CHAPTER ONE

INTRODUCTION

Power in the People[1]

DENNIS SALEEBEY

In the lore of professional social work, the idea of building on people's strengths has become axiomatic. Authors of textbooks, educators, and practitioners all regularly acknowledge the importance of this principle. Many of these calls to attend to the capacities and competencies of clients are little more than professional cant. So let us be clear: The strengths perspective is a dramatic departure from conventional social work practice. Practicing from a strengths orientation means this—*everything* you do as a social worker will be predicated, in some way, on helping to discover and embellish, explore and exploit clients' strengths and resources in the service of assisting them to achieve their goals, realize their dreams, and shed the irons of their own inhibitions and misgivings, and society's domination. This is a versatile practice approach, relying heavily on the ingenuity and creativity, the courage and common sense, of both clients and their social workers. It is a collaborative process depending on clients and workers to be purposeful agents and not mere functionaries. It is an approach honoring the innate wisdom of the human spirit, the inherent capacity for transformation of even the most humbled and abused. When you adopt the strengths approach to practice, you can expect exciting changes in the character of your work and in the tenor of your relationships with your clients.

Many of us believe (or have at one time believed) that we are building on client strengths. But sometimes we fall short. To really practice from a strengths perspective demands a different way of seeing clients, their environments, and their current situation. Rather than focusing exclusively or dominantly on problems, your eye turns toward possibility. In the thicket of trauma, pain, and trouble you can see blooms of hope and transformation. The formula is simple: Mobilize clients' strengths (talents, knowledge, capacities, resources) in the service of achieving their goals and visions and the clients will have a better quality of life on their terms. Though the recipe is uncomplicated, as you will see, the work is hard. In the chapters that follow, you will encounter descriptions of the strengths

[1]Part of this chapter is based on D. Saleebey. The strengths perspective in social work: Extensions and cautions. *Social Work, 41*(3), 1996, 295–305. With permission of the National Association of Social Workers.

approach used with a variety of populations, in a variety of circumstances. You will be exposed to schemes of assessment, methods of employment, examples of application, and discussions of issues related to moving from a concentration on problems to a fascination with strengths.

In the past few years, there has been an increasing interest in developing strengths-based approaches to practice, case management in particular, with a variety of client groups—the elderly, youth in trouble, people with addictions, people with chronic mental illness, communities and schools (Benard, 1994; Clark, 1997; Kretzmann & McKnight, 1993; Miller & Berg, 1995; Mills, 1995; Parsons & Cox, 1994; Rapp, 1998; Benard, 2004; Pransky, 1998). In addition, rapidly developing literature, inquiry, and practice methods in a variety of fields bear a striking similarity to the strengths perspective—developmental resilience, healing and wellness, positive psychology, solution-focused therapy, assets-based community development, and narrative and story to name a few.

THE FASCINATION WITH PROBLEMS AND PATHOLOGY

The impetus for these elaborations comes from many sources, but of singular importance is a reaction to our culture's continued obsession and fascination with psychopathology, victimization, abnormality, and moral and interpersonal aberrations. A swelling conglomerate of businesses and professions, institutions and agencies, from medicine to pharmaceuticals, from the insurance industry to the mass media, turn handsome profits by assuring us that we are in the clutch (or soon will be) of any number of emotional, physical, or behavioral maladies. Each of us, it seems, is a reservoir of vulnerabilities and weaknesses usually born of toxic experiences in early life. The *Diagnostic and Statistical Manual* of The American Psychiatric Association (APA) has become the primary handbook for the diagnosing of mental disorders. Not only is it widely used, insurance companies typically require, for reimbursement purposes, a diagnosis made from the DSM lexicon. While DSMs I and II were modest documents having less than 100 pages each of description of mental disorders (causality was also a focus), and were written by a handful of psychiatrists in predominantly psychodynamic language, DSM III was a sea change in this psychiatric glossary. Fueled by a group who wanted to emulate the descriptive precision and clarity of the early psychiatrist, Emil Kraepelin (who over time wrote 11 increasingly large editions of his psychiatric diagnostic manual), DSM III had hundreds of pages of descriptions of various categories of mental illness. It also was intended to be descriptive, not analytic. Many more disorders were included between its pages. Since that time, the APA has put the DSM on a 12 year cycle (by the way, it and its attendant manuals, and guides are highly successful and, for professional books, runaway best-sellers). For example, DSM IV, out in 1994, was followed by DSM IV TR (Text Revision) in 2000. DSM V will probably be out in 2006, followed by V TR in 2012. And each addition will surely have new disorders (look at the back of DSM IV TR under the heading Criteria Sets

and Axes Provided for Further Study and you will see a list of disorders-in-waiting). All of this is to say that we are in a relentless march toward hemming in each aspect of the human condition, even human nature itself, as reflective of some behavioral, emotional, and/or cognitive ills.

Not only are we mesmerized by disease and disorder, many of us have been designated as casualties by the ever growing phalanx of mental health professionals, turning mental health into a thriving and handsomely rewarding business. Prodded by a variety of gurus, swamis, ministers, and therapists, some of us are in hot pursuit of our wounded inner children and find ourselves dripping with the residue of the poisons of our family background. If you listen carefully, you can hear the echoes of evangelism in some of these current cultural fixations. And these are cultural preoccupations as well. The Jerry Springer show is no anomaly, except perhaps in regard to the level of schtick and tastelessness it exudes. Kenneth Gergen (1994) sees the result of this symbiosis between mental health professions and culture, as a rapidly accelerating "cycle of progressive infirmity" (p. 155). He wryly observes,

> How may I fault thee? Let me count the ways: impulsive personality, malingering, reactive depression, anorexia, mania, attention deficit disorder, psychopathia, external control orientation, low self-esteem . . . (p. 148)

To make these observations is not to callously disregard the real pains and struggles of individuals, families, and communities; neither is it to casually avert our glance from the realities of abuse of all kinds inflicted on children; nor is it to deny the tenacious grip and beguiling thrall of addictions. It is, however, to foreswear the ascendancy of psychopathology as society's principal civic, moral, and medical categorical imperative. It is to denounce the idea that most people who experience hurt, trauma, and neglect inevitably suffer wounds and become less than they might be. It is to return a semblance of balance to the equation of understanding and helping those who are hurting. The balance is hard to come by because the language of strength and resilience is nascent and just developing and, therefore, scant. Sybil and Steve Wolin (1997) say this about the two paradigms (risk and resiliency):

> As a result, the resiliency paradigm is no match for the risk paradigm. Talking about the human capacity to repair from harm, inner strengths, and protective factors, professionals feel that they have entered alien territory. They grope for words and fear sounding unschooled and naïve when they replace pathology terminology with the more mundane vocabulary of resourcefulness, hope, creativity, competence, and the like . . . . We believe that the struggle can be tipped in the other direction by offering a systematic, developmental vocabulary of strengths that can stand up to pathology terminology that is standard in our field. (p. 27)

Social work, like other helping professions, has not been immune to the contagion of disease- and disorder-based thinking. Social work has constructed much of its theory and practice around the supposition that clients become clients

because they have deficits, problems, pathologies, and diseases; that they are, in some essential way, flawed or weak. This orientation leaps from a past in which the certitude of conception about the moral defects of the poor, the despised, and the deviant captivated us. More sophisticated terminology prevails today, but the metaphors and narratives that guide our thinking and acting, often papered over with more salutary language, are sometimes negative constructions that are fateful for the future of those we help. The diction and symbolism of weakness, failure, and deficit shape how others regard clients, how clients regard themselves, and how resources are allocated to groups of clients. In the extreme, such designations may even invoke punitive sanctions.

