Learning Strengths-Based Practice: Challenging our Personal and Professional Frames.

by Robert Blundo

Abstract

The strengths perspective challenges our personal and professional conventions, our habits of the mind. Shifting from the world of traditional practice to that of a strengths frame challenges our cultural and professional traditions that assume that "truth" is discovered only by looking at underlying and often hidden meanings that only professional understanding and expertise can decipher and amend. This paper explores this challenge as necessary if practitioners are to truly embrace a practice based upon strengths, resilience, and empowerment.

YOU HAVE BEEN ASSIGNED a new case at your agency. The individual is a college student in their junior year at the local university where classes began a little more than a week ago. Please read the following process recording and note your thoughts as you take in the information being presented. That is, please note the "data" or specific information that appears most important or significant to your beginning understanding. Now, even though you may want more information, think of what immediately comes to mind in terms of defining the problem or diagnosis, and importantly, how would you go about starting to work with this person?

> *I called last week to make this appointment because I just felt that I was not going to make it. I felt so anxious and stressed at school the other day, I had to leave and did not attend my first class session. Actually, it was my first day back in school since taking a break last year. I had pushed myself too hard with work, school, and trying to keep the gay alliance going, I just couldn't do it anymore. My drinking was getting worse and I was yelling at my partner so much I was always leaving to get away to calm down. My dad would hit my mother and he drank a lot. Maybe I am just too much like him.*

So, what do you think? What comes to mind when you think of what you have been told? Do you need more information? What type of information or data do you think would be needed in this case? What thoughts do you have about treatment?

If your social work background is similar to mine, you might be thinking about the multiple problems or maybe even a dual diagnosis to start. Maybe you considered an evaluation of the drinking problem, obtaining more information about sexual orientation, family history of possible abuse, maybe an evaluation of suicide potential, possibly using the anxiety and/or depression scales. Treatment is definitely needed, with couples work perhaps later on.

The material of this case is very limited, but for most social workers just a few pieces of information can get us thinking and concluding, even though the material is just preliminary at this point. What we usually see as most provocative are the "problems" apparent in the story being told. We look for what is going wrong, symptoms, what might be failings, pathologies, and beginning histories to substantiate these early assumptions being constructed into a mental picture of our client. For the most part, this usually a picture of what is problematic or wrong. It is the faults and weaknesses that we key in on as most significant in our listening. In many ways, we are rewriting or translating the story told by the client into our own professional language, a language largely made up of concepts having to do with problems, pathology, deficits, and failings to which we will apply some form of

Families in Society: The Journal of Contemporary Human Services

intervention. Now, for a moment, try a second look at what was revealed in the person's story. It has been a week since the "incident" of anxiety at school and there have been no reports of anxiety since then. In other words, this person has managed to keep going for the past week. Even though it is not clear, the information states that the client missed the "first class session" on the first day back to school, but they appear to have made it to the other classes that day and the remaining classes during the week prior to seeing you. The comment about the drinking referred to a time last year while the student was under stress. At least in this presentation, there is no mention of a drinking issue at present.

The individual demonstrated awareness of their provocative behavior with their partner and, importantly, addressed the issue by leaving so as not to provoke any further distress on the relationship that we only assume may have included threats of physical acts. Note though that physical acts were not actually mentioned at that point. The client addressed their own previous stress by choosing to take time off from school to take care of their self and possibly their relationship. The person made an effort to help himself by calling for an appointment and has kept that appointment even though the anxiety levels appear to have lessened. Finally, this individual shows a willingness to be open to talking about themself with you.

If your experience was similar to mine at first reading, you must have been struck by the contrast between the two interpretations or versions of the client's story. It is this contrast that is at the heart of shifting perspectives from a traditional medical/pathology paradigm-based practice to a strengths/solution-focused, perspective-based practice. Making this shift in practice is a considerable challenge for social workers like myself who have been educated and tutored in the basic tenets of the profession's knowledge base and practice methods. It is additionally difficult for students just learning practice skills. Students come ready-made with a bias toward seeing problems and then trying to fix them by making suggestions to the client.

