The Strengths Perspective in Social Work Practice: Extensions and Cautions

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The strengths perspective in social work practice continues to develop conceptually. The strengths-based approach to case management with people with severe mental illness is well established. More recently, there have been developments in strengths-based practice with other client groups and the emergence of strengths orientations in work with communities. To augment these developments, converging lines of thinking, research, and practice in areas such as developmental resilience, healing and wellness, and constructionist narrative and story have provided interesting supports and challenges to the strengths perspective. This article reviews some current thinking and research about using a strengths orientation and assesses conceptual endorsements and criticisms of the strengths perspective.

Key words: *empowerment; health; resilience; social work practice; wellness*

Over the past few years, a strengths-based approach to case management with people with severe mental illness has emerged (Saleebey, 1992; Sullivan & Rapp, 1994; Weick, Rapp, Sullivan, & Kisthardt, 1989). More recently, the profession has developed strengths-based practice with other client groups—elderly people, youths in trouble, people with addictions, even communities and schools (Chamberlain & Rapp, 1991; Kretzmann & McKnight, 1993; Miller & Berg, 1995; Parsons & Cox, 1994). In addition, ongoing research, thinking, and practice in areas such as developmental resilience, healing and wellness, and constructionist narrative and story have provided some interesting supports and challenges to the strengths perspective. This article briefly outlines some of the principles and lexicon of the strengths orientation and addresses some emergent and supportive ideas in other disciplines and professions to re-examine some elements of social work theory and practice.

In part the impetus for the evolution of a more strengths-based view of social work practice comes from the awareness that U.S. culture and helping professions are saturated with psychosocial approaches based on individual, family, and community pathology, deficits, problems, abnormality, victimization, and disorder. A conglomeration of businesses, professions, institutions, and individuals—from medicine to the pharmaceutical industry, from the insurance industry to the media—assure the nation that everyone has a storehouse of vulnerabilities born of toxic experiences (usually occurring earlier in life) that put him or her at risk of everything from sex addiction to borderline personality disorder (Kaminer,

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1993; Peele, 1989; Peele & Brodsky, 1991; Rieff, 1991).

The DSM-IV (American Psychiatric Association, 1994), although only seven years removed from its predecessor, has twice the volume of text on disorders. Victimhood has become big business as many adults, prodded by a variety of therapists, gurus, and ministers, go on the hunt for wounded inner children and the poisonous ecology of their family background. These phenomena are not unlike a social movement or evangelism.

Practicing from a strengths perspective does not require social workers to ignore the real troubles that dog individuals and groups. Schizophrenia is real. Child sexual abuse is real. Pancreatic cancer is real. Violence is real. But in the lexicon of strengths, it is as wrong to deny the possible as it is to deny the problem. The strengths perspective does not deny the grip and thrall of addictions and how they can morally and physically sink the spirit and possibility of any individual. But it does deny the overweening reign of psychopathology as civic, moral, and medical categorical imperative. It does deny that most people are victims of abuse or of their own rampant appetites. It denies that all people who face trauma and pain in their lives inevitably are wounded or incapacitated or become less than they might. It decries the fact that the so-called recovery movement, now so far beyond its original intended boundaries, has

> pumped out a host of illnesses and addictions that were by earlier standards, mere habits, some good, some bad. Everywhere in public we find people talking freely, if not excitedly, even proudly, about their compulsions—whether it be gambling, sex, shopping, exercise, or the horrible desire to please other people. We are awash in a sea of codependency, wounded inner children, and intimacy crises. (Wolin & Wolin, 1993, p.7)

To exemplify, in a homely way, this cultural obsession with pathology, a few notes and numbers culled from the media and professional sources follow:

- Eighty million Americans are codependent (Kaminer, 1993).
- Twenty million Americans are gambling addicts (Peele, 1989).
- Ninety-six percent of all families are dysfunctional (Rieff, 1991).
- Since 1990, there has been a 300 percent increase in claims filed with the Prudential Insurance Company for multiple personality disorder (Harper's Index, 1993).
- There is a 3 in 5 chance that if you go to a physician you will be put on a regimen of medication (Harper's Index, 1992).