The lexicon of pathology gives voice to a number of assumptions and these in turn have painted pictures of clients in vivid but not very flattering tones. Some of these assumptions and their consequences are summarized below.

The person is the problem or pathology named. Diagnostic labels of all kinds tend to become "master statuses" (Becker, 1963), designations and roles that subsume all others under their mantle. A person suffering from schizophrenia *becomes* a schizophrenic, a convention so common that we hardly give it a thought. Once labeled a schizophrenic, other elements of a person's character, experiences, knowledge, aspirations, slowly recede into the background, replaced by the language of symptom and syndrome. Inevitably, conversation about the person becomes dominated by the imagery of disease, and relationships with the ailing person re-form around such representations. To the extent that these labels take hold, the individual, through a process of surrender and increasing dependence, becomes the once alien identification (Gergen, 1994; Goffman, 1961; Scheff, 1984). These are not value neutral terms, either. They serve to separate those who suffer these "ailments" from those who do not; a distinction that if not physical (as in hospitalization) is at least moral. Those who are labeled, in ways both subtle and brutish, are degraded—certainly in terms of social regard and status. However, these labels provide a measure of relief for some suffering individuals and their families—knowing, finally, what the matter is. In addition labels are certainly better than being thought of as possessed by demons. Nonetheless they do create a situation for far too many individuals of self-enfeeblement—moral, psychological, and civil (Gergen, 1994, p. 150).

The language of pessimism and doubt: Professional cynicism. Accentuating the problems of clients creates a wave of pessimistic expectations of, and predictions about, the client, the client's environment, and the client's capacity to cope with that environment. Furthermore, these labels have the insidious potential, repeated over time, to alter how individuals see themselves and how others see them. In the long run, these changes seep into the individual's identity. Paulo Freire (1996) maintained for many years that the views and expectations of oppressors have an uncanny and implacable impact on the oppressed. Under the weight of these once-foreign views, the oppressed begin to subjugate their own knowledge and understanding to those of their tormentors.

The focus on what is wrong often reveals an egregious doubt about the ability of individuals to cope with life's challenges or to rehabilitate themselves. Andrew Weil (1995) laments the profound pessimism and negativity in his own

profession, medicine, about the body's innate inclination to transform, regenerate, and heal itself.

> I cannot help feeling embarrassed by my profession when I hear the myriad ways in which doctors convey their pessimism to patients. I . . . am working to require instruction in medical school about the power of words and the need for physicians to use extreme care in choosing the words they speak to patients. A larger subject is the problem of making doctors more conscious of the power projected on them by patients and the possibilities for reflecting that power back in ways that influence health for better rather than worse, that stimulate rather than retard spontaneous healing. (p. 64)

The situation is so bad that Weil refers to it as medical *hexing*—dire medical predictions and inimical attributions by physicians powerful enough to create anxiety, fear, depression, and resignation in patients. This is a common consequence of the biomedical model—a model that has profoundly influenced some fields of social work practice. The biomedical model and its more widely influential kin in the human service professions, the "Technical/Rationalist" model (Schön, 1983), are despairing of natural healing and people's capacity to know what is right. Extraordinarily materialistic, these models disregard the functional wholeness and fitness of anything under their scrutiny—including human beings. Social work's continuing emphasis on problems and disorders and the profession's increasing commerce with theories that focus on deficits and pathologies tend to promote the portrayal of individuals as sites of specific problems and as medleys of singular deficiencies. Such an attitude takes the social work profession away from its avowed and historical interest in the person-in-context, the understanding of the web of institutional and interpersonal relationships in which any person is enmeshed, and the possibility for rebirth and renewal even under dire circumstances.

Distance, power inequality, control, and manipulation mark the relationship between helper and helped. The idea that we have empirically grounded or theoretically potent techniques to apply is beguiling. But in some way it may create distance between clients and helpers. Distance itself, whether the distance of class, privileged knowledge, institutionalized role, or normative position, may imply a power inequality between helper and helped. In the end, the client's view may become fugitive or irrelevant. In discussing "resistant" clients, Miller and colleagues (1997) say this:

> If a therapist . . . suggests or implies that the client's point of view is wrong, somehow invalidates, or upstages the client, 'resistance' may appear. After all, even if not already demoralized, who wants to be reminded of failure, criticized, and judged, or made to feel that you have to follow orders? What we come to call resistance may sometimes reflect the client's attempt to salvage a small portion of self-respect. As such, some cases become impossible simply because the treatment allows the client no way of 'saving face' or upholding dignity. (p. 12)

The surest route to detachment and a kind of depersonalization is the building of a case—assembling a portfolio on the client created from the identity-stripping

descriptions of, for example, DSM IV TR or the juvenile justice code. Furthermore, the legal and political mandates of many agencies, the elements of social control embodied in both the institution and ethos of the agency, may strike a further blow to the possibility of partnership and collaboration between client and helper.

Context-stripping. Problem-based assessments encourage individualistic rather than ecological accounts of clients. When we transform persons into cases, we often see only them and how well they fit into a category. In this way, we miss important elements of the client's life—cultural, social, political, ethnic, spiritual, and economic—and how they contribute to, sustain, and shape a person's misery or struggles or mistakes. The irony here is that, in making a case we really do not individualize. Rather, we are in the act of finding an appropriate diagnostic niche for the individual, thus making the client one among many and not truly unique. All individuals suffering from bipolar disorder hence become more like each other and less distinctive. In doing this, we selectively destroy or at least ignore contextual information that, although not salient to our assessment scheme, might well reveal the abiding distinctiveness of the individual in this particular milieu. It might also indicate important resources for help and transformation as well as problem-solving.

