FIS

Contextual Meanings of the Strengths Perspective for Social Work Practice in Mental Health

Barbara Probst

ABSTRACT

Although the strengths perspective seems a natural framework for social workers practicing in mental health, it often plays a minor role in planning and evaluation. Two issues complicate its use: (a) The concept of strengths has different meanings and functions, depending on whether viewed as part of assessment, intervention, or outcome, and (b) the strengths perspective is an applied concept operating only through the medium of a specific intervention, not a modality whose efficacy can be independently evaluated. When these factors are ignored, the role of the strengths perspective can seem vague, peripheral, too obvious and "soft" to be a serious component of the change process—yet, understood in context, it is an essential element of social work's unique approach.

The strengths perspective, first articulated by Dennis Saleebey and colleagues in the 1990s, is in many ways the natural expression of a uniquely American optimism and idealism—a belief in self-improvement, self-reinvention, pioneerism, and the power of positive thinking (Saleebey, 2005). Its roots can be found in populism, unionism, suffragism, settlement houses, and immigrant mutual aid societies (McMillen, Morris, & Sherraden, 2004), manifestations of a cultural emphasis on capacity rather than obstacles or limitations. It also emanates from the long history of European humanism, with its focus on meaning rather than measurement (Goldstein, 1990) and its principles of individual self-determination, personal fulfillment, and the dignity and worth of all people. As Saleebey (1996) makes clear, the strengths perspective is not an explanatory theory or a specific methodology, but a fundamental orientation toward hope, healing, purpose, and meaning that can be applied to a range of interventions.

Given the appeal of this approach, it is surprising that the strengths perspective does not have a more central place in social work practice in mental health. This is largely due to the dominance of the problem-based *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), published by the American Psychiatric Association. By shaping the way emotional, social, and behavioral difficulties are defined, the *DSM* has determined not only the "answers," but also the kinds of questions that are asked and even the language with which they are asked—a language of disorders, symptoms, and treatments. Social workers, who provide more therapeutic services to those defined as mentally disordered than any other group of professionals (Kirk, 2005) and thus rely on the *DSM* at least as much as members of other helping professions, have tended to be ambivalent about its role. On the one hand, the *DSM* has provided legitimacy and status, enabling social workers to serve as therapists, while on the other hand, its emphasis on pathology runs counter to fundamental social work values.

This ambivalence has a long history. Two decades ago, Kutchins and Kirk (1988) conducted a national survey of social workers to discover the extent to which they used the *DSM* (at that time, *DSM–III*) and their reasons for its use. Half the respondents thought the *DSM* did *not* serve the purposes of clinical social work, only a third found it helpful in treatment planning, and another third believed it actually led to inappropriate treatment. Reasons for use had to do with insurance reimbursement and agency requirements, but little to do with clinical utility, especially from the orientation of person-in-environment. Hsieh and Kirk's 2005 study supports this view: Their survey of 3,000 mental health professionals found that *DSM* criteria, considered independently of context, could not validly differentiate mental disorders (pathological in origin) from problems in living (adaptive responses to a problematic environment). Numerous other articles have been written (Maddux, 2005; Wakefield, 2005; among others) detailing the flaws, biases, omissions, and lack of validity of *DSM* categories and criteria. Additional research suggests that many people do not utilize mental health services because of the stigma that accompanies pejorative labels (Corrigan, 2007). Most important, perhaps, is the *DSM*'s lack of commentary on the causes of disorders, making it hard to connect symptoms to treatments (Saleebey, 2001).

In light of these and other problems, the strengths perspective would seem to offer a natural alternative framework for social workers focusing on mental health. Yet the strengths perspective presents its own issues and challenges. Because these issues are often unarticulated, they complicate the use of a strengths orientation in actual practice. Two key issues are:

1. Multiple meanings, dependent on timing—The concept of *strength* has different meanings, depending on the point in the helping process in which it is viewed. In assessment, a *strength* represents an existing asset; during the course of an intervention, it provides the means through which the client participates; and in evaluation, an increase in a particular strength serves as evidence of change. Clinicians who are unclear about which construct they reference may have difficulty communicating with one another or with clients (or may mistakenly assume they *are* communicating).
2. Multiple meanings, dependent on context—The strengths perspective is fundamentally an applied concept that can operate only through

the medium of a specific intervention, not a distinct modality whose efficacy can be independently evaluated. This is also often misunderstood, resulting in confusing and fruitless debates about whether there is empirical evidence for the utility of the strengths perspective per se (e.g., Staudt, Howard, & Drake, 2001)