The appreciations and understandings of the strengths perspective are an attempt to correct this overwrought and, in some instances, destructive emphasis on what is wrong, what is missing, and what is abnormal.

Elements of the Strengths Perspective

The strengths perspective demands a different way of looking at individuals, families, and communities. All must be seen in the light of their capacities, talents, competencies, possibilities, visions, values, and hopes, however dashed and distorted these may have become through circumstance, oppression, and trauma. The strengths approach requires an accounting of what people know and what they can do, however inchoate that may sometimes seem. It requires composing a roster of resources existing within and around the individual, family, or community.

It takes courage and diligence on the part of social workers to regard professional work through this different lens. Such a "re-vision" demands that they suspend initial disbelief in clients. Too often practitioners are unprepared to hear and believe what clients tell them, what their particular stories might be (Lee, 1994), especially if they have engaged in abusive, destructive, addictive, or immoral behavior.

It is also important in rediscovering the wholeness of clients to recognize that the system—the bureaucracies and organizations of helping—is often diametrically opposed to a strengths orientation. In both formal and informal venues and structures, policies, and programs, the preferred language replaces the clients' own lexicon with the vocabulary of problem and disease (Goldstein, 1990; Saleebey, 1992). Finally, the professional language and the metaphorical devices social workers use to understand and help sometimes subvert the possibility of understanding clients in the light of their capacities. Pursuing a practice based on the ideas of resilience, rebound, possibility, and transformation is difficult because, oddly enough, it is not natural to the world of helping and service. Table 1 contrasts the

Table 1

Comparison of Pathology and Strengths

Pathology	Strengths
Person is defined as a "case"; symptoms add up to a diagnosis.	Person is defined as unique; traits, talents, resources add up to strengths.
Therapy is problem focused.	Therapy is possibility focused.
Personal accounts aid in the evocation of a diagnosis through reinterpretation by an expert.	Personal accounts are the essential route to knowing and appreciating the person.
Practitioner is skeptical of personal stories, rationalizations.	Practitioner knows the person from the inside out.
Childhood trauma is the precursor or predictor of adult pathology.	Childhood trauma is not predictive; it may weaken or strengthen the individual.
Centerpiece of therapeutic work is the treatment plan devised by practitioner.	Centerpiece of work is the aspirations of family, individual, or community.
Practitioner is the expert on clients' lives.	Individuals, family, or community are the experts.
Possibilities for choice, control, commitment, and personal development are limited by pathology.	Possibilities for choice, control, commitment, and personal development are open.
Resources for work are the knowledge and skills of the professional.	Resources for work are the strengths, capacities, and adaptive skills of the individual, family, or community.
Help is centered on reducing the effects of symptoms and the negative personal and social consequences of actions, emotions, thoughts, or relationships.	Help is centered on getting on with one's life, affirming and developing values and commitments, and making and finding membership in or as a community.

strengths approach with conventional pathology-based approaches.

Language

"We can act," wrote William James (1902) in reflecting on 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 make a genuine difference in our moral life" [italics added] (p. 55). But, as Joseph Conrad (1900) knew, words can harbor danger as well: "There is a weird power in a spoken word. . . . And a word carries far—very far—deals destruction through time as the bullets go flying through space" (p. 185).

Language is like a pseudopodia with which we reach out to the world, grasping its shape and incorporating, for our own, the sustenance there. Words do have the power to elevate or destroy. The profession's discourse on clients can be noble or base depending on the words used. Words can lift and inspire or frighten and constrain. Words are the aliment that feeds the sense of self. Thus, social workers are obligated to examine their dictionary of helping.

Certain words are key to the strengths perspective. *Empowerment*, rapidly becoming a hackneyed idea and term, means assisting individuals, families, and communities in discovering and using the resources and tools within and around them (Kaplan & Girard, 1994). The empowerment imperative also requires that social workers help people become aware of the tensions and conflicts that oppress and limit them and help them free themselves from these restraints (Pinderhughes, 1994).

Resilience means the skills, abilities, knowledge, and insight that accumulate over time as people struggle to surmount adversity and meet challenges. It is an ongoing and developing fund of energy and skill that can be used in current struggles (Garmezy, 1994).