Unlike shifts in techniques, models, skills, and intervention protocols that many social workers are familiar with, such as adding onto one's repertoire a set of cognitive-behavioral intervention skills, taking on the challenge of learning strengths-based practice requires a more fundamental shift in how we think and view the world. The strengths perspective requires a significant alteration in how we think about those with whom we work, how we think about ourselves as professionals, the nature of the knowledge base for practice, and the process of social work practice itself. It is the fundamental nature of this shift that is the challenge to practitioners as well as students just learning the profession. This is a significant issue for social work practitioners, students, and educators if social work is to embrace this egalitarian, collaborative working relationship that builds upon the strengths and resilience of individuals, families, and communities.

This paper looks at this challenge in terms of the learning process of students new to the profession as well as practitioners comfortably settled into the familiar world of pathology and deficit assessment and intervention. A brief review of the background and entrenchment of the medical/pathology/expert model of practice taught and practiced today sets the context of the challenges found in shifting perspectives. This is followed by an exploration of some of the specific challenges that emerge when learning this new paradigm. Two specific issues—overcoming our natural biases to help and our trained biases such as professional knowledge/expertise and professional practice traditions—are explored by contrasting the traditional deficit-based assessment/practice with the strengths-based position of collaborator and strengths/solution-based practice.

The Deficit/Pathology Knowledge Base Becomes Synonymous with Social Work

The preoccupation with problems, human deficits, what is broken, gone wrong, or failed, has dominated the attention of social work and exists today in the form of the medical/pathology/scientific paradigm that underlies the traditional social work theories, practice models and educational materials found in our texts and our social work curriculums (Rapp, 1998; Goldstein, 1997; Specht & Courtney 1994; Lubove, 1965).

By the early 1900s, the work of organizations like Charitable Organization Society (COS) and workers such as Mary Richmond were moving the friendly visitor away from seeing poverty and human difficulties as merely moral failings in need of moral uplifting to one that viewed human suffering as something that could be rationally understood. Mary Richmond, who was greatly influenced by the community medical practice efforts being made at Johns Hopkins University Hospital in Baltimore, Maryland, specifically formulated the start of much of our present day social work language and thinking. The use of the "study, diagnosis and treatment" model used in the emerging science of medicine was adapted to the practice of social work.

Mary Richmond (1917) called the process "social diagnosis" and described the developing social work perspective in this manner:

> *Social diagnosis is the attempt to arrive at as* exact a definition as possible *of the social situation and* personality of a given client. The gathering of evidence, or investigation, *begins the process,* the critical examination *and* comparison of evidence *follows, and last come its* interpretation and the definition *of the social difficulty. Where one word must describe the whole process,* diagnosis *is a better word than* investigation, *though in strict use the former belongs to the end of the process [emphases added] (p. 62).*

These concepts became the bases of social work practice within the developing schools of social work over the next decades and became the benchmark of good practice. Thus began the diligence accorded lengthy process recordings and intake summaries focused on obtaining a broad spectrum of information believed necessary in constructing the diagnosis of the problem similar to that underlying a medical disease. We still see this assumed need reflected in the enormous amount of information social workers are encouraged to gather today. The majority of our present-day social work practice texts that are used in schools of social work contain pages of assessment forms, inventories, and grids created to assist the social worker in gathering an abundant amount of information. Mary Richmond's translation of the medical pathology model of practice in medicine is still the primary process used and taught today. This orientation is at the heart of how most social workers think of practice today—focusing on the problem or what underlies the problem, looking for the cause of the problem by gathering evidence or data, assessing the data, reformulating the problem into a diagnosis (cause and effect), and developing a plan or intervention to address the "diagnosis" or problem as understood by the social worker.

During this early developmental period, social work practitioners and scholars began to embrace psychiatry and the emerging scientific inquiry into personality development, in particular psychoanalytic thinking and practices, along with the methods and practice procedures of medicine. The emerging knowledge base for future generations of social workers would be focused upon the internal mental life of their clients, as Mary Jarrett (1919) proclaimed in her paper "The Psychiatric Thread Running Through All Social Case Work." (Robinson, 1930). It is the internal mental life of clients that would be at the heart of social casework. Social work was developing as a profession with a specific common mode or practice to be called "social casework" and a body of knowledge and practice principles to support that work.