When these issues are not taken into account, the role of the strengths perspective can seem vague and peripheral—too obvious and "soft" to be a serious component of the process of change or part of a discipline subject to true academic scrutiny—yet the role of the strengths perspective can emerge as even *more* central to the therapeutic process when it is studied with greater precision. Examining its use and meaning at different points in the clinical process, and in relation to different modes of intervention, can shed light on its contribution to the process of change.

To explore how the strengths perspective functions in action and in context (i.e., how it is utilized by social workers in mental health settings), this article will examine (a) the role of strengths in assessment, (b) the relationship of strengths to change, and (c) structures and supports for utilizing a strengths-based approach. While these topics are addressed separately, they are intertwined in both practice and research. This is because a clinician's orientation toward assessment and the assessment tools used, as well as the context in which both assessment and treatment are carried out, have an impact on outcome.

The Role of Strengths in Assessment

Numerous articles have been written about the limitations of assessment, based primarily on identification of problems. Concentrating on deficits during assessment can lead to self-fulfilling prophecies when the client and/or social worker accept a view of the client as broken or deficient (Cowger, 1994) and diagnosis becomes the cornerstone of identity (Graybeal, 2001; Saleebey, 1996; among others). Reinforcing competence, on the other hand, "mitigates the significance of unequal power between the client and social worker and, in so doing, presents increased potential for liberating people from stigmatizing diagnostic classifications" (Cowger, 1994, p. 265).

Cowger (1994) proposes 12 guidelines for strengths-based assessment, though he is careful to note that these guidelines do not capture all the assessment content that might be needed—including, at times, information about problems and dysfunctions. Rather than providing an exhaustive template, the guidelines are meant to engage the client in the process of strengths-based assessment, which is "the measurement of those emotional and behavioral skills, competencies, and characteristics that create a sense of personal accomplishment; contribute to satisfying relationships with family members, peers, and adults; enhance one's ability to deal with adversity and stress; and promote one's personal, social, and academic development" (Epstein & Sharma, as cited in Tedeschi & Kilmer, 2005, p. 230).

When working with children, assessing strengths as well as problems has additional benefits. It gives parents a more holistic, balanced, optimistic view of their children, which in turn fosters communication and trust between parents and social worker (Tedeschi & Kilmer, 2005). Highlighting strengths also serves to establish positive expectations, document progress in specific areas, and convey the message that adults do not see the child as globally defective or hopeless (Rudolph & Epstein, 2000).

Assessment of Resilience

Some writers, finding the notion of strengths difficult to operationalize, have focused on *resilience*, considering resilience to be strengths put into action. Resilience is viewed not as a trait but as the dynamic interplay between adversity and a variety of assets that can mediate the risk produced by the adverse situation (Norman, 2000). Because resilience is dynamic and an individual's ability to make use of potential strengths varies from situation to situation, it cannot be assessed outside of a specific context (McQuaide & Ehrenreich, 1997). To an extent, resilience can be determined only retrospectively, because its existence is demonstrated by an individual's success in overcoming odds, sustaining competence in the face of stress, or recovering from trauma.

Most authors agree that resilience consists of three clusters of variables or protective factors: (a) individual factors including dispositional or inborn attributes such as temperament, intelligence, optimism, and self-efficacy; (b) family factors such as a stable, nurturant family milieu; and (c) community factors such as a supportive social environment with resources, positive role models, and high expectations (Benard, 2006; Tedeschi & Kilmer, 2005). It is not clear, however, whether the same elements protect against initial harm, promote development, and foster recovery from adversity—that is, whether aspects of resiliency are task-specific. Aspects may also be tied to developmental stage, with certain features becoming more salient at certain times.

