# LATIHAN ASERTIF

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**Pengertian**

Asertif dapat diartikan sebagai kemampuan untuk menyatakan diri dengan tulus, jujur, jelas, tegas, terbuka, sopan, spontan, apa adanya, dan tepat tentang keinginan, pikiran, perasaan dan emosi yang dialami, apakah hal tersebut yang dianggap menyenangkan ataupun mengganggu sesuai dengan hak-hak yang dimiliki dirinya tanpa merugikan, melukai, menyinggung, atau mengancam hak-hak, kenyamanan, dan integritas perasaan orang lain. Perilaku asertif tidak dilatarbelakangi maksud-maksus tertentu, seperti untuk memanipulasi, memanfaatkan, memperdaya atau pun mencari keuntungan dari pihak lain.

Inti dari perilaku asertif adalah kejujuran, yaitu cara hidup atau bentuk komunikasi yang berl skan kepada kejujuran dari hati yang paling dalam sebagai bentuk penghargaan pada orang lain, dalam cara-cara yang positif dan menetap, yang dicirikan dengan kemampuan untuk mengekspresikan diri tanpa menghina, melukai, mencerca, menyingung, atau menyakiti perasaan orang lain, mampu mengntrol perasaan diri sendiri tanpa rasa takut dan marah. Dalam kehidupan atau komunikasi sehari-hari, orang yang asertif akan lebih memilih pola interaksi “I’m okay, you’re okay” atau menggunakan pernyataan-pernyataan yang lebih mencermintan tangungjawab pribadi, seperti penggunaan kata-kata ”saya” dari pada ” ” atau ”kamu”. Misalnya, ”saya sedih, marah, dan malu ketika saya tahu ...” dari pada ”kamu pembohong, tidak disiplin, dan tidak dapat dipercaya karena ....”. Dengan demikian, orang yang asertif akan memiliki kebebasan untuk meluapkan perasaan apa pun yang dirasakan, dan berani mengambil tanggung jawab terhadap perasaan yang dialaminya dan menerima orang lain secara terbuka. Memiliki keberanian untuk tidak membiarkan orang lain mengambil manfaat dari perasaan yang dialaminya, tetapi orang lain pun memiliki kebebasan untuk mengungkap apa yang dirasakannya.

Pemahaman perilaku asertif dapat dengan mudah dipahami bila dibandingkan dengan perilaku non asertif, baik yang sifatnya pasif atau agresif. Dalam perilaku pasif, seseorang tidak tidak memberikan reaksi atau mengekspresikan perasaan negatif yang dialaminya secara jujur dan terbuka, tetapi dilakukan dengan menyimpan perasaannya tersebut, menarik diri, menerima, atau menggerutu. Perilaku non asertif-pasif hakekatnya adalah bentuk ketidakjujuran emosi, kegagalan diri atau kekalahan diri yang didasari oleh perasaan-perasaan takut, cemas, mengindari konflik, keininginan untuk mencari jalan keluar paling mudah, dan bahkan ketidakmampuan untuk memahami diri dan memenuhi kebutuhan untuk bersikap sabar. Pola komunikasi yang berkembang pada kelompok nonasertif-pasif adalah “I’m not okay, you’re okay”.

Sedangkan pada perilaku nonasertif-agresif, reaksi yang diberikan diekspresikan keluar dan dilakukan secara terbuka melalui tindakan aktif berupa pengancaman atau penyerangan, dilakukan secara langsung atau tidak langsung, baik dalam bentuk fisik atau verbal. Tindakan yang dilakukan secara langsung, misalnya marah-marah, memukul, menuntut, dominan, egois, menyerang, dsb. Sedangkan tindakan tidak langsung, misalnya dengan menyindir, menyebar gosip, dsb. Tindakan agresif ini biasanya sengaja dilakukan dengan maksud untuk melukai, melecehkan, menghina, mempermalukan, menyakiti, merendahkan dan bahkan menguasai pihak lain. Dalam pola komunikasi mereka cenderung menggunakan pola "You're not okay, I'm okay". Dengan kata lain, seseorang dikatakan bersikap non-asertif, jika ia gagal mengekspresikan perasaan, pikiran dan p ngan/keyakinannya secara tulus, jujur, sopan, dan apa adanya tanpa maksud untuk merendahkan hak-hak atau mengancam integritas perasaan orang lain, sehingga justru menimbulkan respon dari orang lain yang tidak dikehendaki atau negatif.

Pada hakekatnya, tindakan asersif yang merupakan tindakan untuk mempertahankan hak-hak personal yang dimilikinya adalah upaya untuk mencapai kebebasan emosi, yaitu kemampuan untuk menguasai diri, bersikap bebas dan menyenangkan, merespon hal–hal yang disukai atau tidak disukai secara tulus dan wajar, dan mengekspresikan cinta dan kasih sayang pada orang yang sangat berarti dalam hidupnya. Apakah seseorang menunjukkan perilaku asertif atau tidak, akan tampak sekali dalam respon-respon yang diberikan senbagi bentuk pembelaan diri, ketika seseorang itu diperlakukan tidak adil oleh orang lain atau lingkungannya.

Faktanya dalam kehidupan sosial sehari-hari, banyak orang enggan bersikap asertif dan memilih bersikap non asertif, seperti memendam perasaannya, berpura-pura, menahan perbedaan pendapat atau sebaliknya dengan bersikap agresif. Keengganan ini umumnya karena dil si oleh rasa takut dan khawatir mengecewakan orang lain, takut tidak diterima oleh kelompok sosialnya, takut dianggap tidak sopan, takut melukai perasaan atau menyakiti hati orang lain, takut dapat memutuskan tali hubungan persaudaraan atau persahabatan, dsb. Padahal, dengan membiarkan diri untuk bersikap non-asertif justru dapat mengancam hubungan yang ada karena salah satu pihak kemudian akan merasa dimanfaatkan oleh pihak lain, tidak menyelesaikan maslah-masalah emosional yang dihadapi, mnurunkan harga diri, atau bahkan dapat menjadi "bom waktu" yang sewaktu-waktu dapat mengancam kelangsungan hubungan pribadi dan sosial dan kesehatan mental seseorang, yaitu resiko terhadap timbulnya kecemasan dan stress.