The supposition of disease assumes a cause for the disorder and, thus, a solution. Naming the poison leads to an antidote. But in the world of human relationships and experiences, the idea of a regression line between cause, disease, and cure ignores the steamy morass of uncertainty and complexity that is the human condition. It also happens to take out of the hands of the person, family and friends, the neighborhood—the daily lifeworld of all involved—the capacity and resources for change. There are many cultural and spiritual avenues for transformation and healing. They, rightly enough, also suppose linkages between the nature of the problem (is it natural or unnatural? spiritual or mundane?) and its relief. But to bury these tools under the weight of a medico-scientific model is to inter a variety of familial and cultural media for change.

Remedies in the lifeworld usually begin with reinterpretations of the problem that come out of continuing dialogue with the situation and with clients. These renderings are mutually crafted constructs that may only be good for this client, at this time, under these conditions. Though they may have the power to transform clients' understandings, choices, and actions, these expositions are tentative and provisional. The capacity to devise such interpretations depends not on a strict relationship between problem and solution but on intuition, tacit knowing, hunches, and conceptual risk taking (Saleebey, 1989). Schön (1983) has characterized the tension between the usual conception of professional knowing and doing and this more reflective one as that between rigor and relevance. Relevance asks these questions of us: To what extent are clients consulted about matters pertinent to them? What do they want? What do they need? How do they think they can get it? How do they see their situation—problems as well as possibilities? What values do they want to maximize? How have they managed to survive thus far? These and similar questions, as answers draw near, move us a step toward a deeper appreciation of all clients' distinctive attributes, abilities, and competencies, and the world of their experience. They require of the social worker and the

client a degree of reflection, the interest in making meaning and making sense. Iris Murdoch said that when we return home and share our day

> We are artfully shaping material into story form. So in a way as word-users we all exist in a literary atmosphere, we live and breathe literature, we are all literary artists, we are constantly employing language to make interesting forms out of experience which perhaps originally seemed dull or incoherent. (cited in Mattingly, 1991, p. 237)

Finding the words that shout the reality of the lived experience of people, and perhaps finding other words that reflect genuine possibility and hope is, in a modest and unscientific sense, finding cause for celebration—of promise.

THE STRENGTHS PERSPECTIVE: PHILOSOPHY, CONCEPTS, AND PRINCIPLES

I want to discuss two major philosophical principles as a way of staking out the claims of the strengths perspective, but in the context of the sometimes numbing and usually complex realities of daily life.

Liberation and Empowerment: Heroism and Hope

Liberation is founded on the idea of possibility: the opportunities for choice, commitment, and action whether pursued in relative tranquility or in grievous circumstance. We have fabulous powers and potentials. Some are muted, unrealized, and immanent. Others glimmer brilliantly about us. All around are people and policies, circumstances and conventions, contingencies and conceptions that may nurture and emancipate these powers or that may crush and degrade them. Somewhere within, and we may call it by different names, lies the longing for the heroic: to transcend circumstances, to develop one's own powers, to face adversity down, to stand up and be counted. All too often social institutions, oppressors, other people, some even with good intentions, tamp out this yearning or distort it so that it serves the interests and purposes of others. Nonetheless, however muted, this precious craving abides. It is incumbent on the healer, the humane leader, the shaman, the teacher, and, yes, the social worker to find ways for this penchant for the possible and unimaginable to survive and find expression in life-affirming ways. Of course, things go more smoothly if people simply play their roles, pay their taxes, and stifle their opinions. Liberation exerts tremendous pressure on the repressive inclinations of institutions and individuals. Collectively, liberation unleashes human energy and spirit, critical thinking, the questioning of authority, challenges to the conventional wisdom, and new ways of being and doing. But liberation may also be modest and unassuming. We may try out new behaviors, forge new relationships, or make a new commitment. Hope and the belief in the possible is central to liberation. Before his death, the great pedagogue of liberation, Paulo Freire, wrote in his last book, *Pedagogy of Hope* (1996), that he had previously underestimated the power of hope.

> But the attempt to do without hope, in the struggle to improve the world, as if that struggle could be reduced to calculated acts alone, or a purely scientific approach, is a frivolous illusion. To attempt to do without hope, which is based on the need for truth as an ethical quality of the struggle, is tantamount to denying that struggler as one of its mainstays . . . [H]ope, as an ontological need, demands an anchoring in practice. . . . Without a minimum of hope, we cannot so much as start the struggle. (pp. 8–9)

I would go so far as to say that the central dynamic of the strengths perspective is precisely the rousing of hope, of tapping into the visions and the promise of that individual, family, or community. Circumstances, bad luck, unfortunate decisions, the harshness of life lived on the edge of need and vulnerability, of course, may smother these. Nonetheless, it is the flicker of possibility that can ignite the fire of hope.

The heroism of everyday life is all around us. People carrying on in the midst of mind-searing stress; people coming to the fore when the needs around them require someone to act and to act out of the ordinary; people whose moral imagination allows them to see, even in distant and unfamiliar places, the utter humanity of those who suffer (Glover, 2000). 9/11 is an instructive example. Fire and police personnel, rescue teams, the people who risked their lives and faced serious harm in helping to clear away the hellish debris (Langewiesche, 2003), social workers who met with survivors and witnesses to help ease the psychological and interpersonal wreckage of the trauma; people trapped in the inferno, facing certain death, who called their loved ones to tell them goodbye and to express their love: many of these pushed the boundaries of the heroic outward and upward. Clearly, the destruction wrought on that day was a deliberate, heinous, and murderous crime. But even on the other side, given their point of view, the terrorists thought themselves to be heroic. In a letter to his wife, speaking of his certain death, one of them wrote, ". . . Know that my death is a martyrdom, my imprisonment hermitage, my exile tourism in God's land. I would like to meet you in heaven, so please help me by waking up at night to pray, fasting during the day, and staying away from temptation." (Cullison, 2004, p. 66) Obviously, we are required here to make a moral judgment about the lethal and vicious acts they committed against us, but we must also look through their eyes to understand more fully the meaning of heroism for the human condition.

Alienation and Oppression: Anxiety and Evil

The circumstances around us will not let us deny the existence of harsh and tyrannical institutions, relationships, circumstances, and regimes. Bigotry, hatred, war, slaughter, repression, and, more quietly but no less devastating, setting people aside, treating them as the despised other, and acting as though they are not fully human, are all daily reminders of the existence of evil, brutality, and despotism. But why is the capacity for evil the seeming companion to the urge to the heroic?

How often do we stand, agape, horrified at what we see or hear about or read about? Vicious acts of cruelty, violence born of intolerance and hate—how can they happen, we cry? Yet, aren't there times when we have been propelled to act or been a party to actions that have inflicted emotional or physical pain on others, often those who are different from us? Why?

We are small, and vulnerable. The cosmos is enormous. We tremble at the insignificance and frailty of our being when cast against the magnitude of time and the vastness of space. At times, our fear and trembling is best handled by taking matters into our own hands, individually or collectively, and dealing the instrumentalities of fear and loathing onto others. Thus we subdue our own uncertainties and obscure our cosmic smallness. It may even be that some of these acts of violence or marginalizing are "immortality projects" designed to blind us to the reality of our own organismic vulnerability and eventual demise (Becker, 1973; Fromm, 1973; Rank, 1941).