Though related, the terms *resilience* and *strength* are not interchangeable; resilience represents a response to events, and strengths are a set of capacities, whether or not they are actualized in a given situation. Clearly, there are strengths, such as a nurturing family or leadership skills, which do not depend on response to an adverse situation and may be accessed proactively. Resilience may thus be viewed as a type of strength. To understand strengths *in action*, however, we need to ask questions beyond whether or not a feature is present—e.g., if the same element can serve as a strength in one context and a weakness in another, on what this difference depends, and how strengths interact with one another and with aspects of vulnerability. As McQuaide and Ehrenreich (1997) point out, what ultimately matters to an individual is having a varied repertoire of strengths and being able to choose flexibly and appropriately among them.

Tools and Protocols

Suggestions for incorporating strengths into assessment have included development of strengths-based tools and protocols as well as proposals for altering or expanding the *DSM*. Some models were developed for specific research purposes or for use in service planning with specific populations, while others aim for a wider use. Each employs its own categories. Graybeal (2001), for instance, organizes strengths-based assessment into resources, options, possibilities, exceptions, and solutions. McQuaide and Ehrenreich (1997) propose categories of cognitive skills, coping mechanisms, temperamental factors, interpersonal skills and supports, and external resources.

Most of the protocols developed for children assess both strengths and problems—e.g., the Child and Adolescent Needs and Strengths-Mental Health (CANS-MH) Scale (Anderson, Lyons, Giles, Price, & Estle, 2003)—although few scales were designed specifically to address competencies. The Behavioral and Emotional Rating Scale (BERS), developed by Epstein and Sharma in 1998, is one such example. The BERS, a 52-item Likert scale designed to assess emotional and behavioral functioning in children ages 5 to 18, yields norm-referenced standard scores and a global strength quotient for children diagnosed with behavioral disorders as well as nondiagnosed children. It considers interpersonal and intrapersonal strengths such as adaptability, leadership, peer social skills, behavioral control, task orientation, family involvement, and school functioning. Highlighting strengths is seen as a way to involve families in service planning, increase motivation, identify skills that can

be utilized during the intervention, and document progress (Cox, 2006).

To examine the impact of the BERS on treatment planning and outcome, Cox (2006) undertook an experimental study of 84 children, all of whom had at least one mental health diagnosis. She found that children receiving the BERS assessment have significantly better outcomes than children receiving the usual *DSM* assessment, but *only when the treating therapist reported a strengths-based orientation*. A related study conducted by Donovan and Nickerson (2007) examined how adding strengths-based data to traditional data impacts perceptions of mental health team members. Team members receiving the combined report, which included BERS scores, predicted more positive academic, social, and overall outcomes than respondents receiving only traditional data. Similarly, Oswald, Cohen, Best, Jenson, and Lyons (2001) looked at 270 children to determine how assessment of strengths, as well as assessment of psychiatric symptoms, contributes to decisions about intensity of service. They found an orderly relationship between strengths and level of placement, even after accounting for the effects of age, race, and level of risk, demonstrating the importance of strengths as a significant variable in clinical decision making.

Expansion of the DSM

There have been numerous suggestions, from proponents of positive psychology as well as from social workers, for incorporating additional dimensions into the diagnostic process (e.g., Cowger, 1994; Graybeal, 2001; Keyes & Lopez, 2005). Proposals fall into four general categories: continuum models (an alternative to the current yes/no categorical system), developmental models, models for distinguishing mental disorder from adaptive response, and suggestions for additional or expanded diagnostic axes. Wright and Lopez (2005), for instance, propose a four-front approach: deficiencies and undermining characteristics of the person, strengths and assets of the person, lacks and destructive factors in the environment, and resources and opportunities in the environment. Strengths thus need to be identified, not only in the individual, but also in the social context—in family, group (whether naturally occurring or formed as part of the intervention), and/or the wider community (Swenson, 2006).

The Relationship of Strengths to Change

Most authors agree that strengths play a role in assessment, but there is still debate about the contribution—if any—of the strengths perspective to treatment outcome. Although it makes intuitive sense that highlighting strengths would foster positive results, establishing a direct connection is tricky. Some authors believe there *is* no connection. In their review of empirical studies, Staudt et al. (2001) conclude that the strengths perspective is little more than a value stance, lacking empirical support for either its uniqueness or its efficacy. They argue that its directives have not been adequately operationalized or measured and that, even in cases where it *does* appear to be linked to positive outcome, it is not possible to determine whether those outcomes are due to specific "strengths-based" methods or simply to the provision of extra services.