These developments became synonymous with the profession itself. It is hard to conceive of social work even today without assuming the standards and knowledge base set down nearly 80 years ago. First, social work embraced and evolved as its foundation the medical/scientific method of data collection, analysis, and diagnosis. This prescribed a focus on the problem or underlying causes to be discovered by means of "objective" observation and inquiry. It demanded the incorporation and reliance upon theories of behavior and emotions to provide the means for understanding the client's problem. It was this "scientific" knowledge possessed by the social worker "expert" that was needed to decipher what had gone wrong or failed in order to address the problems. Secondly, it had embraced the psychoanalytic model of understanding and practice principles. Social work was now focused upon the inner life (psychology) of the client and the idea of personality development or, more to the point, defective intrapsychic development, the need for historical data concerning early childhood development underlying current conflicts, the significance of emotions and catharsis, unconscious motivations and defenses, as well as a professional stance in the relationship. This developing model of practice and theories of behavior and emotion were to guide the social worker's relationship with the client, the social worker's understanding of the client and his or her circumstances, as well as the nature of the intervention process itself.

The die was cast and social work would inevitably be drawn further into the medical/pathology model of practice as its fundamental perspective. Since these early developments, the core body of social work knowledge development has been derivative of this early start. These ideas and concepts have become, even to this day, ingrained in the mind of the profession as so fundamental to the practice of social work that it nearly impossible to consider a practice that does not include most of this underlying perspective in some form or another.

The Tenacity of Our Traditional Paradigm

The depth of the attachment to the ideas perpetuated by this fundamental knowledge base were reflected in the severe criticism Helen Harris Perlman's (1957) book titled, *Social Casework: A Problem-solving Process*, received from her colleagues. They could not accept the use

of what was considered just one of many ego-functions, that is "problem-solving," as the bases for social casework theory and practice. Florence Hollis (1964) reiterated this attitude in her highly influential casework text, *Casework: A Psychosocial Therapy*. She insisted that "case work will drastically impoverish itself if it follows the lead of Horney and Sullivan in trying to explain human behavior primarily in interpersonal terms, omitting those key intrapsychic phenomena that from the start influence the child's perception of an reaction to his interpersonal experiences" (p. 11).

It is the tenaciousness with which we humans attach ourselves to meanings about our world that is at the center of the challenge of learning the strengths perspective. Irving Goffman's (1974) concept of "frames" captures this ongoing process within each of us as individuals and as we come together to create a "profession." The notion of living within a "frame" refers to the constructed meanings or definitions we share with others that provides us with "models" of daily interactions and practices. For example, when we enter a restaurant, we have little to think about other than what we might want to order. Unless we have never been into or read about or heard about a restaurant, most of the activity will seem very natural and seemingly without thought about the process itself. Everyone participating in the "restaurant" experience knows what they are expected to do.

There are numerous rules and roles to be played out in getting a quick bite. It is only when someone does not follow the script that we are aware of the "frame" or process. Once ensconced within the world of constructed meaning shared by others in the profession, doing things differently is met with attempts to maintain the predominate frame. To suggest changing the frame is very difficult, as suggested above with the examples of Helen Harris Perlman and Florence Hollis. It is like being asked to change "reality" as we live it out day-to-day in our professional relationships. A consequence of constructed realities is that each of us selectively attends to that which matches our world view. We therefore see a world as we have imagined it and in a way that our theories and actions reinforce the sense of its existence. This frame or constructed reality being shared by others with whom we work and live, shared and reinforced by our profession in terms of its teachings and socialization processes, is comfortable and "real" as if a natural phenomena. So real, it is often hard to become even aware of the existence of our frames and constructed meanings. It is only when something shakes up the process, like in the restaurant, that we became aware of being engaged in a set of expectations and rules, or action and thought.

Shifts in frames are not easy tasks. It is disturbing and uncomfortable to contemplate. It is easier to attach small asides to existing frames, even though incongruent with aspects of the dominant frame we live in. This is what most often takes place within social work practice literature. Authors incorporate new ideas, but often as attachments to older frames without altering the basic structures of practice. In some sense they "talk the talk" but don't "walk the walk." This is particularly true as the issues of empowerment, strengths, self-determination, and diversity start to emerge within the profession's language. But it usually stays just that, language without substance in terms of shifting the basic frames of thinking and action. For example, authors such James Kottler (2000), Naomi Brill (2000), and Bradford Sheafor and colleagues (2000) talk about client strengths, self-determination, and empowerment without integrating these ideas into a practice reflective of the deepest meaning these new frames or perspectives would provide practitioners. Therefore, these new perspectives become diluted and overshadowed by the familiar social work paradigm. Students and practitioners assume that because they "think about" strength, add strengths questions to their assessment battery, or use the words, that they have understood the significance these ideas might bring to their practice and to the profession.