But from the ashes of destruction, mayhem, and oppression may emerge the human spirit, the capacity for the heroic. So we can never dismiss the possibility of redemption, resurrection, and regeneration. However, the sweep of history, the grandeur of wholesale creation and destruction eventually find their way into the nooks and crannies of our lives. These sweeping generalities occur in the small confines of daily life as well. You see a single mother and her 10-year-old daughter. They have come to the family service agency you work for. The mother is worried. Her daughter, once sweet and compliant, a joy to be around, is becoming morose, uncommunicative, anxious, and weepy. The quality of her work at school is plummeting, and friends seem unimportant to her. Father left the family suddenly and left them in dire financial straits. It had been a marriage of youthful misjudgments the mother allows, but, she says, in spite of the financial hardships maybe it is better that he has gone. The mother wonders if her daughter's current woes aren't related to his leaving about 6 months ago. You spend considerable time over the next weeks exploring the situation with the mother and daughter. Eventually you discover that for a period of almost 2 years the young girl had experienced physical and sexual depredation and brutality at the hands of her father. She had vowed to herself never to tell anyone! Never to let him know how much he had hurt her. Never! And she maintained her vow until he left. Now she was falling apart, grieving, experiencing rage, and feeling the wounds of violation. But in the ashes of devastation, this young girl's spirit, against all odds, flourished. Now the mother and the social worker must make an alliance with this tiny, amazing soul.

We have seen that the preoccupation with problems and pathologies, while producing an impressive lode of technical and theoretical writing, may be less fruitful when it comes to actually helping clients grow, develop, change directions, realize their visions, or revise their personal meanings and narratives. What follows is a brief glossary of terms supporting an orientation to strengths as well as a statement of the principles of practice central to a strengths perspective. These are meant to give you a vital sense of what a frame of mind devoted to the strengths of individuals and groups requires.

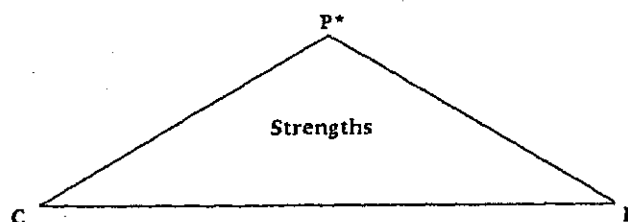
THE LEXICON OF STRENGTHS

"We can act," wrote William James (1902) in reflecting upon Immanuel Kant's notions about conceptions, "as *if* there were a God; feel as *if* we were free; consider nature as *if* she were full of special designs; lay plans as *if* we were to be immortal; and we find then that these words **do** [emphasis added] make a genuine difference in our moral life" (p. 55). Language and words have power. They can elevate and inspire or demoralize and destroy. If words are a part of the nutriment that feeds one's sense of self, then we are compelled to examine our dictionary of helping to see what our words portend for clients. Any approach to practice speaks a language that, in the end, may have a pronounced effect on the way that clients think of themselves and how they act. Not only that, our professional diction has a profound effect on the way that *we* regard clients, their world, and their troubles. In the strengths approach to practice, some words are essential and direct us to an appreciation of the assets of individuals, families, and communities.

A simple device for framing and remembering the essentials of the strengths perspective can be found in Figure 1.1.

These words capture, I think, the core values of the strengths lexicon. The central dynamic of strength discovery and articulation lies in hope and possibility; the vision of a better future or quality of life.

Plasticity (and the placebo effect). It is a miracle of the brain that it "never loses the power to transform itself on the basis of experience and that the transformation can occur over short intervals. . . . your brain is different today than it



Where C stands for:

Competence, capacities, courage

And P symbolizes:

Promise, possibility, positive expectations

And R signifies:

Resilience, reserves, resources

FIGURE 1.1

*Thanks to my daughter Meghan for suggesting this.

was yesterday. " (Restak, 2003, p. 8) It was once thought that after adolescence the brain is pretty much structural monolith, hardly changing. But now, thanks to sophisticated imaging techniques, it is clear that the brain, in ways minute and substantial, continually undergoes change. Most of these changes take place at the synapse (the place where neurons communicate with each other), and are the result of experience and learning or simply one's current state of mind (LeDoux, 2002). These relationships are, at one site or another, in flux and are the basis of plasticity. Therefore, we have a marvelous capacity to alter, extend, and reshape behavior, feeling, and cognition. Of course, much of what happens here is beyond our conscious recognition.

The placebo effect has been long noted (even before modern medicine although it was not called that). In contemporary usage it refers to a phenomenon in the clinical trials of various medical procedures and medications. Typically, one group is given the actual drug and another is given an inert substance (although now it is becoming more common to give a placebo that does provoke side effects so that people are less likely to guess they are being given the placebo). Neither the administrators of the drugs and placebos nor the "patients" know which is which. A drug's power is thought to be measured in the extent to which it is superior to the placebo in promoting the appropriate effects. In many clinical trials of psychoactive drugs it is not uncommon for 40–60% of the placebo group to experience the therapeutic outcome provided by the drug. And we do not really know how many of the people who get the actual drug experienced a placebo rather than a drug effect (or some combination of the two). Recently, four physicians, using the Freedom of Information Act, were able to get the results of clinical trials done over the last 15 years from the Food and Drug Administration (FDA) for six of the most popular antidepressant drugs. Pharmaceutical companies conduct clinical trials and then send the results to the FDA. Up until now no one has had access to the results of these trials, so we have to take the drug company's word that its drug is effective. These researchers conducted meta-analyses of the clinical trials and found, no matter how generous or conservative their statistical analysis, that there were no clinically significant differences between the placebos and the drugs (Kirsch et al., 2003). Whatever else this means, it does, I think, bespeak the power of hope, positive expectations, and belief in the healing ministration. It seems odd that we would not have made more of the placebo effect (even if it is only a short-term one).