However, as noted, assessing the empirical value of a "strengths approach" is not so straightforward. The strengths perspective is an orientation, not a methodology, and thus needs to operate through the medium of a method, intervention, therapy, or service. The intervention can be viewed as a *mediating* variable, the link that connects the strengths perspective to a particular client and actualizes it—and without which the notion of strengths cannot have an impact. Alternatively, the strengths perspective can be seen as a *moderating* variable, affecting the way a treatment is delivered. Since a strengths perspective can be attached to any methodology and any methodology can thus be an expression of a strengths approach, it makes no sense to examine the efficacy of the strengths approach itself as if it were an independent variable.

The question, therefore, is not whether there is (or can be) empirical evidence that the strengths perspective "works," but what its precise role might be in the process of change—depending on which definition of strengths is employed and to which point in the process it corresponds. During assessment, strengths can be defined as the skills, personal attributes, resources, and other positive features already present in the client's life, whether active or latent. As noted, identifying strengths during assessment provides a more complete picture as well as stimulating hope, confidence, empowerment, and collaboration. Then, during intervention, strengths can play a dual role. For the clinician, the strengths perspective shapes the way a particular methodology, such as cognitive-behavioral therapy, is employed. For the client, strengths relates to self-efficacy, providing tools and pathways for participation as an active agent instead of being a passive recipient of a "treatment." Finally, during evaluation, strengths are seen as results—the new or augmented capacities made possible by the intervention. Thus, an increase in one or more strengths is a way to determine if change has taken place.

As noted previously, when the concept of resiliency is used as a proxy for strengths, the evidence seems clearer that assets *can* be linked to outcome. Norman (2000), summarizing the research literature on factors contributing to resiliency, identifies eight personality features and three environmental or interpersonal factors that numerous studies have shown to be associated with positive outcomes. The wealth of empirical studies cited in Norman's article as well as others (e.g., Benard, 2006) seems to contradict Staudt et al.'s (2001) assertion that a strengths perspective has no discernable impact.

Contextual Structures and Supports

No "perspective" can lead to action, however, without a supportive context. In examining whether (and if so, how) the strengths perspective can play a more explicit role in mental health practice, the overarching question is this: Is there a nurturing environment that can support a shift from a deficit-based to a strengths-based approach?

Writing in 1996, Saleebey didn't think so: "The system—the bureaucracies and organizations of helping—is often diametrically opposed to a strengths orientation" (p. 297). Service venues, policies, and programs, in the procedures followed and the language used, endorsed a problem or weakness perspective. A decade later, in 2006, Saleebey was more optimistic, pointing to the rapid development in practice approaches that bear a striking resemblance to the strengths perspective—e.g., the recovery movement, positive psychology, solution-focused therapy, asset-based community development, and prevention. Benard (2006) also mentions youth development, restorative justice, and systems of care as practices that resonate with the strengths approach. Emphasizing protective factors, resources, renewal, hope, empowerment, and wholeness, these models rely on a positive framework rather than focusing on what is wrong, broken, or lacking.

Federal Policy

At the broadest level, support for a strengths-based approach comes from the New Freedom Commission on Mental Health, created by the federal government in 2002 and culminating in its 2003 report *Achieving the Promise: Transforming Mental Health Care in America*. A sweeping set of recommendations, the Commission report states that

the goal of a transformed mental health system is recovery: "Care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience, not just on managing symptoms" (p. 5). A strengths perspective is embedded in the very language of the report—e.g., use of the word "consumer" rather than "patient," and the emphasis on recovery and resilience rather than stabilization (Goal 5.1).

To put large-scale recommendations into action is a long-term, multistep endeavor that involves transforming the insurance and health care delivery systems as well as training mental health professionals. Structural changes need to take place to address the major obstacles, outlined in the Commission's report, of stigmatization, unequal access to services, and a fragmented mental health service delivery system. These obstacles are results of a traditional system that has promulgated treatment approaches and definitions of illness that diminish resiliency and self-determination (Oswald, 2006). The call for reorientation toward recovery is, in essence, a response to the failure of the present system.

Overall, emerging trends in mental health care do seem to point to a growing context for implementation of a strengths perspective. These trends include the recovery movement, systems of care and multisystemic treatment, and prevention and resiliency research.