Jeffrey Kottler's (2000) book, *The Nuts and Bolts of Helping*, is a good example of what might be considered standard practice skills within several human service domains, including social work. The focus of the text is on instructing the beginning practitioner—not the client— as the significant player in the helping process. This is as it should be if we are seeing the world from the perspective of the traditional medical model of social work. In fact, this observation might even sound absurdly obvious, unworthy of being discussed here at all. Yet it is just this assumption that reflects the significance of our traditional frame. We have all learned and accepted the traditional frame that it is the expertise of the social worker, the mastering of theories, practice skills, and experience that will make the difference in the client's life.

For example, Kottler (2000) centers the work being done on the expertise of the worker. He states that to understand what a particular client needs as they sit in front of you crying and despairing, you must have a theory to help you "explain" what is going on in terms of causing this problem and what "you believe should be the focus of treatment" (p. 30). Similarly, Naomi Brill (2000) notes

that it is the worker's appraisal of the situation and those involved that is at the heart of the process. The worker must gather the data and facts, evaluate this information and come to some definition of the problem. The resulting dictum states that "we can fully understand the present only in light of what has happened in the past" and without understanding underlying causes we cannot sustain a cure or prevent recurrence (Brill, 2000, p. 116).

The premise of these practice attitudes and procedures comes out of the traditional medical/pathology frame. It is the incapacity of the client that is being addressed, not only in terms of the underlying cause of the problem but in the person's ability to create any change. Brill's traditional professional stance exemplifies the fundamental importance of the worker's expertise in the traditional model of practice and the incapacity of the client. She states that the "worker who does not possess more and better knowledge about how to deal with the concerns of their clients than do either the clients or the general public have no right to intervene in people's lives" (Brill, 2000, p. 102). She is not talking about the process skills of working with another person, she is asserting authoritative knowledge about another person's own life and how it is being lived out. In support of this position, Brill quotes a client who says " I know what's wrong—I need her to tell me what to do and how to do it" (Brill, 1998, p. 102). This is classic medical model practice training. It is the trained "expert" who is central to any change that is to take place.

> *Not much has really changed in the last 50 years. Although we sound more sophisticated and "eclectic" in our thinking, the basic model of the "professional expert" using "scientifically" based knowledge of human development and pathology takes place every day. We engage in an assessment, at which time "available information is organized and studied to make sense of the client's situation and lay the foundation for a plan of action. When the assessment is completed, the social worker [is] able to describe the problem or the situation accurately and identify what needs to be changed to improve the client's situation" (Sheafor, Horejsi, & Horejsi, 2000, p. 301). Then the appropriate "approach" can be employed to address the problem as understood by the worker. How can concepts such as empowerment, strengths, and self-determination be assumed inside a frame such as this?*

The Sheaffor, Horejsi, and Horejsi (2000) text, *Techniques and Guidelines for Social Work Practice*, is a good example of how social work educators have started to expand the use of concepts such as empowerment, strengths, and self-determination in their texts. In the new fifth edition of their text there is a section on practice frameworks for social workers dedicated to presenting strengths concepts. One can read statements scattered throughout the text that reflect an appreciation of strengths and empowerment. As a matter of fact, strengths appears as one of five perspectives presented to the student and is followed by fifteen "selected practice theories and models" (p. 96–113). Yet, the strengths perspective exists in stark contrast to an overriding traditional medical/pathology frame. In the text, students are presented with criteria to consider when evaluating the validity and usefulness of a practice perspective, the authors include rules such that the perspective: (1) should help the worker analyze and understand highly complex and often chaotic situations, (2) provide guidance and direction during various phases of the change process, and (3) it should rest on empirical foundations. The worker is warned not to be attached to any one perspective and assumes a level of expertise on the part of the worker to select, after careful and critical appraisal, the appropriate perspective for the particular client at the particular time. Of course, this expert choice is based upon professional, empirically based knowledge. Once again, the social worker is the key to change. Change is based upon the social worker's understanding and ability to select the appropriate approach to a particular client and a particular problem—of course after appropriate assessments are made by the worker. It is only by having at hand an arsenal of multiple "paradigms" or perspectives, as well as practice theories and techniques that are interchangeable armaments of the social worker, that change can take place for the client. The authors go on to suggest that