Terbentuknya perilaku asertif pada seseorang umumnya dipengaruhi oleh banyak faktor yang sifatnya kompleks, seperti pola asuh dan harapan orang tua, faktor kebudayaan, sosial ekonomi, status, harga diri, dan cara berpikir yang ditumbuhkan atau yang diperoleh dari pengalaman-pengalaman hidupnya dalam berinteraksi dengan lingkungan.

Berdasarkan hal di atas, dapat ditafsirkan bahwa perilaku asertivitas adalah gaya komunikasi terbuka dan jujur. Dengan perilaku asertif dapat meningkatkan hubungan positif, komonunikatif, adaptif, dan proporsional, meningkatkan kesehatan mental diri sendiri, serta tidak terjerumus dalam hidup yang penuh kepalsuan dan tekanan. Sedangkan perilaku nonasertif merupakan bentuk komunikasi yang tidak efektif, yang didalamnya mengandung unsur-unsur ketidak jujuran, pengingkaran, pelarian, melukai, membahayakan, penyerangan, penolakan, merugikan, manipulasi, atau menyalahkan.

**Karakteristik orang yang asertif**

Secara umum, orang yang asertif dicirikan dengan sikapnya yang terbuka, jujur, sportif, adaptif, aktif, positif, dan penuh penghargaan terhadap diri sendirimaupun orang lain. Beberapa ciri lain, diantaranya adalah:

a. Mampu mengekspresikan pikiran, perasaan, dan kebutuhan dirinya, baik secara verbal maupun non verbal secara bebas, tanpa perasaan takut, cemas, dan khawatir.

b. Mampu menyatakan “tidak” pada hal-hal yang memang dianggap tidak sesuai dengan kata hati atau nuraninya.

c. Mampu menolak permintaan yang dianggap tidak masuk akal, berbahaya, negatif, tidak diinginkan, atau dapat merugikan orang lain.

d. Mampu untuk berkomunikasi secara terbuka, langsung, jujur, terus terang sebagaimana mestinya

e. Mampu menyatakan perasaannya secara jelas, tegas, jujur, apa adanya, dan sopan.

f. Mampu untuk meminta tolong pada orang lain pada saat kita memang membutuhkan pertolongan.

g. Mampu mengekspresikan kemarahan, ketidak setujuan, perbedaan p ngan secara proporsional.

h. Tidak mudah tersingung, sensitif, dan emosional.

i. Terbuka untuk ruang kritik.

j. Mudah berkomunikasi, hangat, dan menjalin hubungan sosial dengan baik.

k. Mampu memberikan p ngan secara terbuka terhadap hal-hal yang tidak sepaham.

l. Mampu meminta bantuan, pendapat, atau p ngan orang lain ketika sedang menghadapi masalah.

**Latihan asertif**

Latihan asertif (assertive training) adalah salah satu teknik dalam tritmen ganguan tingkah laku dimana klien diinstruksikan, diarahkan, dilatih, serta didukung untuk bersikap asertif dalam menghadapi situasi yang tidak nyaman atau kurang menguntungkan bagi dirinya. Menurut Goldstein (1986) latihan asertif merupakan rangkuman yang sistematis dari ketrampilan, peraturan, konsep atau sikap yang dapat mengembangkan dan melatih kemampuan individu untuk menyampaikan dengan terus terang pikiran, perasaan, keinginan dan kebutuhannya dengan penuh percaya diri sehingga dapat berhubungan baik dengan lingkungan sosialnya. Sedangkan Rees & Graham (1991) menyatakan bahwa inti dari latihan asertif adalah penanaman kepercayaan bahwa asertif dapat dilatihkan dan dikembangkan, memilih kata-kata yang tepat untuk tujuan yang mereka inginkan, saling mendukung, pengulangan perilaku asertif dalam berbagai situasi, dan umpan balik bagi setiap peserta dari trainer maupun peserta.

Tujuan utama latihan asertif adalah untuk mengatasi kecemasan yang dihadapi oleh seseorang akibat perlakuan yang dirasakan tidak adil oleh lingkungannya, smeningkatkan kemampuan untuk bersikap jujur terhadap diri sendiri dan lingkungan, serta meningkatkan kehidupan pribadi dan sosial agar lebih efektif.

Sedangkan prosedur umum dalam latihan asertif adalah sebagai berikut:

1. Identifikasi masalah, yaitu dengan menganalisis permasalahan klien secara komprehensif yang meliputi situasi-situasi umum dan khusus di lingkungan yang menimbulkan kecemasan, pola respon yang ditunjukkan, faktor-faktor yang mempengaruhi, tingkat kecemasan yang dihadapi, motivasi untuk mengatasi masalahnya, serta sistem dukungan.
2. Pilih salah suatu situasi yang akan diatasi, dengan memilih terlebih dahulu situasi yang menimbulkan kesulitan atau kecemasan paling kecil. Selanjutnya, secara bertahap menuju pada situasi yang lebih berat.
3. Analisis situasi, yaitu dengan menunjukkan kepada klien bahwa terdapat banyak alternatif yang dapat dilakukan untuk mengatasi masalahnya tersebut. Identifikasi alternatif penyelesaian masalah.
4. Menetapkan alternatif penyelesaian masalah. Bersama-sama klien berusaha untuk memilih dan menentukan pilihan tindakan yang dianggap paling sesuai, mungkin, cocok, layak dengan keinginan dan kemampuan klien serta memiliki kemungkinan pleuang berhasil paling besar.
5. Mencobakan alternatif yang dipilih. Dengan bimbingan, secara bertahap klien diajarkan untuk mengimplementasikan pilihan tindakan yang telah dipilih.
6. Dalam proses latihan, hendaknya diperhatikan hal-hal yang terkait dengan kontak mata, postur tubuh, gerak isyarat, ekspresi wajah, suara, pilihan kalimat, tingkat kecemasan yang terjadi, serta kesungguhan dan motivasinya.

7. Diskusikan hasil, hambatan dan kemajuan-kemajuan yang terjadi, serta tindak lanjutnya.

8. Klien diberi tugas untuk mencoba melakukan hal-hal yang sudah dibicarakan secara langsung dalam situasi yang nyata.

9. Evaluasi hasil dan tindak lanjut.

Dalam latihan asertif, perilaku berbahasa yang terkait dengan intonasi, kesantunan, cara mengungkapkan, pemilihan kalimat, dan ketrampilan-ketrampilan pragmatis lainnya sangat penting, sehingga harus diperhatikan dan dilatihkan. Misalnya, dengan mengucapkan dengan lembut kata ”maaf” terlebih dahulu sebelum merespon atau menyatakan perasaan yang sebenarnya, menyatakan alasan yang sebenarnya berdasarkan pada fakta yang dilihat, didengar, dipikir, dan dirasakannya, bukan berdasar kepada sifat-sifat pribadi, serta dalam memberi masukan sebagai alternatif yang lebih baik. Sedangkan secara teknis, pelatihan asertif disamping dapat dilakukan secara langsung, dapat pula dilakukan melalui teknik modeling ataupun bermain peran.