Empowerment. Although rapidly becoming hackneyed, empowerment indicates the intent to, and the processes of, assisting individuals, groups, families, and communities to discover and expend the resources and tools within and around them. Stephen Rose (2000) says this about empowerment practice as he came to understand it:

> Central to this [empowerment] practice was understanding the notion as a relational expression, not a technique or instrument. In empowering relationships, meaning was restored to each person; earned trust was built into the explicit acknowledgement of the purpose of the practice; interactions were explored for their links to social structures and their interests; and clients' lives were envisioned

> simultaneously as unique in terms of meaning, but collective or population-based in terms of patterns of domination and system barriers to validity. (p. 412)

To discover the power within people and communities, we must subvert and abjure pejorative labels; provide opportunities for connections to family, institutional, and communal resources; assail the victim mind-set; foreswear paternalism; trust people's intuitions, accounts, perspectives, and energies; and believe in people's dreams. Barbara Levy Simon (1994) builds the concept of empowerment with five necessary ideas: collaborative partnerships with clients and constituents; an emphasis on the expansion of client strengths and capacities; a focus on both the individual or family and the environment; assuming that clients are active subjects and agents; and directing one's energies to the historically disenfranchised and oppressed. Pursuing the empowerment agenda requires a deep conviction about the necessity of democracy. It requires us to address the tensions and conflicts, the institutions and people that subdue and limit those we help, and compels us to help people free themselves from these restraints (Pinderhughes, 1994). Too often, helping professions (although social work has been very wary of falling into this trap) have thwarted this imperative by assuming a paternalistic posture, informing people about what is good for them, and exhorting people to do the right thing. The strengths approach imposes a different attitude and commitment. The strengths of individuals and communities are renewable and expandable resources. Furthermore, the assets of individuals almost always lie embedded in a community of interest and involvement. Thus, the ideas of community and membership are central to the strengths approach.

Membership. To be without membership, writes Michael Walzer, is to be in a "condition of infinite danger" (1983, p. 32). To be without membership is to be alienated, to be at risk for marginalization and oppression. People need to be citizens, responsible and valued members of a community. To sever people from the roots of their "place" subverts, for all, civic and moral vigor. The strengths orientation proceeds from the recognition that all of those whom we serve are, like ourselves, members of a species, entitled to the dignity, respect, and responsibility that comes with such membership. But, too often, people we help have either no place to be (or to be comfortable) or no sense of belonging. The sigh of relief from those who come to be members and citizens and bask in the attendant rights and responsibilities, assurances and securities, is the first breath of empowerment. There is another meaning of membership and that is that people must often band together to make their voices heard, get their needs met, to redress inequities, and to reach their dreams. Jonathon Kozol writes eloquently about the lived experience of people, especially children, who are poor and struggle with the ignorance, hostility, lack of regard, and destructive policies of the outside world. He describes places of refuge, resurrection, and membership. St. Ann's Church and School in the South Bronx is one such place. Here, Mother Martha, the pastor, invites the membership of children and adults. The reality of segregation and separation from the mainstream is never very far from the halls of St. Ann's.

> Despite the isolation and betrayal that may be suggested by these governing realities, St. Ann's is not a place of sorrow, but at least during the hours when children fill its corridors and classrooms with their voices and their questions and their paperpads and their notebooks and their games, it is a place of irresistible vitality and energy and sometimes complicated hope, and now and then uncomplicated joy. For grown-ups in the neighborhood, it is an energizing place as well, although the burdens that they bring with them when they come here in times of crisis to seek out the priest can often seem at first overwhelming. (2000, p. 33)

The same kind of trustful energy is poured into community-building and neighborhood development projects all over this country. In her investigation of programs that work Lisbeth Schorr (1997) says this about successful community building programs:

> Community building . . . is more an orientation than a technique, more a mission than a program, more an outlook than an activity. It catalyzes a process of change grounded in local life and priorities. Community building addresses the developmental needs of individuals, families, and organizations within the neighborhood. It changes the nature of the relationship between the neighborhood and the systems outside its boundaries. A community's own strengths—whether they are found in churches, block clubs, local leadership, or its problem-solving abilities—are seen as central. (pp. 361–362)

You can see that the ingredients of the strengths perspective abound in this definition of community building—empowerment, membership, and, certainly, indigenous resilience.

Resilience. A growing body of inquiry and practice makes it clear that the rule, not the exception, in human affairs is that people do rebound from serious trouble, that individuals and communities do surmount and overcome serious and troubling adversity.

> At best or worst, depending on one's perspective, only about a third [of children who face dramatic stress] generally succumb; approximately two thirds do not. The purpose of resilience research is to learn how and why [this two thirds] beat the odds. (Wolin & Wolin, 1996, p. 246)

Much of this literature documents and demonstrates that particularly demanding and stressful experiences, even ongoing ones, *do not lead inevitably to vulnerability, failure to adapt, and psychopathology* (Benard, 2004; Katz, 1997; Werner & Smith, 1992; Wolin & Wolin, 1996). Resilience is not the cheerful disregard of one's difficult and traumatic life experiences; neither is it the naive discounting of life's pains. It is, rather, the ability to bear up in spite of these ordeals. Damage has been done. Emotional and physical scars bear witness to that. In spite of the wounds, however, for many the trials have been instructive and propitious. Resilience is a process—the continuing growth and articulation of capacities,

knowledge, insight, and virtues derived through meeting the demands and challenges of one's world, however chastening.

Healing and Wholeness. Healing implies both wholeness and the inborn facility of the body and the mind to regenerate and resist when faced with disorder, disease, and disruption. Healing also requires a beneficent relationship between the individual and the larger social and physical environment. The natural state of affairs for human beings, evolved over eons of time and at every level of organization from cell to self-image, is the repair of one's mind and body. Just as the resilience literature assures us that individuals have naturally occurring self-righting tendencies, even though they can be compromised (Werner & Smith, 1992), it seems also the case that all human organisms have the inclination for healing. This evolutionary legacy, of course, can be compromised by trauma, by environmental toxins, by bodily disorganization, and, not the least, by some of our professional intervention philosophies and systems. But, the bottom line is this: If spontaneous healing occurs miraculously in one human being, you can expect it to occur in another and another. Such organismic ingenuity only makes common sense. Otherwise, how could we have survived as a species for hundreds of thousands of years without hospitals, HMOs, physicians, psychiatrists, pharmacists, or talk show hosts? Healing occurs when the healer or the individual makes an alliance with, or instigates the power of, the organism to restore itself (Cousins, 1989; Pelletier, 2000; Weil, 1995). So healing and self-regeneration are intrinsic life support systems, always working and, for most of us, most of the time, on call. Such a reality has dramatic implications, not just for medicine but for all the helping professions. At the least, it challenges the assumption of the disease model that only experts know what is best for their clients and that curing, healing, or transformation comes exclusively from outside sources.

Dialogue and Collaboration. Humans can only come into being through a creative and emergent relationship with others. Without such transactions, there can be no discovery and testing of one's powers, no knowledge, no heightening of one's awareness and internal strengths. In dialogue, we confirm the importance of others and begin to heal the rift between self, other, and institution.

