication skills when training methods are appropriately adapted using visual aids, demonstrations, and practice-based learning. Lin et al. emphasized that increased cognitive understanding is often accompanied by changes in attitudes, beliefs, and psychomotor abilities, enabling meaningful behavioral change.¹⁵ Consistent with this view, parents in this study reported greater confidence in managing adolescents' emotions after understanding the distinctions between passive, aggressive, and assertive communication styles.

The duration and intensity of the intervention appear to have contributed to its effectiveness. Prior research suggests that sustained behavioral training is necessary to achieve meaningful and lasting changes in parental behavior.⁷ In this study, assertiveness training delivered across six sessions over six days resulted in statistically and clinically significant improvements in parental assertiveness ($p < 0.05$), accompanied by perceived improvements in adolescents' emotional regulation ($p < 0.05$). These findings align with evidence that assertive therapy, as a form of behavioral therapy, requires an initial cognitive framework to facilitate emotional responsiveness and behavioral consistency.^{12,21}

Assertive therapy also supports parents in recognizing unmet emotional needs in adolescents and responding constructively rather than reactively. Parents trained in assertive communication learn to accept both their own emotions and their adolescents' emotional expressions, reducing tendencies toward emotional suppression or confrontation.^{9,21} Parents in this study reported that prior to training, they often sought immediate compliance from adolescents, prioritizing short-term resolution over emotional understanding.²⁰ Following training, parents demonstrated greater patience, emotional awareness, and reflective responding.

Adolescents benefit directly from assertive parenting through improved emotional recognition, emotional regula-

tion, problem-solving skills, self-confidence, and social competence.²² As adolescents mature, peer influence increases while parental closeness may diminish, increasing vulnerability to negative external influences such as substance use. Assertiveness-based interventions have been shown to strengthen adolescents' resistance to substance abuse and maladaptive behaviors.¹⁷ By fostering assertive parental communication, this intervention indirectly strengthens adolescents' resilience during a critical developmental period.

When adolescents approach parents with emotional concerns, assertive parenting involves listening without immediate contradiction, maintaining attentive presence, withholding premature advice, and responding with clarifying prompts that encourage emotional reflection (e.g., "*How do you feel right now?*"). Such practices validate adolescents' experiences while promoting emotional insight and autonomy.

Limitations

This study has several limitations. The relatively small sample size was influenced by public health restrictions during the COVID-19 pandemic, as the study area was classified as a high-risk zone. To mitigate potential bias, homogeneity testing between groups was conducted, instrument validity and reliability were established, and data collectors received standardized training to ensure consistency in data collection. Assessment of intervention outcomes relied on both observational data and parental self-evaluation of perceived changes in adolescents' emotional regulation.

Despite these limitations, the study demonstrated significant improvements in parental assertiveness following the intervention, with sustained behavioral changes observed one month after completion of five intensive 60-minute sessions. Providing participants with time to internalize and practice assertive skills may have enhanced the intervention's effectiveness. These findings suggest that assertiveness training may be scalable and applicable to other communities with similar demographic and psychosocial characteristics.

CONCLUSIONS

Collaboration between local health offices and psychiatric nurses is essential for the early detection and management of adolescent mental health problems. Training programs for nurses, including those in general and mental health service units at community health centers, can equip them with assertiveness training techniques to support adolescents experiencing self-concept and emotional regulation challenges. The integration of assertiveness group therapy into the competencies of community-based mental health specialist nurses ensures that evidence-based interventions are consistently applied, promoting the psychosocial well-being of adolescents and strengthening the capacity of community mental health services.

Statement of Authorship

All authors certified fulfillment of ICMJE authorship criteria.

Author Disclosure

All authors declared no conflicts of interest.

Funding Source

This study was funded by University of Pembangunan National Veteran Jakarta.

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