Dalam kaitan dengan latihan asertif, terutama self asertive training, Jacinta Rini (2001) mengajukan beberapa tips untuk mampu mengatakan “tidak” terhadap permintaan yang tidak diinginkan, yaitu:

1. Tentukan sikap yang pasti, apakah ingin menyetujui atau tidak. Jika belum yakin dengan pilihan, maka bisa minta kesempatan berpikir sampai mendapatkan kepastian. Jika sudah merasa yakin dan pasti akan pilihan sendiri, maka akan lebih mudah menyatakannya dan juga merasa lebih percaya diri.

2. Jika belum jelas dengan apa yang dimintakan, bertanyalah untuk mendapatkan kejelasan atau klarifikasi.

3. Berikan penjelasan atas penolakan secara singkat, jelas, dan logis. Penjelasan yang panjang lebar hanya akan mengundang argumentasi pihak lain.

4. Gunakan kata-kata yang tegas, seperti secara langsung mengatakan “tidak” untuk penolakan, dari pada “sepertinya saya kurang setuju.. sepertinya saya kurang sependapat...saya kurang bisa.....”

5. Pastikan bahwa sikap tubuh juga mengekspresikan atau mencerminkan “bahasa” yang sama dengan pikiran dan verbalisasi. Seringkali orang tanpa sadar menolak permintaan orang lain namun dengan sikap yang bertolak belakang, seperti tertawa-tawa dan tersenyum.

6. Gunakan kata-kata “Saya tidak akan....” atau “Saya sudah memutuskan untuk.....” dari pada “Saya sulit....”. Karena kata-kata “saya sudah memutuskan untuk....” lebih menunjukkan sikap tegas atas sikap yang tunjukkan.

7. Jika berhadapan dengan seseorang yang terus menerus mendesak padahal juga sudah berulang kali menolak, maka alternatif sikap atau tindakan yang dapat

lakukan : mendiamkan, mengalihkan pembicaraan, atau bahkan menghentikan percakapan.

8. Tidak perlu meminta maaf atas penolakan yang disampaikan (karena berpikir hal itu akan menyakiti atau tidak mengenakkan buat orang lain). Sebenarnya, akan lebih baik katakan dengan penuh empati seperti : "saya mengerti bahwa berita ini tidak menyenangkan bagimu.....tapi secara terus terang saya sudah memutuskan untuk ..."
9. Janganlah mudah merasa bersalah, karena seseorang tidak bertanggung jawab atas kehidupan orang lain...atau atas kebahagiaan orang lain.
10. Bila perlu lakukan negoisasi dengan pihak lain agar kedua belah pihak mendapatkan jalan tengahnya, tanpa harus mengorbankan perasaan, keinginan dan kepentingan masing-masing.

Adapaun menurut Duckworth dan Mercer ( Fisher,2006) terdapat beberapa komponen kunci dalam latihan asertif (K*ey Components of an Assertiveness Training Protocol), meliputi:*

1. Assertiveness training usually begins with a didactic presentation of (a) the rationale for the use of assertive behavior; (b) definitions of assertiveness, passiveness and aggressiveness; and (c) the basic content and procedural guidelines that govern assertive behavior
2. Self-monitoring assignments are given and in-session role plays are undertaken to identify problematic interactions
3. For the particular skill set being targeted, the verbal content of a sufficiently assertive response is delineated and the appropriately assertive delivery of that verbal communication is modeled by the therapist or confederate
4. The client practices assertive behaviors in the context of in-session role-plays that are similar to the identified problematic interactions
5. The evaluation of the role-play performance should always begin with the solicitation of comments from the client. This strategy allows the therapist to (a) evaluate the client's understanding of the verbal and nonverbal behaviors that comprise the assertive response and (b) evaluate the accuracy and objectivity with which the client evaluates his or her performance. Evaluating one's performance subsequent to role-plays may be made difficult by recall burden. Videotaping role-plays is recommended to reduce recall burden and to provide specific, visual evidence for performance problems and performance gains over time
6. Feedback is provided by the therapist and/or confederate and instructions for further refinement of the assertive performance are provided. When there is a considerable discrepancy between the therapist-modeled assertive behavior and the client's performance, it is often useful to provide feedback in the form of a review of a videotape of the role-play

7. Real-world practice of assertive behavior is next. Again, the client provides a technical and affective evaluation of the assertive performance in the real-world situation.

8. Reinforcement and reiteration of reasonable performance goals is essential throughout the assertiveness skills training process  multicomponent intervention package aimed at the treatment of severe aggression, there is little research that empirically establishes the contribution of combined therapies above and beyond the independent effectiveness of either monotherapy (Ziegler, 1996).

# Assertiveness Training

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## WHAT IS ASSERTIVENESS?

Assertive behavior usually centers on making requests of others and refusing requests made by others that have been judged to be unreasonable. Assertive behavior also captures the communication of strong opinions and feelings. Assertive communication of personal opinions, needs and boundaries has been defined as communication that diminishes none of the individuals involved in the interaction, with emphasis placed on communication accuracy and respect for all persons engaged in the exchange.

Assertiveness is conceptualized as the behavioral middle ground, lying between ineffective passive and aggressive responses. Passiveness is characterized by an overattention to the opinions and needs of others and the masking or restraining of personal opinions and needs. This over-attention to and compliance with the opinions and needs of others may serve as a strategy for conflict avoidance and/or maintenance of particular sources of social "reinforcement." Aggressiveness often involves the imposition of one's opinions and requirements on another individual. Implicit in the discussion of assertiveness is the suggestion that assertive behavior is the universally preferred behavioral alternative, and that assertive behavior necessarily leads to preferred outcomes. The degree to which assertive behaviors are to be considered superior to either a passive or an aggressive stance is determined by the situational context. The success of assertiveness does not always lie in tangible outcomes (e.g., request fulfillment). The success of assertiveness sometimes lies in the degree of personal control and personal respect that is achieved and maintained throughout the assertive exchange.