Dialogue requires empathy, identification with, and the inclusion of other people. Paulo Freire (1973) was convinced, based on his years of work with oppressed peoples, that only humble and loving dialogue can surmount the barrier of mistrust built from years of paternalism and the rampant subjugation of the knowledge and wisdom of the oppressed. "Founding itself upon love, humility, and faith, dialogue becomes a horizontal relationship of which mutual trust between the dialoguers is the logical consequence" (pp. 79–80). A caring community is a community that confirms otherness, in part by giving each person and group a ground of their own, and affirming this ground through encounters that are egalitarian and dedicated to healing and empowerment.

The idea of collaboration has a more specific focus. When we work together with clients we become their agents, their consultants, stakeholders with them in

mutually crafted projects. This requires us to be open to negotiation and to appreciate the authenticity of the views and aspirations of those with whom we collaborate. Our voices may have to be quieted so that we can give voice to our clients. Comfortably ensconced in the expert role, sometimes we may have great difficulty assuming such a conjoint posture.

Suspension of Disbelief. It would be hard to exaggerate the extent of disbelief of clients' words and stories in the culture of professionalism. While social work because of its enduring values may fancy itself less culpable in this regard than other professions, a little circumspection is warranted. As just one example (and probably somewhat unfair because this is a brief excerpt from a text on social work practice that generally assumes a positive view of clients), Hepworth and Larsen (1990) wrote:

> Though it is the primary source of information, verbal report is vulnerable to error because of possible faulty recall, distorted perceptions, biases, and limited self-awareness on the part of clients. It is thus vital to avoid the tendency to accept clients' views, descriptions, and reports as valid representations of reality. Similarly, it is important to recognize that feelings expressed by clients may emanate from faulty perceptions or may be altogether irrational. (p. 197)

Two observations: First, the idea that there are valid representations of reality is questionable. That is, there are many representations of the real world. Is, say, a Lakota understanding of fever any less relevant in context than a Manhattan internist's? Second, to begin work with clients in this frame of mind would seem to subvert the idea that clients often do know exactly what they are talking about and that they are experts on their own lives. And, are social workers own interpretations less subject to faulty recall, or their own interpretive forestructures less likely to be slathered over clients' own understanding? Perhaps, the suspension of belief in clients' accounts comes from the radiation of scientific thinking throughout our culture and into the professions. The ideal of the scientific investigator as objective and dispassionate observer has been transfigured into a certain incredulity about, and distancing from, clients. If the rise of the professions (and the ideology of professionalism) was part of the extension and reinforcement of the institutions of socialization and social control during the Victorian era, then a certain detachment and restraint in accepting clients and their stories made sense (Bledstein, 1978).

Professionals have contained the affirmation of clients in a number of ways:

- by imposing their own theories over the theories and accounts of clients
- by using assessment in an interrogative style designed to ascertain certain diagnostic and largely preemptive hypotheses that, in the end, confirm suspicions about the client
- by engaging in self-protective maneuvers (like skepticism) designed to prevent the ultimate embarrassment for a professional—being fooled by or lied to by a cunning client

The frequent talk about manipulative and resistant clients in many social agencies may stem from the fear of being made the fool. To protect self-esteem, nonnormative lifestyles, self-interests, or benefits, clients may have a vested interest in not telling the truth. But we must consider the possibility that avoiding the truth may be a function of the manner in which the professional pursues and/or asserts the truth. The professional's knowledge, information, and perspective are privileged and carry institutional and legal weight. The client's do not.

In summary, the lexicon of strengths provides us with a vocabulary of appreciation and not aspersion about those with whom we work. In essence, the effort is to move away from defining professional work as the articulation of the power of expert knowledge toward collaboration with the power within the individual or community toward a life that is palpably better—and better on the clients' own terms.

PRINCIPLES OF THE STRENGTHS PERSPECTIVE

What exactly is a perspective? It is not a theory. Theories seek to explain some phenomena, or at least describe them analytically. It is not a model. Models are meant to represent, logically and graphically, some aspect of the world. A perspective is somewhat harder to define. At the least it is a standpoint, a way of viewing and understanding certain aspects of experience. It is a lens through which we choose to perceive and appreciate. It provides us with a slant on the world, built of words and principles. We have already reviewed some of the words. What follows now are some of the principles.

The principles that follow are the guiding assumptions and regulating understandings of the strengths perspective. They are tentative, still evolving, and subject to revision. They do, however, give a flavor of what practicing from a strengths appreciation involves.

Every Individual, Group, Family, and Community Has Strengths. While it may be hard at times to invoke, it is essential to remind oneself that the person or family in front of you and the community around you possess assets, resources, wisdom, and knowledge that, at the outset, you probably know nothing about. First *and* foremost, the strengths perspective is about discerning those resources, and respecting them and the potential they may have for reversing misfortune, countering illness, easing pain, and reaching goals. To detect strengths, however, the social work practitioner must be genuinely interested in, and respectful of, clients' stories, narratives, and accounts—the interpretive angles they take on their own experiences. These are important "theories" that can guide practice. The unearthing of clients' identities and realities does not come only from a ritual litany of troubles, embarrassments, snares, foibles, and barriers. Rather, clients come into view when you assume that they know something, have learned lessons from experience, have hopes, have interests, and can do some things masterfully. These may be obscured by the stresses of the moment, submerged under the weight of crisis, oppression, or illness but, nonetheless, they abide.

In the end, clients want to know that you actually care about them, that how they fare makes a difference to you, that you will listen to them, that you will respect them no matter what their history, and that you believe that they can build something of value with the resources within and around them. But most of all, clients want to know that you believe they can surmount adversity and begin the climb toward transformation and growth.

Trauma and Abuse, Illness and Struggle May Be Injurious but They May also Be Sources of Challenge and Opportunity. The Wolins (1997) point out that the "damage model" of development so prevalent in today's thinking only leads to discouragement, pessimism, and the victim mind-set. It also foretells a continuing future of psychopathology and troubled relationships. Individuals exposed to a variety of abuses, especially in childhood, are thought always to be victims or to be damaged in ways that obscure or override any strengths or possibilities for rebound. In the Wolins' "challenge model," children are not seen as merely passive recipients of parental unpredictability, abuse, disappointment, or violence. Rather, children are seen as active and developing individuals who, through these trials, learn skills and develop personal attributes that stand them in good stead in adulthood. Not that they do not suffer. They do. Not that they do not bear scars. They do. But they also may acquire traits and capacities that are preservative and life affirming. There is dignity to be drawn from having prevailed over obstacles to one's growth and maturing. The Wolins (1993) refer to this as "survivor's pride." It is a deep-dwelling sense of accomplishment in having met life's challenges and walked away, not without fear, even terror, and certainly not without wounds. Often this pride is buried under embarrassment, confusion, distraction, or self-doubt. But when it exists and is lit, it can ignite the engine of change.