Membership means that people need to be citizens—responsible and valued members in a viable group or community. To be without membership

is to be alienated, and to be at risk of marginalization and oppression, the enemies of civic and moral strength (Walzer, 1983). As people begin to realize and use their assets and abilities, collectively and individually, as they begin to discover the pride in having survived and overcome their difficulties, more and more of their capacities come into the work and play of daily life. These build on each other exponentially, reflecting a kind of synergy. The same synergistic phenomenon seems true of communities and groups as well. In both instances, one might suggest that there are no known limits to individual and collective capacities.

Strengths

Personal qualities and strengths are sometimes forged in the fires of trauma, sickness, abuse, and oppression. A sense of humor, loyalty, independence, insight, and other virtues might very well become the source of energy for successful work with clients even though their seeds were sown in trouble and pain (Vaillant, 1993; Wolin & Wolin, 1993). What people learn about themselves and others as they struggle to surmount difficulty can become knowledge useful in getting on with one's life. People learn from their trials and tribulations, even those that they inflict on themselves (Anthony & Cohler, 1987; Wolin & Wolin, 1993).

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People learn from the world around them, through formal education or through the distilling of their day-to-day experience. Clients can often surprise practitioners (and themselves) with the talents they have (or once had but let fall into disuse or out of memory). Such talents, whether juggling, cooking, baking bread, or tending to the needs of the ill, may become tools for helping to build a better life.

Extremely important sources of strength are cultural and personal stories, narratives, and lore. Cultural approaches to healing may provide a source for the revival and renewal of energies and possibilities. Cultural accounts of origins, development, migrations, and survival may provide inspiration and meaning. Personal and familial stories of falls from grace and redemption, failure and resurrection, and struggle and resilience may also provide the diction, symbols, metaphors, and tools for rebound (Lifton, 1993). Finally, people who have overcome abuse and trauma often have "survivor's pride" (Benard, 1994; Wolin & Wolin, 1993). Such pride is often buried under shame, guilt, and alienation, but it is often there waiting to be tapped into.

Resilience

Resilience should not be understood as the blithe denial of difficult life experiences, pains, and scars; it is, rather, the ability to go on in spite of these (Rutter, 1985; Wolin & Wolin, 1993). Damage, to be sure, has been done. Despite the wounds inflicted, for many the trauma also has been instructive and chastening. Resilience is not a trait or static dimension. It is the continuing articulation of capacities and knowledge derived through the interplay of risks and protections in the world. The environment continually presents demands, stresses, challenges, and opportunities. These become fateful, given a complexity of other factors—genetic, neurobiological, familial, communal—for the development of strength, of resilience, or of diminution in capacity.

Research on developmental resilience has introduced ideas that challenge three dominant concepts about development: (1) there are fixed, inevitable, critical, and universal stages of development; (2) childhood trauma inevitably leads to adult psychopathology (Benard, 1994; Garmezy, 1994); and (3) there are social conditions, interpersonal relationships, and institutional arrangements that are so toxic they inevitably lead to decrements or problems in the everyday functioning of children and adults, families, and communities (Rutter, 1994).

Perhaps the most celebrated study of developmental resilience in children as they grow into adulthood is the longitudinal research in Kauai, Hawaii, begun in 1955 by Werner and Smith (1992). In their earlier report, Werner and Smith (1982) reported that one of every three children who was evaluated by several measures to be at significant risk for adolescent problems actually developed into competent and confident young

adults at age 18. In their follow-up study, Werner and Smith (1992) revealed that two of three of the remaining two-thirds had turned into caring and efficacious adults by age 32. One of their central conceptualizations was that individuals have self-righting tendencies. From that, they concluded that some of the factors that ensure the emergence of self-correction of the life course can be identified. They also concluded that a significant protective factor for many children is a steadfast, caring relationship with at least one adult. This adult (in a few cases it was a peer) does not have to be a family member or physically present all of the time. These relationships provide a protective belt for the child, and they also invigorate the self-righting capacities of the child. Finally, and most important, Werner and Smith argued that it is never too late to change a life trajectory from dissolution to aspiration and accomplishment.

