Rooted in Strengths:

Celebrating the Strengths Perspective in Social Work

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Preface

In the late 1980s, a group of University of Kansas School of Social Welfare (KUSSW) faculty and doctoral students began to talk about reframing our view of clients' capacities relative to their own course of treatment. Despite the emergence of social work as a helping profession, a strengths-based approach to work with clients and communities has not always been understood as critical to practice. Historically, clients, particularly highly vulnerable clients, were seen in terms of their deficits. This deficit approach to working with individuals led to a culture of "fixing" clients with the task of doing so implicitly placed on the social worker, practitioner, etc. Flipping that view to recognize that each individual had innate strengths and abilities to offer in their own change process and the importance of recognizing and valuing the client perspective in that process was forming at KUSSW.

What emerged at KUSSW was a way of thinking and a practice model that represented the shifting perspectives from deficit to strengths when working with people. In 1989, "A Strengths Perspective for Social Work Practice" (Weick, Rapp, Sullivan, & Kisthardt, 1989), a seminal article calling for and defining a strengths perspective for social work practice, was published by a group of University of Kansas School of Social Welfare faculty and students in the journal Social Work.

The Strengths Perspective emphasizes the human capacity for resilience and resourcefulness and recognizes the need for individuals and communities to form and achieve their own goals and aspirations. While acknowledging the difficulties

that clients experience, the Strengths Perspective reframes obstacles as challenges, opportunities, and motivators for change, and places social workers as collaborators with clients, their families, and communities in the change process. The article and related work completed at the time set the foundation for the Strengths Perspective to become a guiding principle for academic and scholarly activity at the University of Kansas School of Social Welfare for the next 30 years.

However, the notion of identifying strengths was not a new one. Various movements had long challenged conventional deficit thinking in social work. Additionally, numerous theories and perspectives including empowerment, social constructionism, feminism, and critical theories emphasize concepts that emerge as key principals of strengths-based practice. In this volume, authors Tanya Smith Brice and Denise McLane-Davison provide a historical view of strengths-based work with Black families based on the writings of Dubois and Billingsley to illustrate the long-held understanding of the importance of recognizing strengths.

Today the Strengths Perspective has become pervasive in social work, viewed as foundational to social work practice in the USA and several other countries. Practical applications, critical reviews, and innovative extensions of the perspective have emerged in social work education, policy development and analysis, organizational practice, and direct practice with clients. Strengths as a starting point are ubiquitous in our field. Current social work students and early career social workers would have little understanding of a deficit approach to working with people. The purpose of this special volume is to highlight the journey, catalog the paradigm shift, and document the historical roots of recognizing individuals' strengths in their own ability to change. Our call to authors was intentionally abstract. Contributors were asked to share their application of the Strengths Perspective in practice, research/scholarship, or teaching, but given no parameters beyond that. It was our hope that we would hear the "story" of strengths work in social work from the unique perspective of the authors. What resulted is a wide-ranging collection of chapters that speaks to the power of strengths in the authors' own words. From traditional research articles to personal narratives, the chapters illustrate how the Strengths Perspective has been applied in the United States and internationally.

The book opens with a reprint of the 1989 article by Weick and colleagues and a chronological reflection by two University of Kansas emeritus faculty including an author from that article. The following chapters are divided into four sections: (1) Strengths Perspective and Education, (2) Strengths Perspective and Macro Practice, (3) Strengths Perspective and Micro Practice, and (4) Strengths Perspective and Practice with Various Populations.

Not only do the chapters in this volume highlight past and current applications of the Strengths Perspective but they also provide a guide for moving forward. Teri Kennedy suggests a strengths-based approach to interprofessional practice and education (SB-IPE), and Megan E. Gandy-Guedes and Megan S. Paceley highlight the

need to shift from a focus on risks among LGBTQ+ youth, which fails to fully recognize their resilience, to an approach that identifies and assesses strengths. Melinda Lewis, Rosemary Chapin, and Hayden Rand look to history to link the strengths approach to strengths-based policy practice/reform to address the pathologizing of entire communities and shift the deficit thinking that prevails in political discourse. Jason Sawyer and D. Crystal Coles encourage us to address critical macro practice through the lens of the Strength Perspective. This focus on macro applications of the Strengths Perspective is an extension of the original thinking and offers exciting direction for large system practitioners. And finally, Amy Mendenhall, Whitney Grube, Nikolaus Schuetz and Elizabeth A. Schoenfeld, Brooke A. White, Amy J. Youngbloom, and Rick Goscha in their work with youth and adults remind us of the challenges of adaptation, the importance of fidelity to the Strengths-based Model of Case Management and our imperative to measure its success in practice.

For this volume, we wanted to mark the importance of the Strengths Perspective in social work practice. In the end, I believe we have created something meaningful that will mark this significant shift in thinking and practice. What follows tells the story of the roots of the strengths approach and the many Strengths Perspective applications in the last 30 years.

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Original 1989 Article 'A Strengths Perspective for Social Work Practice'

Ann Weick, Charles Rapp, W. Patrick Sullivan and Walter Kisthardt

(Originally published in the journal *Social Work* in July 1989)

Dichotomies pervade human life. In trying to cope with complex realities, human societies have created stark divisions between the good and the bad, the safe and the unsafe, the friend and the enemy. It is a curious fact that greater attention invariably is paid to the negative poles of the dichotomy: to the bad, the unsafe, the enemy. This pull toward the negative aspects of life has given a peculiar shape to human endeavors and has, in the case of social work and other helping professions, created a profound tilt toward the pathological. Because of the subtle ways in which this bias is expressed, its contours and consequences must be examined to set the stage for a different perspective. The strengths perspective is an alternative to a preoccupation with negative aspects of peoples and society and a more apt expression of some of the deepest values of social work.

TRACING THE ROOTS

Social work is not unique in its focus on the pathological. Throughout history, cultures have been preoccupied with naming and conquering outsiders and waging battles against the enemy in people's souls. Judeo-Christian heritage has given rise to a clear sense of human frailty through its concept of sin and has used that concept to limit or punish those thought to transgress moral norms.

Social work's origins are in the concept of moral deficiency. The Age of Enlightenment created the philosophical backdrop against which to consider in a new way the

plight of the less fortunate; but, given the economic environment in the late 1800s and the religious convictions of those in the Charity Organization Society, the strategy was one of moral conversion. Poverty was attributed to drunkenness, intemperance, ignorance, and lack of moral will (Axinn & Levin, 1975, pp. 89-94). Change was to come about not through provision of monetary assistance but through persuasion and friendly influence. The emphasis on human failing as the cause of difficulties established a conceptual thread whose strands are found in practice today.

The focus on moral frailty went through an evolution that both softened and disguised its presence. Soon after the turn of the century, social workers began calling for a more professional approach to the work of helping people (Lerby, 1978, p. 181). The adoption of the empirical method used in the natural sciences was the stimulus for the social sciences and for the emerging professions to define themselves not as crafts or philanthropic efforts but as organized, disciplined sciences (Lerby, 1978, p. 348). Mary Richmond was one of the earliest proponents of using a logical, evidence based method for helping (Goldstein, 1943, p. 29). Through her and others' efforts, increasing attention was paid to defining the problems in people's lives so that a rational, rather than a moralistic, strategy of intervention could be pursued.

The development of this formulation of professional practice was intersected in the 1930s by increasing interest in psychoanalytic theory as the theoretical structure for defining individuals' problems (Smalley, 1967, pp. ix-x). But the cost of this affiliation with psychoanalytic theory and its derivatives was an ever more sophisticated connection with human weakness as the critical variable in understanding human problems.

These weaknesses became reified with the language of pathology. A complicated clinical nomenclature grew up as a descriptive edifice for these new psychological insights. The art of clinical diagnosis was born-an art far more complicated than Richmond's logical steps to assessment. In keeping with the scientific belief that a cause must be found before a result could be achieved, attention was paid to all individual behaviors that signified a diagnostic category. Once a diagnosis was established, treatment could proceed. In this process, every category of clinical diagnosis focuses on a human lack or weakness, ranging from the relatively benign to the severe.

CURRENT DIRECTIONS

The profession has not been oblivious to the importance of recognizing individual strengths in practice encounters. Indeed, in 1958, the Commission on Social Work Practice included as a main objective of the field to "seek out, identify, and strengthen the maximum potential in individuals, groups and communities" (Bartlett, 1958, p. 6). Current writers, such as Hepworth and Larsen (1986), Shulman (1979), and Germain and Gitterman (1980), have given attention to the danger of focusing narrowly on individual pathology while ignoring strengths.

However, a subtle and elusive focus on individual or environmental deficits and personal or social problems remains in recent frameworks. The "ecological perspective" of social work practice, a model developed by Germain and Gitterman (1980), illustrates this point.

Germain and Gitterman (1980) built on the social work tradition of focusing on the interface between person and environment, introduced ecological concepts such as adaptation, and suggested that attention should be focused on the transactions that occur between people and their environments. They contended that it is in these complex transactions between a person and the environment that "upsets in the usual adaptive balance or goodness-of-fit often emerge'' (Germain & Gitterman, p. 7). These "upsets," from their point of view, often are the result of ''the stress generated by discrepancies between needs and capacities on one hand and the environmental qualities on the other" (Germain & Gitterman, p. 7). In short, it is either the characteristics of the individual or of the environment that create a problem. Emphasis thus rests on the ability to assess adequately the nature of the problem. Although Germain and Gitterman acknowledged the importance of "engaging positive forces in the person and the environment," the goal is to reduce "negative transactional features" (Germain &Gitterman, p.19). Ina subtle way, negative aspects still dominate this view.

A focus on the adequate assessment and diagnosis of the "problem" has deep roots in the profession and remains a central tenet of modem practice texts. For example, Compton and Galaway (1984) saw the focus of social work as "using a problem-solving focus to resolve problems in the person-situation interaction ... " (p. 12). Hepworth and Larsen (1986), who devoted an admirable amount of attention to the identification and use of strengths, also considered the problem-solving process as essential to social work practice and promoted the importance of "assessing human problems and locating and developing or utilizing appropriate resources systems" (p. 23).

Problem-solving models are closely tied to the notion of intervention. As Compton and Galaway (1984) described it, "Intervention refers to deliberate, planned actions undertaken by the client and the worker to resolve a problem" (p. 11). Although writers such as Shulman (1979) sense the need to identify the strengths of both the individual and the environment, the focus of intervention is on the "blocks in the individual-social engagement" (p. 9). Read closely, these views all suggest that accurate diagnosis or assessment of a problem leads naturally to the selection of particular "interventions" that, it is to be hoped, disrupt the natural course of individual or social difficulty. The difficulty or problem is seen as the linchpin for assessment and action.

THE PROBLEM WITH PROBLEM FOCUS

Attention to people's inability to cope is a central expression of the prevailing perspectives on helping. Approaches differ in the way the problem is defined, but

virtually all schools of therapeutic thought rest on the belief that people need help because they have a problem that in some way sets them apart from others who are thought not to have that problem. The terminology, ''having a problem,'' suggests that problems belong to or inhere in people and, in some way, express an important fact about who they are. The existence of the problem provides the raison d'etre for the existence of professional helpers. In an extreme form, it creates a view of professional helping that has a hidden logic and questionable results.

Concern about establishing the precise cause of a problem ensnares social workers in a strategy for dealing with the problem in those terms. If it is determined that a person's difficulties are linked to family dynamics in early childhood, then the approach "teaches" the person this view of the problem and justifies the attention on understanding these formative relationships. If the cause of family problems is thought to be patterns of communication, then the approaches will train the family in new communication skills. No matter what the cause, there will be some strategy to teach the clients the nature of their problems and the particular route to recovery.

Using Gregory Bateson's work, Watzlawick, Weakland, and Fisch (197 4, p. 39) analyzed this approach in relation to alcoholism. They showed that the view of the problem is carried into the solution. If alcoholism is defined as the disease of excessive alcohol consumption, then the therapeutic approach must be centered on abstinence. Getting an alcoholic to stop drinking is the first step in recovery. In this way, alcohol is both the center of the problem and the treatment. Even when someone is successfully sober for long periods of time, alcohol remains a central concern of his or her life. The · image of the bottle is as prevalent in sobriety as in drunkenness.

When the cause of a problem is defined, the problem exists in a new way. The process of naming something heretofore unnamed creates it as a reality toward which therapeutic effort must be directed. Instead of the vague unease or intense discomfort a person in her or his situation experiences, the source of the difficulty is identified and feelings are focused on it. It is named-a process that carries with it a magical quality because it makes something comprehensible that had been puzzling, frightening, and mysterious. The sense of control that often comes with naming provides a sense of initial relief. The unknown has been categorized and labeled. By making the problem subject to rational processes, the person in the grip of the difficulty sees that it has some shape and can be contended with. The power of the professional comes from naming the problem and from having in mind a strategy for overcoming the difficulty.

This process of naming occurs in a language that belongs to the professional, not the client. Diagnostic categories establish classes of conditions with which a client is matched. To accomplish this match, a clinician must look for broad commonalities rather than idiosyncratic characteristics. The client's situation must be made to fit predetermined categories and those categories are not ones that the client would

devise as an adequate description of his or her situation. To categorize someone as depressed provides only the most global assessment. It does not reveal the meaning of that person's struggle nor the strengths that lie hidden in that person's story.

Problem-based assessments encourage individualistic rather than social environmental explanations of human problems. Although it generally is understood that people live in complex social milieus that dramatically affect them, assessment rarely takes into account larger social variables. Even when conditions such as poverty are seen to limit severely people's ability to manage their lives, attention often is concentrated exclusively on efforts to change the behavior of those affected. The difficulty in changing social conditions deters helpers from keeping those factors in the picture, and results in a view of people as the cause of their own problems.

The problem-deficit orientation sets up other barriers for clients. One manifestation occurs frequently in residential treatment programs. Deficiencies in behavioral skills are identified in the initial assessment, and a treatment plan is devised to teach these skills. When the person demonstrates these skills, the staff is inclined to count it as a successful intervention. However, success is marred by other "dysfunctional" behaviors that are observed and the strategy of correcting them is similarly programmed. This pattern may be repeated numerous times, turning what was expected to be a 3-month stay into several years of treatment. The focus on problem behaviors develops a life of its own, and is paradoxically reinforced by the fact that the residential environment in itself creates "problematic" behavior. Although a focus on such behavior may temporarily alleviate its expression, there is no evidence that the results of such residential intervention will carry into the person's life after release from the program. Gearing treatment goals to problem behaviors ensures that there will be a never-ending requirement for continued intervention and little sense of success.

Finally, the activity of searching out the problem creates the illusion that there is an identifiable solution or remedy for it. Underlying the problem approach is the belief that an accurate naming of the problem will lead to an appropriate intervention. Although that belief may occasionally be justified, the daily practice experience is, far less precise. Many professionals find that naming a situation provides no clues about how best to proceed-and that the real clues emerge from the continuing and ever-changing interaction with clients who are in the situation. In addition, the very act of diagnosing the problem may add a new layer of problem that complicates any notions about a clear course of treatment.

The focus on the problem and the process of defining it established the contours of much of what is identified as helping. Three dynamics are clear: (1) the problem invariably is seen as a lack or inability in the person affected, (2) the nature of the problem is defined by the professional, and (3) treatment is directed toward overcoming the deficiency at the heart of the problem. This triumvirate helps ensure that the helping encounter remains an emergency room, where wounded people come to be patched up.

DEVELOPING A STRENGTHS PERSPECTIVE

In the face of this pervasive bias toward weakness and pathology, it is difficult to imagine that it is either wise or possible to create a substantially different set of assumptions to underlie the helping process. One of the signs of a dominant view is the suspicion it generates about any approach that contradicts its premises. For all those trained in the current models of helping, it may seem foolish or dangerous to ignore what seems to be the clear presence of pathological behavior or to consider any approach that would sever the ties between recognition of human difficulty and interventive strategies for dealing directly with its causes. The theoretical superstructure that surrounds and bolsters the dominant approach forms a deeply help belief system that is not easily swayed, much less relinquished.

The motivation for a critique of the problem focus comes from two fronts. On a philosophical level, the intense focus on problems makes it difficult for practitioners to express some of the fundamental values of the profession. The belief in the dignity and worth of each individual and the corresponding belief in individual and collective strength and potential cannot be realized fully in the midst of concerns about assessing liabilities. On a practical level, the concern with the problem places the practitioner in a position of authority, making it difficult for clients to trust their own sense of how to proceed with their lives. As a result, they may be tied to professional help for extended periods.

The value of the profession provides the necessary foundation for an approach to helping that is dedicated to the development of people's strengths. In the words of Smalley (1967), "The underlying purpose of all social work effort is to release human power in individuals for personal fulfillment and social good, and to release social power for the creation of the kinds of society, social institutions, and social policy which make self-realization most possible for all men [or women]. Two values which are primary in such purposes are respect for the worth and dignity of every individual and concern that he [or she] have the opportunity to realize his [or her] potential as an individually-fulfilled, socially contributive person." (p. 1)

This statement of purpose and these values are the core of social work and provide the framework for a value-based approach to social work practice.

Building an approach to practice on the central values of the profession accomplishes two important objectives. First, it ties the practice of social work to its philosophical roots in a conscious, explicit way. Values become the constant measure against which the quality of practice is judged. Second, it acts as a corrective for the imbalance caused by the preoccupation with people's deficits and liabilities. A strengths perspective rests on an appreciation of the positive attributes and capabilities that people express and on the ways in which individual and social resources can be developed and sustained.

Before discussing the practical applications that flow from this approach, the assumptions on which this approach is founded must be recognized. These assumptions reflect a particular value position and are beliefs, rather than empirical facts. They are offered as a way of showing the philosophical position that underlies the approach and as a basis on which to judge both their consonance with social work values and their reflection of the experiences of people's lives.

All people possess a wide range of talents, abilities, capacities, skills, resources, and aspirations. No matter how little or how much may be expressed at one time, a belief in human potential is tied to the notion that people have untapped, undetermined reservoirs of mental, physical, emotional, social, and spiritual abilities that can be expressed. The presence of this capacity for continued growth and heightened well-being means that people must be accorded the respect that this power deserves. This capacity acknowledges both the being and the becoming aspects of life.

In the midst of a recognition of capacity for growth is the simultaneous recognition that no person perfectly expresses this capacity on all or even most of the planes of development during his or her lifetime. A few rare individuals may show high levels of artistic, spiritual, or intellectual development, but for most people, the evidence of life shows far more modest results. In a strengths perspective, a conscious choice is made to attend exclusively to those aspects of a person's life that reflect the gains made, however modest they may be judged.

Attention to the strengths people have, rather than to their failings, reveals an important assumption of the model. By placing an emphasis on the already realized positive capacities of an individual, the individual will be more likely to continue development along the lines of those strengths. Continuing growth occurs through the recognition and development of strengths. The interplay between being and becoming and between what a person is in totality and what may develop into greater fullness mark the essential dynamic of growth.

But an emphasis on the positive aspects of human capability serve as a stimulus for new growth. An emphasis on the positive aspects of human capabilities as the best stimulus for growth runs directly counter to prevailing conceptions about problems and deficits. An assumption is made in the strengths perspective that the quality of growth is enhanced by attending to the positive abilities already expressed, rather than to their absence. A singular focus on the strength already expressed is the vehicle through which additional talents and abilities can be developed. This position asserts that people do not grow by concentrating on their problems. In fact, the effect of a problem focus is to weaken people's confidence in their ability to develop in self-reflective ways. The fact that people have lacks is acknowledged, but the best strategy for supporting further gains is a conscious emphasis on the gains already made.

Because of the current bias toward weakness rather than strength as an expression of human qualities, there are several ancillary principles that guide the strengths

focus. The first is a belief that people have the capacity to determine what is best for them (Weick & Pope, 1988). This long-honored social work value recognizes that people have an inner wisdom about what they need and that ultimately, people make choices based on their own best sense of what will meet that need. Those who hold a strengths perspective assume that this inner wisdom can be brought into more conscious use by helping people recognize this capacity and the positive power it can have in their lives.

Giving people confidence to proceed with the difficult choices in their lives acknowledges another principle: that people do the best they can. Even though the systems of social rules suggest that there is an objectively correct way to proceed in human life, most people experience a different reality. They realize that the situations they face are idiosyncratic, not only from event to event in their own lives but compared with events in others' lives. Given the complex way that situations occur, it is difficult to imagine that there is one best way to proceed. One tenet of a strengths perspective is that in the midst of complexity, people proceed in the best way they can. Even when they are making what seem to be wrong choices from an outsider's viewpoint, they are exercising their capacity to find what is best for them.

Recognizing the complexity of human situations reinforces another social work insight about the interplay between individuals and environments. The personal history and unique composite of personality characteristics of individuals interacts constantly with the political, economic, social, and natural forces in society. The combinations and permutations of this vast welter of factors necessarily shakes beliefs about predictability and certainty. It is impossible for even the best trained professional to judge how another person should best live his or her life. The nonjudgmental attitude in social work dictates not only that social workers should not judge but that social workers cannot judge. Instead, the principles of knowing what is best and doing what is best places the power of decision where it should be with the person whose life is being lived.

STRENGTH-BASED PRACTICE

Although social workers intuitively are comfortable with the concepts of a strengths perspective, it may seem difficult to imagine actually practicing primarily from this perspective. The institutional and professional barriers appear insurmountable. Yet a practice approach based on this perspective has been developed and has produced encouraging outcomes for a population that is most likely to be labeled as pathological: chronically mentally ill people (Modrcin, Rapp, & Poertner, 1988; Rapp & Chamberlain, 1985; Rapp & Wintersteen, 1985). The key to this approach has been a singular emphasis on the strengths and resources of the client, rather than on the client's symptomatology and behavior problems.

A strengths assessment is necessary to practice according to a strengths perspective. The assessment focuses exclusively on the client's capabilities and aspirations

in all life domains. In making this assessment, both the client and the social worker seek to discover the individual and communal resources from which the client can draw in shaping an agenda. The question is not what kind of a life one has had, but what kind of a life one wants, and then bringing to bear all the personal and social resources available to accomplish this goal.

Social workers are not required to judge. Strengths are not thought to represent symptoms of underlying pathology. Therefore, there is no need for a clinical diagnosis. A client's expressed aspirations are accepted as sincere. Acceptance and validation replace skepticism about what clients can "realistically" achieve. A brief example can highlight aspects of this approach.

Harry, a 45-year-old man, grew up in rural Kansas. He had been referred to the community support program upon discharge from the state hospital. Harry had been hospitalized 20 years ago, and carried a diagnosis of chronic schizophrenia. He had been placed in a board-and-care home that was located in a large urban area.

The community support staff became Harry. It was reported that he was noncommunicative, had poor hygiene skills, and was hallucinating regularly. These problems were compounded by a report from the boarding home that Harry was packing his bags each night as if to leave. The staff predicted imminent rehospitalization.

Harry was referred to a social worker trained in the strengths perspective. Through the process of a strengths assessment, Harry's knowledge of and interest in farm work came to the fore. The social worker took seriously this expression of interest and began working with Harry to find a place where he could use his skills.

They located a ranch on the edge of town where the owner was happy to accept Harry as a volunteer. Harry and the owner became friends and Harry soon established himself as a dependable and reliable worker. After a few months Harry recovered his truck, which was being held by his conservator, and began to drive to the farm daily. To the delight of the community support staff, Harry began to communicate and there was a marked improvement in his personal hygiene. At the time of termination with the case the owner of the ranch and Harry were discussing the possibility of paid employment.

The work with Harry may appear to be typical of social work practice, because it combines such fundamental aspects as a caring relationship and the creative use of community resources. But the distinctive aspect of the strengths approach is the belief that people can grow only when the social worker actively affirms and supports their ability to do so. In Harry's case, the social worker consciously chose to look beyond his symptoms of uncleanliness, hallucinations, and silence. Instead, through the medium of a caring relationship, the social worker helped uncover and focus the goals and aspirations central to Harry's interests. Because of this affirmation, Harry was able to draw on his own resources and those of his community to reshape the direction of his life.

When a strengths perspective is used, a new array of questions then commands attention. For example, instead of asking, "What's wrong with this family?" the question becomes, "What are the strengths in this family that will help them grow and change?" Instead of asking, ''Why is this person mentally ill or delinquent or abusive?" the question can be, ''What do they need to develop into more creative and loving adults?'' Such a shift in focus lends itself to a series of related questions about the ways individuals already have shown resilience in the face of pain and alienation and the resources that exist within family and community for nourishing that resilient spirit. In the last analysis, it is not the development of specific methods that will justify this approach but a heightened commitment to the professed belief that social work practice builds on people's talents, aspirations, wisdom, and courage. Acting on that belief lies at the heart of the strengths perspective.

CONCLUSION

In a strengths perspective, the emphasis on positive qualities and attributes creates a qualitatively different context for social work practice. It aligns the doing of social work with its system of values. Rather than teaching people ever more sophisticated formulations of their problems, emphasis is placed on helping people learn to recognize and appreciate their strengths. Uncovering these strengths and framing them in an accessible and useful way becomes a core social work process. Within this perspective, the words of Mary Richmond (1922) once again are relevant: "Individuals have wills and purposes of their own, and are not fitted to play a passive part in the world" (p. 258).

The roles of the professional and of the client are dramatically changed in this approach. The client decides what course of action to pursue. In contrast with more traditional diagnostic frameworks, within which individuals cannot compete with the theoretical or formal conceptions of their problems, the language of strengths belongs to the client. People can identify the resources available within themselves and their lives. If anything, a strengths perspective is a strategy for seeing; a way to learn to recognize and use what is already available to them. The professional person thus becomes a translator who helps people see that they already possess much of what they need to proceed on their chosen path.

Focusing on human strengths is one significant strategy for helping people reclaim a measure of personal power in their lives. A strengths perspective has successfully been applied to a group who have been burdened throughout their lives with the label of chronic mental illness. If an emphasis on the hidden strengths of people who have been categorically excluded has been helpful in their achieving new dignity and purpose, the lesson is one to be considered in all realms of practice. If the profession chooses to do so, helping people recognize and build on their strengths may once again become a powerful maxim for social work.

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As Professors Emeritus, Charles Rapp and Alice Lieberman were members of the University of Kansas School of Social Welfare community during the emergence of the strengths perspective within the field. Below are their recollections of how the Strengths Perspective became a foundational value within the School of Social Welfare.

Reflections

Charles A. Rapp & Alice Lieberman

As we write this 30 years from the publication of "*A Strengths Perspective for Social Work Practice*", the strengths perspective has been utilized and applied worldwide across populations. Less than 10 years ago, an international conference was held in Nepal on strengths-based practice that brought presenters from Uganda, the Philippines, Kenya, Lapland, India, Australia, Slovenia and Nepal. A book detailing the strengths-based innovations developed in these countries was subsequently produced (Pulla, Chenowith, Francis & Bjakaj, 2012). In mental health alone, there are strengths model case management projects in Australia, New Zealand, Netherlands, several provinces in Canada and a large controlled trial is currently being conducted in Hong Kong. In the United States, similar efforts are being undertaken in California, Kansas, Iowa, and Texas. Beyond mental health, applications have been established or proposed in substance abuse (Rapp, 2006), with older adults (Nelson-Becker, Chapin & Fast, 2009), and families (Bernard, 2006). Additionally, the strengths perspective has informed community development (Saleebey, 2006) and social policy approaches (Chapin, 2017; Rapp, Pettus & Goscha, 2006).

Contributing to the reach of the strengths perspective across populations and geographic locales has been deeply gratifying to the University of Kansas School of Social Welfare community. And despite decades of collaboration with colleagues worldwide to refine it and expand its applications, the core of the strengths perspective remains both deceptively simple and unchanged: the strengths perspective reflects a universal philosophical truth that change efforts, whether at the person-

al, organizational, or community level, will not be successful until we harness our positive attributes—our talents, skills, collective histories, environmental resources, etc.—and use those to move forward. What follows is our recollection of the paths we took that contributed to the strengths perspective solidifying as a foundational principle within the social work profession.

A Strengths Approach to Mental Health

The term "Strengths Perspective" was widely introduced in the article "A Strengths Perspective for Social Work Practice," published in the journal *Social Work* in 1989. However, strengths-based practice work in the KU School of Social Welfare began in 1982 when the state mental health authority, responding to a federal initiative, requested that the School develop a model of case management for work with people with serious mental illness. Ronna Chamberlain, a new doctoral student with a rich background in adult mental health and first author Charles Rapp took a teleological approach by first identifying the desired core outcomes (independent living, employment, avoiding psychiatric hospitalization and social support) that clients, families, and providers desired. Then, based on our ideas of individual client strengths and environment/community strengths, we developed a set of principles, tools and a brief training program; recruited four social work practicum students; and received sanction to implement the approach within the local mental health center's community support program. After one year, we examined the data collected, and the results revealed a reduction in psychiatric hospitalization and gains in social support and other indicators of well-being (Rapp & Chamberlain, 1985).

The 1989 Social Work Article

The next six years, from 1984 to 1990, witnessed a continued increase in demonstrations of what we called the Developmental-Acquisition Model of case management. The bulk of these projects occurred in Kansas and from them came additional research reports and conceptual articles. Studies by KU doctoral students and faculty on the strengths model of case management demonstrated a consistent pattern of positive results (Modrcin, Rapp & Poertner, 1988; Rapp & Wintersteen, 1989; Kisthardt, 1993).

Interest from other state mental health authorities grew steadily and resulted in requests for training, consultation, and keynote speeches. In these early days, an audience would be variously split among those who claimed they were already doing the strengths approach and those who thought it was not possible and that we were foolish for suggesting it. Those of us involved in these activities, with only occasional consideration of possible broader relevancy, largely thought that at best we were in the process of developing some ideas, tools, and methods that would better help people struggling with a serious mental illness.

As the scope of this work broadened, others in the School began to consider how it applied more broadly to social work practice. Ann Weick, who held a longstanding interest in philosophical frameworks in social work practice, foresaw implications for

how the approach could be applied beyond serious mental illness, and exploration of these ideas with others led to the article that appeared in the journal *Social Work* entitled, "A strengths perspective for social work practice" (Weick, Rapp, Sullivan, & Kisthardt, 1989).

The article served as a published statement of what is now known as the Strengths Perspective. It also helped identify people who thought similarly, whose practice was at least partly consonant with the ideas in the paper, and it provided words for otherwise unarticulated thoughts. It also provoked ideas for possible applications in areas other than adult mental health.

The Forums

Based in part on the success of the adult mental health case management projects and the publication of the article, our KU colleague Professor Dennis Saleebey identified six people from around the country who had similar or at least compatible interests, and asked them to join 5 KU faculty and PH.D. students to share their ideas. Each was asked to put ideas in a paper and attend a small forum where these ideas could be exchanged and discussed. The papers were distributed to each of the participants prior to the forum. At the forum, each author was given about 15 minutes to summarize their paper highlighting the key ideas. Most of the day was devoted to a discussion of the ideas by these 11 people. A small audience of KU faculty and students were able to view the proceedings. The papers were subsequently edited and Dr. Saleebey added introductions and concluding essays. Ten years after the first KU mental health project, this collection became the first book devoted to the strengths perspective (Saleebey, 1992).

The forum and the book stimulated considerable interest within the School and in the profession. Much of it was supportive of the ideas but it was not without a sizeable segment of people expressing doubts or even hostility. The on-going debate was necessary and healthy for the further development of the perspective. It forced many of us to consider issues previously ignored, to be increasingly precise about our ideas and practice applications, and to spur further research into the results of the strengths perspective applications. The book also helped us identify other strengths-oriented scholars and practice innovators around the country. Some years later, Saleebey held a second forum at KU. New practice applications in substance abuse, older adults, public social services, protective services for children and youth, and community development practice were identified. Subsequent editions of the *Strengths Perspective in Social Work Practice* were significantly longer, mirroring the growth of the strengths perspective in thought and activity, and each had a larger readership than the first edition. The book eventually went to six editions, ending in 2012. At the time of Dr. Saleebey's death in 2014, he was working on the seventh.

Synergy within the KU School of Social Welfare

From the early 1990s onward, the strengths perspective became a major topic of discussion in the KU School of Social Welfare whether in formal curriculum or

research meetings, or in hallways, offices, or by the coffee pot. These conversations ranged from the amicable to the pleasantly contentious as our faculty searched for understanding, applications, and evidence that the strengths perspective was more than just the current fad. This high level of activity created a palpable synergy within the Twente Hall community. And yet, this shared occupation of our intelligence on a single topic should not be viewed as universal agreement. Part of the synergy was in fact due to skepticism and differences as we struggled along. Almost half of the faculty and several Ph.D. students published at least one article related to the strengths perspective during this period with most of those publishing multiple articles. A quarter of the faculty published books devoted to the strengths perspective or had substantial content related to it Petr (2004), Lieberman (1998), Chapin (2007), Canda (1999).

As we prepared for CSWE accreditation in the early 1990s, the faculty formally voted to make the strengths perspective one of the four themes of our BSW and MSW curricula. This then instigated even more dialogue. As many of us have come to know, in order to effectively teach something, one needs a rather full understanding of the particular topic. How to integrate the strengths perspective into each of our courses was a significant challenge that enriched our understanding of it as we proceeded.

Historically, it has been rare that an entire school of social work is seemingly defined by a particular thinking or model. In the late ’40s and early ’50s, the University of Pennsylvania School of Social Work was intrinsically linked to ”functionalism” as a model of casework. It seemed to hold sway for about a decade. The strengths perspective has been similarly linked to the KU School of Social Welfare for over 30 years.

Prompting Other Innovation

While the strengths perspective enjoyed increasing intellectual activity and application in a wider range of practice areas, KU scholars continued to apply the perspective in ever more innovative ways. One stream of intellectual development that was quite important focused on explicating a strengths perspective on the environment. Two members of the KU family were particularly influential in this regard. Professor James Taylor’s article “Niches and Practice: Extending the Ecological Perspective” (p 217-228) in Saleebey’s second edition of the *Strengths Perspective in Social Work* (1997) described how the strengths perspective approach to environmental processes and impacts propelled us to reconsider and extend our views of both the ecological and strengths perspective. W. Patrick Sullivan, now on the faculty at Indiana University, became the principal author who over the years enriched the conceptual understanding of a strengths-focused view of the environment and described specific methods that grow from it. His first article, written as a Ph.D. student at the School, described how rural areas needed to develop community support programs “without walls” that employed natural community resources on behalf of people with serious mental illness if they were to be effective (Sullivan, 1989).

Building upon the early work with the state mental health authority, a wider range of supportive strengths-based innovations were also developed within the School. This included the status method of client outcome monitoring (Rapp et al.,1988), scales for monitoring the fidelity of implementation to strengths model principles and methods (Fukui et al., 2012), technologies for field mentoring as an improved way for direct service staff to be taught discrete practice skills (Carlson, Goscha, & Rapp, 2016), and strengths-based group supervision (Fukui et al., 2014). Rick Goscha was instrumental in the development of most of these supportive innovations and deserves much credit as the disseminator of the strengths model within mental health programs in the U.S. and abroad.

Moving Forward

The years of achievement in building, refining, and extending the strengths perspective pale in the face of what still remains to be done. There are simply too few reports of the effectiveness of strengths perspective interventions and fewer still using rigorous research designs. Given the growing number of applications, the opportunities should be present. For example, beginning studies by Mendenhall, Grube and associates on the strengths approach with youth with psychiatric disabilities are promising, but demand further studies testing the effects on client outcomes (Mendenhall, Grube & Jung, 2019; Mendenhall & Grube, 2017; Grube & Mendenhall, 2016; Grube & Mendenhall, 2016; Scheutz, Mendenhall & Grube, 2019).

Secondly, the development and testing of fidelity measures for strengths perspective interventions are critically important. The strengths perspective continues to be subject to multiple interpretations of exactly what it is in practice. We need to be able to separate those who claim allegiance to a strengths perspective approach but where there is a minor reference to strengths, but little or no fidelity to the principles (e.g. merely having a small space for strengths in an otherwise deficit-based assessment). Such an effort would force us to be specific about the salient methods and allow our research to more powerfully link results to the actual interventions. In practice, fidelity measures could act as an influential tool for supervisors and those working in quality improvement. This recommendation is buoyed by the study by Fukui, et.al (2012) that found that client outcomes varied by the level of fidelity with strengths model case management implementation.

A third area of needed attention concerns skills in translating strengths into more powerful individual goal plans (case plans) and accessing the strengths of the natural community on behalf of our clients. In many situations, we continue to use formal, often segregated, social services thereby restricting opportunities, reducing community integration and access to resources, and ultimately decreasing achievement. Priority should rather be placed on the rich strengths and possibilities offered by the natural communities.

Prior to his death, Dennis Saleebey wrote a series of notable essays sketching the conceptual roots of the strengths perspective. The best attempt was perhaps his

introduction to his book entitled "Power in the People" (2009). The development of the strengths perspective could benefit from additional efforts to trace its intellectual history and to more precisely describe the links with affiliated approaches such as restorative justice, empowerment, positive psychology, capability theory and resilience.

Concluding Thoughts

For those of us involved in the early strengths work, nothing on our 30-plus year journey with the strengths perspective was anticipated. It was one surprise after another: from that first study which yielded surprisingly positive findings to the aforementioned article being accepted by *Social Work* (Weick et al, 1989) to the worldwide attention it has ultimately gained. These recollections are just a small glimpse into the strengths-based work done within the University of Kansas School of Social Welfare over the last 30 years. We have always been, and continue to be, proud of the School and its achievements. To be a part of such a collective effort was among the proudest moments of our careers.

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Strengths Perspective

& EDUCATION

The Strength of Black Families: The Elusive Ties of Perspective and Praxis in Social Work Education

Tanya Smith Brice & Denise McLane-Davison

"These are times when our most prolific commodity is language, and language has a great deal to do with alienation and legitimacy."
- Chicago Catalysts: Declare War on White Racism, 1968

"We must go a step further. If it is clear that the practice of social work by blacks for blacks must operate from a new theory, then this theory of liberation must be fully and unquestionably developed to its fullest by those blacks. This new social theory must not be arrived at by outside sources who would distort the true meaning of liberation."
- LeVerne McCummings, Chairman Philadelphia Alliance of Black Social Workers, 1969

The strengths perspective, although briefly commented on by E. Franklin Frazier's (1939) early research describing the Negro family, becomes intrinsically tied to the cultural scholarship produced thereafter which pointed to the impact of structural oppression on the Black family. The political era of the Civil Rights, Women's Rights, and The Black Power Movement demanded the inclusion of rigorous research that centered racial and gender identity as significant narratives for inclusion in curriculum (Collins, 1998; Solomon 1976, Chunn, 1975). The emergence of Black Studies and Women's Studies, along with student-led and national organizations incorporating the same identity politics, also became familiar parts of the intellectual land-

scape. Billingsley (1968), Hill (1972), Nobles (1974) and Solomon (1976) emerged as prominent scholars who disrupted the common rhetoric of the pathologized Black family through their emphasis on connecting African cultural values, traditions, and generational behaviors as strengths. Their newly articulated strengths perspective humanized persons of African ancestry and helped to unpack the common labels of "negro underclass", "underprivileged", and "ghetto" (Nobles & Goodard, 1985). Through their scholarship, they helped to usher in a critical lens that contextualized the environmental underbelly of America's legalized structural oppression. The collective identity of their lived experiences as scholars and simultaneously as members of the Black community were brought into alignment as they linked Black lives to positive characteristics such as extended family networks, self-help, mutual aid, collective responsibility, link-fate, community stability, and power (Chunn, 1975; Nobles & Goodard, 1985; Boyd-Franklin, 1989, Harvey 1985).

The Black family, as described in *The Strength of Black Families* (Hill, 1972;1997) is the fundamental source of:

1) Strong work orientation
2) Strong religious orientation
3) Strong belief in family
4) Strong achievement orientation
5) Adaptability of family roles. (Chunn, 1975, p.9).

The Black family is understood as the core institution of Black life (Dubois, 1898; Frazier, 1939, 1957; Billingsley, 1968, Ladner, 1972; Harvey 1985). The Black family is the incubator of generational knowledge, traditions, values, and behaviors who serves as a protective mechanism against external threats and serves as a catalyst for the next ecological cycle (Billingsley, 1968, 1973, 1973b; Collins, 1989; Hill, 1972; Logan and Freeman, 1990; Nobles, 1974). And yet, Black family strengths have largely been overlooked through scientific inquiry, in support of a western positivist epistemology that reproduces structural inequities (Nobles & Goddard, 1985, Glasgow, 1980, Solomon, 1976, Boyd-Franklin, 1989; Royce-Turner, 1980, Martin & Martin, 1995; Hill 1972; Wells-Wilbon, McPhatter, & Vakalahi, 2016).

The strengths of Black families are further woven into institutions such as the National Association of Black Social Workers (NABSW) and some of the initial social work programs at Historically Black Colleges and Universities (HBCU's), and other culturally-informed curriculum in social work. NABSW, founded in 1968, regards the preservation of the Black family and community as its primary responsibility (Johnson, 1978). Thus, for over 50 years the strengths perspective has guided their members' research, scholarship, practice and curriculum through the institutionalization of NABSW's journals, newsletters, conferences, and trainings. (Chunn, 1975; Harvey 1985; Nobles & Goddard, 1985; Waites, 2009; McLane-Davison, 2017; Wells-Wilbon, McPhatter, & Vakalahi, 2016). Clark-Atlanta University, Howard University, Morgan State University, and the University of Michigan's Schools of social work have all

benefited from the Black strength-perspective as a key competency of their programs. Many of the founding and pioneering members of NABSW were prominent members of the faculty and administrative teams that pushed for this inclusion. Thus, as the Whitney M. Young, Jr. School of Social Work, Clark-Atlanta University, Atlanta, Georgia, celebrates its centennial in 2020 and has the distinction of being the first HBCU School of Social Work, the academic home of E.Franklin Frazier (1939) *The Negro Family*, as well as, Dubois, (1903) book *The Souls of Black Folk;* it may also be considered the birthing ground of the Black strengths perspective.

Keeping in step with our academic fore-parents, the authors have intentionally utilized the historical documents of Black scholars as historical markers to center the Black strengths perspective as it emerged through the voice of a new group of Black scholars during the 1960s. This scholarship is further institutionalized through the founding of The National Association of Black Social Workers, Inc. and in social work programs at Historically Black Colleges and Universities (HBCUs). Lastly, we explore how the Black strength perspective expanded the critical lens of social work research and pushed for a culturally-informed curriculum as praxis of social work education.

THE STRENGTHS PERSPECTIVE

The strengths perspective is a lens through which systems are viewed. It is a perspective that requires one to rely upon innate tools or characteristics that enable that system to withstand challenges to that system (Hill, 1972). The social work practitioner makes a choice to view a system through a strengths perspective. African-centered scholarship relies upon a strengths perspective to frame the lived experiences of African Americans (Nobles, 1974; Harvey, 1985; Boyd-Franklin, 1989; Waites, 2009). Billingsley (1968) reminds us that the strengths perspective requires the social worker to see the family as "the most basic institution of any people, the center and source of its civilization" (Forward). Billingsley (1968) goes on to describe the role of the Black family in society,

> ...the family is not an independent unit of society. It is not the causal nexus of social behavior. It is highly interdependent with a great number of other institutions for its definition, its survival, and its achievement. The Negro family, then, cannot be understood in isolation or by concentration on its fragments, or on particular forms of family life, or by concentration on its negative functions. The Negro family can best be understood when viewed as a varied and complex institution within the Negro community, which is in turn highly interdependent with other institutions in wider white society (Forward).

It is this perspective that served as a catalyst for the founding of NABSW, in May 1968, at the 95th annual meeting for the National Conference on Social Welfare

(NCSW) in San Francisco, California. The conference theme was "An action platform for human welfare". There was a division program that supported the conference entitled, "The ghetto and the politics of welfare". According to Wayne Vasey, President of NCSW, and Professor of Social Work at the University of Michigan, the 1968 conference "was the largest Forum in history, in attendance, with almost 8,200 registered, and certainly the most tumultuous in recent years" (National Conference on Social Welfare, 1968, p. 156). There were several influential events occurring that preoccupied the minds of many of the conference participants and leadership. The Poor People's March, led by Martin Luther King, Jr's Southern Christian Leadership Conference (SCLC) and other groups like the National Welfare Rights Organization (NWRO), took place in Washington, DC the same week of the NCSW conference. Welfare rights organizations sent representatives to the NCSW conference, such as the National Federation of Student Social Workers and the Social Workers' Welfare Movement who charged the organization with "welfare colonialism" for failure to address structural poverty (Berry, 1989). The California fruit workers were on strike during this time and sent representatives who also protested the U.S. governments importing migrant workers from Mexico to break the labor unions. There were also widespread student protests at universities and colleges across the country addressing the Vietnam War (Berry, 1989).

Black social workers were organizing around the country to address "gross [social] inequalities after World War II" (Jaggers, 2003, p. 14) and to combat racial discrimination in social welfare agencies and schools of social work (Jaggers, 2003). A contingent of those Black social workers protested during the National Association of Social Workers (NASW) conference on the Urban Crisis in April 1968, for discussing the "urban crisis" without the inclusion of the voices of Black social work leaders. This contingent of Black social workers named themselves the Association of Black Catalysts: Our Black Thing (ABC: OBT), but were most commonly referred to as ABC or The Catalysts. They decided at the NASW conference to attend the NCSW conference in San Francisco in May 1968 to raise the same concerns as was raised at the NASW conference. As was the case with each of the other protesting groups, the ABC expressed concerns about the NCSW's unwillingness to take a position on pressing social issues. Specifically, the NCSW preamble states that "this conference does not take an official position on controversial issues and adopts no resolutions except occasional resolutions of courtesy (Vasey, 1968, p. 159)".

The members of The Catalysts demanded that the leaders of NCSW address these presenting social issues. Consequently, five members of the ABC "commandeered" (Jaggers, 2003; Vasey, 1968) the plenary stage at the start of a convening session. Other members stood in the center aisle of the plenary session. George Silcott, Professor of Social Work at New York University and founding member of the ABC, read a position statement that reflected displeasure with NCSW's preamble, which was seen as being in direct contradiction to the conference's theme of action. Specifically, while the NCSW's preamble suggests that the conference does not take a position on social issues, the president, Wayne Vasey, delivered an "action-oriented [mes-

sage that states] the need for a massive attack on a wide front of human problems" (Jaggers, 2003, p. 19). The ABC viewed Vasey's stance as contradictory, yet preferable, to NCSW's stance.

These Black social workers demanded that there be a revision of the organization's preamble. In addition, Black social workers critiqued NCSW for being an "American white institution in so far as the members of its Board and planning committee do not reflect an ethnic composition commensurate with its expressed concern" (Vasey, 1968, p.160). This critique is evidenced by the list of program speakers. While there were sessions such as, "Work and Income Policies for the Negro in Urban Slums", there was but one Black presenter on the program. Whitney M. Young, Jr., Executive Director of the National Urban League, provided the closing address, where he expressed support for the actions of the ABC. Furthermore, Black social workers demanded that the people "who speak, write, research and evaluate the Black community be Black people" and that White social workers need to focus on resolving the "problem of White racism" (Vasey, 1968, p.160). The position statement ended with the following statement (Jaggers, 2003),

> We are committed to the reconstruction of systems to make them relevant to the needs of the black community, and are pledged to do all that we can to bring these about by any means necessary (p. 21).

It is this statement that serves as the basis for the founding of the National Association of Black Social Workers in May 1968, in San Francisco, California. It is this organization that has formally connected the strengths perspective to strengths-based scholarship and practice with Black families.

SOCIAL WORK CURRICULUM ABOUT BLACK FAMILIES

The National Association of Black Social Workers realized the necessity of Black people addressing the social issues confronting the Black family. Black social workers were confronted with the question of how to move social work education to center their understanding of the strengths of Black families from a deficit model of pathology and abnormality (Johnson, 1978; Jaggers, 2003). They realized that there needed to be an integration of this content throughout the social work curriculum. Consequently, NABSW demanded that Schools of Social Welfare respond in a culturally appropriate way. Specifically, NABSW made the following demands:

- More fieldwork placements in the Black community, with Black supervisors
- Pay community consultants in fieldwork for their expertise
- Black people should be included in the design and implementation of admissions and financial aid towards the recruitment of more Black students

- Hiring freeze on White faculty until half of the faculty are Black
- Black students, faculty, and community members should be a part of the hiring and recruitment process of new Black faculty and administrators
- Develop Black curricula that meet the needs of Black students, faculty and the communities they serve (Johnson, 1978; Jaggers, 2003).

Members of NABSW who were also social work faculty members began the implementation of these demands. Douglas Glasgow, of Howard University, developed curricula that reflected strategies for preparing Black social work practitioners to work with Black families. Howard Brasbon, of the University of Michigan, introduced "minority content in social work curriculum". James Craigen and Morris F. X. Jeff, of Atlanta University, developed curricula that prepared Black social work practitioners to empower Black families to live at maximum potential despite oppressive social environments. Robert Hill (1972) and Andrew Billingsley (1978) became the most influential authorities on the strengths of the Black family through their books as faculty in sociology at Morgan State University. Faculty often returned to the NABSW's annual conference and presented on new research, scholarship, or classroom innovations they had made to reflect the accuracy of a strengths approach to working with individuals, families, group work, communities, and community-based organizations.

The annual NABSW conferences provided opportunities to vet scholarship created by Black scholars about Black families. As an example, Gwendolyn Spencer Prater, a California State University-Los Angeles faculty member, presented at the 1978 NABSW conference on the topic of *"Family Therapy with Black Families"*. Her research sought to determine models of treatment used in family therapy, and whether Black clients' views of family treatment was congruent with that of their social worker's view of family treatment. Prater found that regardless of race or gender of the social worker, the social worker was more likely to view Black family behavior as abnormal. Interestingly, the clients were more likely to view their families as not amenable to therapy. Prater concludes that there is a need for culturally competent training in schools of social work. It was the White social worker's view of Black families as being homogeneous that alienated Black families in the therapeutic process. This view leaves the family gaining no value in the therapeutic process, and the social worker seeing that family as abnormal. Prater's findings support NABSW's call for a redesign of social work curriculum to reflect a more culturally appropriate pedagogical approach to social work education.

PRACTICE WITH BLACK FAMILIES

Social work practitioners often implemented strategies introduced at the annual NABSW conferences in their practice. For example, long-time member Robert Hill, a

widely recognized scholar on the Black family, identified five strengths of the Black family (Hill, 1972). They are strong work orientation, strong religious orientation, strong belief in family, strong achievement orientation, and adaptability of family roles. Hill's description of these strengths was tested in four majority Black communities in Ohio (Royse & Turner, 1980). The authors noted the following:

> A review of the literature suggests that the characteristics identified by Hill are not widely recognized and that there is a dearth of scholarly research on the specific topic of the strengths of black families….It is important that the strengths found in black families be revealed so that social workers and other professionals will be able to utilize those traits in the helping process (p. 407).

The authors administered a questionnaire to 128 families. They found that the families in this study overwhelmingly identified with the family strengths identified by Hill (1972). The authors concluded the following,

> It remains the social worker's responsibility to make an individual assessment based on the particular client's strengths and weaknesses. The strengths reported here may provide a starting place for all social workers who need to identify the strengths of black families and to understand how those strengths influence social and environmental aspects of behavior (p. 409).

Again, this study highlights the need for schools of social work to prepare social workers to have a strengths perspective when engaging Black families.

It is important that schools of social work revisit the strengths perspective and a strengths-based approach advanced by Black scholars (see Billingsley, 1968; Hill, 1972; Nobles and Goddard, 1984; Nobles, 1985) as a strategy to shift from negative, pathology-based research that characterizes the study of Black families. Nobles (1985) posits that researchers have relied heavily on "scientific evidence, information, theory and analyses" that suggests that the Black family is inherently part of a malfunctioning system. Nobles and Goddard (1984, pp. 53-54) identified five themes within research about Black families:

- The Poverty Acculturation theme suggests that Black families became successful as a direct result of acculturation, and by accepting and living out the norms, values and beliefs of the dominant society in which they are living.
- The Pathology theme suggests that Black families are inherently disorganized and lacking in structure
- The Reactive Apology theme suggests that Black families are the same as White families, except for the experience of discrimination and poverty.

- The Black Nationalist theme or Africanity theme acknowledges that Black families while living in the Western world and in environments that are alien to their African origins, have retained their African identities.
- The Domestic Colonialism theme implied that Black family dynamics are better understood in the context of domination, economics and politics, conceiving the Black family as operating within a wider system such as a colony.

The only strengths-based theme identified by Wade and Goddard (1984) is the Black Nationalist or Africanity theme. This theme relies on the scholarship of Black scholars for operationalization, and Black practitioners for implementation. Black scholars have developed theoretical models to counter pathological views of the Black family (Billingsley, 1968, 1973; Hill, 1972; McAdoo, 1982, 1988; Nobles, 1978; Nobles and Goddard, 1984). These scholars provide a historical, sociological, psychological and political context that supports a strengths-based view of Black families.

Black social work scholars have continued to advance the narrative of the necessity for a strength-based lens when practicing with Black families. Barbara Solomon (1976, 1987) posits that to engage in culturally appropriate practice with Black families requires the social work practitioner to use an empowerment approach. Solomon sees empowerment as a healing and strengthening mechanism for disempowered and oppressed Black families. Sadye Logan has developed models for social work practice with Black families that are culturally appropriate (Logan & Freeman, 1990), and strengths-based (Logan, 2018). Logan provides models for specific practice areas with Black families, such as with children (Logan, 1981), mental health care (Logan, Denby, & Gibson, 2013), health care (Logan & Freeman, 2012), and substance abuse (Logan, McRoy, & Freeman, 1987). Furthermore, Logan advocates for the reliance upon African cultural values in working with Black families (Logan, 1996; Logan & Freeman, 2004). Cheryl Waites furthers the narrative for relying on African cultural values when working with intergenerational Black families (Waites, 2008, 2009). Nancy Boyd-Franklin (1989) provides therapeutic models specifically for practice with Black families across the generations. Anne Chavis (2004) has developed a technique for using genograms that capture the cultural nuances of the Black family. Iris Carlton-LaNey highlights strength-based models of social work practice used by Black social workers to address the needs of Black families and communities during the Progressive Era that are relevant to contemporary social work practice (Carlton-LaNey, 1994, 1997, 2001, 2004, 2014). This roll call of Black social work scholars is not intended to be an exhaustive list, but a sample of the scholarship that has modeled ways in which to practice with Black families using strength-based approaches.

There is a need for predominantly White Schools of Social Work to revisit the demands of the National Association of Black Social Workers, as described by Johnson (1978) and recounted by Jaggers (2003), that social work programs are inclusive

of African American scholarship and culturally appropriate practice with African American families and African American communities in social work curricula. There appears to be a proportionate number of African American graduates in BSW programs (19.3%), in MSW programs (16.6%), and in Ph.D. programs (16.1%) (Council on Social Work Education, 2017). However, the faculty of social work programs still remain largely White (US Department of Education, 2019). Of all university faculty, across all disciplines, approximately 6% are African American or Black. Social work faculties mirror this racial disparity (Beimers, Warner, Mackie, 2013; Robbins, Regan, Williams, Smyth, & Bogo, 2016). While there are studies on the state of field education in CSWE-accredited programs (Fisher, Holmes, & Lewis, 2015), there is a need to examine the demographics of field instructors and the impact on student learning outcomes and student experiences.

CONCLUSION

While there is a plethora of research by Black scholars highlighting the importance of a strengths-based perspective when working with Black families and communities, these voices, both historical and contemporary are largely silenced in schools of social work, as well as social work scholarship. As a result, social workers are often prepared to view Black families from a pathological lens that renders their approaches incapable of addressing their own challenges. The social workers then cause more harm by disempowering Black families, resulting in distrust between the practitioner and the Black family. To echo the call of the founders of the National Association of Black Social Workers, schools of social work must develop culturally appropriate curricula and hire culturally appropriate faculty to truly support a strength-based approach for working with Black families. Billingsley, in a keynote address at the 1978 NABSW Conference stated the following,

> The relationship between families and education for Black Americans is one of the most misunderstood and sometimes deliberately confused relationships in the whole arena of higher education. There were a few of us who began writing things that made sense back in 1967, 1968, 1969, and 1970, and we thought for a while, for a brief moment in history, that we had made our point. We thought we had corrected the misconceptions, we thought we had made an impact on America's scholarship. Sad to say we have just scratched the surface, for America's scholarship is just as resistant to change as American society itself, and equally resistant to change (p.xxiii)

Unfortunately, Billingsley's lament about the state of higher education is still relevant today. Despite the scholarship by Black social work scholars and the testing of practice models by Black social work practitioners, it appears that the misconceptions have not been corrected, that we have only just scratched the surface. Social work education seems to be resistant to change.

END NOTE

The authors use the terms Negro, Black, and African American interchangeably in this chapter to describe people of African descent in the United States. The terminology is indicative of the politics of the time period.

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A Future of Strength: The Strengths Perspective and Developing Social Workers

Shelby L. Clark, Becci A. Akin & Kelechi Wright

INTRODUCTION

In the 30 years since the birth of the strengths perspective, it has experienced continued celebration and been marked as a pivotal approach for promoting effective engagement with people in a variety of contexts. From parenting to leadership, human resources to education, and therapy to case management; the strengths perspective has been studied and incorporated into professional practices both within and outside of the social work discipline (Aguinis, Gottfredson, & Joo, 2012; Lopez & Louis, 2009; Marty, Rapp, & Carlson, 2001; Sheely-Moore & Bratton, 2010). However, social workers initiated the genesis of the perspective (Rapp, 1998; Weick, Rapp, Sullivan, & Kisthardt, 1989) and, therefore, bear the mantle of the legacy, institutionalization, and continuation of practicing strengths-based work. Despite widespread adoption of the ideology of the strengths perspective, attention is needed to ensure its ongoing use and relevant application to social work.

In 2018, more than 700,000 social workers were employed in the United States (Bureau of Labor Statistics, 2018). Job growth is steady for the profession and projected to increase by 11 percent by 2028 (Bureau of Labor Statistics, 2018). As the number of social work professionals increases, understanding and meeting the needs of developing social workers is paramount to the sustainment of strengths-based social work. The projected expansion of the profession also suggests that the methods and strategies for incorporating the strengths perspective into the education and

practice of developing social work students may need rethinking. Strengths-based work is not business as usual. Saleebey (2013) explained that it is a direct departure from traditional social work practices, such as those that focus on psychopathology and deficit-driven treatment. Likewise, ensuring the passing of the torch may require a direct departure from traditional social work education. In aligning with the strengths perspective, social work professionals and educators have a responsibility to consciously collaborate in their efforts to assist developing social workers in establishing competencies, capabilities and confidence that will enable them to build their career upon a strengths-based foundation.

THE STRENGTHS PERSPECTIVE IN THE EDUCATION OF RISING SOCIAL WORKERS

Many developing social workers will initially be exposed to the strengths perspective in the classroom. While substantial literature exists on the topic, teaching the strengths perspective must move beyond reading about it into the space of the application. Words must be coupled with action. Students will be maximally supported in knowing how to apply the principles of the strengths perspective when educators can invigorate and model strengths-based work in the classroom and field. The perspective comes alive when each interaction within the educator/student relationship actively incorporates strengths-based principles.

For some, strengths-based work has become little more than simply identifying what a client is good at and the resources they have available to assist with overcoming challenges (Saleebey, 2013). The strengths perspective is a filter through which social workers view their clients. It shapes how a client is perceived and moves the motivation for intervention from fixing clients to honoring their inherent worth and capacity (Saleebey, 2013). Social work educators who embrace the strengths-based work must view and engage students in ways that align with this perspective.

APPLYING STRENGTHS PERSPECTIVE PRINCIPLES TO SOCIAL WORK EDUCATION

Saleebey (2013) identified six guiding principles of the strengths perspective. In this chapter, the authors apply these six principles to social work education. For the purposes of this chapter, social work education is defined as the formal education received in classroom and field practicum settings. The term “social work educator” refers to instructors both in the classroom and field. Additionally, this chapter identifies the parallel process that occurs between how social work educators engage their students and how social work students then engage their clients. Traditionally, parallel process literature has focused on the relationship between supervisors and supervisees, and supervisees and clients (Mothersole, 1999). However, these principles can also be applied to the student and teacher relationship (Barretti, 2007; Elson, 1989).

Principle one. Saleebey (2013) explained the first principle of the strengths perspective in social work is an understanding that, "Every individual, group, family and community has strengths" (p.17). Likewise, as applied to social work education, every student has strengths and social work educators hold the primary responsibility of identifying and building upon them. As educators orient themselves towards students' strengths, students are assisted in learning to orient themselves to the strengths of their clients. Strengths oriented educators are on the side of their students and their success. Educators open the way to learning, growth and change when they believe in their students and actively demonstrate this through words of encouragement, thinking *with* rather than *for* students, and allowing students the right to genuine wonder and curiosity (Denial, 2019; Fisher, 2000; Magnet et al., 2014).

Feedback from instructors to students can provide the basis for how students learn to provide strengths-based feedback in their social work practice. Aguinis and colleagues (2012) suggested strengths-based feedback is a mechanism for improving performance by specifically linking strengths, skills, and successes to areas for growth without an overt focus on weakness or correction. A key to using a strengths orientation in providing feedback requires that educators actively identify what students do well while honoring their agency. For example, rather than a classroom instructor directing students to change some components of a paper or presentation, a strengths-based social work educator may say something to the effect of, "You might consider adding x or y to this portion of your paper." Field instructors observing students as they engage with clients in practice may also make similar suggestions. For example, when students describe roadblocks with clients, field instructors may explore the student's observations of what hasn't worked and why. Rather than telling the student what to do next, field instructors may assist the student in brainstorming with questions such as, "What solutions have worked in the past for the client?" and "When is the client at their best?" Field instructors may offer suggestions and ask the student, "How do you think the client would respond if you tried x?"

When providing feedback, strengths-oriented educators may draw specific attention to when students are noticeably learning and improving. This process becomes a way of identifying the demonstration of their capacities and abilities for growth and change. Providing suggestions rather than dictating directions about what a student should or should not do gives the student the power to determine their own course of action. Educators may also lead with open-ended questions, rather than directives, that can promote students' development of critical thinking and self-reflection skills. Additionally, these strategies position students as capable thinkers and instills the sense that their educators have confidence in them, and in turn, bolsters students' confidence in themselves. Indeed, strengths-based education prioritizes both competence and confidence as equally important outcomes of the educational process, recognizing that confidence is critical to competent practice.

When social work educators are able to view classroom and field interactions as mirrors that reflect back what they are teaching, they can assess how well they themselves model the strengths perspective. Educators' self-assessment of student engagement serves an important function for revealing and understanding their own instructional strengths and capacities (Lopez & Louis, 2009). A strengths-based social work educator may ask themselves, "How are students demonstrating that I have effectively taught and incorporated the strengths perspective?" To assess this, educators may facilitate opportunities for students to participate in peer reviews of assignments, team-based projects, presentations, role-plays, and field interactions. These activities provide students with opportunities to practice strengths-based work in addition to allowing the instructor to assess how adequately the strengths perspective is being taught and applied.

Principle two. Saleebey (2013) taught that "Trauma and abuse, illness and struggle may be injurious, but they may also be sources of challenge and opportunity" (p. 18). Mental health professionals, including social workers, report higher rates of childhood trauma histories than people in other professions (Black, Jeffreys, & Hartley, 1993; Rompf & Royse, 1994). Social work education often focuses on the importance of boundaries and avoiding countertransference to support social workers with their own trauma histories and life challenges from allowing these to interfere with their relationships with clients in negative ways (Raines, 1996; Urdang, 2010). Beyond a focus on healthy boundaries, it may be important for social work educators to allow room for students to embrace their life experiences and consider how, if harnessed and used with wisdom and discernment, they may be sources for increased empathy, rapport, and strengths-engagement. As described above, educators may call on the parallel process as a highly relevant feature of teaching and learning. Specifically, social workers can identify the strengths and resilience developed from their own life experiences, which may facilitate their capacity for also acknowledging and honoring the strengths and resilience their clients have acquired through their adversities and challenges.

Related to the idea of using difficult life experiences as a catalyst for acknowledging resilience, scholars have advanced the concept of self-reflection. Applegate (2004) posited that in an effort to meet practice standards, the focus of social work education has shifted away from social work students' inner life and critical thinking and towards being skill-based and performance-oriented. Urdang (2010) explained that critical and analytical skills include self-reflection skills, and that self-reflection should be taught and encouraged in social work education. Self-reflection comprises examination of one's own thought processes and life experiences to consider how the two are linked. Self-awareness and self-reflection are the basis for how social work students develop professional self and may protect students from boundary violations and ethics violations (Urdang, 2010).

Principle three. Saleebey (2013) encouraged social workers to, "Assume that you do not know the upper limits of the capacity to grow and change and take individual,

group and community aspirations seriously" (p.18). Social work educators come to the classroom with their own expectations for students and preconceived ideas of how students should engage with the course. These expectations may translate to judgments of students based on how well they perform in relation to instructor, course and field standards. What is perceived as poor or average performance may lead to poor or average expectations of what students are capable of achieving? Saleebey (2013) wrote, "The central dynamic of the strengths perspective is precisely the rousing of hope, of tapping into the visions and dreams of the individual, family or community" (p. 8). Strengths-oriented educators see students as people who are malleable and full of potential and possibility.

Robustly and authentically supporting all students, not just those that excel at course assignments and who are compliant with educator expectations, in identifying and pursuing their aspirations demonstrates to developing social workers ways to honor the capacities and aspirations of compliant and non-compliant clients alike. Educators who maintain hope for students model how to engage the strengths perspective in spite of deficit-oriented systems. Social work students will be taught ideals, values, and perspectives that may rub against the reality of their work and the systems in which they engage from time-to-time (Saleebey, 2013; Weick, 1983)

Social work students who find themselves in practicums where deficit identification is the norm may struggle to reconcile the strengths-perspective with their field experiences. This friction should be acknowledged, and educators should actively engage students in discussion about how this incongruence between their guiding principles and field realities impacts their abilities for doing strengths-based work. Additionally, the traditional education system, like many other systems in which developing social workers engage, can lack a strengths orientation. This provides an opportunity for instructors to create dialogue and model strategies for implementing and sustaining strengths-based work while interacting with systems that are structurally built upon a focus of what's wrong rather than what's right. Classrooms and field experiences can be transformed into spaces where students' strengths are the focal point of their educational experiences. While educators must function within the limits of university policies and grading systems, they can model how to transcend deficit-oriented systems. First, an educator may simply acknowledge the limits of the systems within which they instruct and identify a commitment to be strengths-oriented in the classroom or field practicum despite these constraints. Secondly, in their commitment to support and assist students to grow and develop, social work educators can create space for conversations, activities, and assignments that support and encourage their students to identify and pursue their own hopes and aspirations for themselves as social work professionals.

Principle four. Saleebey (2013) taught, "We best serve clients by collaborating with them" (p. 19). Social work students are best served through a collaborative relationship with their educators. Freire (1970) advocated for an egalitarian education system where instructors and students act both as learners and teachers. Freire (1970)

criticized what he called the piggy bank method of education in which instructors act as depositors who continually install education into passive, inanimate students. In a piggy bank method of education, students are expected to do nothing more than receive information from the expert in the room. From Freire's (1970) perspective, education should be a co-created experience in which students and teachers learn and teach together. Freire saw collaborative education as an intentional and intense departure from the status quo mirroring how strengths perspective pioneers envisioned strengths-based work as a divergence from traditional social work norms (Freire, 1970; Saleebey, 2013).

Both Freire's work and early strengths perspective writings indicate a need for a more equal relationship between educators and students. Freire further explained that without breaking down the traditional power structures of piggy bank education, teachers move into the role of an oppressor. Social work instructors have the potential to liberate or oppress the minds of their students. Weick (1994) wrote, "At the heart of oppression is a profound alienation from one's own power which leads to a too ready acceptance of the power of others" (p. 219). Strengths-oriented social work educators' direct students to connect with their own power rather than to privilege the power of the instructor. Rather than alienating students from their own power and capacity, strengths-oriented educators honor it and turn students towards it. Although power differentials are inherent within educator/student relationships, just as they are in the social worker/client relationship, consistent collaboration between educators and students serves as a buffer against oppression and teaches students collaborative strategies for working with clients.

To create power-sharing opportunities, instructors may seek regular feedback on the course and their teaching with informal methods. They can then use the feedback to make mid-course corrections that were driven by students' ideas. Other tactics may include collaborating with students by engaging them in rubric development or making grading a collaborative experience where the instructor and student discuss together what grade they feel the student should be assigned (Denial, 2019). Freire (1970) believed creating a dialogue between learners was the key to critical thinking and dismantling the oppressive use of power in education. Where critical thinking ends, oppression begins (Freire, 1970). Strengths-oriented educators actively co-create spaces with their students where they are encouraged to think and discuss together. Educators can acknowledge and highlight the insight and expertise revealed by students through questioning and sharing their perspectives.

Educators can powerfully demonstrate collaboration by acknowledging when they make a mistake or experience a struggle within the teaching and learning interchange. Likewise, they can allow students latitude to make mistakes and model for the understanding and patience in these circumstances. Magnet, Mason and Trevenen (2014) explained when educators accommodate student mistakes, such as missing an exam or turning an assignment in late, it is important to encourage the student to be mindful to extend similar generosity to others when the students

find themselves in positions of power in the future. This is a particularly significant lesson for social work students who will likely find themselves working with people in especially vulnerable situations. Remembering the generosity once given to them can assist social workers in extending flexibility, understanding, and grace when they have clients who potentially relapse, or miss a visit with a child in foster care or fail to pay a bill.

Principle five. Saleebey's (2013) fifth principle of strengths-based social work was the belief that, **"**Every environment is full of resources" (p. 20). In environments where social workers, instructors, and students often feel strapped for resources it can be challenging to make the conscious effort to apply the strengths-perspective. Moving from a mindset of scarcity to a strengths-oriented mindset neutralizes power. Weick (1994) illuminated the relationship between maintaining power and making it seem that resources are scarce. When environments are seen as lacking resources, they are perceived as less powerful. Using the strengths perspective to distinguish what resources an environment possesses shifts the viewpoint from one of lack to one of abundance. Importantly, social work educators fully embrace the strengths perspective when they can acknowledge and teach the strengths perspective as applying to micro-interactions within a traditional social worker to client relationship as well as to mezzo and macro work.

By purposely inviting students to consider practice concepts that apply to both micro and macro contexts, instructors can illustrate tools that are consistent with strengths-based work. In the classroom, students and teachers can use case vignettes or practicum examples to conduct strengths assessments of organizations, communities, and systems. Other macro-level techniques that can readily center a strengths perspective are community mapping and service array analysis. Rather than assessing only the gaps and barriers within systems and policies, instructors can lead students to identify and more fully understand systems' resources and capacities, which may reveal themselves in various forms, such as personnel, expertise, technology, financial assets, vision, and leadership. Similar to direct practice with individuals and families, strength-based work that considers systems, may uncover significant leverage points for creating positive change.

Principle six. Saleebey (2013) stressed the importance of **"**Caring, caretaking and context" in strengths-based social work practice (p.20). Care is at the core of what the social work profession does and has been since its beginning (Weick, 2000). Caring begins in the classroom and follows into the field. Relationships foster growth and change. Indeed, social support and resilience are connected to the psychological well-being of students (Malcok & Yalcin, 2015). Positive relationships between students and instructors can influence grades even in challenging courses (Micari & Pazos, 2012). The art and act of caring is built on relational concepts such as human connection and kindness (De La Bellacasa, 2012; Magnet et al., 2014).

While techniques to demonstrate care might seem simple, their importance should not be minimized. Caring takes conscious effort, time, and emotional resources. In other words, caring education translates to very real labor on the part of educators and this should be acknowledged not devalued in the academy (Magnet et al., 2014). Denial (2019) articulated, "To extend kindness means recognizing that our students possess innate humanity, which directly undermines the transactional educational model to which too many of our institutions lean, if not cleave" (n.p.). Not only does kindness breakdown oppressive practices, it also opens the way to curiosity which, in turn, opens the way to deep, meaningful learning (Fisher, 2000; Magnet et al., 2014).

Caring in educational settings looks like a genuine interest in students' lives and their development; actively building trust and developing relationships with them to ensure an environment is created where optimal learning can occur (Denial, 2019; Magnet et al., 2014). It looks like reflecting on what syllabi communicate about who educators are, who they believe students to be, and how they will support students in achieving their academic and professional goals. It looks like making the "classroom accessible to everyone" (n.p., Denial, 2019). Caring does not mean being overly lenient or boundary-less relationships (Denial, 2019; Magnet et al., 2014). On the contrary, honest, authentic conversations, challenge educators and students in ways that allow them to grow (Denial, 2019). Conversations that encourage growth can be difficult to have and can involve communicating information that may be difficult to hear. Practices of "calling-in" rather than "calling-out" and in addressing concerns privately may best support students in change (Magnet et al., 2014). When students know they are cared for, the relationship supports them in receiving this information.

One strategy for taking a caring stance towards students may be to include a statement about student wellness in syllabi. These statements may acknowledge the many demands in students' lives both within and outside of the classroom setting. Student wellness statements encourage students to prioritize their self-care and well-being and can provide a space to connect students to mental health and other services should they be needed. Additionally, they can communicate that the instructor is available to problem solve if challenging circumstances arise that make it difficult for the student to meet the demands of the course for any reason.

CONCLUSION

Building on the work of strengths-perspectives' scholars and pioneers, educators in the social work discipline must deviate from traditional views of education by positioning students' potential, possibility, and power at the center of their learning experiences. Strengths-oriented educators move from an evaluative role where their primary responsibility is to critique and assess students toward an encouraging and facilitating role where they uplift and assist students to maximize their capacities and achieve their aspirations. Incorporating the strengths-perspective into

social work education enables educators to honor the process of growth and change continually occurring in the minds and lives of their students. Each interaction between educators and students provides an opportunity for continuing to enliven the legacy of the strengths perspective. Ultimately, developing social work students will shape the future of strengths-based social work. They will determine the reality of the practice and one day have their own opportunities to share the power of their strengths perspective knowledge and skills.

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Supporting Students Utilizing the Strengths Perspective: Classroom Activities & Assignments that Encourage and Empower Student Success

Kenya Jones

"*It denies that all people who face trauma and pain in their lives inevitably are wounded or incapacitated or become less than they might"* is the most prominent strengths perspective definition for this chapter (Saleebey, 1996. Saleebey, 2006)." This impeccably describes how all students should be viewed and understood. As an alum of three Historically Black Colleges Universities (HBCUs), I experience a great sense of pride and reverence to teach at an HBCU. Strength in the familiarity of institutions and seeing students brings back memories of myself. On the other hand, a challenge can be transference, and countertransference, between students and myself because of such a presumed relationship, as an unconscious redirection of past feelings. This is of great significance as "we" both have made assumptions that we've entered this space via the same experiences or circumstances, which is often untrue and represents a false sense of commonality. Essentially both the student and I need to enter each experience open to learning, understanding our differences and acknowledging our strengths.