## BASIC FACTS ABOUT ASSERTIVENESS TRAINING

The acquisition of assertiveness behavior is not specific to any discrete stage of childhood development but instead is a function of instruction, modeling, and rehearsal. Assertive behavior is acquired, practiced and refined as the individual develops. Problems with assertiveness can occur early in development in the form of overly shy or aggressive behavior, and later as social anxiety disorder and avoidant personality disorder. In outlining the facts about assertiveness, we have chosen to outline problem sets that can be conceptualized as due at least in part, to a deficit in assertiveness.

*Prevalence*. Low levels of assertive behavior, as evidenced by the presence of social anxiety disorder, is a highly prevalent problem. It is estimated that nearly 13.3% of all

people in the US suffer from social anxiety at some point in their lives (Kessler et al., 1994). Social phobia is most prevalent amount people who are young (18–29 years of age), undereducated, single, and of lower socioeconomic status; social phobia is slightly less prevalent among the elderly (Magee, Eaton, Wittchen, Duckworth, M. P. & Mercer, V. (2006). McConagle, & Kessler, 1996). Avoidant personality disorder occurs in less than 1% of the general population (Reich, Yates, & Nduaguba, 1989; Zimmerman, & Coryell, 1990). Displays of aggressive behavior may be relatively common, yet the prevalence of extreme aggression as evidenced by the presence of antisocial personality disorder is relatively rare, occurring in only about 1–3% of the general population (Sutker, Bugg, & West, 1993).

*Age at onset*. Extreme shyness is known to be present in a large percentage of children. The mean age at onset for social phobia is 16 years old. The age at onset for social phobia occurs later than the onset for simple phobias but earlier than the onset for agoraphobia (Ost, 1987). Studies have found that the number of children with social phobia is increasing (Magee, et al., 1996). Aggression also appears to be expressed in early adolescence. In a study of African-American and Hispanic adolescent males it was found that children who had high levels of externalized behavio problems also tended to assert themselves in a hostile manner (Florsheim, Tolan & Gorman-Smith, 1996).

*Gender*. Although a larger percentage of men evidence assertive behavior than women men are also more likely to engage in aggressive behavior (Eagly & Steffen, 1986). Extreme aggression, as sometimes captured by antisocial personality disorder or psychopathy, is significantly more common in men (Dulit, Marin, & Frances, 1993; Sutker et al., 1993). Although women are represented more frequently among populations of persons experiencing anxiety disorders, social anxiety disorder occurs with relatively equal frequency across women and men. The gender ratio for social anxiety disorder is 1.4 to 1.0, females to males. Avoidant personality disorder also occurs equally across women and men. Taken together, these findings suggest that assertiveness may be an appropriate technique for men and women who engage in overly passive or overly aggressive behaviors.

*Course*. Extreme passivity, as captured by social phobia, begins in adolescence increases into the late 20s, and then declines in later life (Magee et al., 1996). Extreme aggression, as captured by antisocial personality disorder, begins in adolescence in the form of conduct disorder, increases through the 20s, and then decreases across the 40s (Hare, McPherson, & Forth, 1988).

*Impairment and other demographic characteristics*. Level of impairment is indicated by the problems experienced by people who are represented at the extremes of the assertiveness continuum. Problems associated with extreme passivity, can range from being bullied to experiencing repeat victimization by partners. Problems associated with aggression can range from suspension of privileges in childhood to serious negative legal consequences in adulthood.

There are differential finding for the impact of assertive behavior among ethnic groups, the impact seems entangled with socioeconomic status and culturally specific styles of communication (Malagady, Rogler, & Cortes, 1996; Zane, Sue, Hu, & Kwon, 1991). Social phobia is found to be equally prevalent among ethnic groups (Magee et al., 1996).

Given that assertive behavior occurs as a part of a broader interaction complex, the likelihood that an individual will engage in assertive behavior is a function of skill and performance competencies, reinforcement contingencies, motivational-affective and cognitive-evaluative factors. Behavioral explanations for the use of passive or aggressive strategies rather than assertive strategies emphasize opportunities for skills acquisition and mastery and reinforcement contingencies that have supported the use of passive or aggressive behaviors over time. Behavioral conceptualizations for passivity often emphasize early learning environments in which passive responding may have been modeled (e.g., care givers who were themselves anxious, shy, or in some other way less than assertive) or more assertive behavior punished (e.g., overly protective or dominating care givers). In the absence of opportunities for acquisition and reinforcement of other interaction strategies, passive behavior persists. Important to any complete behavioral conceptualization of passive behavior would be an evaluation of the reinforcement that is associated with current displays of passive behavior, that is, how is passivity currently "working" for the individual? Behaviors that are reinforced are repeated. Repeated engagement in passive behavior suggests repeated reinforcement of such behavior. Passive responding may be reinforced through the avoidance of responsibility and decision-making. With what amount of attention, positive or negative, are passive responses met? The individual employing passive strategies may need to reconcile his or her "active" influence on situations with the alleged passivity.

Aggressive behaviors can be learned through the observation of aggressive models and reinforced through their instrumental effects. Even in the absence of overt goal attainment, aggressive behaviors may be experienced as intrinsically reinforcing by virtue of the autonomic discharge associated with such behaviors. Aggressive behavior may serve as a socially sanctioned interaction style (Tedeschi & Felson, 1994). Aggressive behavior may also be a consequence of the absence of opportunities to acquire alternative social interaction strategies. Motivational-affective factors are important to patterned displays of passive and aggressive behavior. Although the affective experience of anger is not sufficien to explain aggressive behavior, feelings of anger do increase the likelihood that the actions of others will be experienced as aggressive and, thereby, elicit aggressive behavior.

Cognitive explanations for passive and aggressive responding would posit that outcome expectations are primary in determining the passive or aggressive response. The passive individual may look to the history of failures in making and/or refusing requests in deciding whether to attempt the ecommended assertive behavior. Outcome expectations may interfere with adoption of the "new" assertiveness. Such outcome expectations must be managed if the likelihood of assertive responding is to increase. The passive individual needs to be cautioned regarding the imperfect relationship between assertive responding

and desired outcomes. Initially, assertive responses may not meet with desired outcomes. It is the *persistence* of the assertive response that will ensure that the probability of the desired outcome increases over time. In the short run, then, the measure of successful assertion may not be the occurrence of a desired outcome but the mere assertive communication of one's opinions, needs and/or limits.