Critical Factors

Many factors, highly variable, interactive, and dynamic, affect how an individual or group will respond to a series of traumatic, even catastrophic situations (Benard, 1994; Chess, 1989; Garmezy, 1994). The critical factors have been termed "risk factors" (they enhance the likelihood of adaptive struggles and poorer developmental outcomes) and "protective factors" (they increase the likelihood of rebound from trauma and stress). I would add "generative factors"—remarkable and revelatory experiences that, taken together, dramatically increase learning, resource acquisition, and development, accentuating resilience and hardiness. As examples of some of the ingredients of resilience and adaptation, Masten (1994) listed the following: competence or functioning over time, the nature of adversities faced, individual and social assets and environmental protections and challenges, the context in which stresses are experienced, and individual perceptions and definitions of stressful situations. She cautioned that these factors must always be understood as dynamic, interactive, and synergistic and as occurring over time.

Community

Over the past few years, another complex of factors has emerged as important in the transactions among risk, protective, and generative circumstances: the community. In communities that amplify individual resilience, there is awareness, recognition, and use of the assets of most members of the community. Informal networks of individuals, families, and groups; social networks of peers; and intergenerational mentoring relationships provide succor, instruction, support, and encouragement (Benard, 1994; Kretzmann & McKnight, 1993). These communities can be understood as "enabling niches" (Taylor, 1993), places where individuals become known for what they do, are supported in becoming more adept and knowledgeable, and can establish solid relationships within and outside the community. In "entrapping niches" (Taylor, 1993), individuals are stigmatized and isolated. Membership in the community is based on collective stigma and alienation.

In communities that provide protection and minimize risk, there are many opportunities to participate, to make significant contributions to the moral and civic life of the community, and to take on the role of full-fledged citizen (Benard, 1994; McLaughlin, Irby, & Langman, 1994). In these communities, high expectations of members are the rule. Youths, elders, and all members are expected to do well, are given opportunities to do so, and are instructed in the use of the tools needed for meeting such expectations. These expectations are related to the life and needs of the community as well as to the developing competencies of the individual (Montuori & Conti, 1993).

Health and Wellness

The ample literature exploring the relationship between body, mind, and environment and health and wellness suggests that this interaction is complex, recursive, and reticulate and always implicated in keeping people well, assisting individuals in regenerating after trauma, and helping individuals and communities survive the impact and aftermath of calamity and ordeal. In a sense, the strengths perspective itself begins with appreciating the body and its tremendous restorative powers as well as its powers to resist disease (Ornstein & Sobel, 1987; Saleebey, 1985).

A budding conception of the human brain also indicates the inherent wisdom of the body and mind. Over evolutionary time, the human brain has grown into a lattice work of neuronal modules that lie beneath many inchoate or heretofore unexpressed capacities. Whether these capacities appear depends mightily on the environment. In a sense, we already "know" what we need to know

to survive. This knowledge may not be manifest in behavior and cognition or in language and learning unless the environment requires and elicits it. The environment, in this way, "selects" from this enormous neurobiological endowment, and, if all goes well, individually and collectively, humankind adapts and thrives (Gazzaniga, 1992). To believe in the naturally selected hardiness and wisdom of the body is to believe in the possibility of any individual or group surmounting difficulty (Dossey, 1989).

Beliefs and Emotions

Positive beliefs about one's self and condition play a significant role in health maintenance and regeneration (Cousins, 1989). Supported by positive beliefs and a supportive environment, the brain acts as a "health maintenance organization" (Ornstein & Sobel, 1987). Emotions, too, have a profound effect on wellness and health. They may act as signals for the body's immune and recuperative responses. It does seem the case that emotions experienced as positive can activate "the pharmacy within" as well as embolden the application of reason in day-to-day life (Damasio, 1994; Ornstein & Sobel, 1987). When people believe that they can recover, when they have an array of positive emotions about that prospect in the context of their daily lives, their bodies often respond optimally. Under certain conditions, the body's regenerative powers can be augmented. These factors may operate at the community level as well.