I challenge myself regularly to be a professional that students can model and aspire to emulate. The core objective within most, if not all, of the classes that I facilitate, is to empower students to see me as they see themselves and to understand that their opportunities are limitless. The educational philosophy of the classroom should be to transform the lives of students from diverse backgrounds, to become leaders who are politically aware and compassionate. Furthermore, it is my goal to ensure that students will engage actively as change agents capable of addressing

societal and global problems. By adding the strengths perspective to the classroom environment, the intention is to help shape and transform student experiences through supportive interactions.

"Words do have power to elevate or destroy" is essential in the classroom environment through verbal and visuals expressions of "it's a safe space" (Saleebey, 1996). The overarching aim of an encouraging and empowering classroom environment is to seek positive, strength-based statements, particularly when students need to be rerouted or steered in a different direction. This approach is equally as important as the wording itself. This chapter will illustrate how the strengths perspective, combined with the Afrocentric perspective is utilized to support students in their success. An emphasis on the importance of positive language use within the classroom will be discussed. Additionally, classroom activities and assignments will be provided, followed by implications for future practice, and a conclusion.

AFROCENTRIC PERSPECTIVE

The Afrocentric perspective (ACP) is undergirded throughout the curriculum in each of the courses in conjunction with the autonomous social work model, and humanistic values at Clark Atlanta University in the Whitney M. Young Jr. School of Social Work. Through each of the courses within the various programs, which consists of Bachelor of Social Work, BSW, Master of Social Work, MSW, and Doctor of Philosophy, Ph.D. in social work, students are introduced to the perspective and its' themes.

ACP is defined as "…*a culturally grounded social work practice-based model that affirms, codifies, and integrates common cultural experiences, values, and interpretations that cut across people of African descent. The Perspective encompasses the intersectionality of race, and other societal factors such as gender, ethnicity, social class, ability status and sexual orientation. Further, the Perspective acknowledges African cultural resiliency as a foundation to help social work practitioners solve pressing social problems that diminish human potential and preclude positive social change* (CAU, 2007; Schiele, 2016; CAU, 2017; Wright, et al, 2018)."

Utilization of ACP and strength perspective together assists students with a sense of membership. Class engagement through activities and discussions, along with their identified experiences of oppression and marginalization enable students to further understand and engage with their clients. Both perspectives help students recognize their strengths and better empower them to discover their resilience from previous challenges as a place to access their strengths and build from within (CAU, 2007; Schiele, 2016; CAU, 2017; Wright, et al, 2018). ACP prepares students to, "address specific psychological, social, spiritual, and economic problems experienced by people of African descent and to address problems confronted by all people (CAU, 2007; Schiele, 2016; CAU, 2017; Wright, et al, 2018)." Within ACP, the strength perspective identifies group characteristics that can be conceived favorably and as a

source of resiliency and human advancement (CAU, 2007; Schiele, 2016; CAU, 2017; Wright, et al, 2018).

ACP combined with the strength perspective empowers as well as acknowledges oppressive circumstances that present students with holistic and empathic experiences that they can emulate when supporting their clients. Student can reference their classroom experiences and recognize how they felt empowered and supported when they were viewed from strength and not from a deficit which provides them with real-life instances. In addition to using ACP in the classroom, it is equally important to encourage students with positive language, which is explored in the next section.

IMPORTANCE OF LANGUAGE IN THE CLASSROOM

The strengths perspective identifies empowerment, membership, and resilience as concepts that illuminate the importance of positive language (Weick, et al., 1989, Weick, 1992). A portion of the role of a social work educator is to acknowledge the strength within oneself to service individuals and groups in developing their skills, obtaining membership within the social work profession, identifying resources, intervening and planning at micro, mezzo, and macro levels. Introducing students to the concept of interconnectedness, seeing all things from a place of oneness, from their personal experiences is momentous to thoughts that they can incorporate into all their coursework, in both their foundation and concentration year alongside their internship.

A predominant teaching objective is to ensure that there are influences to student development beyond the classroom. A space is created within all classes labeled "Hot Topics", current events are incorporated with course readings and newly discovered concepts. Students are invited and encouraged to discuss topics they deem relevant. This encourages diplomacy, empowerment and freedom by providing them a platform for their voices to be heard. Listening to their concerns, they then begin to lead facilitations of selected topics, with co-facilitation from an instructor to incorporate ACP, and strengths perspective concepts. Through classroom engagement, students begin to volunteer as they appreciate having shared responsibility for integrating strength, and accountability to one another through their classroom community. This combination undergirds their understanding of other social work theories, concepts, ethics, values and social justice issues. The importance of strength-based language in the classroom, with ACP, delivers an important acknowledgment of teaching from strength rather than a deficit approach. In conjunction with the strengths perspective, this space exemplifies support and empowerment which can enhance student development.

With positive and encouraging words during classroom conversations, on-line discussion interactions, as well as oral and written feedback on assignment submissions, students can hear and identify their strengths and feel energized through

constructive feedback to become resilient (Saleebey, 1996; Saleebey, 2006; Weick et al, 1989; Weick, 1992; Staudt, 2001). Students are encouraged to make connections from their feelings to understanding and empathizing with their client population. Social work students have diverse learning styles that must be recognized in the classroom environment. Various teaching methods are applied that support student learning styles such as:

- Concrete and Active Experimental Learners: case presentations, technology, DVDs, tapes, role-playing, and have students present what they have read using PowerPoint, role plays, and graphs
- Abstract Conceptual Learners: articles, book chapters, and research focused on various theories and their usages for specific assessments and treatment interventions with clients
- Reflective Learners: technology, role plays and case presentations where students can participate and observe others in social work and client interactions.

Combining positive language during class experiences, sharing Hot Topics responsibilities, and teaching to all learners demonstrates strength-based teaching approaches that can be utilized within various phases and course types. The next section covers several classroom activities and assignments that establish a hands-on application of the strength perspective in addition to benefits for the facilitator/educator.

CLASSROOM ACTIVITIES & ASSIGNMENTS

This section outlines strength-based activities and assignments that have been identified and aligned in connection to the strength perspective for integration into various social work classroom settings.

REFLECTION PAPER

"All must be seen in the light of their capacities, talents, competencies, possibilities, visions, values, and hopes, however dashed and destroyed these may have become through circumstance, oppression, and trauma (Saleebey, 1996; 2006)." A reflection paper requests students to describe an interaction between themselves and experience from their field practicum. This assignment presents an opportunity to share initial personal thoughts and feelings. Students discuss their engagement, interaction with a client, and link these experiences to course readings as well as in-class connections. The reflection paper also builds upon social work competencies that examine ethical and professional behaviors, as well as diversity.

For the facilitator: Interpreting and listening to student views as they identify feelings regarding their placements conveys opportunities for identifying transference, and countertransference. Similarly, to the classroom experience, it is important to

acknowledge assumptions and relatability to various populations. Does familiarity bring support or hindrance to the situation? This assignment also offers an opportunity to assess students' personal values, which allows the facilitator to integrate positive language around earlier traumas.

GENOGRAMS & ECOMAPS

"*Too often practitioners are unprepared to hear and believe what clients tell them, what their particular stories might be, especially if they have engaged in abusive, destructive, addictive, or immoral behavior* (Lee, 1994, Saleebey, 1996; 2006)." Genograms and ecomaps are activities that can further assist students in acknowledging their strengths. Genograms are visual tools that produce a family history as well as explain various family dynamics. Ecomaps are also a visual tool that incorporates the community and family relationships as well as offers a person the opportunity to see what relationships are beneficial as well as those that present challenges. By completing their own genograms and ecomaps as class activities students can identify their own resilience. This can further assist students in completing these tools with clients in addition to supporting their clients in feeling empowered. These activities both the genogram and ecomap build upon social work competencies that engage and assess individuals, families, groups, organizations, and communities.

For the facilitator: Hearing students share within these activities and being rooted in the strengths perspective through emphasizing a safe space and offering students an opportunity to share out loud their experiences can create membership. This involvement presents an opportunity to see commonalities inside the class group. Both genograms and ecomaps contribute to diversity with purposeful incorporation about ACP to the discussion, can also add an awareness of oppression and marginalized groups. The opportunity to understand the impact of these feelings that may be internalized from these experiences is provided. If/when students elect to share in class, other students feel more comfortable in sharing their experiences as they identify a bond even if the bond is around a deficit; as they become entrusted by the membership group.

CULTURAL COMPETENCE INTERVIEW

"Extremely important sources of strength are cultural and personal stories, narratives, and lore. Cultural approaches to healing may provide a source for the revival and renewal of energy and possibilities. Cultural accounts of origins, development, migrations, and survival may provide inspiration and meaning. Personal and familial stories of falls from grace and redemption, failure and resurrection, and familial stories of falls from grace and redemption, failure and resurrection, and struggle, and resilience may also provide the diction…. (Saleebey, 1996; Saleebey, 2006)."
A cultural competence interview assignment can further illuminate strength and diversity as well as highlight social and economic injustice. Within this assignment, students identify a person of a different race, and gender than themselves to un-

derstand intersectionality by acknowledging similarities along with differences. In addition to conducting the interview, students are to do an activity and conduct a literature review on the selected population interviewed. This assignment seeks to increase understanding of another individuals' lived experience by exploring ways of engaging by hands-on application. By moving beyond individual experience and seeing another, one can access additional empathy and move beyond theory into evidence-based practice assessing with greater understanding. This assignment also builds upon social work competencies that advance human rights, identify social and economic justice, as well as engages in practice-informed research.

For the facilitator: Instructing from the strength perspective within this assignment involves listening and understanding that students may have resistance and not see or understand another person's journey. Incorporating on-going in-class conversations that utilize positive language and incorporation of ACP presents students with a safe space that remains open for creativity and understanding that can transfer into their field practicum experiences.

COMMUNITY ACTION PLAN

"I*t requires composing a roster of resources existing within and around the individual, family, or community* (Saleebey, 1996; Saleebey, 2006)." A community action plan activity enables the student to share a strategy for community advocacy for a specific social action. An activity that connects directly to a community can further illustrate their strength in strategizing for a community need through advocacy for a specific social action. This assignment builds upon social work competencies that engage in policy practice, and intervene with individuals, families, groups, organizations, and communities.

For the facilitator: This assignment presents an opportunity to consider what students value as concerns and how they see improvement and opportunities for change. This is an example of the resilience concept within the strength perspective. For example, past student submissions consisted of petitions and organized community meetings. Students conducted research and exhibited the impact of voting through demonstrations. This assignment incorporates strength perspective concepts such as membership, empowerment, in addition to resilience (Saleebey, 1996; Saleebey, 2006; Weick et al, 1989; Weick, 1992; Staudt, 2001).

Each of the assignments, including the reflection paper, cultural competence interview, community action plan, in-class activities such as genograms and ecomaps individually and collectively offer ways in which the strengths perspective is demonstrated in the application of the student as well as the facilitator. Additionally, with the incorporation of ACP, social, and economic injustices are identified as well as potential strategies to promote repair. Within social work practice classes students thrive through class engagement and hands-on application experiences that shift

beyond lectures to shared experiences within a diplomatic classroom environment that benefits both the facilitator and student.

IMPLICATIONS

"*People learn from their trials and tribulations, even those they inflict on themselves* (Anthony & Cohler, 1987; Wolin & Wolin, 1993)." Turning knowledge into implications for future social workers to utilize in going forward is essential. The Generalist intervention model strategy is most appropriate when incorporating the strengths perspective into classroom instruction (Coady et al, 2016). Suggestions for successful classroom engagement with strength perspective engagement for facilitators would be to:

- Hear and listen to class apprehension as well as individual student matters.
- Engage with students to understand their experiences. This builds a foundation as a place of membership; here they have an opportunity to learn what strengths they already possess.
- Make an assessment. Collective experiences in the class are a safe place that emphasizes empowerment. Students are learning through the entire process and can become stressed as well as conflicted with the development of their professional values and how they may differ from their personal. Ensure a student that this is normal and, more importantly, it is OK!
- Planning and goal setting should be shared. The initial syllabi can have room for adjustments as needed for the benefit of the entire class, which can consist of adjusting start/end times, and due date changes. Listening and applying flexibility presents an open channel for communication.
- Intervening and Evaluating are both incumbered in-class assignments and rubrics, it is important to grade honestly. Being authentic, providing constructive feedback, keeping an open-door policy as well as including a place for anonymity are all needed for a successful strength-based classroom.

The strength perspective does not solely rest in positive wording. The strength perspective recognizes the importance of resilience (Saleebey, 1996; Saleebey, 2006; Weick et al, 1989; Weick, 1992; Staudt, 2001). If a student is not performing well, inform them and subsequently offer room for improvement. Be open as an instructor to see the process and be comfortable with the outcome. Also being mindful of transference and counter-transference feelings as these concepts are taught for students to understand with clients, yet infrequently are they discussed in classroom experiences which can resonate strongly on both the instructor and student.

CONCLUSION

This paper demonstrates opportunities for enhancing courses specifically in social work with the incorporation of the strength perspective. The chapter highlights the incorporation of ACP at Clark Atlanta University, the importance of positive language use in the classroom, as well as offers classroom activities, assignments, and future practice implications for course facilitators to be successful.

Utilizing the strengths perspective within the classroom can create a sense of unity that can positively influence students' work within their practicum and their future within the profession of social work.

Ultimately, facilitators that utilize the strengths perspective within their classroom will see an enhancement in their connection with their students. Additionally, clients that interact with the students in their practicum are more likely to experience a much more well-rounded social worker.

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Extending the Story: Weaving the Strengths Perspective into Study Abroad Initiatives

Jennifer Chappell Deckert

Social work educators are active in their pursuit of authentic and experiential learning about different cultural norms, people, and environments. Study Abroad Initiatives (SAI) vary in length, purpose, focus, and form across the social work curriculum (Clapp-Smith & Javidan, 2010; Graham & Crawford, 2012; Hamad & Lee, 2013; Jones, et. al, 2012). SAI are primarily based in social work educational settings. However, professional-based SAI are increasingly available. This paper primarily addresses social work education but also includes professional social work development through SAI. Generally, SAI seek to foster transformative learning experiences by exposing social work students to dramatically different cultural environments through immersion into another cultural context.

Increased interest and focus in globalization in social work practice and education has heightened participation and interest in SAI. However, they can also be interpreted as imbalanced and invasive (Bandyopadhyay, 2019; Nordmeyer, Bedera, & Teig, 2016; O'Sullivan & Smaller, 2019; Rotabi, Gammonley, & Gamble, 2006, Smith, 2018). SAI usually involve travel by privileged, primarily white northern social work students to contexts in the global south where there are people with less privilege, darker skin, and a greater likelihood of social and/or economic disparities, which can be problematic. Traditionally, SAI tend to reinforce learning dichotomies that focus on difference, especially extreme differences. Social work strengths perspective pioneers Weick, Rapp, Sullivan, & Kisthardt (1989) outline the dangers of a dichotomized perspective in social work:

> Dichotomies pervade human life. In trying to cope with complex realities, human societies have created stark divisions between the good and the bad, the safe and the unsafe, the friend and the enemy. It is a curious fact that greater attention invariably is paid to the negative poles of the dichotomy: to the bad, the unsafe, the enemy. This pull toward negative aspects of life has given a peculiar shape to human endeavors and has, in the case of social work and other helping professions, created a profound tilt toward the pathological (p. 350.)

The objective of learning/understanding a different context is important and necessary in a field that prides itself on understanding multiple perspectives. However, social work engagement in SAI, by focusing on dichotomized norms from different cultures, can also reinforce colonization, the centering of white privilege, and voyeurism. Thurber (2019) identifies many concepts that problematize SAI, including voyeurism, voluntourism, "instagramability," white saviors, privilege tourism, orphan tourism, and migrant tourism. Doerr (2016) warned against initiatives that favor personal growth over cultural interaction and social change.

Just as Weick, Rapp, Sullivan, and Kisthardt (1989) warned of dichotomized perspectives in social work, other strengths-perspective scholars offer suggestions to the field that have the potential to bolster SAI and make them less abrasive and more sensitive to the populations with whom we long to connect. Chapin (1995) in her discussion of strengths-based policy initiatives suggested that an "emphasis on common human needs rather than social problems mitigates the labeling process and helps to illuminate the various ways people get help in meeting needs without being labeled as deviant or deficient" (p. 509). Probst (2010) called for a paradigm shift in social work teaching that avoided biases toward the negative and fostered a willingness to examine power and authority in social work. And Roff (2004) applied the Strengths Perspective to macro practice in nongovernmental organizations that shifts the emphasis toward affirming and developing community members. This paper examines these concerns about SAI in the light of the Strengths Perspective, and argues that social workers need to re-examine the deficit-based model of SAI, and reimagine the development and facilitation of initiatives that focus on capacities, hope, and potential instead.

THEORETICAL GROUNDING

SAI are an important component of social work learning in education, research, and professional practice. It is important to understand them within the context of theory. The following section of this paper provides an overview of the strengths perspective in social work and transformative learning theory in order to propose a new frame for SAI that could move the field of social work forward.

Strengths Perspective in Social Work

The strengths perspective is a postmodern approach to social work that prioritizes process, shifts in expertise, and a profound belief in potential (Weick & Saleebey, 1998). Prior to this approach, social workers trended toward problems, deficits, and looking for what was "broken, gone wrong, or failed" (Blundo, 2001, p. 297). Strengths perspective pioneer Ann Weick and her colleagues argued for extending the story to include client-identified knowledge and hope that could be found whenever the social worker stepped away from the "norms" of psychoanalytic and/or moral judgment in assessment. They argued that social workers needed to focus on accurate assessments, with an open stance that fostered creativity and authentic collaboration with client populations of all sizes. This, according to Saleebey (1996) took "courage and diligence" (p. 297).

Critics of the Strengths Perspective argue that it ignores pain, is naïve, and/or simplistic (Brun & Rapp, 2001), and that it does not do enough to challenge systems of oppression (Dans, 2001). Gray (2011) also states that it is too individualistic and focused on individual responsibility, self-control, and self-interest. Others argue that the distinctiveness of the Strengths Perspective is not well operationalized or measured and that there is not enough evidence or conceptual clarity for it to be useful to the field (Staudt, Howard & Drake, 2001).

Even so, scholars argue of the danger of privileging pathology in social work, and the ways in which it reinforces power imbalances and false dichotomies of good vs. bad (Grant & Cadell, 2009). The primary problems with social work in the late 80s (as identified by Weick, et. al, 1989) included an assumption that social workers had a special ability to fix problems, that problems were centered in individuals more than contexts, that the role of the professional was to define and solve a problem, and that treatment plans were focused solely on problem-alleviation. Their proposal for strengths addressed these issues in three primary ways: (1) A call to return to the basic core values of the social work profession, centering on dignity, hope, potential, and relationships, (2) A shift in focus that emphasized the potential for growth and learning, believing that "all people possess a wide range of talents, abilities, capacities, skills, resources, and aspirations" (p. 352), and (3) The mandate to expand conversations about capabilities beyond individuals and use them to create systemic change.

Transformative learning theory

Transformative learning theory describes a process by which learners move from prior understandings (frames of reference) to new perspectives through learning that is self-reflective, thoughtful, and critical. For Mezirow (1997), a frame of reference includes two dimensions: the "habits of the mind" and a "point of view." The former relates to the understandings we have assumed based on our cultural, social, economic, political, or psychological background. They are more fixed and difficult to understand without some degree of exposure to other worldviews. The latter is more subject to change based on reflections of experiences, our problem solving

and exposure to challenge. Malleability depends on environmental and/or interpersonal influence.

A frame of reference is transformed through the challenge of problem-solving and an interactive dialogic process with others. Mezirow (1997) contends that empowerment and the development of autonomy is intrinsic to the learning process. In order to be effective in collaborative problem solving, the learner needs to be critically reflective of their assumptions about others. In order to be effective in the personal transformation of a frame of reference, the learner needs to be critically reflective of self. Both involve critique, challenge, and reflection. It is a simultaneously active and affective process (p. 10). Educators in this model serve as "provocateurs" who offer support and a respectful space for discovery.

There are various interpretations of the transformative learning theory. Rather than focusing on specific processes or objectives to be met, a holistic approach to learning is encouraged, which includes engaging in affect, intuition, and relationships in the learning process. The emphasis, therefore, becomes to understand learning through honoring alternative, non-traditional ways of knowing. In addition to challenging the students, this approach challenges the instructor or facilitator, as it also requires their own self-reflection and openness to change (Snyder, 2008; Taylor, 2010).

Many theories of transformative education for social change are based on a Freirian model of conscientization (Freire, 1970), and the call in peace studies for a "moral imagination" (Lederach, 2005, p. 5). This moral imagination requires a loose acceptance of feelings balanced with concern and includes creativity, the ability to imagine potential alternatives to an unsatisfactory situation, setting goals with multiple ways of reaching them, and making a plan to reach these goals (Rivage-Seul, 1987).

Transformative learning relies heavily on a dialogic process of meaning-making through new experiences. It is often prompted by stressful experiences (intercultural experience, personal identity crisis, natural disaster, loss, or accident) that make the individual question their existence and their purpose in life (Taylor, 2010). Bourjolly, Sands, Finley & Pernell-Arnold (2016) conducted a case study analysis of a multicultural program called Partners Reaching to Improve Multicultural Effectiveness (PRIME) using transformative learning theory. Their study used multiple methods to explore uncomfortable micro-aggressions that happened in the class and resulted in emotional reactions that led to transformative learning. They recognized the complexity and intersectionality of their participant perspectives and confirmed their prior assertions that "pathways to intercultural sensitivity are nonlinear" (p. 97).

Another primary element in this theory posits that in order to learn about others, it is important to start with the self. In order to be effective in collaborative problem solving, the learner needs to be critically reflective of their assumptions about oth-

ers. In order to be effective in the personal transformation of a frame of reference, the learner needs to be critically reflective of self. Both involve critique, challenge, and reflection. It is a simultaneously active and affective process (Mezirow, 1997). This theory informs perplexity by the challenges it gives to prior assumptions/understandings of the world.

Rossiter (2011) calls for an "unsettled social work" (p. 990), where the ethics of the philosopher Levinas encourages us to examine the status of the profession of social work and the ways in which it may deny expertise from everyday people. She argues that we need to put these ethics before knowledge, by moving beyond particular positions that totalize and be open to new understandings that come from the lived experience and uniqueness of whomever we are with (e.g., migrant populations). We do this by suspending judgment and moving beyond critical social work that is based in knowledge, to a place of "sociality" that promotes this Levinas ethic of the other as unique and valuable. Specifically, we use active listening, with an "openness to revelation" (p. 993) where we value the answer more than the question.

According to Ruch (2002), reflection includes an analysis of structural and personal power, identifies the importance of effective and sensory perceptions, and integrates the use of multiple sources of knowing (experiential, intuitive, non-hierarchical, non-gendered and tacit). The emphasized skill in reflection includes curiosity and "not knowing" (p. 352). Fook & Gardner (2007) described a facilitated model for group reflection. During this process, there is a recognition of the perplexity faced by the practitioner: "In particular it acknowledges the place of emotions and especially anxiety, in professional practice and recognizes them as valid sources of knowledge and understanding that need to be embraced" (p. 356). The process is emancipatory and empowering. It encourages a deeper level of understanding that is inclusive and embraces ambiguity. The educator's role in this model is presented as a "co-explorer." The author explains the "metacognitive" part of practitioner development, which requires tolerance of uncertainty and a willingness to be vulnerable.

Saleebey & Scanlon (2005) also employed Freire in their argument for critical pedagogy in social work education. They see a need for a radically altered pedagogy that challenges traditional and hegemonic tenets that are accepted by the status quo. They think transformation in the classroom could happen through the use of more group processes/group work, dialogic learning, more reflection, and sharing of personal experiences with oppression. In this process, a "healthy appreciation for ambiguity and disagreement" (p.13) will be fostered. This, in itself, is social work that contributes to social action through a facilitation of shifting perspectives and new understandings. Blunt (2007) agrees: "Transformative learning occurs when learners develop an enhanced awareness of how their knowledge and values guide their own perspectives. Acts of learning can only be referred to as transformative if there exists a process by which primordial questioning and reconstruction of how an individual things of behaves occurs during the learning" (p. 96).

Transformative learning theory relates to critical theory through feminism. Feminist principles of attention to process, connection, empowerment, and integration also contribute to transformative dialogue on this topic, where there is an integration of ideological perspectives and social/experiential process that helps empower people to understand, potentially even accept a different perspective (Coates & McKay, 1995). These are the key elements for a change in perspective.

Both Transformative Learning Theory and the Strengths Perspective require careful self-examination and reflection, call for a re-evaluation and shift in the "frames" or "habits of the mind" through which we see the world, a "suspension of disbelief," and call for a more collaborative, dialogical, and mutual approach to learning and connection, based on the strengths and resilience of humankind (Blundo, 2001; Guo & Tsui, 2010; Perkins & Tice, 1994; Saleebey, 2000).

This theoretical discussion illustrates the ways in which the Strengths Perspective and Transformative Learning Theory can be paired to expand the story of how and what we do in SAI. This is increasingly important to the field during a time when we are compelled to re-evaluate traditional structures of knowledge-development and global understanding. The following section of this paper reviews scholarship specific to SAI.

OVERVIEW OF STUDY ABROAD LITERATURE

Through SAI, students and instructors can benefit from moving beyond a simple educational model of acquiring facts to a deeper, more meaningful, even transformative learning process. This may begin with both a physical and personal immersion into a foreign context. Most scholarship in this area focuses on young adults or college students and academic-related learning, with limited data on adult or non-academic learning (Stone & Petrick, 2013). Scholarship in this area illustrates that these processes are full of complexities and contradictions (Kubota, 2016).

Study abroad offers students access to "real-life" experiences that challenge them and provide opportunities for new growth and understanding. With increases in globalization and transnationalism, a "global mindset" requires flexibility, mental plasticity, multiple frames of reference, and cosmopolitanism (Cseh, Davis, & Khilji, 2013). The demand for thinking and understanding the interrelatedness of the world has never been higher. A global mindset involves the willingness of a person to step outside their cultural norm and accept that there are multiple ways of knowing, behaving, and understanding (Ranker, 2020). This can be taught through SAI, and various contexts, depth of reflection, lengths of term, cultural background, and pedagogy can lead to different outcomes for study abroad learners.

Clapp-Smith & Javidan (2010) found that in study abroad experiences between one and six months there were increases in a "global mindset." Between six months and two years, there was no additional variance. However, in international exchange

experiences lasting longer than two years, there was an increased development in a global mindset. Length of study abroad is also associated with shifts in cultural identification and willingness to dialogue with local partners (Hamad & Lee, 2013), which can facilitate new understandings. Of primary importance in this process is the ability to be critically self-reflective and to engage in experiential learning. There is some evidence of the benefit of even short-term immersion programs, including "getting out of the bubble," crossing a boundary, and meaning-making (Jones, et. al, 2012, p. 207). These effects are especially prominent when the participants are able to integrate their learning and experiences into their "normal" life (Rowan-Kenyon & Niehaus, 2011).

Graham & Crawford (2012) evaluated three different models for study abroad programs that facilitate transformative learning experiences. They found that while different pedagogical models prompted different types of learning, all resulted in learning that stemmed from some kind of disorientation of previous knowledge and a shift in personal worldview. Likewise, Mills, Deviney, and Ball (2010) asserted that study abroad experiences need to stretch students beyond their comfort level, but not to the degree that they are shocked and cannot sufficiently adapt from the experience.

The sweet spot of transformative learning in SAI occurs when there is an increase in reflective and reflexive learning, and not just an acquisition of facts or exposure to a new context (Orbe & Orbe, 2018; Witkin, 1999). Some scholars have criticized learning/study tours imperialist or oppressive, exacerbating power differences and encouraging a feeling of altruism for the participants because of the perception that they are giving something or doing good (Bandyopadhyay, 2019; Nordmeyer, Bedera, & Teig, 2016; O'Sullivan & Smaller, 2019; Rotabi, Gammonley, and Gamble, 2006, Smith, 2018). Instead, the focus of these initiatives needs to be on inter-cultural dialogue, personal, professional and social development, and challenges to identity/self (Rotabi, Gammonley, & Gamble, 2006; Tack & Carney, 2018). The most effective way for this to happen is through cultural mentoring, dialogue, and relationship building during study abroad (Engle & Engle, 2003; Paige & VandeBerg, 2012). Mutuality, understanding power dynamics and colonialism is a key element to the success of SAI.

The theme of giving oneself (through self-reflection, immersion, and critique of past assumptions) is consistent in the literature (Perry, Stoner, Tarrant, 2012; Sharma, Phillion, & Malewski, 2011; Witkin, 1999). This deep learning can lead to reduced judgment and more self-confidence, social flexibility, and cosmopolitanism. This is especially evident with experiences of immersion, the identification that things are not "normal," attempts at communication in a second language, and sufficient time allowed for self-reflection (Clapp-Smith & Wernsing, 2014).

A second important ingredient in transformative learning and SAI is experiential learning. Students immersed in a culture get direct experience interacting with and

dialoguing with local experts, which may suggest that going alone or more immersive programs may be more effective. These interactions spark a more intimate challenge to personal assumptions and, through affect and relationship, allow for a more personalized opportunity for reflection.

John Dewey's (1938) contributions in experiential learning included challenges to prior understandings (or frames of reference), recognizing challenge or conflict between self/other, reflective interpretation for making meaning through a critical examination of self, and a claim of on-going transformation of one's own perspective. He suggested that this process happens because of three key elements: 1) a meaningful transaction between the student and the environment; 2) a personal connection made between the individual and the education; and 3) critical reflection about the experience/environment. This process helps us become more open and aware, increasing cultural sensitivity (Velure & Fisher, 2013). According to Perry, Stoner, & Tarrant (2012):

> The sort of educative experiences that Dewey referenced are related to life, based on problems to be solved that awakened curiosity, of interest and intrinsically valuable to the learner, and brought with them a level of perplexity, doubt, or what Mezirow (1997) referred to as disorienting dilemmas (p. 680).

A study by Greenfield, Davis, & Fedor (2012) evaluated differences in learning between an international social work course taught in a domestic setting as compared to a study abroad setting. While there were strong learning outcomes in both settings, the students in the study abroad class reported increased skills in cultural sensitivity, functional knowledge, and awareness of global interdependence and interpersonal adjustment. The authors posit that these increases were a result of the experiential learning opportunities and direct personal contact and dialogue the students had while studying abroad.

In addition to setting, SAI can have different outcomes for people who identify as multicultural or monocultural. Nguyen, Jefferies, & Rojas (2018) found improvements in self-efficacy and cultural intelligence after a short term study abroad experience, but only for monocultural students. They suggested that multicultural students already have a high degree of cultural intelligence, so the change was not significant.

Depth of understanding and reflection is certainly an important consideration. Pike and Sillem (2018) argue that a student's sense of marginality at not belonging in a particular context can be constructive to their aptitude as a global citizen. However, it can also backfire because the perception of threat to their identities by understanding differences may exacerbate binary or polarized views of the world (Nguyen, Jefferies, & Rojas, 2018). There are also arguments that the illustrated "benefits" of SAI simply support "…a neoliberal social imaginary [which] constructs an image of the neoliberal subject as equipped with communication skills, a global mindset, and

intercultural competence and thus as competitive in global labour marketplaces" (Kubota, 2016, pp 348-349). Or, that SAI outcomes reinforce stereotypes and power differences instead of breaking them down (Thurber, 2019).

The question of transformation requires consideration for both the hosts and the visitors involved, especially considering that the majority of SAI participants are white and privileged. O'Sullivan & Smaller (2019) interviewed host communities in Nicaragua and found that hosts did not have a transformative experience and found that the students involved in an international service-learning experience were not sensitive to local needs or interests and that the experiences were disruptive. So while there is evidence of attitude shifts, there is less evidence of shifts in structural or systemic issues that perpetuate power differences (Pike & Sillem, 2018). So, transformative learning at what cost?

Velure, Roholt & Fisher (2013) suggest that engaged and decolonizing pedagogy methods that include counter-storytelling and question hegemonic structures and privileges previously unknown to the student. This understanding of power difference is much more evident in contexts where the student is encouraged to think about identity, culture, and the "the other." If the goal of the study abroad experience is to help facilitate transformation through dialogue and exchange, pedagogy that reflects critical theory and structural/power dynamics is necessary. Students can return to their cultural base and share new understandings and meaningful interactions in a way that fosters a broader shift in perception.

Lindsey (2005) proposed a connection between study abroad experiences and an enhanced commitment to social work values, including the following: open mindsets; increased awareness of personal values; a challenge to societal norms and increased social awareness; an increase in awareness of discrimination and appreciation for difference; an increased desire for social justice; and increased development related to professional identity. There is a strong alignment with study abroad objectives and social work values, specifically related to self-determination, social justice, and the dignity and worth of the person (Rotabi, Gammonley & Gamble, 2006). This paper extends these suggested connections to specifically incorporate the Strengths Perspective.

STRENGTHS PERSPECTIVE AND SAI

There is an important opportunity in social work scholarship, education, and practice to expand our understanding of SAI to include more components of the Strengths Perspective and Transformative Learning Theory. These shifts will help us expand the story of SAI to include more reflective, sensitive, and anti-oppressive practices and to begin addressing the identified concerns about SAI related to dichotomized perspectives, colonialism, and imperialist approaches. Table 1 outlines specific recommendations for expanding what we have learned from these two frameworks into SAI.

Table 1: Alignment of the Strengths Perspective, Transformative Learning Theory, and Study Abroad Initiatives

Key Elements of Strengths Perspective	Concepts from Transformative Learning Theory	Recommendations for Study Abroad Initiatives (SAI)
Resists dichotomies	Relies on new experiences that perplex and challenge assumptions or "suspends judgment"	It is important to avoid single-story narratives and be open to the nuances and alternative perspectives that show up in SAI.
Systematic assessment of strengths and power through multiple sources of knowing		SAI participants should understand and analyze power dynamics in the relationship between and within their home and host environment.
Requires self-reflective and critical service providers		SAI participants must critically reflect on their own background and assumptions about people and contexts that are unfamiliar to them. They need to adopt a questioning and open stance for understanding.
Challenges previous assumptions or frames of mind through a shift in perspective		The critical analysis of power includes identifying and challenging previous assumptions about a different context for learning (i.e. all migrants are poor or have dark skin).
Environment is seen as rich in resources	Perceptual malleability depends on environmental and interpersonal exposure to new ideas	SAI initiatives should be developed and planned with an emphasis on environmental strengths that reinforce new perceptions in participants and counter-narratives of negativity and despair.
Goal-oriented with emphasis on common human needs	Process-oriented examination of potential alternatives	SAI should have clear goals that focus on mutual learning and exchange but also understanding the problem-solving process in an experiential way.
Builds collaborative relationships of hope, dignity, empowerment, resilience, and possibility		SAI should not leave participants feeling hopeless or doubtful about solutions, but should inspire them to be proactive about social change and to focus on stories of resilience and hope.
Prioritization of client system perspective and emphasis on choice and local expertise	Changing perspectives is interactive and mutual.	Local expertise and local perspectives should be prioritized, with collaborative partnerships in planning and participation.

Social workers have an opportunity to make improvements in SAI, and the Strengths Perspective can expand our strategies by engaging these recommendations to address four key impact areas in social work.

First, SAI needs to be shaped by a social work values-based pedagogy, centered on dignity, empowerment, and hope. An important component of dignity includes a clear analysis of power relationships. For example, Pike & Sillem (2018) suggest that SAI should primarily be done between similarly developed countries, in order to avoid a sense of exploitation or voyeurism. Social work students can do this by maintaining a nonjudgmental attitude, and by critical self-reflection. Social work educators can do this by incorporating multiple narratives (not a "single story"), power analyses, attending to the sensitive and respectful use of language, incorporating experiential and reflective activities, investing in local economies (rather than multinational corporations, and focusing on local and "regular" life events. In doing so, they have "…opportunities to prepare students in challenging the dominant social forces and power relations behind the reproduction of inequalities" (Jönsson & Flem, 2018, p. 905).

Second, SAI need to center their work on fostering the potential for mutual growth and learning, which leads to professional developed social workers. Saleebey (1996) suggested this when he called for "a mutual sharing of knowledge, tools, concerns, aspirations, and respect" (p. 303). Social work educators and practitioners need to increase pre and post-trip preparation so they can expand their learning to include various perspectives and critical thinking (Nguyen, Jefferies, & Rojas, 2018; O'Sullivan & Smaller, 2019). In that vein, SAI should only be one part of broader learning, and not just a token course (Passareli & Kolb, 2012). Pipitone (2018) argued that SAI should include "…pedagogies that engaged students with local rhythms, meanings, and histories; social interactions; and cultural tools that engaged students in alternative ways of knowing and being in the world before, and during the trip." (Pipitone, 2018, p. 54).

Third, there should be a broader attempt to incorporate non-western theories and frameworks for understanding cultural differences (Blundo, 2001; Canda, Furman, & Canda, 2019; Chappell Deckert & Koenig, 2019; Deardorff, 2016; Jönsson & Flem, 2018; Koenig, et al, 2017; Pipitone, 2018). This would be beneficial for social work students and professionals. Koenig & Spano (2010) illustrated this when they argued for social workers to redefine their understanding of expertise in the helping relationship, expand their knowledge & understanding, take on a stance of non-action, and foster "all-at-one-time knowledge" (p. 57). It helps to shift power dynamics and move towards mutuality and away from dichotomized perspectives.

Finally, SAI can expand capabilities and the potential for systemic change, and the drivers of that systemic change should be local. Local leaders and social work professionals from the host setting should be the role models for students as they learn about strategies for community change (Nguyen, Jefferies, & Rojas, 2018). These

partnerships should be encompassed in respect and authentic, long-term relationships (Thurber, 2019). SAI should not focus on consumerism or tourism, but rather "…engage students in critical thinking and nurture a commitment toward responsible social action, ultimately contributing to a more just global community" (Pike & Sillem, 2018, p. 36).

Globalization has certainly changed the face of social work education, leaving social work educators with the challenge of how to incorporate important global learning objectives in a way that is sensitive and does not create more damage through colonialist, racist, and/or voyeuristic strategies. Social work educators and professionals now have an opportunity to take leadership in the development of strengths-based SAI that foster critical and reflective learning, prioritize dignity and respect for local cultures and economies, and encourage social action for long-term and sustainable solutions to global problems. One way to begin those shifts is to weave more of the core strengths perspective principles into the development and implementation of these initiatives. In that way, social workers across the world can develop and experience SAI more critically, and use them as a springboard for movement toward sustainable and authentic social change.

END NOTES

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Strengths Work in Social Work Education at HAWK, Germany

Corinna Ehlers

INTRODUCTION

Professions in human services are committed to supporting the personal development of the people they work with. According to the international definition of social work[1], empowerment and enhancing the wellbeing of people is a central mission of social workers. However, in times of budget cuts, austerity programs and an increasing caseload this mission proves to be an enormous challenge for social workers or other practitioners as well for clients. For the last 30 years, neoliberal management strategies have been implemented in many countries with the goal to make care systems more efficient. The management strategies put a focus on output rather than outcome. With these changes in place, the clients' interests often cannot be focused on intensely anymore. Instead of empowering people, professionals in human services are held back and constrained.

In Germany, the research findings of Beckmann, Ehlting and Klaes (2018) and Poulsen (2012) in the field of youth welfare show that the workload is high and social workers have become responsible for a greater number of tasks over the last years. A little over half the questioned social workers in Poulsen's survey answered that the workload was "very high" (Poulsen 2012: 49). In her research project, Poulsen interviewed about 100 social workers from 2010 to 2011 using a questionnaire. The interviewees named the following as stress factors: work intensification, excessive bureaucracy and time pressure. Furthermore, their own handling of over-

whelming work situations was mentioned. Poulsen (2012: 56) cites one of the interviewed persons: “The greatest challenge is not to lose oneself in work.”

In these conditions, the strengths perspective can be helpful in that it returns the focus to the clients and their needs as well as supporting social workers themselves. The strengths perspective offers possibilities to face these challenging work situations by supporting self-management abilities. Good self-management, for example, can be helpful in dealing with the balancing act of being there for the clients as well as incorporating the interests of the organizations and one’s own needs. The strengths perspective also provides ways to strengthen social workers in their challenging working conditions. Because strengths work is such an essential part of human services, it should start with exploring the strengths of the professionals, and this should start during education. Before other people can be supported, it is important to be aware of one’s own strengths and how they can be used to empower others. For social workers in this current working environment, it is crucial to develop good self-management skills, which are also closely connected to their strengths.

Therefore, strengths work should be a fundamental element in social work education. At the faculty of Social Work and Health at the HAWK in Hildesheim (university of applied sciences), within the study program of social work, we established a strengths lab and developed a workshop called Stärken-Parcours to improve our students’ awareness of their strengths. The workshop aims at enabling the participants to explore their strengths and figure out how they can use them within their study program as well as in their professional work.

This article will describe the theoretical framework of the workshop Stärken-Parcours and will briefly introduce the five-step process of discovering an individual’s strengths sweet spot. In conclusion, the first impressions from the evaluation of the workshops held in 2018 and 2019 will be presented.

THEORETICAL FRAMEWORK OF THE WORKSHOP

The strengths-based practice models of Saleebey (2013 109 et seq.) and Niemiec (2018: 58 et seq.) can be summarized in the following strengths model (see figure 1). It combines three elements:

1. Adopting a strengths perspective
2. Discovering and developing strengths
3. Focusing, setting goals and taking action with an emphasis on strengths

First of all, it is necessary to be aware and to put on the “strengths glasses”. Not only social workers, therapists, counselors and educators but also the people they work with have to be ready to adopt a strengths perspective and change their view on things. Saleebey (2013:109 et seq.) points out that it is important to listen to the

story of the clients and value their stories. Already through listening and observing without judgement it is possible to learn about other people's strengths.

The second element combines exploring and evolving strengths. Current strengths and resources are reflected on with the clients. Furthermore, it is helpful to find out which strengths and resources were available in the past. Apart from that, clients' aspirations should also be considered. Finding out more about the significant personal meaning of strengths helps to develop and enhance them. It is part of the strengths evolution to talk about the meaning of strengths, how strengths interact with one another and how they can be used. The third element is about setting a focus and designing a change process. Meaningful goals are a key element in personal development. They should be linked with strengths because character strengths and needs are a driving force in activating resources.

The strengths workshop is based on the principles and methods of the strengths perspective and includes elements of positive psychology. During the 1980s, the first approaches of the strengths work started at the KU School of Social Welfare. Saleebey (2013) and his colleagues established the strengths perspective in social work based on human psychology, system theories, solution focus work. According to Saleebey (1996, 2013b: 102 et seq.), strengths are an interplay of individual experiences, capabilities and hopes. In the mid-1990s, within the field of psychology, Martin Seligman as the chairman of the American Psychological Association announced the age of Positive Psychology. In contrast to conventional approaches in psychology, positive psychology focuses on health and wellbeing. Both the strengths perspective and positive psychology pay attention to strengths and resources rather than to problems and deficits. Looking at literature in both areas, one notices a large number of publications that approach the issue of what strengths are and why it is important to focus on them. Building on this foundation, it is possible to find a common ground for what strengths are: according to the context, strengths are a personal power source, while resources are accessories, social contacts or possibilities in the environment. Personal strengths can help to activate resources.

Strengths assessments consider strengths and resources through the three dimensions of time: present, past and future (Rapp & Goscha 2012, Biswas-Diener 2010). In form and content, strengths assessments can be versatile because the term 'strengths' is so broad. In the scientific community values and character, strengths seem to be an important element as well as talents and skills. Furthermore, the sense of meaningfulness or joy while doing certain things is considered to be a strength. These activities can be a hint of which particular strengths are meaningful to a person. From motivational psychology, it is known that conscious and unconscious needs play an important role in our action control, which is also crucial for defining goals.

Various authors (Cf.,e.g., Peterson & Seligmann 2004; Linley 2010, Saleebey 1996, 2012, Rapp and Goscha 2012, Clifton and Nelson, 2010) have defined strengths, and

there are many established and scientific strengths assessments, for instance, the tools VIA IS, Realise2 or Strengthfinder, available. In these assessments, single elements of strengths are well described and explored, but these different pieces were not thoroughly connected. For a better understanding of what strengths are, it seems helpful to link the different areas within a spectrum. This also allows a classification of the range of the three strengths areas. Especially in the field of social work, it is indispensable to consider the strengths spectrum in the environment of the clients. The following figure illustrates the strengths spectrum with the sweet spot in the middle.

Figure 1: Strengths spectrum (Ehlers 2019)

The three areas will be briefly exemplified starting with the character strengths. Values are our beliefs and attitudes that are important to us. Closely linked to our values are our character strengths. According to Peterson and Seligman (2004), character strengths are positive parts of our personality that influence our thinking, our feelings and our actions.

Based on their research, the authors identified 6 virtues and classified 24 character strengths that were related to the virtues. For example, creativity, curiosity, judgement, love of learning and perspective are assigned to virtue, wisdom and knowledge. All people have all 24 character strengths, but the composition and intensity are unique for each person. Character strengths are considered to be important because they influence the way other strengths areas evolve (Niemiec 2014: 26). The VIA classification offers a general vocabulary for identifying strengths as well.

Besides character strengths, the area of capabilities, talents and skills is important. Whereas talents are inborn and have to be discovered to become improved, skills or capabilities can be learnt and trained. Everyone has diverse talents and capabilities, but often enough they are not recognized because they seem to be normal to the person in question. Both talents and skills can be improved throughout life. Gardner

(2008) developed a chart of multiple types of intelligence. What is significant is a differentiated reflection of these intelligence types, not the question of which intelligence type is more important. The following chart gives an overview of the different types with some examples.

Table: Multiple Types of Intelligence from Gardner (2008)

Linguistic-verbal intelligence debating reading writing poetry learning other languages	**Logical-mathematical intelligence** calculating finding solutions organising understanding formulas
Bodily-kinaesthetic intelligence playing and dancing physical activity dexterity	**Musical- rhythmic intelligence** making music singing and humming listening to music recognizing rhythms
Visual-spatial intelligence drawing and doing handcrafts having spatial sense recognizing patterns and shapes having a sense of orientation	**Interpersonal intelligence** being an attentive listener being tolerant mediating and connecting being a leader
Intrapersonal intelligence enjoying solitude developing one's own opinion having high moral standards reflecting on one's own thoughts	**Naturalist intelligence** loving and taking care of animals being outside gardening

The third area is about needs. All humans have diverse needs. Besides basic needs, like food and sleep, there are universal needs, like autonomy, relatedness, competence and freedom (Deci & Rayn 1993, Kuhl 2001). According to Maslow (2014), higher needs, like self-fulfillment, are sensitive. Thus, the context has to be right before people can work on their self-reflection or self-management. Until basic needs, like food and shelter, are guaranteed, it is often hard to focus on personal development. Being aware of one's own needs can help to find out what is essential for wellbeing. Awareness of needs is important to learn about motivation and also helps to enhance the wellbeing of people.

The concept of non-violent communication introduced by Marshall Rosenberg (2016) comprises a range of needs. Within seven main categories, there are differ-

ent variations of needs, like sleep, recovery and rest or self-acceptance. Within the strengths work it is important not only to find out about the different areas but also explore how the strengths play together.

THE STRENGTHS SWEET SPOT AND GOAL SETTING

In tennis, the so-called sweet spot marks a point on the racquet. When the player hits the ball with that certain point and at the right angle, the hit will be more powerful and precise, the serve will have more impact and will land more powerfully in the opponent's part of the court. Thus, in order to act more effectively, the interplay of different elements is important.

It is similar to mental strength when it comes to a long-term commitment to changes like finding a new job, getting out of an unhealthy relationship, coping with a chronic health condition. In such situations, strengths and motivation are needed for a journey of change and/or recovery. Short-term activities can often be regulated through the mind. For long-term changes, it is necessary that personal values, character strengths and needs be aligned. When this is accomplished, we can act out of our power zone more effectively. Activities that come from the sweet spot seem to be easier to handle and feel energizing rather than exhausting. Working out of the strengths power zone is often connected with the so-called 'flow': people are fully involved in their tasks, they enjoy what they are doing to an extent where they may become oblivious to their surroundings, to time and space.

To identify the sweet spot, it might be helpful to ask the following questions: How do your strengths areas interplay? How do your strengths have a positive impact on one another? What is the characteristic of your strengths area (x)?

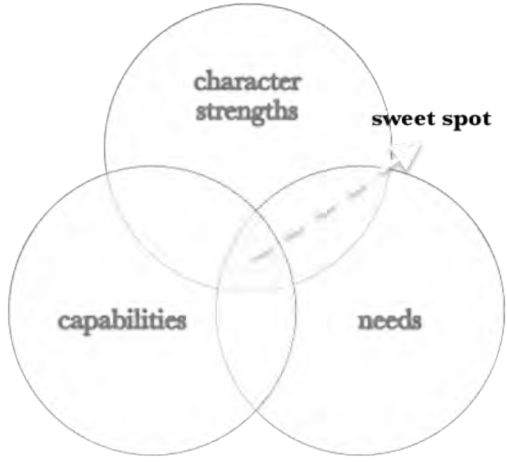

Figure 2: Strengths spectrum with sweet-spot

Strengths-focused goal work means prioritizing and concentrating on the relevant areas. A strengths focus means being clear what kinds of goals are motivational, important and inspiring to a person. This could be having a private space for recovery or being able to take care of a pet before the paperwork can be done.

Knowing one's own needs is conducive to good self-management. According to Martens and Kuhl (2013: 120 et seq.), self-motivation is an impulse from the inside to do something. The strengths-focused goal work aims at identifying self-motivation. The Zurcher Resource Model (ZRM®) by Storch and Krause, which is used as a tool in this goal-setting work, is rooted in motivational psychology and neuroscience. The model offers different methods that help to develop self-management and considers cognitive and emotional aspects in order to find individual meaningful goals. The so-called motto-goals have a highly motivational character because they take into account motives and subconscious needs and describe an attitude of what a person would want to be like. Motto-goals can integrate strengths and are helpful as a passion statement.

HAWK STRENGTHS WORKSHOP "STÄRKEN-PARCOURS"

The University of Applied Sciences Hildesheim (Hochschule für Angewandte Kunst und Wissenschaft - HAWK) offers a variety of study programs in three different locations. The Faculty of Social Work and Health with study programs in the fields of Social Work, Early Childhood Education and Health is based in Hildesheim. The bachelor and master social work programs are generalist-oriented with a focus on theories and concepts of social work. A critical reflection on professional practice and personal experiences in social work are a fundamental part of our education. In our study programs, we strive to give our students a broad theoretical knowledge as well as practical expertise. Due to changes in society, it is not only clients who are faced with challenges; professionals must also deal with challenging work situations, as mentioned in the beginning of the article. Therefore, we decided to support our students at the HAWK in their personal development. As part of our social work-study program, we established a strengths lab (in German "Stärkenlabor") to promote strengths work in our study programs[2]. Strengths work during education offers possibilities for learning and developing a professional identity. The strengths lab provides a place where students can learn about the strengths perspective and explore their own strengths.

Often, when I introduce strengths work in seminars, participants say "Yes, I know..." Most people assume that strengths work is about the things that you are good at. For example, in Germany, a typical question at job interviews is: "What are you good at?" So, a lot of people have an answer at the ready. They say general things like "I am well organized, I am creative..." Strengths work, however, goes much deeper and is much more precise. As I have described in my previous explanations, it is not only about which capabilities people have but about the interplay of their character strengths, the things they like doing and the things that are meaningful to them.

This is an ongoing process with a continuous reflection on strengths and consideration of how strengths can be used in daily life and work. “What are my strengths (character strengths, skills & needs)? And how do I use them?” are important questions for professional development. Therefore, this self-reflecting process should start early in education as an ongoing process. As part of this work, we developed a workshop for students to discover strengths. The main tenets of the workshop are:

- Promote strengths work within the study programs social work
- Teach about the strengths perspective
- Enable social work students to discover strengths and plan how to use their strengths
- Promote a strengths language
- Provide a space for students (and staff) to work on their strengths together in groups

In a five-step process, the students can discover different strengths areas based on a strengths spectrum that includes character strengths, capabilities and needs (Ehlers 2019). Upon completion of this task, the participants consider how their different signature strengths play together and identify an individual strengths sweet spot, which reflects their personal signature strengths in each area. The last step in the workshop includes thinking about how the participants can use their strengths in their daily life.

Here are the 5 steps at a glance:

1. Discover which character strengths you have. Which are the most meaningful to you?
2. Think about the activities you like and which capabilities/skills you have.
3. Reflect on what kind of needs you have. What do you need to feel well?
4. Think about how your strengths from the different areas come together.
5. Consider how you can use your strengths in your daily life. Which of the insights are important to you? What goal would you like to achieve with your strengths?

The workshop lasts about 1.5-2 hours. In a welcoming unit, the students and tutors introduce themselves. After a short input about the Stärkenlabor and the strengths perspective students have time to work through a set of questions and tasks. We provide a workbook with questions and exercises. Additional information and illustrations are placed on moveable boards around the room. The students from the strengths lab walk around and answer questions. Toward the end of the workshop, the group comes together and reflects on the process. The students also exchange their thoughts and ideas about their strengths with one another in the process. Within the self-reflection, it is also necessary to check if strengths are overhyped or

if they have downsides. When a positive trait or character strength is used too much it can be irritating for other people. A question should also be asked if excessive use can be disturbing for the person himself/herself. For example, for helping professionals, kindness is often a character strength. Altruism and compassion as a form of showing kindness are good. But social workers who overdose on their strength kindness can lose their professional distance, might not be able to set boundaries or do too much for their clients instead of empowering them.

This workshop was held in November 2018, May 2019 and November 2019 during a special project week that is placed in the middle of a semester. The workshop was offered as an additional training course. In January 2019 it was also held with a group of exchange students from Finland and our students. Each workshop counted around twenty participants. The training materials and the workshop concept were developed together with students, and the workshops were carried out by the students from the strengths lab. On the one hand, this peer-based approach enables the students who take the workshop to open up in a context where the regular teaching staff is not in charge. On the other hand, students from the strength lab who carry out the workshops can improve their skills, like working with groups, organizing and teaching.

EXPERIENCES AND OUTLOOK

The HAWK strengths lab and its strengths workshop are quite new. So far, we do not have broad research data. Since we developed tools for self-reflective strengths-work together with the students, we continuously elicited and selected feedback and adapted the self-reflection tools.

At the end of a workshop session, the participants were asked to give feedback. Students mentioned about all workshops that:

- it was a surprising change of perspective
- it was a broadening of our view of ourselves and our clients
- the workshop helped to enhance the awareness of different strengths
- it allowed for interesting and exhilarating self-reflection
- it provided a useful instrument for working with the clients/practical work and benefited all parties involved
- it was good to investigate closely each strengths area and then look at how the elements play together

For the workshop, in May 2019 we developed an online questionnaire that had a character of a pre-test. The questionnaire is comprised of 17 questions. Four of them are open questions with the option to leave a comment, and 13 questions could be answered with a five-point Likert scale. The link was sent to the students who left their e-mail address after the workshop and offered to evaluate the

workshop. Six participants answered the questionnaire. For all of them, the topic strengths orientation was important. Five said it was important for them, one said it was rather important. To the question "How important do you think is an orientation toward strengths for your work?" five participants also said it was important, one said it was rather important. Most participants were satisfied with the workshop (5 said they were satisfied, i.e. it was important, one said it was rather important). By way of improvement, one participant recommended more time at the end of the workshop for the collective reflection. Altogether, the small survey was helpful for the further development of the questionnaire as well as for the workshop. Based on the experience with this first survey we will adapt a few questions and rethink the scaling. In the future, we will repeat the survey after each workshop to find out how the students can benefit from the strengths workshop.

From all our feedback we can summarize that students find the change of perspective toward strength interesting and they point out the importance of the topic for social work in general. Moana, who works as a tutor in the strengths lab, describes her learning experience:

> *"For me working in the strengths lab is not only a good opportunity to upgrade on my studies to get a deeper understanding about one particular topic, as it is the strengths orientation in this case, but also to get to know my own values and strengths better and learn about different perspectives. This has a big impact on my professional attitude as well. For me living the attitude of the strengths orientation is deeply connected to values like empathy, helpfulness, making decisions, being open towards and patient regarding other people, empowering and self-determination. And I think those values (and many more) are important in Social Work.*
>
> *So ultimately working in the strengths lab is a process of personal reflection that also shapes my professional attitude and my ability to reflect on that. Both empowers me to work with other students on this topic.*
>
> *I work with the strengths lab for almost two years now and it is an ongoing process, a cycle that never stops, of learning and reflecting that especially in correspondence with other people leads to new interesting insights over and over again."*

In addition to the strengths workshop, we are currently developing a second workshop with a focus on goal setting. This workshop should enable the students to clarify their thoughts about which goals are important for them concerning their studies, personal development or their transition to work practice. Furthermore, we are planning to develop an online course so our students can explore their strengths in their own time whenever they want to. Also, we are considering implementing the strengths workshop in our welcoming program for our first semester.

Based on our experiences I would like to recommend to other study programs including (self-reflecting) strengths work in their curriculum. This could be a small exercise to put on the strengths glasses and view a situation from a different angle or it could be a reflection on what works well in classrooms. In order to establish strengths-based behavior, it is helpful to repeat mindful exercises over and over again. Furthermore, I would like to encourage educators to offer workshops on a voluntary basis where students can explore their strengths and reflect on them. In our experience, it was helpful that the workshops were carried out by tutors. This way we could realize a peer-to-peer approach. Somehow or other in order to strengthen the profession of social work it is important to offer social work students opportunities to explore and reflect on their strengths in an ongoing process throughout their education.

END NOTES

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[2] Many thanks to Moana Neumann, Katharina Krüger und David Zimmer for their support and engagement in the strengths lab.

[3] The workbook is available for download: https://www.hawk.de/sites/default/files/2019-10/staerken_parcour_heft_15_2019_002.pdf

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Rooted in Strengths: The Branching of Interprofessional Practice and Education

Teri Kennedy

> "*…all the branches of a tree at every stage of its height when put together are equal in thickness to the trunk*" (The Notebooks of Leonardo Da Vinci, No. 394, Richter, 1970, as cited in Eloy, 2011, p. 1).

Since the 1989 publication of 'A Strengths Perspective for Social Work Practice' in the journal *Social Work* by University of Kansas researchers, the strengths perspective has represented the sturdy trunk of a tree nourished by the deep-seated values of the social work profession. Its introduction served to prune the dead branches of "moral deficiency," "human failing," and "pathology" (Weick, Rapp, Sullivan, & Kisthardt, 1989, p. 350) born of problem-focused approaches to human behavior and arising from the long shadow of Abraham Flexner and the influence of the medical model upon the development of professions (Gitterman, 2014). Its adoption encouraged the new growth of healthy branches supporting the intrinsic strengths of "peoples and society," ultimately bearing fruit representing "some of the deepest values of social work" (Weick et al., p. 350).

An off-shoot of the strengths perspective, strengths-based case management (SBCM), was first demonstrated to be effective with individuals transitioning into the community from state psychiatric hospitals (Rapp & Chamberlain, 1985). A study by Siegal, Rapp, Li, Saha, and Kirsk (1997) suggested that "SBCM may operate as a stand-alone treatment intervention, rather than just as an adjunct to treatment" (as cited in Rapp, 2007, p. 185). In 2001, Marty, Rapp, and Carlson contributed a tool that assessed key elements of SBCM, and in 2006, Saleebey developed a conceptual foundation for the strengths perspective (as cited in Rapp, 2007).

Subsequently, SBCM was extended from its original behavioral health application to the treatment of individuals living with substance use disorders and HIV. The ap-

proach was credited with improved aftercare retention and "reduced drug use and criminal justice involvement" for individuals with substance use disorders (Rapp, Siegal, Li, & Saha, 1998; Siegal et al, 1996; Siegal, Li, & Rapp, 2002, as cited in Rapp, 2007, p. 185). SBCM was later found effective linking recently diagnosed HIV-infected individuals with HIV medical care (Craw, Gardner, Marks, Rapp, Bosshart, Duffus, Rossman, Coughlin, Gruber, Safford, Overton, & Schmitt, 2008). Each of these approaches served to leverage the strengths of individuals, while focusing on the skills and abilities of strengths-based case managers, rather than teams, to facilitate successful care transitions and aftercare.

In 2012, Gottlieb, Gottlieb, and Shamian posited that the "strengths-based movement has the potential to become a 'game-changer' in nursing and to transform healthcare" (p. 40), transitioning from a fragmented, depersonalized, less accessible "disease/illness model" to one "in which people and communities assume greater control and responsibility for their own health and healthcare decisions" (Frist, 2005, as cited in Gottlieb et al., p. 39). The proposed route to this change was through Strengths-Based Nursing Leadership (Gottlieb et al., 2012) and Strengths-Based Nursing Care (Gottlieb, 2012).

Strengths-Based Nursing Care focused on "understanding, uncovering, discovering and releasing biological, intrapersonal, interpersonal and social strengths to deal with challenges and to meet personal, team and system goals" and to "get the most out of what is important and meaningful to them," while focusing on the nurse-person relationship as central to the healing process (Gottlieb et al., 2012, p. 41). As a theoretical perspective, SBC valued person- and family-centered care, empowerment, whole-person care, context-based care, health promotion and illness prevention, self-care, and collaborative partnership involving "a collaborative relationship between the person/family and the healthcare provider" (p. 41). While embracing and articulating important strengths-based values and addressing people, teams and systems, SBC was still framed around a specific profession and their relationship with the person and family at the center of care.

Although focused on the inherent strengths of people and society, the strengths perspective was often framed around a specific role (i.e., case manager), profession (e.g., social worker or nurse), or process (i.e., strengths-based case management, strength-based nursing care) as they related to the care of individuals and families, rather than to the interprofessional team or team-based care. This presents an opportunity to apply the strengths perspective to an interprofessional team-based approach to health and social care.

This chapter will explore the development of interprofessional practice and education (IPE) and the evolving role of the patient voice through the lens of the strengths perspective. It will propose a new model of Strengths-Based Interprofessional Practice and Education (SB-IPE) incorporating appreciative inquiry and narrative

methods. Opportunities to advance a model of strengths-based interprofessional practice, education, policy, research, and theory are explored.

INTERPROFESSIONAL PRACTICE AND EDUCATION

> *Interprofessional practice and education has the "potential to transform health care and health professions education" (NCIPE, 2015, b, para 3).*

According to the World Health Organization, *interprofessional education* occurs "when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes" (WHO, 2010, p. 13). Interprofessional practice and education (IPE) has experienced "a long history of ebbs and flows of interest, resurgence and refocus for over 50 years" (Brandt & Schmitt, 2013, as cited in Brandt, 2014, p. 6), and has been referred to as "the 'new' forty-year-old field" (Brandt, 2015, p. 9). The field has also experienced evolving language from interprofessional education (IPE), to interprofessional education and collaborative practice (IPE/CP), to the current *interprofessional practice and education* (the new IPE) (National Center for Interprofessional Practice and Education, 2015). During the 1960s and 1970s, "interprofessional education" took hold as a promising practice exploring "what students should learn together and how they should learn it" (Gilbert, 2010, as cited in Fransworth, Seikel, Hudock, & Holst, 2015, p. 1). Alternating between "interdisciplinary education" and "interprofessional education," a 1972 Institute of Medicine report recommended that academic health centers and "regional consortia of health professions schools…foster educational teamwork" ("Highlights of Recommendations"). See Table 1 for a brief history of IPE in the United States.

The social work profession shares a noteworthy role in the history of IPE. Beginning as a nascent concept of "interprofessional" collaboration between medicine and social work (Cabot, 1901, as cited in Schmitt, Gilbert, Brandt, & Weinstein, 2013), the earliest known use of the phrase "interprofessional education" involved a collaboration between psychology and social workers (Dickson, Levinson, Leader, & Stamm, 1949, as cited in Kennedy, 2020). The first use of the phrase "interprofessional team" occurred in a trio of three publications by social work educator and researcher, Rosalie Kane, including a doctoral dissertation (1975, June) and two workforce monographs (1975, a; 1975, b).

The origins of IPE in healthcare can be traced to the early 2000s, when the Institute of Medicine (IOM) released a trio of reports: *To Err is Human* (2000), *Crossing the Quality Chasm* (2001), and *Health Professions Education: A Bridge to Quality* (2003). These three groundbreaking reports focused on patient safety, quality imperatives, and workforce optimization, concentrating interest in health system redesign and the importance of IPE.

In 2010 the World Health Organization (WHO) released *Framework for Action on Interprofessional Education & Collaborative Practice*, laying the groundwork to advance the field of IPE by creating common language and meanings. In addition to defining interprofessional education, as previously noted, *collaborative practice* in health-care was defined as occurring "when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings" (WHO, 2010, p. 13). Importantly, WHO defined *health workers* as "wholly inclusive… [of] those who promote and preserve health…whether regulated or non-regulated, conventional or complementary" (2010, p. 13) and *professional* was framed as "an all-encompassing term that includes individuals with the knowledge and/or skills to contribute to the physical, mental and social well-being of a community" (p. 13).

These inclusive definitions by WHO have highlighted the individual and collective value of each member of the healthcare team and fostered the participation of direct care workers, community health workers (CHWs), lay health educators, and other individuals who make important contributions to health and social care as members of the interprofessional team. CHWs who are members of the populations they serve, including *promotoras* or *promotoras de salud* (Spanish for "health promoters") (Deitrick, Paxton, Rivera, Gertner, Biery, Letcher, Lahoz, Maldonado, & Salas-Lopez, 2010, p. 386) and traditional or indigenous healers (Moorehead, Gone, & December 2015), foster health and wellness by honoring and unleashing the strengths of culture and language that reside within people and communities (Knutson Woods, Blaine, & Francisco, 2002).

A significant milestone occurred in 2010 with passage of the Patient Protection and Affordable Care Act (U.S. Congress), also referred to as the ACA and Obamacare. The ACA established "community-based interdisciplinary, interprofessional teams…to provide support services to primary care providers" (p. 435) and advanced several concepts and measures supporting patient-centered care (see The Patient Voice).

In 2011, the Interprofessional Education Collaborative (IPEC) established four core competencies, and related sub-competencies, for interprofessional collaborative practice:

- *values/ethics for interprofessional practice*
- *roles/responsibilities*
- *interprofessional communication*
- *teams and teamwork*

These competencies reinforced the strengths and unique contributions that each member of the healthcare team brings to the process of health and social care. They recognized the importance of each discipline's foundational values and ethics, contribution of unique and navigation of overlapping roles/responsibilities, and the

interplay between disciplines through interprofessional communication and teams/teamwork.

In 2016, IPEC released an update that organized the four core competencies within a single domain of interprofessional collaboration and broadened the competencies to better achieve the Triple Aim, with an emphasis on population health. Evidence in support of this focus on interprofessional collaboration was compelling. The presence of collaboration within hospitals was found to have reduced rates of mortality, negative patient outcomes, and costs; and increased organizational commitment, and provider satisfaction and responsiveness (McKay & Crippen, 2008, p. 109). On the other hand, the absence of collaboration was found to be "a contributing factor to the fragmentation of care and poor outcomes which plague our healthcare system" (Henneman, Lee, & Cohen, 1995, as cited in McKay et at., p. 109).

Table 1: Time Capsule of Interprofessional Practice and Education in the United States (Kennedy, 2020)

Year	Milestone	Publication
1901	Concept of "interprofessional" teamwork emerged from a collaboration between medicine and social work	(Cabot, as cited in Schmitt, Gilbert, Brandt, & Weinstein, 2013)
1949	Newly discovered earliest use of "interprofessional education" between psychology and social work	(Dickson et al., as cited in Kennedy, 2020)
1969	Previously reported early use of "interprofessional education"	Interprofessional Education in the Health Sciences
1972	Suggested fostering "educational teamwork" through consortia of academic health centers and health professions schools ("Highlights of Recommendations")	Educating for the Health Team (IOM)
1975	First known use of "interprofessional team"	The Interprofessional Team (Kane, June; 1975, a; 1975, b)
2000	Addressed the role of health care providers to improve patient safety and reduce medical errors	To Err is Human (IOM)
2001	Envisioned a health system that is safe, patient-centered, timely, efficient, and equitable with new roles/responsibilities for health care workers	Crossing the Quality Chasm (IOM)
2003	Proposed educating all health professionals "to deliver patient-centered care as members of an interdisciplinary team" (p. 3)	Health Professions Education: A Bridge to Quality (IOM)

Table 1: (continued)

2010	Established definitions for "interprofessional education" and "collaborative practice" (p. 13)	Framework for Action in Interprofessional Education and Collaborative Practice (WHO)
2010	Established "community-based interdisciplinary, interprofessional teams" and advanced patient-centered care provisions	Patient Protection and Affordable Care Act (U.S. Congress)
2011	Addressed the role of nursing in health care redesign, as equal partners at full scope of practice	The Future of Nursing: Leading Change, Advancing Health (IOM)
2011	Established core and sub-competencies for IPE	Core Competencies for Interprofessional Collaborative Practice (IPEC)
2012	Creation of the National Center for Interprofessional Practice and Education in the United States	Coordinating Center for Interprofessional Education and Collaborative Practice: Funding Opportunity Announcements. (US Department of Health and Human Services)
2015	Introduced the interprofessional learning continuum conceptual model linking the education-to-practice continuum, learning and health-related outcomes, and enabling and interfering factors	Measuring the Impact of Interprofessional Education on Collaborative Practice and Patient Outcomes (IOM)
2015	interprofessional practice and education (the "new IPE")	National Center for Interprofessional Practice and Education (NCIPE, a)
2016	Organized core competencies within the single domain of interprofessional collaboration and broadened competencies to better achieve the Triple Aim, emphasizing population health	Core Competencies for Interprofessional Collaborative Practice: 2016 Update (IPEC)
2019	Voluntary harmonization of terminology and consensus guidelines related to accreditation of IPE for 24-member health professions accrediting agencies	Guidance of Developing Quality Interprofessional Education for the Health Professions (HPAC)
2019	Identified key characteristics of high-functioning interprofessional clinical learning environments (IP-CLEs) including "patient-centeredness, continuum of learning, reliable communications, team-based care, shared accountability, and evidence-based practice" (Weiss et al., p. 9)	Achieving the Optimal Interprofessional Clinical Learning Environment (NCICLE)

The promise of interprofessional practice and education (IPE) is to improve the experience of care for people, improve the health of populations, and reduce the per capita cost (or improve the value) of care, known as the Triple Aim (Berwick, Nolan, & Whittington, 2007). In 2014, this concept was expanded to include improving the experience of providers, referred to as the Quadruple Aim (Bodenheimer & Sinsky), amidst mounting evidence of the impact of provider burnout and resulting turnover on quality of care and workforce retention.

Notwithstanding the promise of IPE, a sobering 2014 scoping review revealed that "despite a four-decade history of inquiry into IPE and/or collaborative practice, scholars have not yet demonstrated [its]…impact…on simultaneously improving population health, reducing healthcare costs or improving the quality of delivered care and patients' experiences of care received" (Brandt, Lutfiyya, King, & Chioreso, p. 393). In response to this challenge, Pechacek, Cerra, Brandt, Lutfiyya, and Delaney (2015) proposed the development of a national intervention network and "National Center Data Repository" (p. 146). This strategy involved identifying and promoting the use of validated instruments and a common core data set permitting national comparisons while promoting intervention research designs and processes (p. 152). As a result of these strategies, research linking interprofessional team-based practice to Triple and Quadruple Aim outcomes--improving the quality and experience of care for people, populations, and providers, while reducing price—has begun to bear fruit. A study by Guck, Potthoff, Walters, Doll, Greene, and DeFreece demonstrated improved patient outcomes (e.g., reduced emergency room visits and hospitalizations, and reduced A1C levels), as well as a dramatic reduction in costs of care (48.2%), for a cohort of high-risk patients, served through an interprofessional collaborative practice model as compared with usual care (2019, p. S82).

On a national level, the National Center for Interprofessional Practice and Education (NCIPE) released important findings in 2019 from the Accelerating Interprofessional Community-Based Education and Practice initiative, spanning 16 sites in 14 states, adding to the evidence-base linking IPE to Triple Aim outcomes. Through the development of interprofessional academic-practice partnerships serving vulnerable populations at the nexus of interprofessional education and collaborative practice, "[m]any sites were starting to see improved health outcomes for patients by the end of the [two-year] grant period" (Harder + Company Community Research, 2019, p. 4). Initial patient- and population-level health outcomes included improved access to primary care, reduced emergency department visits and hospital readmissions, improvements in A1C indicators for people living with diabetes, and improved patient reports of satisfaction with their care (pp. 28-29).

In early 2019, the Health Professions Accreditors Collaborative (HPAC) released a guidance presenting a voluntary harmonization of accreditation standards endorsed by 24 health professions accreditors, including "consensus terminology and definitions" (HPAC, p. 6). Finally, the National Academies of Sciences, Engineering, and Medicine (NASEM) recommended strengthening health professions education and

practice alignment, shifting the preparation of health professionals from a focus on acute care to meet the burgeoning demand for ambulatory and home-based care, and developing new models of care, delivery, and payment that broadened the concept of the health workforce (NASEM, 2019, p. 6).

Interprofessional practice and education (IPE) holds the promise of improving care for people, populations, and providers, while reducing price, and seeks to eliminate health and health care disparities. In combination with IPE, the strengths perspective can be leveraged to underscore the valuable perspectives and contributions of, and overlaps and relationships between, all members of the interprofessional team. It is an inclusive practice that harnesses the strengths of the values and ethics and roles and responsibilities of health and social care providers across disciplines, encompassing direct care workers, community health workers, and lay health educators and bringing forth the strengths of culture and language in partnership with people and communities. Leveraging strengths is also important to leadership in IPE, informing a model of spontaneous leadership "where all members of the team can provide leadership at different times depending on their strengths, skills and the situation" (Harder + Company Community Research, 2019, p. 22). In these ways, the strengths perspective offers an essential ingredient required to foster the effectiveness of IPE.

THE PATIENT VOICE

> *"The road map to the future in health care is driven by patients and families, leading out of the hospital into outpatient, community and home settings. It's ambitious, noble and challenging work that is pivotal to the future of health systems and health professions education."* (NCIPE, 2019)

From the beginning, the strengths perspective valued the patient voice, believing that "people have the capacity to determine what is best for them" (Weick and Pope, 1988, as cited in Weick et al., 1989, p. 353) and that even "in the midst of complexity, people proceed in the best way they can" (p. 353). The notion of agency has undergone dramatic changes over time as a result of the introduction of strengths-based principles.