> *Expertness—or at least the appearance of expertness—can have a positive impact on the initial phases of the helping process. Such things as certificates and diplomas on the wall, a large office, proper use of language, and professional dress can increase the client's respect for the helper and the result in the client being more open to influence." (p. 142)*

This does not represent an understanding of the fundamental implications of a strengths perspective and empowerment on the social work process itself. It does reflect what Laslie Margolin (1997) describes as "social workers inserting themselves into client's lives, initiating

actions, judging outcomes, controlling technologies and meanings" (p. 119). Traditional social work practice is disempowering as workers use technical skills such as confrontation, overcoming resistance, and managing the manipulative client while at the same time manipulating the relationship to enhance compliance with professional decisions. For example, Hepworth (1993) alerts the worker to the manipulative client "gaining varying degrees of control of the helping relationship [and therefore] constrain[ing] the maneuverability of the social worker, thereby undermining the helping relationship" (p. 682). In contrast, from a strengths perspective, the "manipulative" client is understood as using considerable skill and thought for a purpose that is meaningful to that person. It is resistance only when these actions are perceived by the worker as the client challenging what the worker wants to take place.

What is most problematic with the inclusion of strengths talk in social work conversations is that the insertion of strengths and empowerment language into a traditional frame gives a false sense of understanding to those learning and engaging in practice. Social workers have thus managed to use the language of strengths and empowerment while maintaining the "prerogative to plan and strategize, direct and control" the process while convincing themselves that they have "empowered" the client (Margolin, 1997, p.122). Leslie Margolin (1997) has referred to this as the "central paradox" of mainstream social work practice conceptualizations of strengths and empowerment. That is, "to become who one truly is, and to do what one truly wants, one has to absorb [the social worker's] definitions, interpretations, and prescriptions" (Margolin, 1997, p. 124). Therefore, to learn the strengths perspective one must seriously challenge the basic foundations of practice knowledge, the 80 years of variations on a basic theme of disease and expertise as it is taught and practiced today. Anything less is a distortion of the meanings employed in a practice from a strengths/empowerment perspective.

Shifting the Fundamental Frame of Practice

In contrast to the continuing adherence to traditional constructs identified with the profession, the strengths perspective offers the profession an opportunity to change frames and learn to collaborate with individuals, families, and communities in a more egalitarian working relationship based upon their strengths and resilience. The client, as well as the client's support system or environment, would move into a central role in the entire social work process. In a frame-challenging, mind-bending example of family practice, a family preservation worker enters a family residence and the first question she asks is, "What is working well that you want to see continue?" (Miley, O'Melia, & DuBois, 1998, p. 4). Needless to say, the family members who were very familiar with professional techniques and attitudes [professional clients] were taken aback as well as those professionals reading this for the first time. This worker's intervention did not and could not eliminate the inherent inequality of the relationship, but did challenge the preeminence of the worker as sole determiner of what should be going on and how this family should be living its life. In many ways this worker's efforts were reflective of the latest research on psychotherapy and counseling which is seriously challenging the traditional practice relationship, as well as the processes.