## ASSESSMENT

### What should be Ruled Out?

Assertiveness appears to be of differential utility in the context of domestic violence. Some research suggests that battered women are potentially at increased risk as a result of assertive behavior in the context of ongoing domestic violence (O'Leary, Curley, Rosenbaum & Clarke, 1985). On the other hand, assertiveness training has been found to contribute to a woman's decision to leave a violent relationship (Meyers-Abell, & Jansen, 1980). Research addressing male batterers suggests that batterers have assertiveness deficits that may contribute to there use of aggression and violence to express their needs and manage the needs of their domestic partner (Maiuro, Cahn, & Vitiliano, 1986). In the context of female sexual victimization, assertiveness training appears to empower women and reduce their exposure to violence (Mac Greene & Navarro, 1998).

### What is Involved in Effective Assessment?

Assessment of assertiveness skills and performance abilities should be broad enough to capture and distinguish among various explanations for performance failure. Traditionally, a hierarchical task analysis is used to determine the causal variable that accounts for the skill/performance deficit (Dow, 1994). Initially assertiveness skills are evaluated in a nonthreatening (or less threatening) environment. Given that the client demonstrates adequate assertiveness skill in the nonthreatening environment, assertiveness skills are evaluated in the context of more clinically relevant social situations. Given that skills are adequately performed in clinically relevant social situations, other contributions to response failure are evaluated including affective and cognitive variables that might mediate the skill–performance relation. Behavioral models of depression suggest that the pursuit of social interaction (and, thus, experience of reinforcement) may be limited by negative affective experiences that are present throughout the interaction (Lewinsohn, 1974). For example, anxiety that is experienced during an assertive interaction may be insufficient to impair performance but may be sufficient to render the interaction a punishing rather than reinforcing event. Assertive behaviors presuppose the existence of adequate social skills. An assertive communication is measured not only by the content of the verbalization but also by the accompanying nonverbal behaviors. Appropriate posture and eyecontact are essential in executing an appropriately assertive response. An appropriately assertive posture would convey relaxed but focused attention, this posture contrasted with an overly rigid posture that might convey either anxiety or obstinacy. Other important nonverbal behaviors include

facial expression and body movements and gestures. Affective displays should be congruent with the content of the assertive communication, not suggesting anxiety, false gaiety, or anger. Body movements that indicate nervousness and uncertainty (e.g. hand-wringing) should be avoided. Movements that convey anger or dominance (e.g., invasion of the other's personal space) should also be avoided. These nonverbal behaviors are included among behaviors identified by Dow (1985) as relevant to socially skilled behaving.

The content of the assertive communication is important in its clarity and form. The tone and fluidity of the request, command or refusal are also important. Generally, the assertive request is characterized by its reasonableness, its specificity regarding actions required to fulfill the request, and its inclusion of statements that convey the potential impact(s) of request fulfillment for both the individual making the request and the request recipient. The tone in which the request is delivered should convey the importance of the request; however, the tone should not imply some obligation on the part of the request recipient to comply with the request. The content and tone of assertive refusals share the quality of being evenhanded and unwavering.

Assessment of skill sets and performance competencies is necessary prior to skills training and throughout the skills acquisition/practice process. Skills for assertive behaving are evaluated through the use of self-report instruments as well as behavioral observation in contrived and natural settings.

*Clinician-administered measures*. Generally evaluations of assertive behavior involve observations of skill displays (e.g., communication, social interactions) in clinical, analogue, and natural settings, rather than using clinically administere measures of assertiveness. Observational ratings of skill assets, deficits, and mastery made by the treating clinician can be formalized by systematically targeting all nonverbal and verbal behaviors considered relevant to assertive behaving. There are structured clinical interviews that assess diagnostic features of anxiety, the reader is referred to the social anxiety disorder chapter in this text for that information.

*Self-report measures*. Assertiveness skill evaluation and training often occurs in the broader context of social skill and social competence. The self-report instruments that purport to measure assertiveness range from actual measures of assertive behaviors to instruments that assess related constructs such as social avoidance, self-esteem, and locus of control. The most commonly used measur of assertiveness skills is the Rathus Assertiveness Scale (Rathus, 1973). Self-monitoring of social behaviors performed in the client's natural environment is essential

to both assessment and treatment of potential skills and performance deficits. Monitoring instructions usually require that the client describe their social interactions with others along a number of dimensions. The client may be instructed to briefly describe interactions with males versus females, acquaintances versus intimate others, peers versus persons in authority, and in structured versus unstructured interactions.

Although real world evaluation of skills is preferable, the office is the most common arena for skills evaluation and practice. Therefore

it is essential that the client provide detailed accounts of problem interactions and that the content and cues of the experimental arena be as consistent with that real world as possible.

*Behavioral assessment*. Behavioral observation is considered the preferred strategy for evaluating assertiveness skills and performance competencies. Usually observations/evaluations of assertive performances are made in clinical or research settings rather than real world settings. Clinic and laboratory settings provide contexts for informal observation (waiting room behaviors and behaviors engaged in by the client during the clinical interview) and formal observation (social interactiontasks and role-plays) of an individual's behavior.

*Clinical interview*. In the clinical setting, the client's waiting room behavior (i.e., his/her interactions with other persons in the waiting room and with clinic staff) is available for observation. Exchanges had during initial assessment sessions also serve as data to be used in establishing the presence or absence of verbal and nonverbal communication skills considered essential to assertive displays as well as contextual/situational/interpersonal factors that may influence the likelihood of assertive behaving and the mastery with which assertive behaviors are performed.

*Social interaction tasks in analog settings*. In evaluating a client's social skill and comfort, the therapist may enlist confederates to engage the client in interactions that test the client's ability to initiate and participate in casual exchanges. These tasks are considered low demand tasks. Usually, these tasks do not contain any of the elements of identified problematic interactions.

*Social interaction tasks in real-world settings*. Of course, the optimal arena for evaluating assertive behavior is the client's natural environment. As often as possible, the real world context should be captured. For example, a male client reporting difficulty initiating social interactions with female peers might be observed in real world settings that are familiar to him and that present opportunities for contact with female peers (e.g., the college library, an undergraduate seminar, a scheduled, on-campus extracurricular event). Other local contact arenas are also acceptable for evaluation of skills including coffee houses, dance clubs, etc.