The Recovery Movement

The recovery movement grew out of the rehabilitative, case management approach developed in the 1970s—itself both a reflection and a result of the shift from an institution-based framework to a community-integration framework of mental health care (Davidson et al., 2006). It shares many themes with the strengths perspective, such as (a) building a healthy identity—not allowing problems to take on "master status," but instead viewing talents, skills, competencies, hopes, interests, and dreams as equally fundamental to self-definition; (b) mobilizing and maximizing assets and natural support systems *already present* in the individual, family, and community; and (c) fostering connectedness, membership, and participation.

Systems of Care and Multisystemic Treatment

Emphasizing the use of family strengths as levers for change, the systems of care, or SOC, approach recommends reframing and employing nonpejorative language with clients and among treatment team members; seeking and acknowledging evidence of client effort and improvement; maintaining a solution-focused stance, calling on what has worked in the past as well as expanding a family's repertoire; and utilizing natural supports at all levels, including family relationships, peers, school, neighborhood, and community (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998).

Recent SOC research includes efforts to develop a typology of strengths with the aim of tying strengths to needs. One such study, a longitudinal case study of the Tampa Hillsborough Integrated Network for Kids, identified seven types of strength to be used for assessment and planning: child or family talents, resiliency factors, possibilities, family and SOC team resources, borrowed strengths, past or historical strengths, and hidden strengths (Davis, Mayo, Sikand, Kobres, & Dollard, 2007). The notion of hidden strengths may provide an especially powerful tool for tapping into underutilized potential.

Prevention and Resiliency Research

Considerable research has also been done in the area of developmental resilience. Studies have consistently documented that the vast majority of children, even those considered to have the most risks and to live in the most resource-deprived environments, manage to achieve good developmental outcomes (Benard, 2006). A longitudinal study in Hawaii, begun in 1955 and lasting over three decades, found that more than three fourths of the children evaluated to be at significant risk still develop into caring, competent, and confident adults by age 32 (Saleebey, 1996). Research has also identified variables that foster resilience—coming from multiple contextual levels of individual, family, and community—and including individual attributes such as temperament and intellectual capacity; a nurturing family environment with persistent caring relationships; and community factors such as high expectation messages and models as well as opportunities for participation and contribution (Benard; Norman, 2000; Tedeschi & Kilmer, 2005).

Similarly, recent prevention literature—unlike early studies that focused solely on predictors or risk factors—has examined protective and promotive factors. Normative models for the development of prosocial behavior are being generated in order to understand the effects of factors that might interrupt or undermine the natural course of healthy development (Hawkins, 2006). These and other trends, supported by federal policy articulated in the New Freedom Commission on Mental Health report, seem to indicate an overall movement toward creation of a "nurturing environment" that can foster strengths-based practice.

Implications

As research begins to build a knowledge base about resilience, prevention, and asset-based family and community development—that is, about the strengths perspective *in action*—a new opportunity may emerge for social work to identify its unique and appropriate turf. If psychiatry is concerned with identifying and understanding problems, then social work can be concerned with identifying and understanding strengths. Social workers can thus develop a science of mental *wellness*, rather than vie for expertise in addressing issues of mental *illness*, and then apply this knowledge to both policy (through advocacy) and direct practice (through incorporating strengths-based assessment tools and strengths-based treatment strategies). In addition, because social workers view human behavior in a social and cultural context, they can expand and deepen our understanding of strengths, situating strengths in culturally relevant frameworks.

If there is an emerging paradigm in social work, of course, it is the notion of evidence-based practice (EBP). While the strengths movement and EBP share an important common feature of being consumer-driven, stressing client choice in selection of both goals and means (Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005), the two approaches are quite different. Thus far, EBP has been concerned with identifying effective methods of symptom reduction, making it fundamentally problem based. Research is also needed to identify "what works" with respect to increasing hope and empowerment (Oswald, 2006). If EBP can be extended—redefining efficacy to include outcomes that have to do with renewal, mobilization of talents, and movement toward self-realization—the two approaches can reinforce each other. It might be most productive to pair the strengths perspective with evidence-based methodology in order to discover which strengths, under what circumstances, at what point in treatment, and at which developmental stages contribute to mental health. It may turn out that strengths and disorders have specific relationships. Rather than constituting two separate lists, assets and symptoms may have "cross-over" relationships that can shed light on treatment decisions based on knowledge about which strengths are useful for addressing which kinds of problems.