In 1957, the American Medical Association's Code of Ethics framed patient opinions as a"[r]easonable indulgence…granted to the caprices of the sick" (AMA, as cited in Millenson & Macri, p. 1). During the 1960s and 1970s, the patient's role began to transform as a result of three concepts: the ethical notion of "patient autonomy as a human right that supersedes physician beneficence" (p. 1), the economic notion of "health care as a marketplace filled with consumers and providers weighing costs and benefits" (Millenson & Macri, 2012, p. 1), and the clinical notion of the "patient's voice" represented in the shift toward "patient-reported outcomes, such as physical functioning…that could provide feedback about ongoing treatment decisions" (p. 2).

In 2001, an Institute of Medicine report, Crossing the Quality Chasm: A New Health System for the 21st Century, recommended "fundamental change" to the American healthcare system, suggesting that "[h]ealth care should be…Patient-centered—providing care that is respectful and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (p. 40). The report outlined six "dimensions of patient-centered care: (1) respect for patients' values, preferences, and expressed needs; (2) coordination and integration of care; (3) information, communication, and education; (4) physical comfort; (5) emotional support—relieving fear and anxiety; and (6) involvement of family and friends" (Gerteis, Edgman-Levitan, & Daley, 1993, as cited in IOM, 2001, p. 49).

In 2010, along with defining interprofessional education and collaborative practice, the World Health Organization established six learning outcomes for a *collaborative practice-ready health workforce*, including "recognizing the needs of, the patient" (p. 26). Also in 2010, the Patient Protection and Affordable Care Act (U.S. Congress), frequently referred to as the ACA or Obamacare, mandated the use of "quality measures" that translated to "patient-centered assessments," referencing "patient-centeredness, patient satisfaction, patient experience of care, patient engagement, and shared decision-making" (Millenson & Macri, 2012, p. 1).

Subtitle F—Health Care Quality Improvements, established the concept of the Patient-Centered Medical Home and introduced a mechanism to support grants or contracts "to establish community-based interdisciplinary, interprofessional teams…to support primary care practices…within the hospital services areas." Care was to include "prevention initiatives and patient education and care management resources into the delivery of health care that is integrated with community-based prevention and treatment resources, where available" (Sec. 3502, (b) Eligible Entities, (3), p. 435) and "services to eligible individuals with chronic conditions" (Sec. 3502, (b) Eligible Entities, (5), p. 435). Health care teams were required to "support patient-centered medical homes, defined as a mode of care that included "whole person orientation; coordinated and integrated care; [and] expanded access to care" (Sec. 3502, (c) Requirements for Health Teams, (2), A-E, p. 436)

In 2019, the National Academies of Sciences, Engineering, and Medicine (NASEM) recognized the value of incorporating the potential "disruption of patient and family voices and perspectives" (p. 24), as well as "care delivery innovation" (p. 56) into health professions education. The same year, the National Collaborative for Improving the Clinical Learning Environment (NCICLE) released two reports. The first focused on the importance and key characteristics of high-functioning interprofessional clinical learning environments (IP-CLE) in preparing the current and future workforce (Weiss, Passiment, Riordan, & Wagner, 2019, p. 3) for "patient-centeredness, continuum of learning, reliable communications, team-based care, shared accountability, and evidence-based practice centered on interprofessional care" (p. 9). The second addressed the need for "all levels of the health care system" to focus quality improvement efforts on the elimination of health and health care disparities

and to prepare future clinicians accordingly (Casey, Chisholm-Burns, Passiment, Wagner, Riordan, & Weiss, 2019, p. 3). Using a patient-centered orientation, *quality improvement* was defined as the "frameworks used to systematically improve the ways care is delivered to patients" (p. 17).

Shifting from Patient-Centered to Person-Centered Care

> "*There is a relation between persons and role… the culture itself prescribing what sort of entity we must believe ourselves to be in order to have something to show through in this manner*." (Goffman, as cited in Wilson, 1988, p. 93)

In 2011, Starfield contended that a patient-centered care perspective was insufficient, arguing for person-focused care. She presented a compelling case that in a patient-oriented perspective care entailed visit-based, episodic interactions focused on disease management of a given number of chronic conditions and distinct body-systems, used professionally-defined conditions based on coding (for billing purposes), and was primarily concerned with disease evolution. In addition to its focus on the person as a role (i.e., patient), this approach is designed with the provider and health system in mind. In contrast, person-focused care (or *person-centered care*) focused upon the person, interrelationships between the individual and provider over time, viewed illnesses as an individual's life-course experience of their health, regarded diseases and body systems as interrelated, saw health conditions as multimorbid, used coding systems as opportunities to reflect on individual's health concerns (e.g., social determinants of health), and was as concerned with an individual's experienced health challenges as with their diseases (p. 63) (see Table 2).

Table 2: Patient-Centered Care versus Person-Focused Care

Patient-Centered Care	Person-Focused Care
Interactions during visits	Interrelationships over time
Episode-oriented experience with health	Episodes as part of life-course experiences
Management of diseases	Diseases as interrelated phenomenon
Comorbidity (number of chronic diseases)	Multimorbidity (combinations of illnesses)
Body systems: distinct	Body systems: interrelated
Coding systems: professionally defined conditions	Coding systems: people's health concerns
Evolution of patient's diseases	Evolution of people's experienced health problems and diseases

(Adapted from Starfield, 2011, p. 63)

Starfield introduced a critical paradigm shift to our approach to care. Patient-centered care focused on the role of patient, albeit temporary and one of a panoply of roles played over a lifetime, while person-centered care focused on personhood. In this construction, the role of the patient is a minor character in a play that spans a lifetime and a wide array of roles, reminiscent of Goffman (1956).

It is critical that health and social care professionals make this transition from role-focused care to person-centered care. The advancement of person-centered care principles through advocacy, education, and policy reform has led to two powerful, yet exquisitely simple, guiding principles: ask what matters and do nothing about me without me. Application of the strengths perspective holds promise for advancing an interprofessional team-based approach to care in which individuals and families are essential members and active participants in, versus simply the focus of, the interprofessional team.

A NEW BRANCH ROOTED IN STRENGTHS: STRENGTHS-BASED INTERPROFESSIONAL PRACTICE AND EDUCATION

While listening to the voices of people, families, and communities as members of the interprofessional team is important to the delivery of health and social care, these same voices can be harnessed to inform a simultaneous redesign of education health and social care. Likewise, it is important to listen to the voices of practitioners, interprofessional teams, and value the collective experience of organizations.

Within communities, organizations, and systems are people who understand their assets and cultures, hold a collective wisdom derived from their shared history and individual biographies, and are deeply invested in their success. This wisdom and experience can be mined for strengths and best practices. Incorporating such wisdom and experience can inform the development of a new model of IPE, Strengths-Based Interprofessional Practice and Education (SB-IPE).

The strengths perspective can be harnessed in service of the goal of managing the change required for simultaneous systems transformation of education and health and social care through SB-IPE. Two promising approaches to advance this new model include *appreciative inquiry* and the use of *narrative methods*.

Appreciative Inquiry and Strengths-Based Interprofessional Practice and Education

> *"Appreciation is about valuing the life-giving in ways that serve to inspire our co-constructed future. Inquiry is the experience of mystery, moving beyond the edge of the known to the unknown, which then changes our lives…where appreciation and inquiry*

> *are wonderfully entangled, we experience knowledge alive and an ever-expansive inauguration of our world to new possibilities."* (Cooperrider & Srivastva, 2017, p. 4)

Appreciative inquiry (AI), formulated in 1987 by Cooperrider and Srivastva, is a constructivist approach "to initiating and managing organizational change" (Dematteo & Reeves, 2011, p. 203) that serves as both "an organizational theory and a tool of social change" (Cojocaru, 2012, p. 122).

> At its heart, AI is about the search for the best in people, their organizations, and the strengths-filled, opportunity-rich world around them. AI is not so much a shift in the methods and models of organizational change, but AI is a fundamental shift in the overall perspective taken throughout the entire change process to 'see' the wholeness of the human system and to "inquire" into that system's strengths, possibilities, and successes. (Stavros, Godwin, & Cooperrider, 2015, p.97).

Four guiding principles are at the heart of AI: Research into the social innovation potential of organizational life should begin with appreciation and should be applicable, provocative, and collaborative (Cooperrider & Srivastva, 2017, p. 55). AI was part of the root structure of strengths-based management (Cooperrider, 2017) and has been described as "arguably the most powerful process of positive organizational change ever devised" (Gergen, from Whitney, Trosken-Bloom, & Rader, 2010, p. x, as cited in Cooperrider, 2017, p. 5).

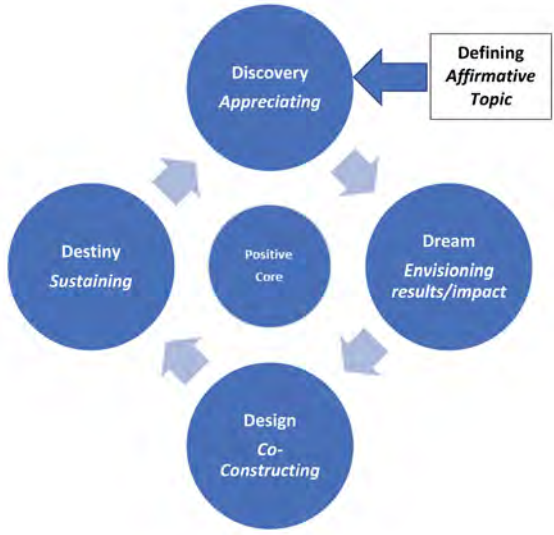

Figure 1: Appreciative Inquiry as a Strengths Perspective. (Adapted from Stavros, Godwin, and Cooperrider, 2015)

MacFarlane (2006) observed that the strengths perspective was "echoed in several theoretical frameworks" including AI, with which it shared "basic assumptions and techniques" (p. 176). The use of AI as a strengths-based approach to patient care transitions was explored by Shendell-Falik, Feinson, and Mohr (2007). Hospital staff used AI to address serious patient safety issues related to patient care transitions, attributed to up to 98,000 death each year (IOM, 2000 and 2001, as cited in Shendell-Falik et al., 2007). AI focused on strengths, in this case identifying and building upon effective patient care transitions. Related outcomes, "such as using resources more efficiently, better documentation and user-designed communication tools, resulted in better patient safety and economic efficiency" (Shendell-Falik et al., 2007, as cited in Sims-Gould et al., 2012, p. 206). In fact, "growing evidence of the benefits of using a strengths-based approach may outweigh a traditional focus on identifying problems in care transitions" (Sims-Gould et al., 2007, p. 206).

Moore and Charvat (2007) described the application of AI to "health promotion and behavior change" (S64) for a population of underserved women experiencing health disparities by giving "voice to [their]…hopes and dreams regarding their health and to assist them in finding the energy to move toward healthier behaviors" (p. S65). In this usage, AI reflected the tenets of strengths-based case management.

A 2012 study sought to understand how interprofessional health care providers sought to identify "success" in post-hip fracture care transitions using a strengths-based perspective to system improvement. "[H]allmarks of 'success' [included] a focus on process—information gathering and communication, and a focus on outcomes—autonomy and care pathways" (Sims-Gould, Byrne, Hicks, Khan, & Stolee, p. 205).

> Because an appreciative approach stresses supportive relationships and shared vision over problem-solving it seemed to have special resonance for those working in health care given the hierarchical interprofessional relationships that exist…[and] appeared to engender positive perceptions of interprofessional collaboration, as indicated in participants' reports of high levels of enthusiasm and commitment for this type of work which can be difficult to undertake (Dematteo & Reeves, 2011, p. 207).

While extolling the potential of AI to advance interprofessional education initiatives, Dematteo and Reeves warn that without an appreciation of the "broader social, economic, and political context," (Grant & Humphries, 2006, p. 405, as cited in Dematteo & Reeves, 2011, p. 204), AI can "overlook a number of structural factors, which will ultimately limit its ability to…secure meaningful and lasting change within health care" (2011, p. 203). Still, Cooperrider (2017) posits that "very few of the hundreds of applications…go to…the key concept of AI as a generative theory building method for the collaborative construction of reality" (p. 5). Given that IPE requires a "collaborative relationship between the person/family and the healthcare

provider" (McKay & Crippen, 2008, p. 41) and education and healthcare transformation are fostered by collaborative, co-created academic-practice partnerships, Cooperrider's and Srivastva's concept of a "collaborative construction of reality" (2017, p. 5) serves as a good fit with IPE.

A 2010 study by Conn, Oandasan, Creede, Jakubovicz, and Wilson applied AI to a two-year organizational change process advancing interprofessional teamwork within a family health team. The authors learned that practice change (e.g., a shift to patient-centered care), or first-order change, "precede[d] change in…the way that members [spoke and thought]…about themselves as an integrated team," or second-order change (p. 284). This finding suggests that AI serves as an initial step in the process of change, but that it may benefit from a paired approach that fosters the necessary second-order change to sustain culture change.

While AI offers a powerful approach to organizational and system change, the process of defining an affirmative topic and moving through the cycle of appreciating, envisioning results and impact, co-constructing, and sustaining, inevitably involves story and narrative. Partnered with AI, the use of narrative could be the missing ingredient to promote second-order change, facilitating the process of eliciting, co-creating, and coalescing the story of change necessary to achieve strengths-based IPE.

Narrative Approaches to Strengths-Based Interprofessional Practice and Education

> *"[N]arrative methods, patient-centered practice, and interprofessional teamwork are all interrelated and have the common goal of improving…care and quality of life*" (Clark, 2015, p. 177).

Providing health and social care from a person- and family-centered perspective is a process of eliciting, listening to, and processing stories and narratives from the patient history, assessment, and care plan, through treatment, care transitions, discharge, and aftercare. Each member of the healthcare team brings their own unique filter to this information based upon their profession's values, socialization, and unique focus.

The process of working with a person and family in the context of interprofessional team-based care involves a process of coalescing the person/practitioner narratives and co-creating a person/team narrative.

> Thus, each professional will co-create, with the patient, a different narrative; when the providers come together as an interprofessional team, it is essential that these different stories be recognized as such and effectively integrated into an overall assessment

> and care plan that incorporates many clinical voices. (Clark, 2015, p. 177)

Shared decision making (SDM) is an approach designed to foster patient-centered care facilitate mutually agreed health care choices between patients and practitioners that are "respectful and responsive to individual patient preferences and needs, and reach clinical decisions…guided by patient values" (Stacey, Légaré, Pouliot, Kryworuchko, & Dunn, 2010, p. 164). Within the Affordable Care Act, *patient engagement* was defined as "the active participation of patients and their families in the process of making medical decisions," while *shared decision-making* was defined as "decision support tools and…methods with which the patient can assess the merits of various treatment options in the context of his or her values and convictions" (as cited in Millenson & Macri, 2012, p. 2). While SDM has been found to be an important contribution to person-centered care, Stacey et al. reviewed 15 unique models of SDM, finding that the few including at least two health professions did not reflect interprofessional collaboration (2010).

> "Person-centred care necessitates that practitioners learn more about the…person as an individual, together with a better understanding of the patient's personal meanings, experiences, and attitudes" (Clarke, 2001, p. 698, as cited in Clark, 2015, p. 178).
>
> This means looking beyond the "mask" of age, illness, and disability to see the person's true self and life. In addition, it connotes the development of a genuine relationship with the patient that reveals underlying values in terms of the choices facing him or her and the constraints on those choices that may exist. (McCormack, 2004, as cited in Clark, 2015, p. 178)

Having a relationship with, and recognizing the needs of, the patient includes "working collaboratively in the best interests of the patient" and "engaging with patients, their families, carers and communities as partners in care management" (WHO, 2010, p. 26). On a system and community level, "[i]ntegrating community members (patients and families) into healthcare delivery planning could enhance engagement in personal health, leading to reduced chronic disease and improved population health" (Pechacek et al., 2015, p. 151).

Considerations for Education, Practice, Policy, Research, and Theory

Academic-practice partnerships and simultaneous system redesign of education and healthcare are grounded in person-centered principles with people, families, and communities as fully participating members of the interprofessional team. Opportunities are ripe to advance SB-IPE practice, education, policy, and research through AI and narrative.

Practice

In practice, SB-IPE could harness the shared voices of people, populations, and professions using appreciative inquiry and narrative to imagine a better system of health care that eliminates health and health care disparities and meets the needs of all people. The 2019 guidance by the National Collaborative for Improving the Clinical Learning Environment can serve as a roadmap to engage and prepare the current and future workforce to work at "all levels of the health care system" (Casey, Chisholm-Burns, Passiment, Wagner, Riordan, & Weiss, 2019, p. 3) towards the elimination of "health care disparities as a unique component of health disparities" (p. 5). In community settings, students and practitioners can be recruited and trained to "work with the community at large to analyze population health data to identify risk factors and root causes that contribute to disease and health outcomes" (Advisory Committee on Interdisciplinary, Community-Based Linkages, 2019, p. 10).

Education

The process of professional identity formation in health professions education requires a parallel process guiding interprofessional identity formation. The latter would improve individual and team navigation of the core competencies of interprofessional collaboration for students and practitioners, namely values and ethics, interprofessional communication, roles and responsibilities, and teams and teamwork. Such training could include learning to operate as border crossers or "boundary spanners… position[ing] students well for work in the increasingly interprofessional realms of health and social care…Seeing [them]selves as boundary spanners is one way to reconcile…professional and interprofessional identities…when they move into interprofessional practice" (Oliver, 2013, Abstract, p. 773). In education, SB-IPE could harness the individual and collective voices of health professionals, educators, and students to co-create an interprofessional identity formation process and boundary spanner role. Such an inquiry could also inform and advance a model of interprofessional spontaneous leadership (Harder + Company Community Research, 2019, p. 22).

Policy

Through the use of AI and narrative and leveraging informatics, reimbursement models could be transformed by identifying person-focused coding specifying perceived health concerns. An example of this work is being conducted by UnitedHealthcare, who are "incorporating social determinants into clinician workflow to improve care management and enhance health" (Shapiro, 2019, slide 9). Such coding could be cross-referenced with social determinants of health and leveraged to inform and tailor approaches to population health. In policy, SB-IPE could harness the voices of people, families, and communities, informing new models of care, delivery, and reimbursement that encompass interprofessional, integrated health and social care.

Research

The need for an interprofessional approach to shared decision-making (Stacey et al., 2010) provides an opportunity to develop, test, and evaluate new SDM models. In research, SB-IPE could harness the voices of people, families, and interprofessional teams to develop a new model of interprofessional SDM. Stacey recommended the "need for a model that is inclusive of an interprofessional approach to SDM" (2010, p. 171). Narrative approaches offer a pathway toward the development of an SDM process inclusive of the voice of people, families, and interprofessional practitioners. "If narrative methods, patient-centered practice, and interprofessional teamwork have one thing in common, it is the accurate and complete co-construction of the patient's story of his or her own life as it is related to health and social care" (Clark, 2015, p. 180).

Theory

In 1996, Saleebey stated that the strengths perspective was "[c]learly not a theory. But its emerging body of principle and method does create opportunities for professional knowing and doing…so common today" (p. 303). By 2009, Saint-Jacques, Turcotte, and Pouliot titled an article, *Adopting a Strengths Perspective in Social Work Practice with Families in Difficulty*: *From Theory to Practice*, implying that the perspective had moved into the realm of theory. By 2011, James stated that "Strengths theory emerged as a perspective in social work discourse as an alternative to the psychoanalytic model of analysis and intervention. In practice, strengths theory is now accepted broadly in health sciences" (p. 224). Given the 30th anniversary of the strengths perspective in social work and its extensions to other fields and contexts, perhaps it's time to re-evaluate the strengths perspective for consideration as a practice theory.

Five-hundred years ago, after closely observing trees, Leonardo DaVinci noticed that "when trees branch, smaller branches have a precise mathematical relationship to the branch from which they sprang" (Palca, 2011, para 3). Similarly, a strengths-based approach to interprofessional practice and education (SB-IPE) can branch from the tree of the strengths perspective, fed by the nutrients of appreciative inquiry and narrative to elicit, co-create, and coalesce the voices of people, families, and communities with that of members of the interprofessional team.

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Strengths Perspective

& MACRO PRACTICE

Strengths Perspective Policy Practice: Conceptual Underpinnings, Development, and Next Steps

Melinda Lewis, Rosemary Kennedy Chapin & Hayden Rand

Even before there was a formal name for the concept of rooting social policy in a recognition of people's strengths and goals, there were efforts to do just that. Early social workers and their allies who campaigned for women's suffrage, did so from an understanding of the tremendous contributions women make to public life—and to increase their legal capacity to contribute even more. Native American leaders who fought for land rights and cultural sovereignty understood well that only policy that honored their strengths could help them meet their challenges (Leeds & Gunsaulis, 2012). African-American social work pioneers who fostered mutual aid and sought to dismantle institutional barriers (Carlton-LaNey, 1999) were pursuing capacity-building grounded in community strengths, even if there was seldom academic documentation or professional legitimation of this impact. Today, then, as social workers celebrate the 30th anniversary of the formal naming of the strengths perspective and its application to policy practice, this commemoration begins from historical and cultural humility.

Acknowledging the great debt today's strengths-based social policy practitioners owe to those who laid this earlier foundation, this chapter focuses primarily on conceptual developments, research, and implementation initiatives from the past three decades. During this time, scholars and practitioners have catalyzed more systematic, extensive, and better-resourced attention to the importance of centering policy change in people's own strengths and to the difference a shift in emphasis, from deficits to strengths, can make in the process and products of policymaking and,

then, in people's lives. The 2019 Proclamation by the Governor of Kansas, *Recognizing the 30th Anniversary of the Strengths Perspective for Social Work Practice,* speaks to this transformative impact, highlighting the strengths perspective's contributions to state policy changes designed to support people in the community instead of institutions.

Elaborating on the work that facilitated this progress and the development of strengths-based policy practice, this chapter discusses strategies practitioners, scholars, and social work students, in collaboration with their clients, have used to (1) build connections between the conceptual underpinnings of the strengths perspective and policy practice and (2) support more widespread use of strengths-based approaches in policy practice. After some background on the strengths perspective, the chapter examines initiatives in the areas of conceptual development, social work education, research, practical implementation, and evaluation. The piece concludes with a consideration of ways these efforts have laid the foundation for further investigation and application and suggests potential approaches that may help to propel future work in this arena, increase use of a strengths approach in policymaking, and improve clients' lives.

BACKGROUND AND CONCEPTUAL UNDERPINNINGS

The strengths perspective is a philosophical approach to social work that centers the goals, strengths, and resources of people and their environment, rather than their problems and pathologies, in the helping process (Saleebey, 1992). While initially discussed primarily in the context of more clinically-oriented social work practice, the strengths perspective's demonstrated power to reframe and renew micro social work practice captured the attention of social policy scholars and practitioners who had long believed that many needed social policy reforms stemmed from an unproductive emphasis on perceived personal failings, rather than people's inherent capacity and evident resilience. They believed that focusing on people's goals and actively assisting them in acquiring resources are keys to effective policymaking, and they were drawn to the approach as an embodiment of core social work values of self-determination and social justice. Consistent with these aims, strengths-based policy practice differs in-process and intended product from that which is deficit-centered. Specifically, the process of strengths-based policy development privileges input from a much wider array of people affected by the policy. Strengths-based policy practice is more than mere solicitation of ideas, however; its utilization demands that clients be involved throughout policy development, implementation, and evaluation. This process promotes hope and a positive perception of the environment. It has the potential to profoundly shape the product—the policies that are ultimately implemented.

As has been recognized in other eras, the economic and political contexts prevalent during the ascendance of the strengths perspective shaped practice and influenced conceptual development, in a symbiotic fashion (Chapin, 1999). For example, the

political and economic drivers that propelled the movement to serve clients outside of expensive institutional settings influenced the work of scholars involved in the conceptual development of the strengths perspective in the 1980s. In turn, the appeal of the strengths perspective helped to facilitate policy changes that might otherwise have been less likely. Practitioners were challenged to help integrate people who had been institutionalized back into their communities. Policy and practice approaches that emphasized strengths were key to this effort. They built on clients' goals and visions for their lives, leveraged informal resources and supports, and sought to remove barriers. Case managers trained in the strengths perspective who worked with clients being served in the community provided real-world insights to help root policy development in clients' lived experiences. They incorporated peer support and collective action into treatment plans and reoriented organizational imperatives to privilege client outcomes. They fought for the resources necessary for deinstitutionalization initiatives to succeed, and they centered the struggles in clients' needs and goals. Today, as financing required to fully realize the aims of strengths-based deinstitutionalization has failed to materialize, strengths-based policy practitioners continue to press for these resources and assert this framing.

Alongside the scholars whose publications were among the first to formally name a strengths perspective, state agency staff, social work practitioners, and client advocates collaborated to improve policies that supported the growth of home- and community-based services. The goal was to create a rebalanced long-term care system that allowed clients to receive services in the community rather than in an institution. A series of policy fora at the University of Kansas brought together client advocates, state bureaucrats, legislators, researchers, and practitioners to hear about best practices and policy changes implemented in other states (Fast & Chapin, 1992; Rapp & Chamberlain, 1990; Rapp & Topp, 1991). This provided the opportunity for these stakeholders to put their heads together to formulate the next steps in transforming state policy and practice. These fora and statewide committees that grew out of them developed strategies to implement policies that reflected clients' preference for home and community-based services and supported their right to self-determination while building on client and community strengths and resources.

Informed by these experiences, the scholars active in this work began to chart the conceptual underpinnings for strengths-based policy practice. In 1995, Chapin published the first article reformulating strengths perspective tenets to guide policy practice (Chapin, 1995). Shaped by lessons from the field, this seminal publication advanced the strengths perspective as a valuable lens for reexamining social policy and reworking the policy change process. Consistent with other applications of the strengths perspective, the strengths-based approach to social policy does not deny the existence of social problems. Instead, it reconsiders their social construction. Rather than defining problems in ways that emphasize people's individual challenges, structural and environmental barriers are positioned as the problems demanding the public response of social policy. Further, strengths-based policy development centers on clients' stories of how they have coped with these barriers and cele-

brates their utility in the policy process (Chapin, 1995, p. 511). Perhaps the most crucial distinction in policy practice from a strengths-based lens is the difference in roles of policy practitioners and those the policy is intended to help. As this foundational piece explains:

> Under the strengths approach, there is no longer the implication that an expert policymaker will inform the public and develop policy goals. Rather, the helper gives voice to clients' perspectives, helps negotiate definitions and goals that include these perspectives, and continues the focus on the client as collaborator (Chapin, 1995, p. 510)

That initial article on strengths-based policy practice was the foundation for a text, now in its fifth edition, that fleshes out the concepts, highlights policymaking that reflects these tenets, and provides exemplars of how strengths principles could guide policy practice in arenas including civil rights, health and mental health, child welfare and aging (Chapin & Lewis, 2020). Between the publication of the initial article in 1995 and the 2020 text, conceptual underpinnings for strengths-based policy practice have been further synthesized, based on input from clients and from faculty, students, policymakers, and practitioners working to develop and implement strengths-based policy in a variety of fields. For example, Perkins and Tice (2001) developed a historical lens for considering whether policies built on strengths and how they might be improved. In 2006, Rapp, Pettus, and Goscha helped to delineate strengths-based policy practice principles. Illustrating the applicability of strengths-based scholarship to policy, their work continues to inform thinking about strengths-based policy practice. Indeed, the principles presented in this chapter build on that work. In 2008, Hill examined barriers to implementing a strengths approach to policy practice, illustrated how a strengths-based framework could be used to evaluate youth policy and suggested ways the barriers to more widespread implementation might be addressed. Many other scholars also contributed to the development of strengths-based policy practice. However, at its core, the drive to develop strengths-based policy practice has been fueled by social work clients and other most-affected populations, whose views of their own lives have always had room to acknowledge both their power and their struggles. A value base that privileges their perspectives is at the heart of the strengths approach, and indeed, of all social work. This value-based foundation is reflected in the outline of the reformulated strengths perspective policy practice principles presented below, to more fully illuminate the current conceptual underpinnings of strengths-based policy practice.

Strengths Perspective Policy Practice Principles (Chapin & Lewis, 2020)

- Client strengths and goals are legitimate starting points for developing social policy. Problems and deficits are not given center stage.
- Clients' perspectives concerning their problems, strengths, and goals should inform the social construction of needs.

- Social policies and programs should build on individual and community strengths and resources and remove structural barriers that disadvantage the target group. When making claims for benefits and services, social workers should emphasize the structural barriers that create unequal opportunities and impair clients' abilities to meet their needs.
- Claims for benefits and services that allow people to overcome these barriers are made based on the right to equal access to resources and opportunities to meet their needs and reach their goals, regardless of gender, race, age, disability, sexual orientation, gender identity, or other characteristics.
- The role of the social worker is not that of the expert, but of collaborator and resource person who helps draw attention to the perspectives of the target group and supports clients in advocating for policies to improve their lives.
- Social policy goals and design should focus on access, choice, and opportunities that can help empower the target group to meet their needs and goals.
- The target group should be involved in all phases of policy development. The process as well as the product, or outcome, of policy development, will be enhanced by their involvement.
- Evaluation should center on the assessment of client outcomes.

When attempting to craft new policy or evaluate existing policy based on these principles, each principle should be considered and consistency between principles assessed (Rapp, Pettus, & Goscha, 2006). However, it is unlikely that a given policy will exemplify all these principles. The policy process is messy, and compromises are typically necessary. Strengths-based policy practitioners collaborate closely with clients to navigate these currents, with the aim of producing policies that more closely adhere to these principles and promote social justice and self-determination.

DEVELOPMENT STRATEGIES

Given this background, in the following segment, we will examine initiatives in social work education, research, implementation, and evaluation that have been advanced to help create the foundation for further development of the strengths approach to policy practice and its use to alter policy and improve well-being. They reflect a variety of approaches to concept building and dissemination. Many of these initiatives are ongoing.

The Role of Education

Introducing students to strengths-based policy practice tenets at the BSW, MSW, and Ph.D. levels is a crucial step in promoting the use of these principles in policy analysis, development, implementation, and evaluation. Moreover, student feedback can help faculty scholars further develop the conceptual base, as when stu-

dents' strengths-based policy practice illuminates different aspects of the policy process and, then, reveals opportunities for clients' experiences and preferences to be centered in those moments. In the classroom, faculty can model a strengths-based approach by encouraging students to assess their own strengths, goals and resources. Such an assessment often helps students to see themselves with strengths sufficient to take action in the policy arena and to press for strengths-based policies and programs that support social work values. Distinct from foundation social work policy courses that focus primarily on policy analysis, many strengths-based policy instructors facilitate opportunities for students to engage in strengths-based policy practice. Students are also challenged to experiment with implementing strengths-based policy practice concepts in their field placements, which often involves collaboration with clients and policymakers. For example, in one of the author's policy classes, students in small groups were tasked with developing a policy practice action plan and chose to focus their work on policies and programs in the high school where some of the students were placed. These policy students had noted a rise in teen pregnancies and heard public concerns about this issue. To explore this trend and possible policy responses, they began by considering the issue from the perspective of those most-affected—teenagers. The policy students examined high school students' concerns about their sex education classes, particularly what they perceived as insufficient content on LGBTQ+ experiences and on birth control options. The policy students developed and executed a plan designed to change school policy so that a more comprehensive sex education policy could be developed. They met with students at the high school and college levels, including groups representing LGBTQ+ students, to get their ideas about needed changes and options for pursuing them. Drawing on the clients' voices and on the strengths of their student team, they framed the issue of teen pregnancy as the teens themselves saw it, and they positioned adolescents as the central stakeholders in this often-contentious issue. The policy students developed informational programs to increase public support for changes to sex education programming. They met with their school board members and state legislators to advocate for more comprehensive sex education. After being involved in this project, one policy student successfully ran for the school board and was instrumental in developing additional policies that gave voice to the concerns of students and parents. Students involved in such strengths-based policy practice initiatives shared insights with other students and with faculty working to advance a strengths-based approach to policy practice. This input helped ground conceptual development and flesh out more complete principles. For example, their experiences pointed to the need to emphasize the importance of an effective feedback loop so that client input and outcomes will be continually gathered as part of policy evaluation and improvement.

This iterative process paralleled advances in strengths-based direct services. There, growing recognition of the transformative potential of services rooted in the strengths approach sparked state investment in case manager education via statewide strengths-based training. When KU faculty and staff conducted such training, they had ample opportunity to gather practitioner feedback on their challenges and

successes, as well as the strengths-based policy changes needed to support their work. These insights, combined with practitioner feedback gathered in regular interaction in other settings, were used to build more robust conceptual underpinnings. Similarly, when students placed in Area Agencies on Aging developed training for their coworkers in the strengths perspective and its application to policy practice to supplement other strengths-based training, practitioners' experiences—informed by their advocacy alongside clients—strengthened the foundation of strengths-based policy practice, as well.

As is often the case, other developments supported the incorporation of these concepts into social work education. A strengths-based policy practice text was first published in 2007 and has been used by instructors around the country to introduce students to strengths perspective policy principles. In addition to examples of how social work students and practitioners have engaged in strengths-based policy practice, the text also includes tangible resources to steep students in a strengths-based approach to policy study and practice, such as an action plan template and a framework for examining historical social policies through the strengths perspective. The text is accompanied by interactive case studies that help students think through how strengths perspective principles may be implemented in policy practice and to reconsider the aims of a policymaking endeavor. Instructors can use these resources to provide a chance for students to experiment with the principles in a virtual environment.

At the Ph.D. level, students bring a level of sophistication to their critique of the use of the strengths perspective in policy analysis and development that can be especially potent for identifying gaps and potential areas for further work. Of course, a lack of sufficient research that builds on the strengths approach is chief among gaps identified. Some doctoral students have incorporated strengths perspective concepts into their dissertations and pointed to needed policy and program changes, particularly in services for older adults, informed by the strengths perspective (Macmillan, 2005; Leedahl, 2013; Sellon, Chapin, & Leedahl, 2017).

Research, Implementation, and Evaluation

Research into the needs and strengths of the target population is often a preliminary step in developing strengths-based policies (Hutchinson, 2019). Such research is critical in developing strengths-based policy practice options. As Hutchinson, who researched coping strategies of women in Mozambique, points out, understanding the resources utilized by marginalized individuals and communities to cope with a particular challenge creates a foundation for determining the responsibilities of governments and organizations to provide crucial social policy investments. In turn, this can inform the next steps in policy practice. This approach ensures that policy changes address systemic challenges, rather than assuming an individual or community's strengths are independent of outside forces and solely adequate for equitable change (Hutchinson, 2019).

Research has also focused on the efficacy of strengths-based policies and practices (Chapin et al., 2013). However, research to test the efficacy of the application of a strength-based approach to policy practice is a greater challenge. Each strengths-based policy principle requires translation into identifiable actions in the policymaking process, an often elusive and potentially contested process. The first two principles, "client strengths and goals are legitimate starting points for developing social policy. Problems and deficits are not given center stage," and "clients' perspectives concerning their problems, strengths, and goals should inform the social construction of needs," have been operationalized to some extent in the requirements for patient participation that have been set for PCORI (Patient-Centered Outcomes Research Institute) grant recipients. However, until there is a stronger literature base examining each element of the principles, different researchers could reasonably differ in their evaluation of the extent a policy reflects strengths-based principles.

Scholars attempting to engage in this type of research face challenges of funding and time constraints. For example, when strengths-based policies were implemented to support a peer support program for older adults, the research imperative was to do program evaluation that would help to get this initiative recognized as an evidence-based practice (Chapin et al., 2013). Even though the strengths-based process that supported policies leading to statewide implementation was briefly discussed in research publications evaluating this initiative, the reality was that neither funding nor time was made available to undertake in-depth research on the effects of a strengths-based policy process. To satisfy ethical mandates for responsible scholarship and realize the substantial promise of strengths-centered inquiry, the field needs research funding that prioritizes policy practice research centered on clients' needs and assets and is sufficient to facilitate the assessment of fidelity to strengths perspective principles, as well as the client outcomes produced by the policy change.

While such well-funded in-depth future research is sorely needed, social workers today can readily implement less complex policy evaluation by focusing on key criteria reflected in strengths-based policy practice principles. Though each principle is important and can be used to develop criteria for analyzing initiatives' focus on strengths, three are particularly critical:

- Extent to which target group is involved in each stage of research, policy development, implementation and evaluation;
- Extent to which social policy goals and design focus on access, choice, and opportunities that can help empower the target group to meet their needs and goals;
- Were client outcomes assessed and used to drive policy and program changes?

These criteria are relatively easily evaluated, and such evaluation can help social workers determine whether they should support the policy. Again, demonstrating

the iterative nature of theory refinement, such research can also inform strengths-based policy practice, by pointing to elements of the policy where practitioners can target initiatives to improve it.

CRITIQUE OF THE STRENGTH APPROACH TO POLICY PRACTICE

An examination of strengths-based policy practice must include a discussion of limitations. Continued critical inquiry is indispensable to further development and consistent with the motivations underlying the conceptual development of the strengths perspective itself, which centered on elevating clients' needs and perspectives, rather than advancing any particular academic interest. Although the strengths-based approach to policy practice has many benefits, its emphasis on including diverse voices and reworking processes can take extra time and may produce an unwieldy array of options. While the examples provided here suggest that novel ideas can result in more effective policy, some client groups and circumstances may prioritize expediency. Certainly, those considerations should enter the practitioners' calculus.

Additionally, there is scant empirical research into the efficacy of strengths-based policy practice. At times, this is because strengths-based policy approaches have such intuitive appeal that rigorous examination comparing their outcomes has been deemed unnecessary. In other cases, economic, political, or social imperatives have precluded empirical investigation. However, research to determine the impact of a strengths-based approach on client outcomes is particularly needed. This research should incorporate clients' perspectives on 'success'.

Some have critiqued the strengths perspective as derivative. While celebrating the unique contributions of many aspects of the strengths approach, strengths-based policy practitioners should consider connections between the strengths perspective and other approaches to social policy practice. This recognizes the assets others have brought to the field and ensures that practitioners bring the fullest complement of promising perspectives to their crucial work. Notably, here, the strengths approach has been critiqued for failure to sufficiently acknowledge its historical roots, including those emanating from a variety of empowerment approaches. Work to examine commonalities with and divergence from the empowerment approach has been undertaken, and more work in this arena is needed (Cox & Chapin, 2002).

Finally, some may argue that the strengths approach to policy practice may simply not be muscular enough to be relevant in the current, polarized, and often paralyzed, age. A pathology focus seems to be the order of the day. However, policy practice approaches built on the values of social justice and self-determination are needed now more than ever. Recent policymaking history illustrates vividly the truth that has made the strengths perspective such an indispensable tool for other aspects of social work practice: while focusing singularly on our problems does not

bring us closer to solutions, building on and leveraging people's authentic assets often can.

NEXT STEPS

The conceptual work of developing specific steps to operationalize strengths-based policy practice principles has begun. This work needs further attention from scholars studying strengths-based policy practices and their effects (Chapin, 2017). It is likely that most progress will be made by taking one principle, devising ways to measure the extent of its use, and then examining its impact on the final product. For example, researchers could examine PCORI grant-funded initiatives where robust patient participation is a mandate to determine if the research contributed to policy and program change, and then, how patient involvement influenced the policymaking process. Such research could provide insight into the efficacy of the principle, "The target group should be involved in all phases of policy development. The process as well as the product, or outcome, of policy development, will be enhanced by their involvement." Methods of research on other principles also need to be devised and then used to examine impact as well as interaction between principles, despite continuing time and funding limitations.

Another critical step in advancing the use of a strengths approach in policy practice is to help individuals, groups, and communities most affected by policies increase their capacity to participate in policymaking. Social workers who have been educated to work with groups and communities and are conversant with the policymaking process can make this knowledge available to community members. This is in keeping with the principle, "The role of the social worker is not that of expert but of collaborator and resource person who helps draw attention to the perspectives of the target group and supports clients in advocating for policies to improve their lives." Social workers can provide leadership training, orient people to policymaking timelines and procedures, support groups in refining their messages and communications channels, and leverage organizational resources to complement grassroots strategies.

Further, since research is often an initial stage of the policy process, social workers can help client groups understand how research can aid them in documenting their experiences, how they can assist in that work, and how such research can be used to shape policy. Methods should be implemented to help traditionally marginalized communities partner in research and policymaking. Social workers should assertively encourage policymakers to create space for this involvement and should ensure that their own scholarship can be a tool for client groups' policy engagement.

The disability community provides a compelling example of how involvement in the policymaking process can result in policy transformation. Their rallying cry is, "Nothing about us without us". Many practitioners and policymakers working in the disability field now fully expect and often depend on disability community

participation in policymaking to make the initial passage more likely and to improve implementation. Among other milestones, the transformative power of this group's involvement is clear in the passage of the Americans with Disabilities Act. Historically, people with disabilities had been marginalized, and their opportunities to contribute to their communities were minimized. However, people with disabilities changed public discourse. Claims for policy changes were no longer permeated by a deficits view; instead, they persuasively asserted that many people with disabilities could make significant contributions if accommodations to facilitate full participation were made. Needs were recast, a new positive view was constructed, and claims for assistance focused more on their strengths.

In attempting to take lessons from this powerful movement, there are additional challenges for some groups social workers seek to help. Although people with disabilities continue to suffer high rates of discrimination, they have traditionally been seen as more "worthy" of help than groups such as people who are homeless, individuals with mental illness, and immigrants. For these clients, social workers need to continue to reframe the negative views propagated in the media and ensconced in many policies, to instead emphasize strengths, the ways structural barriers have impeded clients, and how strengths-based policies could help. Crucially, this work can be done most effectively in accordance with strengths-based policy practice principles, as partnering with affected populations will, itself, help to counter a deficit view of their lives. Among the most potent examples of this work, today is the 'Dreamer' movement, led by immigrant youth and supported by social workers and other allies. Immigrant youth chose to employ language that explicitly connects their aspirations to the policies that would make them more possible. They also led efforts to change how media outlets talk about immigrants, took control of the strategies used to advance their aims, and selected policy targets that build on a presumption of capacity and promise. Similarly, social workers can join with clients and colleagues to change public conversations, reject deficit-centric language, and publicize stories that create a fuller understanding of the strengths as well as the needs of these groups.

Helping the public and policymakers see our clients as people capable of contributing to policymaking begins with social workers committing to practicing in a way that demonstrates that truth, every day. Social service agencies can be laboratories for experimenting with how best to integrate client perspectives into agency policies; in the process, this work can highlight the advantages of doing so. Some social work agencies have made tremendous strides in rethinking governance bodies so that clients are more equitably included in shaping policies. Community mental health centers and others have been leaders in innovating and resourcing peer models that position clients to not only provide direct services but also inform and help revise agency procedures. Many advocacy organizations have developed creative channels to help clients participate more fully in the policymaking process. For example, practitioners are experimenting with ways to use online fora, social media, and crowdsourcing approaches to increase the involvement of the groups

most impacted by proposed policies. When they incorporate clients' perspectives into shaping both the process by which policies are developed and changed and the intended aim of a given policy effort, these activities evidence the strengths perspective in policy practice. Scholars interested in the fuller conceptual development of strengths-based policy practice need to encourage this experimentation and collaborate closely with agencies so that lessons learned can be incorporated into the conceptual base and disseminated to those interested in implementing a more strengths-based policy practice approach.

Practice that incorporates a growing understanding of Trauma-Informed Care also holds promise in improving policies and programs to help our clients. This understanding has helped policymakers move from a characterological lens of human behavior to one that recognizes the impact of early and traumatic experiences. This has strengthened recognition of the importance of early childhood prevention programs and family support. However, as Leitch has pointed out, incorporating trauma-informed perspectives can result in overemphasis on negative events and neglect of positive protective factors (Leitch, 2017). Although not intentional, centering on trauma can foster a single-point focus that allows problems to again take center stage. However, no matter how vulnerable a person, family, or community is, they also have strengths and goals. It is crucial that individual and community assets receive adequate attention as policies and programs to address trauma are developed. To depathologize problematic behaviors and provide strengths-based supports for people who have experienced trauma, we must reassert the importance of a values-committed approach to policies, practices, and programs.

Our critique of a trauma orientation finds that insights it offers are important and necessary, but insufficient. An additional strengths lens is needed. Similarly, in many cases, the most positive benefits may accrue when the strengths approach is used along with other approaches such as empowerment, and with other lenses such as those designed to focus on issues of diversity. Indeed, cultural differences can influence the very definition of strengths, ways they can be supported, and how to best help groups participate in policymaking. Analysis of these influences can help social work policy practitioners attend to how a policy can be strengths-based for one group but not for another. A stark historical example is the Homestead Act, which was strengths-based for predominantly white settlers but decimated the resources of Native Americans and further fueled the wide racial wealth gap. Finally, combining strengths approach tenets with theoretical approaches such as conflict theory may help us to better prepare our clients for more effective involvement in today's policymaking arena.

Research needs to be designed to test the efficacy of a strengths-based approach to policy practice, in comparison to other approaches. Further, critical elements present in successful policies but not in unsuccessful ones should be identified to determine if the successful ones are more likely to reflect strengths-based principles. However, it may be that the best option for social work policy practitioners

is to view the strengths-based framework as a critical means of analysis that centers on values foundational to social work, rather than as the sole measure of a policy's success or failure.

CONCLUSION

Robust conceptual underpinnings can be used to foster more widespread adoption of the strengths approach to policy practice—in pursuit of better outcomes for clients. Today, when whole communities are pathologized and marginalized, there is great need for a values-committed policy orientation that emphasizes social justice and respect for all people. Social workers must insist that understanding the strengths and goals of our clients is integral to crafting effective policy. Problems must not be allowed to crowd out the indispensable focus on resilience, strengths, and goals. By centering the experiences of those often overlooked and underrecognized, policy practice rooted in the strengths perspective can contribute to changing the political landscape. As was true at the naming of the strengths perspective 30 years ago, in a year that also saw the Exxon-Valdez oil spill, the height of the HIV epidemic, and historic realignment in Europe, we should not allow turbulent times to slow our work.

In our view, shaped by our own values and biases, the promotion of strengths-based policy practice offers a potential antidote to the emphasis on deficits permeating many current policy debates. As posited in relation to the strengths approach more generally, the growth and development of this approach to policy practice depend on many factors (Rapp, Saleebey, & Sullivan, 2005). There must be further conceptual development informed by the experiences of clients and practitioners who are attempting to implement strengths-based policy principles. There needs to be research into the comparative effectiveness of policy initiatives rooted in the strengths approach and wider dissemination and acceptance of strengths principles in pedagogical and policymaking circles. These elements are interdependent; progress in each will be shaped in large part by progress in the others. We have seen the positive impact that strengths-based policies can have on clients, communities, and practitioners. Initiatives to increase the use of the strength approach in policy practice are well worth the effort.

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Strengths Perspective in Critical Macro Practice: Tentative Guidance for Transformative Strengths-Based Policy, Organizational, and Community Practice

Jason M. Sawyer & D. Crystal Coles

INTRODUCTION

This chapter aims to expand both theorizing and application of strengths perspective in policy, organizational, and community contexts across inter-professional settings in human services. It begins with a brief overview of the history of strengths perspective and its pivotal influence on social work, human services, community psychology, community development, and other disciples. It goes on to bring to light traditionally dominant policy, organization, and community practice foundations within interdisciplinary human service practice. By highlighting these historically situated and presently reinforced rational, bureaucratic, and linear approaches; it argues for intentional integration of strengths perspective into macro practice environments. Aligned with early scholars and practitioners that use critical perspectives as a foundation for the development of strengths perspective, and who assert its practical efficacy in numerous direct practice settings, it affirms broadening strengths perspective to policy, organizational, and community settings.

In the interest of clarity, throughout the chapter, we use the term macro practice to describe human service activities within policy, organizational, and community settings (Reisch, 2017). Additionally, following the lead of other scholars in establishing critical community practice (Butcher, Banks, Henderson, & Robertson, 2007; Evans, 2015), many terms we conceive, such as *critical strengths-based practice, critical macro practice, critical policy practice,* and *critical organizational practice*. These

terms, defined in further sections, differentiate these approaches from their more traditional, rational, and incremental counterparts.

Beginning with a brief historical overview of strengths perspective, authors define *critical strengths perspective,* detail essential elements of *critical macro practice*, and provide examples of these distinct approaches in practice. The piece offers a critical lens to frame strengths perspective in macro contexts and demonstrates ways in which it can be applied in multiple policies, community, and organizational settings. Concluding with a set of tentative guides and considerations for *critical strengths-based practice*, such as prefigurative practices, humanization, intersectionality, democratic practice, and critical consciousness; we hope it offers tools, opens dialogue among practitioners and scholars, encourages active scholarship in this area, and spurs the necessary flourishing of truly transformative *critical strengths-based practice*.

STRENGTHS PERSPECTIVE: A BRIEF OVERVIEW

Strengths perspective originated thirty years ago as a response to the increased labeling, deficit and pathology have driven approaches to social work practice. Established as a fundamental departure from the conventional practice perspectives dominating contemporary social work history, it called for a shift from a focus on problems, disease, and pathology to capacities, resiliency, resources, and potentials (Blundo, 2009; Saleebey, 1992). Strengths perspective sought to place focus on equal partnership, agency, and resiliency of individuals and communities in which social workers serve to privilege human development over pathology (Blundo, 2009). It ushered in hosts of applied approaches across various closely aligned disciplines, such as social work, clinical psychology, community psychology, community development, and mental health (Willets, Asker, Carrard, & Winterford, 2014; McKammon, 2012; Maton, 2008; Oko, 2006). Depending upon context, each of these approaches emerged based on their own disciplinary needs and challenges. Even within social work, strengths-based practices differed based on typology, mode, or area of practice, but numerous scholars and practitioners continue to develop strengths-based approaches across disciplines (Saleebey, 2013).

Given its emphasis, the strengths perspective's most vital advances fell within direct, clinical, and individual practice. Pivotal contributions have been made over time in the areas of mental health, case management, criminal justice, gerontology, and family practice (Anderson, Cowger, & Snively, 2009; Weik, Kreider, & Chamberlain, 2009). Using narrative and constructionist approaches, practitioners developed ways to honor people's inherent capabilities through their unique storied experiences promoting social justice, liberation, and empowerment (Walsh, 2013; Epston, & White, 1990). Systems-level change undergirded by a strengths perspective, although emphasized and theorized over time, proved a more elusive challenge (Gray, 2018; Willets, Asker, Carrad, & Winterford, 2014).

Many of the same economic, political, and social factors affecting individual and group level work influence practice in policy, organizational, and community contexts. At this pivotal point in contemporary history, more concrete guidelines are needed at the macro level that collectively empower, liberate, transform, and de-pathologize. Further theorizing through the lens of strengths perspective across macro practice contexts in policy, organizational, and community practice settings can serve multiple functions.

Dominant Policy, Organizational, and Community Practice Approaches

Policy Practice: Reformative Approaches

Policy practice combines policy development, policy implementation, and policy advocacy in organizations, legislative bodies, and social institutions (Jansson, 2019). Historically, dominant policy development, planning, and advocacy centers on rational approaches to change based on a set of predetermined outcomes (Netting, Kettner, McMurtry, & Thomas, 2017). Pyles (2009) reinforces this notion in her definition of policy planning as "technical processes for addressing social welfare issues through public policies and programs" (p. 59). Scholars generally defined it as set data-based analytic strategies to achieve prearranged goals (O'Connor, & Netting, 2011).

In our current historical moment, policy practice within organizations, legislative bodies, and institutions continues to reinforce existing social structures and hierarchical institutional arrangements. Linear reasoning, pragmatism, and incremental reform dominate practice settings devoted to policy design, development, implementation, and advocacy. Change based on expert-driven problem formulation and paternal problem solving govern reformative policy practice approaches emphasizing slow changes that slightly adapt already existing systems often assumed to be socially just (Karger, & Stoescz, 2018; Netting, & O'Connor, 2011).

Organizational Practice: Rational Bureaucracy, Neo-liberalism, and Privatization

Traditional organizational practice, along with a rapidly increasing litany of businesses, professions, and institutions from the pharmaceutical industry to the human service industry, produce very large profits by presenting the public with problems related to the human condition. This assures the public that we are in the clutches of any number of possible emotional, physical, or behavioral ailments (Saleebey, 2013). Privatization refers to shifting the burden of social welfare, human services, and human development to private, for-profit entities (Karger, & Stoescz, 2018). Rapid organizational transitions to privatization fundamentally affect organizational practice (Freundlich & Gerstenzang, 2003; Meezan & McBeath, 2003). These often problematically impact organizational structure and practice of non-governmental organizations (both non-profit and for-profit types) that interface with government policy at federal, state, and local levels. Community development, mental health, foster care, therapy, and various other human service industries are a thriving busi-

ness, due to the recent decades-long privatization wave driven by managerialism, neoliberalism, and a shrinking social safety net (Block, & McKnight, 2012; Mosely & Ros, 2011).

Multiple scholars discuss the neo-liberal, administrative, and rational bureaucratic dynamics dominating our current helping systems (Reisch, 2013). From this perspective, privatization allows for the facilitation of management in a large, complex system in order to increase productivity (O'Connor & Netting, 2009; Paulson, et al., 2002). Rational bureaucracy, driven by business practices of early 20th-century modernity, based on predictive management, administrative control, linearity, hierarchy, and worker alienation, perpetuates the notion of the individual as deficient and the source of social problems. These practices dominate and pervade our social systems via accrediting bodies, universities, social welfare institutions, and the broader political economy (Preston, & Aslett, 2014; O'Connor, & Netting, 2009; Weber, 1922).

Community Practice: The Business of Community Development

Community practice encapsulates community development, community planning, and community action (Weil, Reisch, & Ohmer, 2013). Neoliberalism applies capitalist logics, free-market principles, and consumerism to community and organizational practice in social work, education, community development, and various other human service professions (Casey, 2016; Reisch, 2013). Due to the neoliberal drift, the interdisciplinary nature of the field, and a host of other social and economic factors, dominant community practice approaches emphasize the accumulation of community wealth, target community capital, fuel public and private partnerships, and privilege the use of rational economic principles (Chapple, 2015). These historic currents run throughout the field and remain the dominant ideological institutional practices that combine instrumental rationality, market-driven principles, hierarchy, accountability, political neutrality, and bureaucratic management principles to address problematized community conditions (Weber, 2015; Gamble, & Weil, 2010; Weil, & Gamble, 1995; Udy, 1959). Fursova (2018) conceptualizes this phenomenon as, "the business of community development" (p. 119).

Community development professionals responded by applying strengths perspective to work in neighborhoods with the influence of Asset Based Community Development (ABCD). The ABCD model primarily centered on mobilizing the gifts, talents, and resources of community residents to address community held concerns and aligned with the core principles of strengths perspective (Saleebey, 2013; Kretzman, & McKnight, 1993). Methods within this strengths-based practice model included collaboratively developing comprehensive asset inventories of residents' gifts, resources, and talents, asset mapping of community strengths, and deep level relationship building (Block, & McKnight, 2012). Appreciative inquiry also emerged as a practice method within communities around this time. It emphasized community participation; community-based knowledge as expertise and affirmed resourcefulness of community members (Bellinger, & Elliot, 2011).

Community practitioners in the fields of social work, community development, and community psychology became influenced by these practices, and began utilizing, evaluating, and adapting them over the past few decades with mixed results (Che, 2018; Guo, & Tsui, 2010; Maton, 2008). Originally conceptualized, designed, and developed as a practice model grounded in a critical perspective, ABCD in particular, rapidly became coopted over the last twenty years by market-driven community development corporations, bureaucracy, and social entrepreneurship discourse and practices (Block, 2018). As a result, many community development and community practice scholars offered scathing critiques of ABCD, due to its drift towards neo-liberal orientation, reformative bent, its current spotlight on incremental neighborhood maintenance, and strengths perspective's "uncritical adoption" of community development theory (Gray, 2018 p. 8; McCleod, & Emejulu, 2014).

CRITICAL STRENGTHS PERSPECTIVE

Given the emancipatory nature and intent of the strengths perspective, how can existing strengths-based approaches inform transformational systems level change? How might current strengths-based approaches be adapted to address macro-level practice in policy, organizational, and community settings? Is a strengths-based perspective truly critical in its orientation? Up until this point, strengths-based approaches predominantly emphasize transformative change at the personal or direct level (Saleebey, 2013; Anderson, et al, 2009); however, critical perspectives offer insight into these challenges and serve as scaffolding from which to move toward much-needed guiding practices for critical strengths-based macro practice. The strengths perspective utilizes critical perspectives in facilitating transformational change at the individual, direct, micro-level (Saleebey, 2009), but how can critical perspectives influence the expansion of applied strengths perspective in macro practice? Authors hope to offer guides to how the strengths perspective combined with critical perspectives may spur structural change.

Critical Perspective

Cited repeatedly throughout the strengths perspective literature, the critical perspective incorporates both radical structural and transformative individual change (Saleebey, 2013; Anderson, et al, 2009; Blundo, 2009; Saleebey, 2009; Saleebey, 1996). We use the term critical perspective to describe the numerous theories, standpoints, and world-views that derive from the mid-20th century to early 21st-century social thought emphasizing oppression, power, hegemony, and dominance embedded within knowledge and social systems. Critical theorists generally view social change as systemic, radical, and transformational as opposed to incremental (Mulally, & Dupre, 2018). Critical perspectives root in classical Marxism, neo-Marxism, conflict theory, and promote the elimination of oppressive structures (Marx, & Engels, 1967). The myriad theories within the critical perspective encompass critical theory, critical race theory, intersectionality, radical feminism, black feminism, democratic socialism, and others (Kaufman, 2016; Harrington, 2011; Bell, 1995; Crenshaw, 1989). What authors propose as *critical macro practice* integrates

those critical theories above that accentuate transformational social systems change to apply them across the dimensions of policy, organizations, and communities.

Critical Macro Practice: Policy, Organization, and Community

Aligned with the holistic definition of the special commission to advance macro practice in social work, macro practice integrates structural dimensions of policy, organizations, and communities within human service systems (Reisch, 2017). *Critical macro practice's* foundation rests on the tenants of critical perspectives through its orientation toward transformative structural change of systems and use of critical theories and approaches as guides. It eschews the conventional administrative traditions currently dominating organizational practice within human service systems (Brady, Sawyer, & Perkins, 2019). As an instrument, it integrates policy, community, and organizational practices within its applied theorizing in order move toward more socially just helping systems that challenge oppressive patterns, promote agency, ensure democratic practices, apply intersectional approaches, underscore a commitment to human rights, value relationships, and prefigure practice structures grounded in relationship (Smucker, 2017; Casey, 2016).

Echoing earlier themes, policy, community, and organizational practice settings are dominated by rational administrative managerial perspectives that value incremental change, and maintenance of a status quo oriented social order (Brady, Schoeneman, & Sawyer, 2014; O'Connor, & Netting, 2011; O'Connor, & Netting, 2009). Privatization, welfare reform, deregulation in various sectors of the political economy, and the rise of neo-liberalism in the last twenty-five years pervade organizations and institutions across multiple human service disciplines. This gives rise to contract services, social entrepreneurship, and the use of capitalist oriented, free market-based principles driving community development, social work, and human services as the dominant ideological institutional practice (Karger, & Stoescz, 2018). Services derived from these frames include financial literacy, community wealth building, and various workforce development programs (Kenny, 2019; Fursova, 2018). These dynamics reinforce people as clients, consumers, deficient sources of profit, in need of services to thrive (Day, & Scheile, 2013). Block and McKnight (2012) analyze this phenomenon as the market creating needs to maximize profit, and caution against the non-profit industrial complex of professionals ever providing communities with services to solve their problems. *Critical policy practice* serves as a mechanism for change that can build agency among people and partnerships among citizens and policymakers.

Critical Policy Practice

Policy practice encapsulates policy analysis, policy advocacy, and policy development within organizations, institutions, and legislative bodies (Jansson, 2018). Policy practice activities target specific goals related to the formal consistent ordering of human affairs (Karger, & Stoescz, 2018). Due to the paradoxical use of policy as a mechanism to perpetuate both oppression and human rights, policy practice can complicate the relationship between transformative liberation and oppression.

Examples include numerous human rights conventions and civil rights laws implemented alongside historically repressive segregationist policies across various social sectors (Day, & Scheile, 2013). These prevalent contradictions complexly shape institutional and organizational behavior within helping systems in the United States context.

Using critical perspective as a standpoint, *critical policy practice* involves moving from a reformative, incremental change orientation to a focus on power, oppression, economics, and human rights. Although it emphasizes the components of policy development, policy analysis, and policy advocacy, it centers on social policy as a tool for collective transformation, liberation, and empowerment. Whereas mainstream, bureaucratically dominated policy practice focuses on linear, rational, reformative change, *critical policy practice* centers systems-level change in policy advocacy, policy analysis, and policy development. Activities within *critical policy practice* are guided by the question, how specifically can policy be used as a tool to liberate people from oppressive hegemonic social structures (Spade, 2015; O'Connor, & Netting, 2011)?

Critical policy practice embraces intersectionality, critical race theories and approaches, black feminist thought, critical feminisms, queer theories, Afrocentrism, critical pedagogy, and other anti-oppressive frames to inform policy development, policy implementation, and policy advocacy (Danso, 2015; Hill Collins, 2009; Butler, 2006; Freire, 1970). These theories and approaches directly underscore the knowledge base, development, and application of *critical policy practice*. Examples span the work of Scheile (2011; 2000) in integrating Afrocentrism into policy analysis and advocacy; the works of Spade (2015), Beam (2018), and Adler (2018) incorporating queer theory into *critical policy practice*; and Bell (1995), Crenshaw (1989), and Hooks (2003) stressing intersectional black feminism and critical race informed policy development and advocacy.

Applied *critical strengths perspective* in policy practice. *Critical policy practice* within a strengths perspective is applied at three levels: policy development, policy analysis, and policy advocacy. *Critical policy development* involves actively engaging people directly in formulating solutions to issues that directly affect them. *Critical policy analysis* orients itself toward what formalized order needs to change in order to create a more equitable, socially just, and fair society with attention to power, oppression, and liberation from oppressive structures. *Critical policy advocacy* moves beyond incremental, reformative change strategies, and pushes for policy solutions that demand liberating, empowering, and equitable institutional arrangements that equalize power.

Various approaches to *critical strengths-based policy practice* presently involve citizen collaboration as a mechanism to demonstrate innovative and inclusive ways of shifting power from politicians typically situated at a distance from the social problems of constituents. Also grounded in critical consciousness, dialogue, and

people as agents in shaping their own world (Casey, 2016; Freire, 1998). At the *critical policy development stage*, two prevalent approaches, participatory budgeting and legislative theatre demonstrate how citizens can be involved directly in the issues affecting them and how policy practitioners can build power among people to propose and enact emancipatory policy development and decision making. Both derived within the global south, provide guides to equalize democratic power within localities (Boal, 1998; Ganuza, & Biacocchi, 2012: Shah, 2007).

Exemplifying *critical policy practice,* participatory budgeting applies democratic practices to public budgets allowing community members decision making power. Its practical stages encompass an inclusive partnership among community members and policymakers. Stage one involves a partnership of representative community members and local government officials who design an inclusive process that meets the needs of the community. The second and third stages center on brainstorming ideas and developing proposals based on existing community conditions through numerous gatherings. Once budget proposals are formally developed, the community votes (Ganuza, & Biacocchi, 2012; Shah, 2007).

Similar to participatory budgeting, legislative theatre works in partnership with communities, legislators, and officials to shape policy directly affecting communities. Although much more emergent than participatory budgeting, it involves a community or set of communities using applied popular theatre techniques to create images, facilitate interactive dialogue, and build extensive summaries of social problems to develop local policy. These techniques breakdown the traditional performer-audience power dynamic, and lessen the distance between legislators and community members. Community members gain a voice and legislators gain new insight into local problems from those directly affected as they experience community problems enacted (Boal, 1979; Boal 1998).

Democratizing practices that view citizens as people with agency runs as a prominent theme throughout *critical policy practice*. Both of these methods blend aspects of all three dimensions of *critical policy practice* and build agency in people typically marginalized by hierarchical bureaucratic systems masquerading as democracy. With an emphasis on active collaborative engagement, empowerment and liberation, and critical consciousness, these three levels of policy practice demonstrate the applicability of the critical strengths perspective in policy practice.

Critical Organization Practice

Critical organization practice contests the rationally dominated orientation of traditional organizations grounded in bureaucracy, linear structure, predictive outcomes, managerialism, and control. *Critical organization practice* generally takes place within social change organizations, yet takes on various organizational structures. The many activities, values, and assumptions undergirding *critical organization practice* stress how to change power dynamics, upset traditional hierarchical organizational structures, and call attention to systemic patterns of oppression both within the

organization and towards the targets of change (Netting, & O'Connor, 2009).

Furman and Gibelman (2013) use the term feminist organizations to describe human service organizations based on relational values, less hierarchical structures, inclusion, and value process over outcomes. O'Connor and Netting (2009) use the term social change organizations as those with missions, "grounded in advocacy, social action, empowerment, and change" (p.183). Social change organizations also assume that organizations remain imbued with the same influential oppressive tendencies as the systems in which they target to change. Critical organizational structure pays close attention to the need to move away from domination, labeling, control, and hierarchies that open the door to oppression within organizational practice and organizational functioning. Using influences from social movements, *critical organizational practice* seeks to mobilize people for structural change moving from false consciousness to more critical truth consciousness (O'Connor, & Netting, 2009; Freire, 1970) within the organization and facilitated through service delivery.

Applied *critical strengths perspective* in organizational practice. Within the context of a *critical strengths perspective*, organizational practice can be transitioned to integrating the traditional organizational model with the critical approach. For example, in traditional organizations, bureaucratic organizations are rooted in patterned behaviors clearly defined by hierarchy, spheres of competence, and rule of procedures outlined for rational coordination of activities (Weber, 1922). Within a critical strengths application, those attributes would be shifted to utilizing dialogue and collaboration (Saleebey, 2002) within the organization between workers and administration. This provides opportunities for worker inclusivity which assures that the organizational focus on human service delivery is met through efficiency and effectiveness metrics determined collectively within the organization. In this way, organizations become more than variables to manipulate in order to address human behavior; thus, workers and the organization represent mutual, interactive influences in which people become shaped by the organization and the organization is shaped by the workers in its boundaries. This theoretical integration provides an opportunity for the ability to have an emphasis on social and cultural needs of the workers within an organization, as well as the economic needs of organizational operations. Within this *critical strengths-based approach* to organizational practice, humanness of organizational members, democratic organizational relations, prefigurative practices, and the need to understand organizational decision-making are placed at the forefront of organizational operations.

Critical Community Practice

Critical community practice proposes a political orientation for practitioners across human service disciplines that advocates social justice, equity, and solidarity (Evans, Kivell, Haarlammert, Malhotra, & Rosen, 2014). The role of the critical community practitioner is to be an agent of social change through mobilization. It is, "action based on critical theorizing, reflection, and clear commitment to working for social justice through empowering and transformative practice" (Henderson, 2007 p.

1). Critical community practice "seeks to transform unjust systems that arise from inequalities perpetuated by dominant groups" (Brady, Schoeneman, & Sawyer 2014 p. 36). Critical community practice accepts conflict as a part of the social change process and embraces social justice, social action, and social change through critical praxis (Mullaly, & Dupre, 2018; Butcher, Banks, Henderson, & Robertson, 2007). Critical community practice centers on transforming structural systems of oppression to more liberating socially just arrangements (Brady, Schoeneman, & Sawyer, 2014).

Various theories and perspectives influence critical community practice stemming from Marxism, critical theory, radical feminisms, intersectional feminisms, black feminisms, critical pedagogy, anti-racism, and anti-oppression (Kaufman, 2016; Danso, 2015; Hill Collins, 2001; Freire, 1970). Aligned with a strengths perspective, it envisions new potentials, innovative possibilities, and different systems that emphasize liberation from oppressive structures (Thomas, O'Connor, & Netting 2011; Reisch, 2005). Many of the characteristics of these envisioned social arrangements encompass wholly new ways of conceiving, prefiguring, developing, and actualizing participatory democratic practice within societies and communities (Smucker, 2017; Bronkema, & Butler Flora, 2015; Scully, & Diebel, 2015).

Applied *critical strengths perspective* in community practice. Influenced by multiple scholars and practitioners that include the seminal work of Horton and colleagues (1990), Saul Alinsky (1971), Freire (1970), and various social movements throughout history, critical community practice mobilizes people for social change using various applied strategies (Tilly, & Wood, 2016). Direct action, social action, popular education, collective empowerment, prefigurative organizing, and social movement building fall within the lexicon of critical community practice models and approaches (Izlar 2019; Chambers, 2018; Pyles, 2013; Graeber, 2009; Horton, Kohl, & Kohl, 1990; Freire, 1970). Direct action uses symbolic, violent, and/or non-violent confrontational tactics intentionally disrupting targets through the practice of mobilized demonstrations of power (Kaufman, 2016; Graeber, 2009). Social Action, closely aligned with direct action integrates advocacy alongside the use of direct action approaches (Gamble, & Weil, 2010). Popular education undergirded by critical pedagogy is based on consciousness-raising and collective knowledge grounded on the experiences of people living under oppressive systems. Applied differently dependent upon context, popular education centers knowledge in the people based on knowledge development, action, and reflection at the intersection of theory and practice (Freire, 1970; Horton, et. al, 1990). Informed by multiple feminist perspectives, popular education, and critical pedagogy, empowerment is a transformative process co-constructed through the practice of dialogue and action (Lee, 2001). Currently and throughout its history, it greatly informs collective work within critical community practice (Bengle, & Sorensen, 2017; Kaufman, 2016; Saleebey, 2013). Its aim is to reduce powerlessness, remove stigma, and eliminate direct and indirect power blocks (Solomon, 1976). It is both an individual and collective phenomenon geared toward the development of critical consciousness and mobilizing for collective action toward an overarching goal of a socially just society (Gutiérrez, & Lewis,

1994; Lee, 2001). Critical feminist community practice also offers ways of organizing an emphasizing process, organizational structure, and methods that mirror social arrangements in which practitioners hope to actualize. Known as prefigurative organizing, these practices hold organizations and community initiatives accountable to begin within themselves in representing these changes internally within organizations and in their activities (Izhar, 2019; Smucker, 2017).

STRENGTHS PERSPECTIVE IN CRITICAL MACRO PRACTICE: TENTATIVE GUIDANCE AND CONSIDERATIONS

In offering the tentative guides below, we build on the analysis of *critical macro practice* and strengths perspective above in order to intentionally link the two in ways that can be applied in macro practice settings. Similar practices within each dimension of *critical macro practice* can aid students and practitioners in developing tools within their contexts in order to cultivate *critical strengths perspective* in macro environments. Overriding principles involve humanization and intersectionality; critical consciousness; inclusivity and democratic practice; and prefigurative practices (Casey, 2016; Crenshaw, 1991; Smucker, 2017).

Humanization and Intersectionality

Humanization, respect, and love for people underpin both strengths and critical perspectives (Casey, 2016; Freire, 1970). Vital to the work in which critical macro practitioners engage remains an underlying recognition of human rights, dignity, and the worth of people. Not only do organizations and communities consist of people, but policies also shape people's experiences, behavior, and access. Policy practice organizations, social change organizations, and critical community initiatives, all comprise and impact people. Humanization also closely connects to intersectional literacy in an increasingly diverse world. Rather than viewing differences and identity as unitary, static, and unidimensional, it accounts for the dynamic complexities of race, socio-economic status, gender, and various other identities that shape experience (Crenshaw, 1991). At the root of humanization lies the assumption of agency. People have the power to shape their own destiny. The *critical strengths-based practitioner*'s role is to co-create spaces that account for differences, unique backgrounds, and the complexity of identities to actualize potentials and possibilities.

Critical Consciousness and Practicing Democracy

Critical consciousness is a process wherein people apply critical analytical skills to examine social reality, and design, implement and evaluate activities to changes those existing realities (Freire, 1970). Its development contests traditional banking models of knowledge development as oppressive. Based on the experience of the learners, dialogue, and building collective knowledge, developing critical consciousness privileges the inherent knowledge learners (Freire, 1998). It fosters inclusivity and democratizes learning spaces by acknowledging the inherent value, worth, and agency of people. Respecting all learning as partial and incomplete, it contests abso-

lute knowledge and recognizes intrinsic awareness of people as agents to interpret and shape their environment through dialogue and democratic practice (Casey, 2016; Kumashiro, 2009).

Within policy, community, and organizational practice, as highlighted earlier, strengths perspective in *critical macro practice* acknowledges the fundamental worth of people working in macro contexts (Blundo, 2009). Honoring critical consciousness as democratizing knowledge and action through dialogue translates to strengths-based critical macro practice in a variety of ways. Worker inclusivity exemplifies principles valuing critical consciousness, democratic practice, and building collective understanding (Saleebey, 2002). Workers, community members, and those directly affected by the effects of policy design, development, and advocacy can drive practice contexts within critical macro practice upending traditional hierarchies of power. This dynamic must be cultivated, and banking models of organizational practice that assume professional leaders as experts in organizations and institutions cannot create critical consciousness for expediency's sake (Freire, 1998). Organizational structure must support and align with the development of critical consciousness. According to scholars of critical pedagogy, active critical consciousness must be self-appropriated (Casey, 2016); however, through inclusivity, dialogue, and democratic practice, organizational leaders can act as facilitators and co-learners in *critical macro practice* spaces to foster values, structure, activities necessary for developing collective critical consciousness. Organizations and communities can intentionally appropriate environments fostering critical consciousness.

Prefigurative Practice

Critical perspectives are not preparation for revolutionary changes to policy, community, and organizational systems. They are a means to abolish oppressive systems of power within our human service systems. Strengths based *critical macro practice* acknowledges that through mobilizing the talents, gifts, capacities, and resources of people, new systemic realities are possible (Block, & McKnight, 2012; Saleeby, 2002). In this way, *critical macro practice* can move from a way of doing to a way of being. Smucker (2017) discusses prefigurative practice not as a method of prescribing how new just realities may look, but by foreshadowing these values, principles, and activities of newly just realities within policy, community, and organizational settings. Prefigurative practices call upon *critical macro practitioners* to embody the systemic vision of a just society within their change initiatives within their organizations, their structures, and their everyday lives (Izlar, 2019). This fundamentally reshapes practice in new ways by embodying new visions of society that seek to formulate new ways of structuring social life in policy, community, organization, and society (Carey, 2016; Mulally, & Dupre, 2018; Smucker, 2017).

CONCLUSION

If the last 30 years has taught the profession of social work anything, it is that the strengths perspective works and is highly effective. From the standpoint of micro

social work practice, having an emphasis on client strengths and resources through the lens of service provision has promoted client success and resiliency. However, shifting the profession's focus on using the strengths perspective within a micro practice context, de-emphasized the utilization of the perspective within policy, organization, and community practice. The strengths perspective is rooted in empowerment, liberation, dialogue and collaborative elements *alongside* its emphasis on client resiliency and strengths; thus, indicating its foundational grounding in a critical perspective and inherent connection to macro practice.