*Role-plays*. In the clinical context, a "true" observation of assertive behaviors is made through the use of role-playing. Based on the client's report of difficult interpersonal interactions/exchanges, interaction opportunities that mimic these difficult interpersonal interactions (to a lesser or greater degree) are engineered and the client's use of assertive behaviors observed. Typically, the therapist serves as the "relevant other" in such role play situations. Research participants or clients are asked to display their skills repertoire in the context of contrived interactions with the researcher/therapist or some confederate. In structuring the role play, the therapist aims to lessen the artificial quality

of the role play and to strengthen the correlation/correspondence/reliability between the client's performance in artificial and natural settings. This is best achieved through the use of dialogue and contextual cues that most closely approximate the naturally occurring problematic interactions. Role-play confederates and scenarios are often selected with relevant contextual factors in mind.

**What Assessments are Not Helpful?**

In the context of assertiveness training, assessment capitalizes on the clinicians behavioral observation skills rather than some of the more traditional paper-andpencil measures such as the MMPI or projective tests.

**TREATMENT**

**What Treatments are Effective?**

Assertiveness training, when employed as part of a more comprehensive cognitivebehavioral therapy package, is useful for the treatment of people whose lack of assertiveness skills manifests behavior appears as either passivity or aggression. When the absence of assertive behavior is explained by affective or cognitive factors rather than a skills deficit, other strategies are recommended as adjuncts to of assertiveness skills training and practice. Examples of such strategies include relaxation training to reduce performance inhibiting anxiety or anger, cognitive restructuring to challenge negative performance predictions and overgeneralizations

regarding performance errors, and cognitive reframing with respect to performance goals and measures of performance success.

**What are Effective Self-Help Treatments?**

There are a plethora of self-help resources available to clients interested in self-initiated efforts towards assertive behaving. These resources are largely in the form of assertiveness training books and internet site targeted directly at the lay person. Although the effectiveness of any individual resource is generally not available to the client he or she may rely on the credentials of the authors or site hosts (e.g., authors who emphasize empirical research and universities as site hosts) to guide their selection of self-help materials.

*Self-help books*.


- Alberti, R. E. & Emmons, M. L. (2001). *Your perfect right: Assertiveness and equality in your life and relationships* (8th ed.). Atascadero, CA: Impact Publishers.
- Burton, S., & Shelton, N. (1993). *Assertiveness skills*. New York: McGraw-Hill.

- Davidson, J. (1997). *The complete idiot's guide to assertiveness* (1st ed.). Indianapolis, IN: Alpha Books.
- Dire, W. (1978). *Pulling your own strings: Dynamic techniques for dealing with other people and living your life as you choose*. New York: Harper Collins.
- Gabor, D. (2001). *How to start a conversation and make friends*. New York: Fireside.
- Magee, S, & Pachter, B. (2001). *The power of positive confrontation: The skills you needto know to handle conflicts at work, at home, and in life*. New York: Marlowe & Company.
- McKay, M., Rogers, P. D., & McKay, J. (2003). *When anger hurts: Quieting the storm within,* (2nd ed.) Oakland, CA: New Harbinger.
- Nay, W. R. (2004). *Taking charge of anger: How to resolve conflict, sustain relationships, and express yourself without losing control*. New York: The Guilford Press.
- Paterson, R. J. (2000). *The assertiveness workbook: How to express your idea and stand up for yourself at work and in relationships*. Oakland, CA: New Harbinger Publications.
- Petracek, L. J. (2004). *The anger workbook for women*. Oakland, CA: New Harbinger Press.
- Valentis, J., & Valentis, M. (2001). *Brave new you: 12 dynamic strategies for saying what you want and being who you are*. Oakland, CA: New Harbinger Publications.

*Self help websites*.

- http://www.couns.msu.ed untuk self-help/index.htm (Michigan State University Counseling Center)
- http://www.uiowa.ed untuk ~ucs/asertcom.html (University of Iowa Counseling Services)
- http://www.uwec.ed untuk counsel/pubs/assertivecommunication.htm (University of Wisconsin-Eau Claire Counseling Center)
- http://www.couns.uiuc.ed untuk Brochures/assertiv.htm (University of Illinois Counseling Services)
- http://oregonstate.ed untuk dept/counsel/assertivenessskills.html (Oregon State University Counseling Department)
- http://www.utexas.ed untuk student/cmhc/booklets/assert/assertive.html (University of Texas at Austin Counseling and Mental Health Center)
- http://www.twu.ed untuk o-sl/counseling (Texas Woman's University Counseling Center)

- http://www.amanet.org/index.htm (American Management Association)

**What are Effective Therapist-based Treatments?**

When it has been established that a skills deficit explains performance failure it is often useful to begin at the beginning. In presenting the rationale for assertive communication, the therapist suggests that the honest and respectful communication of one's preferences and opinions maximizes the potential for achievement of relationship goals in both professional and intimate contexts. The therapist would begin the presentation of the rationale with a description of the three forms of communication that characterize most verbal exchanges.

*People usually express their needs/desires and opinions in one of three ways: aggressively,*

*passively or assertively*. The therapist follows this statement with descriptions of each of the three common form of communication.

(1) The aggressive expression of needs usually involves the goal of getting one's needs met or having one's opinion endorsed no matter the cost to the other individual or individuals participating in the exchange. Aggressive communication is often characterized by "shoulds" or "musts" or other language that suggests that the recipient is bound or required to meet the expressed need or agree with the expressed opinion. Aggressive communication is also characterized by nonverbal behaviors that are of the "in your face" quality. Aggressive communicators may ignore the boundaries of personal space, standing overly close to another individual. They may speak in loud, angry tones, and in a number of other ways convey subtle pressure or even threat to the other individual or individuals participating in the communication exchange.

(2) Passive communication is problematic, not because of obvious demands placed on the recipient, but because passive communications often do not reflect the true needs or preferences of the speaker. Passive communications involve the use of acquiescent language. The passive communicator often responds to others' statements of preferences and opinions with statements such as "if you think so" or "whatever you want is fine" or "no problem, I can take care of that." In the shortterm, the passive communicator may be seen as ensuring the pleasure and happiness of the recipients of such behavior. Passivity may also serve to assure the passiv individual that relationships will be maintained. The problems with passive communications are usually experienced over time. The passive communicator begins to resent the fact that their true needs and opinions are not being honored within these relationships. The recipient of passive communications may feel that the passive individual is only half-heartedly participating in the relationship and is avoiding responsibility for making important decisions within the relationship.