Individuals, groups, and communities are more likely to continue development and growth when they are funded by the currency of their capacities, knowledge, and skills (Delgado, 2000; Kretzmann & McKnight, 1993). While the strengths perspective is powered by a similar belief, the observation of many who practice using a strengths approach is that many people who struggle to find their daily bread, a job, or shelter are already resilient, resourceful, and, though in pain, motivated for achievement on their terms. Kaplan and Girard (1994) put it this way:

> People are more motivated to change when their strengths are supported. Instead of asking family members what their problems are, a worker can ask what strengths they bring to the family and what they think are the strengths of other family members. Through this process the worker helps the family discover its capabilities and formulate a new way to think about themselves. . . . The worker creates a language of strength, hope, and movement. . . . (p. 53)

Assume That You Do Not Know the Upper Limits of the Capacity to Grow and Change and Take Individual, Group, and Community Aspirations Seriously. Too often, professionals assume that a diagnosis, an assessment, or a profile sets the parameters of possibility for their clients. In our personal lives, looking back, we sometimes marvel at the road we traveled—a road that we, at the outset, might not have even considered taking—and the distance that we

have come. For our clients, too often, we cannot imagine the prospect of similar dizzying and unanticipated destinations. The diagnosis or the assessment becomes a verdict and a sentence. Our clients will be better served when we make an overt pact with their promise and possibility. This means that we must hold high our expectations of clients and make allegiance with their hopes, visions, and values.

It is becoming increasingly clear that emotions have a profound effect on wellness and health. Emotions experienced as positive can activate the inner pharmacoepia, those chemicals that relax, help fight infection, and restore. This is undoubtedly part of our evolutionary success; our ability to adapt to situations, even highly toxic ones, that were not foretold in our genome (Damasio, 1994). When people believe that they can recover, that they have prospects, that their hopes are palpable, their bodies often respond optimally. That does not mean that people do not get sick. It does mean that when people are sick, healers can make an alliance with the body's regenerative powers and augment them with real but nonetheless fortifying and uplifting expectations (Weil, 1995). Roger Mills's (1995) health realization/community empowerment projects (detailed in Chapter 13) are based on similar principles. Mills's idea is that everyone has innate wisdom, intelligence, and motivating emotions and that these, even if muted by circumstance, are accessible through education, support, and encouragement. The goals of his projects are to "reconnect people to the [physical and mental] health in themselves and then direct them in ways to bring forth the health of others in their community. The result is a change in people and communities which builds up from within rather than [being] imposed from without" (Mills, 1993, cited in Benard, 1994, p. 22). So it is that individuals and communities have the capacity for restoration and rebound.

We Best Serve Clients by Collaborating with Them. The role of expert or professional may not provide the best vantage point from which to appreciate clients' strengths and assets. A helper may best be defined as a collaborator or consultant: an individual clearly presumed, because of specialized education and experience, to know some things and to have some tools at the ready but definitely not the only one in the situation to have relevant, even esoteric, knowledge and understanding. Ms. Johnson knows more about thriving in a public housing project than anyone I can think of. Over the course of 35 years, she successfully raised 11 children. She maintained a demeanor of poise, and she demonstrated intelligence and vigor, even as her community underwent dramatic, often frightening changes. Her contributions to the community are, simply put, amazing. She has much to teach us and other residents of her community. I certainly would not presume to work *on* Ms. Johnson but would be privileged to work *with* her.

We make a serious error when we subjugate clients' wisdom and knowledge to official views. There is something liberating, for all parties involved, in connecting to clients' stories and narratives, their hopes and fears, their wherewithal and resources rather than trying to stuff them into the narrow confines of a diagnostic category or treatment protocol. Ultimately a collaborative stance may make us less vulnerable to some of the more political elements of helping: paternalism, victim-blaming (or, more currently, victim-creating), and preemption of client views. It is

likewise important to get the stories and views of clients out to those who need to hear them—schools, agencies, employers, local governments, churches, and businesses. This is part of the role of advocacy. The policies and regulations that affect many of our clients are crafted in the halls of Congress and are often far removed from their daily reality. Furthermore, these policies rarely take advantage of the wisdom and resources of their intended beneficiaries and recipients.

Every Environment Is Full of Resources. (See Chapters 11, 12, 13, and 14.) In communities that seem to amplify individual and group resilience, there is awareness, recognition, and use of the assets of most members of the community (Kretzmann & McKnight, 1993). Informal systems and associations of individuals, families, and groups, social circuits of peers, and intergenerational mentoring work to assist, support, instruct, and include all members of a community (Schorr, 1997). In inclusive communities, there are many opportunities for involvement, to make contributions to the moral and civic life of the whole; to become, in other words, a citizen in place. No matter how harsh an environment, how it may test the mettle of its inhabitants, it can also be understood as a potentially lush topography of resources and possibilities. In every environment, there are individuals, associations, groups, and institutions who have something to give, something that others may desperately need: knowledge, succor, an actual resource or talent, or simply time and place. Such resources usually exist outside the usual matrix of social and human service agencies. And, for the most part, they are unsolicited and untapped. Melvin Delgado (2000), in his articulation of the capacity-enhancement approach to urban social work practice, describes the five critical assumptions of that approach: " (1) The community has the will and the resources to help itself; (2) it knows what is best for itself; (3) ownership of the strategy rests within, rather than outside, the community; (4) partnerships involving organizations and communities are the preferred route for initiatives; and (5) the use of strengths in one area will translate into strengths in other areas . . . a ripple effect" (p. 28).

Such a view of the environment, while seeming to comfort those who believe that people(s) should pull themselves up by their collective and individual bootstraps, *does not* abrogate the responsibility for working for social and economic justice. It does, however, recognize that while we await political transformation, there are reservoirs of energy, ideas, talents, and tools out there on which to draw. To regard the environment as only inimical or toxic moves us to disregard these resources or mistakenly judge them as disreputable. When it comes, the community that is aware of and employing its human and social capital to the degree possible is in a much better position to drink the cooling waters of social justice.

Caring, Caretaking, and Context. The idea that care is essential to human well-being does not sit well in a society beset by two centuries of rugged individualism. Deborah Stone (2000) says that we have three rights to care. First, all families must be permitted and assisted in caring for their members. Second, all those paid caregivers need to be able give the support and quality care that is commensurate with the highest ideals of care without subverting their own well-being. Finally, a right to care boils down to this: that all people (and there may be 38

million children under the age of 10 who clearly need care and anywhere between 30 and 50 million adults who need some degree of care) who need care get it. We do have a horror of dependence. But, as Stone says,

> Caring for each other is the most basic form of civic participation. We learn to care in families, and we enlarge our communities of concern as we mature. Caring is the essential democratic act, the prerequisite to voting, joining associations, attending meetings, holding office, and all the other ways we sustain democracy. (p. 15)

In one sense, social work is about care and caretaking. Ann Weick (2000) makes the case that social caretaking as an activity is the profession's hidden (and first) voice; hidden because it is also woman's voice. Caretaking is, in a diffuse sense, also the work of the strengths perspective.