There is growing evidence that it is actually the client that is responsible for the changes that take place. It is what the client brings in terms of strengths, resilience, and social supports that are responsible for most of what is going to change and how it is going to change. The evidence is clear that psychotherapy and professional "helping" are effective across the board, whatever the model or techniques used (Bergin & Lambert 1978, Lambert & Bergin, 1994). But, surprisingly, there is strong evidence that our techniques or interventions are responsible for only about 15% of the outcome (Lambert, 1992). The factor most responsible for the outcome (40%) is what Lambert (1992) has called "extratheraputic change." That is, those factors or qualities that are part of the client and the client's environment such as social support and fortuitous events. The practitioner does play a significant part in terms of the relationship that accounts for about 30% of the change. Here it is the experience felt by the client and not the worker that is at play. That is, it is the client's perceptions of the worker that creates the quality of the relationship. This plays a part if the client experiences the worker as warm, understanding, accepting, and encouraging, not if the worker thinks of himself or herself in this way. Another key factor in client change is what Lambert (1992) refers to as "expectancy or placebo effects" which complete the remaining 15% of the change influences. Jerome Frank (1973) noted this same factor in Persuasion and Healing. It is the belief that something can be done or an inherent hopefulness that is expressed in the very act of seeking help. These findings leave a great deal of room for social work education and training but suggest a different emphasis, a different frame or perspective. The center of attention would move to understanding how clients make changes and how

practitioners can support that unique and individualized process in the most productive ways. The focus would shift to the client's abilities even in the face of "overwhelming evidence" to the contrary.

How do we challenge our lived theories of practice, beliefs, and sense of being a "professional" in the traditional social work sense? It often takes the form of a shift to some place outside the frame, similar in some ways to Helen Harris Perlman's (1957) efforts, a shift that offers an alternative variation to the standard frame or offers an entirely new alternative. This variation or alternative is often seen as misinformed, lacking understanding, not reflecting training or experience, and maybe just "nuts." Gaining insight into our own "group think" is like opening the door to uncertainty and uneasiness, and this is the challenge to truly exploring the strengths frame and seeing what it can offer.

Shifting Frames to a Strengths Perspective

The strengths perspective is a significant alteration of thinking for traditional social workers as well as students just learning social work practice. Dennis Saleebey (1997) strongly emphasizes that "everything you do as a social worker will be predicated, in some way, on helping to discover and embellish, explore and exploit client's strengths and resources in the service of assisting them to achieve their goals" (p. 3). The emphasis shifts from problems and deficits defined by the worker, to possibilities and strengths identified in egalitarian, collaborative relationships with clients. Dennis Saleebey (1997) describes the frame of the strengths perspective in three basic concepts:

- Given the difficulties they have, and the known resources available to them, people are often doing amazingly well—the best they can at the time.
- People have survived to this point—certainly not without pain and struggle—through employing their will, their vision, their skills, and, as they have grappled with life, what they have learned about themselves and their world. We must understand these capacities and make alliance with this knowledge in order to help.
- Change can only come when you collaborate with client's aspirations, perceptions, and strengths, and when you firmly believe in them. (p. 49)

But these inspiring words are not easy to use as a guide, as my initial example hopefully demonstrated. To make them more than words, to translate them into practice, is a significant challenge. One of the most important steps in meeting this challenge is what Saleebey (1997) has referred to as "suspending disbelief" in the client's understandings, explanations, and desired outcomes. Unlike the advice of Hepworth and Larsen (1990), who caution the worker to "avoid the tendency to accept client's views, descriptions, and reports as valid representations of reality," the strengths perspective embraces the worldview of the client (p. 197). It is truly "starting where the client is" rather than "starting where the theory is." Duncan, Hubble, and Miller (1997) describe it this way:

> *We have learned to listen more, turn off the intervention spigot, stay still, and direct our attention to them [the client], recalling, as Ram Dass once said, "The quieter you become the more you will hear." The greater success we have experienced in doing this, the more room clients have had to be themselves, use their own resources, discover possibilities, attribute self-enhancing meanings to their actions, and take responsibility. (p. 207)*

But how do you shift such habits that seem part of our social understandings as well as the traditional doctrine of social work professionalism? I am speaking of a real shift in orientation or basic viewpoint rather than merely adding a component. This shift is similar to altering what Aaron Beck (1972) refers to as "automatic thoughts" in that our professional habits of the mind or frames occur without recognition on our part. Yet, these frames are the "lens" through which we interact with clients. It is this accustomed or habitual professional thinking that guides our perceptions, thinking, and understanding that must be "de-centered" as the cognitive therapist would say, or "externalized" in terms of its dominant traditional social work narrative as White and Epston (1990) refer to a similar process in narrative therapy.