The strengths perspective has become pervasive in its usage and application in micro practice; however, its ability to remain sustained within the context of societal manifestations of change depends on its interconnection with critical perspectives. The complexities of policy, organization, and community practice as a space within social work increasingly requires a critical lens. Societal circumstances forcefully necessitate social workers' abilities to detangle complexity at levels of micro and macro practice; however, ensuring that this practice capacity is rooted not only in a critical lens, but one that is strengths-based will protect the profession from transitioning into oppressive and deficit focused practices.

Using a *critical strengths perspective* in social work practice provides the opportunity for social workers to assess policy, organizational, and community practice using activities that promote collaborative dialogue, the undergirding of liberation and empowerment, and the foundational belief that every practice sector must originate within the context of strengths perspective. This merging of critical and strengths perspectives challenges traditional understandings of the role of a social worker and offers guidance for addressing power, privilege, orientation, and impacts of social work practice. A *critical strengths perspective* presents a necessary framework to integrate and evaluate policy, organization, and community practice, thereby maximizing the possibility of *truly* socially just systems to help actualize a socially just society.

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Tracing the Impact of the Strengths Perspective: A Personal Narrative

Cynthia A. Lietz

The development of the Strengths Perspective represented a profound paradigm shift in the field of social work. Thirty years since its inception, the impact of this framework on social work practice and policy is undeniable. Although some might claim that some of the ideas associated with this perspective might seem simple, this shift in the underlying assumptions that undergird the field has been profound. I myself am about to celebrate 30 years in social work, first as a student, then a practitioner, and later, an academic. In this chapter, I will use my personal narrative to illustrate the ways this perspective impacted not just my own work and approach to social work practice, but as an indicator of how these ideas have and can continue to define the field moving forward.

SHIFTING SOCIAL WORK'S FOCUS FROM PROBLEMS TO STRENGTHS

I started college at 17 years old with a desire to pursue a career that would allow me to help people. Like many, I chose psychology as my major and was busy taking classes in theory, statistics, and diagnosis of mental health disorders. During my junior year, I experienced a sense of disillusionment about what I was and was not learning. I was lamenting to my psychology faculty advisor one day when I stated, "I am learning a lot about the causes of social problems, but I still do not know what I would say to a person who might be sitting across a desk from me in need of help." Even as early as 20 years old, I was worried about the translation of theory and

research to practice, and I recognized that I would be graduating in a year and could remain ill-prepared for doing the very thing I wanted to do, that was, to help a person in need. My psychology professor heard something specific in that conversation, and he asked me, “Have you ever taken a class in social work?” I responded, “Social work, what’s that?”

I am incredibly grateful to this faculty advisor because this one question ended up driving my professional life in a direction that was exactly where I wanted to go. I took his advice and took an *Introduction to Social Work* course that spring semester. Within just the first few weeks of that course, I came to recognize that social work’s mission and core values resonated with me in a powerful way. It was too late to change my major, so I quickly added a social work minor to my undergraduate studies and then headed off directly to pursue a master’s degree in social work. That was 1991, just two years after the article published by Weick, Rapp, Sullivan, and Kisthardt (1989) and just before the first edition of Saleebey’s seminal text was published in 1992, both advancing a paradigm shift called the Strengths Perspective.

As academics know, the translation of new knowledge to the field is slow, often slower than we would prefer. Because of the timing, neither of these publications nor the ideas promoted within them made their way into the course syllabi or classroom teaching during my graduate-level education in social work. I had a wonderful experience in my MSW program but it is important to note that like all of my peers, I was trained in a problem-centered approach. My coursework focused on assessing, diagnosing, and treating mental health disorders. My research courses taught single-subject design focused on measuring incident rates of symptoms. My practice classes focused on important theoretical frameworks such as family systems theory, person-in-environment, and cognitive behavioral theory, all important contributions to the field, but all were framed in identifying and addressing dysfunction. The idea of asking about a client’s strengths was only lightly mentioned and might be listed on a biopsychosocial assessment, but there was no discussion about using those strengths to guide practice. Strengths seemed to me to be an afterthought. Our focus was solely on problem identification and reduction.

During those first two years, I had two impactful internship experiences working with youth and families involved in the child welfare system. This was hard work, yet, I loved it. This launched a 12-year practice career in two states during which I worked almost exclusively with mandated clients who were involved in the child welfare system and most of whom were also co-involved in the juvenile justice and/or mental health systems. When working with this population, it is true, I saw problems. In fact, I assessed, measured and treated some of the most serious issues we face in social work practice.

During my first year of doing this hard yet important work, something struck me. When reading the referral packets for these clients, I was overwhelmed by the presenting problems that were being described in the intake paperwork. However,

when I met the actual people who were struggling with these problems, and when I came to connect with them as human beings, I realized that most of them were functioning far better than I would have expected considering what they had and were facing. I immediately felt that the problem-centered approach in isolation did not prepare me to fully understand the people with whom I was working. I felt it only told part of the story and in fact, this approach directed me as a young professional to only consider part of the story. I was again left unsatisfied.

Similar to my conversation with my undergraduate faculty advisor, I again found myself lamenting about these concerns to a colleague. Although I did not yet have the language to explain what I was concerned about, when I described this practice conundrum, she suggested that I read the book *The Resilient Self* by Wolin and Wolin (1993). I found that book transformational in that it acknowledged something I was observing in my own practice, that people can indeed overcome even some of life's most difficult challenges. This then set me on a path of trying to think bigger about what is possible for the young people and families with whom I was working. I tripped into some early work on family-centered practice and then finally came across the first edition of Dennis Saleebey's (1992) text *The Strengths Perspective*.

Reading this text had a profound impact on me and influenced every step of my career moving forward. Why was it so powerful? This text spoke directly to what I was observing in practice. Saleebey, Weick, and others did not suggest that people do not have real problems and needs, nor that we should be Pollyanna in our approach to problems and somehow not acknowledge the pain and suffering that flows from loss, poverty, discrimination, and violence. Never would these leaders nor would I take lightly the very real pain experienced by the people we serve in social work. That is a dramatic mischaracterization of the Strengths Perspective that I have spent two decades trying to combat. It is not about avoiding problems or minimizing their impact. It is also not about moving away from a commitment to prevention. Any time we can prevent a child from being hurt by a caregiver, we should do all we can to stop that painful experience. The difference is not about our desire to address very real pain and problems, the pivotal contrast being put forth in the Strengths Perspective remains in *how* we go about addressing these concerns.

Risk-focused research suggests that a person who experiences a high level of cumulative stress faces a higher likelihood of negative outcomes (Fraser, Richman, & Galinsky, 1999). This research is important because it helps inform the field of prevention. If we know that smoking increases the likelihood of cancer, we can educate young people about the dangers of smoking. If we know that facing serious financial stressors increases the likelihood of family conflict and violence, we should do all we can to eradicate poverty. The pioneers who developed the Strengths Perspective were not soft on poverty or child maltreatment. However, if our only mechanism for understanding people, families, and communities is through this lens of risk, what do we then say to clients who are referred to us who already experienced child maltreatment or already experienced poverty? Is our answer, "That's a shame, the

trajectory of your life will now forever be defined by these experiences?" That cannot and should not be our answer. Considering the vast majority of people I served throughout my career fell in that category, that answer leaves very little hope for the population I served. It also leaves very little hope for a young professional who still just wanted to help people.

In his text, Saleebey (1992) discussed how important it is that social workers not put an upper limit on what is possible for the children, adults, families and communities we serve. This is the essence of the fundamental shift in our thinking as practitioners. Yes, we must address the problems being presented head-on. However, we must do so from a perspective of hope. We must not just assess problems, but also the strengths and the protective factors that help children, youth, families and communities overcome the very problems we seek to alleviate. And, we use those internal and external strengths to activate the process of resilience as a way of yes, addressing the problems we are there to address.

I found the ideas associated with a Strengths Perspective simple, and yet profound. They fundamentally shift our mindset and create a tremendous amount of opportunity that was previously not present. These strengths-based practice principles provided me with very real and practical things I could do and say as a social worker to empower the people with whom I worked. I later adapted these ideas into my work as a supervisor and developed Strengths-Based Supervision (SBS; Lietz, 2013) to help supervisors understand their role in advancing strengths-based, family-centered practice principles by modeling these very concepts in supervisory conferences. Ultimately I pursued a PhD and left direct practice to launch a research agenda focused on cultivating the process of resilience for families who were considered high risk for break-up or discord (Lietz, 2007; Lietz & Strength, 2011; Lietz, Julien-Chinn, Geiger, & Piel, 2016). The ideas put forth by Saleebey, Weick and others in the early 1990s undeniably impacted social work practice, research, and teaching for me, and for so many others.

My students often ask me if I left social work practice because I was "burned out." It is a fair question considering the stress associated with direct practice, particularly when working with the population I served. My answer is quite clear, "No, I did not leave practice because I was discouraged about the people I served. I loved to practice and in fact, still miss it." I was, however, at times discouraged about our field. I observed many caring and ethical professionals who were engaging in high-quality practice. However, I far too often also observed practitioners who were not instilling the kind of hope Saleebey called for back in 1992. I moved into teaching and research to advance these very ideas to ensure that all people are treated in a way that honors their cultural identity, uses their strengths to guide the work, is relational, seeks to understand people not defined by a problem they seek to address, and one that instills an undeniable sense of hope.

In this chapter, I will offer three examples of how the Strengths Perspective informed my work as a direct practitioner, later as a supervisor, and finally, as a scholar. My hope is that these examples will provide illustrations of real-world application of the Strengths Perspective. I do find that students and practitioners value these ideals but have difficulty practically translating strengths-based principles into day to day social work practice. My hope is that these examples will offer some practical ways to consider what it really means to fully embrace the idea that believing in one's capacity to grow and change and using a client's past successes and resources is transformational.

RESILIENCY BASED SOCIAL LEARNING

As a result of the work of Saleebey, Weick and others, I can say that my approach to social work practice was fundamentally altered. Early in my career, this impacted my own practice and more specifically, the individual, family, and group counseling that I conducted with youth and their families. I authored an article describing how I integrated a strengths-based approach to the groups that were assigned to me (Lietz, 2007). For example, I was able to launch a group for single parents with a colleague, a group that had traditionally experienced very low engagement. We reimagined this group through a strengths-based lens. For example, we infused the voice of the parents into the decision making about logistics like scheduling but also regarding the topics that would be discussed. Parents were also given ownership over leading the group. Each parent chose a group session, did some light research and was responsible for facilitating one night. This not only incorporated the expertise of the parents into the planning of this group, it also created an opportunity for building confidence and cultivating mutual aid from a group of people with a shared experience. For more information about this and other groups, see Lietz (2006).

As time moved on, the strengths perspective influenced not just my practice, but my oversight of others. As I moved forward in my career, I was promoted to supervisor and then clinical coordinator of one program. This was the first time I had the ability to influence practice beyond just my own. As the clinical coordinator, I was responsible for setting the standards for our program. As I did an initial review of our practice, I realized that we did not have a coherent practice model guiding our work. Each counselor was doing his or her own practice without agreeing upon how we wanted practice to be implemented consistently at our organization. I set forth a plan to bring our team together through a strategic planning process. We made a list of all of the theories and models informing each individual counselor and ultimately pulled that together into a coherent model to drive our work.

The model we created is titled Resiliency Based Social Learning (Lietz, 2004), and describes the work we conducted at a residential treatment program for children and youth aged 6 to 17. Individual and family therapy was an important part of the program. We also led an onsite therapeutic school and because it was a residential program, the young men lived in cottages which included a system of reinforce-

ments to teach and then reward positive behavior. Interventions grounded in social learning theory such as labeling, practicing, reinforcement, and role-plays were all important interventions that occurred before and with greater intention once the practice model was developed. What was new was the addition of resilience as one of the overarching constructs that guided this program.

Resilience is a process of coping and adaptation that occurs over time (Luthar, Cicchetti, & Becker, 2000). It acknowledges that while we all experience loss and difficulty as part of the human experience, people who have a multitude of serious risk factors within a short period of time are considered at high risk for negative outcomes (Fraser, Richman, & Galinsky, 1999). The cumulative effect of risk can increase relationship conflict, mental health symptoms, and poor health outcomes more generally. The young men who were placed in our treatment facility experienced a great deal of stress in their backgrounds that led them to this placement. Taking a problem-centered approach would have involved advancing counseling and programmatic decisions focused solely on the difficulty they brought with them.

The Strengths Perspective was an essential part of reframing this program from one that was focused on risk-only, to one that sought to identify and grow the internal and external strengths needed to activate the process of resilience in these young. To advance this approach, all of the counselors, school teachers, and cottage staff were trained in resilience and social learning theory. The counselors learned how to infuse these theoretical concepts into the individual, family and group counseling sessions. At the end of each school day, the cottage staff held a daily group with the clients to transition from school to cottage. In the past, this had been a negative experience where staff reviewed mistakes from the day and instituted consequences for any poor behavior that occurred during the school day. This happened in front of the peers and increased the likelihood that any negativity that had occurred continued on into the cottage milieu. Once the theory was enhanced by the Strengths Perspective using a resilience framework, each week the daily cottage group was transformed to instead focus on one of the seven resiliency factors: relationships; humor; insight; creativity; initiative, morality, and independence (Wolin & Wolin, 1993). On Monday, the clients learned how to define the term, on Tuesday they would read a story illustrating how someone had used that resiliency factor to overcome a challenge, on Wednesday they discussed how they have used that same skill in the past, on Thursday they discussed how they could use it moving forward and on Friday, they debriefed all of the conversations from that week. In this way, the cottage group was completely reimagined as a result of taking a strengths-based approach. It was used for skill building of protective factors rather than processing negative events of the day. Not only did this shift impact how the clients experienced the group, it also set the tone for how the evening would proceed in the cottage. The skill-building of the protective factors was then brought in the counseling and also often emerged in the language during the school day. This change meant the three units (counseling; school; cottage) were now working according to

a common framework and that framework was grounded in a perspective of hope and a belief in the ability for people to grow and adapt.

Framing all of the work that happened in that residential treatment center in a commonly agreed-upon theoretical approach was important in that it increased the focus and intentionality of this program across multiple different functional areas. Choosing resilience as one of the overarching theoretical constructs meant the approach was inherently strengths-based. The program sought to activate the current internal and external strengths of the clients being served. The psychoeducational groups were conducted to cultivate new strengths by teaching these young people how to build new protective factors that were grounded in research. This was an important development for this program, but, it also had an unintended positive consequence. As the therapists, case managers, teachers, and behavioral health technicians were framing their work with these young men in the strengths perspective, I noticed a shift in the organizational culture and climate. The consistency increased a sense of comradery and teamwork across these disciplines. In addition, the interaction was more hopeful and positive. As the language used with the clients spread throughout the program, so did the language used when communicating with one another, an observation that influenced the next step in my career.

STRENGTHS-BASED SUPERVISION

In addition to overseeing the clinical programming, I was promoted to supervisor and had the opportunity to directly oversee the work of our student interns and practitioners, some of whom were working toward social work licensure. Because I had come to see firsthand the powerful impact of using a strengths perspective in my work with clients, it just seemed natural that this same approach should also inform my supervision. I had learned about the parallel process and the idea that the ways supervisors interact with their direct reports parallel the ways that direct reports interact with the children, youth, and families they serve (Shulman, 2005). I was working at this point in a private agency serving young people involved in the child welfare system, but I started my career as an intern working with children who were placed in foster care by a large public child welfare system. I was watching as child welfare leaders were seeking to advance Family-Centered Practice (FCP), a strengths-based, family-centered approach to ensure the safety, permanency, and well-being of children and youth. Despite working toward adopting a strengths perspective in this practice setting, I was observing the challenge it takes to accomplish organizational culture and climate change in one of the most stressed systems in social work.

Later when I moved from practitioner to faculty member, I was invited to provide training regarding supervision as a result of my experience as a social work supervisor. This process allowed me to develop Strengths-Based Supervision (SBS; Lietz, 2013). SBS was created to increase intentionality around supervision. Many social workers are promoted to be supervisors because they were effective practitioners. Although that is a good start, that does not necessarily mean that they have the

skills necessary to manage a workforce. Historically, there was very little training offered in the process of social work supervision, although more recently, this has changed some. SBS provides language regarding supervisory processes allowing supervisors to move away from what organically emerges, to making intentional decisions about how to conduct the important role of supervision. Grounded in the idea of the parallel process, SBS involves having supervisors model strengths-based, family-centered practice principles in supervision.

What does it mean to model strengths-based practice principles in supervision? Strengths-based practice is empowering and expects the voice of the client or family to inform decision making. To model this practice principle, supervisors would be sure to include the voice of their direct reports in decision making. The strengths perspective is hopeful and believes that coping and adaptation is indeed possible. In this same way, supervisors should approach their direct reports from a position of hope. They should also instill a sense of hope when talking about cases in the process of clinical supervision. Strengths-based practice involves moving away from cookie-cutter case plans and focused on individualizing case plans to fit the personal and cultural preferences of the client. In this same way, supervision should foster creative, critical thinking allowing direct reports to learn how to think outside of the box. Questions regarding a client's culture are important clinical supervisory questions that should help highlight the importance of identity and difference. Finally, modeling a strengths-based approach to supervision means uncovering and utilizing the strengths of each direct report in accomplishing the important work before them. It also means driving the conversation toward one that uses past successes and internal and external resources to accomplish goal progression. The strengths-based practice is collaborative, relational, contextual, creative, and culturally grounded. In the same way, supervisors need to adopt this approach if they are to model the very practice principles they seek in their workforce.

A set of four supervisory components are integrated into SBS (Lietz, 2013) to support the effective implementation of strengths-based, family-centered practice principles. First, supervisors using SBS must be sure to fulfill the three functions of social service supervision: administrative, educational, and support (Kadushin & Harkness, 2014). This first component ensures supportive supervisor/supervisee relationships are formed enabling a supervisor to simultaneously monitor and mentor the workforce.

Second, SBS involves the use of both in-depth and crisis supervision. Practitioners need supervisors to be available in a crisis, but too often, this becomes the sole approach to supervision. When supervision only occurs when there is a crisis, supervisors do not have an opportunity to offer consultation regarding cases that are stuck but not in crisis mode. It also means successes are not recognized or discussed, something that remains in contradiction with taking a strengths-based approach.

Third, SBS involves the use of individual and group supervision modalities. Individual supervisory conferences allow a supervisor to get to know the strengths and goals of each direct report, something that is valuable in advancing FCP. At the same time, group supervision allows a supervisor to leverage the strengths and diversity of the team when addressing complicated cases. Group supervision helps to prompt critical, creative thinking, and it fosters a sense of mutual aid across the team, ideas that are all consistent with the strengths perspective.

Finally, SBS involves modeling strengths-based, family-centered practice principles in supervision. Grounded in this idea of a parallel process, supervisors are asked to develop a supervisory program that remains theoretically coherent to the practice model of the organization. If an agency adopts a practice such as family-group decision making with clients, then supervision should similarly take a team approach to making decisions as professionals. If an organization seeks to instill a sense of hope with its clients, the organizational culture and climate should facilitate this same approach across all units of an organization.

Research suggests the adoption of strengths-based principles has been slow in some settings including child welfare (Michalopoulos, Ahn, Shaw, & O'Connor, 2012; Sandau-Beckler et al., 2002; Smith & Donovan, 2003). Choosing a model of supervision that remains theoretically consistent with the organization's practice model increases the opportunity for practitioners working directly with children, youth, adults, and families to observe and replicate these very practice principles. Taking a problem-centered approach to supervision undermines the ability of an organization to fully adopt the strengths perspective (Cohen, 1999). Adopting a model of supervision such as SBS allows supervisors to not just teach the practice model, but also demonstrate this approach to practice through their interactions with their direct reports.

FAMILY RESILIENCE

As I moved from social work practice to academia, I was excited by the opportunity to influence the field by advancing a practice-oriented research agenda that would address some of the concerns I was observing in the field. As I contemplated how I wanted to spend the next several decades of my career, I reflected back on my practice experience to inform this important decision. It was clear that the Strengths Perspective had a substantial impact on my mindset and approach to practice with children, youth, and families. I appreciated the work by Wolin and Wolin (1993), Werner & Smith (1992), Fraser (2004), Ungar (2008), Luthar and Cichetti (2000), and so many others who provided research regarding the protective factors that are helpful in activating the process of resilience for young people. With that said, as mentioned, I was committed to taking a strengths-based, family-centered approach. That meant that I included family members, biological and/or foster parents in my work with youth whenever possible. Most of my career focused on conducting family therapy, yet the family theories remained very problem-centered. I decided there

was a gap in the literature related to how the construct of resilience can be applied to families at a systems level. Although there was some important early work in this area (McCubbin, McCubbin, & Thompson, 1993; Walsh, 1998), I felt more work was needed to understand how family units cope and adapt despite adversity, particularly in a social work context.

My family resilience research involves utilizing mixed methods designs to identify a sample of families who rate as high risk while also scoring within the healthy range on a standardized assessment tool. Using a narrative approach to data collection, in-depth qualitative interviews are conducted with families who then describe their stories of family resilience. Thematic analysis is used to identify consistencies that emerge across these family narratives. Findings from this research indicate resilience is a process of coping and adaption that occurs over time. As illustrated in the figure below, a model of family resilience emerged from this research which includes five phases and ten protective factors that help units adapt overtime (Lietz, 2007; Lietz & Strength, 2011; Lietz, Julien-Chinn, Geiger, & Piel, 2016). This research will be translated to practice through the creation of a manualized intervention that can be used in social work practice with families who are experiencing a high level of stress or trauma. Understanding how to integrate a strengths perspective to social work with families has important implications when working with families who are grieving, facing trauma, overcoming a history of intergenerational violence, caring for older adults, or facing other types of changes to the family system. Understanding the process and strengths that activate resilience can provide interventions that fit within a broader family-centered practice framework.

The Strengths Perspective has informed the way I look at risk and resilience; these ideas are framed in a perspective of hope. Resilience is a process of coping and adaption that can be cultivated. We cannot and should not put an upper limit on what someone is capable of – instead, we persistently embrace what is possible, passionately communicate a sense of hope, and patiently take one step at a time.

CLOSING THOUGHTS

To say that the work of Saleebey, Weick and others informed my work is an understatement. The Strengths Perspective fundamentally altered how I approached my work as a social work practitioner who worked with youth and families involved in the child welfare system for over ten years. This perspective then shaped how I approached my role as supervisor and manager, allowing me to develop a leadership style that was theoretically consistent with the organization's strengths-based practice model. As I moved forward, I translated these ideas beyond my own practice setting by developing SBS, a model of supervision that has been adopted by over 2,000 supervisors in multiple locations including Arizona, Texas, Idaho, Michigan, and Florida. I adopted a research agenda focused on advancing family-centered practice including the development of a model of family resilience. I currently lead Bridging Success, a campus-based program that seeks to provide access and support in post-secondary education for young people with a history in foster care. Young people who age out of foster care have far lower college attendance and graduation rates than their peers. Because of the influence of the strengths perspective, we are creating solutions to this challenge that are grounded in a resilience framework. Finally, my teaching is fundamentally grounded in a strengths perspective.

This is just one story of a career forever changed by the meaningful contributions of leaders advancing the Strengths Perspective. My story offers an illustration of how powerful ideas shape one's mindset and therefore, the practice approach moving forward. This story also demonstrates the legacy of this work; as my path has changed due to this perspective, so are people who were impacted initially by the strengths-based approach to supervision and more recently, when this approach informs all of those impacted by the teaching and research that followed.

As this text celebrates 30 years of impact by these pioneers, the conversation should turn to how this work can be further developed, fine-tuned, and advanced. At the same time the Strengths Perspective was being advanced, so was an evidence-based approach to practice. I am pleased to see models like Motivational Interviewing (Miller & Rollick, 2012) that can be conducted using strengths-based principles is recognized as an evidence-based approach that assists people with behavior change regarding eating, diet, substance misuse or managing symptoms associated with a health or mental health issue. However, more work is needed to manualize, test, and translate specific strengths-based practices to our list of recognized evidence-based practices in social work. Without more rigorous research, we are at risk of losing the impact of these influential ideas on the field.

Finally, as the medical field is moving toward precision medicine, one that considers and applies evidence-based medical interventions in a way that is personalized to meet each patient's unique make-up and needs, so should social work consider how evidence-based practices are applied contextually and individually. The idea of individualizing practice to meet the personal and cultural preferences of the client is an idea put forth by leaders advancing the Strengths Perspective three decades ago. The precision medicine movement may offer some guidance to social work regarding how to allow research to inform practice in a uniquely individualized fashion. Thirty years of impact should be extended for decades to come through new refinements and advances to early influential ideas that continue to guide the field today.

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Strengths Perspective

& MICRO PRACTICE

Strengths Model Case Management: Moving Strengths from Concept to Action

Richard J. Goscha

Social work has long acknowledged the importance of focusing on the strengths of people and their environments. From the early years of Jane Addams and the settlement house movement (1902) to Bertha Capen Reynolds (1951) to Charlotte Towle (1953) to Germain and Gitterman (1979), voices from within the social work profession have repeatedly called for a focus on the capabilities, resilience, and empowerment of people and communities that have been marginalized throughout history. The University of Kansas School of Social Welfare drew upon the voices of these early pioneers and articulated the strengths perspective in the 1980's (Weick, Rapp, Sullivan, & Kisthardt, 1989), challenging the field to put the strengths and resources of people, communities, and their environments at the center of the helping relationship. Yet, despite these calls for an emphasis on strengths, deficit-based approaches continue to dominate conventional social work practice (Saleebey, 2009).

It was within this tension that Strengths Model Case Management was developed. The Strengths Model represented a significant paradigm shift for mental health, social work, and other helping professions. People with mental illnesses have historically been oppressed by the societies in which they live, and this has often been reinforced (albeit unintentionally) by professionals responsible for helping them. When the Strengths Model was developed, traditional case management approaches often focused on pathology and diagnosis, held low expectations for what people with mental illnesses could achieve in their lives, and frequently used stabilization and maintenance as measures of success. The Strengths Model arose in response to

this, viewing people not only as capable and possessing a unique array of personal and environmental strengths but also challenging and inviting professionals to focus their efforts and support toward helping people achieve life goals and roles that anyone else in the community might pursue.

This chapter provides an overview and the philosophical underpinnings of Strengths Model Case Management. The principles, research, and tools will be presented, along with a case example to demonstrate how the philosophy and practice approach work together. The chapter will conclude with a view of the implementation process for Strengths Model Case Management within an organizational setting and implications for the model moving forward. The purpose of this chapter is to emphasize the importance of taking strengths from a verbalized concept to an actionable set of practice and organizational behaviors designed to improve the lives of the people.

STRENGTHS MODEL CASE MANAGEMENT

The Strengths Model started with humble beginnings as a pilot project. In 1982, the University of Kansas School of Social Welfare secured a $10,000 grant from the state mental health authority to develop a case management model. Charlie Rapp, a faculty member at the School of Social Welfare, and Ronna Chamberlain, a student in the doctoral program, approached this task by devising a list of commonly mentioned goals stated by clients receiving community mental health services in Kansas at the time. Rather than typical goals seen on mental health treatment plans (e.g., stay out of the hospital, reduce symptoms, improve social skills, improve hygiene, etc.), clients spoke of aspirations related to having their own place to live, employment, education, relationships, and being part of the community. It was imperative that the model being developed provided a pathway for people to pursue these desired outcomes.

The vision was based more on the premise that there had to be a more effective way to work with people than continuously trying to remediate deficits than it was to fully conceptualize a new model of care. Yet the learning that was developed by this small group of social work students and their professor has resulted in a set of tools, methods, and interventions that have stood the test of time for over thirty years. Eleven studies have tested the effectiveness of the Strengths Model with people who have serious mental illnesses. Four of the studies employed experimental or quasi-experimental designs (Stanard, 1999; Macias et al., 1997; Macias et al., 1994; Modrcin et al., 1988), and six used non-experimental methods (Tsoi et al., 2018; Fukui et al., 2012; Barry et al., 2003; Ryan, Sherman, and Judd, 1994; Kisthardt, 1994; Rapp and Wintersteen, 1989; Rapp and Chamberlain, 1985). These studies have collectively produced positive outcomes in the areas of psychiatric hospitalization, housing, employment, reduced symptoms, leisure time and social and family support. Organizations implementing Strengths Model case management have extended beyond the borders of Kansas to include California, Oregon, Iowa, Oklahoma, Texas, and several countries (Canada, Hong Kong, the Netherlands, Australia, New Zealand, Japan, and Taiwan).

The resiliency of the model over time has been due to its relevancy to people across cultures, conditions, and environments. Though the model arose out of a specific context to focus on individuals who had been diagnosed with a serious mental illness, the model has always been focused on what we share in common as people, rather than what separates us along lines of disability. The belief behind the Strengths Model is that we all desire to feel connected, accepted, loved, heard, respected, and safe. We all desire to contribute, to learn, to be a part of something greater than ourselves, and feel that our lives mean something. While we share a common array of desires and aspirations as humans, there are often wide disparities between what each of us wants in life and what we actually experience. Many of the people we serve have experienced and often continue to experience, economic inequality, oppression, stigma, discrimination, marginalization, trauma, and social injustice. While the Strengths Model is not a panacea for these societal conditions, the model challenges us to do more with the resources we have to help people build and rebuild lives despite these conditions.

Strengths Model Case Management is both a philosophy of practice and approach to practice embedded within specific tools and methods designed to help people: 1) identify and achieve meaningful and important life goals; and 2) increase their ability to exercise power related to how they view themselves and how they interact with their environment.

A key component of Strengths Model practice is helping people make movement on two critical levels that impact a person's recovery and wellbeing: 1) movement from entrapping intrapersonal narratives to empowering intrapersonal narratives; and 2) movement from entrapping environmental niches to empowering environmental niches. Figure 1. illustrates the positioning of Strengths Model Case Management as it relates to helping people make movement from entrapping narratives and niches to empowering ones.

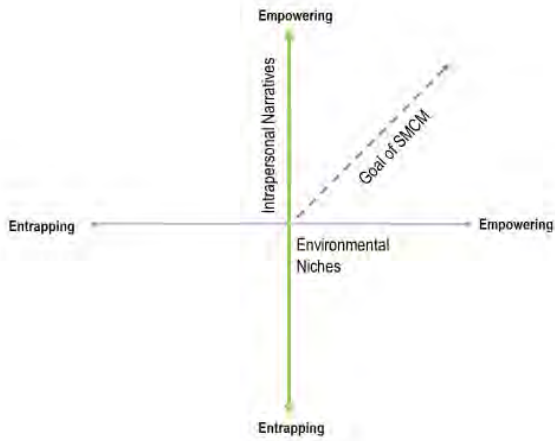

Figure 1. Empowering and Entrapping Intrapersonal Narratives and Environmental Niches

Intrapersonal narratives are the messages we tell ourselves that have a profound impact on our behavior (Hayes, 2004). While many times these messages can be empowering (e.g., "I am intelligent," "I am a good parent," "I am hardworking," "People enjoy being around me."), they can also be entrapping (e.g., "I can't do this because of the anxiety or voices," "I don't deserve anything better," "I have nothing to contribute to others or my community," "I ruin everything," "I am just an addict."). These entrapping intrapersonal narratives can constrain people from making movement toward the life they want by contributing to and reinforcing fears, self-doubt, self-blame, and resignation. Entrapping intrapersonal narratives can develop and become engrained as a response to traumatic events or experiences, negative messages we internalize through the words of others, or views about ourselves that we personalize based on stereotypes, stigma, and discrimination.

The Strengths Model recognizes that helping people build or rebuild a life is not just about changing our internal thoughts. The people we work with do experience real problems, barriers, and challenges that can constrain movement toward a desired life. People can also be caught in entrapping niches in which movement and choice may seem limited. A "niche" is "the environmental habitat of a person or category of persons" (Taylor, 1997). This could include the places where people live, work, and socialize, but it can also include the relationships people engage in, their social networks, and systems designed to provide help and support. These niches can fall on a continuum of empowering (those that provide abundant opportunities for learning, growth, support, and movement to other empowering niches) to entrapping (those that restrict or suppress learning, growth, and support, and are devoid of opportunities to move to more empowering niches).

Entrapping environmental niches include, but are not limited to homelessness, poverty, abusive relationships, unemployment, social isolation, resource-poor neighborhoods, and unsafe housing. These niches are often stigmatized and create additional barriers for people achieving valued goals and roles in their life. Strengths Model Case Management provides intensive community-based support to help create opportunities for people to move toward empowering niches (employment; educational diplomas, certificates, or degrees; supportive relationships; meaningful involvement in the community; a place that offers safety and feels like home) by marshaling and building upon useable strengths that the person already possesses.

The Strengths Model rests on six core principles (Rapp & Goscha, 2012):

> **Principle #1:** People can recover, reclaim, and transform their lives. The Strengths Model emphasizes that the capacity for growth and recovery already exists within the individual or family. The Strengths Model does not define recovery as a cure or remission of symptoms as viewed from a medical lens. Rather, the Strengths Model honors the resiliency of each individual to continue building or rebuilding a life despite life circumstances. Recovery

is about an individual's ability to recover their sense of self, their identity, their hopes and dreams (apart from clienthood or disability) and recognize and leverage the capabilities and strengths they possess to achieve desired life goals and roles. Our job as helping professionals is to help create conditions in which growth and recovery are most likely to occur. It is important to recognize that we do not possess the power to control or predict how one's recovery journey will unfold, so we embrace the dignity and worth of each person before us and work from a lens of possibility and opportunity.

Principle #2: The focus is on an individual's strengths rather than deficits.
Recovery is not fueled merely by overcoming problems, barriers, and challenges. In fact, many people recover despite the problems, barriers, and challenges faced in their lives. The Strengths Model does not ignore problems. The Strengths Model practitioner validates the person's experience and responds to the immediate challenges that people face. Yet merely solving problems, at best, returns the person to an equilibrium. However, exploiting strengths and opportunities promotes growth. People tend to flourish based on their individual interests, aspirations, and strengths. Rather than ignoring problems, the Strengths Model calls for us to push further and exploit the strengths and capabilities that will help the person build or rebuild the life they desire.

Principle #3: The community is viewed as an oasis of resources.
This principle is a corollary of the previous one. Strengths Model practice focuses not only on the strengths of the individual but also on the strengths of the environment. Most obvious to helping professionals are what communities lack and the difficulties encountered accessing the few resources available. From a strengths perspective, we must find pockets of strengths in our communities—the employers, property managers, teachers, neighbors, family, friends, and other community members who could be mobilized to help people achieve specific goals. While the community can contribute to the distress in a person's life, the community also provides the opportunities and resources needed for people to thrive. The concept of finding empowering niches is important here.

Principle #4: The client is the director of the helping process.
Helping professionals bring expertise and information about various strategies, resources, options, and methods for achieving specific client goals; however, it is important to recognize that people

receiving services are the experts concerning their own values, preferences, desires, and experiences. Opportunities to reinforce the person as the director of the helping situation must be found, created, and promoted. The benefit of this approach is to keep workers centered on what is meaningful and important to the person rather than what professionals or others within the system deem "best" for the person. Strengths Model practitioners should do nothing without the person's approval and should involve the person in decisions during every step of the process.

Principle #5: The relationship is primary and essential.
The relationship is primary and essential because, without it, a person's strengths, talents, skills, desires, and aspirations often lie dormant and are not mobilized toward goal achievement. It takes a strong and trusting relationship to discover a rich and detailed view of a person's strengths and capabilities and to create an environment where a person is willing to share what is most meaningful and important to them. A Strengths Model-based relationship can be viewed as being a traveling companion with people along their recovery journey rather than acting as a travel agent. Strengths Model practice is predicated on the worker having a sincere and genuine investment in helping the person achieve important life goals while respecting autonomy and self-determination.

Principle #6: The primary setting for our work is in the community.
Given the stated principles of self-determination and a focus on naturally occurring resources within the environment, it should be clear that office-based interventions are contraindicated in the Strengths Model. People do not recover inside the walls of the organization's physical facilities; they recover in the community. A community outreach mode of service delivery offers rich opportunities for assessing a person's strengths and helping a person make use of these strengths to positively impact their life. Some people need help to navigate the complex social interactions necessary to achieve the goals they desire, which may include working with property managers, employers, teachers, family members, community agencies, and other individuals and organizations. Working with a person in the community settings where these interactions occur helps to avoid overgeneralization of problems and keeps the work focused in ways that are most relevant and useful to the person.

These principles provide both a philosophical base as well as day-to-day guidance for tasks and goals. Further, the Strengths Model employs two primary tools:

THE STRENGTHS ASSESSMENT

The Strengths Assessment is started during the engagement phase of the helping relationship but evolves as the worker learns more about a person's talents, skills, environmental strengths, interests, and aspirations. Initially, the Strengths Assessment is used to establish goals that are meaningful and important to the person, but ultimately becomes a portrait of the "whole" person, embellishing those aspects of the person that currently contribute or have previously contributed to the person's wellness. Good Strengths Assessments are developed through a conversational approach, with the worker demonstrating a sincere interest in knowing more about the person. The Strengths Assessment is used over time to help the person develop strategies toward goal achievement and to help them find personally empowering places and roles ("niches") where they can demonstrate competence and confidence. The Strengths Assessment can assist the worker to create a person-centered treatment plan that ensures that services are provided in the context of something that is meaningful and important to the person.

THE PERSONAL RECOVERY PLAN

The Personal Recovery Plan is the base from which movement begins once a meaningful and important goal has been identified. While problems, barriers, and challenges a person may face are not ignored within the Strengths Model, they are always viewed within the context of how they impact something the person desires to achieve in their life. Examples include: "I want to better manage symptoms of depression so I can care for my son," or "I want to be free of drugs and alcohol so I have more money for my own place to live," or "I want to learn strategies to deal with anxiety and self-defeating thoughts so I can feel comfortable going out in public" (e.g., go to the grocery store, go to church, take a walk in the park, spend more time with family). The Personal Recovery Plan becomes an active "to do" list within the helping relationship and is used during nearly every contact with the person once started. While there may be other goals from the person's treatment plan that are being worked on, the Personal Recovery Plan ensures that the primary goal identified by the person is always given attention and never lost, even in the presence of an occasional crisis or short-term concern.

The two Strengths Model tools work together to help people move beyond the organization's services and find niches in their communities where they can thrive. This is accomplished by identifying and using highly individualized strengths they already possess and then building upon those. Strengths are also used to help people overcome problems and barriers that interfere with their life goals. The Strengths Model works hard to strengthen people's natural supports whenever possible, to help people develop anchors within the community rather than formal services and supports.

CASE EXAMPLE

Kenny heard persecutory voices since he was young. Because of this, he also experienced intense social anxiety being around others. He always feared that others could hear the same voices he heard, and they would judge him. Kenny had been fascinated with martial arts since childhood and remembered taking a community education class to learn karate when he was 14 years old. Though he enjoyed the class, his mother could not afford to pay for more lessons. Even so, he continued to practice the skills and techniques he learned on his own.

Now an adult, Kenny continues to hear voices. Though the medications help to soften them somewhat, he avoids social situations whenever possible. A standard goal of his treatment plan is to increase social interaction. He has made little progress on this goal. Attempts to encourage him to do things in the community often proved futile.

While doing a Strengths Assessment with Kenny, his worker learned about his love of martial arts and some of the skills he developed over the years. Kenny rebuffed initial discussions about taking another karate class, but he continued to discuss karate. Over time, Kenny asked more questions about taking karate classes, such as where they were held, what the instructors might be like, what if everyone there was better than he was, how he would afford the class, what if the voices got bad during a class, etc. The worker offered to explore each of these questions with Kenny and they eventually started a Personal Recovery Plan with the goal of earning a black belt in karate.

Together they visited the two martial arts studios in town. He really liked the instructor at one place and was allowed to observe a few of the different classes offered. He was even offered a free two-week membership. Kenny also became comfortable enough to discuss that he heard voices with the instructor. This turned out to be a good match. The instructor had a brother with autism, and he understood the difficulties some people experience in social situations. They talked about how he could leave class whenever he felt uncomfortable and return at any time. Kenny succeeded in the class and eventually received his black belt in karate.

This case example highlights a significant trajectory shift in the life of a person. Kenny had spent nearly 10 years receiving services from a community mental health program. When Kenny entered services in his late teens, it was in response to a desperate plea from his family for help. He had withdrawn from all social encounters, was doing poorly in school, started shouting at voices that others could not hear, his behaviors were at times antagonistic, and he stopped caring for his personal hygiene. Kenny was started on antipsychotic medication, assigned a therapist, and started attending groups. Initially, there was relief for the family when he started to stabilize, but it was short-lived. Over the next 10 years, Kenny was in and out of the hospital, had difficulty keeping housing, had difficulty with adherence to medica-

tions, and had difficulty forming relationships due to the increasing paranoia and anxiety. Furthermore, Kenny was losing hope, assuming the role of clienthood, and passively resigning his life over to illness.

When Kenny started working with a case manager skilled in Strengths Model practice, his life situation did not immediately change, nor did the problems and challenges he experienced. What changed was an elevation in expectations for what was possible and a focus on the well-aspects of Kenny's life, even amid distressing voices, confusion, and fear. The Strengths Model recognizes that people cannot organize a recovery journey around the absence of things or deficits. As Pat Deegan aptly states, "You can't organize recovery in a vacuum" (Deegan, 2018). You can't build or re-build a life merely around staying out of the hospital, or not hearing voices, or not using drugs or alcohol. The Strengths Model approaches building or re-building a life in the same manner anyone in the community would do so: around something of meaning, importance, and value to the person and leveraging the tangible strengths we already possess (either personal or environmental). For Kenny, that meant building around his desire to do karate and the skills and talents where he already had competency.

The Strengths Model tools (the Strengths Assessment and the Personal Recovery Plan) serve as a visual representation of the life-building work that is the hallmark of strengths-based practice. The most valuable tool in the Strengths Model is not the Strengths Assessment nor the Personal Recovery Plan; it is the workers themselves. The tools are mere repositories for key information that is elicited within the dynamic relationship between two people: the worker and the client. It takes a purposeful, curious, intentional, and dedicated worker to see strengths amid a plethora of deficits, problems, and obstacles. The strengths-based worker must continuously develop the relationship with the client by creating an environment of trust, empathy, and genuineness in order to engage the client around the well-aspects of their life. The worker must also communicate their sincere investment into the life of another person; that the person's hopes and dreams are important, their pain is real, and the worker is invested in working alongside them to help them move forward.

While it is important for the worker to see the strengths a person possesses, it is more important for the client to be able to see their strengths and use them. Herein lies the primary value of using the Strengths Assessment and the Personal Recovery Plan. At its core, these visual tools are a means to communicate both hope and empowerment to the client. Snyder (2010) defines hope as consisting of three major components: goals, pathways, and agency. Using Snyder's (2010) framework, goals are the mental targets that guide human behavior, pathways are the ability to generate multiple routes to the desired goal, and agency is the perceived ability to initiate and generate movement along a pathway. Figure 2 is the beginning of a Strengths Assessment that was generated over a few conversations between Kenny and his worker.

Figure 2. Kenny's Strengths Assessment

Strengths Assessment for Kenny

Current Strengths: What are my current strengths? (i.e. talents, skills, personal and environmental strengths)	**Individual's Desires, Aspirations:** What do I want?	**Past Resources – Personal, Social, & Environmental:** What strengths have I used in the past?
Housing/Daily Living		
I currently live with my mother – she cooks the best meals I like living in a small town. I can get almost anywhere without a car.	I would like my own apartment.	I have lived on my own in an apartment. I like the freedom. I was able to cook my own meals and decorate it the way I like.
Financial/Insurance		
I am currently receiving SSI. My mom gives me money when I'm running low.	I would like to get off SSI and work.	I worked for a few months stocking shelves at a grocery store. I like to organize things and make sure everything is where it needs to be. I volunteered once for Salvation Army during Christmas. I liked that I got to see people, but not have to talk to them.
Vocational/Educational		
I know how to do some karate – basic moves and kicks	I want to get back into karate I want to get a job so I can have more money to go out to eat when I want.	I took karate classes when I was 14. I was pretty good.
Social Supports		
"My mom cares about me. I know that" – she let me come home when I had no other place to go. She cooks for me.	I would like someone to do things with, like go to a movie or someone to teach me how to camp.	My dad was a support to me before he died a few years ago. I went camping with my cousins when I was younger. I had a best friend in elementary school before he moved away. He got me into comic books.

Health		
I am in good physical shape. My mom bought me a weight set for my birthday.	I want to be off all medications. I want to be good to my body. I want my doctor to listen to me when I tell her the medications are not working for me.	I used to enjoy weight training class in school. I could bench 250 pounds at one point.
Leisure / Recreational		
I like to read comic books. I like Teenage Mutant Ninja Turtles, Snake Eyes, and Zen the Intergalactic Ninja. I like going to be a comic book store in town.	I want to learn more about camping and survival skills.	I have always collected comic books. I used to have a bike
Spirituality/Culture		
I believe there is something greater than us in this universe. It gives me hope that all is not lost.		

What are my priorities?

1. I want to get back into karate
2. I want to get my own apartment
3. I want to how to camp out.
4. I want to get a job that I enjoy with not a lot of people

Additional comments or important things to know about me:	
This is an accurate portrait of the strengths we have identified so far in my life. We will continue to add to these over time in order to help me achieve the goals that are most important to me in my recovery journey. _____ Client's Signature Date	I agree to help this person use the strengths identified to achieve goals that important and meaningful in their life. I will continue to help this person identify additional strengths as I learn more about what is important to their recovery. _____ Case Manager's Signature Date

Some things that you will note from reading through this initial Strengths Assessment is the absence of specific problems, barriers, or challenges that Kenny is experiencing. Nor is there the inclusion of any deficit-based language (e.g. unemployed, limited social support, no high school diploma, etc.). There is an intentionality to this approach in the Strengths Model. This does not mean that challenges Kenny faced were not discussed between the worker and Kenny, which may have included the distressing voices he was experiencing, or difficulties he was having controlling his emotions, or his increasing use of alcohol to deal with anxiety. The Strengths

Model posits that these conversations lack the impact and relevance to the person outside of a context that is meaningful and important to the person. It is much more impactful to have a conversation about symptoms, behaviors, and problems when it is framed within the context of what the person desires to accomplish. For Kenny, this was getting back into karate, getting his own apartment, learning how to camp, and eventually getting a job.

Using the Strengths Assessment also starts from the position that most people are aware of the problems, barriers, and challenges they experience. They are much less aware of the well-aspects of their life. The problems, barriers, and challenges that people experience often serve as the lens through which people filter other aspects of their life. This filter can contribute to and reinforce the entrapping narratives that people communicate to themselves. The Strengths Assessment serves as a vehicle to create space for an alternative narrative to initially co-exist and eventually possibly replace an entrapping narrative with a more empowering one.

In Kenny's case, the Strengths Assessment represents a truth about himself that is just as real as the voices he experiences, the fact that he is not currently employed, or the fact that he feels intense anxiety being around people. The Strengths Assessments brings to the forefront that even amid the challenges Kenny has and is currently experiencing, he still has hopes and dreams for his life. And Kenny still has concrete strengths that could be mobilized to build the life he wants, including the specific ways his mom currently supports him, he loves and knows how to do some karate, reads comic books, lifts weights, and believes in a higher power. All these things exist independently of his challenges and in fact, are things that contribute to him being well and are worthy of being amplified. The Strengths Assessment is about building hope and gaining traction for movement forward. For Kenny, these were the seeds that needed nourishing for growth.

While the Strengths Assessment is an important tool in the arsenal of the Strengths Model practitioner, it only realizes its full impact when accompanied with the Personal Recovery Plan. As noted previously, Snyder (2010) mentions three components of hope: goals, pathways, and agency. The Strengths Assessment opens the door to goals and potential pathways. The Personal Recovery Plan selects a pathway that best aligns with the internal motivation of the person and one where the person can exercise a capability they possess (agency).

Figure 3 shows the initial Personal Recovery Plan (PRP) that Kenny and his case manager Sarah started after Kenny decided he wanted to pursue karate classes.

Figure 3 only demonstrates steps that were taken in the first month. There were many more steps that were added between the time Kenny turned in the trial membership form and his eventual attendance at the ceremony where he was presented with his black belt. It is also important to note that not all the steps that are recorded on the PRP in Figure 3 were recorded on the same day. The PRP is an

Figure 3. Kenny's Personal Recovery Plan

Personal Recovery Plan for Kenny

My goal (This is something meaningful and important that I achieve as part of my recovery): I want to get back into karate again. I want to get a black belt

Why this is important to me: I want to be able to accomplish something and karate is something I think I can be good at.

What will we do today? (Measurable Short-Term Action Steps Toward Achievement)	Who is Responsible?	Date to be Accomplished	Date Accomplished	Comments:
Identify places that offer karate classes in Jefferson County.	Sarah	5/12	5/12	Identified 2 places that offer karate
Visit Victory Martial Arts	Kenny and Sarah	5/17	5/17	
Visit Mid-America Karate Academy	Kenny and Sarah	6/2	6/2	Really liked instructor.
Discuss pros/cons to take classes at either of the two facilities	Kenny and Sarah	6/7	6/7	Decided on Mid-America Karate Academy
Fill out form for free two-week membership at Mid-America Karate Academy.	Kenny	6/8		
Turn in free trial form and find out when next class starts				

The goal listed above is something important for me to achieve as part of my recovery.	I acknowledge that the goal listed above is important to this person. Each time we meet, I will be willing to help this person make progress towards this goal.
My Signature Date	Service Provider's Signature Date

iterative process where only 1-2 steps are recorded during each session. The goal of the PRP is movement. It is not to plan out in one setting everything that "might" occur along the way to achieving a particular goal. This approach is intentional in the Strengths Model. It keeps the worker aligned with the pace that the client is ready to make movement toward the goal. It reinforces the choice and autonomy of the client as to the pathway and approach the client views as best for each step. It

allows the opportunity to celebrate even the smallest steps as progress and worthy of acknowledgment. For some clients, this is particularly important when trying to create space for empowering narratives as it emphasizes the client's capabilities and generates hope around possibilities.

Lastly, this approach allows for immediate re-assessment if the step doesn't go as planned. At times people can retreat or even abandon a goal when something doesn't go well, which can potentially reinforce an entrapping narrative (e.g. "I knew I couldn't do this," "This is never going to happen," "I give up"). The iterative approach to the PRP allows the worker the opportunity to acknowledge the client's effort, re-visit the importance and value of the overall goal, explore alternative pathways toward achieving the goal or even re-attempting the same step with added supports or breaking it down into smaller, more manageable, and achievable steps. The important thing is for the worker to help the client arrive at the next "best step" for them based on the information and outcome of the preceding step to generate movement.

The work of the Strengths Model centers around movement more so than the achievement of the stated goal itself. People change their mind about goals and what they want. People are constantly re-evaluating goals as they take steps toward it. Most people are actually looking for the "active ingredients" they hope will be derived from the goal they set. For example, a person may set a goal of losing weight. If we explore this goal with the client further, we may find that the person is unhappy with how they look and believes losing weight might make them more attractive to a potential partner. But what if the person loses 50lbs, but never finds that partner who they envision will enjoy spending time with them and sharing common interests? Did they achieve their goal? On the other hand, what if the person ends up gaining 10lbs, but finds that partner who adores them for who they are? Did they achieve their goal?

This is what makes the iterative approach of goal planning in the Strengths Model so critical. It keeps the worker constantly focused on the thought process and meaning the client assigns to each step of the goal planning process. It keeps the worker from getting too far ahead of the client and overly myopic on accomplishing the stated goal. Instead, efforts are channeled toward helping people make movement, whether this means deciding to take another step toward the goal, addressing an entrapping narrative that obstructs movement, re-evaluating a goal after understanding more about what a person desires, changing or setting a new goal, discussing alternative pathways and options, or sometimes even being comfortable with a client's indecision as they process options for a pathway forward.

IMPLEMENTATION OF STRENGTHS MODEL CASE MANAGEMENT ON AN ORGANIZATION LEVEL

The case example of Kenny shows the Strengths Model at work at the individual worker-client level. While helping direct service workers learn how to use the tool,

and specific methods, techniques, and interventions embedded within the model, the Strengths Model has its greatest impact when the development of these skills is part of a larger organizational shift and commitment to providing recovery-oriented services. From 1989 to 2004, instruction on Strengths Model practice was approached primarily through a two-day workshop. In 2002, Kansas joined the National Evidence-Based Practices project through Dartmouth and began a more robust and systematic process to the implementation of evidence-based practices based on implementation science (Rapp, Goscha, and Carlson, 2010). Kansas started with the implementation of the Individual Placement and Support (IPS) model of Supported Employment and Integrated Dual Disorders Treatment (IDDT) in 2002 and added Strengths Model case management in 2004. Implementation support for Strengths Model case management was provided over a two-year period and included the following sets of activities:

Pre-implementation: This involved activities such as determining outcome measures to evaluate effectiveness, define processes to use data to guide continual improvement efforts, determine organizational structures and supports needed to implement the practice effectively, identify members of the leadership team to oversee implementation efforts, and identify a champion(s) to keep the Strengths Model on the organizational agenda.

Implementation: This included the 2-day Strengths Model workshop and also involved online coaching calls and onsite visits to help staff build skills in areas such as: engaging people around their definition of recovery; assessing strengths; understanding motivation and goal setting; understanding the "active ingredients" desired through specific goal pursuits; use of naturally-occurring resources; maximizing choice and autonomy; generating movement through an iterative process of personal goal planning, and working towards graduated disengagement. Support was also given directly to the supervisor to learn how to review Strengths Model tools and provide feedback to staff, learn how to conduct in-vivo field mentoring sessions with their staff to help staff apply skills in actual practice with clients, and support to establish Strengths Model group supervision.

Sustainability: This involved fidelity reviews to determine alignment with specific practice standards and detailed fidelity reports to guide improvement efforts. In 2004, the University of Kansas Center for Mental Health Research and Innovation developed a 9-item fidelity scale divided into three core areas: 1) structure, 2) supervision/supervisor, and 3) practice/service.

The importance and impact of a structured implementation process for a practice that involves complex skills sets like Strengths Model case management cannot be overstated. The impact can be seen in the study by Fukui et al. involving 14 teams at 10 agencies serving an average of 953 clients (2012). In this study, there was a statistically significant association found between higher fidelity to the model and positive outcomes related to psychiatric hospitalization, competitive employment,

and post-secondary education. To date, this is only one of two Strengths Model studies in which fidelity was measured (the other being Tsoi et al., 2018, which also produced positive results), increasing the confidence that the intervention clients received was aligned with Strengths Model practice.

Table 1. Agency Commitments Required by Fidelity Item

Fidelity item	Agency commitment
Structure	
1. Caseload Size	Commitment to keep average caseload size for case managers under 25:1. This could be an individual case manager who has a caseload of 25:1 or a combination of staff (case manager/peer support worker) who can support the person in the community whose combined time equates to a caseload under 25:1.
2. Community Contact	Commitment to ensure that 75% or more of case management contacts with the clients occur in the person's home or in the community (not at the offices of the agency)
Supervision/Supervisor	
3. Group Supervision	Commitment to start the group supervision process within the first three months of implementation. This does not have to be a new meeting, it can be a re-organization of a current team meeting where clients are discussed.
4. Supervisor	Commitment to allow the team supervisor time to review Strengths Model tools and give feedback to staff (In the beginning, as teams are learning Strengths Model practice, this might be two hours per week and built into coaching calls with the supervisor.). Commitment to allow the team supervisor time (at least once per month) to provide field mentoring for case manager.
Practice/Service	
5. Strengths Assessment – Quality	Commitment to start using one Strengths Assessment with one client following the initial Strengths Model workshop. Within six months, a Strengths Assessment should be started on each client being served by the case management team.
6. Strengths Assessment – Integration	Commitment to improving the quality of treatment plans by using information attained through using the Strengths Assessment
7. Personal Recovery Plan	Commitment for each case manager to start using one Personal Recovery Plan with one client within six months of implementation. Within one year, case managers should be using the Personal Recovery Plan with 75% of all clients being served by the team.
8. Naturally Occurring Resources	Commitment to using naturally-occurring resources with clients to achieve goals whenever possible
9. Hope Inducing Practice	Commitment to align with clients around goals that are meaningful and important to them and respect client choice and autonomy whenever possible.

Implementation of Strengths Model case management at an organizational level requires commitment at a leadership level. Table 1 outlines the agency commitments, related to each item on the Strengths Model fidelity scale that are needed prior to providing the full range of implementation support. Many of these items (i.e. caseload size, community contact, use of naturally occurring resources) are grounded in research over the past 40 years on effective case management practices (Rapp & Goscha, 2004). Others, like group supervision (Rapp, Goscha, and Fukui, 2014) and key supervisor behaviors (Carlson, Goscha, & Rapp, 2016), and the choice and autonomy subitems of hope inducing practice (Dixon, Holoshitz, & Nossel, 2016) are supported in the literature.

In addition to these commitments, the organization must collect and report monthly client outcomes. At a minimum, these outcomes must include: independent living, competitive employment, post-secondary education, satisfaction with supportive relationships, and satisfaction with community involvement. These outcomes take primary importance within the Strengths Model because they are areas that people within any community build upon to achieve health and wellness. While Strengths Model case managers work with people in a variety of areas where there are challenges and concerns (e.g. health concerns, mental health symptoms, substance use, legal, transportation, benefits, and activities of daily living), it is more consistent with Strengths Model practice when work in these outcomes are viewed in the context of key recovery-oriented outcomes. For example, “I want to manage diabetes so I can do more things with my family (supportive relationships),” “I want to stop hearing voices so I can think at work (employment),” “I want to quit using so I can keep my apartment (housing).” This focus of key recovery-oriented outcomes differentiates Strengths Model case management from other models of case management. All models of case management focus on helping people address immediate needs; the Strengths Model strives to help people build or rebuild a life that brings meaning, purpose, and valued identity.

While many organizations have aspired to implement Strengths Model Case Management over the years, it’s dissemination into routine practice in mental health has been plagued by difficulties experienced by implementing any evidence-based practice (Bond et al., 2014). Implementing evidence-based practices is complex and often requires changes in the state infrastructure of policy and financing, the design of how programs are structured, and practice methods used by staff. For a practice like Strengths Model Case Management to be implemented at high fidelity, there must be a synergy of interventions in five critical areas: state policy levers, program leadership, fidelity and outcomes reporting, supervisor training and support, and staff training (Rapp, Goscha, & Carlson, 2010).

The state mental health authority strongly influences the implementation of any evidence-based practice (Isett et al., 2008; Rapp et al., 2005; Bond et al., 2009). Strategies that have been employed include publicly recognizing high-performing evidence-based practice providers, enhanced reimbursement rates, paying agen-

cies for better clinical outcomes, and fast-tracking providers using evidence-based practices in the competitive bidding process (Stewart, 2018). In Kansas, the state incorporated into their managed care contract a rate structure for case management reimbursement that was higher for agencies that achieved high fidelity in Strengths Model Case Management.

Leadership at the site level was the common facilitating factor for programs that sustained high fidelity in an evidence-based practice in the National EBP Study conducted by Dartmouth University (Bond et al., 2009). When implementing Strengths Model Case Management in Kansas, two major mechanisms were used to facilitate support from local leaders. One was a contract signed by the agency executive with the University of Kansas (who provided the implementation support) and the state mental health authority (who certified teams achieving high fidelity in the Strengths Model to be eligible for the enhanced reimbursement rate). Elements of this contract included: 1) participation in the activities needed to successfully implement Strengths Model Case Management (e.g. leadership teams meetings, fidelity reviews, and staff training; 2) creating a plan to resolve barriers to achieving high fidelity; 3) making the structural changes necessary to implement the practice (e.g. lowering caseloads, increasing the time case managers saw clients in the community versus the office; decreasing staff to supervisor ratio, etc.); and 4) ensuring that the team supervisor can devote the time needed to help staff build skills, lead group supervision, and review and give feedback to staff on their use of the Strengths Assessment and Personal Recovery Plan in practice. The second mechanism was the creation of a leadership team to oversee the successful implementation and sustainability of the model. Typically, the leadership team was comprised of the senior executive leader or other staff who had decision-making authority within the organization, the program leader, the team supervisor, a representative from case managers implementing the model, a representative from the state mental health authority, as well as client and family representation. In Kansas, leadership teams often met quarterly for the first two years of implementation and annually thereafter. The role of the leadership team is to review progress, discuss barriers, and develop strategies and action plans to remove obstacles to improved fidelity.

Fidelity reviews are a critical element of any EBP implementation (Bond et al. 2009; Rapp et al. 2008). In Kansas, these reviews were conducted every six months for the first two years of implementation and annually thereafter for Strengths Model Case Management. Each review, typically lasting one day, was conducted by two reviewers knowledgeable in Strengths Model practice and also included a representative from the state mental health authority (who was responsible for certification). Each review culminated in a report that contained the scores, evidence for the ratings, highlights of achievement, and recommendations for improvement. After review by the agency executive, the fidelity review report was submitted to the leadership team to take action. While fidelity reviews by themselves may not spur action, when linked with the financial incentives as described above, there is increased motivation on the part of an organization to take the necessary steps to achieve high fidelity.

The role of the supervisor is indispensable to the successful implementation of an evidence-based practice (Corrigan et al., 2001; Rapp et al., 2008). The Strengths Model Case Management fidelity scale requires the implementation of key supervisory behaviors. This includes: 1) leading the team in group supervision for 90 minutes to two hours depending on team size; 2) reviewing Strengths Assessments and Personal Recovery Plans and providing feedback to staff; 3) and providing field mentoring. Field mentoring, in particular, has been an important driver in helping staff build the needed skills to do Strengths Model practice (Carlson, Goscha, & Rapp, 2016). Field mentoring refers to a supervisor accompanying their staff in the field for the purpose of teaching or improving a specific skill or method of practice. While we would like to believe that the way a staff person practices can be gleaned from what is written on practice tools such as Strengths Assessments and Personal Recovery plans or recorded in case notes, it is only in the direct observation of staff interacting with clients that we can learn the processes and approaches used as part of their practice. Effective field mentoring is not intended to be an exercise in micromanagement, but rather conducted in the spirit of learning and professional growth. It is an essential component of Strengths Model Case Management implementation to ensure that staff are implementing the "spirit" of the model, not just adhering to the structural elements and completing required tools.

While the structural elements of the model are important, it is the development of staff skills that is at the heart of the model and the essential ingredient needed to affect practice change. Yet, it is an area that is not often given the attention it requires in the implementation of an evidence-based practice (Carlson, Goscha, & Rapp, 2016). Training is necessary, but an insufficient mechanism by itself, to become proficient in a complex skillset like Strengths Model practice. While Strengths Model Case Management implementation starts with a 2-day workshop to understand how the philosophy, principles, tools, interventions, and methods of the model fit together, opportunities for skill development are embedded throughout the two-year implementation process. Early in implementation, much of the focus is on building the skills of the supervisor via web-based coaching calls and onsite visits so they are equipped to provide clinical direction and support for their staff. Supervisors learn how to create a learning environment through group supervision, how to review tools and provide feedback, how to conduct field mentoring sessions, how to use outcome data to guide quality improvement efforts, and how to track the development of staff skills using the Strengths Model Core Competencies tool. The process of helping staff build skills is iterative. The skill-building exercises used in the initial 2-day workshop are geared toward one primary goal: to help each participant start one Strengths Assessment with one client. The goal is movement, mirroring the process staff are expected to do with clients.

Implementation of Strengths Model Case Management at an organizational level takes time, energy, resources, and commitment. Many dedicated organizations over the years have demonstrated that implementing the model to high fidelity is doable. While making the investment in a model that is effective may seem daunting,

mental health systems already expend a considerable amount of time, energy, and resources doing what they currently do, whether it makes a difference in the lives of the people they serve or not. So, the question for policymakers and mental health leaders is how should we invest our time, energy, and resources? A phrase commonly attributed to Paul Batalden, Professor Emeritus in Pediatrics at the Dartmouth Institute, is "every system is perfectly designed to get the results it gets." If we are to improve outcomes for the people we serve, we are obligated to continuously scrutinize the design of our service delivery systems.

Implementation of Strengths Model Case Management at an organizational level elevates the commitment and accountability that mental health leaders verbalize to improve the lives of people diagnosed with serious mental illness. It is an acknowledgment that in order to help people build or rebuild lives, apart from our systems of care, that have meaning, purpose, and valued identity, then we must provide more than just treatment for mental health symptoms and behaviors. We must strive to create opportunities for people that are similar to opportunities for anyone else in the community.

CONCLUSION

We are in an era of mental health services where the term "strengths" exists in common nomenclatures, like terms such as empowerment, recovery-oriented, and person-centered. Our desire is that these terms are reflective of our practice and organizational designs. However, what we believe about our practice and behaviors and what we actually do are not always aligned. Thirty years ago, Ann Weick and others at the University of Kansas School of Social Welfare challenged us to align "the doing of social work with its system of values" and that "uncovering these strengths and framing them in an accessible and useful way" is a core social work process (Weick, Rapp, Sullivan, and Kisthart, 1989, p.354). Strengths Model case management has continued to evolve over the years to keep that spirit alive within the profession by helping people exercise their own power for change and movement toward the life they want. Strengths Model case management provides a structured set of methods and interventions, that are grounded in practice tools, and can be embedded within an organizational design.

Strengths Model case management is not a panacea for the challenges we face as a society. It does not abdicate social workers' responsibilities to advocate for social change and human rights. But it calls us to take action and create opportunities where we can for people who must navigate a pathway forward. The Strengths Model is a challenge to elevate our expectations of what people can achieve, amplify our awareness of the strengths, capabilities, and resiliency people possess, and vigilantly seek opportunities where people can thrive, not just survive.

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Form Follows Function: Adapting the Strength Model to Facilitate Implementation and Sustainability

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Case management is a common social service intervention that has been applied across a range of disciplines, populations, and types of organizations. Despite its widespread use, the activities constituting case management are often poorly specified (Lukersmith, Millington, & Salvador-Carulla, 2016). The Strengths Model is an important exception—not only does it offer a structured approach to service delivery, but it provides enough flexibility to facilitate implementation and support sustainability. The goal of this chapter is to help practitioners think creatively about implementation, so they can meet the needs of their organization while remaining true to the core components of the Strengths Model. In the first part of this chapter, we discuss the delicate balance between implementing a model to fidelity and making adaptations to address organizational barriers and constraints, highlighting some of the prior modifications made to the Strengths Model to ease implementation. In the second part of the chapter, we describe one agency's approach to implementation, the structural adaptations staff made to the Strengths Model, and the benefits and challenges associated with their approach.

THE TENSION BETWEEN FIDELITY AND ADAPTATION

As policymakers and funders push for the adoption of interventions that have previously demonstrated positive outcomes, service providers are subject to increased pressure to apply "model" programs to new contexts and broader populations (Metz & Albers, 2014). Despite this growing expectation, the adoption of

evidence-based programs among community-based organizations has been relatively low, due in part to the lack of support agencies receive from developers in implementation (Aarons, Hurlburt, Horwitz, 2011). To support transportability and dissemination efforts, many interventions—including the Strengths Model—have established fidelity scales to guide agencies in their implementation (e.g., Marty, Rapp, & Carlson, 2001; Paulson, Post, Herinckx, & Risser, 2002).

Fidelity is broadly defined as the degree to which an intervention is delivered as specified by the developers (Mowbray, Holter, Teague, & Bybee, 2003), and fidelity instruments provide a roadmap for how a model should be implemented in order to produce the desired results. Studies have found that stricter adherence to fidelity guidelines is generally linked to desirable program outcomes (e.g., Durlak & DuPre, 2008). The same appears to be true for the Strengths Model. Specifically, Fukui and colleagues (2012) examined the fidelity scores for 14 case management teams using the Strengths Model and found that increases infidelity fully accounted for the improvements in psychiatric hospitalizations, postsecondary education, and competitive employment observed among clients. Interestingly, fidelity scores were unrelated to changes in independent living, which the researchers ascribed to the relatively high rate of independent living observed across the sample (resulting in a ceiling effect).

Although remaining true to the intended design of a model has important implications for its efficacy during implementation, prioritizing perfect adherence above all else may be undesirable and even counterproductive (e.g., Barber et al., 2006). Indeed, there is increasing recognition of providers' need to make adaptations to better suit their organizational context, as interventions do not perfectly translate from one setting to another (Glasgow, Lichtenstein, & Marcos, 2003; Lee, Altschul, & Mowbray, 2008). Adaptations refer to any changes or modifications made to the original design of an intervention during adoption or implementation, often with the goal of addressing contextual factors that would otherwise undermine programmatic fit (Castro, Barrera, & Martinez, 2004). Providers may feel compelled to make adaptations when navigating structural constraints (e.g., program duration; Hill, Maucione, & Hood, 2007), working with limited financial resources (Swain, Whitley, McHugo, & Drake, 2010), accounting for cultural differences (e.g., Castro et al., 2004), or otherwise attempting to maximize programmatic relevance and participant engagement (Anyon et al., 2019).

Given the pervasiveness of adaptations made during implementation (Moore, Bumbarger, & Cooper, 2013), it is important to note that fidelity and adaptation are not mutually exclusive concepts. Provided the adaptation does not sacrifice the "core components" of the intervention or the specific mechanisms that have been linked to client outcomes, there is the potential for modifications to support fidelity and enhance sustainability (e.g., Aarons et al., 2012). As Stirman and colleagues (2012) put it, "Simply measuring fidelity and characterizing modifications as deviations may obscure the very refinements that facilitate the continued use of some innovations"

(p. 11). The general consensus is that adaptations become problematic when they begin to "drift," or change in ways that result in a fundamental misapplication of the model (Aarons et al., 2012). Thus, specifying the critical ingredients of an intervention is essential to support its diffusion, adoption, and sustainability.

CORE COMPONENTS OF THE STRENGTHS MODEL

The Strengths Model introduced a recovery-oriented approach to case management and encouraged practitioners to shift their focus from clients' deficits to their strengths (Rapp & Sullivan, 2014). The goal of the model is to support individuals in cultivating personally meaningful lives by helping them access naturally occurring resources and pursue their self-defined goals (Rapp & Goscha, 2012; Rapp & Sullivan, 2014). The six core principles of the model are (1) individuals can recover, reclaim, and transform their lives, (2) the focus is on strengths instead of deficits, (3) the community is full of resources, (4) the client directs the helping process, (5) the relationship between the client and their case manager is primary and essential, and (6) work primarily takes place in the community (Rapp & Goscha, 2012). Although it was originally developed for adults with serious mental health issues, the Strengths Model has been applied—in whole or in part—to a range of different populations, described more fully below (e.g., Francis, 2014; Rapp & Sullivan, 2014).

Acknowledging the widespread adoption of the Strengths Model and the need for quality assurance tools to support its dissemination, Marty and colleagues (2001) surveyed a sample of experts to identify the core components of the model. Building off a preexisting list of behaviors integral to the Strengths Model, the researchers began by consulting with local experts to revise and refine the list to ensure its comprehensiveness (individuals with demonstrated familiarity with the model were considered experts). Several rounds of feedback and revisions resulted in a questionnaire consisting of five subsections—engagement, strengths assessment, personal planning, resource acquisition, and structural components—that captured the essential elements of the model. This survey was circulated to a broader sample of experts, who were asked to rate the relevance of each item to the Strengths Model and respond to a handful of open-ended questions. Results revealed a high degree of inter-rater reliability across the five subsections, with 94% of the items considered to be critical aspects of the model. Respondents were able to differentiate between the core aspects of the Strengths Model and other service delivery models, and there was substantial agreement with respect to the ideal target population, caseload size, and composition of the case management team.

Upon identifying the core components of the Strengths Model, the developers introduced a fidelity scale in 2003 to help practitioners measure their adherence to the model. This scale has been refined over the years, and its most recent iteration consists of nine sections; each section is comprised of one to nine items scored on a 5-point scale. These nine sections are used to measure structural aspects of implementation (caseload ratios, community contact, group supervision), super-

visory components (file reviews, file feedback, field mentoring, and the ratio of direct service workers to supervisors), and key elements of clinical practice (use of the Strengths Assessment and Personal Recovery Plan, the integration of these two tools, the use of naturally occurring resources, and hope-inducing practices; Teague, Mueser, & Rapp, 2012).

As hoped, the development of this fidelity tool has supported implementation and quality assurance efforts (see, e.g., Krabbenborg, Boersma, Beijersbergen, Goscha, & Wolf, 2015). However, as the strengths-based philosophy has grown in popularity, the adoption of the Strengths Model far outpaced the use of its fidelity tools (Rapp & Sullivan, 2014). Below, we provide a brief overview of prior extensions and adaptations of the Strengths Model.

PRIOR APPLICATIONS AND ADAPTATIONS OF THE STRENGTHS MODEL

Over the last 30 years, use of the Strengths Model has expanded far beyond its home state of Kansas. For instance, the Strengths Model has been adopted by organizations in Egypt (Ibrahim, Callaghan, Mahgoub, El-Bilsha, & Michail, 2015), Israel (Gelkopf et al., 2016), the Netherlands (Krabbenborg et al., 2015), Hong Kong (Tsoi et al., 2019), and Australia (Chopra et al., 2009), among others (see Francis, 2014). In applying the model, many practitioners made adaptations to streamline implementation. For instance, some had to translate the tools into different languages and account for cultural variations in participants' understanding of "strengths" (e.g., Tsoi et al., 2019). In other cases, some of the adaptations were more pronounced. For instance, Ibrahim and colleagues (2015) blended elements of the Strengths Model with treatment as usual at an inpatient psychiatric facility. Services were group-based and, instead of emphasizing the importance of individual goal planning, focused on providing psychosocial and life skills training. Despite these adaptations, participants showed improved functioning and reduced symptomology compared to individuals receiving treatment as usual.

Although the model continues to be used primarily with adults with psychiatric disabilities, practitioners rapidly applied the Strengths Model to other populations, starting with individuals in treatment for substance misuse (e.g., Rapp, Siegal, & Fisher, 1992). Since then, the Strengths Model has been successfully used with people diagnosed with HIV/AIDS (Craw et al., 2008), men preparing to exit prison (Hunter, Lanza, Lawlor, Dyson, & Gordon, 2016), caregivers (Whitley, White, Kelley, & Yorke, 1999), and survivors of domestic violence (Song & Shih, 2010).