Thus, instead of continuing to argue about whether the strengths perspective is a "real theory," has been sufficiently operationalized, or can be empirically tested, it may be more fruitful to examine how it can be used in various applications and at various points in practice. Research is needed in a number of areas:

- Conceptualizing strengths, not simply compiling lists
- Understanding the action of strengths at different points in the helping process
- Situating strengths in developmental and cultural context
- Understanding how specific strengths can be useful for addressing specific issues.

Research of this nature could play an important role in defining social work's unique approach to helping individuals and families—linking inner and outer assets to evidence for "what works" in addressing stressors and disorders, while preserving social work's fundamental belief that people cannot be defined by what is "wrong" with them. At the same time, this can provide opportunity for fruitful collaboration with psychologists, counselors, humanists, and epistemologists, and can provide a means of expanded inquiry for social work educators and students. By furthering our understanding of "what goes right" in human lives, all will benefit.

References

Anderson, R. L., Lyons, J. S., Giles, D. M., Price, J. A., & Estle, G. (2003). Reliability of the Child and Adolescent Needs and Strengths–Mental Health (CANS–MG) scale. *Journal of Child and Family Studies, 12*(3), 279–289.

Benard, B. (2006). Using strength-based practice to tap the resilience of families. In D. Saleebey (Ed.), *The strengths perspective in social work practice* (4th ed., pp. 197–220). Boston: Pearson.

Corrigan, P. W. (2007). How clinical diagnosis might exacerbate the stigma of mental illness. *Social Work, 52(*1), 31–39.

Cowger, C. D. (1994). Assessing client strengths: Clinical assessment for client empowerment. *Social Work, 39*(3), 262–268.

Cox, K. F. (2006). Investigating the impact of strength-based assessment on youth with emotional or behavioral disorders. *Journal of Child and Family Studies, 15*(3), 287–301.

Davidson, L., Tondora, J., Staeheli, M., O'Connell, M., Frey, J., & Chinman, M. J. (2006). Recovery guides: An emerging model of community-based care for adults with psychiatric disabilities. In A. Lightburn & P. Sessions (Eds.), *Handbook of community-based clinical practice* (pp. 476-501). New York: Oxford University Press.

Davis, C. S., Mayo, J., Sikand, K., Kobres, M., & Dollard, N. (2007). A typology and narrative illustration of procedures for following a strengths-based approach in a children's community mental health system of care. In *A system of care for children's mental health: Expanding the research base, 19th annual proceedings* (pp. 89–97). Research and Training Center for Children's Mental Health. Tampa, FL: University of South Florida Press.

Donovan, S. A., & Nickerson, A. B. (2007). Strength-based versus traditional social-emotional reports: Impact on multidisciplinary team members' perceptions. *Behavioral Disorders, 32*(4), 228–237.

Goldstein, H. (1990). Strength or pathology: Ethical and rhetorical contrasts in approaches to practice. *Families in Society: The Journal of Contemporary Human Services, 71*(5), 267–275.

Graybeal, C. (2001). Strength-based social work assessment: Transforming the dominant paradigm. *Families in Society: The Journal of Contemporary Human Services, 82*(3), 233–243.

Hawkins, S. D. (2006). Science, social work, prevention: Finding the intersections. *Social Work, 30*(3), 137–152.

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents.* New York: Guilford Press.

Hsieh, D. K., & Kirk, S. A. (2005). The limits of diagnostic criteria: The role of social context in clinicians' judgments of mental disorder. In S. A. Kirk (Ed.), *Mental disorders in the social environment: Critical perspectives* (pp. 4561). New York: Columbia University Press.

Keyes, C. L. M., & Lopez, S. J. (2005). Toward a science of mental health: Positive directions in diagnosis and interventions. In C. R. Snyder & S. J. Lopez (Eds.), *The handbook of positive psychology* (pp. 45–59). New York: Oxford University Press.

Kirk, S. A. (2005). Introduction: Critical perspectives. In S. A. Kirk (Ed.), *Mental disorders in the social environment: Critical perspectives* (pp. 1-19). New York: Columbia University Press.