Following the mode of cognitive therapy, we each would need to "distance" ourselves from the automatic thoughts. That is, in order to shift perspectives from our traditional medical model to a strengths perspective, it would be necessary to first recognize the frame and then to view our professional conceptualizations as "hypothesis" rather than "fact." This would permit dissociating oneself from the constructs we operate from and to examine them form a different point of view. We each would suspend our traditional professional constructs and look at the client from the perspective of strength and resilience. Working with students just entering into social work training has been very helpful in my own de-center-

ing process. Many students come with a "natural" affinity or bias for looking at what is wrong or broken and quickly set about to offer suggestions or answers for the "client" to follow. Together, we have explored the strengths perspective from within solution-based conversations held during class. In doing so, we have confronted our own assumptions or frames. The "clients" [actually students who are being interviewed in class and talking about real issues or challenges that they are dealing with at the time] reveal that they have been successful in addressing their issue in ways none of the members of the class or myself would have guessed or suspected. Being confronted with awareness of our own "automatic" perceptions and assumptions—mine being professional training and theirs the natural desire to do something—holds us back from listening to the issues as described by the client, and comes with a sense of uneasiness to all of us in the classroom. For all of us to develop trust in the experiences, we began to purposely eliminate any questions about background or about the problem. In its place, we went straight to the type of question often used by Berg (1994): If six months from now you were to believe strongly that our work together was successful or it had a made a difference, what would be different then that would let you of that success? In each case, with some clarification and the checking of our assumptions about the answers, a clearer and specific goal emerged that was something much different than anyone in the class would have suggested. Such goals were inclusive of support systems and reflected reasonable expectations and outcomes on the part of the "client." The steps that needed to be taken were likewise straightforward and specific. As a matter of fact, many times the client had actually accomplished the goals, what strengths/solution-oriented helpers think of as "exceptions," similar to White and Epston's (1990) narrative notion of "unique outcomes" or lived experiences that are outside the dominant story, not part of the problem-saturated talk. These are the alternative stories or outcomes that represent possibilities or strengths from which goals and change is possible. The results of our experiment left the students, the "client," and myself energized, hopeful, and surprised by what had happened time and time again.

It is often the simplest comment that goes unnoticed by my students and myself as we strain to "hear strengths" over the noise of "problems" being searched for by our minds. For example, in a video demonstrating Berg's (1995) work with a couple, my students are always caught up with the fact that the husband is not wearing a wedding ring. They always want to ask "Why?" and "How the wife must feel!" and, of course, the easy deduction that he is "having an affair." They are so caught up in "problem-saturated" thinking that they often miss the work that Insoo and the couple are doing together. The students are asked to speculate as to the outcome of the first interview. They have a hard time imagining anything productive happening. Some believe that the issue of the ring needs to be addressed, while some want to hear more about feelings and past histories. When the second interview is shown, Insoo herself is surprised by the turn of events when the couple returns two weeks later for the second interview. The couple have engaged in changes in their lives that neither Insoo nor my students could have conceived or suggested. The students missed the strengths, resilience, and unique outcomes possible when clients direct their own lives. It was those "extratherapeutic" factors, combined with Insoo's asking for directions, asking what the couple wanted different—that played out in the significant shift that emerged. It was the decisions of the couple, based in part on Insoo's clarification of the desired outcomes, that assisted the couple in making their own shifts. The problem, as presented initially by the couple, did little to predict the outcome. The fundamental point for the students was the challenge this process presented to their assumptions of something being broken and needing fixing. The same easily holds true for professionals and habitual ways of working.

Conclusion

The strengths perspective is an attitude and frame from which to engage those with whom we are working. It shifts our perspective from a worker-directed effort to a client-directed effort in collaboration with the client. Professional knowledge is about how to be available in a different way. That is, a way that exploits the strengths and resilience of the client.