In recent years, the Strengths Model has been applied to a range of youth populations, including youth with serious mental health issues (Mendenhall & Grube, 2017), youth experiencing homelessness (Krabbenborg et al., 2015), and other vulnerable youth (Arnold, Walsh, Oldham, & Rapp, 2007; Craig, 2012). Each site made some type of adaptation to improve either cultural or developmental fit. Some of

these adaptations were structural in nature, whereas others were more philosophical. For instance, Krabbenborg and colleagues (2015) expanded the theoretical framework of the model to include citizenship, social quality, and self-determination—constructs deemed highly relevant to Dutch culture, particularly for youth experiencing homelessness. In addition, they introduced a three-phase, systematic approach to service delivery (as well as several new tools, such as ecomaps) to help case managers navigate their day-to-day work with clients. These adaptations allowed for a more tailored approach to implementation while remaining true to the core components of the Strengths Model.

More recently, the Strengths Model has been adopted by a non-profit in Austin, Texas, that provides wraparound services to highly vulnerable transition-age youth. Given the range of programs offered by this organization, the unique characteristics of the target population, and the complexity of their funding streams, staff had to find creative ways to work toward fidelity. In the remainder of the chapter, we describe LifeWorks' experience using the Strengths Model, focusing on the specific adaptations made to ease implementation, the benefits and challenges that staff experienced as a result of these modifications, and implications for practice.

IMPLEMENTATION OF THE STRENGTHS MODEL AT LIFEWORKS

LifeWorks is a large non-profit in Austin, Texas, that provides a comprehensive array of services to vulnerable transition-age youth. Programming includes office- and community-based mental health services, high school equivalency classes, supported employment, aftercare services for youth aging out of foster care, and a continuum of housing options, ranging from street outreach to permanent supportive housing. Eight of LifeWorks' 19 programs include case management as the primary intervention.

Youth receiving case management at LifeWorks have often experienced a range of hardships, including homelessness or housing instability, systems involvement, early parenthood, and complex trauma (see Schoenfeld & McDowell, 2016). As is often the case with vulnerable youth (Petr, 2003), youth seeking services at LifeWorks have been involved with child welfare, juvenile justice, mental health systems, or other social services. The goal of these systems is to solve some underlying "problem," encouraging providers to focus on the past (instead of the future), identify and address deficits (instead of strengths), and assign labels or diagnoses (instead of adopting a whole-person perspective; Saleebey, 1996). This approach is perpetuated by funders, contractual requirements, and precedent. The resulting services promote the pursuit of generic or normative outcomes, rather than outcomes defined by the clients themselves. Given these parallels and the growing evidence that a strengths-based, goal-focused approach may be effective for youth (as described above), LifeWorks decided to implement the Strengths Model across its eight case management programs.

Before the Strengths Model, the agency did not have a standardized approach to case management. As a result, services varied across programs, case managers were unable to look to their peers in other programs for guidance, and youth's experiences differed dramatically from program to program. Although all services were ostensibly "strengths-based," there was no shared understanding of what being strengths-based meant in practice.

When LifeWorks first implemented the Strengths Model, staff tried to remain true to the original design, including the supervisory structure outlined in the fidelity guidelines. Specifically, each supervisor was expected to conduct weekly group supervision, file reviews, individual feedback sessions, and field mentoring. However, the agency was unable to reallocate the supervisors' existing responsibilities, so each manager was left trying to squeeze an additional eight hours of work into an already full week. What's more, several managers supervised small teams of only two or three case managers (who, in turn, had small caseloads), which made the supervisory expectations feel unnecessarily burdensome and of limited utility.

Because of the way services were structured and staffed, leadership recognized it would be unrealistic to expect programs to reach fidelity. After closely examining the fidelity guidelines, staff realized the supervisory responsibilities could be removed from program managers and consolidated into a single position. This role could fulfill all the supervisory requirements associated with the model. In 2018, LifeWorks hired a director of evidence-based programming (DEBP), who is responsible for overseeing the implementation of the Strengths Model. To facilitate implementation, the DEBP created three "teams" comprised of case managers from multiple programs. As a result of this structure, the total amount of staff time dedicated to implementation decreased dramatically (from 40 hours per week, when overseen by the program managers, to 24 hours per week, under the supervision of the DEBP). To promote further philosophical and programmatic alignment, other support staff at LifeWorks (e.g., employment specialists, peer supporters) were invited to attend group supervision and utilize the same tools and documentation as the case managers.

To better understand LifeWorks' approach to implementation, 37 interviews were conducted with case managers, supervisors, support staff, and executive leadership. Specifically, we were interested in the benefits and challenges associated with each of LifeWorks' two major structural adaptations to the Strengths Model: (1) the centralization of supervisory responsibilities, and (2) the creation of interdisciplinary teams. First, the raw data were separated into codable segments ("quotations"), which were then sorted into two categories for each adaptation (i.e., the benefits and challenges associated with the adaptation). Two authors (BW and AY) coded the quotations independently, using a coding scheme originally developed as part of the National Implementing EBP Project (Torrey, Bond, McHugo, & Swain, 2012) and refined by Bond et al. (2014). This coding scheme consisted of seven domains impacting the sustainability of evidence-based programs: workflow, prioritization, client compatibility, reinforcement, workforce, leadership, and financial. Coding

discrepancies were reviewed with the primary investigator (ES), and codes were finalized through consensus.

ADAPTATIONS TO THE STRENGTHS MODEL

Centralized supervisory responsibilities. As described above, a director of evidence-based programming (DEBP) position was created to oversee LifeWorks' implementation of the Strengths Model and carry out the supervisory responsibilities in lieu of the program managers. Case managers, supervisors, and executive leadership all praised this structural adaptation. Nearly half of the staff mentioned workflow benefits (49%, including 63% of executive leadership and 83% of supervisors), and more than half described the reinforcement opportunities offered by this structure (57%, including 73% of case managers and 100% of supervisors). Specifically, staff thought this adaptation allowed for greater consistency in implementation, reduced burden on program directors, and increased philosophical alignment.

Across the board, staff valued having a single position dedicated to supporting case managers in their use of the Strengths Model. As the resident expert in the model, the DEBP was a key resource for staff and represented a single source of "truth" regarding the model and its implementation. As one case manager put simply, "you know who you can go to if you have a question." Staff also described how the DEBP helped ensure that case managers were able to consistently translate the model's principles into practice. When the program managers were responsible for the supervisory components, this resulted in varying perspectives, interpretations, and recommendations. One person likened this structure to a customer service department:

> You may get different answers because there's…different people giving you information. But if you have that one specific [individual with expertise in] the model, then you will have consistent delivery of content and responses to questions as they come up.

Staff also appreciated that the DEBP was able to devote her full attention to the implementation of the Strengths Model and not be distracted by other programmatic or administrative concerns. One case manager summed it up nicely: "Where our other supervisors are maybe focused on funding requirements and contractual agreements, this person [the DEBP] can really look at how we implement this model to fidelity."

The competing demands on supervisors' time also interfered with their ability to provide quality feedback or be easily accessible to their teams. Case managers were hesitant to approach their supervisors for support in the model, but the DEBP role alleviated these issues:

> …before, [my supervisor] did a great job, but I'm like, "I don't want to ask her any questions," because she would do research and I

> can't take away [her] time—she's doing a million other things…I think having [the DEBP] dedicated to the role, having the ability to schedule time with her…I think that's great.

What's more, the DEBP provided staff with access to a broader, agency-wide perspective. Rather than being limited to their own programmatic lens, the DEBP offered staff an "unbiased" point of view. Case managers regularly approached the DEBP for assistance when navigating complex situations with their clients, and this position's ability to disseminate information and best practices was perhaps its biggest asset:

> I think the benefits are having one pair of eyes and one pair of ears who can see across all programs and understand the shared learnings…it allows for cross-pollination of processes. It allows for the ability to find a best practice and immediately moves it across programs…When you are seeing all the challenges people face and all the wins that people are having, you are then able to find those winning practices and… within a short period of time, everybody has that knowledge and can start doing it. The same thing with, "Oh, wow, here's a pitfall we're falling into." You can immediately address that...

Overall, having a dedicated position helped the Strengths Model become more deeply ingrained and a defining aspect of the organization's culture. Staff expressed how "the Strengths Model is such a part of LifeWorks and where we're going [as an agency] that you hear about it daily." Such repeated exposure to the model and its principles increased understanding and buy-in among staff. As described by one member of the executive team:

> …we don't hear any more about concerns around understanding… [like] "What is the Strengths Model?"…And that used to be [the case], so I think that's now our current practice and philosophy and belief and part of our culture…I can't tell you the last time I heard about…a situation coming up with the staff not understanding….

Less than a third of the staff mentioned any challenges associated with centralizing the supervisory components of the model (30%, including only 13% of case managers). Of these, the majority expressed concern about possible role confusion between the DEBP and the supervisor, particularly with respect to managing difficult client situations (an aspect of "workflow," as outlined by Bond et al., 2014). Importantly, supervisors did not mind relinquishing the file reviews, file feedback sessions, and field mentoring to the DEBP, but some missed facilitating group supervision. One supervisor explained, "Especially in the beginning, I felt disconnected to my own program…I kind of felt like my people were taken from me…."

To address this concern, supervisors were encouraged to attend group supervision alongside their case managers, and case managers were coached to keep their supervisors informed about their clients. Additionally, the DEBP scheduled a monthly meeting with the supervisors. In these meetings, supervisors receive updates about their case managers' performance, opportunities for improvement, and other key information pertaining to the model (e.g., results of fidelity reviews). As a result, supervisors are better equipped to monitor their staff's performance, reinforce the DEBP's trainings, and help their team move closer toward fidelity.

Ultimately, because these remedies were introduced shortly after the creation of the DEBP position, staff's concern about role confusion was largely framed as a hypothetical or a potential risk, rather than an actual problem. However, without careful delineation of responsibilities and regular communication, this type of structural adaptation could lead to conflict or competition between the supervisors and the DEPB.

Aside from the overinflated concern about possible role confusion, only one other barrier to sustaining the DEBP position was mentioned more than once. Specifically, staff expressed concern about the DEBP's long-term bandwidth, especially as new case management programs continue to be introduced: "As LifeWorks grows and diversifies…[h]ow do we do more evidence-based programming and keep that centralized model without diluting [quality]?" Such problems are not insurmountable, however; if the number of case managers exceeds the capacity of the DEBP, an additional position could be created (or the responsibilities of an existing position could be reallocated) to ensure there is adequate support.

The creation of interdisciplinary teams. For years prior to the adoption of the Strengths Model, LifeWorks struggled with how to improve communication and collaboration across programs. Although youth typically only worked with one case manager at a time, many were enrolled in more than one program and worked with multiple staff (e.g., peer supporters, employment specialists). This often led to role confusion, duplication of effort, and a general lack of clarity regarding one's responsibility toward a shared client.

By assigning case managers from different programs to the same "team" and inviting other direct service staff to attend, group supervision became a forum for mutual learning, resource sharing, and intentional collaboration. Staff found this interdisciplinary approach to be extremely beneficial, with more than half referencing workflow benefits (54%, including 50% of support staff, 67% of supervisors, and 88% of executive leadership). Staff appreciated having access to people with different expertise and programmatic backgrounds—not only did they feel like it benefited their work and, in turn, their clients, but they also felt like it promoted a shared vision and greater agency alignment. As one staff member described:

> …everyone became part of the Strengths Model….[During group supervision] we bring in all disciplines, whether they are, again, doing the case management model or not, so that we truly have the well-informed understanding of where the client is right now... by creating those bridges, we have just really enhanced our ability to function as an agency instead of a collection of programs.

The creation of these interdisciplinary "teams" also provided staff with a shared language and a standardized approach to service planning. Regardless of program affiliation, staff have a consistent way of helping youth pursue their goals and an equally consistent way of sharing their work with colleagues. For instance, one peer supporter described service planning as follows:

> …a goal is like, 'I want to not use [substances] for two days'…and then we establish steps around that goal, and it's like, 'Well, who around you can support you?' And it…goes back to Strengths Assessment because a lot of that is, like, resources in your community and resources like support systems. So, we reference that, and we…build off of those strengths to make them into steps.

To further streamline workflow and ensure that services are well-coordinated, all staff who share a client use the same Strengths Assessment and service plan. Because these documents are stored in the agency database, staff have greater visibility to the work being done with clients who are shared across programs. Such visibility reduces duplicative work and allows staff to more strategically divide tasks: …we are all working on a different angle [of] the same issue, which truly does support the youth in a more comprehensive way and we're not undermining each other by accident…that sort of synergy and shared priority amongst programs…is probably the most transformative piece of the Strengths Model as that has trickled out beyond case management.

This sense of alignment was more than merely operational; staff reported feeling less isolated and more connected to their coworkers. For case managers specifically, knowing that they were all using the same framework and being held to the same standards, regardless of their program affiliation, was also an added benefit. Except for two individuals (5%; one of who worked in an outlying area and whose concerns mainly stemmed from her geographic separation), staff did not perceive any challenges associated with this interdisciplinary approach.

RECOMMENDATIONS FOR PRACTICE

Staff's overwhelmingly positive response to these structural adaptations have important implications for Strengths Model practitioners. These modifications led to improvements in workflow (e.g., reduced burden, increased programmatic alignment) and reinforcement (e.g., improved supervision, shared learning). Although

staff pointed out a few opportunities for improvement—specifically with respect to other aspects of workflow (i.e., possible role confusion)—these challenges are not insurmountable and highlight the feasibility of this approach to implementation.

Centralizing the supervisory responsibilities of the Strengths Model may increase the likelihood of organizations achieving fidelity, particularly if the organization has multiple case management programs or is otherwise structurally complex. Additionally, if supervisors have significant administrative or contractual responsibilities, they may not have sufficient bandwidth to provide quality feedback to their case managers. Reallocating responsibilities and providing opportunities for role specialization is associated with improved collaboration and greater organizational effectiveness (Bassett & Carr, 1996; Reeves, Lewin, Espin, & Zwarenstein, 2010). The creation of the DEBP position allowed for greater role specialization among staff and introduced a new (and highly effective) mechanism for sharing information across programs, two factors that facilitate an agency's ability to implement evidence-based programming (see Aarons et al., 2011).

Although several staff indicated that assigning the supervisory components of the Strengths Model to someone other than the program manager might result in role confusion, this did not appear to be an issue in practice. By creating opportunities to meet with the DEBP on a regular basis, supervisors were able to remain informed about their staff's performance and continue to support the agency's journey toward fidelity.

As with the DEBP position, staff believed the move toward interdisciplinary teams offered more benefits than challenges. This structure lent itself to improved cross-program collaboration and communication, which are critical yet difficult to support in large, departmentalized organizations (Yang & Maxwell, 2011). Although interdisciplinary teams are a standard feature of some case management models (e.g., Bond & Drake, 2015), they are the exception rather than the norm among those using the Strengths Model. Provided staff build authentic partnerships characterized by a shared service philosophy, regular communication, and clearly delineated roles, these types of collaborations are associated with improved client outcomes (e.g., Slack & McEwen, 1999).

One straightforward way to support interdisciplinary teams is through shared documentation. By working off the same tools, staff have greater visibility to each other's work, allowing for increased care coordination and more integrated services (Kunkell & Yowell, 2001). However, organizations must ensure that the documentation meets the needs of all staff involved and is not overly burdensome (see, e.g., Stanhope & Matthews, 2019).

Although LifeWorks has not yet achieved high fidelity in the Strengths Model, it is not uncommon for this journey to take two or more years (see, e.g., Krabbenborg et al., 2015; Bond, Drake, McHugo, Rapp, & Whitley, 2009). The agency has conducted

three fidelity reviews to date (approximately every six months), and their scores have shown consistent improvement over time. During their most recent review, the teams received scores of 3.3, 3.4, and 3.7 (their average scores on the Supervision subscale were 3.6, 3.9, and 4.0). Thus, it appears that the structural adaptations that were made are not likely to preclude the organization's ability to achieve full fidelity. Of course, these types of structural adaptations may not be necessary for every organization. However, they pose a promising solution for agencies with numerous case management teams, small team sizes, a significant proportion of clients enrolled in more than one service. Depending on the size and complexity of the organization, it might make more logistical sense to have two positions responsible for overseeing implementation instead of just one. Organizations that do not have the resources available to create a new position can explore repurposing an existing position or otherwise reallocating managerial responsibilities to allow for more focused oversight of the model.

CONCLUSION

The two structural adaptations described in the latter part of this chapter—the consolidation of supervisory responsibilities into a single position and the formation of interdisciplinary teams—illustrate that flexible approaches to implementation are not necessarily at odds with fidelity. Agencies should feel empowered to critically evaluate their existing structure and available resources to develop an implementation structure tailored to their organizational context, rather than feeling pigeonholed by how things have historically been done. By making adaptations that support or amplify the key components of the Strengths Model, programs can achieve positive outcomes for their clients in a sustainable way.

END NOTES

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Strengths Model for Youth: Moving toward a Client-Centered, Strengths-based Model of Case Management in Community Mental Health

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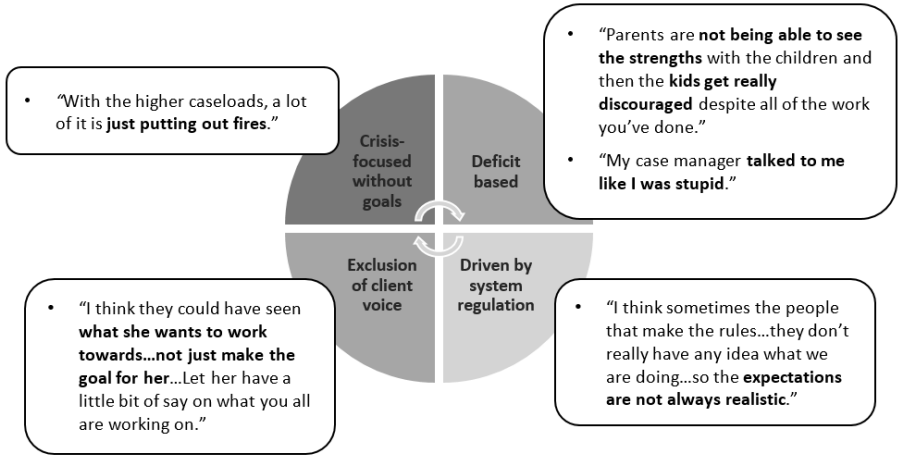
Approximately 13 to 20% of U.S. children and adolescents experience a mental disorder in a given year (Perou et al., 2013), with only half of these youth receiving mental health care (Kataoka, Zhang, & Wells, 2002; Merikangas, Nakamura, & Kessler, 2009). Even when children do access mental health services, approximately 40% to 60% discontinue before completing their treatment (Baruch, Vrouva, & Fearon, 2009; Hoste, Zaitsoff, Hewell & le Grange, 2007; Miller, Southam-Gerow & Allin, 2008; Oruche, Downs, Holloway, Draucker & Aalsma, 2014). These statistics highlight the critical need for identification and implementation of effective child and family interventions for the mental health service system. Case management is a widely offered service within the children's mental health system, but there is a scarcity of literature and research on models of case management and their effectiveness. This chapter introduces one model of case management, Strengths Model for Youth, and summarizes the current evidence on its effectiveness.

TRADITIONAL CASE MANAGEMENT FOR YOUTH IN MENTAL HEALTH SYSTEMS

Case management is a commonly implemented community-based intervention that is offered to youth being served in the mental health system. However, the definition and purpose of case management is often ambiguous (Grube & Mendenhall, 2016a; Grube & Mendenhall, 2016b). Figure 1 illustrates common characteristics of the community mental health system based on two studies in a Midwestern state,

which included focus groups with mental health professionals and interviews with caregivers and youth.

Figure 1. Common Characteristics of Community Mental Health Services for Youth



Case Management Culture

Describing the environment in which they work, mental health professionals identified the children's mental health system as having a negative, deficit-based culture with many challenges to effective service delivery, including lack of caregiver knowledge and involvement, poverty or low family resources, restrictive policies, and high caseloads (Grube & Mendenhall, 2016b). This study also found that the lack of a formal framework or model for case management often results in case managers perpetually addressing the latest crisis without ever establishing goals or addressing skill development (Grube & Mendenhall, 2016b).

Case Management Challenges

Caregivers and youth receiving case management services within the community mental health system have identified several challenges to receiving effective services including lack of fit between the youth and service provider (e.g. differences in gender), exclusion of the youth's voice, provider turnover, and lack of coordination between services or providers as problematic (Grube & Mendenhall, 2016a; Grube & Mendenhall, 2016b). Additionally, the lack of formal structure for case management services, as well as a failure to adequately explain the services, left parents confused about the purpose of case management (Grube & Mendenhall, 2016a).

Strengths Model for Adults in Mental Health Systems

In adult mental health treatment settings, the Strengths Model of case management is a theoretically driven, clearly defined model of case management (Rapp & Goscha, 2012). Based on the Strengths Perspective, this recovery-oriented approach to case management assists people with mental illness to recover and reclaim their

lives by helping them identify and secure resources to achieve their self-identified goals. The Strengths Model has demonstrated positive outcomes for adults including reduced hospitalizations and increased participation in secondary education, independent living and employment. This client-driven, strengths-oriented case management approach offers a comprehensive solution to addressing many of the issues present in the children's mental health system.

STRENGTHS MODEL FOR YOUTH

"We must look on children in need not as problems but as individuals with potential…I would hope we could find creative ways to draw out of our children the good that there is in each of them."
- Archbishop Desmond Tutu

With adaptations made for implementation with youth and their families, Strengths Model for Youth case management provides a formal framework for delivering case management services in the mental health system (Mendenhall & Grube, 2017). The overall goal of Strengths Model for Youth is to help youth grow and succeed in their home and community. The model achieves this goal by identifying and amplifying the positive aspects of youth and empowering youth to identify their own personal, meaningful goals for treatment. The following sections describe the philosophy and key components of the model, the adaptations made to the adult model, and the impact the model has on professionals and clients.

Strengths Model Philosophy

The philosophy of strengths case management is based on the theory of strengths which encompasses concepts from empowerment and systems theories. In regards to empowerment, in order to truly empower someone, an environment that emphasizes an individual's right to choose and provides an opportunity for choice is critical (Rapp & Goscha, 2012). These two ideas are inherent in the model's design. The model requires case managers to actively engage with youth regarding their goals and requires case managers to provide youth choices in achieving those goals. Systems theory concepts, specifically the concepts pertaining to ecological perspectives and environmental niches, are also found within the model's design. Taylor (1997) describes niches as "the environmental habitat of a person or category of persons". Strengths models of case management require a case manager to consider an individual within the context of their niche (home, school, peer network, etc.) and to identify the enabling aspects of those niches. Incorporating principals of systems and empowerment theories and previous strengths-focused work, the Strengths Model of case management emerged in Kansas in the 1980s as a formal practice model for the adult mental health system.

Strengths Model Theory of Practice

Theoretically-driven adolescent case management models are scarce (Arnold, Walsh, Oldham & Rapp, 2007). However, the Strengths Model for Youth begins to address this gap in outpatient mental health care for youth. Using the theoretical concepts described previously and the adult version of the Strengths Model, specific Strengths Model for Youth practice modalities have been developed. The Strengths Model for Youth is designed to help youth grow and succeed in their home and community settings (Mendenhall & Grube, 2017). The model focuses on identifying and amplifying the strengths and resources that a youth has available in their lives to then develop and work towards personal and meaningful goals. The principles of Strengths Model for Youth (Table 1) parallel the principles for the adult model by keeping the youth as the director of the helping process but are also modified to include parental participation and to change language about mental health recovery to language about growth and success instead. These modalities and the adaptation process are further described in this section.

Table 1. Principles of the Strengths Model for Youth

Principle #1: Capacity Youth with behavioral and emotional difficulties have the ability to take active ownership of their lives, allowing them to continuously transform and grow.
Principle #2: Strengths The focus is on a youth's strengths rather than deficits.
Principle #3: Community Resources The community is viewed as an oasis of resources.
Principle #4: Youth Directed The youth, along with parental/guardian participation, is the director of the helping process.
Principle #5: Relationship The relationship is primary and essential.
Principle #6- Home and Community Setting The primary setting for our work is in the home and community.

Adaptation Process

Adaptation of the Strengths Model case management for adults to fit with implementation in the children's mental health system occurred as an iterative year-long process in collaboration with a pilot team of case managers in one Midwestern community mental health center. When adapting the adult model for utilization with youth, changes were made to account for differences in three areas: youth development, family involvement, and systemic differences (Mendenhall & Grube, 2017). Modifications were necessary to ensure that the Strengths Model was developmentally appropriate. These modifications included changes in terminology and language, particularly on the Strengths Assessment and Personal Recovery Plan. For example, the domains on the Strengths Assessment were changed to be more

relatable for youth with "spirituality/culture" shifting to "personal/family beliefs and tradition," and "financial/insurance" shifting to "personal belongings and stuff."

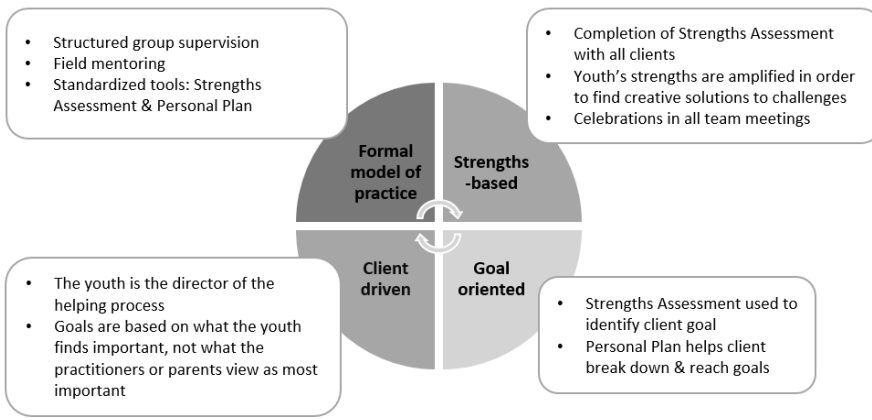
Another change that was made regarding language throughout the model was to eliminate the word "recovery." Previous studies (Grube & Mendenhall, 2016a; Grube & Mendenhall, 2016b), as well as the pilot process, revealed that "mental health recovery" was not an idea or phrase that resonated with youth and could even be off-putting as they often did not think they had anything wrong, and it was associated with substance use. So throughout Strengths Model for Youth materials, the word "recovery" was removed or replaced with "growth" and "success."

The model was also changed to incorporate parent and caregiver involvement. Modifications included adding signature boxes for parents on the model tools and development of materials to share with parents when starting case management explaining the purpose of services and the approach being used. Systemic adaptations to the model included incorporation of the additional support services and providers available within the children's mental health system into the model, such as wraparound and parent support.

Components of Strengths Model for Youth

Strengths Model for Youth has four main components or formal structures that drive the model. These components are: Strengths Assessment, Personal Plan, Field Mentoring, and Group Supervision. Each of the components is described in the following sections, and Figure 3 illustrates how the model philosophy and model components integrate together to shift services to operate from a formal practice model that is strength-based, client-driven, and goal-oriented.

Figure 3. Strengths Model for Youth: Characteristics of Case Management



Strengths Assessment

The Strengths Assessment is a tool designed to help a youth and case manager identify not only the personal and environmental strengths and resources that a youth currently possesses but also has accumulated or made use of in the past (Mendenhall & Grube, 2017). Additionally, the assessment helps the youth to identify personal hopes, desires, and dreams for the future (see Figure 4).

Figure 4. Strengths Model for Youth: Strengths Assessment Categories

Current Strengths and Resources: What are my current strengths? (personal qualities, talents, skills, or personal, family, social, and environmental resources)	**Future Strengths and Resources:** What are my wants, hopes, and dreams?	**Past Strengths and Resources:** What strengths have I used in the past? (personal qualities, talents, skills, or personal, family, social, and environmental resources)
Home/Daily Living		
Personal Belongings/Stuff		
School		
Family/Friends		
Wellness/Health		
Hobbies, Sports, and Other activities		
Personal/Family Beliefs and Traditions		

Which of my goals, wants, hopes, or dreams in the middle column are most important to me?

On the Strengths Assessment, youth are asked to identify current and past strengths and resources across seven domains as well as any that they would like to have in those domains in the future. These domains are: home/daily living; personal belongings/stuff; school; family/friends; wellness/health; hobbies, sports, and other activities; and personal/family beliefs and traditions. The form concludes by encouraging the youth to consider potential goals with the following question: "Which of my goals, wants, hopes or dreams in the middle column [future strengths and resources] are most important to me?" The bottom of the form includes boxes for youth, parent, and service provider signatures. See Figure 7 in the case example at the end of this chapter for a full example of a completed form.

Importantly, the Strengths Assessment is intended to be used by case managers as a tool to guide ongoing conversation and work with the youth rather than as a single formal assessment to be completed in one sitting. Strengths should be added to the Strengths Assessment as discovered throughout the course of services. The assessment can also be shared with caregivers to highlight youth strengths and to provide them the opportunity to add strengths they recognize in the youth.

Personal Plan

The Personal Plan is a tool designed to help a youth make progress on a goal that they identify as important to them (Mendenhall & Grube, 2017). Figure 5 shows the categories to be completed in the collaboratively developed plan. The goal is derived from information provided in the "future strengths" column of the Strengths Assessment, and goals should be specific, measurable, attainable, relevant, and timely. The youth and case manager use strengths and resources in combination with other naturally occurring resources to develop a plan divided into small, attainable steps for accomplishing the goal. Each time the youth and case manager meet, they should revisit the plan, gauge progress, and develop next steps.

Figure 5. Personal Plan Categories

For:
My Goal:
Why is this important to me:
This relates to my Plan of Care because:

Date:	What we came up with today? (Measurable Steps)	Who is going to do this? (Me, case manager, parent/ guardian, e.g.)	Date to be completed:	Date Completed:	Comments:

For each step, the Personal Plan provides space to identify the date, what the step is, who is responsible for the step, a target date for completion, a date when it was completed, and relevant comments. Case managers are encouraged to utilize the comments section to include notes about successes or why a step was not completed each week (e.g. weekly appointment canceled, youth was ill).

The top of the Personal Plan asks the youth to not only identify the goal but also why it is important to them and how it relates to their overall clinical Plan of Care. Identifying the goal's connection to the clinical reason for services is important for demonstrating to the youth, their family, and the case manager that progress and success in the goal area can positively impact symptoms or other presenting issues. See Figure 8 in the case example at the end of this chapter for a full example of a completed form.

Field Mentoring

Field mentoring is a structured supervisory process used to help case managers develop and refine their use of skills and tools further within the context of an actual session with youth and their families (Mendenhall & Grube, 2017). A field mentoring session provides an opportunity for supervisors to model specific skills for case managers or for supervisors to observe case managers using skills and provide feedback after the session. Not only can field mentoring be a key component of training for new case managers but also provides experienced staff with the opportunity to receive support when they are feeling stalled in their work with a particular youth or family.

In the Strengths Model for Youth, supervisors are encouraged to conduct at least two hours of field mentoring a week, with each case manager having the opportunity to receive field mentoring monthly. Prior to field mentoring, the mentored case manager should outline in detail the current status of work with the family and what support the case manager is hoping to gain from field mentoring.

Group Supervision

Group supervision is a formal, structured team meeting process that centers on support and affirmation, idea generation, and learning. Strengths-based group supervision establishes a positive team culture that centers on the youth, actively avoiding negativity and focusing too much on the client's history or struggles. These two-hour team meetings start with team celebrations (an opportunity for any team member to share a positive event in their life, whether professional or personal), followed by one or two strengths-based case presentations, and closing with limited administrative content. Case presentations are not assigned, rather any case manager wishing to present is encouraged to, giving the case managers the opportunity to present on youth and families for whom they are struggling to move forward on a goal.

In the case presentations, the case manager shares the client's Strengths Assessment with the team, describes the youth's goal, and explains what he or she (the staff member) is seeking assistance with. The team is given time to review the Strengths Assessment and ask questions related to it or the goal, with the intent to understand the youth and family so that creative, specific, and useful suggestions can be offered. Following the question-asking period, the team brainstorms ideas to help the presenting staff member in their work with the youth. The goal is to have at least 20 ideas generated for the case manager, with a focus on ideas that involve naturally occurring resources. Following the brainstorming session, the presenting staff person reviews the ideas and decides which one(s) they will pursue with the youth in the following week. In the next group supervision meeting, the team checks in with the case manager who presented the previous week to discuss how the suggestions were implemented and what the next steps are with the youth. In order for the group supervision process to remain strengths-focused, the team supervisor is responsible for ensuring that questions asked by the team are based on the strengths assessment and that the presenting case manager is limited in the amount of irrelevant or problem-focused background information being shared.

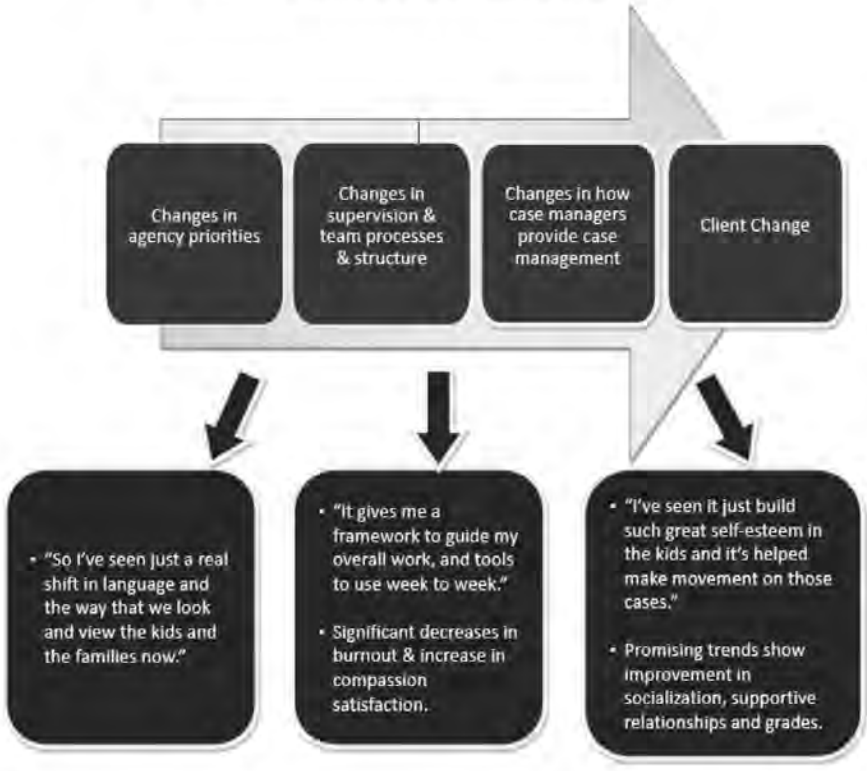
IMPACT OF STRENGTHS MODEL FOR YOUTH

Significantly, a shift to a strengths-based culture in a child-serving system seems to prompt and encourage changes at all levels. The impact of Strengths Model for Youth begins with changes in agency structure and culture, followed by changes in service delivery, which ultimately generates client or youth change. Figure 6 illustrates the stages of impact with examples from implementation at a community mental health center.

When implementing Strengths Model case management, the agency's views of clients become more strengths and goal-focused. Consequently, how services (specifically case management) are delivered becomes more structured and positive. The additional support for case managers through Field Mentoring and Group Supervision combined with the more positive and holistic perspective of clients leads to improved professional quality of life for case managers. Engaging the youth in mental health services in a way that centers their voice and desires increases their motivation and treatment buy-in. With more service engagement and goal-directed work, youth outcomes improve and they are able to graduate from services more quickly

Figure 6. Impact of Strengths Model for Youth from Agency to Client Change

(Mendenhall et al., 2019; Schuetz et al., 2019; Schuetz et al, 2020)



and effectively. Notwithstanding the importance of this change to benefit youth, the shift in focus to youth-centered strengths impacts all parties involved, from the organization to the provider to the youth and family being served.

Agency Impact

One study explored how agency-wide implementation of the model affected the organizational culture and approach to case management services with this population. The study found that case managers appreciated having a framework which guided them, but also allowed them to use their own judgment to fit the model to each specific client. An unexpected side effect of the model was that the team-based focus of the model strengthened the case management team dynamic, increasing a sense of support amongst the groups. The additional documentation required for the model was broached as a problem, especially with the initial implementation, but more case managers who had been implementing the model for longer explained that as you learn the model, it doesn't take as much extra time, and the benefits outweighed any additional time needed.

Finally, workers described how the model changed how they think about and talk about the clients they serve. They expressed that they felt more hopeful for their clients, and thought about them with more positive regard. Even the language they used to discuss the clients became more positively oriented. This change appeared to deepen the workers' empathetic understanding of the clients' dispositions. Whereas previous team meetings could sometimes spiral into venting sessions about frustrations with clients and anything not going well, they now focused on more inspiring attributes while still validating the hard work of the team members. The effects from the change extended beyond direct client contact, and even beyond the context of work entirely, as many workers noticed they experienced similar changes in how they thought and spoke about their families and friends.

Provider Impact

At the individual provider level, Strengths Model for Youth case management affects the day-to-day delivery of case management with individual clients. Case managers note that having structure for their weekly sessions helps them stay focused and organized, and less worried about what they will do with a client for each session. Additionally, the formal model helps the case managers stay focused on the bigger picture of guiding a client to their own goals, rather than becoming sidetracked by common crises. Case managers also noted the model relieved some of the pressure of trying to determine what the client really wanted or needed because with the model, the client decides for themselves what to work towards. There is less worry that the client will not want to work during each session, because it is a goal the client chose and is excited about. As a result of the formal structure and the resulting positive client outcomes, staff noticed that they were able to successfully close cases more frequently once they started implementing Strengths Model for Youth, which allowed them to serve more youth.

Additionally, an exploratory study found preliminary evidence suggesting the Strengths Model for Youth may positively impact aspects of child and adolescent mental health case managers' professional quality of life (Mendenhall et al., 2019). The study found a significant increase in case managers' compassion satisfaction and a significant decrease in burnout after implementing SM-Y for six months. A decrease in secondary trauma also was observed but was not statistically significant. While not every result had large effect sizes, these initial findings indicate the model could help improve the work experience of case managers.

Youth Impact

Preliminary evidence indicates case managers using the Strengths Model for Youth believe the model has a positive impact on their clients (Schuetz, Mendenhall, & Grube, 2019). Case managers noted that the model has an intermediate impact on their relationship with the youth and on how the youth views themselves and services, as well as a longer-term impact on well-being outcomes. These intermediate impacts include increased youth investment in services and improvements in youth motivation and self-esteem. Many youths who struggled to identify personal strengths when beginning services, after receiving services for some time, came to discover many positive aspects of themselves that they proudly list on their assessments. Case managers noted changes in how parents regarded their child(ren)'s strengths, reporting that parents gained a more positive perspective of their child. As for long term impact on youth well-being outcomes, case managers and parents observed improvements in school grades and attendance, family relationships, and increased socialization.

CONCLUSIONS

Preliminary findings suggest that Strengths Model for Youth is a promising approach for providing case management services to youth in community mental health settings. However, more rigorous research centered in other community mental health settings needs to be conducted to understand and assess the impact of the model on agencies, families, and individual youth.

Strengths Model for Youth was adapted and evaluated specifically for youth twelve to eighteen years of age. Case managers reported that some aspects of the model might be utilized successfully with some children younger than age twelve who are cognitively advanced. Additionally, a small number of case managers reported success in utilizing versions of the Strengths Assessment or Personal Plan which includes simplified language and pictures adapted for younger children. Nonetheless, these versions have not yet yielded measurable outcomes. To assure rigorous assessment, a thorough adaptation process should be designed and tested to determine how the model can be effectively utilized with younger children. Likewise, the experience of transition-age youth who receive Strengths Model case management should be explored to determine whether or not their unique needs are met by either the adult or youth strengths model of case management.

As the Strengths Model for Youth case management approach has been utilized in community mental health, the crossover potential of the model has emerged from the evidence gathered thus far. Mental health case managers reported positive anecdotal feedback from both school and child welfare staff when they have shared aspects of the model (e.g., Strengths Assessment) or when they have utilized group supervision to address struggles the youth is facing in interaction with other systems. Future efforts could focus on how to frame the philosophy and tools of Strengths Model for Youth for adoption by other youth-serving systems including child welfare, education, and juvenile justice.

Finally, the role of parents and the family is a critical component of successful work with youth and families. Strengths Model for Youth has incorporated informed parent involvement in various aspects of the model, but additional efforts should be explored to enhance parents' engagement with the model and to develop and test methods and tools to encourage or promote strengths-based parenting.

Strengths Model for Youth is a formal model for providing case management in community mental health which allows youth to drive goal development and attainment by identifying and capitalizing on their strengths and resources. The model has the potential to positively impact youth mental health services from the agency level all the way to the individual client level. It equips supervisors and case managers with a formal model and tools, helping case managers feel more prepared in their roles, and empowers youth to engage in services that are positive and driven by their passions. Below is a case example of the successful utilization of Strengths Model for Youth with one youth in a community mental health setting.

CASE MANAGEMENT EXAMPLE: IMPLEMENTING STRENGTHS MODEL FOR YOUTH

The following is a case example of the application of Strengths Model for Youth. This example is derived from Strengths Model for Youth implementation in a community mental health center. The example tells the story of how the Strengths Model for Youth, with a case manager working in tandem with the youth client, accomplishes a goal identified as most important to the youth.

Presenting Problem

Prior to being trained in Strengths Model for Youth practice, a case manager began working with a 12-year-old male. The case manager described the first appointment with the adolescent and family as extremely challenging. At the initial appointment, the case manager met with the child and the child's family at the family home. During this meeting, the child's behaviors which were identified as problematic were discussed, and an initial plan of care was developed. Problem behaviors included aggression, poor academic achievement, frequent anger outbursts, suicidal

ideation, and lack of ability to control emotions. All of these behaviors were detailed and discussed in depth.

At the conclusion of the meeting, per agency and Medicaid requirements, the case manager attempted to obtain signatures from all participating members, including the adolescent. At this time, the adolescent became extremely agitated and began to destroy things in the home. The case manager and the family were unable to de-escalate the adolescent. The police were called and the adolescent was taken and admitted to an adolescent unit at an acute care psychiatric hospital.

The adolescent remained hospitalized due to suicidal behaviors and was placed in a residential psychiatric treatment facility for several months. During this time, the community mental health center made an agency-wide decision to train all staff in Strengths Model for Youth practice. By the time the adolescent was discharged and returning to his home, the case manager had been trained in the Strengths Model for Youth. After discharge, case management services utilizing a Strengths Model for Youth framework were initiated.

Strengths Assessment

When the case manager began working with the adolescent for the second time, the behaviors that were described at the initial appointment were the same. However, the case manager began the first appointment post-discharge by introducing the Strengths Model for Youth Strengths Assessment, as opposed to developing the plan of care. The case manager had already identified some of the adolescent's strengths and pre-filled in those sections. The case manager then shared what they had identified as strengths with the adolescent. The case manager slowly filled in the Strengths Assessment at each meeting with the adolescent and spent the first several meetings engaging with the adolescent and learning about his interests. The clinical plan of care was developed simultaneously with the Strengths Assessment. The case manager described the Strengths Assessment process as extremely helpful, as it allowed him to build trust with the adolescent, and they could slowly begin to address some of the problem behaviors by identifying the youth's strengths that could be used to alleviate some of the clinical symptoms the youth was experiencing. For example, the adolescent identified his interest in athletics and weight training. The case manager suggested the idea of joining a community gym or the school's weights club, and he could attend when the adolescent began feeling overwhelmed or began noticing feelings of stress.

Strengths Assessment

For _____YOUTH_____Date_____XX/XX/XX_____

Current Strengths and Resources: What are my current strengths? (personal qualities, talents, skills, or personal, family, social, and environmental resources)	**Future Strengths and Resources:** What are my wants, hopes, and dreams?	**Past Strengths and Resources:** What strengths have I used in the past? (personal qualities, talents, skills, or personal, family, social, and environmental resources)
Home/Daily Living		
- I am good at playing PS3 - I take the trash out, it helps mom - I can be nice and polite - I like to play football and ride a scooter around my neighborhood	- I want to be able to do more chores and be more independent - I want to get a set of weights so I can be better at wrestling	- I used to have more friends in our old neighborhood
Personal Belongings/Stuff		
- Like to use my fidget spinner because it takes my mind off stuff - Like to use my bike when I need to get some air	- I would like an x-box 360 so I can play video games more - I want a new weight set	
School		
- I am pretty good at math. - The wrestling coach seems to be cool and I like him	- I want to join the wrestling team - I want better grades so I can do stuff at school - I want to be in normal classes	- I used to have a lot of friends at school - Really loved recess and was good at the jungle gym
Family/Friends		
- I have online gaming friends that I can talk to sometimes. - I am close with Dad. I feel like he understands me. - I live with my mom and two sisters. I sometimes see my grandma.	- I want to have more friends I can do things with. - Want to get along better with my mom. I want to have a better relationship with my mom and listen to her	- I used to be pretty funny and could make people laugh. At our old house, we could play football outside in the yard.
	Wellness/Health	
- I am in good shape for wrestling/ I am pretty healthy/Like to lift weights, it seems to help me think	- Get in better shape to be better at wrestling/get stronger/ have better emotions. Be able to think.	

Hobbies, Sports, and Other Activities		
- I am a pretty good athlete. I like to play sports because I am good at them. They also help me make friends. They give me things to do. - I am good at videogames and have friends that I play with online.	- I want to get better at wrestling and be on the team in high school. I would like to play football maybe	
Personal/Family Beliefs and Traditions		
- I believe in God	- I want to spend more time with my Dad	- We used to go to church every Sunday

Which of my goals, wants, hopes, or dreams in the middle column are most important to me?

1. Being good at wrestling
2. Having a good relationship with my mom
3. Getting more videogames
4. More friends at school and wrestling

Additional comments or important things to know about me:		
First Signature: I agree that this is a true picture of the strengths we have identified so far in my life. We will continue to add these over time in order to help me achieve the goals that are most important to me in my personal journey. _____ My Signature & Date	**Second Signature:** I agree to help my youth use the strengths identified to achieve goals that are important and meaningful in their life. I will continue to help my youth identify additional strengths as I learn more about what is important to their personal journey. _____ Service Provider's Signature & Date	**Third Signature:** I agree to help this youth use the strengths identified to achieve goals that are important and meaningful in their life. I will continue to help this youth identify additional strengths as I learn more about what is important to their personal journey. _____ Service Provider's Signature & Date

Personal Plan

After several weeks of engagement and strength identification, the adolescent shared with the case manager that he was interested in participating in a school activity, specifically wrestling. However, his grades were extremely poor, and he did not think his parents would allow him to participate due to prior behaviors. At this time, the case manager began to use the Personal Plan tool to help the adolescent achieve this goal. The case manager shared the adolescent's goal with the parents and helped the parents understand how participating could help improve some of the mental health challenges the adolescent was experiencing. The parents agreed

to allow the adolescent to participate if the adolescent would begin attending school regularly and would achieve passing grades. The case manager began using the Personal Plan on a weekly basis. At this time, the case manager also reached out to the school's wrestling coach and included the wrestling coach in the child's clinical plan of care and Personal Plan.

Personal Plan

For _____#####, 12 years old_____

My Goal: 1/10/18- "I have fallen behind in Math so I would like to change my Personal Goal of getting all my Math assignments completed and turned in so I can continue to be a part of Wrestling Club and available for tournaments."

Why is this important to me: 1/10/18- "Again I really enjoy wrestling and have been told that I'm good at it. I could get a scholarship someday for college."

This relates to my Plan of Care because: 1/10/18- "Getting my grades back up benefits my Plan of Care because I am working on bettering myself and getting involved in out of the home activities

Date:	What we came up with today? (Measurable Steps)	Date to be completed:	Date Completed:	Comments:
1/10/18	Gather a list of all missing math assignments for the semester from math teacher; talk about extra credit options	1/17/18	1/13/17	Had 4 missing worksheets
1/17/18	This week complete two of the missing math worksheets; study math index cards for one hour one day this week	01/24/18	1/22/18	Completed one math worksheet; did study cards

1/24/18	Check-in with math teacher about finishing remaining missing work; finish 2 missing math worksheets	01/31/2018	01/30/18	Completed all missing math worksheets and did extra credit; have test that needs to be retaken
1/31/18	Create a study schedule for the week in order to retake math test	02/7/2018	02/04/18	
2/7/18	Check-in with teacher about grade and progress	02/14/18	2/11/18	Made schedule Missing work is all caught up; Has more extra credit; grade is passing

I agree that the goal listed above is something important for me to complete as part of my journey, _____ My signature _____ Date	I agree that the goal listed above is something important to this youth. Each time we meet, I will be willing to help this youth make progress towards this goal. _____ Service Provider's Signature _____ Date	I agree that the goal listed above is something important to my child. I will be willing to assist my child to make progress towards this goal. _____ Parent/Guardian Signature _____ Date

Field Mentoring

While working with the adolescent and his family, the case manager utilized field mentoring several times and described it as extremely beneficial. The case manager used field mentoring to help make weekly steps with the adolescent for the Personal Plan and break down some of the adolescent's goals into small, manageable goals. The case manager also said field mentoring helped him remain optimistic with the adolescent, as the supervisor continually encouraged the case manager to be curious with the adolescent and encouraged him to keep the adolescent focused on his tangible goal of joining the school's wrestling team. The case manager also indicated field mentoring sessions with his supervisor helped elicit new information for the Strengths Assessment.

Group Supervision

In addition to utilizing field mentoring and the Strengths Model for Youth tools, the case manager also utilized the group supervision process while working with the adolescent. Through the group supervision process, the case manager obtained several ideas to present to both the adolescent and his family. The topics for the group supervision brainstorming sessions were aimed at coming up with ideas for how the case manager could better engage with the adolescent at the initiation of services and when the adolescent lost motivation towards his goal. The following list of ideas that were generated from the group supervision process when the adolescent was struggling to remain motivated. These ideas were generated by the team of case managers, clinicians, and the team supervisor.

1. Go to a local college wrestling meet
2. Go over next year's wrestling schedule
3. Have adolescent talk with upperclassman about pros of doing team all 4 years
4. Have adolescent talk with coach
5. Go to a sporting goods store and have adolescent look at new equipment
6. Look up colleges that offer wrestling scholarships
7. Use field mentoring
8. Suggest taking a brief break from weight lifting in order to refocus
9. Research wrestling clubs
10. Do a vision board
11. Play card game in which you sort values
12. Plan one night to socialize with someone from the wrestling team
13. Review progress so far
14. Have mom and dad identify adolescent's progress
15. Identify something else adolescent wants to do at end of season

Case Conclusion

After several weeks of case management sessions, the adolescent eventually achieved his goal of joining the school's wrestling team and was able to maintain the behavior in school, achieve passing grades, and attend regularly. The case manager began to initiate a maintenance plan for when the wrestling season concluded. The case manager was brainstorming ways to keep the adolescent motivated in school post-wrestling season with the adolescent's care team, which now included his wrestling coach. At this time, the wrestling coach informed the family that he was also a coach of a year-round wrestling club. The parents were in agreement that if the adolescent could maintain his behaviors, he could participate in the wrestling club. The case manager then utilized the Personal Plan tool to develop a closure plan. Using the Strengths Model for Youth tools, the adolescent successfully graduated from services.

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The Strengths Model in Hong Kong

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INTRODUCTION

Mental health practice involves the continuous process of learning and refinement, especially when practitioners focus on the strengths and aspirations of individuals who are coping with serious mental illnesses (Tse et al., 2016). Cross-cultural considerations include beliefs, language, the role of social support, and the distinctive characteristics of specific communities that require localization in designing and offering mental health services. In this chapter, we describe the experience of adopting the Strengths Model in Hong Kong, starting with an introduction to the mental health system in the city. We then illustrate the development and implementation of the Strengths Model for the Chinese population in Hong Kong. We also briefly review research studies focusing on the Strengths Model in mental health practice in this cultural context (Tsoi et al., 2018; Tsoi, Tse, Canda, & Lo, 2019; Tse et al., 2019). The process of localization described in this chapter required the building of complex relationships among Strengths Model founders, scholars, organizations, caseworkers, and people facing mental health challenges.

THE MENTAL HEALTH SYSTEM IN HONG KONG

Mental health needs

The territory-wide study on Common Mental Disorders (CMDs), the Hong Kong Mental Morbidity Survey (HKMMS) 2010-2013, indicated the clinical diagnosis of

adults aged 16-75 years with a prevalence rate of one week was 13.3% for CMD (Lam et al., 2015) and 2.5% for psychotic disorders (Chang et al., 2015). The highest proportions of diagnoses include depression, generalized anxiety, and mixed anxiety and depressive disorders. The amount of public resources allocated to mental health services is insufficient in proportion to significantly increasing demands in recent years, particularly those associated with the social unrest since June 2019 in Hong Kong (Cheung, 2019; Hong Kong Government, 2013b). Hong Kong has a limited number of psychiatrists; the latest Mental Health Atlas reported that Hong Kong has a ratio of 4.39 psychiatrists per 100,000 population, a low rate compared to that in other countries, such as Japan (10.1/100,000) and England (17.65/100,000). The city's nursing workforce has a ratio of 29.15/100,000, whereas Japan has 102.55 and England has 82.23 (Chan, Lam, & Chen, 2015). Furthermore, Hong Kong has a substantially high caseload rate for community psychiatric social workers of 5.9 social workers per 100,000 people in the population, compared to 17.93/100,000 in the United States (World Health Organization, 2011). According to a survey authorized by the Food and Health Bureau of the Hong Kong Government on access to psychiatric care, the average period from symptom onset to initial psychiatric consultation is 42 weeks (Chan et al., 2012). Increased efforts are thus necessary to develop and retain mental health professionals. In addition, in a study conducted by Lam et al. (2015), it was found that less than 30% of those in HKMMS with CMDs had received professional help during the previous year, suggesting either a shortage of services or barriers to care. All of the above figures reflect the way in which a much larger population suffering from different mental health problems has not received professional services.

Psychiatric and Social Services

The most recent census reported a total population of 7.4 million in Hong Kong (Census and Statistics Department, 2019). Approximately 92% of the population includes people of Chinese nationality and 8% are referred to as ethnic minorities (Census and Statistics Department, 2016). Since 1990, the Hospital Authority of Hong Kong (HA), which is a statutory body, has managed all of the city's public hospitals, including the clinical administration of public mental health services (Cheung, Lam, & Hung, 2010). Regional psychiatric facilities have been expanded to support the growing need for inpatient care and outpatient services. In 2015/16, of the 228,700 Hong Kong citizens who received HA psychiatric services (Hong Kong Government, 2017a), over 60% of the services provided were to people suffering from different types of CMDs.

Overall, the public mental health system in Hong Kong has taken shape with many similarities to community care in the West. A community psychiatric nursing service became available in 1982, followed by community psychiatric teams in 1994. As the services were extended throughout the community, new Integrated Mental Health Clinics came into service in each geographical district in 2012. These clinics are managed by family doctors and are sponsored by the HA's primary care centers. The doctors receive supervision from experienced psychiatrists. To this day, the clinics

are running on a small, experimental scale. All of the above community care has contributed to a gradual reduction in the average length of inpatient stays from over 90 to around 60 days in the past decade. Furthermore, the HA implemented the case management care model (known as the personalized care program, or PCP) in 2010 (Hong Kong Government, 2017b). This model is aligned with similar support for home-based crisis interventions and other assertive treatments used in Western countries. This program allows an assigned case manager to follow up with a person who has a severe mental illness through a close alliance and individual care plans (Hong Kong Government, 2013a). To date, 315 case managers, mainly psychiatric nurses and occupational therapists with knowledge of mental health services, have taken care of more than 15,000 clients with severe mental illnesses, who are being treated in Hong Kong's public sector. The government seeks to improve the ratio of case managers to clients from the current 1:50 to 1:40.

While the HA mainly manages services for inpatients, the Social Welfare Department (SWD) is responsible for carrying out public policies and for developing and arranging social welfare services in Hong Kong. Most notably, the SWD offers an array of services for people affected by mental illnesses, with the aim of enhancing rehabilitation and community reintegration. Since 2010, the SWD has established 24 Integrated Community Centres for Mental Wellness (ICCMW), which are allocated across the region. These centers are recognized as the core providers of community mental health services in Hong Kong (Hong Kong Government, 2013a). In addition, the SWD also provides services for the younger population, children, families, the elderly, and offenders (Hong Kong Government, 2013a). The Disability Discrimination Ordinance (Cap. 487), approved in 1996, is a legal framework for maintaining equal work, housing, and education opportunities, as well as reducing harassment and discrimination toward individuals with disabilities or severe mental illnesses (Hong Kong Government, 2013a).

Along with the SWD, the Labour Department, the Employees Retraining Board, and the Vocational Training Council, as well as NGOs, all offer a range of employment support services, such as vocational training and workshops, for the public. Other community-based services include counseling and other resource centers that are largely staffed by health professionals and psychiatric medical social workers

In addition to services directly offered by the government, in an effort to increase residential care, non-governmental organizations (NGOs) provide alternative community-based residential services. These residential services are subvented by the SWD and include halfway houses, supported hostels, and long-stay care homes. These social rehabilitation service options support the re-integration into the community of people with severe mental illnesses after they have been discharged from the hospital (Cheng, 2011).

Prevention and Early Detection

There have been a number of preventive programs in Hong Kong in recent years. The HA collaborated with the SWD to establish community-based programs for the prevention and early identification of mental health issues among various target groups. In 2001, The Early Assessment and Detection of Young Persons with Psychosis (EASY) program was created for individuals aged 15-25 years (extended to 15-64 years in 2011) presenting early symptoms of psychosis. The Elderly Suicide Prevention Programme (ESPP) was established in 2011, assisting adults aged 65 or above with depression or suicidal ideation. In addition, the Child and Adolescent Mental Health Community Support and Community Mental Health Intervention projects provide more focused support for children and adolescents.

THE IMPLEMENTATION OF A RECOVERY-ORIENTED STRENGTHS MODEL IN HONG KONG

Recovery-Oriented Services

The concept of mental health recovery may still be foreign to people with mental illnesses and professionals in Hong Kong (Ng et al., 2008; Ng, Pearson, Chen, & Law, 2010; Davidson & Tse, 2014). However, some progress has been made in the past two decades. As the Mental Health Service Plan for Adults states, "the vision of the future is of a person-centered service based on effective treatment and the recovery of the individual" (Hospital Authority, 2011, p. 5). Even though such principles have been advocated only in recent years, practices promoting people's empowerment emerged as early as the 1980s (Tsoi, Lo, Chan, Siu, & Tse, 2014). Multiple agencies have adopted recovery-oriented practices, such as peer support services, recovery colleges, supported employment, and the clubhouse model, all of which encourage participants to develop and use their strengths. In the area of hospital-based psychiatric care, for example, the regional psychiatric unit in Kowloon Hospital is a place where people with mental illnesses have served as peer specialists on the mental health team and as representatives on the rehabilitation team since 2012. The oldest psychiatric institution in Hong Kong, Castle Peak Hospital, recruits peer helpers for their user-led clinical programs. Within social services, NGOs run peer support groups with participants who share similar struggles in different recovery stages. Peer support workers facilitate these groups, which support members in coping and living with mental illnesses by having them "walk with" one another. Furthermore, the first multi-agency peer support training course was launched in 2012. It is a three-year pilot project funded by MINDSET and involving four NGOs. It aims to facilitate people who have recovered from mental illnesses in helping others on their recovery journey (Davidson & Guy, 2012). The peer support service provided in the social welfare sector was established as a formal intervention in March 2018, with about 50 full-time and part-time peer support positions. As of April 2019, approximately 20 full-time equivalent support workers had been recruited to work in the public hospital sector.

The Journey

The journey to the adoption and implementation of the Strengths Model in Hong Kong is mostly about relationships. It is a story of close collaborations across different cultures, languages, and settings. The use of the strengths-based approach debuted in Hong Kong as early as the year 2000. Professor Kam-Shing Yip from Hong Kong Polytechnic University completed exploratory case studies, applying the strengths perspective to his work with adolescents in the community (Yip, 2003; Yip, 2005; Yip, 2006). Similarly, Kevin Hui (The Society of Rehabilitation and Crime Prevention, Hong Kong) and his team conducted a six-month, single group, pre-post design study on the effectiveness of strengths-based case management (Hui et al., 2015). Nevertheless, the first major systematic development of the Strengths Model Case Management (SMCM) in Hong Kong lies within the collaboration among The University of Hong Kong (HKU) and three leading NGOs.

The year 2003 marked a meaningful encounter between Professor Charles Rapp from the University of Kansas (KU) and Tse from the University of Auckland, New Zealand. Tse attended a mental health conference in Christchurch, New Zealand, where Rapp spoke as a keynote presenter. Rapp is the founding author of SMCM and the seed of implementing SMCM out the United States was sown in their conversation. In 2009, Tse relocated back to Hong Kong and joined the Department of Social Work and Social Administration at HKU after working in New Zealand for over 20 years. As Tse delved into SMCM, he met Dr. Richard Goscha (another of SMCM's founding authors, from KU) and their friendship has borne many scholarly fruits in the years since 2009. In 2012, Tse and his doctoral trainee, Tsoi, implemented SMCM and conducted a non-randomized controlled trial at the residential services of three NGOs: the long-stay care homes of the Tung Wah Group of Hospitals, the halfway houses of Caritas Hong Kong, and the supported hostels of the Baptist Oi Kwan Social Service. Tse has a long history of close partnerships with these agencies' supervisors – Ms. Eppie Wan, Mr. Stephen Wong, and Ms. Chan Sau Kam – who aided the rolling out of the Strengths Model in their supported accommodations. It was with much anticipation that the team invited Goscha to provide training for caseworkers in Hong Kong. Over 100 mental health professionals attended his four-day workshop in April 2012 (Tsoi et al., 2018). As the model took shape at the three residences in 2013, Goscha continued to supervise via monthly video conferences. Tse provided ongoing local group supervision in later years. From 2014-2015, the integrated community centers of the Society of Rehabilitation and Crime Prevention (SRACP) and the Richmond Fellowship of Hong Kong both adopted the Strengths Model. Regular supervision and training were also provided at these agencies by trainers from KU and Australia. In the following year, the Hong Kong Recovery and Strengths Perspective Social Work Association was set up as a division of its Taiwan mother organization, led by Professor Song Li-Yu from National Chengchi University.

The Strengths Model – New Era in Asia Symposium was held at HKU in October 2016. Goscha made his second visit to Hong Kong and led the event, together with Song and Tse. The team shared their experiences with SMCM in the United States

and Taiwan. Tse and the three NGO supervisors also shared their learning and the challenges they had faced regarding their work in Hong Kong. Goscha provided training for caseworkers during his visit, conducting a total of 23 supervision sessions throughout those years. The year 2016 continued to be celebratory for the Strengths Model in Hong Kong, as the SMART Institute (Strengths Model Application Research and Training) was also founded that year. A unit in the Department of Social Work and Social Administration at HKU was co-hosted by the Tung Wah Group of Hospitals, Caritas Hong Kong, and the Baptist Oi Kwan Social Service. The institute is dedicated to the evidence-based practice of SMCM and its clinical application, research, and training in the city. Continuing to this day, the SMART Institute has organized a range of events, including conference presentations, seminars, and workshops, to promote and educate people about SMCM. These community activities are targeted not only at mental health practitioners, but also at caregivers, as an introduction to discovering strengths within families. Tse continues to facilitate the training of case managers and peer support workers in the HA, as well as mental health practitioners from different NGOs in Hong Kong and Macau. In addition, Tse et al. have conducted three rigorous research studies for peer-reviewed publications in the local context between 2013 to 2019 (see "Study Results" below). In celebrating the SMCM work at a long-stay care home, the Tung Wah Group of Hospitals published a book entitled 我是資優生 (*A World of Talents*). The book contains stories of residents with mental issues and their recovery experiences with the strengths-based approach at a long-stay home. Besides, since 2016, Caritas Hong Kong has published a series of Daily Planners to promote the Strength Model's concepts. The planners consist of various self-learning exercises, with reference to the Strength Model, and are distributed to frontline workers and service users.

The Process and Elements of Implementation

The adoption of the Strengths Model in Hong Kong has been marked by several milestones, with continuous development in the present day. As illustrated in the above section, its growth has been made possible through the sharing of practical wisdom and goals among scholars and practitioners. It started with Tse's overseas visits, during which he shared his work with recovery-oriented approaches and contributed his new knowledge of the Strengths Model to the field at home. Strong collaborations continued due to the commitment of NGOs, intensive training for caseworkers, trial cases, and ongoing supervision. Once the caseworkers' professional development had been strengthened, they began their SMCM work in residential services. Research studies (for details of these, please see the next section on integrating implementation with research) were carried out to examine the outcomes and process in order to establish a more extensive evidence base for SMCM. These have been followed by continuous training and teamwork as the SMCM service has extended to more homes. The maintenance and growth of this community are guided by a quality implementation framework that includes ongoing professional development, guidance, and support for supervisors and caseworkers, as well as fidelity reviews.

The efficient flow of the service community relies on key components for SMCM implementation. These elements are in place to ensure the quality of services delivered to people with mental illnesses and are characterized by five "Cs" (Wan, 2019).

1. Commitment from senior management not only ensures the leadership of operational functions, but also drives the structural movement. The shift in service direction requires the teams' dedicated efforts in cultivating the community's new culture.
2. Capable staff is a crucial element in executing SMCM. The case managers' values, attitudes, and competence are their fundamental assets when adopting and applying the Strengths Model, given their close engagement with service users.
3. Clinical support ensures the professional development of caseworkers and enhances evidence-based practice. Goscha and Tse provide regular training and supervision, while Tse and his teams learn from and share their research findings. There are also regular fidelity reviews and evaluations on the implementation of SMCM.
4. Continuous training has been emphasized throughout the process of implementation. The regularity of coaching is critical for building up case managers' competence and morale. Ongoing training is given through group supervision, field monitoring, and monthly guidance.
5. Collaboration among organizations has been the foundation of SMCM's adoption in Hong Kong. The community expands due to the collective strengths of the three NGOs and HKU, as well as their continuing efforts in learning from, supporting, and sharing with one another. In summary, the elements of SMCM implementation are based on the values of extension and the constant movement of all involving parties.

Barriers to Care and Challenges

Stigma and discrimination associated with mental health issues remain major barriers for people seeking help from and accessing mental healthcare. Strengths-based interventions are no exception. We conducted a longitudinal, repeated cross-sectional study of self-stigma, social stigma, and coping strategies among people with mental health problems. The baseline survey was completed by 193 participants recruited from psychiatric outpatients in 2001. Another sample of 193 outpatients matched in age, gender, and psychiatric diagnosis was recruited in 2017 for cross-sectional comparison. In addition, 109 of the 193 participants (56.5%) were successfully contacted and re-assessed in 2017 (for further details, see Chung, Tse, Lee, & Chan, 2019; Chung, Tse, Lee, Wong, & Chan, 2019). The major finding of this investigation was that there was only a slight reduction in perceived stigmatization among participants with mental illnesses in Hong Kong from 2001 to 2017. A lower proportion of service users of outpatient clinics interviewed in 2017 agreed

that most people would not marry a person who had a history of mental illness and would not accept someone who previously had mental illnesses as a close friend, but viewpoints regarding untrustworthiness, dangerousness, devaluation, avoidance, and personal failure remained unchanged. Personal experiences of rejection and coping strategies were similar in the two cross-sectional samples. Regarding the longitudinal study, the 109 participants who were re-assessed in 2017 reported similar experiences regarding stigma, compared to their responses in 2001. Although public expenditure on mental health education has grown exponentially in the past two decades in Hong Kong, our findings highlight that the stigma experienced by people facing mental health challenges has not improved proportionally. Fear of stigmatization due to the discouraging levels of community acceptance of mental illness may cause people to be reluctant to seek help when a problem arises (Siu et al., 2012). Government agencies and NGOs must continue their community and education activities in encouraging more positive attitudes. Moreover, sufficient service provision is crucial to proper care for people with mental illnesses at early stages.

INTEGRATING IMPLEMENTATION WITH RESEARCH

From 2013 to 2019, Tse et al. conducted three research studies on SMCM in Hong Kong (2016, 2018 and 2019). They include a non-randomized controlled trial, a randomized controlled study (in progress), and an international comparison of Western strengths-based practices and practices in Hong Kong. These studies suggest the importance of translating the Western approach to fit the needs of a Chinese population. Their results provide insights into the outcomes of current clinical applications and offer directions in which to extend the localized implementation of the Strengths Model.

A Non-Randomized Controlled Trial

A non-randomized study was carried out to evaluate the effectiveness of SMCM for individuals with mental illness in Hong Kong (Tsoi et al., 2018). In the 12-month controlled trial, the effects of the treatment in the intervention group were compared with those in a treatment-as-usual control group. Participants were selected from six residential sites run by the Tung Wah Group of Hospitals, Caritas Hong Kong, and the Baptist Oi Kwan Social Service. These six residential service units were invited to participate in the study, based on their previous experience (or lack thereof) of the Strengths Model. The SMCM intervention or non-SMCM intervention (control group) that each individual received was therefore based on the setting in which he or she resided. Since the allocations of individuals to the intervention or control groups were not random, this is a non-randomized controlled trial. In a sample of 124 participants, over 85% were diagnosed as having schizophrenia and the rest with bipolar disorder. All possessed adequate Chinese reading and comprehension skills. Data were collected at pretreatment and at the fourth and 11th months for comparison. Seven assessment tools (e.g., the Maryland Assessment of Recovery in

people with serious mental illnesses, States of Hope, the Working Alliance Inventory) were used as outcome measures.

The SMCM intervention was provided by caseworkers who were trained by Goscha and his team members. During a 12-month period, individual sessions took place for 30 to 60 minutes every two to three weeks. The caseworkers met with participants at nearby parks and fast food places in the community, following the SMCM's sixth principle (i.e., the primary setting is the community, Rapp & Goscha, 2012, pp. 61-62). The sessions were facilitated with the aim of discovering the individuals' strengths. The Strengths Assessment was used to set recovery agendas and the Personal Recovery Plan was used to align participants' strengths with their desired goals. Fidelity monitoring, including chart reviews of tools, interviews, and the evaluation of group supervision, was conducted. The detailed fidelity report and scores were prepared by Tse and a person with lived experience of mental illnesses and was moderated by Goscha. With everyone's effort, the average fidelity score improved from 2.6/5 before the trial to 3.7/5 during the intervention period. Scores close to 4 out of 5 meant that the interventions provided in the trial had reached the desired features of SMCM practices, such as a good ratio of caseworkers to service users, satisfactory supervision, and clinical support for workers.

To the best of the authors' knowledge, this was the first study with preliminary evidence of high-fidelity SMCM's positive effects on service users' outcomes conducted in a healthcare system structured differently from that of the U.S. The study reported significant differences in outcomes between the intervention and control groups regarding psychiatric symptoms, the achievement of goals by users and caseworkers, and caseworkers' well-being (Tsoi et al., 2018). As for goal achievements rated by caseworkers, the intervention group made better progress in achieving their recovery goals – or, in general, what the literature refers to as "functional recovery" (Leonhardt et al., 2017; Tsoi et al., 2018). In practice, the results suggest that frontline social workers should be empowering individuals with mental illnesses through their journeys of strength discovery (e.g., what are the users' aspirations, talents, and previous/current successes). Ongoing support and stable and trusting therapeutic relationships are critical elements contributing to successful intervention outcomes (Tsoi et al., 2018). The caseworker outcomes highlight the effectiveness of SMCM in reducing caseworkers' emotional exhaustion. It is our understanding that this was the first study involving the influences of SMCM on caseworker burnout. A potential new direction for future research was suggested in regard to considering individual and organizational changes that may affect caseworkers' well-being (Tsoi et al., 2018). Another observation was that the visual plot of the results of the key clinical outcomes across various agencies demonstrated a strong link between higher fidelity settings and better outcomes. This finding regarding fidelity provides the basis for further research on organizational characteristics that may influence fidelity (Tsoi et al., 2018).

Randomized Controlled Study

At the time of writing, the latest study protocol is designed for a randomized controlled trial (RCT) to assess the effectiveness of SMCM with Chinese individuals with mental health challenges in Hong Kong. It aims to conduct rigorous research that provides evidence and implications for local strengths-based interventions supported by the ongoing measurement of fidelity scores during the course of study (Tse et al., 2019). In addition to the RCT focusing on outcome evaluation, we will also carry out a qualitative study to examine the therapeutic elements contributing to the intervention outcomes.

Before the trial, the authors made preliminary cultural adaptations according to their best knowledge of SMCM. These were carried out considering cultural sensitivity, which may be weak in previous research in the Western context (Tse et al., 2019). Some adaptations were conducted by clinicians in the years from 2012 to 2013, before we planned to conduct the present RCT. This work included translating the Strengths Assessment and Personal Recovery Plan forms into Chinese, using local terms and providing examples referring to the concept of strengths. This study investigates the compatibility of SMCM with Chinese culture, considering aspects such as Chinese people's views, family traditions, and reservations regarding the expression of their strengths and successes. These cultural values may be influenced by linguistics, folklore, metaphors, icons, and introspection from Taoist philosophy and Confucius's Doctrine of the Mean (Zhongyong 中庸) (Tse, Divis, & Li, 2010; Tse et al., 2019; Song & Shih, 2010). It also examines the structural compatibility of SMCM with aspects such as caseload size and the ratio of supervisors to caseworkers. Mental health services in Hong Kong operate within a different structure compared to the U.S., with higher caseloads, for example; the HA reported a 1:47 ratio of community caseworkers to individuals with severe mental illnesses. The above cultural and community factors provide valuable insights into the best possible SMCM implementation in local Chinese or Asian mental health settings (Tse et al., 2019).

The RCT is making strong progress. A total of 210 participants have been recruited from the ICCMWs of three NGOs in Hong Kong. Participants are randomly assigned to an SMCM intervention group and a control group. The inclusion criteria include: 1) service users of mental health services in ICCMWs; 2) aged 18 years or above; 3) Chinese and can speak Cantonese and read Chinese; 4) diagnosed with a mental illness, including major depressive disorder, anxiety disorder, bipolar disorder, and psychotic disorders, by a psychiatrist; and 5) able to provide written informed consent to participate in the study and agree to be allocated to either an SMCM intervention or a control group (Tse et al., 2019). Data are collected at six and 12 months for comparison between the SMCM intervention and the control group.

The ICCMWs staff are the caseworkers delivering the intervention in the SMCM group. They are required to have received training by Goscha, with ongoing group supervision, in order to deliver the intervention. There are individual sessions of 30

minutes with the participants every two weeks. The Strengths Assessment and the Personal Recovery Plan are used to help users set recovery goals. The Fidelity Scale is also included to monitor the service unit every six months. For the control group, a generic intervention (i.e., treatment as usual) is delivered to the participants. This includes medical appointments, recovery groups, hobby groups, and general community activities. The control group's caseworkers call service users or meet them at center activities as an attention placebo; thus, if there are any differences between the intervention and the control group, we can be certain that the differences are not due to the extra attention individuals receive in the intervention group. Furthermore, this study aims to involve people with lived experience of mental health challenges. Nine people in recovery from mental illnesses provided feedback in regard to revising the Chinese questionnaire in a pilot study conducted in 2017. Individuals with lived experience of mental illnesses are recruited as paid fieldworkers for the data collection process, and the study results will be disseminated among both the participants and the wider public.