Kutchins, H., & Kirk, S. A. (1988). The business of diagnosis: DSM–III and clinical social work. *Social Work, 33*(4), 215–220.

Maddux, J. E. (2005). Stopping the "madness": Positive psychology and the deconstruction of the illness ideology and the DSM. In C. R. Snyder & S. J. Lopez (Eds.), *The handbook of positive psychology* (pp. 13–25). New York: Oxford University Press.

McMillen, J. C., Morris, L., & Sherraden, M. (2004). Ending social work's grudge match: Problems versus strengths. *Families in Society: The Journal of Contemporary Social Services, 83*(3), 317–325.

McQuaide, S., & Ehrenreich, J. H. (1997). Assessing client strengths. *Families in Society: The Journal of Contemporary Human Services, 78*(2), 201–212.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America, final report* (DHHS Pub No. SMA-03-3832). Rockville, MD: Author.

Norman, E. (2000). Introduction: The strengths perspective and resiliency enhancement, a natural partnership. In E. Norman (Ed.), *Resiliency enhancement: Putting the strengths perspective into social work practice* (pp. 1–16). New York: Columbia University Press.

Oswald, D. P. (2006). Recovery and child mental health services. *Journal of Child and Family Studies, 15*, 525–527.

Oswald, D. P., Cohen, R., Best, A. M., Jenson, C. E., & Lyons, J. S. (2001). Child strengths and the level of care for children with emotional and behavioral disorders. *Journal of Emotional and Behavioral Disorders, 9*(3), 192–199.

Rudolph, S. M., & Epstein, M. H. (2000). Empowering children and families through strength-based assessment. *Reclaiming Children and Youth, 8*(4), 207–209.

Saleebey, D. (1996). The strengths perspective in social work practice: Extensions and cautions. *Social Work, 41*(3), 296–305.

Saleebey, D. (2001). The diagnostic strengths manual? *Social Work, 46*(2), 183–187.

Saleebey, D. (2005). Balancing act: Assessing strengths in mental health practice. In S. A. Kirk (Ed.), *Mental disorders in the social environment: Critical perspectives* (pp. 23–44). New York: Columbia University Press.

Saleebey, D. (2006). The strengths perspective: Possibilities and problems. In D. Saleebey (Ed.), *Strengths perspective in social work practice* (4th ed., pp. 279–303). Boston: Allyn & Bacon.

Staudt, M., Howard, M. O., & Drake, B. (2001). The operationalization, implementation, and effectiveness of the strengths perspective: A review of empirical studies. *Journal of Social Service Research, 27*(3), 1–21.

Swenson, C. R. (2006). Ideas of self and community: Expanding possibilities for practice. In A. Lightburn & P. Sessions (Eds.), *Handbook of community-based clinical practice* (pp. 63–74). New York: Oxford University Press.

Tedeschi, R. G., & Kilmer, R. P. (2005). Assessing strengths, resilience, and growth to guide clinical interventions. *Professional Psychology: Research and Practice, 36*(3), 230–237.

Torrey, W. C., Rapp, C. A., Van Tosh, L., McNabb, C. R. A., & Ralph, R. O. (2005). Recovery principles and evidence-based practice: Essential ingredients of service improvement. *Community Mental Health Journal, 41*(1), 91–100.

Wakefield, J. C. (2005). Disorders versus problems of living in DSM: Rethinking social work's relationship to psychiatry. In S. A. Kirk (Ed.), *Mental disorders in the social environment: Critical perspectives* (pp. 83–95). New York: Columbia University Press.

Wright, B. A., & Lopez, S. J. (2005). Widening the diagnostic focus: A case for including human strengths and environmental resources. In C. R. Snyder & S. J. Lopez (Eds.), *The handbook of positive psychology* (pp. 26–44). New York: Oxford University Press

Barbara Probst, MSW, LCSW, is adjunct professor, Graduate School of Social Service, Fordham University. Correspondence can be sent to the author at barbprobst@aol.com or Graduate School of Social Service, Fordham University, 113 West 60th Street, 7th floor, New York NY 10023.

Manuscript received: January 4, 2008
Revised: April 15, 2008
Accepted: April 24, 2008