For a professional practitioner to fully appreciate the implications of the strengths perspective, it is necessary that they engage in a personal analysis, just as if attempting to shift "automatic thoughts" or to engage "unique outcomes," as alternative narratives to the dominant professional perspective. It is only in the de-centering or recognition of the traditional frame that any shift can be made. For my students and myself, de-centering comes in the form of surprise and uneasiness. When the "client" is made the center of practice in a true sense, uncertainty and "not knowing" take center stage. A truly mutual/collaborative dialogue ensues, resulting in unique outcomes

unsuspected by the professional or the eager student. But, what always follows is a mistrust of our own experiences. It is the uncertainty, the not knowing, and maybe the unfamiliarity of relying on the client to take the lead in giving direction to the work to be done that is so uncomfortable. Isn't it the job of the social worker to "treat" the client with an intervention based upon empirically grounded expert knowledge about how lives are to lived as well as the unconscious motivations and defenses that must be understood and overcome? These expectations on the part of the professional's habit and the student's eagerness to help need to be challenged again and again until an actual shift in frame takes place and becomes an active part of a strengths-based practice. Once the frame is shifted, it is easier to then integrate the necessary and appropriate process demanded by agencies and funding sources, and more importantly, that will enhance the collaborative effort toward client-directed change.

The strengths perspective challenges our professional conventions, our habits of the mind. Thinking in terms of strengths and resilience confronts our Western European cultural tradition that assumes that "truth" is discovered only by looking at underlying and often hidden meanings, making causal links in some sequential order leading to the "cause" of it all. Challenging this cultural and linguistic tradition, as well as a process that has become synonymous with the social work profession, is a serious task that needs to be undertaken if social work is to embrace a belief in human resilience and strengths.

References

Beck, A. T. (1972). *Depression: Causes and treatment.* Philadelphia: University of Pennsylvania Press.

Berg, I. (1995). *Family based services: A solution-focused approach.* New York: W.W. Norton & Company.

Bergin, A. E., & Lambert, M. J. (1978). The evaluation of therapeutic outcomes. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (2nd ed.) (pp. 139–190). New York: Wiley.

Brill, N. I. (1998). *Working with people* (6th ed.). New York: Longman.

Duncan, B. L., Hubble, M. A., & Miller, S. D. (1997). *Psychology with "impossible" cases: The efficient treatment of therapy veterans.* New York: W.W. Norton.)

Goffman, I. (1974). *Frame analysis.* Cambridge, MA: Harvard University Press.

Goldstein, H. (1997). Victors or Victims? In D. Saleebey (Ed.), *The strengths perspective in social work practice* (2nd ed.). White Plains, NY: Longman.

Hollis, F. (1964). *Casework: A psychosocial therapy.* New York: Random House.

Hepworth, D. H. (1993). Managing manipulative behavior in the helping relationship. *Social Work, 38,* 674–682.

Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999). *The heart and soul of change: What works in therapy.* Washington, DC: American Psychological Association.

Lambert, M. J. (1992). Psychotherapy outcome research. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94–129). New York: Basic Books.

Lambert, M. J., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed.) (pp. 143–189). New York: Wiley.

Lubove, R. (1965). *The professional altruist: The emergence of social work as a career.* Cambridge, MA: Harvard University Press.

Margolin, L. (1997). *Under the cover of kindness: The invention of social work.* Charlottesville, VA: University Press of Virginia.

Miley, K. K., O'Melia, M., & DuBois, B. (1998). *Generalist social work practice: An empowerment approach* (3rd ed.). Boston: Allyn and Bacon.

Perlman, H. H. (1957). *Social casework: A problem-solving process.* Chicago: The University of Chicago Press.

Rapp, C. A. (1998). *The strengths model: Case management with people suffering from severe and persistent mental illness.* New York: Oxford Press.

Richmond, M. E. (1917). *Social diagnosis.* New York: Russell Sage Foundation.

Robinson, V. A. (1930). *A changing psychology in social case work.* Chapel Hill, NC: The University of North Carolina Press.

Saleebey, D. (1997). The strengths approach to practice. In D. Saleebey, (Ed.), *The strengths perspective in social work practice* (2nd ed.). White Plains, NY: Longman.

Sheafor, B. W., Horejsi, C. R., & Horejsi, G. A. (2000). *Techniques and guidelines for social work practice* (5th ed.). Boston: Allyn and Bacon.

Specht, H. & Courtney, M. (1994). *Unfaithful angels: How social work has abandoned its mission.* New York: Free Press.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends.* New York: W.W. Norton & Company.

***Robert Blundo** is associate professor, Department of Social Work, University of North Carolina–Wilmington, 601 S. College Road, Wilmington, NC 28403; e-mail: blundor@uncwil.edu.*

Original manuscript received: June 28, 2000
Revised: October 4, 2000
Accepted: October 4, 2000