The current RCT in progress will increase our understanding of the effectiveness of SMCM on individuals' recovery and any unintended results of strengths-based services for individuals with mental illnesses. The essential therapeutic ingredients and fidelity features of SMCM will be illustrated, along with their effects on recovery outcomes. This research will closely examine enhancements made to SMCM adaptation for the Chinese community, ensuring a culturally responsive practice.

Critical Review and Cultural Considerations

The researchers in Hong Kong led a critical review of the use of strengths-based approaches in mental health services (Tse et al., 2016). The critical review examined the quality of seven selected articles and drew implications for cross-cultural, recovery-oriented practice. The review included peer-reviewed journal articles with quantitative research on strengths-based interventions published between January 2001 and December 2014. From a search of 619 articles, 55 were identified as relevant to the review and seven met the inclusion criteria. The quality of the studies was appraised using the Quality Assessment Tool for Quantitative Studies, with the majority rating from moderate to weak among diverse research designs. The review presented evidence that the strengths-based approach creates positive effects for outcomes including service satisfaction and utilization, hospitalization rates, and educational and employment attainment, as well as multiple interpersonal outcomes, such as a sense of hope and self-efficacy (Tse et al., 2016). The studies confirmed the advantages and feasible application of high-fidelity, strengths-based approaches for clinical settings and in healthcare. The review highlighted the high level of engagement between caseworkers and service users in strengths-based interventions, as well as the benefits of recruiting peer supporters. The lack of routine review and monitoring of users' strengths were discussed, and the discussion suggested that SMCM could improve the monitoring of clinical practice (Tse et al., 2016). Therefore, Tse et al. suggested more high-quality and well-designed clinical studies to further examine the effectiveness of strengths-based approaches (Tse et al., 2016).

The main discussion in the critical review was directed toward the need to consider cultural nuances when delivering SMCM. First, all studies identified in the review were conducted in the Western context. Culture can greatly influence a person's expressions of feelings and beliefs regarding mental health, strengths, and goals (Tse et al., 2016). The Strengths Model is of Western origin; there are thus many challenges to be faced in the process of ensuring it is culturally adaptable for the Chinese community. Forms of linguistics, metaphors, folklore, and icons are culturally unique, and they all contribute to the perception of strength. In Chinese, the word "strength" can be translated as 優勢 (*youshi* or superiority), 強項 (*qiangxiang* or forte), or 潛能 (*qianneng* or potential) (Tsoi et al., 2019). The interpretation of each term is based on a person's understanding from his or her own cultural perspective. For example, the bamboo is a common metaphor for strength and virtue, given the evergreen plant's ability to grow even in harsh weather conditions. It can be seen across Asia, symbolizing perseverance and tenacity in Chinese, Japanese, and Vietnamese cultures. Moreover, it is important to explore various cultural and philosophical views regarding the concept of "strength". Most Asian communities (namely, Chinese, Japanese, and Korean) are inspired by the teachings of Taoism, Confucianism, and Buddhism (Tsoi et al., 2019). Their philosophy encourages simplicity in life, a clear mind with minimal desires, and a habit of self-transcendence and self-retrospection. Confucianism advocates the ideas of harmony, self-sacrifice, service, and forgiveness (Tsoi et al., 2019). Taoism shares similar roots, placing a great deal of emphasis on modesty (Tse et al., 2010). In light of these considerations, cultural sensitivity and creativity are at the core of mental health practitioners' work with service users in the process of exploring strengths.

Subsequent to the critical review, Tsoi and Tse conducted a small-scale, creative qualitative study using photos as stimuli, with a small sample of Chinese community participants (Tsoi et al., 2019). The participants were presented with different photos, such as a person with a cane, bamboo, and a financially deprived family in a crowded space. They were asked to identify the kinds of strengths they could see in the photos. The questions aimed to encourage the participants to use their own words to describe the strengths pictured. The outcomes revealed the following characteristics of strength, as narrated by the research participants:

1. Strength as a flexible, adaptable capability that may allow a step back at times. This is a Chinese belief stemming from the imagery of a formless flow of water and streams (epitomized by the saying "be water"). It is interpreted as contrasting the Western idea of strength as persistence and force.
2. Strength through relationships. These include support systems from family, friends, and the community, and the empowerment and advantages that flow through relational factors.
3. Strength as a vocational ability. A person's educational advantages and abilities to work represent his or her strengths.
4. Strength in character. A person's qualities, such as a caring spirit, loyalty, kindness, filial piety, and patience, are his or her strengths.

The above findings have two implications. First, they provide valuable information reflecting how Chinese culture may interpret strength differently from Western culture. Second, the findings show the importance of adopting culturally responsive SMCM tools that are endorsed by individuals from non-Western contexts about discovering their strengths. For example, after extensive consultations with individuals with mental illnesses and mental health workers, the English word "strength" is translated to 優勢 (*youshi* or superiority). We emphasize the way in which the concept of strength stretches beyond personal strength and can include one's career, spiritual beliefs, family, and community or relational strength. Hence, further research in non-Western settings is warranted so that SMCM can evolve further, enabling it to cater for users from different cultures.

Discussion

A range of mental health services are available in Hong Kong, including pharmacological treatments, inpatient care, and personalized care programs for community-based services. Strengths-based, recovery-oriented approaches have increasingly been integrated into community-focused services in the past decade (Hospital Authority, 2011). This growing trend warrants more research work focusing on both outcome and process evaluations. Furthermore, our recent study, which included an assessment of staff burnout (i.e., caseworkers involved in the strengths-based intervention reported lower levels of stress, compared to the control group), provided a new direction for further investigations. This brings attention to the urgent need of mental health workers in Hong Kong for support (Tsoi et al., 2018). Future studies are advised to include an evaluation of fidelity reviews and staff burnout in relation to the effectiveness of SMCM for people facing mental health challenges.

The Strengths Model emphasizes the personal strengths and self-defined goals of individuals in the context of their communities (Rapp & Goscha, 2012). It calls for careful consideration of individuals' understanding of strengths on a deep, personal level during the process of therapy (Tse et al., 2016). In recent years, Tse and his team have made diligent efforts to study cultural influences on their implementation of the Strengths Model in Hong Kong. Traditional Chinese beliefs and philosophical values shape people's perceptions of strengths and aspirations, and they have been at the center of the application of SMCM in the city since the beginning. The path to localization requires fundamental steps to be taken in exploring cultural aspects that influence an Asian service user's understanding of strength. The current translated tools confirm the adaptability of SMCM to an Eastern city. The next steps that can enhance the implementation require gaining further insights into metaphors, folklore, and other traditional Chinese family teachings in relation to the concept of strength. Such knowledge can add to the overall strengths-based practice by making it more personalized and relevant for local users. It can also help caseworkers to develop their competence by delivering the intervention more effectively. It is a priority for caseworkers to understand patients' concepts of strength in order to instill hope and self-efficacy; their recovery goals will then become achievable and applicable to their community. In this way, the individuals involved are

empowered in regard to discovering their niche and using the resources available to them. Further research involving high-quality clinical studies is necessary to evaluate the effectiveness of the Strengths Model and its adaptation in these distinctive communities.

As the Strengths Model continues to extend toward new communities in Hong Kong, its implementation components follow the principles of the co-construction of goals. Chan (2019) from the Baptist Oi Kwan Social Service proposed a future SMCM plan that consists of four main directions:

1. Platform – the development of a digital platform. Community resource libraries, chatrooms, and strength assessments will become available online. This digital approach will connect case-workers more closely with service users and raise awareness of the services available.
2. Leadership – training individuals in recovery to become peer support workers. This aligns with current peer support worker recruitment processes at psychiatric facilities and NGOs.
3. Setting – implementing SMCM in hospital-based acute services and vocational settings. This is a natural extension of the model from community settings to hospitals and reflects the Hong Kong people's pragmatic view of "recovery" in regard to the way in which healing and the installation of hope should begin as soon as a person becomes unwell.
4. Target – identifying more target groups that can benefit from SMCM. Strength discovery is a favorable method that can be used to support people with learning disabilities, autistic features, or multiple physical disabilities (i.e., verbal and behavioral challenges). Caregivers are also in need of personal recovery and wellness; strengths-based approaches can create protective factors, especially in Chinese communities, which have a strong family orientation. Finally, strength exploration and self-motivation are needed for the elderly population. "JC JoyAge" is a holistic support project for elderly mental wellness. It constitutes a collaboration between The Hong Kong Jockey Club Charities Trust and HKU's Department of Social Work and Social Administration, as well as other NGOs. The project supports elderly people suffering from depressive symptoms and the project is in the process of adopting the Strengths Model.

CONCLUSION

The story of the Strengths Model in Hong Kong is encouraging. The Strengths Model focuses on facilitating the re-integration of people with mental illnesses into their communities and so its local adaptation focuses on the distinctive strengths and

goals of these communities. Following the strengths-based beliefs of progress and movement, the implementation of SMCM continues to strengthen meaningful relationships in different roles and to extend to a wider range of services. The clinical practice of the Strengths Model in Hong Kong ensures its fidelity standards of ongoing training and supervision, the commitment of management, and the collaboration of organizations. The exploration of unique cultural influences and the refinement of its application will continue with rigorous research. This journey has involved discovering people's strengths, as well as the strengths of recovery-oriented mental healthcare in Hong Kong.

END NOTES

Acronyms Used in This Chapter	
CMDs	Common Mental Disorders
EASY	Early Assessment and Detection of Young Persons with Psychosis
ESPP	Elderly Suicide Prevention Programme
HKMMS	Hong Kong Mental Morbidity Survey
HA	Hospital Authority of Hong Kong
ICCMW	Integrated Community Centres for Mental Wellness
NGO	Non-Governmental Organizations
PCP	Personalized Care Program
RCT	Randomized Controlled Trial
SWD	Social Welfare Department
SRACP	Society of Rehabilitation and Crime Prevention
SMART	Strengths Model Application Research and Training
SMCM	Strengths Model Case Management
HKU	University of Hong Kong
KU	University of Kansas

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Introduction and Development of Strengths Perspective and Strengths-Oriented Case Management in the German-Speaking Area

Corinna Ehlers & Matthias Müller

INTEGRATION OF THE STRENGTHS PERSPECTIVE FROM THE SOCIAL WORK THEORY STANDPOINT

Our (Corinna Ehlers, Matthias Müller) connection to the strengths perspective is formed by personal ties, as we came upon strengths-oriented work at the University of Kansas not only through specialist literature but first and foremost through personal channels. Beside contacts with the colleagues at the School of Social Welfare (Rosemary Chapin, Rick Goscha, Chris Petr and Amy Mendenhall), it was also the exchange with the practitioners (e.g., from Bert Nash Community Mental Health Center) that affirmed us in our intention to delve deeper into the strengths work and to transfer these approaches to Germany as well.

Both of us have been active as case management educators in the training of case managers for years, and we are deeply interested in the practice of case management in the social work areas of activity, based on our social work background. In the German-speaking area, case management has evolved, out of social work, to become a generalist method which is now employed in very different areas of practice. Thus, case management takes place in social work, in healthcare and nursing care, in working with disabled people and in the insurance industry.

Since we wished strengths-oriented case management to be understood as an explicitly social-work case management approach (M. Müller 2018), it was necessary

to embed the strengths perspectives into the theoretical discourse of social work in the German-speaking area. Even though the person-in-environment approach, the person-centered dialogue management, the eco-social approach, the system-theoretical approaches to thinking and acting as well as the theoretical constructivist perspective and the approaches of orientation towards solution and resources are, of course, under the influence from the USA, the discussion of the approaches in the German-speaking area stands nonetheless on its own.

To introduce the strengths perspective to the German social work community, it seems necessary to connect the strengths perspective to common and well adopted theoretical approaches in Germany. In consideration of the historical experience, this is helpful because the development and professionalization of social work in Germany was interrupted due to the Nazi regime. After the Second World War social work was influenced by US-American approaches. Theories like *person-centered approach, eco-social approach* or the *solution-focused approach* had and still have an impact on practical social work in Germany. However, there is also a rich background of theories in the German-speaking area, and hence it is important to connect these different theoretical approaches as well as to point out their respective relationship with the strengths perspective.

The second point is that social work education in the last century was mainly conducted in colleges of higher education or universities of applied sciences with a focus on practical social work. For this reason, our research tradition is very young. With the following overview, we would like to summarize the conjunction of established theoretical frameworks in Germany with the strengths perspective.

Table 1: Overview Theories and Strengths Perspective

Theory	**Connection to Strengths Perspective**
Person-in-environment approach (Richmond 1917) Many ideas of Richmond were adopted by Alice Salomon, a pioneer of social work and founder of the first social work school in Germany	It is important to realize, with regard to the strengths orientation, that it likewise revolves around the viewpoint that reflects upon people within their environment. Not only individuals but also the environment come into focus. An essential part of social work is to influence the living conditions and to create possibilities for the client's development. Problems and resources are thus a unique interplay between individuals and conditions in each instance, according to this view. Strengths-oriented working modes possess a dual focus as well: they work with people (for example, the strengthening of the self-management abilities), and they create systems like organizations or communities by generating possibilities and options. This process is less about interventions of the social work but rather – in a strengths-oriented sense – about creating forms of cooperation and shaping relationships.

The *person-centered approach* (Rogers 2003: 63)	The strengths orientation assumes, as Rogers suggests, that people have the potential in them to develop themselves in line of what is constructive for them, that they are capable of growth, and that they know what is good for them, so this inner drive is to be followed in the process of help.
Eco-social approach of the Life Model (Germain/ Gitterman 1999)	In regard to the strengths perspective, people and environments are mutable. This means that a person can change and, in doing so, deliver adjustment and achievements in coping. Also, habitat and niches are changeable, and thus the adjustment and the coping become possible. These processes are not causally controllable, but strengths-oriented social work on the person, the social space and beyond that starts at the societal level.
Systems theory approach to thinking and acting (Luhmann 1997	Luhmann's theory shows clearly for the strengths perspective that communication plays a central role in constituting the situation of help. In the course of this, systems (society systems, organizations, interaction systems) process the communications according to their own rules These rules are not foreseeable and not controllable either. Specialists are always a part of the help processes; they are always involved and never external – neutral – observers. The systemic view shows, for instance, that function systems shape their own context. The help should connect to these contexts. Persons have then ascribed meanings only from the viewpoint of system contexts. These viewpoints can be connected to strengths or inhibit them.
Systemic-constructivist approaches (Gergen/ Gergen 2000)	*Systemic-constructivist approaches* clearly show, with respect to the strengths perspective and against the background of the person-in-environment approach, the Life Model and the systems theory view, that a human being and the social environment of a human being exert significant influence on the construction of realities. If social niches or social systems are comprehended as social groups which live in their specific living spaces (habitat), then it becomes clear that the perceptions and ways of thinking of the respective groups are influenced by one another or, alternatively, by their own perceptions and by the environmental circumstances (the social context) in the process of their formation. Conversely, they shape the latter, too, so it is a reciprocal process.
Solution-focused approach (Shazer de 1989)	The strengths perspective is based on the assumption that people have abilities and resources at their disposal which help them to cope with their problems. Additionally, the 'problem' is not always present with the same intensity, and there are always exceptions where the problem is less present or not there at all. The task of social workers is to pinpoint the exceptions from problematic situations and the 'hidden', unused resources. Furthermore, social workers support clients in integrating the resources into the helping process. The clients are thus empowered and also strengthened in their self-help potential so that they are able to regulate their own issues themselves to a great extent.

FINDINGS FROM US DISCOURSE ON THE STRENGTHS PERSPECTIVE: THE DIFFERENTIATION BETWEEN STRENGTH AND RESOURCE

Knowing full well that in the social sciences and the humanities there often exist no consistent definitions, and clear delimitations between notions hardly exist either, US discourse on strengths perspective provided us with a thought-provoking impetus towards differentiating professionally between the terms 'strength' and 'resource'. In what follows we would like to summarize the findings that proved to be important to us:

- A differentiation between the terms 'strength' and 'resource' is substantial for understanding the strengths perspective since in the German terminology and in the German colloquial language the term 'strength' is used synonymously with 'resource'. Strength implies more than merely the existence of personal, material or social resources; strength focuses on the aspiration of a person, i.e. their pursuits, hopes, ambitions and their trust in themselves. The strengths orientation thus puts into the foreground, in particular, the alignment of the helping process towards the interests and the will of the clients.
- It was important to us to make clear that the means, properties or objects are not resources per se, but they are made to be that through an individual attribution. To comprehend the strengths perspective, the meaning of the subjective attributions is of substance, since subjective attribution is people's own construction, and it is essentially defined by their strengths. It happens especially in helping processes that the sensitivity to the personal attributions of clients is decisive. Parallel to that, properties and means exist which are generally evaluated by many people as positive, i.e. as a resource. Schubert and Knecht (2012: 19)* suggest using the terminological differentiation between "generally effective" and "supra-individually effective" resources. Generally, effective resource (e.g., character traits like self-confidence) are what we comprehend as an aspect of strength.
- Strengths are an important asset to people- and environment-related resources (physical, cultural, symbolic, relational, social and community-related resources). Irrespective of individual wishes and pursuits, the different cultural, social or physical resources are, of course, also present, but they are more difficult to activate or they possibly do not get activated at all. To speak figuratively, the motor, the power to utilize these resources, also when coping with problems, is lacking. A personal strength like courage or love of learning can be the driving force to activate a resource. Strengths and resources have a reciprocal relationship and refer to each other.

Despite the substantive proximity of the terms ‘strengths’ and ‘resources’ in the German-speaking area, differentiation is thus possible and necessary. In this process, and for the comprehension of the strengths perspective, it is important that strengths essentially define how the resources can be accessed. Strengths act as keys to the fundamental driving force for the helping process (cf. Ehlers 2013).

This terminological clarification of strengths and resources was important to us for the transfer of the strengths-oriented case management model of Rapp and Goscha (2012) into the German case management discourse. The reason is that we see a meaningful shift of focus and systematic extension of the actually well-known approaches to social work in the German-speaking area in the principles of Saleebey (2013) as well as in the concepts and methods of Rapp and Goscha (2012). They are aimed clearly and first and foremost at the personal hopes, prospects and dreams of the clients. The benefits of such a perspective are in the personal development and growth of the clients in their attempt to overcome difficulties. Strengths-oriented work thus does not confine itself to stabilizing the unsatisfactory circumstances but expedites an improvement of the life situation and living conditions. The communication of possibilities, hopes and growth infuses all levels of casework and (care) system work in the strengths-oriented work (cf. Chapin 2012, Rapp & Goscha 2012: 32).

Alongside the now established terminological clarity, the strengths perspective is moreover comprehensively linked with the theories and views of the social work in the German-speaking area, and the strengths perspective brings in a new professional impulse here.

STRENGTHS-ORIENTED CASE MANAGEMENT

Only after the thorough clarification and terminological differentiation described above have we deployed strengths-oriented case management in our interpretation. In this process we started with the following constituting characteristics of case management:

- Differentiation between case level and (care) system level.
- Consistent orientation towards the needs and requirements of the addressees.
- Systematic case processing throughout the phases.
- Taking into consideration the reciprocal relationships between informal and formal systems.
- Interconnectedness and coordination of formal and informal help.
- Continuous trans-sectoral and responsible supervision and support of clients (cf., e.g., DGCC 2015, Ehlers & M. Müller 2013).

We have named the following characteristics for strengths-oriented case management modeled on Saleebey (2013), Rapp and Goscha (2012), Greene and Lee (2011: 40) in connection with the explanations of the specialist group we led: “Case

Management in the Area of Activity of Social Work" of the Deutsche Gesellschaft für Care und Case Management (DGCC) and the Deutsche Gesellschaft für Soziale Arbeit (DGSA) (2014)[1]:

- Strengths-oriented case management advocated the safeguarding of human rights. People's dignity is respected and protected. Case managers work with their clients on their (the clients') taking part in life according to their interests and being part of actively shaping their own lives (participation). They support people in developing and making use of their abilities.
- Strengths-oriented case management works with people's motivation.
- Strengths-oriented case management assumes that every human being (also in critical life situations with limitations of different scale) can learn and grow as well as develop and change themselves.
- Strengths-oriented case management constitutes itself in a continuous relationship work between case managers and people who they work with. It is marked by dialogue communication processes. The clients are regarded as experts in their respective situations. They are co-producers of the helping process.
- Strengths-oriented case management programs implement multi-dimensional ways of thinking and working. A bio-psycho-social viewpoint is characteristic of those.
- Strengths-oriented case management takes place in an outreach form and in the social space.
- Strengths-oriented case management promotes help towards self-help and supports informal help forms.
- Strengths-oriented case management involves different levels when processing cases: with the addressees (case level) and with organizations, with political decision-makers as well as funding agencies ((care) system level).

These characteristics reflect the theoretical framework of German social work as well as the main principles of the strengths perspective. Embedded in these guidelines lies a five-step process[2] for our concept of strengths-oriented case management. It looks as follows:

1. Clarification phase:
Case management processes, as a rule, commence with a conceptual clarification prior to the contacts with the clients. Before the actual initial processing steps of the casework with the addressees are set into motion, a content-related alignment of the action concept takes place on the organizational level in reference to the target groups, the course of action in the strengths-oriented case processing or the

cross-linking. The fundamental ideas of the strengths perspective (Saleebey 2013) according to explanations of Rapp and Goscha (2012) with their assumptions and core principles, such as empowerment and participation, are conceptually recorded in the case management program. There are set criteria for the identification of complex cases, which lead to a corresponding range of choices for counseling and/or case management cases. Apart from that, the case intake gets clarified in the organization.

2. Strengths-oriented case assessment:
Based on trusting relationships, the wishes and hopes of the clients are discussed, personal competences and possibilities as well as supporting social relationships and opportunities are explored within the framework of the strengths-oriented case assessment. In the case assessment, strengths-oriented case management takes into account the multi-dimensional ways of thinking and working by, for instance, considering problematic situations from the bio-psycho-social perspective at the same time. A comprehensive strengths-oriented case assessment also takes place from different perspectives, with particular attention paid to subjectively perceived strengths and interests.

3. Strengths-oriented goal-setting and support plan:
On the basis of the interests, hopes and positive expectations, as well as the concrete needs and requirements of the clients, the corresponding individually motivated goals, are discussed. Framework and action goals are derived from those and formulated jointly. Resulting from the action goals, an assistance plan is developed, in which individual tasks for informal and formal helpers are set. Personal strengths and opportunities in the social space or community are taken into consideration all along and consistently in this process.

4. Implementation of the support plan and monitoring:
Within the scope of implementing the support plan, the required case-related aids are linked with one another. Informal aids and peer-support approaches receive special consideration in this process. The coordinated help process is monitored by, for instance, analyzing deviations from planning and adjusting the support plan if necessary. The work is moreover documented in a professionally appropriate way in order to keep it comprehensible for the third parties. Change steps of the addressees are acknowledged with appreciation and professionally supervised if necessary.

5. Strengths-oriented evaluation:
Towards the end of the help process, the following issues get reflected upon between clients and professionals: How did the process run? What results were achieved? Additionally, it must be clarified how personal development processes can be secured long-term. Beyond the case-related assessment, a cross-case assessment of case management processes within the scope of accountability to executive boards and politics takes place.

The casework is not a linear process. It follows a rhizomatic, interconnected and circular order (cf. Haye & Kleve 2011: 125).

A wide variety of tools for the case processing in the singular work phases is available, such as network maps, strengths assessment, personal recovery plan as well as various techniques (e.g., competence in conducting talks, visualization). However, not all tools have to be put to use in each case. With strengths assessment and personal recovery plan as well as strengths-based supervision we recommend, in any event, using the standard tools of the strengths perspective which adhere to the procedures, according to Rapp & Goscha (2012). We have incorporated the tools, which are presented in the table below, in coordination with the five phases of strengths-oriented case management (Ehlers/ M. Müller/ Schuster 2017: 210).

Table 2: Tool Kit of Strengths-Oriented Case Management (SOCM)

Process phases	Tool
1. Clarification phase	• Client information • Checklist for the choices of SoCM clients • Counselling agreement • Release from confidentiality
2. Strengths-oriented case assessment	• Network card • Problem multi-perspective grid • PELG (problem perception and definition/ explanation models/ solution attempts/ goals) • Strengths assessment • Strengths card • Lifeline • Situation assessment
3. Strengths-oriented goal-setting and assistance planning	• 'Bouquet of hypotheses' • Miracle question • Care plan • Personal recovery plan
4. Cross-linking and implementation of the support plan and monitoring	• Care plan • My personal recovery plan • Checklist regional care supply system
5. Strengths-oriented evaluation	• Client questions • Evaluation questionnaire clients

It is important to note that in Germany we do not have a strong tradition of evidence-based social work. Besides, social work services often do not have a stan-

dardized methodology or program they work with. Social workers mostly work with a personal selection of methods depending on their training. This individual range of methods and instruments within a service can be an advantage, but it also seems to be a hurdle to evaluating the work and developing an evidence-based practice. Therefore, it was important for us to offer, with the SoCM, a conceptual framework with a steady process (five phases) and a variety of tools. The most common instruments are explained and available in our book (Ehlers/ M. Müller/ Schuster 2017). However, we point out that it is helpful to work with a core set of instruments, like Rapp & Goscha (2012) suggest (strength assessment, personal recovery and strengths-oriented supervision).

Strengths-oriented supervision as the professional supervision of the strengths-oriented case management process is not a component of the case processing phases but is clearly seen as a task of the organization in which the strengths-oriented case management program is executed. Supervision is not practiced in a standardized form in social work as compared to the different international developments. In the Anglo-Saxon countries, guidance and mentoring of voluntary as well as full-time staff members in social organizations ("senior supervision" or "supervision within a given organization", Belardi 2001: 6) developed based on the early academization of social work. Supervision is then understood as a continuous, individual and professional reflection with team management or superiors. The reflection takes place against the background of the work concept (e.g., strengths-oriented case management) and monitors whether the specialists work according to this concept, what is successful in this process, and what they need in order to even better implement the professional demands that are stipulated in the work concept. Thus supervision is conceived here as an internal professional control.

Conversely, in the German-speaking area, another concept of supervision prevails as a rule. Based on the late academization of social work in the 1970s, social work executive and management levels, which would allow supervision in the Anglo-Saxon understanding, did not exist in Germany. For this reason, social workers were and are often trained, instructed and professionally mentored by persons with qualifications in other fields. Resulting from these circumstances, a mainly outside-the-organization, freelance supervision developed in Germany. It is, on the one hand, practiced at a perfectly high standard; on the other hand, it is shaped by the vast supply of freelance supervision offers, stark ignorance of the field and heavy psychotherapeutizing (cf. Belardi 2001). Supervisions within the organization which take into account whether the strategic concept (e.g., strengths-oriented case management) gets implemented by the staff or which would support the staff in implementing this concept are rather uncommon in the German-speaking area for this very reason. As there is thus a distinct supply of outside-the-organization supervision, we as a strengths-oriented group counseling have particularly shifted into focus and elaborated the significance of the within-the-organization group supervision as an internal specialist controlling according to Rapp and Goscha (2012).

FURTHER DEVELOPMENTS OF STRENGTHS-ORIENTED CASE MANAGEMENT IN THE GERMAN-SPEAKING AREA

The statements above serve to explain how we introduced the strengths perspective and strengths-oriented case management in Germany with the publication of "Strengths-Oriented Case Management. Processing Complex Cases in Five Steps" (Ehlers/ M. Müller/ Schuster 2017). In this work, we especially emphasized the points which, in our view, establish clear connections to the US discourse. We also highlighted the differences which denote that we have developed the strengths perspective against the background of our understanding of strengths, theory and social work, to become an approach adapted to the German general conditions - and standing on its own, "rooted in strengths". The practice development in Germany, however, has not yet reached the stage where research monitoring of the concept can be approximated in practice.

At present we are working on spelling out the strengths perspective yet further (Ehlers 2019) and on appropriating strengths-oriented case management for various fields of practice in social work in the German-speaking area (M. Müller 2016, 2020; Gierz/ Große/ M. Müller 2020).

A working model with methods for a strengths-focused target work was developed for strengths-oriented work with people, also independently of the case management context (Ehlers 2019). This is supposed to make it easier to put on the 'strengths glasses' in daily work, to explore strengths and to formulate motivational goals with a focus on people's strengths. The heart of this model is the strengths spectrum, which enables a structured assessment of strengths in the three areas: 1) personal character strengths, 2) abilities/skills and 3) needs. In the different approaches of the strengths assessment that are presented here the focus is on the single strengths areas, like the talents or character strengths. With the aid of the strengths spectrum, the three elementary strengths areas are explored in a differentiated manner prior to considering the interplay of the strengths areas the so-called strengths sweet spot. The target work is then particularly about recognizing strengths from the sweet spot and putting them to use systematically in daily life. The methods of formulating strengths-focused goals with action plans based on the Zurich Resource Model (Storch/ Krause 2011) are used for this purpose.
The strengths spectrum was taken up at the HAWK (University of Applied Sciences and Arts, Faculty of Social Work and Health) within the scope of the strengths lab[3], and a workshop was developed for the strengths work during the studies. The objective of the strengths lab is to promote the strengths work of future social workers even during their training. The strengths lab is a space for learning and doing research where study and work materials for the strengths work are developed. The workshop "Strengths Course" is offered on a voluntary basis once per term. In keeping with a peer concept, the workshop is offered by students for students. The participating students have an opportunity to explore their strengths within the framework of self-reflection but also to use the group for reflection processes.

Since the concept of strengths-oriented case management, as initially published in the German-speaking area, was not bound to a particular field of work, it is an essential task now to make it known in the various fields of practice of the social work and to accentuate the practice benefit of a strengths-oriented working mode. The first step in this direction was already made as early as 2016, before the publication of our book "Strengths-Oriented Case Management. Processing Complex Cases in Five Steps" (Ehlers/ M. Müller/ Schuster 2017) for the migration and integration counseling (M. Müller 2016). The tasks of the migration and integration counseling (MBE) in Germany are, among other things, to carry out needs-oriented individual case counseling within the framework of case management (BMI (Federal Ministry of the Interior) 2016, p. 549). It comprises the following goals:

- "The MBE should deliberately initiate, regulate and supervise the process of integration of grown-up immigrants" (BMI 2016, p. 549).
- "The MBE should make a qualitative contribution towards enabling immigrants to act autonomously in all matters of daily life. This should also contribute to restricting the immigrants' dependence on social transfer payments to a necessary minimum" (BMI 2016, p. 549).
- "The immigrants should be promptly introduced or referred to the existing thematic support and counseling offers (so-called standard services). They should furthermore be persuaded to continuously and actively participate in the integration process" (BMI 2016, p. 549).

The migration and integration counseling has the political assignment to practice case management, but it lacks professional orientation in the implementation of case management itself. With the publication "Case Management in the Migration Counseling for Grown-Up Immigrants (MBE) – a Working Aid" (M. Müller 2016), a strengths-oriented professional framework of good practice for two out of six major organizations conducting such counseling in Germany was published. Many tools for the practice from our version of strengths-oriented case management (Ehlers/ M. Müller/ Schuster 2017) were transferred onto the social work with migrants. The next step (M. Müller 2020) for the work with migrants and strengths-oriented case management takes it further and comprises also the youth migration services. These are likewise politically obligated to implement case management in counseling young people (aged 12 – 26), their goals being similar to the migration and integration counseling. For this purpose, a strengths-oriented specialist migration service case management is presented, which bears far more on strengths assessment, personal recovery plan and strengths-oriented group supervision. Alongside these three central tools, more attention is paid to the strengths-oriented community ties.

The second practice substantiation takes place for clinical social work. The discussions and practice developments in the clinical social work in the German-speaking

area have occurred largely detached from the discussions of case management so far. With the special issue "Strengths-Oriented Case Management in the Psychiatric Care of Hard-to-Reach Clients" (Gierz/ Große/ M. Müller 2020), a link to the clinical social work has been established, which makes it clear what working methods make sense from the strengths perspective of the so-called "heavy user", "high utilizer" or "high-cost user", and how it can be accomplished that with strengths-oriented case management and strengths assessment, personal recovery plan and strengths-oriented group supervision the help is aligned closely to the strengths and the will of the clients. The deployment of strengths-oriented case management for clinical social work, which started with this special issue, will be continued with a further publication (Große/ M. Müller 2020) and likely with a panel at the Trinational Congress of the German, Austrian and Swiss expert associations for social work in the spring of 2020.

Seeing as case management in the German-speaking area – as already mentioned – is conceived in a rather generalist way and, against this background, is applied to very different working areas, the discussion around social work case management is still very young (Soziale Arbeit 2018). A long time there had been no standards for social work case management that would be attuned to the demands of social work. This gap was closed by the colleagues of the Österreichische Gesellschaft für Soziale Arbeit (ogsa) in 2019 with the publication "Standards for Social Work Case Management" (Goger/ Tordy 2019). In this first publication on the subject in the German language, the differentiation between strengths and resources was taken up, and the strengths perspective is explicitly referred to while doing so (Saleebey 2013; Ehlers/ M. Müller/ Schuster 2017).

CONCLUSION

The strengths perspective is, at least in the German-speaking area, a new perspective on the practice of social work. It enables a special kind of thinking and working with clients (cf. Saleebey 1996: 303), expands the established resource approaches by adding personal pursuits, hopes and interests of people. And yet the strengths perspective is about a new direction of social work in the German-speaking area, which is attempting to align itself to the positive and the constructive power of the people's self-concept and to steer the working process along those lines.

In strengths-oriented case management, we see a chance to shift the support process very closely to the user and to shape it and navigate it consistently based on people's pursuits. In this respect, the strengths-oriented point of view is about a radically subject-oriented perception, which enriches social work.

Our book (Ehlers/ M. Müller/ Schuster 2017) was the beginning of designing social work consistently from the strengths perspective. This was the point of departure for subsequent works of ours (Ehlers 2019; M. Müller 2016; 2020; Gierz/ Große/

Müller 2020) and our colleagues' (Goger/ Tordy 2019). Research that can substantiate the evidence of strengths-oriented case management in the German-speaking area is difficult to finance; it must be endeavored, however, for the sake of the future. Irrespective of this, the first "Roots in Strength" will contribute to the strengths perspective gaining significance in the German-speaking area which it has long been enjoying worldwide.

From our experiences, we would like to point out two things for ongoing development and implementation of the strengths perspective in different countries worldwide. First, it would be worth promoting a continuing international discussion on how strengths and resources could be classified. This could be helpful for research and development of new theories as well as for defining new tools.

Secondly, it seems important to consider how strengths-based approaches can flourish in times of austerity. Many countries are facing challenging times with budget cuts and changing policies. More than ever, strength-based social work is in danger of being misunderstood and instrumentalized as a money-saving model. Therefore, it would be helpful to discover more about best practice models within their area-specific context, like certain theories or policies.

END NOTES

*We would like to thank Anna Ptitsyna for her support translating the text into English.

†For better readability, the German text phrases are translated into English.

[1]The discussion paper can be accessed at http://www.dgcc.de/wp-content/uploads/2013/02/2015_02_Diskussionspapier_CM_Soziale-Arbeit_Feb_2015.pdf (last downloaded on 22.5.2015).

[2]This operational sequence is based on the explanations by Ehlers (2011).

[3]See https://www.hawk.de/de/hochschule/fakultaeten-und-standorte/fakultaet-soziale-arbeit-und-gesundheit/labore/staerkenlabor

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Strengths Perspective

& PRACTICE WITH VARIOUS POPULATIONS

See the Ball. Hit the Ball.

One Social Worker's Real-Life Adventure with the Strengths Perspective

Lori Madrid

So, this chapter is likely to be unlike others you read in Social Work books, mostly because the way I do things tends to be unlike the way most social workers do them. I firmly believe one of the most powerful aspects of social work is incorporating the personal use of self into our craft. An MSW research paper I came across defines this perfectly as "...authentically bringing all I'm made of into the therapeutic relationship for use as a therapeutic tool" (Daley, 2013). Some of the "all that I'm made of" includes the incorporation of humor into what I do. I believe this is one of my core strengths and research supports me on this. Laughter and use of humor have been linked to self-care and professional quality of life (Bloomquist, Wood, Friedmeyer-Trainor, & Kim, 2016). Fortunately, I'm predisposed to chortle. You might call me odd, or you might call me eccentric. Or, if you are strengths-based, and of course you are strength-based because you're a social worker, you could call me "innovative." Yeah, "innovative," that sounds better. Let's stick with that.

Sure, sometimes my staff says I'm a living cartoon, but don't write me off yet. Just like you wouldn't write off a client. Hang in there, because there's a lot of good stuff to follow. I take my work extremely seriously. I honor my clients. I learn so much from them. I work tirelessly to change whatever systems I can for the greater good. I teach at universities to help guide the next generation of social workers. I learn from my mistakes.

This chapter is designed to help you reflect on how to use the Strengths Perspective in assessing your own work. I will chronical my personal journey first, and while you

read this, I'm sure you will draw parallels or pass judgement. (It's human nature, so feel free.) Then, in the end, there will be an opportunity to reflect on your own path. What is your personal use of self? What strengths do you bring into your interactions with clients? How have you changed over the years? What is your long-range plan? What things, if you tweaked them right how, might launch you into connecting even more powerfully with the people you have been lucky enough to serve?

Let's get started. I'm taking a big risk here because I'm going to share with you the enormous mistakes… whoops, let me reframe in a strengths-based way. I'm going to share with you the times in which I might have strayed from making the best possible choices throughout the years. We can celebrate those times because those choices taught me lessons that have landed me in my current social work sweet spot. Throughout this story, I'll share some thoughts on how events in my life can be framed from a deficit perspective or a strengths-based perspective. For example, let's reflect on how I started this chapter:

DEFICIT-BASED	STRENGTHS-BASED
This is getting off to an odd start.	This is getting off to an innovative start.
Hm, is she taking this seriously?	Hm, humor will make this learning fun.

IN THE BEGINNING

Alrighty, Social Work 101. Whenever we start with a client, we do an assessment, right? Sometimes a lengthy assessment, sometimes something simple. This varies across the board, but in general, it's important to know where someone is coming from. At least a little bit of history. Something that paints a bit of a picture of what came before. Let's use this same strategy in reflecting on ourselves. How were we raised? What biases were we taught? How did we learn to communicate our needs? What experiences molded us and landed us in whatever situation we are in that we are suddenly reading an odd, ahem … innovative, article in a social work book? Personally, when assessing any situation, I resonate with Grant and Cadell's premise that,

> It is vital that we not consider health and illness dichotomously, but rather understand than one can, actually must, experience both strengths and needs simultaneously. To recognize one's needs does not negate the presence of strengths, and so it is not necessary to downplay the struggles someone faces. Conversely, by being present with someone's pain we are not forgetting or minimizing their strength.(Grant & Cadell, 2009, pg. 429)

Let's proceed with this mindset. In my case, I like to joke that when I was born prematurely the doctor turned me upside down, smacked me on the bottom, and announced to my mother, "Oh, look, you have a social worker!" And I'm pretty

sure that while I laid in the incubator, the nurses probably talked to me about their relationship problems and I gurgled responses that somehow made them feel better. You might be chuckling right now because chances are, you are a bit like that yourself. When you go to an event suddenly people you just met are talking to you about their very intimate problems and you are in a weird way feeling honored while also just wanting to sneak away and get some more chip dip. But that all being said, yeah, I was born to do this work.

My mother was not married when I was born - which wasn't okay back when I was born. She raised us all as a single parent. We were on food stamps when food stamps were actually stamps, a coupon book the mailman would leave in the mailbox. Even as I'm typing this, I remember sitting at the window with my nose pressed to the glass looking for that mailman. I can feel how cool the glass was and how my breath would fog it up. I must have thought if I just looked harder for him, he'd show up more quickly. We needed those stamps. I was hungry.

We also received free lunches. We lived in a very small town and I know that only one other family also got free lunches. I knew this because the free lunch kids had to stand at the end of the lunch line with a red ticket so that the lunch lady would know our lunch was free. I didn't fully understand what that all meant but it did not feel good. Standing at the back of that line with that red ticket made me feel icky in my stomach. And not just because it was hungry.

This was my indoctrination to the "shame' of poverty" and it wasn't until I entered school that I recognized what Ali, et. al (2014) refer to when stating that "globally, there is growing evidence that shame is experienced as a consequence of poverty." I'm pretty sure that's what that icky feeling was.

When I was in college getting my BSW, I was walking along the quad when I overheard a guy sitting under a tree strumming his guitar and belting out the chorus to a song he'd obviously written, "Reagan cut the cheese for the poor." I burst out laughing, he looked up at me with a conspiratorial grin saying, "You grew up on welfare didn't you?" And I proudly stated "Yes, I did! Reagan cut that cheese and I ate it!"

As I got older, I knew there was something different, maybe even wrong, about me, but I couldn't put a finger on it. In fourth grade, I spent a lot of time at my friend, Johnna's. I liked being there. They always had food. One day we were walking through her living room and I saw a man sitting there reading. Every time I was at Johnna's that fella seemed to be around. I finally asked her, "Hey, what's that guy always doing here?" She looked quizzically at me, pointed at the man and asked, "Him?" I said, "Yeah," And she simply replied, "That's my dad." I was 10 years old and didn't know that houses came with dads.

Now we're all smart enough to know that, growing up poor doesn't necessarily have a negative impact. Lots of people who grew up poor do just fine. It's when we

look at other indicators of childhood events, such as those outlined in the often-cited Adverse Childhood Experiences (ACES) study that we see childhood stressors having a lifelong consequence. That groundbreaking study exposed the correlation between negative experiences in childhood, such as parent divorce, family member incarceration, childhood abuse and so forth, with negative health conditions later in life (Felitti et al., 1998).

I score high on a rating of adverse childhood events. Consequently, I have a number of poor health conditions. I was diagnosed with throat cancer ten years ago. The doctor was confused. I never smoked or drank alcohol. I did admit that I was an avid user of profanity. He laughed and said that dropping the f-bomb does not cause cancer.

I started out at a disadvantage, but I turned out pretty well under the circumstances so in college I researched resilience because I was eager to find out why I'd done kind of okay. The research I came across pinpointed a number of factors affecting resiliency. Resilient people have some type of strong spiritual belief, it doesn't matter which belief - Christianity, Hinduism, believing in unicorns and fairies, just something to believe in. A growing body of research supports this connection between spirituality and resilience (Peres, Moreira-Almeida, Nasello, & Koenig, 2007) and therapists recognize the importance of considering the social and spiritual contexts of a client's life (Graybeal, 2001). Resilient individuals also have at least one caring adult they can trust. So, I lucked out. I did believe in God. His son and I hung out. As a six-year-old, I could belt out "yes, Jesus loves me," with the best of them. I also kind of dig both unicorns and fairies, so I've covered all of my bases on this.

My speech coach was the guy who believed in me. I remember a time he told me I'd need to sub in for a debater who'd called out sick. I had no time to prepare. I was scared. I told him, "No. I can't." He said, "You can, and you will." And I did. And I did great. Now I hear his voice in my head. If someone tells me I can't, I tell them, "I can, and I will." And I do.

As for humor? A social worker, priest and monk walk into a bar … just kidding.

I've emerged as a practitioner with a resilience perspective, and I believe, as Benard posited back in 1993 that people have a "resilient nature" (Benard, 1993). So, how did this negative yet resilient start serve me as I started becoming my amazing social working self? Read on.

THE BSW YEARS

I remember being called into my counselor's office as a junior in high school and he asked me where I planned to go to college. I just stared at him frozen. I didn't know how to answer. I didn't know what college was. No joke. I had no idea what he was asking me.

I have no recollection of what I said to him, but he explained things about ACTs and SATs and LMNOPS. I just took whatever test I was supposed to take and subsequently aced them. Suddenly, in addition to our monthly food stamps, letters also started coming in the mail from colleges all over the country. I was confused and excited but mostly sad because all of these schools cost money. We didn't have any money. We had nothing. Zero. Zilch.

So then, my counselor helped me learn about the wonderful world of student loan debt. I got some scholarships and then I needed my mom to sign papers so that I could get loans. She refused. The thought of me going to college made my mother very angry. The thought of me going to college, whatever college was, scared and repulsed her. I have no memory of how I finally convinced her to sign those papers, but I distinctly remember as I was packing, she came to my room and yelled at me that I was only going to college because I thought I was better than them! Who did I think I was?? Yell, yell, yell. We were enacting a truth noted in the 2015 report on Child Poverty and Adult Success that, "the educational achievement of one generation [or lack thereof] can also ripple through to the next." (Ratcliffe, 2015, pg. 9).

Eventually, I ended up at a rural state university in the BSW program, and this is where I finally started to learn about my personal strengths. I went there knowing I was the poor girl whose family members behaved badly and had poor reputations, but this was a fresh start and I loved learning and loved being away from my family chaos.

In one of my first social work classes, I had a professor with whom many of us were less than thrilled. Of course, I can't remember why now, but we were all 18-year-old geniuses, and this educated woman with decades of experience just wasn't living up to our standards. My classmates asked if I would be the one to confront her regarding our extensive list of her failings. I was confused about why I had drawn the short straw on this. One of them gave me probably the best compliment I've ever received. She said, with a tone of admiration, "You're able to tell someone to go to hell in such a way that they think they're going to enjoy the trip".

Hmm. Okay, I'll admit it, she was right. So, let's use our Strength-Based lens on this. I had, what? The gift of diplomacy? Tact? Finesse? Whatever it was, I had it in spades, and this is still one of the strengths I use on a daily basis. Let's pause for another reflection:

DEFICIT-BASED	STRENGTHS-BASED
Thinking she "knew everything" is a recipe for disaster.	She was entering the field with a lot of confidence.
Being able to "call someone out" shouldn't be considered a strength.	Being able to articulate concerns in an honest and kind manner is a tremendous skill.

Back to my story. I continued to let these people who I've decided aren't nearly as smart as I am educate me. And I earn my BSW. And then I became really smart. I pretty much knew everything.

THE MSW YEARS

Oh my god! I knew nothing. Zero. Zilch. I arrived at Graduate School.

Here is where the regrettable mistakes come into play. During these two years, I come face to face with my ignorance and recognize it immediately. It follows me around and taunts me. It wants us to get matching tattoos. It thinks my blunders are very funny.

I decided, having gotten my BSW in one of the most sparsely populated states that I wanted to go where the real problems were for my MSW training. Remember I knew everything, and I wanted to face danger and angst and affliction, so I applied to schools in New York City. This city needed me to come and solve its problems. I was the genius hero who would right the wrongs. Yeah, I know how this thinking violates, "self-determination of the client", "seeing the client as the expert" and so forth. I know that now … back then… not so much.

A series of garden variety miracles led to my moving from small rural town to an Upper East Side apartment across the street from the Mayor's mansion to work as a nanny for an actress who was in the middle of a divorce from her also famous husband. My room overlooked the East River and maids cleaned up after me every day, so I took care of the children and the maids took care of me. You know, the basic way that everyone goes to grad school.

I lived with them for about eight months until graduate school started and then moved into a teeny apartment with a roommate I never saw and built up a clientele of uber-wealthy people whose children I would watch on evenings and weekends so that I could pay for said super teeny apartment.

I magically ended up getting into one of the top-rated social work schools. I basically got in because I was so naive that I didn't realize I should have been very nervous during the admissions interview. There were 15 students in a group interview, and I was so relaxed and happy. They were not. I was talkative and open. They were not. I was confident. They were not. They all knew that this school admitted only 100 students a year. I did not.

Ignorance was bliss and I was awarded one of those 100 coveted spots. The books we read were written by our instructors. At my first internship, I was trained in person with Salvador Minunchin, the preeminent Family Therapist. On Friday nights, my classmates and I would go and watch Albert Ellis demonstrate Rational Emotive Therapy on the upper west side, where for $10 students could observe the master

doing actual sessions on a stage, take copious notes and dream of the day we would change the world by slaying the countertransference dragon and finally figuring out how to successfully write treatment notes.

This time was simultaneously exhilarating and angst-filled. I lived in a bizarro world in which my time was spent juxtaposed between working with families struggling with homelessness in Spanish Harlem and providing outpatient psychotherapy to foster children in the Mott Haven section of the Bronx (which at that time had the highest per capita homicide rate in the nation), and spending summers in the Hamptons and school breaks with a family in Austria skiing or on the pristine beaches of Hawaii.

I loved the children I worked with as a social worker and I loved the children I worked with as a nanny. The poorest in the city and the richest in the city. Pinging back and forth between such divergent spectrums I learned that despite all the differences, ultimately everybody just loved their children and were doing the best they could to get them food in one case or into the preschools that would put them on an Ivy League track in the other case.

One of my biggest "learnings" during this time is that rich people aren't evil. They aren't even "bad". Having grown up poor, I was indoctrinated into what might be considered a reverse prejudice, that "rich people are bad", and was a living testament to the idea that American attitudes about wealth connect to "deep-seated, complex, values and beliefs about morality and equality"(Kornhauser, 1994, pg 120)

One of my biggest "ah-ha" moments came when I was nannying, and we'd gone to visit the grandfather. I was walking up the fancy staircase with the boys and the mother was following behind me. I marveled at how smooth the hand railing was. I turned to the mother and asked with I'm sure an accusatory tone, "Oh my god, is this staircase made out of marble?" She looked at me pleadingly and said, "I don't want to answer that because it will only make you mad". She was a lovely woman who deeply loved her children who just happened to have a grandfather with a marble staircase. No one was evil. They were just rich. It was no more her fault that she ate caviar than it was my fault that I'd grown up eating government surplus cheese.

In my second internship year, I had a supervisor who studied some ilk-of-Buddhism. He was serenity incarnate in a setting that exuded chaos. The Council on Social Work Education identifies field education as the profession's signature pedagogy (Council on Social Work Education, 2008)a global perspective, respect for human diversity, and knowledge based on scientific inquiry, social work's purpose is actualized through its quest for social and economic justice, the prevention of conditions that limit human rights, the elimination of poverty, and the enhancement of the quality of life for all persons. Social work educators serve the profession through their teaching, scholarship, and service. Social work education—at the baccalaureate, master's, and doctoral levels—shapes the profession's future through the edu-

cation of competent professionals, the generation of knowledge, and the exercise of leadership within the professional community. The Council on Social Work Education (CSWE, and he ticked off all the boxes for supervisory excellence.

I was in a cohort with three male interns under his tutelage and he worked diligently (although it looked effortless) to ensure that we were doing the requisite introspection to be the best practitioners we could. Some nights after a day of stumbling through sessions we interns would convene at a local pub and play dueling errors, outdoing each other by recounting our blunders. "How could I have said, that?" "What was I thinking?" And ultimately my classmate, who had come to social work after being a professional frisbee player (no, I'm not making that up), made a very salient point in commenting, "Man, I wish I was studying accounting because at the end of the day they know there is a real final correct answer - we're never going to have that." He was right.

During one group supervision, as the four of us interns sat at the feet of our some ilk-of-Buddhism clinical supervisor discussing challenges, my frisbee playing intern buddy was talking about a case that was convoluted and chaotic and felt hopeless. Our supervisor decided to use a sports term to explain what frisbee boy should do. He said the thing that has guided all of my clinical work since that day. Actually, it's guided all of my living in the world choices and thoughts and actions. He said, "See the ball. Hit the ball."

"Huh?' the four of us asked in unison. He repeated "See the ball. Hit the ball." In his modulated wisdom he explained that basically there is a whirlwind of things happening here that are swirling around the issue and taking our attention off what is important. Take a moment - look through the swirling, then find what the real issue is and address the real issue. "See the ball. Hit the ball." Simple. Perfect.

These two years of training created a huge shift of understanding. Beginning to see that I ultimately know very little although I have a lot of knowledge, was simultaneously startling and grounding. I was, for the first time, really understanding that the clients are the experts in their experience. This reflects back to Graybeal (2001) touting the belief that the client holds the clues and creativity that lead to solutions (pg. 214). I can help guide, I can offer a safe space to talk, I can listen and comment if asked, but I'm not actually the superhero here, they are.

I would marvel at the bravery of the 16-year-old girl who'd witnessed a shooting, the four-year-old who used dolls to play out a time in which his mother's boyfriend molested him, the 11-year-old girl who admitted she'd made up the story about her foster father inappropriately touching her because she thought that would make it so CPS would move her to live with her siblings in their foster home. These kids were strong. These kids were fierce.

Nothing was black and white. Nothing added up at the end of the day. There were no right answers. It was essential to be able to embrace ambiguity as is discussed in the present day Acceptance and Commitment Therapy, so that when obstacles inevitably appear on the journey one is not "being blown over by them, but holding on to what is true, like a reed in the wind, with flexibility and without rigidity" (Bennett & Oliver, 2019, pg. 56).

This was hard, but I knew what to do. I had amassed a mountain of student loan debt. I had learned from the masters. I had the honor to work among brave and powerful children and it had been worth every penny because I walked away from those two years knowing this:

See the ball. Hit the ball.

DEFICIT-BASED	STRENGTHS-BASED
Rich people are selfish and maniacal, and they create all the problems.	We all exist somewhere in the economic social structure. This does not need to define our worth.
I'm going to save the day.	People are experts in their own experience.
My Master's Degree is evidence that I know so much more than everyone else about social work, and people and life.	I'm lucky to have a master's degree as the first step in a lifetime of learning.
This is too convoluted.	See the ball. Hit the ball.

IN THE TRENCHES

And so, after I'd earned my illustrious MSW and began in the field I was confident that: I have a lot of knowledge but I don't really know all that much; I have a lot to offer clients while I learn from them; and I'm considered an expert, which I kind of am, but not really. The list goes on and on and kind of spirals out of control, just like this paragraph. I begin to understand that work is a process.

Then I spend a gob of years in the field.

I started out working for a foster care agency at a place in Brooklyn that was in a very difficult to get to location. I wrote that sentence in a difficult to read way because it mirrors how hard it was to get to this place. It was odd. And I can't change this up and "strengths base" it by saying it was innovative. It was odd. And far. And hard for parents to get to. You took the regular subway to a bus and then had to take a special shuttle bus with an unpredictable schedule and this was just odd.

This bore out the assertion made in a 2013 literature review that transportation barriers negatively impact healthcare access for people with low incomes, (Syed, Gerber, & Sharp, 2013)delayed care, and missed or delayed medication use. These consequences may lead to poorer management of chronic illness and thus poorer health outcomes. However, the significance of these barriers is uncertain based on existing literature due to wide variability in both study populations and transportation barrier measures. The authors sought to synthesize the literature on the prevalence of transportation barriers to health care access. A systematic literature search of peer-reviewed studies on transportation barriers to healthcare access was performed. Inclusion criteria were as follows: (1 and this was supremely frustrating. Anyway, I only worked there for a very short period of time until I was offered a much better paying job in the illustrious (and dangerous) South Bronx at the same place I'd done my internship, and I had major learning during those few months.

Relationship, Relationship, Relationship

I was working with a little girl who was the girl that caused everyone to cringe when she entered the building and came down the hall. She was six, and too loud, and couldn't keep her hands to herself and she crawled under tables and she was …. well… difficult. I was new. My heart beat fast when I heard her enter the building. I didn't know what to do except "See the ball. Hit the ball." So, the ball equaled "too loud" - we practiced "quiet voice." The ball equaled, "hands all over the place" - we practice - "intertwine your fingers". And as for "crawling under the table", we practiced, "I'll come under the table with you." She liked that and eventually, we didn't need to do that anymore.

Her mother would come to meet with me too. I liked her mom. I was impressed that she could figure out the subway, bus, weird shuttle. She came from far. She was tired. She loved her "difficult" little girl. She was trying hard. The deck was stacked against her. She came to every meeting. She came this far weird way to sit across the desk and talk to a neophyte social worker who didn't know what she was doing. She was patient with me.

When I told her, I was leaving for a different position I saw tears start to form in her eyes. They hung in her eyes not quite ready to fall. Her chin wrinkled as she said, "But what about my little girl? You understand her. She needs you." And then the tears fell out of her eyes and I think we both knew that what she meant was, "What about me? You understand me. I need you."

I was a social worker and I had an MSW so I didn't cry when she said that. I reassured her. I told her there would be someone who would follow me who would understand her daughter and help her daughter. She didn't look convinced. Frankly, I wasn't convinced either. But I was a good social worker, and I didn't cry. Until I got on the shuttle that led to the bus that led to the subway, and I cried the whole way home. And even remembering that, twenty-four years later, I cry a little because

this work touches our clients and ourselves in very profound ways. I remember this event entirely. It changed me.

I left that position and went back way uptown to work as an outpatient Psychotherapist in the South Bronx. I was so excited about this until I went into my office the first day and saw the DSM III – R on my desk. (Okay, don't laugh, there really was a time when the DSM was in just its third iteration!) I thought, "Oh, my Lord, they are going to let me diagnose people." Gulp. I am going to be the one who decides the diagnosis. Did I learn this? Sure. Do I know how to do it? No way! Yikes! Ok, breathe. This will be okay. Remember, you still have a supervisor. Your supervisor will help you with this. It will be fine. It was.

Race and Culture

Next, I moved on to work as an outpatient psychotherapist in the South Bronx. I had so much to learn, not just about the work, but also about what it meant to be a white woman working in the Bronx. And here was my major error. I didn't think it mattered. I made the mistake of thinking I was "color blind." I didn't care about, take into account, or pay attention to race. I prided myself on this. My boyfriend was from Haiti. My friends were the color of the rainbow. This was wrong, wrong, wrong, but I thought I was right. Again, my naiveté lead me to miss so much of the nuance of what my clients were facing. Some specific errors surrounding culture, race and socioeconomic status started to become apparent.

When talking to the receptionist who scheduled my appointments, I asked her about Mexican food. She was furious! She was Puerto Rican. Which was different from Dominican. Which was different from Spanish. Which was different from Mexican. I knew nothing about this. I was from a rural white community. I learned this fast. I did a lot of apologizing.

A Latina colleague was talking with me one day about how similar she and I were because we both came from middle-class backgrounds. I told her I wasn't middle class, that I was raised in poverty. She said, "No you weren't," as though that were a fact. I explained that I was. I explained that I grew up on food stamps. I told her the Regan cut the cheese for the poor joke. She wouldn't believe me. She said I was middle class. End of discussion.

Then the most startling example happened when I had worked there for about two years. One of the case managers and I traveled down to Brooklyn on the subway to a court hearing regarding children on her caseload for whom I provided therapy. We were both going to be testifying. It took almost two hours on a crowded stuffy subway to get there. The courthouse wasn't air-conditioned and the cases were running long so we spent the day sitting on benches in a semi-sauna waiting for our case, which was finally heard at four-thirty in the afternoon. On the way back we were both tired and sweaty and emotionally drained from the stress of the hearing. She looked at me very seriously and started to cry saying that she felt so badly because

ever since I'd started working there, she'd told people she didn't know what that "f-ing white b*tch" was doing there! Today was different. Today she realized that she had been wrong about me. I did care about the kids. I did work hard. I was so shocked. It hadn't occurred to me that for the past two years I wasn't welcome or that people felt that way about me. Had I paid more attention I would have done better.

I loved that job in the South Bronx so much, but I didn't make enough money to live in New York. I made less money each month than I needed to pay my bills and went deeper and deeper into debt until I realized I would need to leave. I was broken-hearted about this, but I headed back to my small home town to work with children in a psychiatric residential treatment center. Now even more learning kicked in! Here's where I learned the power of the team approach.

The Power of the Team

At this facility, all of the children we served had DSM IV (see, time is passing) diagnosis. They all see a psychiatrist for medication, and we managed their living environments and education. This is a terrific model and the therapy team is outstanding. I realize we all have our niches. The categories included the Substance Abuse Program, the adolescent girls and boys, our EMDR and sexual trauma specialists, and the youth minister among others. I landed with the younger kiddos. I'm blessed with the ones from the age of 6 to 10 who communicate most adeptly with their play. Remember, I'm a fan of humor. I'm a human cartoon. Sometimes we literally see a ball and hit it. I am at home here. I love it.

I marvel at the expertise of my colleagues and as often as possible seek their advice. Our clinical director is a genius. For real. She knows everything. She remembers everything. I want to be just like her.

During this time, I witness an amazing transformation in one of my clients whom I'll call Sara. Sara was eight and was in placement due to long-standing sexual abuse. She was deeply depressed. I found her to be brave and smart. We'd worked together for about four months and she'd made steady progress but suddenly everything plateaued. Her mother had attended all the family session and things were going well, but the treatment seemed to be at a standstill. We'd identified that Sara had this sick feeling in the pit of her stomach all the time. When I'd asked her to tell me more about it, she said that it felt like there was a ball in her stomach with worms and bugs crawling around in it and there were boogers and "yucky stuff" and it just felt gross. I'd used all the tricks in my toolbox to get rid of that ball. I could see that ball, but I couldn't hit that ball.

I felt lost so I reached out to the EMDR specialist. I didn't fully understand how EMDR worked, but my intuition, even back then was that this would move her forward. Later, In 2013 the World Health Organization recognized Eye Movement Desensitization and Reprocessing as an effective psychotherapy for treating PTSD

in children, teenagers and adults (WHO, 2013). This was at least a decade before much research had been done, but my own belief was that the therapist down the hall had this great skill that could help. That therapist agreed she'd do a few sessions with her.

I still did my weekly sessions and Sara would also do EMDR with the other therapist. After a few weeks, I went to pick Sara up from class for our session. We were walking down the hall to my office and something seemed very wrong. Sara was looking up at me and talking to me, but I was confused and actually kind of scared. Something was different. Something was wrong. And then I intentionally changed the path we were taking so that we were walking by more staff in case something bad happened with her and I needed staff assistance. I couldn't pinpoint what was wrong. She looked weird. Then I realized I could see her teeth. I'd never seen her teeth. Then I realized I could see her teeth because she was smiling. I had never seen her smile. I thought something was wrong because she was happy. What? She was happy? So, when we got to my office, I asked her about the ball in her stomach and she smiled and said, "It's gone!" "Wow!" I said, "It's gone? What happened to make it be gone?" And she said, "Jesus took it!" "Jesus took it?" I asked. "Yes, every morning I go to chapel and I prayed and prayed that Jesus would take it and he did!" And I believe that the combination of the Youth Minister and the EMDR Specialist and Sara's own strength saw that ball of worms and hit that ball.

Observing these skills in my teammates inspired me to get further training. I learned play therapy and loved the premise that you trust that the child has the capacity to solve their own problem (Kool & Lawver, 2010). I learned equine therapy because I'd seen the power of the work my colleagues did with this. The evidence is promising in support of this modality (Selby & Smith-Osborne, 2013)Intervention, Comparison, and Outcome (PICO but even without their research I'd seen it work with my own eyes, I was learning that a part of my strength was learning more, but also learning that this whole process is not about me. Clients solve their own problems.

Eventually, I ended up moving to Arizona - where I got married and adopted two children from foster care. Everything changed. Because the girls had experienced trauma, I decided to stop working at that time and tend to their needs, help them settle in, get them on a positive trajectory. Once the youngest started school, I took a job as a school social worker so that I would have the girls' same schedules. A few weeks later I got throat cancer. Later that year I stopped being married. I do not recommend doing those last two things.

The field has really begun to recognize the need for self-care in a salient way. Becoming nearly immobilized, as happened in my case, brings that need to the fore. I was thrust into a situation in which I had to seek help on every level. I was a woman who helped "heal" people with her words, and suddenly I was basically silenced. My friend, Debbie, stood in the "old people" aisle for me at the store (I was on the little scooter thing because I didn't have the energy to walk) and helped me pick out the

best quality adult diapers. I couldn't work for at least a year, my financial situation was tenuous, and my health was dismal. But remember, I knew how to see the ball. The ball, in this case, was my daughters, and my friends rallied to help me with them until my health slowly improved and then I was back to work in the schools.

I gave up being a school social worker and instead ran the afterschool program. I felt it was my ethical obligation to stop practicing as a social worker until I had my strength back and my mind cleared. This work lacked the challenge of the hectic New York City streets and serious mental health issues of the children in residential care but it was the right work. My "self-care" was making sure that I was still helping kids but in a different way. I moved more slowly. I thought more slowly. But I kept on keeping on.

A few years later I was back in full swing, working as a social worker in the schools, adjunct faculty at several universities, raising my totally perfect at all times adopted daughters and learning, learning, learning. I built strong relationships in the school district. I sought out talented practitioners to learn from and grow with. And then I started to see some serious issues with children not getting the help they needed. I saw children who needed therapy but were not getting it. The hurdles included poverty, lack of insurance, poor transportation, parental fear and not enough of me to go around. This was not okay. These kids needed help and they weren't getting it.

Then stakes rise for me. I'm so fed up with children not getting what they needed due to bureaucratic nonsense that I walk around with my own ball of low-level rage in my stomach. Finally, driving across town, seething, I have my aha! moment. I remember Einstein saying you can't solve a problem with the same thinking that created the problem in the first place. I know how to solve this. I'm going to use new thinking. I'm gonna knock down these hurdles. I'm gonna fix this! I see that ball of rage and I hit that ball.

I'm gonna quit my job and start a non-profit so I can solve this problem myself.

My friends all say, "We love you. We get why you want to do this. But don't do it! Don't jump off this cliff! For God's sake, don't quit your job!"

And I love my friends. They are smart. They are giving me great advice. And just like when I'd earned my BSW, it's all come full circle and I feel really smart. I pretty much know everything. And I ignore them and I quit my job.

FOUNDING A NON-PROFIT

Oh my god! I know nothing. Nothing. Zero. Ziltch.

Geez, macrimeny. Let's take a beat here to figure out what brought us to this place. What makes a social worker of reasonably sound mind and judgment commit

what might be viewed as career suicide? What level of desperation - or perhaps more aptly described - inspiration - led to this?

I'll admit, I knew this would be rocky. I had two adolescent daughters who were counting on me as their mother. Taking this step made our financial situation even more tenuous. It made my stress level dramatically increase. It made my ability to give the time and devotion they deserved dramatically decrease. I talked to them about it. I told them the negative ramifications. I told them the risks. I told them this made me kind of afraid. Then with the lack of wisdom and selfishness of all teenaged girls, they said, "This is the right thing. The kids need you. You have to do this."

What? It stops a parent in their tracks when they see their children take the impeccable right action. My daughters did this right before my eyes. I cried.
These girls are wise. They had been in foster care and swept out of it when they came to live with me and my husband. They had been "saved." They still struggled with the pain that comes from a non-Disney like early childhood. They had compassion and I was proud of them. And as it turns out, they were kind of proud of me too.

So, the die had been cast. It was time to regroup, focus on my strengths and go back to my social work roots. See the ball. Hit the ball. Here the ball is: I am outnumbered by the needs. Easy solution, the way in which I would save the world is to do what everyone laments needing to do - I would clone myself! I would train social work interns to go out and meet with those students who couldn't access support and to do exactly what I did with them because I knew we could get positive results.

I convened a Board of Directors, I filled out a gazillion forms, I talked to the local university, then with the ducks all soundly lined up, I prepared to have a courageous conversation with my school district boss, Kim, to let her know I had figured out how to solve all the problems in the world and that I was quitting my job so I could go do that.

Kim patiently heard me out and then said, "No. I'm not letting you quit."

"Huh?" was the best reply I could muster.

Kim said, "No. You're going to stay here. You're going to solve all of the problems in the world right here. Now get out of my office, so I can figure out how I can make that happen." It turns out Kim is strength-based too, and I can only imagine the mountains she had to move to clear the way for the nonprofit to be launched. Within about two weeks she had gotten "yesses" from "no" men, had gotten school principals clamoring to be involved and had even found funding. That's a whole lot of social work mo-jo from a non-social worker.

I had become a "student" again and needed to learn about leadership, program management, fundraising, marketing, the whole gambit. So much to learn! So thank goodness for the team perspective.

The program flourished. Interns learned so much from this robust internship experience and the school children made huge strides in their social-emotional development. We discovered some very important secondary gains. For example, a grandmother who worked at one of the schools commented that her grandchildren loved our program. I reminded her that her grandchildren aren't in our program. She replied, "Oh I know, but the kids who are mean to them are, and they aren't being mean anymore!" This is a direct testament to Systems Theory and the ideology that once you change one element of a system, it changes the entire system (Janchill, 1969).

One of the School Resource Officers in a school we served demonstrated a textbook example of Bandura's Social Learning Theory (Bandura, 1986) when she came to tell us that she was being honored by the Anti-Defamation League as the Educator of the Year! We were so excited for her and then she explained that "your program is the reason I won the award." This was confusing because we hadn't even worked that directly with her, but she continued saying, "Watching the way you all work with the children and treat people, changed everything about the kind of police officer I am!"

Rave reviews poured in from teachers and principals and parents. Kids were getting better and they were getting better fast. Three years into the program other districts reached out and it was time to expand. I really did need to quit my "job" to do this expansion. It was less scary now. We had credibility and there was at least a little funding. I was able to hire some of the previous stellar interns as staff and they've done outstanding innovative work. And that's where I sit today. And I know a whole bunch of stuff. I'm really smart. And I'm smart enough to know I know very little.

FOCUS ON YOU

So, in the spirit of seeing the ball and hitting said ball, let's wrap this chapter up by focusing on top strengths you have in your personal arsenal. Examples from mine include:

> I was fortunate to have a challenging upbringing which taught me compassion and resilience.
>
> I understand and honor the power of a strong team. I welcome learning from mistakes. I am becoming better at focusing on self-care. I willingly seek honest feedback even when it doesn't feel flattering. I engage in courageous conversations.

And now, to you. Let's reflect on your journey. How were you raised? What biases or strengths were you taught? How did that history play out for you? How does it propel you forward or hold you back? What did you learn from instructors or colleagues that create the strengths you have? How has your practice evolved over the years? How do you see the ball and hit the ball?

CONCLUSION

Our evolution as individual social workers is our own very delicate personal journey. We've all overcome unique challenges and drawn from distinct strengths. It would be silly to believe that there is much more overlap than "we are all in the field to help," but this consistent thread also binds us as practitioners. The more we individually hone our craft, the stronger the field becomes. And as we learn to embrace both our foibles along the way and the wisdom we've gained from them, we gain compassion and insight. And ultimately we learn to mindfully see the ball and hit the ball.

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Moving Away From a Risk Paradigm to Study Rural Communities Among LGBTQ+ Youth: Promotion of a Strengths Perspective in Research, Practice, and Policy

Megan S. Paceley

Lesbian, gay, bisexual, transgender, and queer (LGBTQ+) youth are growing up in a society that stigmatizes and marginalizes their sexual and/or gender identities. Stigma and marginalization have deleterious effects on LGBTQ+ youth including higher rates of depression, suicidality, anxiety, stress, and substance use and lower rates of self-reported physical health (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Burton, Marshall, Shisolm, Sucato, & Friedman, 2013; Day, Fish, Perez-Brumer, Hatzenbuehler, & Russell, 2017; Fish, Schulenberg, & Russell, 2019; Mereish & Poteat, 2015; Paceley, Fish, Thomas, & Goffnett, 2019; Paceley, Goffnett, & Gandy-Guedes, 2017; Pollit, Mallory, & Fish, 2018; Tucker et al., 2016; Woodford, Paceley, Kulick, & Hong, 2015). This research has been important in establishing that LGBTQ+ youth are not inherently more likely to experience poorer outcomes than heterosexual and cisgender youth; rather, their risks are situated within oppressive systems and societies. A predominant focus on risk, however, fails to account for the individual strengths and resilience of youth. Additionally, given the association between stigmatizing environments and well-being, it is important to examine the social environments in which LGBTQ+ youth are situated.

One important and understudied social environment that LGBTQ+ youth traverse is their geographic community. The community may act in ways that enable stigma and marginalization or promote well-being and resilience. For example, communities may include hostile attitudes toward LGBTQ+ people, which may lead to increased stress (see Woodford et al., 2015). Alternatively, communities may sup-

port SGM youth by providing access to SGM-affirming resources and positive social climates. Additionally, the community encompasses many of the youth's other social contexts, such as family, school, church, and/or work. One key distinction between the communities in which LGBTQ+ youth live is size. Research on community size has primarily examined the differences between LGBTQ+ youth's experiences growing up in rural versus urban communities or compared the experiences between LGBTQ+ and heterosexual or cisgender youth living in rural communities.

Like the research on LGBTQ+ youth themselves, the majority of research on rural communities as they pertain to LGBTQ+ youth is situated within a risk paradigm. The positioning of rural communities as inherently risky and hostile toward LGBTQ+ youth fails to provide opportunities to identify a community's strengths and opportunities to support the resilience of LGBTQ+ youth. Additionally, it limits our ability as researchers to make recommendations that community leaders may hear and apply in order to reduce risk and promote resilience for LGBTQ+ youth; recommendations that engage with the strengths of communities rather than focus on their deficits. It also frequently compares rural communities to urban communities, positioning urban as the "norm" to which rural communities are compared. Gray (2009) advocated for viewing rural communities as different from, but not inferior to, urban communities, a perspective that aligns well with social work.

Given the importance of the rural community context for LGBTQ+ youth and the predominant focus on community risk, it is essential for researchers to consider the ways in which the strengths perspective might provide a unique and important framework through which to research rural communities. In the past ten years, an increase in research on LGBTQ+ youth has utilized a strengths perspective, or examined factors such as resiliency and positive youth development; however, the strengths perspective has rarely been applied to the rural communities in which many LGBTQ+ youth are growing up. The strengths perspective offers researchers opportunities to examine rural communities holistically, focusing on risks in the contexts of strengths and opportunities and exploring ways to promote both well-being and risk reduction for LGBTQ+ youth.

This chapter serves as a call to action for scholars engaged in research with LGBTQ+ youth to consider rural communities from a strengths perspective. Focusing on strengths does not negate the recognition of risks within rural communities; rather, it allows for a comprehensive examination of the factors within rural communities that may promote well-being and reduce risks and offers opportunities for strengths-based practice recommendations. The following sections include an overview of the strengths perspective, a summary and critique of the research surrounding rural communities and LGBTQ+ youth, and recommendations for future research situated within a strengths perspective.

STRENGTHS PERSPECTIVE

Within clinical social work practice, the strengths perspective emerged out of a need to move away from the pathology-focused nature of social work. A strengths perspective provides tools for social workers to engage with individuals with a focus on resilience, personal and community resources, and strengths, rather than focus solely on their risks or problems (Saleeby, 1996). Although initially developed as a practice approach, the strengths perspective has been utilized within community-based practice, education, and research (Saleeby, 1996). Utilizing the strengths perspective in a community context requires identifying the ways in which a community is supporting its members and opportunities to promote resilience and reduce risk. Saleeby (1996) identified supportive communities broadly as nurturing the strengths of community members, providing opportunities for residents to impact their community, and creating supportive networks. Research within a strengths perspective does not fail to acknowledge challenges or risks; rather it frames them within individual strengths and the ways in which communities can cultivate resilience.