> Recognizing the capacity for toughness and tenderness, for clear reason and fluid intuition, for radical hope and dry-eyed reality brings us back to the challenges of caretaking. But rather than discounting its demands and possibilities, the lesson of our first voice tells us to pay attention to every dimension it encompasses. Social work is social caretaking. . . . We need to turn our attention to the humblest activities of social caretaking and offer our boldest ideas about strengthening the social web connecting us all. (p. 401)

Like social caretaking, and social work, the strengths perspective is about the revolutionary possibility of hope; hope realized through the strengthened sinew of social relationships in family, neighborhood, community, culture, and country. That contextual sinew is fortified by the expression of the individual and communal capacities of all.

SOME PRELIMINARY THOUGHTS

Social work has had something of a dissociative history with regard to building on client strengths. From its inception as a profession, the field has been exhorted to respect and energize client capacities. Bertha Capen Reynolds(1951) looked at the issue in terms of workers' obligations:

> The real choice before us as social workers is whether *we* are to be passive or active. . . . Shall we be content to give with one hand and withhold with the other, to build up or tear down at the same time the strength of a person's life? Or shall we become conscious of our own part in making a profession which will stand forthrightly for human well-being, *including the right to be an active citizen?* (p. 175, emphasis added)

The historical and continuing tension between the desire to become more professional, more technically adept, to focus on "function" rather than "cause" (Lee, 1929), to elevate social work to a new level of respect and comparability among the professions, and, on the other hand, to retain the interest in social action and the redress of social inequities seems to have been resolved recently in

favor of the former. The writing, lexicon, and perspective of, say, clinical social work and those of social action or community development are quite different, maybe even at odds. While there is no implacable conflict between the interests of social work practice and social action, the infusion of psychodynamic thinking, the rise of private practice and vendorship, the mass appeal of DSM IV TR among other factors have driven social work toward a model of practice that is more heavily aligned with psychological thinking and psychopathology theories (Specht & Courtney, 1993). The theories that define such an alignment are typically oriented toward family and individual dysfunctions and disorders. While we must respect the impact of problems on the quality of life for our clients, we must also exercise extraordinary diligence to assure that the resources and positive attributes of clients draw our attention and define our efforts.

It does seem to be the case that group work has a long history of attention to the strengths and resources of group members and their neighborhoods. Andrew Malekoff (2001) puts it this way:

> There is so much talk today about strengths and wellness. This is hardly a new or revolutionary concept. But it has been neglected for too long. However, good group work practice has been paying attention to people's strengths since the days of the original settlement houses over 100 years ago, mostly without fanfare. (p. 247)

Although today's social work practice texts typically nod in the direction of client strengths but provide little guidance to the student or worker about how to make an accounting of strengths and how to employ them in helping, we are currently seeing movement away from the problem or pathology perspective. The solution-focused approach is one example. In essence, it regards clients in the light of what they have done well, those times that the problem has not been apparent, or those times when exceptions to difficulty have occurred. Furthermore, client goals and visions are the centerpiece of the work to be done. It is not unusual for solution-focused practitioners to ask how things would be positively different if a miracle occurred overnight and the problem no longer held (de Jong & Berg, 2001). The literature on resilience, discussed briefly earlier in this chapter, also provides conceptual and clinical ground for employing client strengths as a central part of the helping process. In the words of Benard (1994; see also Chapter 12), "Using resilience as the knowledge base for practice creates a *sense of optimism and hope*. It allows anyone working with troubled youth to, as poet Emily Dickinson urges, "dwell in possibility," to have confidence in their futures and, therefore, to convey this positive expectation to them" (p. 4).

Finally, the research on the effectiveness of a strengths approach, although very preliminary, suggests that it may be an effective and economical framework for practice or case management (Rapp, 1998). Related research on power of mind/health realization; resilience-based practice; solution-focused therapy; community-building; and the research done on the critical factors in successful therapy provide some associated support for the elements of a strengths perspective that make a difference. Research actually done from the vantage point of a strengths approach includes the views and concerns of the stakeholders (subjects and clients)

from the outset. The results of the research are to be used to achieve stated objectives of the stakeholders and/or to aid in the solving of identified problems.

In Chapter 15, I will discuss in more detail some of the converging lines of research and practice that are reinforcing the strengths perspective. I will also address some of the persistent and significant criticisms of it.

CONCLUSION

This edition of the book continues the effort to expand the conceptual, clinical, and practical elements of the strengths perspective. At its philosophical core, this perspective merely affirms or, rather, re-affirms, our dedication to understanding and revering the resources and resourcefulness that individuals, families, and communities bring to us when they seek our help. The central proposition of social work practice, as I see it, is to exploit the best in all of us; to work together to surmount adversity and trouble; to confront the appalling with all the tools available within us and around us; to wrestle distress and disillusionment to the ground with determination and grit; to grab the hands of others and march unwaveringly, even heroically, in the direction of hopes, dreams, and possibilities.

Let it be said once again. *The strengths perspective is not about ignoring trauma, problems, illness, and adversity.* While practitioners of the perspective disagree about the role of problems in the work that they do, all believe that this approach, at the very least, is about restoring some balance to our efforts—a balance that requires that we appreciate the struggles of an individual, family, or community but that more importantly we look at those struggles for hints and intimations, or solid evidence of strengths, capacities, and competencies. The emphasis on problems and pathologies, no matter what we claim as a profession, surely is careening out of control. The medical/psychiatric/pharmaceutical/insurance cartel (and I use the term advisedly) has a tightening grip on the ways that we see and consider human nature and the human condition. It is de rigueur in popular culture, in the media, in clinics and agencies, even in personal relationships to allow what is problematic to seize our perceptions and interest. As social workers we are obligated to resist the siren call of the medical model in our work together with clients.

Duncan and Miller (2000) put it well:

> If therapists are to resist the pull to steer clients automatically toward diagnosis and medication, the belief in client capacity to conquer even extreme (and often dangerous) personal circumstances must go deep. Clients can use an ally in overcoming often dramatic obstacles to personal recovery. When professionals use their inevitable positions of power to hand power back to the clients rather than block client capacities, clients can even more readily reach their goals. (p. 216)

DISCUSSION QUESTIONS

1. What are the most significant contrasts between a strengths approach and a problem-focused one?

2. If you were to employ the strengths perspective in your practice, what would your first steps in working with a client be?
3. What are the barriers you have found in approaching your practice with individuals, families, groups or communities from a strengths vantage point?
4. What do you consider to be your strengths? How do they shape or affect your practice? How do they shape your personal life?
5. Think of a client you have worked with. Did you ever account for some of the client's (whether an individual, family, or community) capacities and assets? Did you use them in practice? How?

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