(3) Assertive communication ensures that the needs and opinions of the speaker are honestly expressed and owned by the speaker. Opinions are expressed as opinions rather than as statements of inarguable fact. This allows other participants in the exchange to comfortably express similar or opposing opinions. In communicator presents the request

in a manner that is at the same time clear but respectful of the recipient's right to refuse such a request. In refusing requests, the assertive communicator states the refusal clearly and unwaveringly while at the same time indicating appreciation for the other individual's circumstances. Again, assertive communication has the goal of mutual respect.

The goal, then, of assertiveness training is the communication needs and opinions in a mutually respectful manner, thereby increasing the probability of having needs met and opinions appreciated, as well as ensuring the maintenance of relationships. The therapist cannot reiterate this goal too often. Prior to the practice of assertiveness skills, the client is made aware of certain content and procedural guidelines that govern assertive behavior. Content guidelines

require that compliments, criticisms, and requests be made with a degree of reasonableness and with a degree of specificity. Procedural guidelines require that requests for behavior change be "sandwiched" between impact statements pertaining to the current behavior and the proposed behavior change. For example, in making a request for behavior change, the client would begin with a statement egarding the negative impact of the other's current behavior, then suggest a reasonable and specific behavioral alternative, and end with a statement suggesting the positive impact of the proposed behavioral alternative for both parties. The behavior change request is sandwiched between the two impact statements. In addition, Dow (1994) recommends that the assertive communicator refrain from making assumptions about the motivations driving others' behaviors, refrain from questioning others regarding their motives, and interject something positive about the individual with whom they are interacting.

In starting the practice of assertiveness skills, the therapist always begins with a review of the more basic elements of assertive communication and continues along a graded hierarchy of skills sets essential to assertive communication across contexts. Traditionally, assertiveness training packages have identified several skill sets as essential to assertive behaving, including nonverbal behavior as communication, giving and receiving compliments, giving and receiving criticism, and making and refusing requests. In addressing each of these skills sets, the therapist wishes to establish three things: (1) the presence and strength of a particular skill in the client's behavioral

repertoire; (2) the situations in which the client competently and reliably displays the particular skill; and (3) the situations in which the client may be called upon to competently display the particular skill.

The presence and strength of a particular assertive skill or skill set may be established formally or informally. A client's nonverbal behaviors are immediately observable by the therapist. In the context of the therapeutic exchange, the therapist may observe nonverbal behaviors that are not at all consistent with the goals of assertive communication. This would signal that, at least within the context of the therapeutic exchange, direct training and practice of assertive nonverbal behavior is justified. When nonverbal behaviors have been observed to be sufficient in this context, the therapist may feel uncomfortable reviewing these more basic elements of assertive

communication. In such situations the therapist is encouraged to (1) acknowledge the appropriateness of the client's nonverbal behavior in the therapeutic context and (2) suggest that the display of appropriately assertive nonverbal behavior is sometimes bound by context, that is, assertive nonverbal behaviors sometimes depend on how comfortable the person feels in a given situation or with a given individual. A review of nonverbal behaviors would be completed along with instructions that the client monitor and evaluate displays of appropriately assertive nonverbal behaviors in the natural environment.

The skills that characterize each level of the assertiveness hierarchy should be approached in a similar manner. For example, if in the ongoing context of therapy the client has evidenced skill in assertively requesting something of the therapist, his instance would be pointed to by the therapist and reinforced through praise. The therapist would then suggest that the display of even well-established skills can be influenced by situations and persons. The various aspects of request making would be reviewed, real-world instances of successful and unsuccessful request making attempts would be solicited, and the client would be instructed to monitor and practice assertive request making in the natural environment. The therapist will structure in-session role plays and homework assignments so that more common and less common request making situations are encountered over the course of such practice. Table 7.1 presents an eight-step guide to assertiveness skills training.

**What is Effective Medical-based Treatment?**

Assertiveness training is usually identified as an effective treatment strategy for problem sets that are characterized by either anxiety in social situations, or aggressive management of interpersonal interactions. In the context of social anxiety disorder, assertiveness training may be one component a multi-component treatment package. Another component of that package may be pharmacotherapy (Pollack, 1999). Although benzodiazepines work quickly and effectively, they are considered secondary due to a high risk of dependence (Stramek, et al., 2002). Beta-blockers ere initially thought to be particularly well suited to the management of performance anxiety, however, there is a lack of evidence to support this claim (Turner, Beidel, & Jacob, 1994). There are many studies demonstrating the effectiveness of tricyclic antidepressants, compared to medication placebo in the treatment of social anxiety disorders (Liebowitz, et al., 1992). Currently, selective serotonin reuptake inhibitors (SSRIs) such as Paxil, Zoloft, and Effexo are approved by the Food and Drug Administration for pharmacological management of social anxiety disorder (Kaminer, & Stein, 2003; Stein, et al., 1998).

There are two major studies that have compared antidepressant medications monoamine oxidase inhibitors [MAOIs and SSRIs] with psychological treatment of social anxiety disorder. Both studies found that while both medications and psychological treatments are highly effective, cognitive-therapy was associated with lower rates of relapse and better outcomes at all points measured across a 12 month follow-up (Liebowitz, et al.,

1992; Clark, et al., 2003). For a more detailed exposition of effective medical management of social anxiety disorder the reader is referred to the social anxiety chapter in this text. Pharmacological management of aggressive behavior usually occurs when the overt aggression is a part of a larger psychiatric presentation. Medication, most typically antipscyhotics, have been found to be moderately effective in reducing aggression in referred psychiatric samples (Walker, Thomas, & Allen, 2003; Ruths, & Steiner, 2004). However, the effectiveness of medication in treating aggression in a nonreferred sample is not as well supported, suggesting the use of nonmedical interventions (Connor, Boone, Steingard, Lopez, & Melloni, 2003).