The strengths perspective aligns closely with research on LGBTQ+ youth that aims to reduce risks such as stigma, victimization, and the pathologization of LGBTQ+ youth (Hulko & Hovanes, 2017). A decade ago, scholars called for research on LGBTQ+ youth to move away from a focus on risk and focus "on understanding the ways in which (LGBTQ+) youth negotiate their development within various social contexts" (Horn, Kosciw, & Russell, 2009, p. 863). Although research on the experiences of LGBTQ+ youth has included a greater focus on resilience, positive development, and strengths, research on their social context, particularly rural communities, remains risk-focused.

LGBTQ+ YOUTH AND RURAL COMMUNITIES

Community size is often conceptualized as urban versus rural, creating a dichotomous divide between towns with populations less than 50,000, for example, and any larger town. This distinction may not account for the varying experiences of LGBTQ+ youth in small college towns or mid-size cities separate from major metropolitan areas yet classified as urban due to population sizes larger than traditionally rural communities. Therefore, some research has explored LGBTQ+ youth's community experiences across a continuum of community size (see Paceley, 2016). Regardless of measurement, rural communities are often situated as risky settings for LGBTQ+ youth (Gray, 2017).

RURAL COMMUNITIES AND RISK

The dominant narrative surrounding rural communities is that they are inherently hostile toward LGBTQ+ youth (Gray, 2007; Kazyak, 2011; Oswald & Culton, 2003; Wienke & Hill, 2013). Some research supports this narrative. Historically, scholars identified how LGBTQ+ people in rural communities experienced high rates of

isolation (Bell & Valentine, 1995; Cody & Welch, 1997; D'Augelli & Hart, 1987) and challenges accessing supportive resources (Cody & Welch, 1997). Although the climate toward LGBTQ+ people has shifted during the past two decades, primarily for gay and lesbian, White, middle-upper class individuals, research on LGBTQ+ people living in rural communities suggest continued challenges and risks. For example, rural LGBTQ+ adults report greater anti-LGBTQ+ sentiment, discrimination, and violence than urban LGBTQ+ adults (Swank, Fahs, & Frost, 2013). Additionally, in one study, rural teachers reported negative attitudes toward sexual minority students (O'Connell, Atlas, Saunders, & Philbrick, 2010).

Currently, research on rural communities and LGBTQ+ youth includes studies of community climate, victimization, and health outcomes. Community climate is defined as the level of support or hostility toward LGBTQ+ people in a community (Oswald, Cuthbertson, Lazarevic, & Goldberg, 2010) and very few studies on community climate have explicitly included LGBTQ+ samples in rural communities. One study found that LGBTQ+ rural youth experience more hostile social climates at school (Kosciw, Greytak, & Diaz, 2009) than urban LGBTQ+ youth. A mixed-method study utilizing surveys and interviews with transgender youth revealed conflicting findings (Paceley, Okrey-Anderson, & Heumann, 2017b). On the survey, rural participants were significantly more likely to rate their community as hostile than youth in small or large urban communities; however, qualitative interviews revealed very little difference in the way youth in rural and small urban communities described the climate. All youth in rural and small urban communities identified their community as including the presence of both support and hostility. One qualitative study explored LGBTQ+ youth's perceptions of their rural or small urban communities in Canada (Hulko & Hovanes, 2018). Some youth identified conservative ideologies as predominant in small towns and indicated they planned to move away when they could. These findings coupled with the findings using adult samples suggests that rural communities may be perceived as more hostile by LGBTQ+ youth, yet further research is needed to explore these complexities.

Victimization and mental or physical health have also been studied within the rural context. Rural LGBTQ+ youth report more acts of physical and non-physical victimization based on their sexuality or gender than urban LGBTQ+ youth (Paceley et al., 2017a). Given what we know about the association between stigma, victimization, and health disparities (Meyer, 2015), it is not surprising, therefore, that studies comparing the experiences of rural and urban LGBTQ+ youth have also found negative well-being outcomes for rural LGBTQ+ youth. For example, rurality is associated with greater suicidal behavior among sexual minority boys and greater substance use by sexual minority girls when compared with urban sexual minority youth (Poon & Saewyc, 2009). Alternatively, Paceley et al. (2019) included community climate in a model comparing health outcomes among rural and urban LGBTQ+ youth and found that community size was not related to physical and mental health outcomes. Perceived climate, however, was associated with mental health such that LGBTQ+ youth in communities they perceived as hostile or tolerant reported greater anxiety

and depression than youth who lived in communities they perceived as supportive. Although community size should not be discounted as important to the health and well-being of LGBTQ+ youth, particularly given that rural youth are more likely to report hostile climates than urban youth (O'Connell et al., 2010; Paceley et al., 2018; Swank et al., 2013), these findings do suggest that community climate may be important to consider alongside community size. This has important implications for social work practice and research; community climate is a factor in communities that may be able to shift to be more positive, whereas we cannot change the size of a community.

Some scholars have examined comparisons between youth with and without marginalized sexualities and genders living in rural communities, rather than comparing them to urban cities. For example, Cohn & Leake (2012) found that rural sexual minority youth reported greater distress than urban sexual minority youth. Ballard, Jameson, & Martz (2017) examined differences in risk factors between rural sexual minority youth and rural heterosexual youth. They found that rural sexual minority youth had significantly higher suicide risks, drug use, sexual risk-taking behavior, and experiences of victimization and violence at school.

In sum, these findings suggest that LGBTQ+ youth in rural communities do face added risks including hostile community climates, increased victimization and discrimination, and poor mental and physical health outcomes. However, there are limitations to this collection of research. In general, there are a small number of studies exploring the rural community context for LGBTQ+ youth and even fewer exploring the specific community-level factors that affect youth's health and well-being. If indeed, rural LGBTQ+ youth are more at risk of victimization, depression, and suicide because of more hostile climates, it will be useful to identify the ways in which the community enables or mitigates these experiences. Additionally, much of the research has compared urban and rural communities, situating urban as the norm to which rural is compared. This creates a narrative that assumes that LGBTQ+ youth aim to escape rural life as soon as they are able and move to urban spaces assumed to be accepting (Weston, 1995).

RURAL COMMUNITIES AND STRENGTHS

Contrary to this common narrative is research and scholarship that disrupt the notion of the "hostile rural community". This research focuses less on identifying risk and more on exploring the lived experiences of rural LGBTQ+ people. This collection of research provides a more nuanced context of rural communities, focusing on both challenges and opportunities for resilience. Strengths-based studies among rural LGBTQ+ adults highlight the positive aspects of living in rural communities and challenge the concept that rural residents are "worse off". For example, Kazyak (2011) interviewed gay and lesbian adults about growing up or living in rural communities. Participants challenged the idea that rurality was associated with hostility and that rural LGBTQ+ people aim to "flee immediately and move to a big city" (p.

8). They identified positive aspects of living in small towns, such as how their neighbors cared more about their individual character than their sexuality. Character was often assessed as having strong ties to the community or being perceived as a good person. Oswald and Culton (2003) surveyed LGBTQ adults in a rural Midwestern state and asked them to qualitatively identify the "best" and "worst" thing about living in their geographic region. Participants described their family and friends, the rural quality of life, the local LGBTQ community, and personal self-acceptance as the best things. They described being accepted by those close to them, having the ability to enjoy a higher standard of living without city stress, being intolerant (versus hostile) communities, and accessing LGBTQ+ groups and organizations. Consistent with the strengths perspective, Oswald and Culton examined strengths alongside challenges. Participants described challenges within the local LGBTQ+ community, homophobia, and lack of civil rights as the worst things. They discussed the LGBTQ+ community as small and invisible and LGBTQ+ resources as inaccessible or nonexistent, residents as anti-LGBTQ+, and lacking statewide protections based on sexuality and gender.

Other research on rural LGBTQ+ adults also challenges the idea that LGBTQ+ people are isolated from others. Several studies have found LGBTQ+ adults report close connections to other LGBTQ+ people in their rural communities (Cody & Welch, 1997; Leedy & Connolly, 2008; Oswald & Culton, 2003). Some research even complicates the idea that rural communities are associated with poorer health for LGBTQ+ people. Wienke and Hill (2013) measured differences between rural gays and lesbians and urban gays and lesbians on multiple measures including happiness and health. They found that rural participants reported greater happiness and health than urban participants.

Research on LGBTQ+ youth in rural communities that are situated within a strengths perspective differs from risk-focused research by engaging with the complexity of rural communities and youth's experiences within them, rather than identifying the ways in which they differ from urban communities. One seminal study explored the lived experiences and identity development processes of LGBTQ+ youth living in rural Appalachia (Gray, 2007). Through ethnographic methods and prolonged engagement with youth, Gray disrupted the narrative that rural communities were isolating spaces where LGBTQ+ youth were unsafe to be open about their identity. She argued that rural communities were different from urban communities and deserved attention to their entire context. Her findings revealed how rural LGBTQ+ youth are resilient and develop their own pathways to well-being and positive identity development that are different from, but not inferior to, urban LGBTQ+ youth. For example, some youth described using the internet to connect with similarly situated peers while others met up at a local Walmart to participate in drag shows.

Dahl, Scott, and Peace (2015) interviewed seven youth growing up in rural Appalachia to understand their coming out and identity development experiences within the rural context. Their questions were open-ended and analyses revealed themes

that endorsed challenges to living in a rural community as well as strengths and resilience. For example, challenges to living in a rural community as an LGBTQ+ youth included the religious nature of the community and the anti-LGBTQ+ sentiment associated with it, as well as navigating relationships with friends and family due to a general lack of acceptance toward people with diverse sexualities and genders. Consistent with other research, participants also indicated a lack of LGBTQ+ resources and support. Alternatively, youth in this study indicated they had positive experiences coming out to some friends and family, both in person and over the internet. The internet provided options for support, networking, and resources that may have been absent in the physical community. Additionally, youth described the sense of resilience and accomplishment they felt at overcoming challenges and accepting and affirming their own identities.

Other research examines factors within the community that can support rural LGBTQ+ youth. For example, Paceley (2016) interviewed LGBTQ+ youth in rural and small urban communities to identify their needs for support and resources. This provided an opportunity to engage with potential challenges and community strengths simultaneously. Participants indicated they needed help in reducing the isolation they felt, broad social acceptance and visibility, emotional support and safety, and assistance with LGBTQ+ identity development. Analyses from the same study revealed the factors that LGBTQ+ youth in rural and small urban communities identified as making their communities supportive (Paceley, Thomas, Toole & Pavicic, 2018). Youth described four areas of support: supportive people, LGBTQ+ visibility, LGBTQ+ resources and education, and LGBTQ+-inclusive policies. Identifying the needs of youth and their perceptions of what factors promote support in the community provides important ways to recommend community interventions that build on the existing strengths and resources in a community. Some studies have also included a focus on protective factors within a broader study also assessing risk and challenges in rural communities. Cohn and Hastings (2010) found that for rural lesbian youth, having supportive families, large amounts of social support, supportive teachers, and access to Gender and Sexuality Alliances (GSAs) at school enhanced their resilience as rural sexual minorities. Additionally, Cohn and Leake (2012) found that among rural sexual minority youth only, high levels of belonging at family and school were associated with lower rates of distress.

Finally, two articles discussed strengths-based community interventions to promote resilience and well-being for LGBTQ+ youth in rural communities. Snively (2008) encouraged the use of youth-adult collaborations to promote the growth of community-based supportive programs for LGBTQ+ youth in rural communities taking the approach that attempting to address problems would be less successful than attempting to promote positive development and strengthen existing protective factors for LGBTQ+ youth. They described the historical development of such a program and the positive benefits on the local rural communities. Hall, Witkemper, Rodgers, Waters, and Smith (2017) used photovoice to engage in a community intervention in a rural community in Southeastern state. LGBTQ+ youth took pictures

to illustrate the issues they faced as LGBTQ+ youth. Adults attended the exhibit of photographs and then completed a survey about their experiences. The majority of the rural adult residents described feeling positive about the project and 81% said the photographs had inspired them to engage in more advocacy and LGBTQ+-affirming behavior.

This literature on LGBTQ+ youth in rural communities highlights the benefits of situating such research within a strengths perspective. The findings indicate that rural communities are much more complex spaces than the existing risk-based literature would suggest. Table 1 displays the key findings from both risk-focused and strengths-focused research.

RECOMMENDATIONS FOR RESEARCH

This summary of the literature suggests that rural communities are more than simply hostile spaces occupied by LGBTQ+ youth. Research also clearly illustrates the potential strengths and opportunities for resilience within rural communities. A predominant focus on risk fails to account for the ways in which rural communities may be supporting LGBTQ+ youth. Additionally, comparing rural communities to urban communities with the goal of understanding differences in risk simultaneously sets up a false dichotomy that ignores the experiences of LGBTQ+ youth in small urban communities and situates urban as the "norm" to which rural communities should aspire to be. As Gray (2007) indicated, rural communities must be studied as separate and different from, but not inferior to, urban communities. The urban/rural dichotomy and identification of risk differences does not prove useful when attempting to consider how to make rural communities safer and more accepting for LGBTQ+ youth.

The strengths perspective provides a promising framework through which to conduct research on rural communities and LGBTQ+ youth. Attending to strengths alongside challenges provides an opportunity to understand rural communities holistically. For example, understanding the mechanisms within rural communities that result in challenges for LGBTQ+ youth may also help us identify mechanisms within the community that can alleviate or mitigate these risks. Simply understanding the risks compared to urban youth provides little information about potential interventions given that urban-based interventions may not translate to a smaller community (e.g. a rural community may not have resources to support the development of an LGBTQ+ community-based organization).

Given the ways in which LGBTQ+ youth's sexualities and genders are marginalized in society, it is also important to attend to the role of oppression and power when situating research within the strengths perspective. Guo and Tsui (2010) argue that while the strengths perspective is important in identifying sources of resilience and strengths within individuals, it may lack attention to the role of oppression and power within society and their effect on individuals experiencing marginalization.

They argue that social workers must go beyond promoting attention to individual strengths and support individuals experiencing oppression and marginalization in "resisting and even subverting power relations" (p. 238). They reiterate Saleebey's (2006) sentiment that social workers should focus on strengths rather than problems, yet note that "strength…is not only found in resilience; it is also evident in resistance and strategies for survival despite adversity" (Guo & Tsui, 2010, p. 239). This suggests that in utilizing the strengths perspective in research on LGBTQ+ youth's rural communities, researchers must also consider the role of power and oppression and the ways in which youth are navigating these contexts within their communities. Additionally, studies on how LGBTQ+ youth are resisting oppressive systems and working within their communities can highlight both LGBTQ+ individual resilience and potential prevention or intervention strategies for use in rural communities.

Considering the ways in which to incorporate the strengths perspective with research on rural communities and LGBTQ+ youth is essential, but not simple. Researchers may identify ways to ask questions that assess resilience, strengths, and challenges within the same study to create a more holistic picture of LGBTQ+ youth's experiences in rural communities. Additionally, mixed-method studies may provide opportunities to ask similar questions in different ways to more fully explore the community context (e.g. Paceley et al). It will be important for research examining rural communities to also include measures of community climate, given the important ways in which they intersect. Although rural communities cannot be turned into larger communities (and we wouldn't want to!), the local climate has the potential to shift to provide increased support for LGBTQ+ youth.

The strengths perspective has a rich history in social work and has important potential when applied to community-based research on LGBTQ+ youth. Recognizing, identifying, and understanding the strengths of rural communities provides opportunities to meet communities where they are in supporting and affirming LGBTQ+ youth, another important social work value. We need more in-depth and thorough research to understand both the challenges and strengths of rural communities in order to truly promote the well-being and resilience of LGBTQ+ youth.

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Identification of Strengths among Southwestern LGBTQ+ Young Adults

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Research on lesbian, gay, bisexual, transgender, and queer (LGBTQ+) youth has predominantly operated within a risk framework, highlighting the risks youth face in their homes, schools, and communities and how these risks are associated with disparate mental health outcomes. This research has been important in establishing the challenges faced by LGBTQ+ youth and the need for interventions to reduce stigma and victimization and promote well-being. However, a predominant focus on risk fails to account for the strengths and resilience of LGBTQ+ youth and positions them as "at-risk" rather than as resilient. This chapter describes a study aiming to redress this gap in the literature by assessing the types of strengths LGBTQ+ young adults identify with and the association between their identified strengths and mental health. First, we provide a summary and critique of the literature on LGBTQ+ youth risks and strengths.

LGBTQ+ YOUTH RISKS

Research has documented that LGBTQ+ youth are at risk of stigma and violence based on their sexual or gender identities (Poteat, Aragon, Espelage, & Koenig, 2009; Ryan, Huebner, Diaz, & Sanchez, 2009). As many as 40% of LGBTQ+ youth report experiencing ten or more types of victimization annually (Sterzing, Ratliff, Gartner, McGeough, & Johnson, 2017). One study found that 98% of LGBTQ+ students reported overhearing anti-LGBTQ+ language at school, while 70% and 50% reported verbal harassment based on sexual or gender identity, respectively (Kosciw, Greytak, Giga, Villenas, & Danischewski, 2018).

LGBTQ+ youth also have documented health disparities when compared with heterosexual and cisgender youth. In a meta-analysis, Marshall et al (2011) found that LGBQ youth have greater rates of depression and suicidality than heterosexual youth. LGBTQ+ youth also have higher rates of risky sexual behavior and substance use (Fish, Schulenberg, & Russell, 2019). Numerous studies have documented the relationship between victimization and health outcomes for LGBTQ+ youth. Discrimination and bullying are associated with increased depression, anxiety (Paceley, Goffnett, & Gandy-Guedes, 2017), and stress (Woodford, Paceley, Kulick, & Hong, 2015). A few studies have identified discrimination or victimization as a mediator between sexual identity and depression (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009), alcohol use (Fish et al., 2019), and self-reported health (Mereish & Poteat, 2015).

Identifying and understanding the risks that LGBTQ+ youth experience and the impact of these experiences on their well-being has been critical to the field of LGBTQ+ youth research. By understanding and acknowledging the ways in which a society that stigmatizes diverse sexualities and genders affect young people who hold those identities establishes the problem where it belongs—within society—rather than as a deficit inherent to LGBTQ+ youth. However, the predominant focus on risk fails to account for the unique strengths and resilience of this population. Over a decade ago, scholars engaged in LGBTQ+ research issued a call to action for researchers to shift away from a risk-focused paradigm when studying LGBTQ+ youth (Horn, Kosciw, & Russell, 2009).

STRENGTHS PERSPECTIVE AND LGBTQ+ YOUTH

Within social work, the strengths perspective provides an important framework within which to study issues affecting LGBTQ+ youth. The strengths perspective underscores the importance of individual strengths as both personal resources and as responses to challenges (Saleebey, 1996). As a social work practice framework, Saleebey (1996) described how a focus on strengths could move practitioners away from "the emphasis on what is wrong, what is missing, and what is abnormal" (p. 297) to a focus on resilience, strengths, and personal resources. The strengths perspective has been adopted and utilized by community-based practitioners, educators, and researchers (Saleeby, 1996). Utilizing a strengths perspective in research with LGBTQ+ youth does not negate the risks and challenges this population faces. Rather, a strengths perspective acknowledges both challenges and opportunities and frames them within the strengths of individual youth and their opportunities to cultivate resilience.

Research on LGBTQ+ youth that explicitly utilizes the strengths perspective has primarily included evaluations of practice models. Craig and Furman (2018) identified LGBTQ+ youth's perspectives of two strengths-based programs for LGBTQ+ youth. Youth reported positive perceptions of both programs; indicating how both interventions gave them opportunities to access social support, build community, enhance their own confidence, and access mentors. Craig (2012) evaluated a

strengths-based case management model serving primarily Black and Latinx LGBTQ+ youth to assess whether youth were able to identify strengths in their own lives as a result of participation in the program; youth were able to identify strengths as being able to ask for help (81%), access social support (80%), having at least one supportive family member (58%), access to community-based support (45%), and support at school (44%). Other scholarly work has focused on describing and promoting strengths-based interventions for LGBTQ+ youth (e.g. Craig, 2013; Craig, Dentato, & Iacovino, 2015; Crisp & McCave, 2007).

Within a strengths framework, although not explicitly identified as such, LGBTQ+ youth research has also focused on resilience. Meyer (2015) defined resilience as "the quality of being able to survive and thrive in the face of adversity" (p. 210). Asakura (2016) utilized grounded theory methodology to explore the resilience pathways of LGBTQ+ youth in Canada. Youth identified resilience strategies that were often in direct response to the challenges faced: establishing safety, self-efficacy and agency, establishing relationships with others, being vocal about their own and others' LGBTQ+ identities, and participating in advocacy and activism. A related study aimed to identify resilience strategies among transgender youth in the U.S. (Singh, Meng, & Hansen, 2014). Youth identified their own resilience strategies as self-defining their own gender, accessing support and resources, community connections with other transgender people, reframing their own mental health concerns, and navigating relationships. Other resilience research has identified the use of online resources (Craig, McInroy, McCready, & Alaggia, 2015b; Singh, 2013), personal self-acceptance (DiFulvio, 2011), connecting with other LGBTQ+ youth (Craig et al., 2015b; DiFulvia, 2011; Singh, 2013; Zeeman et al., 2017), and engaging in activism (Craig et al., 2015a; Singh, 2013; Zeeman et al., 2017) as resilience strategies utilized by LGBTQ+ young people.

Outside of social work, positive psychology offers a framework for understanding the strengths of LGBTQ+ youth. One of the three pillars of positive psychology is the strengths of character (Seligman & Csikszentmihalyi, 2000) and is often used to understand pathways to positive outcomes such as overcoming stigma (Antebi-Gruszka, 2016) and positive youth development (Park & Peterson, 2008). The strengths of character model (Peterson & Seligman, 2004) categorizes 24 personal traits into six strengths categories (see Table 1) and have been used in research with LGBTQ+ individuals. Miller (2010) found that college students with a balanced sense of well-being scored higher on character strengths associated with interpersonal wisdom. Antebi-Gruszka (2016) used the strengths of character framework to create a stigma-related strengths model. This model was used to examine the relationship between stigma and character strengths; findings suggested that the development of certain character strengths could bolster an LGBQ person's stigma-related strengths and therefore improve their well-being. Taube & Mussap (2019) examined character strengths in transgender and gender diverse adults and found some strengths to be related to resilience. These studies suggest that the strengths of character framework have promised to better understand pathways to positive

outcomes for LGBTQ+ persons, although the research is still preliminary and needs further development, especially with people who hold historically marginalized racial identities (Taube & Mussap, 2019).

Several gaps exist in this literature. First, the field remains predominantly risk-focused; more strengths-based research is essential to move the field away from a risk paradigm to one focused on strengths. Second, we lack research exploring the ways in which LGBTQ+ youth utilize their own internal strengths as a response to the challenges they face. Finally, among LGBTQ+ youth research, more research is needed in regions of the country characterized as hostile to LGBTQ+ people, including the Midwest and South. Understanding resilience within these more challenging contexts is critical as we move forward. Therefore, this study utilized the strengths of character model to identify the strengths of LGBTQ+ young adults within one Southwestern State and the association between those strengths and their mental health. Our research questions include:

1) What internal strengths do LGBTQ+ young adults rely on?
2) Are there any differences in identified strengths by social identity characteristics?
3) Are there differences in identified strengths in the severity of depression, anxiety, and stress?

Methods

Secondary data from a pilot needs assessment survey were used to examine the strengths of LGBTQ+ young adults in the Southwest. The needs assessment survey was conducted in 2018 by an LGBTQ advocacy group in a rural, conservative Southwestern state and was administered to LGBTQ+ young adults attending a leadership summit (further identifying information is not provided so as to maintain the anonymity of participants). The survey was voluntary and no incentive for participation was provided; informed consent was given to participants during the main event of the symposium and was attached to the survey. It included sections on program evaluation; campus and community experiences; the Depression, Anxiety, and Stress Scale (DASS); and strengths of character, as well as other topics. The survey was a pilot of a needs assessment intended to be replicated with other youth in the region who did not attend the leadership summit. Only demographics, the DASS, and strengths were utilized for these analyses.

Participants

All attendees of the leadership summit were eligible to participate. Young adults between the ages of 18-29 were selected from the overall dataset. Of the 80 people in attendance, 41 participated in the survey (51.25%); of those, 30 provided answers in the strengths section of the survey (the last section). The drop in responses towards the end of the survey was likely due to its length. Missing responses were analyzed for patterns and found to be missing at random; these participants were excluded from the analysis. Participants' mean age was 21.33 (*SD*=2.510), the sample was

mostly non-Hispanic white (70%), cisgender (50%), masculine gender expression (45%), pansexual/panromantic (33%), disclosed their sexual orientation or gender identity to only certain people (63%), and mostly did not receive free or reduced lunch during primary/secondary school (an indicator of childhood poverty) (63%) (see Table 2).

Measurement

Demographics. Demographic data included in these analyses are racial identity, gender identity, level of identity disclosure, and childhood poverty. Participants identified their racial identity by selecting all that applied among a census-based racial classification and then consolidated to one identity (including multiracial) for analysis. Given the small sample, participants were further grouped into two categories: 1) white (only indicated a white racial identity), or 2) person of color (indicated at least one marginalized racial identity).

Participants identified their gender in two ways: 1) describing their gender identity in their own words; 2) assign a label to their gender identity. This enabled participants to self-identify rather than choose from a predetermined list of identities. For the purposes of analyses, participants were grouped into two categories: 1) cisgender, or 2) transgender, non-binary, etc.

A measure of identity disclosure was used to determine how open participants were about their sexual orientation and/or gender identity. Participants identified to what extent they are open about their sexual orientation/gender identity from among three options: I am not out/open in any aspect, I am out/open with only certain people, I am out/open in every aspect.

Childhood poverty was measured by asking participants to self-report whether or not they received free or reduced lunch at any point in their primary or secondary education.

Depression, Anxiety, & Stress. The Depression, Anxiety, & Stress Scale (DASS) 21-item version was used to measure participants' level of depression, anxiety, and stress. Participants indicated how often a statement applies to them using a 4-point scale ranging from 0 (did not apply to me at all) to 3 (applied to me very much, or all of the time) (Lovibond & Lovibond, 1995). The DASS-21 is scored using the summation of scores, then multiplying by two to match the metric of the original DASS (42 items) for interpretation.

Strengths of character. To measure participants' perceptions of their internal strengths, we utilized survey questions created from the strengths of character classification (Peterson & Seligman, 2004). The six strengths are: wisdom and knowledge, courage, humanity, justice, temperance, and transcendence (see Table 1 for operational definitions and traits). Participants chose among a list of traits to answer the question, "I rely on these strengths to help me when I am facing challenges." Selected traits were coded as one; non-selected traits were coded as zero. Cron-

bach's alpha for these data was 0.89 for the total of all items, and for each subscale: wisdom and knowledge α=0.53, courage α=0.37, humanity α=0.65, justice α=0.27, temperance α=0.55, and transcendence α=0.65.

Analyses

Descriptive statistics are provided for each of the six strengths categories and the total number of strengths using a ratio of mean to total possible number. Independent sample t-tests were conducted to determine if there were significant differences between dichotomized demographic groups and strengths. Correlational analyses were used to determine if scores on the DASS were associated with the number of strengths in each of the six categories.

Results

Table 3 provides details of the descriptive statistics for the categorized strengths and the total number of strengths. Ranked highest to lowest, the six categories in order were: humanity (0.723), wisdom & knowledge (0.62), transcendence (0.61), justice (0.58), temperance (0.52), and courage (0.45).

Four independent sample t-tests were conducted to determine whether there was a difference between groups based on race, gender identity, level of identity disclosure, and childhood poverty on the mean of self-reported strengths in each of the six categories and the total number of strengths (see table 3). There were no statistically significant differences based on gender identity or level of disclosure.

There was one statistically significant result based on race in self-reported strengths in the justice category. Participants in the people of color category self-reported a mean of 2.22 and those in the white category self-reported a mean of 1.52 out of a possible total of 3. The t-test result indicated that participants of color self-reported 0.7 more strengths in the justice category than did those in the white category ($t(28)=-2.034$, $p\leq0.05$). There were five statistically significant differences based on childhood poverty; four of the six strengths categories (wisdom & knowledge, humanity, justice, and transcendence) and the total strengths count. Those reporting childhood poverty had a statistically significantly higher number of strengths in each category except courage and temperance. Participants with childhood poverty self-reported 6.22 more strengths than did participants without the poverty indicator ($t(25)=-2.706$, $p\leq.01$).

Mean scores on the DASS include a rating from normal to extremely severe: depression, M=17.79 (SD=12.04), moderate; anxiety, M=17.29 (SD=11.17), severe; and stress M=19.8 (SD=11.28), moderate. The only statistically significant correlation between DASS sub-scores and strengths categories was between courage and the depression subscale ($r=-.404$, $p<.05$); higher depression scores were correlated with lower numbers of strengths in courage category.

Discussion

This study identified Southwestern LGBTQ+ young adults' personal strengths, determined if there were social identity group differences, and assessed if there were associations between the number of strengths selected and depression, anxiety, and stress. The findings indicate that humanity was the most frequently selected character category, which included the traits of love, kindness, and social/emotional intelligence. This is not surprising given that the sample was comprised of LGBTQ+ young adults attending a symposium with themes of social, economic, and environmental justice. Indeed, the humanity aspects of the symposium could have attracted participants whose strengths lie in humanity-based traits. The finding that the courage category was least selected may also be a reflection of the sample composition since the participants are LGBTQ+ minorities living in a very anti-LGBTQ+ political and social climate.

The finding that there were no statistically significant differences among gender identity groups/level of disclosure and strengths of character may reflect the similarities of this specific sample or a need to investigate whether a mediating factor can help explain the lack of a statistically significant finding. Racial identity was associated with the strengths category of justice indicating that the participants of color had a higher number of strengths in the justice category (social responsibility, loyalty, and teamwork), fairness, and leadership. In previous research, there were no differences among racial groups (Peterson & Park, 2004). Additionally, participants who had experienced childhood poverty reported a greater number of strengths than those who did not. Meyer (2016) found that participants who were middle-class and white reported less violence than low-income participants of color and yet ranked their violence as more severe. They related this to prior research suggesting that people's reference groups affected how severe they perceived their violent experiences. Since white, middle-class LGBTQ+ participants had friends who had experienced lower rates of violence (like themselves), they were more likely to indicate their experiences were severe. This may function in the same way as the identification of strengths. LGBTQ+ individuals growing up with a marginalized racial identity or in poverty may have had the need to develop strengths in the face of oppression and may also be more aware of their strengths as they see them in their reference group. Further research is needed to examine this phenomenon.

Findings also revealed that the only relationship that was statistically significant between the number of strengths and mental health was that between the depression subscale and the courage category; as depression severity increased, courage strengths decreased. The finding that nearly no associations exist may align with Park's (2004) assertion that character strengths can moderate negative consequences of stress, which can include mental distress and mental illness. Thus, the more character strengths a person has, the potentially fewer symptoms of mental distress they have. In the present study, participants scored quite high on all domains of character strengths which may, in turn, influence the presence of mental distress symptoms. The finding that the courage subscale was negatively associated with

depressive symptoms may be due to those depressive symptoms exceeding the participants' strengths, particularly in the areas of persistence and vitality, two important components of the courage domain. Antebi-Gruszka (2016) determined that persons with moderate experiences of stigma also had more strengths of character, but found several mediating factors were involved, such as cognitive flexibility, brooding, social support, and suppression. The lack of significant findings in the current study may be due to not examining mediating factors such as these. The strengths of character in the study by Antebi-Gruszka were measured using the Values In Action (VIA) scale, a psychometrically valid instrument, which the current study did not use. Thus, it may be worthwhile to replicate the current study with a more psychometrically valid measure of the strengths of character.

These findings also call attention to the need to understand LGBTQ+ identities and strengths from an intersectional perspective. Intersectionality describes how facets of identity are situated in privilege and/or oppression and cannot be separated when attempting to examine marginalization (Crenshaw, 1991; Murphy, Hunt, Zajicek, Norris, & Hamilton, 2009). Multiple studies have documented the ways in which transgender women and people of color (Testa et al., 2010), immigrants, (Helm-Hernandez & DeFillipis, 2018), and people within low socioeconomic statuses experience greater victimization and discrimination than white, cisgender, U.S. citizens. Given the commitment to social justice in social work, scholars have called on researchers to incorporate intersectionality in our work with historically marginalized populations (Mehrotra, 2010). Although intersectionality attends to the ways in which multiple marginalized identities (e.g. based on race, gender, and sexuality) affect people's experiences, it is not incompatible with the strengths perspective. Murphy et al. (2009) described intersectionality as a mechanism for social change because it provides room for personal agency and empowerment.

Limitations

The findings of this study should be considered in the context of its limitations. First, it is a pilot study and thus the findings are tentative and should be subject to further inquiry in a larger, more representative study. Second, the size of the sample is limiting especially when splitting it into subgroups for comparison (e.g., race, gender identity, level of identity disclosure, and childhood poverty), the subgroup sample sizes became too small to have adequate power to identify between-groups differences, if they do exist. Lastly, the sample itself may not be representative of all LGBTQ+ youth in this context given that the sample was obtained from a leadership summit. Thus, the findings may differ significantly from other LGBTQ+ youth in the region.

CONCLUSION

By combining intersectionality, concepts in positive psychology, and an understanding of LGBTQ+ youth's perceived strengths, this study has important implications for understanding and utilizing a Strengths Perspective with LGBTQ+ youth. As indicated

earlier, a Strengths Perspective attends to both challenges and resilience, situating both within the strengths LGBTQ+ youth hold. Yet, the strengths-based social work literature on LGBTQ+ youth has primarily focused on evaluating interventions, rather than understanding LGBTQ+ youths' perceptions of their own strengths. We argue that, within a Strengths Perspective, we must engage with LGBTQ+ youth about the strengths they feel as if they possess and assist them in cultivating additional strengths to promote resilience. It is essential that practitioners and researchers alike understand the individual and community resilience strategies relevant to and utilized by LGBTQ+ young people, as well as the individual strengths identified by youth themselves. In this way, this pilot study demonstrates promise for the application of the strengths of character framework within a social work strengths perspective to understanding LGBTQ+ youth and young adults.

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The Circles of Sexuality: Promoting a Strengths-based Model Within Social Work that Provides a Holistic Framework for Client Sexual Well-being

George W. Turner

Social workers who work from a strengths-based perspective take advantage of a client's innate capacity to rebound and recover. It is this person-centered practice approach that guides social workers to see their role as helping clients discover their own internal gifts and graces (Saleebey, 1992) potential, hopes, and dreams (Kisthardt, 1997; Saleebey, 1997). Since the emergence in 1982 from the University of Kansas, the strengths perspective has proven practice applications for a range of issues including spirituality (Canda & Furman 2010); substance use (Siegel et al., 1995), domestic violence (Bell, 2003), and mental health assessments (Francis, 2014) as well as with diverse populations such as children (Mendenhall, Grube & Jung, 2019); the elderly (Chapin & Cox, 2001), Muslims (Abdullah, 2015), partner violence victims (Song & Shih, 2010), and offenders (Lee, Uken, & Sebold, 2004). And while scholarship has looked at applications for the lesbian and gay community (Crisp & McCave, 2007; Dentato, Orwat, Spira & Walker, 2014; Craig, Dentato, & Iacovino, 2015; Craig & Furman, 2018), with the exception of a few scholars (Turner, 2012; 2016a; 2016b), not much research has discussed the intersection of the strength's perspective and a holistic or general understanding of client sexual well-being.

The strengths perspective perfectly positions social workers to be sexual health/well-being practitioners, researchers and educators. As a profession based on human relationships, social workers are likely to encounter sexuality-related issues in a variety of practice settings (Speziale, 1997). Furthermore, social workers operate from a biopsychosocial lens when looking at dimensions of human functioning and

"value the importance of human relationships" (CSWE, 2015, p.8). Sexual relationships must be acknowledged as part of this mandate and explicitly expanding the social work biopsychosocial lens to a more inclusive biopsychosociosexual lens would help center this vital aspect of client life, sexual well-being, within the social work profession.

Research (Prior, Williams, Zavala, & Milford, 2016) suggests human sexuality is not adequately presented in most HBSE textbooks. Also, others (Bay-Cheng, 2010; Gezinski, 2009; Swank & Raiz, 2010) have noted a lack of social work clinical skills to address client sexuality. This gap in social work skills is problematic, negatively impacting social worker's ability to provide comprehensive, accessible, medically accurate, shame-free, inclusive and pleasure affirming, sex-positive informed client services. This begs the question, how can the social work profession "the largest and most important social service profession in the United States" (Whitaker, Weismiller, & Clark, 2006, p. 9) move towards becoming a more sexually literate profession? The answer may be in highlighting the alignment with a hallmark of the social work profession, the strengths perspective.

This chapter is an attempt to bridge this fissure within social work by putting forward the proposition that the strengths perspective provides a framework for social workers to more fully embrace human sexuality. The chapter will first situate sexuality and the strengths perspective by reviewing the legacy of Dr. Dennis Dailey, KU Professor Emeritus, followed by a definition of sexuality. The next segment identifies how sexuality is problematized by society and social work. A discussion is subsequently presented on why client sexuality is paramount to social work. Then the chapter explores a view of client sexuality through the strengths perspective model: The Circles of Sexuality. Finally, an examination of areas of development and possible future direction is provided. The goal of this chapter is to promote, enhance, and ground sexual well-being within social work.

THE UNIVERSITY OF KANSAS AND THE LEGACY OF DR. DENNIS DAILEY

Dr. Dennis Dailey, professor emeritus, joined the University of Kansas School of Social Welfare faculty in 1969 and taught courses on human sexuality until his retirement in 2005. Dailey viewed human sexuality through a strength's perspective lens as highlighted in his Circles of Sexuality model (Dailey, 1981). He demonstrated this approach to his students through a popular course, Human Sexuality in Everyday Life, stating the class is designed to help his students end up in healthy relationships. He would often bemoan, "Using romance novels from Dillons as your guide to a successful relationship is not exactly your best shot, but a lot of people do," (Laessig, 2009, parra 5). Dennis recognized the deep need students have for understanding human sexuality and he was not afraid to teach from a place of vulnerability, honesty and frankness. He also educated countless MSW students, teaching Practice and an elective on Sexual Misuse. His classes were deeply raw often mirroring his clinical ap-

titude for bringing people to difficult conversations and nurturing them as they travelled along challenging and often taboo conversations around emotional intimacy, sexual trauma, shame, and loneliness. However, Dailey's approach drastically veered from the typical pathology view of human sexuality within health professions, including social work. He practiced a strengths-based approach exhibited by his daring acknowledgment of pleasure, diversity and the human capacity for positive sexuality. This simple, yet pioneering idea, that client sexuality is an asset provided a framework for clinical social workers to see human sexuality from a strength's perspective. Additionally, for students it invoked a novel concept- our sexuality is good! For some, this was the first time human sexuality had been discussed as a positive, a strength. Dailey impacted generations of students to become sexually healthier and countless social workers to practice from a sexually literate, sex-positive, strengths approach. Dailey's fans adored him; however, his style - often confronting, deeply intimate, and animated was not always well-received by all. He is an uncompromising educator, fierce sexuality advocate and a gifted therapist. Every social worker has a hero, someone they strive to emulate. Dennis is that social worker for me. He was my teacher, clinical supervisor, and mentor. He groomed me to be the social worker I am today - to practice from a genuinely curious space, to be able to sit in the uncomfortableness of a client's story and to honor a client's strength to do difficult work.

HISTORY OF SEXUALITY AND SOCIAL WORK

Gochros in 1974 recognized a deficit in our social work pedagogy around sexuality training and not much has changed. A comprehensive history of social work education addressing human sexuality is presented by McCave, Shepherd & Ramseyer-Winter (2014). These authors present a content analysis specifically on textbooks, journals, and conferences. At the time of their publication, they noted that there was not a social work textbook addressing sexuality; however, the text Sexuality concepts for social workers (Ingersoll & Satterly, 2020) is now an option.

In addition to my own work looking at sexuality and social work in a variety of domains including sexual justice, (Turner, Vernacchio & Satterly, 2018), microaggressions experienced by Queer academics (Turner, Pelts & Thompson, 2018), sexual voice for people with intellectual disabilities, (Turner & Crane, 2016a); and sexual pleasure and adults with intellectual disabilities (Turner, & Crane, 2016b), there has been a growing renaissance of other social work scholars highlighting this connection (Kattari, Atteberry-Ash, Kinney, Walls, & Kattari, 2019; Brandon-Friedman, 2019; Dodd & Tolman, 2017; Lee, Fenge, & Collins, 2017; Schaub, Willis, Dunk-West, 2017). This is significant in light of social work students reporting a sense of being inadequately prepared on the topic of client sexuality (Laverman & Skiba, 2012; Logie, Bogo, & Katz, 2015; Newman, Bogo, & Daley, 2009). Given that the Council of Social Work Education (CSWE, 2015) notes, "the purpose of the social work profession is to promote human and community well-being" (p. 5) this finding is troubling. Arguably, social workers not prepared to address client sexuality will fall short of fulfilling this purpose.

DEFINING SEXUALITY

For social workers to wade into this discussion, we should start by exploring how to define the term sexuality or more importantly, identify the default meaning used by the majority of social work clients. The term sex is seemingly ubiquitous, left to euphuisms and colloquial rules. However, for many, including social workers, sex means one thing -penetrative intercourse, specifically penile vaginal intercourse (Schroeder, 2009). As social workers, if we are to strive to be sexual health advocates, we must expand the profession's understanding of human sexuality beyond the pedestrian intercourse-centric focus which often privileges a heterosexual, penis-vagina view. The term sexuality was defined by the National Guidelines Task Force (2004) of the Sexuality Information and Education Council of the United States (SIECUS) as being "a natural part of being human; [it] is multifaceted, having biological, social, psychological, spiritual, ethical, and cultural dimensions" (p. 51). Thus, social workers, often a part of a client's health care teams, should advocate for the sexual health of those clients. And, in order to do that social workers must be fully informed about human sexuality. To that end operationalizing sexuality would benefit social work. According to the World Association for Sexual Health's (WAS) Declaration of Sexual Rights (WAS, 2014):

> Sexuality is a central aspect of being human throughout life, encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, and relationships. While sexuality can include all these dimensions, not all of them are always experienced or expressed (WAS, 2014, p. 1).

THE DISEASE, DISASTER AND DYSFUNCTION OF HUMAN SEXUALITY

The sexuality discourse is laden with an oppressive cloud of shame, myth, judgement, and negativity. US culture founded on puritanical underpinnings of sexual fear, ignorance, censure, and condemnation is steeped in erotophobia. You see this in our antagonist relationship with sexuality through phrases of disgust, danger or opposition (Real Reason, 2008a, 2008b). Allied health fields, including social work, reinforce this sex-negativity with a pathology focus on the three Ds: disease, disaster, and dysfunction, (McGee, 2003) which may be even more prevalent in discussions involving marginalized communities and sexuality. Despite embracing a strengths perspective in most areas of practice, a deficit medical model still grips many social workers' views on sexuality. Have schools of social work normalized a societal view of sex-negativity with their lack of attention to client sexuality? Sadly, many programs core curricula are not inclusive of courses or lectures on sexual orientation, sexual development, sexual identities or sexual activity (McCave, Shephard, Winter, 2014). And even though many social workers work directly in

practice areas of sexual abuse, trauma and violence, some might argue that many social workers are not well prepared to address these issues let alone other client concerns such as sexual dysfunction, infidelity, infertility, or sex education. And, how often do social workers as part of our advocacy work engage in conversation around sexual pleasure?

WHY A STRENGTHS-BASED VIEW OF CLIENT SEXUALITY IS PARAMOUNT TO SOCIAL WORK

Research has discussed that sexuality is crucial to a client's identity and well-being (Bancroft, 2009). Yet, in a study by Marwick (1999) despite 85% of patients stating they wanted to discuss sexuality with their physician, they were dissatisfied with their primary care provider's attempt to discuss sexual functioning (Metz & Seifert, 1990). Further, in a study by Sobecki, Curlin, Rasinski, & Lindau (2012) of OBGYNs only 40% routinely asked about sexual problems. Fewer asked about sexual satisfaction (28.5%), sexual orientation /identity (27.7%), or pleasure with sexual activity (13.8%). Most shockingly, was that a quarter of ob/gyns reported they had expressed disapproval of patients' sexual practices.

So, if physicians are not available to discuss client sexuality or address it from a supportive and affirming (strengths-based) stance, who is available? I propose that this is a perfect fit for social workers. We can discuss sexual concerns, offer resources and referrals to specialized providers, support client choice, and honor client self-determination in their fulfillment of who they are as a sexual citizen. Further to this point, social workers are trained to explore sensitive topics (Bywaters & Ungar, 2010), have advanced interpersonal skills, and utilize a strengths-perspective to counter a pathology focused view of clients. These attributes perfectly position us as "sexual well-being enablers" (Lee, Fenge, and Collins, 2017, p. 10).

Simply, sexuality is a social work issue because it is a human issue. For example, our work as social workers may include sexual well-being topics such as: a) helping youth navigate dating anxiety, build porn literacy, sift through the mountain of misinformation about sex on the internet; b) informing mental health clients about prescriptions and their impact on sexual function and desire; c) coaching parents on raising lesbian, gay, bisexual, transgender, queer, intersex, asexual, two-spirit (LGBTQIA2S+) youth, d) identifying sex toys that make sex accessible for clients with chronic pain or a disability, e) brainstorming less painful sexual positions for aging clients, f) supporting veterans with missing limbs or altered appearances to grieve the loss of a sexual self-image, and g) working with religious clients to heal from sexual guilt or shame messages. The point is if you are a social worker being sexually literate and "askable" provides you tools to more holistically see your clients. As Chipouras, Cornelius, Daniels, & Makas, (1979) offer, "People do not express their maleness or femaleness only in the bedroom. Sexuality is a part of all the activities in which a person engages; work, socialization, decoration of one's home, expressing affection. Sexuality, then, is an expression of one's personality and is evident in

everyday actions" (p. 16). Yet, most social workers are often unprepared, unwilling, and unable to discuss client sexuality.

Preparing social workers to see client sexuality within a strength's perspective might be a reasonable start for social workers. A strengths perspective acknowledges that our clients bring their sexuality with them as they do their ethnicity, spirituality, values and beliefs. It celebrates the full capacity of our clients as "an inherent, essential, and beneficial dimension of being human" (American Association of Sexuality Educators, Counselors, and Therapists, AASECT, section Vision of Sexual Health, para. 3).

It can be argued that the umbrella of human sexuality is a significant part of client life; thus, it is imperative for all social workers to be well equipped to address sexual health with clients in order to help eliminate sexual health disparities. The realization that social workers do encounter client sexual concerns is not new in the literature (Blinder, 1985; Dailey, 1981; Gochros, 1985), nor the fact that clients often see the social worker as an authority on human behavior (Glasgow, 1981). Yet, despite a solid argument for social workers to be more sexually literate, the profession has a poor track record explicitly embracing human sexuality.

Often social workers liaise between health care providers and client service organizations. Additionally, they often spend considerably more time with clients than general medical providers. This often facilitates relationships that are in tune with multiple layers of client life, intimate, and able to explore difficult conversations. The case for social workers filling this health care gap is further made by patients reporting physicians do poorly in several primary clinical areas necessary for sexual health care such as lack of empathy, overly judgmental responses, lack of cultural sensitivity, obvious discomfort, and worry around privacy protection (Marwick, 1999; Sadovsky & Nausbaum, 2006). These are areas where social workers typically have exceptional training and skills. Strengths-based training allows social workers to embrace client sexuality and incorporate it within our work.

CLIENT SEXUALITY VIEWED THROUGH A STRENGTHS PERSPECTIVE

The strengths perspective has been a counter-narrative to the typical medical model with social workers recognizing the toxicity of a deficit lens when viewing clients, families and communities. With their focus on client strengths, social workers are positioned to welcome a client's sexual life into the work. A strengths perspective sexual health ally should actively collaborate with clients, focusing on a client's own assets, resources, and abilities (Rothman, 1994; Weick, 1983; Weick & Pope, 1988).

Further, social workers trained in the strengths perspective can utilize other components of the strengths model including: (a) self-determination by supporting a women with her reproductive choices, (b) access by ensuring a client who is dis-

abled has trained care workers who will provide transportation to an adult toy store; (c) looking beyond deficits by viewing the pleasure in sexual encounters not only the risks; (d) conscious raising by advocating for more sex positivity within agency policy and discourse; (e) client collaboration by working with inter-faith groups to create a sexuality education program for seniors in the community; (f) capacity building by discussing dating tips with a youth traversing the emotional roller coasters of relationships; (g) resilience by highlighting a couple's skills in past trauma to help them navigate the potential challenges of a lost pregnancy or infertility struggles; (h) systemic assets by co-identifying with a family their support systems such as political representation in their lobbying to expand service provision or lessen stigma around sex education in their school system; (i) and finally, hope by exploring a client's dreams regarding love, relationships, sexual intimacy and desire. Our training in the micro, mezzo and macro levels allows social workers to examine and explore the interactions of these systems within the client's life in relation to sexual well-being.

Using a person-centered approach prepares social workers to promote an environment of client choice that accepts sexual decisions made by clients that may differ from the social worker. A strengths perspective provides a platform to challenge the predominant societal sex-negative narrative. This includes tackling institutional bias against sexuality while advocating for comprehensive, accessible, medically accurate, shame-free, inclusive and pleasure affirming, sex-positive sex education and sexuality services that support all clients.

THE CIRCLES OF SEXUALITY: A STRENGTHS-BASED SEX-POSITIVE APPROACH

Dennis Dailey's (1981) Circles of Sexuality (see figure 1) offers five distinct areas (Sensuality, Intimacy, Identity, Reproduction, and Sexualization) and provides a holistic, multi-layered, strengths-based perspective in which social workers can view sexuality. A sixth circle, Values, Feelings and Attitudes considers how and where our beliefs are impacted. Grounding my work in this model has provided a lens to see clients – to see all of them, the sexual innateness that they bring into our work. It allows me to walk confidently alongside my clients in their review of who they are as a sexual being. It allows me to create space for and to celebrate this part of my client's life. I welcome it into the room and honor its significance by incorporating it into my work with the client. I bring an appreciation of pleasure (a strength) to conversations with clients and do not shy away from these topics. Utilizing the Circles of Sexuality model has provided me a valuable tool to do my work, a clinical framework to explore the crucial area of client sexuality and provides several distinct advantages.

First, it gives social workers a platform to expand the popular societal discourse beyond the typical intercourse centric view, which I might add is almost always heterosexual and vaginal penetration focused. The Circle of Sensuality focuses on pleasure, touch, and physical feelings. It acknowledges, "the psychological and physiological

enjoyment of one's own body and often, a partner, including but not limited to the genitals; and the tension release of orgasm" (Dailey, 1981, p. 316). It includes valuable talking points within social work such as pleasure, skin hunger, fantasy, body image, and attraction templates. These have significant practice implications.

The second advantage is that it introduces and validates the importance of emotional intimacy. For social workers, this underscores a valuable client asset., the sense of closeness clients can achieve with friendships, family members and romantic partners. The Circle of Intimacy, frames emotional connections with others through vulnerability, risk-taking and the willingness to be known. Using emotional intimacy to locate client success for sustainable healthy and fruitful relationships is a valuable social work tool.

The third advantage with the Circles of Sexuality is that clients can explore aspects such as sexual orientation, gender roles, gender identity and biological gender and be supported by a comprehensive model of sexuality. The Circle of Sexual Identity is a person's understanding of who they are sexually including a sense of maleness and femaleness. This is crucial in social worker's support of gender fluid and gender non-conforming individuals as well as our work around social justice issues. For example, it provides a platform for social workers, to confront gender role myths that men are always interested in sex or counter slut-shaming narratives for women who enjoy sex or pursue multiple partners. Many social workers do this type of sexual justice work (Turner, Vernacchio & Satterly, 2018) and recognizing that they are using a strengths perspective model allows them to situate their practice within social work which may have seemed to them or others to be outside the scope of practice of social work.

A fourth advantage with the Circle model, while it discusses reproduction, it doesn't solely focus on what Dailey called, 'the blue-light special' which is a nod to, once-popular retail store, Kmart's attempt at creating a sale frenzy for bargain shoppers. For many, if there is any formal sex education it is most likely here, the Circle of Reproduction and Sexual Health. Many sex ed programs, including those in public high schools where the majority of sex ed takes place focuses on reproduction (specifically pregnancy avoidance) and perhaps STI and safer sex. Important topics for clients, but not the only aspects of human sexuality that are critical for client well-being. Clients can often become myopic in their view only seeing their sexuality through this one lens, which often has historically been based in fear-based tactics steeped in shame. Social workers who can expand a cultural narrative that only sees a person as sexual, who is of reproductive age, addressing dating and sexuality concerns with youth and older clients. This is not to say that social workers should ignore safer sex talks. We especially need to be more proactive in educating populations including social work students with public health campaign messaging such as "undetectable = untransmittable"[1]. Additionally, we should lead grass-roots organizing for the replacement of remaining "abstinence-only" sex ed programs with comprehensible, accessible, medically accurate, shame-free, inclusive and affirming,

sex-positive sex education for our youth especially marginalized communities. Also, we should advocate for global policies that view sex education as a human right.

A fifth advantage is that Dailey's model illuminates how sex can be used to manipulate or influence others. The Circle of Sexualization acknowledges this prevailing often informal way of dealing with human sexuality and how it is woven into the fabric of many of our clients' lives. It is here where sexual rape, abuse and violence are located and ironically one of the few areas that social workers attempt to address. However, without a balanced understanding like the one provided with the Circles model, social workers can become very punitive and pathology focused when operating in this area. Within this circle, social works can have healthy conversations with clients around flirting and the power inherent in sexuality. I once noted to a male client that he seemed to only interact with me in a highly charged sexual manner. His conversations were often laden with sexual innuendos as if we were at a gay bar. When I explored this with him it seemed that was how he approached most of his conversations with males, especially ones he felt threatened by or at a disadvantage with. He would use mean-spirited, sexually provocative language as a tool to throw the other person off or level the playing field. When I offered him the idea that we (two men) could have an emotionally intimate relationship (one that was not going to lead to physical intimacy) it was both a novel and welcomed albeit difficult concept.

A sixth advantage with Dailey's Circles model it that it allows an exploration of the familial, religious, cultural location a client has with their sexuality. This sixth, Attitudes, Values and Feelings Circle encapsulates all of the other circles. It prompts clients to consider where and how they were provided messages about sexuality that have influenced their beliefs. This circle challenges us to question the role of and messages received from individuals, family, cultural, identity, religious, professional, legal, intuitional, scientific, and political. It gives clients a space to question why they believe the things they believe. More importantly, it allows them to re-consider or re-write those rules that inform their sexuality. This is where social workers can dive deep into sexual shame and guilt, especially toxic messages of hate, shame, or fear a client may have received regarding topics like being LGBTQIA2S+, masturbation, terminating a pregnancy, not wanting children, and infidelity.

Finally, a seventh advantage is that a social worker can explore the weight or prevalence of each of these in a client's life. By introducing the idea that not everyone receives attention to all these circles or equal attention, a social worker can ask a client to physically draw each of the circles representing how each was covered or not covered in their sex education. A variation might be asking a client to draw the circles in how they currently are represented in their life. This was the exercise I used with the before mentioned gay male client and his Sexualization Circle was huge next to an almost non-existent Intimacy Circle. This visual cue can be a wonderful teaching tool providing clients a physical picture of how they currently operate within their sexuality. It can also be a way to operationalize for a client what balanced

sexuality looks like or discuss elements of positive sexuality. A social worker versed in strengths can use this in assessment and treatment phases to highlight client sexual resilience, sexual assets and sexual capacity building. For further discussion on the model see Sexuality Concepts for Social Workers, by Ingersol and Satterly (2019).

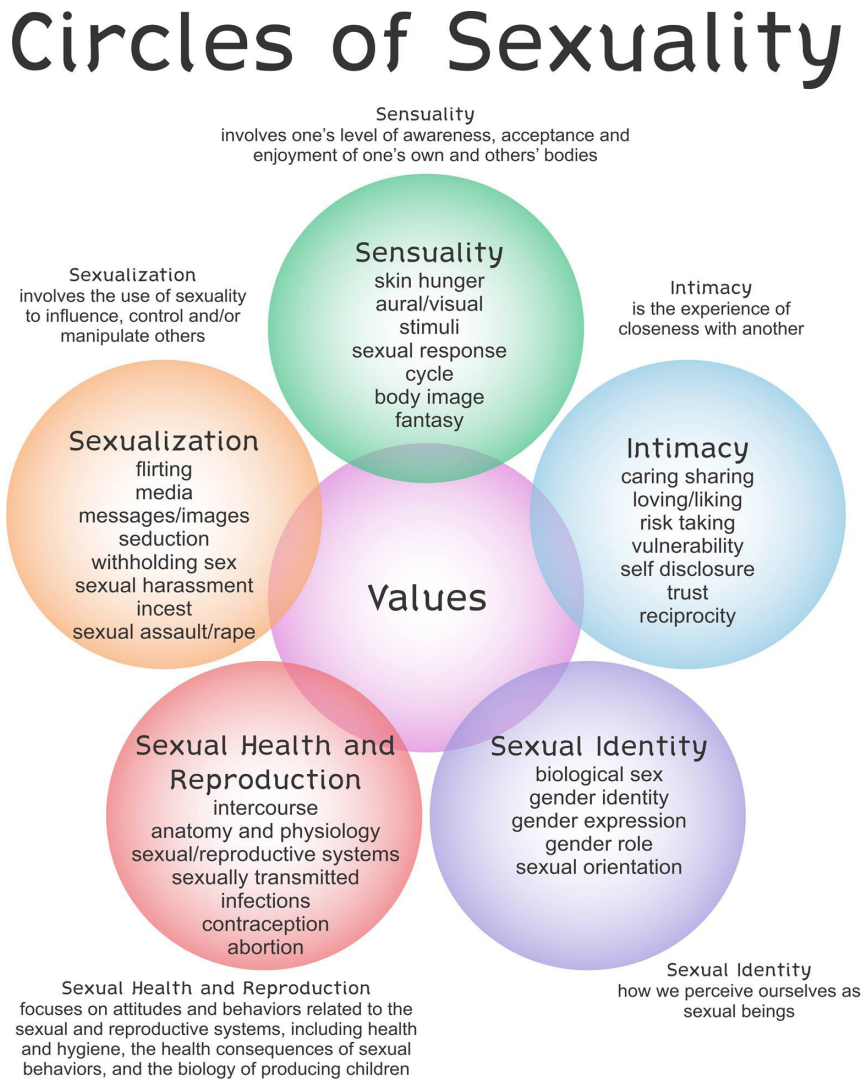

Figure 1: Circles of Sexuality
Areas of Development and Possible Future Direction
Image provided by the Unitarian Universalist Association and the United Church of Christ, adapted from Life Planning Education, 1995, Advocates for Youth, based on the original work of Dennis M. Dailey, professor emeritus, University of Kansas.

Saleebey (1996) warned that "one of the characteristics of being oppressed is having one's stories buried under the forces of ignorance and stereotypes" (p. 301). The strengths model and specifically Dailey's Circle of Sexuality provide a practice model for social workers to more fully and explicitly integrate client sexuality into our work. We can avoid the tendency to bury client sexuality by recognizing that the strengths model encourages social workers to center a client's sexuality "to create an atmosphere in which people's strengths can move out of the shadows and into the foreground" (Nichols and Schwartz, 1995, p. 447). If social work is going to adopt a professional stance that is less trepidation and more celebratory of client sexuality, I suggest five areas for social workers to incorporate in order to move toward becoming a sexual well-being enablers including: (1) Integrate a new view: sex positivity; (2) Embrace pleasure as part of the strengths model; (3) Move beyond gender and LGBTQIA2S+ = Sex; (4) Center sexuality training; (5) Position sexual justice within social justice.

A NEW VIEW: SEX POSITIVITY

The first recommendation is that social work should claim a bold new view- sex-positivity. We must move away from the hypocrisy of claiming to follow a strengths perspective but in matters associated with client sexuality overmedicalize it with "oppressive healthism" (Carter, Entwistle, McCaaffery, & Ryschetnick, 2011). Only seeing client sexuality as a medical issue is but one trap that social workers can fall into. Another trap is the silence of ignoring or avoiding the topic altogether. Dailey (1981) proposes that inhibition leads to a "tyranny of silence [which]...produces a social milieu in which myth, distortion and bias abound" (p. 312). Social work should not be culpable in this sexual reticence; we tackle tough discussions and illuminate the shadows. Silencing sexuality within our professional discourse, training, and practice contributes to a culture of distorted sexuality, sexual shame, and sex-negativity. Dailey further notes that "highly ephemeral feeling states and widely varying behaviors do not represent a systemic conceptual picture of the richness of sexuality as a basic human function" (1981, p. 315).

It is not enough to believe that "sex is a positive thing" social workers should be "working towards a more positive relationship with sex" (Glickman, 2000, para. 7). To be clear, the fact that our society is inundated with sexual imagery and access to sex in more ways than ever does not mean that we live in a culture of sex-positivity. A family, for example, can frequently use sexual innuendos, tell sexual jokes and sexualize relationships, but still operate within a cloud of intense sex-negativity. Juxtaposed to sex negativity where sex is feared, viewed as risky and approached as something to be managed, sex positivity has been described by others (Williams, Thomas, Prior, and Walters; 2015; Donaghue, 2015; Glickman, 2000) as natural, emphasizes pleasure, practices open conversation, inclusive of diverse non-procreation sexual activities, honors self-determination, encourages a judgment-free approach, as well as celebrates happiness and well-being. Dailey (1997) exemplifies a sex-positive social worker by sharing his commitment to a sex-positive perspective:

> The next time you choose to give expression to your sexuality, in whatever way you choose and with whomever they choose… . I want that experience to be unbelievably, incredibly, fantastically, memorably really good, really pleasurable! I do not want that experience to be burdened by guilt, shame, or humiliation, or by an unwanted pregnancy, an STD, feelings of coercion, or any form of hurt. I want it to be an absolute dynamite experience! I want you to know enough and be behaviorally prepared to avoid some of the possible hurts and to guarantee the highest level of pleasure for all involved (p.94).

EMBRACE PLEASURE AS PART OF THE STRENGTHS MODEL

Recommendation two is for social workers to make the connection that sexual pleasure is a client's strength. Not only must we be willing to acknowledge the client's sexuality but that of sexual pleasure as a fundamental aspect of client sexuality (Edwards & Coleman, 2004; Hull, 2008; WAS, 2008). A sex-positive social worker recognizes that explicit sexual conversations and advocating for sexual pleasure does not cause irresponsible sexual behavior or experimentation. According to Dailey (1997), a sex-positive social worker emphasizes "the enhancement of sexual pleasure (both physical and emotional)" (p. 93) and works toward "creating a positive environment for learning even when the subject matter has negative or fear-provoking elements" (p.95). As we situate human sexuality unambiguously within social work, it will be critical to not only recognize the centrality of sexual pleasure but that of sexual rights and sexual health to a client's health and wellbeing (Gruskin, Yadav, Castellanos-Usigli, Khizanishvili, 2019; Starrs et al. , 2018; Turner & Crane, 2016b).

Practice implications include when our clients get caught up in the performativity of sex, which can lead to sexual dysfunction. Social workers can normalize other aspects of physical encounters beyond vaginal/ penile penetrative intercourse, introducing a pleasure model of sex.[2] This provides an opportunity for social workers to validate clients who do not engage in that form of sexual behavior, which may include members of the LGBTQIA2S+ community. This also can be a powerful tool when working with youth who may not always want but feel pressured to engage in penetrative intercourse. Social workers can offer alternative messaging around outer-course (i.e. body rubbing, mutual masturbation, kissing). Another practical application is bringing to the forefront skin hunger, which notes that the skin is the largest sex organ and that nearly everyone has an intense desire for physical contact such as touching, caressing, and holding. Many of the populations that social workers provide services, such as the elderly, are starving for physical contact. And while a person's needs for touch are distinct, access to socially acceptable ways to meet this need is something for social workers to consider, especially when working with certain populations such as those institutionalized that may have limited availability to dating or sexual activity. Problematic behaviors such as excessive hugging or hair stroking may be attempts to get these physical needs met and may provide valuable

clinical insight for social workers. Tapping into fantasy, memory and other sensory aspects of sensuality take advantage of what Dailey (1981) describes as the "mind is the most important and powerful sex organ" (p. 318). Social workers can use this with clients who may not have access to sexual partners highlighting the client's capacity for self-pleasuring. Finally, being able to discuss body image is crucial with our work with youth, around eating disorders, people's experience of fatphobia, and clients grieving the loss of body parts such as those post cancer treatment or returning from war.

MOVE BEYOND GENDER & LGBTQIA2S+ = SEXUALITY

Third, as highlighted by the Circles of Sexuality, social work efforts that solely define sexuality one-dimensionally (i.e. sexual orientation) are reductive and a mistake. While preparing social workers to practice with cultural humility is crucial and providing training to work with the LGBTQIA2S+ community is essential, we are remiss if we delude a professional understanding of sexuality to solely issues of gay affirmative practice (Hafford-Letchfield, 2010) or social work attitudes toward lesbians and gay men (Martinez, 2011). While these notably elucidate important topics like heterosexist practice and institutional heterosexism, social work training on sexuality must be training that encapsulates knowledge, skills and comfort around a broader educational, multi-dimensional understanding of human sexuality, one that Rowntree (2014) describes as encompassing "people's everyday desires, practices, relationships and identities… (p. 362)

Ways of not knowing sexuality creates a hierarchy of privilege (Jeyasingham, 2008). So, by social workers only focusing on sexual orientation, we are remiss in preparing competent practice that addresses a full spectrum of client sexuality as outlined in the Dailey model. To be clear the nascent approach of couching LGBTQIA2S+ content in culturally competent practice must be challenged. We can do better than the obligatory "gay awareness" lecture. At a minimum, the LGBTQIA2S+ community deserves social workers who are well-versed in symbols, historical dates, and contemporary figures within the LGBTQIA2S+ community such as knowing the significance of the Stonewall Inn[3]. Additionally, social workers should understand cultural nuances when LGBTQIA2S+ clients seek support for issues such as information on Pre-exposure prophylaxis (PrEP)[4] (HIV prevention medications), chem sex[5], sex-on-premise spaces[6], circuit parties[7], body image pressures, negotiating kink or open- relationships, and navigation of sub-cultures (i.e. bear, leather communities).

However, I want to stress those cultural or community issues are separate from a more holistic sexual well-being approach. Sexually literate social workers should be prepared to embrace and support LGBTQIA2S+ clients beyond sexual orientation issues including sexual literacy around general sexuality issues that may be experienced by clients such as: how mental health medications impact sexual desire and functioning. Other issues might relate to commercial lubrication, menopause, sexual shame, lack of sex education, grieving sexual function, and barriers to sexual inti-

macy. A holistic view of all of our clients as sexual individuals with a right to sexual health and access to qualified sexual health professionals is merited. Social workers need more than an appreciation of marginalized communities but also should have practice skills to address basic sexuality issues.

CENTER SEXUALITY TRAINING

The fourth recommendation is that social workers need to be sex smart and askable. Social workers can help facilitate clients exercising a sexual voice which often can be subject to being "shamed, segregated, and silenced" (Turner & Crane, 2016a, p. 5), most notably in marginalized communities. But to do that the academy needs to explore where human sexuality belongs in our professional training. Does it take up residency within elective courses, integrated into the current curriculum, or even offered as part of field education placements? I would argue we need more attention on a formalized curriculum within our core requirements for social work students. This is especially salient given that we have an opportunity to become the discipline that is noted as providing the health care profession with sexual health advocates, practitioners and educators. Teaching implications include a radical revamping of our approach in preparing future social workers. The Council on Social Work Education (CSWE) should require foundational sexuality literacy training. An introductory or foundation human sexuality course would provide an overview of human sexuality, increasing the social worker's knowledge, skills, and comfort essential to practice around a myriad of sensitive issues in human sexuality. The course would also provide theoretical models to ground practice and allow social workers to identify their own values. Finally, this course would provide an experiential setting for social workers to practice discussing a variety of sexuality topics. This goal of sexuality literacy will ideally better equip social workers to be sexual health social workers, the front-line experts in facilitating client sexual health, thereby contributing to healthy communities.

POSITION SEXUAL JUSTICE WITHIN SOCIAL JUSTICE

Fifth, sexual justice is social justice. Social workers must position sexual justice within our longstanding social justice efforts. Sexual justice is more than reproductive choice and as noted by Turner, Vernacchio & Satterly, (2018) "framing sexual justice as social justice may enhance student learning and professional development" (p.504). As important as reproductive justice is, the umbrella of sexual justice expands into an array of diverse topics including advancing sexual well-being training within the social work academy.

Social workers have a long-standing tradition of being at the forefront of social justice campaigns; we fight for marginalized communities; we engage in anti-oppressive work; we strive to practice cultural humility. In this space, it is imperative that we recognize how cultural values and norms impact sexuality and more importantly can influence and contribute to oppression. Sexuality is often where human rights

abuses happen. (Sloane, 2014). A culture of sexual pathology is further supported by privileging a few to be sexual, usually falling into the demographic of white, male, Christian, well-endowed (i.e. penis and/or breasts), young, (but not too young, parenthood age), commercially attractive, able-bodied, heterosexual and married while simultaneously demonizing anyone outside of this acceptable few. By limiting access, knowledge and support we create others to be managed. Problematizing sex is a favored tool for management of the disenfranchised. However, if social workers are going to work around power, privilege and oppression they must acknowledge this use of sexuality to control and subjugate groups. More importantly, they must become sexual health advocates in order to counter these tactics.

CONCLUSION

I recognize that my clients are the experts of their life, including their sexual lives, and my role is to travel alongside in partnership. How I bring sex-positive values and interventions is a marker of my commitment to be a strengths-based sexual well-being social worker. The strengths perspective is a social work model that can support a client, specifically around what Saleebey (2002) described as "the revolutionary possibility of hope" (p. 18) -hope to be desired, hope to fall in love, hope to have fulfilling sexual encounters, hope to have sexually literate, sex-positive social workers. Social workers are ideally positioned to be a part of this client support need. I have tried to outline a bold vision for advancing the explicit inclusion of human sexuality within social work by painting a picture of social workers operating as sexual health allies. A strengths-based approach to client sexuality has tremendous potential to reach social workers who have traditionally overlooked or dismissed their role regarding client sexuality. The goal was to provide a framework to increase social workers' understanding of their role and responsibility to be positive sexuality educators, researchers and clinicians. Positioning human sexuality within a strengths-based model, the Circles of Sexuality, provides a map into potentially uncharted territory of sexual health/ well-being for social workers and may help facilitate a more robust and rich discourse on sexually literate social work practice.

END NOTES

[1] In 2016, the Prevention Access Campaign, a health equity initiative with the goal of ending the HIV/AIDS pandemic as well as HIV-related stigma, launched the Undetectable = Untransmittable (U = U) initiative. U = U signifies that individuals with HIV who receive antiretroviral therapy (ART) and have achieved and maintained an undetectable viral load cannot sexually transmit the virus to others. This finding reinforces existing consensus by the World Health Organization (WHO) and more than 750 other organisations worldwide that people whose HIV viral load is stably suppressed cannot sexually transmit the virus. For more information, see https://www.nih.gov/news-events/news-releases/science-clear-hiv-undetectable-equals-untransmittable

[2] For more information on alternate models see Al Vernachio's "The Pizza Model" (https://www.ted.com/talks/al_vernacchio_sex_needs_a_new_metaphor_here_s_one?language=en).

[3] The Stonewall Inn, a haven for the New York's gay, lesbian and transgender community, located in the Greenwich Village neighborhood of Lower Manhattan, New York City is widely considered the epicenter of the modern gay rights movement. In June 1969, police raided the bar which launched the Stonewall riots, a series of spontaneous, violent demonstrations by members of the gay (LGBT) community. Pride month is now celebrated with parades, parties and community events in June around the world to commemorate this grass-roots self-advocacy movement. On June 24, 2016, President Barack Obama officially designated the Stonewall National Monument making it the United States' first National Monument designated for an LGBT historic site.

[4] Pre-exposure prophylaxis (or PrEP) is when people at risk for HIV take daily medicine to prevent HIV. PrEP can stop HIV from taking hold and spreading throughout your body. Studies have shown that PrEP reduces the risk of getting HIV from sex by about 99% when taken daily. PrEP is much less effective when it is not taken consistently. For more information, see https://www.cdc.gov/hiv/basics/prep.html

[5] Chem sex or "Party and Play" are phrases commonly seen on sexual networking apps for men who have sex with men (MSM), that refer to substance use for sexual enhancement. These drugs include crystal methamphetamine, mephedrone and/or GHB/GBL by before or during sex.

[6] Commonly referred to as "bathhouses" or "saunas" by the gay community, these spaces are available in most large metropolitan cities. Sex on Premises (SOP) venues is the term used primarily in British and Australian medical literature for the various commercial venues expressly for engaging in public sex. These spaces may include a darkened backroom at a bar, bookstores with cubicles, or dedicated club style venues with various play rooms including spaces with a bed.

[7] Circuit parties are large often professionally produced international dance events associated with the LGBT / gay culture. Lasting several days, the consumption of "party drugs" and increased sexual opportunities are also part of the attraction of these events.

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Strengths-based Social Work with Older People: A UK Perspective

Holly Nelson-Becker, Liz Lloyd, Alisoun Milne, Emma Perry, Mo Ray, Sally Richards, Mary Pat Sullivan, Denise Tanner & Paul Willis

Social work in the UK and US had similar origins with a historical focus on both community-based work, similar to Jane Addams' settlement house, and individual casework/care management aligned with Mary Richmond's approach to care (Gollins et al., 2016). The visit by Jane Addams in the 1880s to Toynbee Hall, a settlement house founded in London in 1884 to assist the poor through providing opportunities that would lead to social reform, is often cited as a key inspiration for the inception of social work in the US (Addams, 1910). In Addam's description, there was an early recognition of a need to balance focus on youth and older people and to create intergenerational capacity in strengths. That interest remains present today and, with burgeoning numbers of people growing older globally (WHO, 2018), countries have responded in varying ways to this challenge to prepare for the future. Often this is driven by a need to reconcile competing agendas. The move to personalisation and personal budgets under recent UK Governments was an attempt to shift control of care to individual choices, a strengths view, but at the same time, those budgets were being reduced in line with Government austerity measures. This policy and practice environment has shaped the conceptualisation of and approaches to strength-based practice for older people in the UK in ways that are different from the US.

This chapter will provide background on the UK policy and practice context for strengths-based approaches and on the work of G-8—a group of gerontological social work academics who advocate for strengthening practice, education and

research in work with older people. It looks specifically at a strengths approach to assessment and care planning and at older people's perspectives on strengths. It concludes with examples of strengths-based practice from research into innovative services employing this approach with older people.

STRENGTHS-BASED APPROACHES IN SOCIAL WORK WITH OLDER PEOPLE IN THE UK

Tight eligibility criteria for statutory services in the UK mean that the older people seen by social workers are likely to be in the fourth age, have complex needs and/or be experiencing a crisis (Ray et al., 2015). Often described as 'frail', it is important to see this contested term as signalling a need for services across the health and social care boundary, rather than assigning older people to a defined patient category (Pickard, 2018). Some older people will have dementia or memory concerns. It is easy in these circumstances to ignore the emotional and psychological strengths that an older person, and their family, may have and to focus instead on deficits and *needs*. After all, for most of their life, they are likely to have faced adversity, adapted effectively to change, and developed coping skills that retain potency in even the most difficult of circumstances (Milne, 2020).

The strengths approach suggests that older people can manage change and do so positively, especially through supportive relationships with friends, family, professionals and other care networks. There are five key factors that support strengths (Nelson-Becker, Chapin, & Fast, 2013).

- Acknowledgement that every older person has strengths, some developed at earlier ages and some that may develop later in the life course is key. Recognizing and developing these strengths facilitates hope.
- The traditional medical model of assessment and intervention may limit rather than increase capacity. Older people maintain capacities to learn, grow, and change.
- A collaborative approach can be therapeutic and empower an older person to achieve aspirations.
- Older people should continue to participate in decisions and determine the direction of the helping process unless they no longer have mental capacity.
- Identifying or co-constructing environmental assets and resources is an important task for older service users, carers, and professional helpers. The larger society should also support ageing together well.

Strengths-based approaches which honour older people as the experts about what they want and need serve to empower older service users and their families as they deal with crisis and difficulty in settings which may be inherently disempowering.

However, for adult care services in the UK where concerns with cost containment and managing risks to vulnerable service users are paramount, implementing strengths-based approaches requires appropriate education and support for practitioners.

A recently developed framework for strengths-based practice for social work with adults aims to drive forward effective practice in this area. It addresses key areas: knowledge and co-creation, theories and methods, skills, experience, and values and ethics (Department of Health and Social Care, 2019). In order for social work professionals to better harness this approach, there is an emphasis on self-reflection, supervision, and quality assurance to sustain an appropriate professional practice. Effective practice with older people specifically is a long-standing concern in UK social work. Before examining the policy and practice context for strengths-based approaches with older people, we outline the development and purpose of the Gerontological Social Work Special Interest Group (The G8).

Gerontological social work special interest group (The G8): History and priorities

The Gerontological Social Work Special Interest Group was formed following the British Society of Gerontology Conference of July 2010. The academic programme included a gerontological social work workshop and symposium that focused on the challenges for social work in light of an ageing population. Prof. Barbara Berkman of Columbia University—a leader of the Hartford Gerontological Social Work programs—was one of the symposium speakers. With support from Brunel University London, a special interest group of approximately eight academics from University Social Work Departments from across the UK began to meet two to three times per year. The group became known as the G8.

The priorities for G8 are to: (1) collaborate with key local and national stakeholders and decision-makers to develop gerontological social work leaders and to inform and build communities and integrated services for an ageing population; (2) infuse gerontological knowledge and skills into social work education to develop a practitioner workforce capable of engaging in innovative and effective practice with older people, their families and communities; and (3) increase social work involvement in high-quality research and knowledge mobilisation activities to promote and extend the evidence-base that underpins both social work and interdisciplinary gerontological practice. Advocating for the value of gerontological social work is a defining dimension of the G8's role.

Collectively, the G8 has published a number of articles (Lloyd et al, 2014a; Richards et al, 2014; Ray et al, 2015), reports (Milne et al., 2014a, 2014b), and delivered papers at a range of academic conferences. Members have also contributed to practitioner-oriented events and guidance, to the development of specialist competencies for social workers working with older people, and to related resources, for example, an online 'case study' entitled 'Working with Complexity' (British Association of

Social Workers, 2018a, 2018b).[1] Members of the group are also involved in research; we turn to the findings of some of this work later in this chapter. We are committed to extending our research portfolio and to expanding our group to include academics from all four UK nations. We continue to seek funding from social work and policy-related sources to enable us to develop our activities further.

The UK context: Policy and practice developments

Strengths-based practice tends to be presented in UK policy and practice as a new departure from procedural approaches based on needs and deficits. However, the central premise of engaging with people in partnership to recognise and build on their strengths to improve their situation is not new to social work and some aspects of strengths-based social work can be more accurately seen as *reclaimed* or *rediscovered*, rather than new (Gollins et al., 2016). Before we proceed to examine strengths-based social work with older people more specifically, it is useful to provide a brief historical and policy context to strengths-based social work in the UK.[2]

Historically, social work with older people has been seen as a *Cinderella service*, attracting lower levels of interest, status, resources, specialist training and research funding compared with other areas of practice (Richards et al, 2014; Ray et al, 2015). Although quality of life for older people undoubtedly improved after the introduction of the welfare state in the 1940s, support for older people prior to the community care reforms of the 1990s consisted of a limited range of options from a prescribed list of services provided directly by local authorities, mainly featuring *home help*, daycare and residential homes. Such services were often seen as isolating older people from their communities and fostering dependency and institutionalisation (Means et al., 2002).

One of the features of strengths-based approaches is harnessing community resources. Community work was one of the main pillars of social work practice in the 1970s, alongside casework and group work, though how far it engaged with older people is questionable. Like other social work approaches, tensions existed between community work as a traditional or professional intervention to help individuals adjust to mainstream society and as a more radical model that sought to transform power relationships and empower local people (Mayo, 1998). The Barclay Report of 1982, commissioned by the Conservative (Thatcher) government to review the roles and tasks of social workers, took a step towards more strength-based approaches in expressing the preference of the majority of the Committee for Community Social Work as distinct from the *safety-net* or *welfare state* model of provision:

> The Working Party believes that if social needs of citizens are to be met in the last years of the twentieth century, the personal social services must develop a close working partnership with citizens focusing more closely on the community and its strengths. (Barclay Report, 1982, p. 198)

However, the Committee also noted the resource implications of the community model, fearing that:

> … by promoting a community approach we may tempt politicians to believe the community can do everything and do it without funds. We cannot emphasize too strongly that a community approach is not cheap ... it will only give value if it is well resourced. To underfund a community approach is to run the risk of discrediting the entire notion of shared care. (Barclay Report, 1982, p. 216)

There was also dissent within the Committee about how far a community approach should go, questioning, in particular, its compatibility with the specialisation required for social workers to fulfil their statutory duties effectively. The government rejected a community social work model in favour of a narrower, more specialist role for social workers. Over time, with the rejection of the community model, community work within or commissioned by the statutory sector became confined to short-term projects with specific and limited performance objectives (Mayo, 1998).

The implementation of the 1990 NHS and Community Care Act saw the metamorphosis of social workers into *care managers*, with a role limited to assessing need and setting up and reviewing *care packages*. Social policy was driven forward by neo-liberalist ideology and its belief in the value of the social care *market*. Central government funds were transferred to local authorities on condition that the majority of this funding was spent on purchasing services in the independent sector. Whilst the purchasing of services remained with local authorities, the provision of services was contracted out to external providers. Assessments under the new system of care management were to be *needs-led* rather than *service-led*. In line with the consumerist model enshrined in the Conservative government's policy, older people with needs that met the eligibility threshold would be enabled to choose services to meet their assessed needs from the mixed economy of welfare services. There were glimmers of strengths-based thinking in this care management model. The Department of Health commissioned a report to guide practitioners carrying out the new tasks of needs-led assessment and care management. The report presented three models: questioning, procedural and exchange models, each seen as more or less applicable in different situations (Smale et al., 1992). The exchange model was advocated as the best initial approach for practice, adopting the stance that everyone is the expert on their own problems and that the worker's role is to act as a guide and resource in problem-solving, rather than a provider of solutions. Many of the concepts discussed in the report reflect strength-based thinking, such as the centrality of relationships and *joining with* people, the building of bridges between people, resources and communities and the worker's role in developing local resources. However, although the exchange model seeks to harness social and community resources, its starting point is *the dependency needs of the service user and others* (Smale et al., 1992, p.17), rather than their strengths and resources.

The managerialism and marketization that characterised social policy, driven by the concern to contain rising social care spending, rendered the exchange model difficult to use in practice (Tanner, 1998, Sullivan, 2009). Instead, assessments were typically characterised by the procedural model, framed around establishing eligibility for a narrow range of needs (primarily personal care). Eligibility criteria and other cost-containing measures, such as block contracting with private providers, undermined the policy goals of facilitating choice and independence.

Disillusionment with community care and the positive reporting of disabled people's experiences of direct payments, whereby service users with eligible needs received a payment that they could use to spend on services of their choice, invested hope in a new policy of personalisation. Rooted in the disability movement, personalisation is underpinned by the notion that access to resources enables people to exercise their rights and responsibilities as citizens. Personalisation was taken forward by the New Labour government as a way of shaping services around the needs and preferences of the individual service user by offering choice and control (Department of Health, 2005). However, neoliberal principles, including a belief in the market as a viable mechanism to deliver care to 'consumers' provided the continuing backcloth to personalisation, as it did to community care before it (Jordan and Drakeford, 2012). Crucially, personalisation was seen as a way of promoting 'independence, wellbeing and choice' at *no additional public cost.* At the heart of personalisation were two contradictory principles, the fair distribution of scarce resources to those in need and a shift from intensive and crisis help to early intervention and preventive services. Without any additional funding and at a time of growing social need, trying to meet the high level need and develop new preventive services within existing resources was highly problematic (Jordan, 2000).

From 2010, a Conservative-led coalition government set in motion a stringent set of measures that went far beyond containing social care expenditure to drastically cutting it under the banner of austerity. Government policy espoused the notion of the Big Society, characterised by themes of consumer choice and the responsibilities of citizens to meet their own welfare needs and those of others via active roles within their families and local communities (Cabinet Office, 2010). There was a heightened emphasis on *doing more with less* and a prevention agenda that partly focused on further retrenchment of the role of the state, promoting the use of ordinary community services that could be accessed by all and harnessing the assets of individuals, families and communities (Clark, 2011). In a climate of reduced services and tightened eligibility criteria for access to services, only older people with very high levels of need are likely to receive local authority support.

Thus, the shift of responsibility from central government to local citizens coincided with harsh cuts in welfare services and it is in this context that strengths-based approaches have flourished in social care policy and practice. The emphasis on supporting people to recognise and build on their own abilities and capacities and that of their social networks and communities can, superficially at least, be seen

as aligning with key political messages and the current economic context. Tensions exist with radical social work's view that social economic and political factors are at the heart of many of the problems which social workers deal with and critics argue that these structural issues have to be targets of change if we are to address causes rather than surface problems (Cowger, 1998). Given that strengths-based approaches draw heavily on the use of community resources, it is also salutary to recall the Barclay Report's (1982) warning, noted above, that failing to fund community approaches adequately risks *discrediting the entire notion of shared care*.

Legal and professional requirements

The legal underpinning for a focus on strengths came with the implementation of the Care Act 2014. The Care Act introduced a wellbeing principle, giving local authorities a duty to promote wellbeing, over and above any responsibilities to provide services to meet a need. Assessment moved beyond identifying the need for services provided by the local authority, as under previous legislation, to the more active role of helping prevent, reduce, or delay the development of needs and helping people to achieve outcomes by means other than the provision of local authority care and support. The statutory guidance states:

> At the same time as carrying out the assessment, the local authority must consider what else other than the provision of care and support might assist the person in meeting the outcomes they want to achieve. In considering what else might help, authorities should consider *the person's own strengths and capabilities, and what support might be available from their wider support network or within the community to help.* (*emphasis added*). (Department of Health, 2014: para 6.33)

Although the Care Act (2014) does not include a duty to use strengths-based approaches, it has been described as the 'perfect framework' for this approach to social care provision (Department of Health and Social Care, 2019, p. 50). The duty to promote wellbeing, broadly defined under nine different areas, and the shift away from the provision of services to a requirement to meet needs lends itself if the practice is undertaken in the spirit of the legislation, to more holistic and person-centred approaches. The statutory guidance also emphasises the importance of community resources, particularly in relation to preventative support, and *recognises that modern care and support can be provided in any number of ways* (Department of Health, 2014, para 1.9). This further opens the door for strengths-based working. Through the application of the Care Act (2014), practitioners are being encouraged to practice in a more individual, less prescriptive and less service-focused manner and to look beyond traditional service provision. Strengths-based approaches provide them with the framework to do this.

As well as the legal responsibilities to take account of strengths, there are also significant professional obligations to adopt strengths-based approaches. The first

standard of the professional threshold that social workers are required to meet for registration as a social worker is the ability to *Promote the rights, strengths and wellbeing of people, families and communities* which includes the requirement to *Value each person as an individual, recognising their strengths and abilities* (Social Work England, 2019, 1.1). Strengths are similarly highlighted in the Professional Capabilities Framework for social work education and professional development which sets out under nine domains the capabilities that social workers should demonstrate at different stages of their career (British Association of Social Workers [BASW], 2018a).

BASW has also led on the development of a related set of professional capabilities specifically for social workers working with older people and one of these is that social workers 'have developed expertise in rights and strengths-based work with older people and their carers, families, networks and communities' (BASW, 2018b, p.11). The necessity of a strengths-focus is also referred to in the Knowledge and Skills statements which set out what social workers working with adults are expected to know. This includes under the heading *person-centred practice* that social workers,

> …should work co-productively and innovatively with people, local communities, other professionals, agencies and services to promote self-determination, community capacity, personal and family reliance, cohesion, earlier intervention and active citizenship.
> (Department of Health, 2015: para 3)

ASSESSMENT AND PLANNING IN A STRENGTHS APPROACH

Good quality assessment has long been recognised as the cornerstone of effective social work practice. As a dynamic process that is undertaken with the older person and their carer and/or significant others, it provides the foundations upon which successful interventions are built. Under the Care Act 2014, the threshold for accessing an assessment is set relatively low. The duty to undertake an assessment applies *where it appears to the local authority that an adult may have needs for care and support* (Care Act 2014 s. 9 [1]).

Historically, older people have not always fared well in relation to assessment practices. Not only has the process of assessment and the requirement to demonstrate eligibility for services led to a deficit approach, where the focus is upon what an individual cannot do, work with older people has also tended to be routinised and agency centred (Richards, 2000). Good quality assessments require a high level of skill from practitioners but the complexity of this task when working with older people has been under-recognised. In addition to core social work skills, practitioners in this area also require sound knowledge and understanding of the impact of ageing amongst diverse groups of older people; awareness of the losses and changes of

later life, and the renegotiations and reinventions that are part of managing the challenges of this life stage.

Despite the Personalisation agenda (see above) which promoted giving individuals choice and control, negative and restricted cultural assumptions about the ways of life open to older people have remained (Carr, 2013). These assumptions along with paternalistic and risk-averse approaches held by practitioners have resulted in older people not always having this promised choice and control (Moran et al., 2013). Differences in personal budgets, the funding that the local authority provides to meet care needs, have also been found with older people typically receiving less than other service user groups and being restricted to basic or traditional forms of support such as help with personal care (Moran et al., 2013; Newbronner et al., 2011).

The recent emphasis upon strengths-based approaches to assessment may be seen as an opportunity to reinvigorate social work practice with older people, to move away from ageist assumptions and place older people on a more even footing with other service user groups. The practice framework and handbook published by the Department of Health and Social Care (2019) sets out the aims of assessment under a strengths-based approach as follows:

> *...to identify:*
>
> - *the person's own strengths, wishes and priorities at various levels.*
> - *the strengths of the person's supporting network such as their family, friends and neighbours.*
> - *their wider network of support, for example, local groups, voluntary organisations, corner shops, the local cafe or library.*
>
> (Department of Health and Social Care, 2019, p. 42)

The practice framework also stresses that there is no one-size-fits-all model and that the individual, who is the expert in their own situation, should be at the centre of the process throughout. Overall, the approach should protect the individual's independence, resilience, ability to make choices and wellbeing (Social Care Institute for Excellence, 2015). In order to achieve these aims and work in a strengths-based way, the importance of relationships and meaningful conversations is also emphasised (Department of Health and Social Care, 2019; Social Care Institute for Excellence, 2015). Such conversations might include elemental questions to enable identification of strengths over deficits (Nelson-Becker, 2018; Nelson-Becker, Chapin, & Fast, 2013) through the use of open language that does not privilege problems. Examples of such questions are:

- What does a good day look like for you? How do you spend your time? (Normal activities)

- What matters most to you in life? (Life satisfaction, meaning, spiritual foundations)
- Who is important to you? What kind of support do you receive? (Social support)
- What has worked well for you previously? (Coping skill inventory)
- What is going well for you now? (Present-oriented strengths and disposition)
- What do you hope for? Why do you wake up each day? (Visioning and ikegai[3])

(adapted from Nelson-Becker, Chapin, & Fast, 2013, p.169)

STRENGTHS-BASED PRACTICE WITH OLDER PEOPLE WITH COMPLEX NEEDS

There are aspects of social work with older people that present additional challenges to the successful application of strengths-based approaches. Increases in UK life expectancy have resulted in many older people living with long term health conditions and associated complex needs. For a small number of older people, dependency is a reality and a high level of daily support is required (Ray et al., 2015). When the level of need exceeds the support available from personal networks and local communities, formal service provision is the only option. However, in many communities, financial austerity measures mean that local resources are reduced or not available and it is often those who are least able to provide for their own care who have the greatest need for care (Lloyd, 2010).

In strengths-based approaches to assessments, individuals are, quite rightly, seen to be the experts in their situation and should play an active part in the assessment process and any intervention. However, individuals may lack insight into their needs or be unable or unwilling to play an active part in this process. If an individual is not fully able to participate, practitioners are advised to overcome barriers wherever possible and to ensure *that all the necessary and appropriate tools are used to maximise involvement* (Department of Health and Social Care, 2019, p. 27).

Ensuring that involvement is maximised requires particular sensitivity and self-awareness on the practitioner's part. When older people living with long term and complex conditions are labelled as frail and dependent, this limits the possibility of appreciating the complex ways in which strengths and abilities co-exist with needs and vulnerabilities. Stereotypes of older people with high support needs as passive and helpless obscure their strengths and resources and ignore the significance of how they make sense of their own situations. Moreover, the sovereign status ascribed to independence and autonomy in public and policy discourse means that dependency and frailty in old age are linked to notions of pity, blame, failure and burden (Grenier, 2007). A political focus on the unsustainable demands placed on health and social care services by an ageing society arguably invoked to

justify economic retrenchment has further reinforced the burden narrative (Lloyd et al., 2014a).

The intersection between advanced age, impairment and decline has been linked to the notion of the fourth age (Grenier, 2012), hypothesised by some like a black hole—an unknown and unknowable status characterised by loss of agency, dependency and indignity (Gilleard & Higgs, 2010). This hypothesis has been contested by a growing body of research which shows that there is little evidence to support an assumption that older people respond to problems less actively than young people (Richards, 2000) or that agency is lost (Grenier & Phillipson, 2017). Moreover, biographical and narrative research with older people with complex care needs consistently shows that older people are resourceful in maintaining their identities and adapting to change.

The strengths perspective within social work has made a clear contribution to an orientation designed to elicit well-being and satisfaction with life, no matter where one is on the health-illness continuum. Even in sub-optimal circumstances, this approach can keep people striving for or maintaining their best outlook on present conditions.

Older people's perspectives on strengths

Biographical and narrative research that places older people at its heart has contributed important insights about what being *strengths-based* means from the perspective of older people who are living with and managing complex health and care needs. A consistent message is that older people often draw on a lifetime's experience of problem-solving, using their internal resources to manage challenge and change (Richards, 2000; Ray, 2006; Tanner; 2010).

One such resource is life-long continuities that give shape to individual biographies and identities. In the face of sometimes rapidly changing needs, it is easy to overlook the importance for older people of continuities, such as relationships, routines, and habits of the heart, that can provide a foundation of stability and security from which to navigate the loss, change and disruption that may accompany ageing. Analysis of the narratives of older people with changing health and support needs draws attention to the importance of life themes in connecting experiences across a person's lifetime as well as contributing meaning, purpose and a stable sense of self (Tanner, 2010). Research with older couples married a lifetime, for example, highlighted how formal services were, at times, resisted or rejected by couples because they threatened the preservation of important individual and couple continuities (Ray, 2006).

An important resource for older people with high support needs is their access to narratives of coping. The dominance of 'strengths talk' (Tanner, 2010, p. 101) and perseverance by older people, can serve as a counterpoint to the realisation that their ability to cope and manage is likely to be severely or fundamentally compro-

mised (Lloyd et al., 2014b). Amongst participants identified as frail (Lloyd et al., 2019), participants recounted narratives of loss and their impact on personal coherence when highly valued aspects of their lives, such as a much-loved home, were threatened or lost. Recognition that a coping/managing narrative co-exists with anticipated and actual deterioration and loss is a critical element in supporting older people. The ways in which older people may be supported to continue to exercise agency and construct strengths-based narratives in the context of rapid and overwhelming change is an important consideration for practice.

Another source of strength consistently highlighted in narrative research with older people is their ability to adapt to change and challenges, such as deteriorating health and abilities (Tanner, 2010; Ray, 2006; Skilbeck, 2017; Lloyd et al., 2019; Lloyd et al., 2014b). Biographical experiences of mastery over challenging situations can build personal resources, strategies and skills that people bring into later life. However, the ability to adapt to change and loss cannot be seen as a straightforward reflection of individual strengths. The wider external environment and structural factors are critical, too, and may support or undermine the ability to withstand loss and disruption (Tanner, 2010; Lloyd et al., 2014b).

An ecological perspective is helpful in identifying the role of the wider environment, including structures and systems, in bolstering or impeding the strategies of older people with high support needs. In terms of the interaction between the individual and social structures, it is clear that older people are concerned not to be a burden on families and care services (Tanner, 2010; Lloyd et al., 2014b). This position is likely to reflect older people's efforts to resist and refute constructions of old age as a time of need and dependency. In the dominant medical discourse, frailty is embodied in individuals rather than seen as influenced or created by structural factors and inequalities experienced across the life course (Grenier, 2007). This renders the significance of social and economic factors in addressing frailty invisible. A strengths-based practice is therefore undermined in two ways: older people with high support needs are seen as lacking agency, abilities and resources at a personal level and the potential contribution of resources in their social environment is overlooked.

This discussion of older people's perspectives highlights further significant points of tension that may undermine the potential in contemporary UK policy for strengths-based approaches to be employed in practice. First, considerable evidence about the factors that older people identify as important in promoting and supporting wellbeing (Glendinning et al., 2006) has not contributed to the transformation of service provision. Secondly, it is unhelpful that the voices of older people with high support needs continue to be substantially absent in public debates about social care and in policy and practice narratives (Lloyd et al., 2014a) as well as in-service development activities. Finally, exploratory evidence suggests that the foundation for social work education with a gerontological focus is uncertain (Richards et al., 2014). Although there is a significant body of gerontological research, including research exploring the experience of older people living with high support needs, this

remains substantially untapped in UK social work education and amongst qualified practitioners.

The current challenges associated with navigating the health and social care landscape for older people with complex needs and the tensions in contemporary social care policy and practice are undeniable. However, as the next section shows, there is growing evidence of excellent services and practices, sensitively delivered.

Examples of strengths-based practice in England: Promising and innovative practice

In 2018-19, we completed a small-scale exploratory study of promising and innovative practice in social work with older adults. The purpose of this study was to refocus attention on the knowledge, skills and values social workers bring to social care services for older adults and to identify the distinctive contribution social workers make to multidisciplinary teams and services based in secondary settings, such as hospitals. Over recent decades, as policymakers have concentrated on the challenges of preventing unnecessary hospital admission and delayed discharge of older people, social care services have become more narrowly focused upon older people's functional health and the role of hospital-based social work.

Five services across England participated in the study. These were targeted at providing care and support for older adults and included social workers as core members of social work-based and multi-disciplinary teams. A strengths-based approach was identified across the participating services as an integral dimension to individual practice and the remit of services. We adopted a case study approach to generate rich in-depth descriptions of each participating service and the role and contribution of its social workers. In each site, we conducted a thematic documentary analysis, examining the aims and objectives of the services and the role of professional social workers. We completed semi-structured interviews with 21 participants: 11 service managers and senior practitioners (6 with social work and 5 with clinical backgrounds), 8 social workers, and two other practitioners. Types of interventions provided included hospital-to-home discharge support; family group conferencing; early intervention support for older adults with long-term health conditions; and dementia wellbeing support for community-dwelling adults.

Across the core themes generated from qualitative data, the strengths-based approach was frequently cited as a prominent model for informing individual practice with older adults. Attention to human rights, a focus on service users' perspectives and wishes, and an emphasis on strengths-based practice were all distinct elements social workers brought to multi-disciplinary teams working with older people and their families. Person-centred and strengths-based approaches often went hand-in-hand as social workers sought to maintain a focus on the wishes and views of the older person with whom they were working. Adopting a strengths-based approach meant starting with what the service user was able to do and identifying ways in which they could be empowered to maximise their independence in an uncertain

future. This included recognising the supportive people around the service user and involving them in helping conversations. Rooted in the value of self-determination, a strengths-based approach was flagged as a way of moving beyond a deficit focus, and a vehicle for tapping into family, community, network and local resources. There was some acknowledgement that social work practice had not always been strengths-focused and senior team members were keen to promote a strengths-based approach when identifying an individual's care and support needs:

> *I think sometimes social workers go in and really focus on what people can't do, and plug in their care package to meet that need. For me, the social workers in our team, we want them to think about what that person can really do and observe it. … It's about our social workers thinking quite dynamically.* (PB3, team manager, early intervention service)

Another social worker described a strengths-based approach as a more familiar perspective to newly-qualified social workers and spoke of the need to change the mindset of more experienced team members who had been practising from a very different approach:

> *What I find is, often strength-based is more aligned to newer workers. I think people who have worked in adult social work care a long time are very much more in a, 'We go in and fix things' kind of mentality. Whereas I think those coming out of university particularly know that we are not there to fix things.* (PD2, social worker, hospital team)

There was also acknowledgement of the tensions between a strength-based approach being imposed by management as a 'cost-saving' mechanism for withholding or withdrawing services and the desire of social workers to maximise this approach to increase good outcomes for older patients:

> *I know we talk a lot about strengths-based models in social work, and I know that's come under some really heavy fire for being a way for local authorities to cut costs and shave packages of care down. I think of it more in terms of, the network that you have is the one you've already chosen, and you've had a lot of time in your life to choose that.* (PD1, social worker, hospital team)

This highlights how long it can take for newer approaches to be embedded in individual practice and that some practitioners may need support to adopt this way of working.

To put a strengths-based approach into practice typically involved innovation in the way social workers applied communication and related skills to give services users a

voice, control and ownership over the care and support they received. This necessitated applying participatory approaches to core procedures, such as assessment:

> *The kind of model I use is strength-based. I'll go in, I'll speak to the person. I'll try and get a picture of their life. I always try and start off with that. It's not always possible if you have got really domineering family members sort of talking about all the things they perceive as going drastically wrong.* (PD2, social worker, hospital team)

For one service (family group conferencing), recognising the strengths of each participating individual was a core part of the service's aims and this model of intervention was considered by team members as a good fit with a strengths-based approach.

There was, however, recognition that a strengths focus could be driven not by the service user but by the social worker. One practitioner emphasised the importance of being prepared for surprise and uncertainty and allowing opportunities for the service user's strengths to emerge through more unstructured conversations rather than being imposed through formal assessment:

> *I think that strength-based practice which is about just me endorsing strengths that I perceive in others that fit with my values and my own perspective, I don't think that's true strength-based work. I think to really work strengths based, you've got to be prepared to be surprised and you've got to be prepared to work with people in a way that is beyond your imagination as a professional.* (PC3, social worker, group conferencing service)

Within hospital settings, there was acknowledgement that the voice of service users was often lost as medical professionals and family members made decisions about the care and arrangements of the individual. A strengths-based approach helped to bring back the focus on the individual and the social network around them, but it was important that social workers were prepared to defend their approach and to convince other, more skeptical, team members of its value. Knowledge of the law was crucially important and gave weight to decision-making, particularly where related to mental capacity and the assessment of individual capacity in relation to a particular decision.

Finally, the strengths-based approach was not applied in isolation. Social workers across the case study sites emphasised the significance of complementary approaches such as relational models of working and the need for knowledge and in-depth understanding of life-course theory, the complexity of human relationships and care, and support needs in later life. A strengths-based approach was one

integral dimension to social workers' practice frameworks that underpinned their application of other skills and bodies of knowledge.

SUMMARY

This chapter set out the policy and practice context for strengths-based approaches for gerontological social work in the UK. G8 is featured to demonstrate the efforts of a group of academics from across the UK who are mobilising the strengths from within the social work community to promote innovative and high-quality gerontological practice and research. Strengths-based practice is presented as a departure from a regulated environment for social work where strengths-based thinking features in social policy but is sometimes more challenging to realise in practice. A more recent re-emphasis on ecological perspectives, a focus on individual assets and resources within assessment and care planning, and the promotion of *strengths talk* within the practice encounter highlight current best practices characterised by a strengths orientation.

END NOTES

[1] A resource that aims to support people working in social care and health to improve outcomes for adults, their families and careers. Available at: https://www.ripfa.org.uk/.

[2] Devolution means that there are differences in policy and practice between England, Wales, Scotland and Northern Ireland that there is insufficient space to cover in this chapter.

[3] Ikegai is a Japanese concept to capture the source (s) of value in one's life or a reason for living (Hasegawa et al., 2003).

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My Sojourn with the Strengths Perspective: Growth and Transformation through Crisis, Illness, and Disability

Edward R. Canda

INTRODUCTION

I count myself extremely fortunate to have spent most of my academic career at the University of Kansas School of Social Welfare, inspired by the Strengths Perspective. I arrived in 1989, just as the Strengths Perspective was being officially named in publication and being set as an orientation for our School (Weick, Rapp, Sullivan, & Kisthardt, 1989). I retired December 31, 2019, in the midst of our year-long 30th Anniversary Celebration of the Strengths Perspective at KU. This chapter is a summary of my sojourn with the Strengths Perspective, including how it inspired my scholarly work and insights about the human possibility for growth and transformation through adversity.

Major principles of the Strengths Perspective can be found in a concise form on our School's website. So here I will only highlight some of its features that are especially pertinent to my work. Strengths-based social workers honor the strengths, resources, and possibilities for growth and positive transformation in each person and group. We collaborate with clients to assess and mobilize their strengths and resources as relevant to their goals and aspirations. We collaboratively work to overcome blocks and barriers and to generate new strengths and resources. And we promote empowerment, well-being, and global and environmental justice for everyone. We realistically acknowledge adversity, struggles, illness, oppression, and calamities, but we keep hope in the possibility for growth and transformation in any

situation and we never reduce people to dehumanizing and possibility-crushing labels, stigmas, and assumptions about deficits, pathologies, and problems (Saleebey, 2000, 2013).

My career has addressed significant life challenges such as refugee resettlement, chronic illness, and mental health recovery. It highlights the ways people grow and transform through creative responses to life difficulties and disruptions from the personal to the global, especially by drawing on spiritual strengths and resources. It also champions proactive encouragement of positive growth as an ongoing way of life, during every phase of life, whether smooth and gradual or marked by pits of crisis or peaks of insight and ego-transcendence.

Inspired by the Strengths Perspective, my intention has been to promote awareness and openness to a growth-oriented way of life. Hopefully, this expands clients' and the general public's awareness of this possibility and supports their choice to live this way, if they wish. Hopefully, this encourages social workers and other helping professionals to be open and supportive of people's full developmental possibilities; to support the optimal potential for clients in whatever situation, according to their priorities; and to promote regional and global conditions of well-being and social and environmental justice that are crucial for this growth. This means that social workers support people in all their circumstances when going easily with the flow of life, when feeling down and out, and when they are ready to move up and through.

MY PERSONAL SOJOURN WITH THE STRENGTHS PERSPECTIVE AT KU

I was attracted to join the KU faculty because I had come to know of the innovative thinking of Ann Weick and Dennis Saleebey in the mid-1980s. They were involved with many other scholars in holding alternative paradigm gatherings within the Council on Social Work Education's Annual Program Meetings of the time. People gathered who were questioning the influence of patriarchal, positivistic, pathologizing, problem-focused, Eurocentric and other biased and restrictive perspectives that had widespread influence in social work education, research, practice, and policy.

My interests in qualitative research methods, social constructionism, transpersonal theory, cross-cultural collaborations, and spiritual diversity were welcomed in this group at a time when many social work education programs were suspicious or dismissive of them. My social work publications prior to joining KU advocated for insights from shamanism and cross-cultural study of transformational rituals to inspire clinical social work (1983, 1988a), a holistic approach to social work drawing on Eastern philosophy and dynamic systems theory (Imbrogno & Canda, 1988), and the formation of an inclusive and comprehensive understanding of spirituality that embraces religious and non-religious views in order to promote a bio-psycho-social-spiritual-natural environmentally attuned social work (Canda, 1988 b & c). These ideas were not widely (or even barely) accepted at the time.

When I learned that KU had openings on the faculty for 1989, I was eager to join a place that included Ann Weick as Dean and Dennis Saleebey as Director of the doctoral program. The fact that they and colleagues welcomed me demonstrated their openness to alternative views of social work. In particular, they recognized that my interests in spiritual and religious diversity were compatible with the Strengths Perspective. For example, my job interview on campus included a presentation from community service and field research on the personal and community support systems created by Southeast Asian refugee communities in the Midwest, such as Buddhist temples, cultural celebration and preservation activities, ethnic mutual assistance associations, and venues for traditional healers such as monks and shamans (e.g. Canda & Phaobtong, 1992). I felt a deep affinity for the strengths vision that was growing in the School. And since then I never regretted my decision to come to KU, which provided me with an academic home and solid base of intellectual and collegial support all the way to retirement.

Under inspiration from my colleagues, I formally integrated the Strengths Perspective into frameworks for spiritually sensitive practice (e.g. Canda & Furman, 1999; Canda, Furman, & Canda, 2020) and for critical study and comparison of human behavior theories (e.g. Robbins, Chatterjee, & Canda, 1998; Robbins, Chatterjee, Canda, & Leibowitz, 2019). I was supported to apply these frameworks in teaching courses on spiritual diversity in social work practice and human behavior theory throughout my 30 years at KU.

I would like to share an example of how KU colleagues encouraged and mentored me in the Strengths Perspective. Dennis Saleebey invited me to contribute chapters to multiple editions of his widely influential book on the Strengths Perspective. These contributions were based on my qualitative research studies of the way people with a chronic illness, cystic fibrosis (CF), utilized spiritual strengths and resources to foster resilience, sense of meaning and purpose, and personal growth in the process of dealing with ongoing adversity and confrontations with mortality. Dennis felt that this was a powerful example of strengths and he wanted me to share my findings more widely, not only based on formal research but also based on my personal experience as a person who has CF. The 2002 chapter was a breakthrough for me in that it challenged me to move more publicly and proactively into a stance of advocacy around disability issues and rights.

As I wrote (Canda, 2002a, p. 76), “One of the tenets of strengths-oriented empowerment research is that researchers should conduct studies that let people speak for themselves… I included myself in this study…this chapter is not about *they*. And also it is not about *me*. It is really about *we*. The doing of this study has been one of the most powerfully transforming (and often befuddling) research projects of my career. This is because my own quandaries, challenges, insights, and stories about having CF have been inwardly recalled, questioned, stretched, and inspired as I talked with participants, analyzed their transcripts, and tried to find a realistic way of presenting them.”

In 2008, Dennis sat down with me for a personal conversation about his plan for the next edition. Although I had included some personal revelations in previous chapters, I kept my own experience toward the background. He encouraged and challenged me to put my own experience directly into the foreground for the next edition. The chapters for the 2009 and 2013 editions extensively used self-reflection, personal narrative, and purposeful self-disclosure joined with the voices of others. In this way, Dennis promoted my own journey of personal strengths consciousness-raising and encouraged me to extend academic and public service activities related to strengths and empowerment for people with disabilities and for holistic approaches to health and well-being.

In the next section, I will summarize major insights on growth and transformation gleaned from four topics of my work: spiritually sensitive practice; cross-cultural and international collaborations; mental health recovery; and chronic illness and health resilience.

MAJOR INSIGHTS ON GROWTH AND TRANSFORMATION

Spiritually Sensitive Social Work

Spirituality is crucial to consider in promoting people's full developmental potential, including ways of growing and transforming through adversity. Spirituality, by whatever names people call it, and whether named or not, is as a process of human life and development with three main qualities (Canda, Furman, & Canda, 2020). It focuses on the search for a sense of meaning, purpose, morality, and well-being in relationship with oneself, other people, other beings, the universe, and ultimate reality however understood. It orients us around centrally significant priorities that guide our ideals and goals for living. It engages a sense of transcendence experienced in life events and life itself as being deeply profound, sacred, or transpersonal. Spirituality can be expressed in religious and nonreligious forms. It can manifest in healthy and harmful ways.

Spiritually sensitive social work supports practitioners, clients and their communities, and educators and students as we:

- Seek a sense of meaning, purpose, and connectedness,
- Strive toward our highest aspirations,
- Maximize our developmental potential,
- Flourish through strengths and resources, with special attention to those related to spirituality,
- Work to overcome personal obstacles and environmental blocks, especially those related to spirituality,
- And work to actualize well-being and justice for all people and all beings.

I and colleagues developed a detailed framework of knowledge, wisdom, values, practices, and policy principles for spiritually sensitive social work that honors diverse religious and nonreligious forms of spirituality (Canda & Furman, 1999 & 2010; Canda, Furman, and Canda, 2020). This framework is infused in the following areas of my work.

Cross-Cultural and International Collaborations

My work with Southeast Asian refugee resettlement through most of the 1980s and ensuing cross-cultural and international dialogue and collaborations throughout my career gave me two tremendous lessons: people are capable of amazing growth through adversity and this requires social conditions that support and nurture that potential.

I was inspired by the ability of many refugees who entered the United States from Vietnam, Laos, and Cambodia to collectively reformulate mutual support systems, such as Buddhist temples and mutual assistance associations, and to individually cope and grow in a drastically new and different living situation (Canda & Phaobtong, 1992; Cheung & Canda, 1994). This was especially remarkable given their experience of trauma, war, genocide, and hazardous escape from their homelands, plus prolonged and uncertain stays in refugee camps, plus adjusting to life in the United States under difficult conditions. They encountered both positive advocacy and support by many sponsoring organizations, families, and communities on one side and, on the other side, forces of discrimination and linguistic, cultural, and religious intolerance.

The positive growth potential of individuals, families, and communities was greatly affected by the extent to which human service organizations were dedicated to support and collaborate with refugees in a culturally appropriate and humble manner (Canda, Furman, & Canda, 2020). When this worked well, local, state, national and international systems and social policies were aligned and well-integrated with each other and with ethnic community support systems and leadership. This included religiously-based resettlement agencies, secular governmental and non-governmental agencies, and federal and United Nations immigration/refugee policies and systems.

On a more personal level, my life has been woven through intimate connections across cultures, most especially with my Bohemian American natal family/ancestry roots and with my Korean wife Hwi-Ja, and my Korean relatives, mentors, friends, and students. My perspective as a social work scholar and my appreciation for the strengths and joys of transcultural connections have been deeply shaped by my mentor in Korean philosophy, Professor Emeritus Yi Dong-Jun of Sungkyunkwan University in Seoul, and my mentor in transcultural social work, Professor Emeritus Daniel Booduck Lee of Loyola University of Chicago. My studies, consultations, and collaborations in many countries and varied cultural and religious settings expanded my consciousness to realize that local/global human/nature positive synergy is crucial to the well-being of everyone and everything (Besthorn & Canda, 2002;

Canda, 2002b). Without local and global conditions of peace and justice, we can scarcely have the opportunities and structural conditions to support full human development. Indeed, without that, the very survival of human beings and many other beings are in jeopardy.

So I offer a statement of Principles for Inclusive Compassion and Justice (Canda, Furman, & Canda, 2020, p. 522) which perhaps is the Strengths Perspective writ large. These principles are inspired by the Capabilities Theory of Sen and Nussbaum (Banerjee & Canda, 2014), efforts for interfaith and interreligious collaborations, and United Nations' statements on human rights, Indigenous Peoples, and sustainable development. They derive from a commitment to support full human development, to prioritize the needs and goals of the vulnerable, to honor global/ecological connectedness, and to respect spiritual diversity in religious and nonreligious forms (Canda, Furman, & Canda, 2020, pp. 382-383). These principles call us to:

Promote of Respect and Caring for

- *The dignity, worth, and rights of each person*, rather than egoistic individualism.
- *The dignity, worth, and rights of families*, rather than nepotistic familism.
- *The integrity of ethnic, cultural and religious communities*, rather than ethnocentrism, racism, and religious exclusivism.
- *The solidarity and sovereignty of Indigenous nations and nation-states,* rather than colonialism, imperialism, genocide, chauvinistic nationalism, and totalitarianism.
- *The earth, its ecosystems, the worldwide community of human beings, and all beings*, rather than world region bias, global north privilege, human-centric, destruction of nature, and environmental racism.
- *Everywhere humans traverse and all beings*, rather than human centrism projected beyond the earth and the pollution and weaponization of space and other planets.

Mental Health Recovery

For many years I worked with research and training projects related to the Strengths Model of Case Management and Mental Health Recovery at KU. Guidelines for strengths assessment include the domain of spirituality/culture along with six other life domains encompassing daily living, financial assets, employment and education, supportive relationships, health and wellness, and leisure and recreation (Rapp & Goscha, 2012).

Collaborations with Rapp and Goscha, other staff, doctoral researchers, and mental health service clients and practitioners led to the development of guidelines for spiritual strengths assessment (e.g. Eichler, Deegan, Canda, & Wells, 2006; Gomi, Starnino, & Canda, 2014; Starnino, Gomi, & Canda, 2012). We found that many peo-

ple viewed religion and spirituality as important for their recovery. Yet even many strengths-based practitioners neglected spirituality in assessment and action plans, often because they felt unprepared or they were cautious that discussion of spirituality could complicate recovery, especially if clients experienced religiously-based hallucinations or delusions. So we set out to develop guidelines for practitioners. We developed a freely available pamphlet that concisely and practically describes assessment principles, suggested questions, and an inclusive view of spirituality (Gomi, Starnino, Canda, Goscha, & Eichler, 2013). The spiritual strengths assessment reflects several Strengths Perspective principles in a specific application:

- Clients take the lead in defining and naming whatever they view as relevant to how they connect with sources of life meaning, purpose, and hope and with whatever is of greatest importance to them.
- Practitioners' role is to seek understanding, not to impose beliefs, judgments, or terminology.
- Practitioners focus on function, actions, and results of people's engagement with spirituality if and as related to their recovery goals.
- Both positive and difficult experiences with religion and spirituality may be addressed in so far as they are relevant to the person's recovery goals.
- Dialogue begins with an open-ended exploration of possible relevance, comfort, and interest of clients and discontinues or continues based on the person's lead.
- If spirituality proves to be of interest and relevance, further dialogue identifies specific practical actions involving spirituality to achieve recovery goals and what role if any the practitioner might have to facilitate them.

In spiritual strengths assessment related to mental health or any other field of practice, it is usually best to flexibly use open-ended questions that invite interest but do not pressure or steer the conversation in a biased or presumptuous way (Canda, Furman, & Canda, 2020). Wording needs to be adapted to the comfort, style, interests, and beliefs of the clients. Here are some examples:

- When you think about your [choose an appropriate word to match the client's situation and comfort level: such as "current situation, goals, difficulty, challenge, diagnosis, illness"]…
- What helps you to find a sense of peace, harmony, happiness, or comfort?
- What are the most important things you want to accomplish?
- What has been a source of hope, wisdom, or coping in the past that you could apply to this situation?
- What connections with people, nature, or spiritual beings or energies are most valuable to you?

- If you have any important beliefs, rituals, or practices of meditation or prayer, please describe how they relate to your situation? How might they be helpful or not helpful?

You can follow up with explorations, such as “please tell me more about that” or “please give an example” or “please tell me a story about that”. Then in order to move toward an action plan, the following questions could be useful:

- You described [whatever you noticed as the main message of the client] as being valuable or helpful to you. Would you like to talk more about how this might be important to your present situation and your goals?
- You mentioned ways that you have had difficulties or struggles with [whatever you noticed as main message of the client]? Would you like to talk more about how this might be important to your present situation and your goals?
- Please describe how you can use [any religious/spiritual or other support or resource identified] to help you deal with your situation in the best way?
- You identified that [whatever is the main goal] is something you want to accomplish. What could be done to help accomplish that?
- Would you like to take this action on your own or would you like me or someone else to help you to do this?
- Let’s plan the next activity to help make this happen.

The significance of spirituality for some people’s recovery journey was well presented in the artwork and words of consumers exhibited publically at a conference we organized in 2004 (Gomi & Canda, 2014).

Figure 1: Journey from Fear to Love

For example, Mick Swank presented a drawing that illustrated his journey from fear-based spirituality to love. (See Figure 1.) The left side of the picture is labeled 'fear' and has a large staring eyeball in the sky above exploding volcanos and a dry desert terrain. The right side shows a Christian cross emerging from the central divide. The sky is filled with the word love and a heart and these are above a peaceful scene of mountains and verdant vegetation.

Connie English drew a picture of hands held together in prayer formation. (See Figure 2.) These hands are entwined by a rosary and each bead is made of a medicine capsule. The artist explained: "There should be faithfulness of taking medicine and prayer. Prayer is the best medicine. Without taking my medicine I would be spiritually bankrupt. I need to pray continually." She had created a complementarity and synergy between prayer and conventional medicine.

Figure 2: Prayer is the Best Medicine

As Jeffrey Holland wrote for this exhibit, "Spirituality has given me a sense of direction. Even in the dark intensity of despair and confusion, it offers a focal point of hope. It offers a sense of purpose to the understandings and mysteries of life. A sense of belonging and being part of the whole instead of a fragmented and isolated part thereof. Life can often be filled with misery and hurt, but there can also be beauty and joy. Most of all there is hope. Hope that can power the motivation and yearning of a lost soul. A hope strong enough to break the barriers and help to overcome the limitations of mental illness. A hope not bound by physical laws, but omniscient, eternal, and infinite."

Chronic Illness and Spirituality

My life and career have been profoundly affected by living with a serious life-threatening chronic illness, cystic fibrosis (CF). CF is a genetically-based condition that typically results in damage to the lungs, pancreas, and other bodily systems. It is

treatable but not curable. People with CF, including me, commonly need to engage in daily extensive use of antibiotics, digestive enzymes, respiratory clearance therapies, and other treatments and hospitalizations as needed. Currently, there are more than 30,000 people in the US with CF and more than 70,000 people worldwide. The average life span is now about 37 years, though this is likely to increase soon due to very recent treatment breakthroughs. I explain this to make clear that CF is a significant challenge to quality and quantity of life, and yet, some people with CF grow and thrive even while the physical symptoms of illness increase.

For example, Dylan Mortimer, a pastor and artist in Kansas City, Missouri, has utilized his experience with CF as an inspiration (Dell, 2018). Some of his artworks are large depictions of lungs in bright colors and covered with sequins. As he said, "Creating artwork has been my push back against being given a deadly diagnosis at birth. It is a search for healing in the seemingly incurable, for hope in seeming hopelessness. I draw inspiration from God, my [lung transplant] donor, friends and family, doctors, caretakers, scientists, and all who have helped keep me alive."

I would expand this to suggest that we can both make art about life challenges and also we can make life itself an art project, through the existential artistry of creative, growth-oriented living. My friend and essayist, Lisa McDonough (2002) wrote that it is healing to realize that our bodies are ongoing stories expressing the timeline of the soul. But owning or finding our story is made difficult when CF is perceived only as a tragedy, rather than as an opportunity or a process of discovery.

The experiences dealing with CF of myself and my brother Tom led me to wonder how others drew on their systems of meaning and spirituality. My first formal study was a survey of all 402 patients (or their guardians) at a major CF treatment center in order to identify the types of nonmedical therapies they were using (Stern, Canda, & Doershuk, 1992). Sixty-six percent of participants reported using at least one type of nonmedical therapy and of these, more than two-thirds related to spiritual practices and beliefs, such as individual prayer, group prayer, faith healing, and meditation. Most reported experiencing some benefits, including relief of symptoms and related distress, increased emotional comfort, and enhancement of overall well-being. I followed up through detailed interviews with 16 adult participants in the survey who had reported that spirituality was important to them, including myself (Canda, 2001, 2002a, 2009; 2013).

To sum up, participants described that CF had many adverse impacts and also provided an opportunity for insight and growth. Adverse impacts included physical symptoms as already explained, emotional distress and troubling thoughts, and impediments to social relationships and work performance. Yet most said that their experience with suffering and working it through heightened their sense of empathy and motivation to care for others. In the spiritual domain, most reported life-enhancing impacts. These included gaining insight into the meaning of life, drawing closer to God or nature and deepening their spiritual practices, believing that they

were guided by God to inspire others, and using the health challenges as a stimulus for overall personal and spiritual growth. Many reported that prayer helped reduce physical symptoms and discomfort. Many kinds of religious activities, including involvement with congregations, promoted a positive outlook on life and reduced confusing and painful thoughts and feelings. Some reported miraculous or extraordinary events, such as unexpected physical improvements, sensing the presence of God or angels, and gaining insights through dreams, visions, and apparitions. Even as physical health decreases and death approaches, it is possible that spiritual growth and overall well-being increases.

For example, in my case, as soon as I learned that my brother Tom had died (in 1991), I traveled to my parents' home for the funeral (Canda, 2001). While I was asleep the first night, I felt someone tap my leg which woke me up. I saw and felt the presence of my brother hovering above the bed. This conveyed a sense of affirmation and support of our connection and that my brother was ok. Then I fell back to sleep. That was an amazing comfort to me. Tom and I had had many conversations about philosophy and spirituality. Many years before we promised that whoever died first would come back to give a sign. And indeed that's what happened to me.

Another interview participant, Joan, said that a dream of Jesus' loving and supporting presence during a frightening period of waiting for a lung transplant yielded a lasting sense of God's support and an angelic presence that comforted her throughout her lung transplant surgery. She said that she and her husband could feel a supernatural strength all the way through the transplant. Fear disappeared. She felt it was alright even if she died during surgery since she was confident in connection with God.

I don't share these stories in order to convince anyone of any particular religious or spiritual beliefs. I recount them to alert social workers that such experiences can be vivid and powerfully significant sources of solace and insight for clients—and they should not be discounted or ignored.

CONCLUDING REFLECTIONS

Transilience

My sojourn with the Strengths Perspective suggests that we need to be careful not to be limited by conventional ideas about functionality, health, normality, coping, and even resilience (Canda, 2013, 2019). There can be a transformative growth-oriented way of life beyond all of that, broken free from that. Such a way of life goes beyond *coping* as avoiding or managing life stressors. It includes but goes beyond *resilience* if that means adapting to significant adversity with positive developmental outcomes. Resilience literally means to 'leap back' to a pre-adversity condition, hopefully with enhanced insight and functioning. Transformative living is not equivalent to a *positive quality of life* as measured by such things as the ability to conduct daily activities since people can experience serious illnesses, impediments, and impairments, including dying, while also growing in insight and sense of life fulfillment.

Even the terminology of *strengths* can be misconstrued to overlook that weaknesses, vulnerability, losses, fragility, and pits of despair can be strengths if transformed through insight and wisdom.

So I recommend the term *transilience* to mean a developmental leap of transcendence. Transilience (Canda, 2013, p. 94) is "…a whole person process of moving forward, backward, upward, downward, sideways, or back-around in a life committed to well-being and well-becoming. Transilience is not restricted to a linear idea of moving forward or backward on a line of health or quality of life indicators. It is not just a matter of reacting to problems or pathologies… [or] building on strengths and resources… It is a life of transformation not restricted to social conventional ideas about health, illness, fitness, strength, goodness, ability, or disability." Transilience describes a way of life in which "…a person addresses all of living and dying, including joys and adversities, within a spiritual path of growth and transformation." The concept of post-traumatic growth seems congruent with transilience, though a transilient way of life need not be arrived at via trauma.

My intention is to highlight transilience as an option for living, not as a judgmental expectation. Just surviving is a prerequisite. And just surviving can be a victory of extraordinary strength under conditions of violence, severe illness, disaster, war, oppression, and genocide. Coping can be the most appropriate and realistic way of responding in trying times. Resilient response to adversity is a creative and courageous endeavor. There should be no imposed judgments or expectations about whether or when people should move into coping, resilience, or transilience or what those should look like.

But for those of us who wish to move into a way of life-based on transformation and thriving and to exert defiance of assumptions of professional helpers and social norms that limit the fullest possibilities of human potential, we need strengths-oriented social workers as allies.

Mindfulness as a Core Strength

I would like to suggest mindfulness as a core strength that can be cultivated as a support for surviving, coping, resilience, and developing a sense of life flourishing and transilience. This is not a selfish pursuit, but rather a process of joining personal and world well-being in the context of the dynamic interdependency all beings (Canda, Furman, & Canda 2020).

Mindfulness, in therapeutic forms adapted from Buddhist roots, has come to be widely established in social work and related health and mental health fields as a valuable practice that can help reduce self-harming thoughts and behaviors; reduce symptoms of anxiety, depression, and stress; and promote overall well-being (Canda, Furman, & Canda, 2020; Canda & Gomi, 2019; Canda & Warren, 2013). Mindfulness involves clear, nonjudgmental awareness in the present moment. It creates awareness of a calm space of mind in-between an immediate experience and one's

reaction to it, thus allowing for clarity of experience and choice for how to respond in the most appropriate manner benefiting self and others. Thus mindfulness can be a powerful strength to apply to all of one's experiences and especially those that are painful, challenging, discouraging, and triggering of harmful habits. It allows us to create choice points for how to respond to adversity, as well as the joys and doldrums of everyday life so that we can maximize the potential for wisdom and growth.

However, for social workers who advocate for mindfulness, we need to be cautious to do so in a way that does not distort and violate Buddhist cultural values and purposes, including those that prioritize compassion and spiritual growth beyond egocentrism. We need to be clear and forthcoming about how therapeutic versions of mindfulness may be similar or different from Buddhist mindfulness. Further, mindfulness should not be used as a panacea to calm or divert people's awareness and resistance against discrimination, oppression, and deprivation of resources (Forbes, 2019; Purser, 2019).

The choice points opened and clarified by mindfulness can be pivots for activism. After all, if social policies and programs and human service organizations restrict and problematize refugee resettlement, or fail to provide affordable and accessible mental health services for all, or prevent universal access to medical services for people with illnesses, then people's strengths need to mobilized in individual and collective action to change these crushing conditions.

Perennial Wisdom

What I am suggesting is nothing new. In retrospect, it seems that my entire academic career has come to a concluding point that recognizes the importance of ancient and enduring wisdom traditions that have called people to a profound way of living. I have only been appreciating and re-presenting perennial insights for a contemporary social work context.

For example, in the Christian tradition, the Gospel accounts of Jesus' passion, death, and resurrection call people to live in a way that transforms and transcends suffering. Jesus enjoined people to take up their cross and follow him (Matthew 10:38 and 16:24; Mark 8:34; Luke 9:23 and 14:27). This is a way of life grounded in the virtue of nonegoistic love (*caritas*, Latin; *agape*, Greek). Laozi, the founder of Daoism in around 6th century BCE, pointed out that physical misfortune is inherent in the human condition of having a body (trans. Feng & English, 1972). But by surrendering oneself humbly and harmoniously to this situation and by loving the world as one's own self, one can become trusted to care for all things. Kong Fuzi (Confucius, ca. 551-479 BCE) emphasized that life should be approached as an opportunity for continuous learning in which we cultivate and express our inner nature of benevolence for the benefit of family and world (Canda, 2002c). Siddhartha Gautama, the Buddha (ca. 480-400 BCE), taught people to seek liberation from egoistic inappropriate desires and aversions through a lifestyle of continuous effort cultivating wisdom, morality, and meditation.

In recent and contemporary human behavior theories (Canda, Furman, & Canda, 2020; Robbins, Chatterjee, Canda, & Leibowitz, 2019), Erik Erikson advocated for people to orient their lives to authenticity, integrity, and meaning-making. Maslow encouraged people to actualize their fullest potential, working through the pits, peaks and ordinary times of life, in order to transcend egoism and to promote a mutual benefit for all. Stan and Christina Grof promote an appreciation for the holotropic mode of consciousness which involves opening to transpersonal, sacred, and synchronistic experiences that orient people in growth toward personal and cosmic wholeness. Theorists of positive aging, dying, and gerotranscendence point out that some people address the experience of aging, mortality, and dying as opportunities for growth of wisdom and for leaving behind a legacy of lessons and benefits for others. As Nelson-Becker (2018, p. 319) put it, "Dying well is about living fully and consciously in whatever way one chooses until the moment of death."

In conclusion, here are the main lessons learned through my sojourn with the Strengths Perspective:

- Daily life is an opportunity for continuous learning and growth, through the steady times and the ups and downs.
- Significant life challenges, disruptions, and breakdowns can be special opportunities for breakthroughs.
- Fulfilling this potential requires persevering commitment as well as a nurturing network of supports and resources.
- Mindfulness can be a core strength for a transilient, growth-oriented way of life.
- The Strengths Perspective at its fullest is a vision and a dedication to promote peace, well-being, and justice for all people and all beings.

This vantage on life is reflected in the symbolism of the lotus in Buddhist and Hindu philosophies. The lotus grows out of mud and murky water that provides nutrients, just as human existence offers the opportunity for growth in wisdom and compassion through an authentic encounter with mortality, suffering, and injustice. The plant's pad floats serenely on the water's surface. The leaves and flower stems rise toward the light. Meditation, mindfulness, and morally attuned lifestyle support the realization of wisdom in daily life. Beautiful flowers bud and open and seed pods mature, as the fruit of persevering spiritual practice. This growth potential requires nurturance by water, earth, and sky, just as transilience may flourish with social and ecological supports. The plants yield beauty as well as many edible parts for the aesthetic and physical nourishment of others, just as the fruits of each person's growth can be for the mutual benefit of self and others. Strengths-oriented social work can serve as a wonderful support for this way of living.

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Her publications address the need to empower communities through social work research including the importance of reducing family violence and developing researcher-agency partnerships.

Amy Mendenhall is a social worker who earned a Bachelor of Arts degree from the University of Virginia, and master's and doctorate degrees from the College of Social Work at The Ohio State University. She also completed a post-doctoral fellowship in the Child & Adolescent Psychiatry Division of the Department of Psychiatry at the Ohio State University Medical Center. Dr. Mendenhall joined the faculty at the University of Kansas School of Social Welfare in 2009, and is currently an associate professor and serves as the associate dean for research and the founding director for the Center for Community Engagement and Collaboration.

Her scholarship and research focus on building knowledge for the systems that serve children, adolescents, and families to enhance community-based services, and in turn, to improve the well-being of children and families. To this end, her work spans the areas of early childhood, child welfare, behavioral and mental health, and education. Some current and past research and evaluation projects have focused on case management models, Mental Health First Aid, Attachment Biobehavioral Catch-up, and the Strengthening Families Program. In particular, Dr. Mendenhall has dedicated significant attention to the study of case management services in the children's mental health service system. Her initial studies of traditional case management found services to be crisis- and deficit-focused and parent/professional-directed, leading her to develop the Strengths Model for Youth (SM-Y), a case management model adapted from the adult version of the Strengths Model. SM-Y is a formal youth-directed model of case management focusing on utilizing a youth's strengths and resources to develop and achieve their identified goals. Preliminary research of the model has demonstrated positive outcomes for both agencies and youth.

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Becci Akin is an associate professor and PhD Program Director in the School of Social Welfare at the University of Kansas. She joined the School as a faculty member in 2013. Before joining the KU faculty, Dr. Akin spent her early career serving as a child welfare caseworker and policy advocate and working in community-based agencies as a macro practitioner on a wide range of human service issues. Dr. Akin has taught at BSW and MSW levels including courses in community practice, social policy, program design, research methods, and agency-based evaluation. Dr. Akin's scholarship focuses on understanding the keys to successful implementation and effective and equitable interventions for families involved in child welfare. Her publications have examined barriers to permanency for families of children with serious mental health problems; predictors of exits to different types of permanency; frontline staff perceptions on implementation of evidence-based interventions; and rigorous study of evidence-based parenting interventions in child welfare. Dr. Akin has served as principal or co-principal investigator on eight federally funded studies. She has published 40 articles in peer-reviewed journals and presented over 75 papers at national and international conferences. She received her MSW and Ph.D. degrees, with honors, from the University of Kansas.

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Whitney Grube is a PhD candidate in the University of Kansas' School of Social Welfare. Whitney is also a full-time member of the School's research staff and has been with the School since 2013. Whitney previously received her MSW from the University of Kansas' School of Social Welfare. Her research and scholarship focuses on children and adolescents experiencing complex and severe mental health disorders, community mental health services, and Medicaid Waivers used as interventions for children labeled as seriously emotionally disturbed. Past research and evaluation projects include the study of the implementation of Strengths-Based Case Management in adolescent outpatient community mental health settings, the effectiveness of an early childhood intervention (Attachment Biobehavioral Catchup), and clinical assessment practices used in the Medicaid Waiver population.

Kenya C. Jones, associate professor, Whitney M. Young, Jr. School of Social Work, Clark Atlanta University, in Atlanta, Georgia is a champion for students and content expert on mentorship, strategic planning, and program development. Dr. Jones is a published author and frequent presenter at numerous professional conferences. Dr. Jones has a vibrant educational career which includes studying British Politics in London, United Kingdom, and working at the Green Party, UK within the media administration team. During her undergraduate education in Criminal Justice at Virginia State University, she participated in the AmeriCorps program at the Richmond Police Department and the Adult Career Development Center. While matriculating at Howard University, Dr. Jones is also the past recipient of the Lloyd D. Smith Fellowship sponsored through the Marshall Heights Community Development Organization, a leadership – training program designed to create solid pathways to success for community leaders. Dr. Jones, a Richmond, Virginia native, is an academic advisor to student organizations and supports several students in presenting their research within the university and national conferences.

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Denise McLane-Davison, PhD is an associate professor of Social Work at Morgan State University in Baltimore, Maryland. Her research centers on Africana Womanist Epistemology, HIV/AIDS, social work leadership and international and African studies. She is the National Archivist for the National Association of Black Social Workers.

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Megan S. Paceley, MSW, PhD is an assistant professor at the University of Kansas School of Social Welfare. Her background is in developing and evaluating queer and trans-community-based organizations. As a social work scholar, her research attends to identifying the factors in queer and trans youth's families, schools, and communities that contributes to risks and strengths, with the long-term goal of developing prevention and intervention efforts to reduce risk and promote resilience.

Emma Perry is a senior lecturer in Social Work at the University of Gloucestershire and has been a member of G8 since 2016. Emma teaches and leads modules across the undergraduate qualifying programme covering areas such as social work skills, human growth and development and social work with adults. Her particular interests are relationships in later life and social work with older people. Prior to entering academia, Emma worked as a social worker, specialising in practice with older people, and assistant manager in adult services. After working for some years as an unqualified social care worker, Mo Ray achieved a degree in Psychology and Education from the Open University. She subsequently trained as a social worker at the University of London, Royal Holloway and Bedford New College. Working as a social worker, manager and staff training officer, Mo decided to undertake further postgraduate study to better appreciate gerontological research and make contact with other practitioners committed to practice with older people. After completing a postgraduate Diploma, Mo registered for part-time Doctoral studies, completing her PhD in 2000. Subsequently, Mo was awarded a Research Fellowship from the ESRC. She subsequently took up a lecturing post in social work at Keele. She was awarded a personal Chair in 2014. Mo joined the University of Lincoln in 2016 where she is

a Professor of Health and Social Care. Her research interests include participatory research methods, care and older people and social relationships in older age.

Hayden Rand is a MSW candidate (2020) in the School of Social Welfare at the University of Kansas.

Charles A. Rapp is professor emeritus at the University of Kansas School of Social Welfare and founding director of the Center of Mental Health Research and Training. He holds a Ph.D. and MSW from the University of Illinois and a B.S. from Millikan University. His professional career has been devoted to enhancing the recovery of people with psychiatric disability through the development of client-centered methods and programs, and advocacy for client rights and social justice. He is the co-originator (with Ronna Chamberlain) and developer of the strengths model of case management and the client-centered performance model of social administration (with John Poertner). The third edition of his book, The Strengths Model: A Recovery Oriented Approach to Mental Health Services with Rick Goscha, was published by Oxford University Press in 2012.

Sally Richards is a qualified social worker and research visiting fellow (formerly Senior Lecturer) in Social Work at Oxford Brookes University. Since her PhD, an ethnographic study of the process of needs assessment for older people, her research and publications have focused on work with older people in social and health care settings and issues in social work education. Sally has a particular interest in spirituality and ageing and in qualitative research methods. She is a founder member of the G8 group of gerontological social work academics.

Jason M. Sawyer, co-founder of think.create.change, is an interdisciplinary artist, teacher, community practitioner, and social justice worker. He is an assistant professor at the Ethelyn R. Strong School of Social Work at Norfolk State University. In his practice career, he has worked in Non-profit Program Management, community organizing, teaching, the performing arts, and policy advocacy. His diverse background includes teaching theatre at the Governor's School for the Arts in Norfolk VA, teaching English abroad, campus organizing, a Policy Fellowship at the Virginia Interfaith Center of Public Policy in grassroots organizing and social advocacy, and working in neighborhood-based community organizing efforts. His research interests lie in critical pedagogy, community organization practice, positive youth development, difference, and arts-based interventions. His research encompasses studies on the use of the creative process in community organizing, youth arts-based program evaluation, community practice model development, and transformative arts practice.

Elizabeth A. Schoenfeld earned her MA and PhD in Human Development & Family Sciences from The University of Texas at Austin. She currently serves as the chief research & evaluation officer at LifeWorks, where she oversees all data- and research-related initiatives for the agency's 19 programs. Under her leadership,

she oversaw the agency's adoption and implementation of the Strengths Model of case management and the supported employment model, Individual Placement & Support. Her efforts to use data to inform service delivery and the adoption of evidence-based programs at LifeWorks was highlighted in the documentary, *Failing Forward: On the Road to Social Impact*. Her current major projects include leading the local evaluation for Austin's Youth Homelessness Demonstration Program and serving as the Principal Investigator for two SAMHSA grants.

Nikolaus Schuetz is a PhD student at the School of Social Welfare at the University of Kansas. His research interests focus on the intersection of physical health and mental health, but he has also conducted research on the strengths model of case management, financial capability, child and adult mental health, and synesthesia. His practice experience includes working as the case manager for an emergency shelter for children and working with families involved with family court in the Kansas City area. He is currently an emergency room social worker at Children's Mercy Hospital, and a private practice therapist. After graduating from Beloit College with a degree in Psychology, his dedication to helping marginalized and oppressed people took him to rural Kenya where he served as a Peace Corps volunteer from 2009-2011 in the public health sector. He subsequently completed his Master's in Social Work at the University of Kansas where he currently conducts research and teaches. He is also currently serving as a member of Resilience, Inclusion, Support, and Empowerment, a committee that supports students of color at the School of Social Welfare.

Mary Pat Sullivan is a registered social worker and social gerontologist, and director of the School of Social Work at Nipissing University in North Bay, Ontario. Her research focuses on the social context of ageing and older age. She is currently co-investigator on an ESRC/NIHR funded study examining rare dementia support with colleagues at University College London and Bangor University and principal investigator of a study entitled 'Old and Lonely: The Loneliness Narrative, Moral Regulation and the Media' funded by Nipissing University. Professor Sullivan is on the Board of Directors of the Alzheimer Society of Ontario and a Fellow of the Salzburg Global Seminar (Dementia-Friendly Communities). Professor Sullivan previously headed social work at Brunel University London where she formed The G8 gerontological social work special interest group in 2010. During this time, she was Honorary Secretary of the British Society of Gerontology and on the editorial board of Ageing & Society. Prior to her academic career, she was a clinical social worker involved in the development, delivery and evaluation of geriatric mental health services in northern and eastern Ontario.

Denise Tanner is a senior lecturer in Social Work in the Department of Social Work and Social Care, University of Birmingham, UK. She is a registered social worker and worked in social work practice in the statutory and voluntary sectors for 14 years before entering academia. The central focus of her research is older people's experiences of social care services and ways to promote their wellbeing. She is particularly

interested in participatory approaches that engage older people as co-producers of research. Recent research projects include a study of older people's experiences of funding their own social care and a study of asset-based approaches used by English Local Authorities. Denise is a Member of 'G8' group of social work academics who work to promote the value of gerontological social work.

Samson Tse, Ph.D. is a professor of Mental Health at the Department of Social Work and Social Administration in the University of Hong Kong.

Emily Tsoi, PhD is a postdoctoral fellow in the Diversity and Wellbeing Laboratory at the Department of Psychology in The Chinese University of Hong Kong. She has travelled to the US as a Fulbright Visiting Scholar in 2015-16 and was affiliated with the School of Social Welfare at the University of Kansas and undertook research activities and clinical shadowing of strengths-based care.

George Turner (www.drgeorgeturner.com) is a lecturer at Western Sydney University (2018) teaching in social work. Previously, Dr. Turner was an associate professor of practice at the University of Kansas School of Social Welfare (2013-16) and a visiting lecturer at Washburn University (2012-13) in the social work department. George has taught both undergraduate and graduate units including: Human Sexuality, Practice, Multicultural Practice, and Psychopathology. A certified sex therapist (AASECT), Dr. Turner operated a thriving private practice in Kansas City, MO. USA (2003-'18) specializing in sexual health, personal wellness, and relationship enhancement. Dr. Turner's research is focused on reducing health disparities by advancing sexual health equity in areas such as sexual justice, LGBTQIA2S+ issues, disability, and sexuality education. Through an exploration of voice, his goal is to use storytelling to illuminate the lived experiences of disenfranchised groups and expose meaning where little or none existed. As an educator, George mentors helping professionals to become skilled advocates, practitioners and researchers for disenfranchised communities. George is a first-in-family/ first-generation college student, thus he strives to honor students' unique perspective and provide a learning environment that values a student's voice.

Eppie Wan, PgDip is a senior supervisor of Tung Wah Group of Hospitals Wong Chuk Hang Complex overseeing and coordinating various mental health services.

Brooke A. White, LCSW, LCDC is a clinician-turned-researcher currently serving as the director of evidence-based programming at LifeWorks in Austin, TX. She has worked as a leader in residential settings, supporting clients with clinical and case management goals, for the majority of her career. In her current role, she supports staff in all 19 of LifeWorks' programs as they implement and utilize evidence-based models by providing training, technical support, and supervision.

Paul Willis is senior lecturer in social work at the University of Bristol, a Senior Research Fellow of the NIHR School for Social Care Research, England and a regis-

tered social worker. Paul qualified as a social worker in Tasmania (Australia) in 2002 and his former practice experience includes school social work with children and adolescents and counselling and community work with sexual and gender minority groups. Since 2011 Paul has led several funded studies on LGBT-related ageing, social diversity and later life. His research has focused on: the inclusion of older LGB people in long-term care environments (2011-2013); health and social care needs of older trans people in later life (2016-2018); and, experiences of loneliness and isolation for older men from marginalised or seldom-heard groups (2016-2019). He is currently leading a 2.5-year study into the social inclusion of older residents from socially diverse backgrounds in housing with care and support schemes. Paul has published work on ageing, sexuality, gender identity and diversity across national and international journals in social work, ageing studies and public health. He is currently the Head of the Centre for Research in Health and Social Care in the School for Policy Studies.

Stephen Wong, MA is a senior social work supervisor in rehabilitation service in Caritas Hong Kong and received training of strengths model in Kansas in 2015.

Kelechi Wright is a doctoral student at the University of Kansas in the School of Social Welfare Program. Prior to beginning her doctoral studies, she worked as a licensed professional counselor as a clinical supervisor in the community based mental health field and as a therapist for individuals, children and families. She received her Master of Education in Counseling Psychology from Temple University in Philadelphia, Pennsylvania. She is a graduate research assistant under the supervision of Dr. Becci Akin, assisting Dr. Akin's team in a government-funded grant that seeks to assess and address challenges in Kansas' child welfare system. Her scholarly interest involves same-race and transracial adoption, impacts of infertility, post-adoptive support services and implementation science.

Amy J. Youngbloom earned her Master of Public Health degree in Epidemiology and Health Equity from the University of Minnesota. She currently serves as a research analyst at LifeWorks, a nonprofit in Austin, Texas, primarily serving transition-age youth with housing, counseling, and workforce and education services. In her role, she assists in ongoing evaluation of programs, assisting with tracking and reporting agency outcomes around client self-sufficiency, and conducting research to better inform the agency's work with transition-age youth. Her current projects include a qualitative exploration of how transition-age youth define self-sufficiency, and evaluating the impact of a community-based psychiatry program on youth attitudes and perceptions of mental health services.

Winnie Yuen, PhD is a lecturer at the Department of Counselling and Psychology in Hong Kong Shue Yan University and her research interest lies in strengths-based intervention.

"All people possess a wide range of talents, abilities, capacities, skills, resources, and aspirations… a belief in human potential is tied to the notion that people have untapped, undetermined reservoirs of mental, physical, emotional, social, and spiritual abilities that can be expressed. The presence of this capacity for continued growth and heightened well-being means that people must be accorded the respect that this power deserves"

-'A Strengths Perspective in Social Work Practice', published in the journal Social Work in 1989

Rooted in Strengths: Celebrating the Strengths Perspective in Social Work builds upon the last three decades since the perspective was formally highlighted as a philosophy to guide social work practice by faculty and students at the University of Kansas in a 1989 article in the journal Social Work. Since then, the Strengths Perspective has grown to be a pervasive influence on the social work profession, while also influencing other movements that have challenged conventional thinking in social work, such as empowerment, social constructionism, feminism and holistic health and wellness.

Today, the Strengths Perspective is used widely in the field of social work, being utilized in child and youth services, family practice, gerontology, mental health recovery, substance abuse treatment and other fields of practice in the United States and several other countries. With dozens of authors from around the world who currently serve as practitioners in the field, instructors and researchers, these chapters provide a look into the Strengths Perspective's use today and its influence in social work and beyond.

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