**Combination Treatments**

With the expectation of an additive effect of multiple treatment types, it may be tempting to combine pharmacological and psychological treatments for anxiety disorders. However, a review of the comparitive treatment efficacy of CBT versus CBT combined with pharmacologic monotherapies for anxiety disorders (obsessive compulsive, panic, social phobia, and generalized anxiety disorder) revealed no clear benefit or detriment of combined therapy compared to CBT alone; findings did suggest some benefit of combined therapy over pharmacotherapy alone (Foa,

Franklin, & Moser, 2002; Rosser, Erskine, & Crino, 2004). Although research and clinical experience suggests that pharmacologic therapies be used as part of a

**TABLE 7.1** ***Key Components of an Assertiveness Training Protocol***

1. Assertiveness training usually begins with a didactic presentation of (a) the rationale for the use of assertive behavior; (b) definitions of assertiveness, passiveness and aggressiveness; and (c) the basic content and procedural guidelines that govern assertive behavior
2. Self-monitoring assignments are given and in-session role plays are undertaken to identify problematic interactions
3. For the particular skill set being targeted, the verbal content of a sufficiently assertive response is delineated and the appropriately assertive delivery of that verbal communication is modeled by the therapist or confederate
4. The client practices assertive behaviors in the context of in-session role-plays that are similar to the identified problematic interactions
5. The evaluation of the role-play performance should always begin with the solicitation of comments from the client. This strategy allows the therapist to (a) evaluate the client's understanding of the verbal and nonverbal behaviors that comprise the assertive response and (b) evaluate the accuracy and objectivity with which the client evaluates his or her performance. Evaluating one's performance subsequent to role-plays may be made difficult by recall burden. Videotaping role-

plays is recommended to reduce recall burden and to provide specific, visual evidence for performance problems and performance gains over time

6. Feedback is provided by the therapist and/or confederate and instructions for further refinement of the assertive performance are provided. When there is a considerable discrepancy between the therapist-modeled assertive behavior and the client's performance, it is often useful to provide feedback in the form of a review of a videotape of the role-play

7. Real-world practice of assertive behavior is next. Again, the client provides a technical and affective evaluation of the assertive performance in the real-world situation.

8. Reinforcement and reiteration of reasonable performance goals is essential throughout the assertiveness skills training process multicomponent intervention package aimed at the treatment of severe aggression, there is little research that empirically establishes the contribution of combined therapies above and beyond the independent effectiveness of either monotherapy (Ziegler, 1996).

**Other Issues in Management**

*Medical treatment*. Of the pharmacotherapy treatments available for social anxiety disorder many have specific therapeutic windows and specified protocols needed for appropriate use. Eight to ten weeks is the minimum prescribed course for full efficacy of SSRIs to be evidenced (Sareen, & Stein, 2000). They are also contraindicated in combination with MAOIs. MAOIs are used when other drug treatments have been unsuccessful. Their use must be carefully monitored as they have adverse reactions with some foods and several common medications. Benzodiazapenes hav addictive properties and must be titrated carefully when removing them form a patient's treatment plan in order to avoid withdrawal symptoms (Tajima, 2004). Beta-blockers are used for quick relief of physical symptoms (Sareen, & Stein, 2000).

*Psychotherapy*. When assertive behavior by an individual is lacking, there is often diminished accuracy and engagement of social communications. Therefore, within treatment for any of the psychological disorders involving problems of communication and social interaction such as major depressive disorder, dysthymic disorder, social anxiety disorder, panic disorder with agoraphobia, separation anxiety disorder, generalized anxiety disorder, pervasive developmental disorder, schizoid personality disorder, and avoidant personality disorder, the primacy of assertiveness training should be ascertained as a component of a comprehensive and empirically

supported treatment appropriate for the specific psychological disorder.

**Assertiveness in Specific Contexts**

When assertive behavior is routinely absent in the context of a particular relationship or relationship set, an evaluation of the relationship history and implicit or explicit rules of

the relationship is appropriate. This information may provide the therapist with clues as to the habit strength associated with the nonassertive behavior and the extent to which the pattern of habitual responding is reinforced by others. A realistic appraisal of the benefits and deficits of the relationship may need to be delineated along with an emphasis on the sufficiency of the self.

*Intimate relationships*. In the context of intimate relationships the greatest challenge to assertive behaving is often the long interaction history that has been established. Nonverbal and verbal components of intimate exchanges may have become habitual and less subject to immediate reinforcement contingencies. Intimate relationships are also unique with respect to the sensitivity of topics that may need to be addressed. The assertiveness skills forwarded for nonintimate interactions are applicable to intimate interactions. Particular attention may need to be given to acknowledging the degree to which a new interaction style is being forwarded.

Sensitive behavior change requests (or request refusals) may involve family traditions, sexual behaving, or lifestyle behaviors. Sensitive topics such as changes in the frequency or type of sexual activities should be addressed in a manner that suggests an interest in experimentation rather than a permanent change to the couple's repertoire. It is also in such situations that the emphasis placed on overt reinforcement of satisfying aspects of current interactions cannot be too strong.

*Business situations*. Business situations are often replete individuals skilled in the art of persuasion. Because of the high level of assertiveness that often characterizes business interactions, specific techniques have been forwarded as helpful when making or refusing some business request. These include: the use of self-disclosure (suggestions of similarity in personal experiences or preferences are influential in "selling" an individual); repetition of request or request refusal (assuming a finite number of arguments for or against a given position, simple repetition of one's position suggests commitment to that stance and may wear down the resolve of the other individual); and singular focus (discussion of nonrelated or tangentially related topics may serve to distract the participants from the critical topic).

**How Does One Select Among Treatments?**

Assertiveness training can be an appropriate strategy for managing problem sets that encompass either passive behaviors or aggressive behaviors. When practiced as a component of psychological treatment for social anxiety disorder, assertiveness training requires that the client be willing to encounter anxiety. Provoking social situations and undergo a process of skills acquisition during which optimally assertive behavior is approximated with increasing success across practice trails. When practiced to manage aggression, assertiveness training requires that the client be willing to forego the emotional and instrumental "pay-offs" associated with aggressive behavior in favor of

outcomes that are acceptable to all involved. Treatment selection is inextricably tied to the client's willingness to engage in the prescribed assertive behaviors.

In establishing the effectiveness of an assertive response, we often consider the outcome achieved. Although the ultimate goal of assertive communication may be influencing the behavior of others, the measure of assertiveness is the extent to which personal opinions, needs, and boundaries have been accurately and respectfully communicated and received. Competent performance of appropriately assertive behavior is best predicted when sufficient attention has been given to the interpersonal context in which the behavior is planned to occur. Treating professionals frequently fail to acknowledge consequences of assertive behaving that the client would consider negative (e.g., loss of perceived control for the formerly aggressive individual and loss of attachment figures for the formerly passive individual). In adopting an assertive stance, individuals are not merely engaging in a simple display of a new behavior set; They are often realigning and reordering relationship priorities.

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