Health Realization and Community Empowerment

The health realization–community empowerment model developed by Mills (1995) is based on educating people and helping them recognize their innate resilience and knowledge that can be used in achieving individual aspirations and improving community vitality. Mills's idea is that resilience, health, wisdom, intelligence, and positive motivation are within each person and are accessible through education, support, and encouragement. The goals of health realization and community empowerment are to "reconnect people to the 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" (cited in Benard, 1994, p. 22). Supportive and instructive relationships, predictable and enduring sources of comfort and guidance, the creation of an ethos of health and accomplishment, and the soothing hand of others may inspire health and promote a better quality of life for individuals and communities.

The resilience and the health and wellness literatures run parallel in many regards. Both imply that individuals and communities have intrinsic capacities for restoration and rebound. Both suggest that individuals are best served, from a health and competence standpoint, by creating belief and thinking around possibility and values, around accomplishment and renewal, rather than centering exclusively on risk factors and disease processes. Both indicate that health and resilience are, in the end, community projects, an effect of social connection, the aggregation of collective vision, the provision of mentoring, and the reality of belonging to an organic whole.

Constructionism: Stories and Narratives

The constructionist view, in its many guises, emphasizes the importance of meaning making in human affairs (Becker, 1968). Human beings can build themselves into the world only by creating meaning, fashioning out of symbols, icons, and words a sense of what the world is all about (Bruner, 1990). The building blocks of meaning making are, for the most part, found in the edifice of culture. Culture provides the means by which people receive, organize, rationalize, and understand their experiences in the world. Central elements of the patterns woven by culture are story and narrative. Individuals impart, receive, or affirm meanings largely through telling and retelling stories and recounting narratives, the plots often laid out by culture. There is always, as Rosaldo (1989) argued, a tension between structure (culture) and agency (selfhood), so that individuals, families, and subcultures (or "minority" cultures) may develop their own stories or shape those laid out by the culture. Groups who suffer the domination of broader social institutions or suppression of their own cultural devices under the dominant culture frequently do not have their stories told or heard, not only in the wider world but also, regrettably, in their own world (Gergen, 1991; Laird, 1989; Rosaldo, 1989). Certainly one of the characteristics of being oppressed is having one's stories buried under the forces of ignorance and stereotype.

Lifting oppression and emancipating the moral imagination, the visions and hopes, and the life chances of people who are dispossessed involve recapturing and reconstructing the "generative themes" (Freire, 1973) of the culture, community, neighborhood, or family. It is a part of the work toward liberation to collaborate in the projection of peoples' stories, narratives, and myths outward to the institutions that have ignored or marginalized them (Saleebey, 1994).

Criticisms of the Strengths Perspective

Many individuals who present the strengths approach in workshops and training for professional social workers, in consultation with agencies, and in the classroom report some common reservations and objections about the strengths perspective from practitioners and students: that the strengths perspective is just positive thinking in another guise, simply reframes deficits and misery, is "Pollyannaish," or ignores or downplays real problems.

Positive Thinking in Disguise

America has a long tradition of the idea of the power of positive thinking from Mary Baker Eddy to Norman Vincent Peale to Anthony Robbins. Though its current face is presented in slicker technological garb, positive thinking has not drifted very far from Emile Coué, who, at the turn of the century, advised repeating "Every day, in every way, I get better and better."

The strengths perspective, however, is not predicated on the repetition of uplifting mantras or the idea that transformation is a matter of a few minutes and a timely miracle. Rather, the idea is that to build something of lasting significance with clients, social workers must use their expertise in the service of capitalizing on client resources, talents, knowledge, and motivation, as well as environmental collateral. There is little else with which to construct possibility and to reach out for promise. This is hard work. People, especially people in trouble or dire straits, are not given to thinking of themselves or others in terms of strengths or as having emerged from scarring events with something useful and redemptive (de Shazer, 1991; Lee, 1994). In addition, if they have been clients of the welfare, social services, or mental health systems, they likely have been inculcated in the doctrine of themselves as deficient and needy. They are not easily dissuaded from this identity (Holmes & Saleebey, 1993).

More important, the strengths perspective requires formation of appreciative, collaborative relationships with clients, which social workers are taught are essential to effective, principled work. To establish such relationships social workers must devise strict and accurate accountings of client assets.

Reframing Misery

The criticism that the strengths perspective simply reframes deficit and misery suggests that clients are not really expected to do the work of transformation and risk action. Rather, they are required merely to reconceptualize their difficulties so that they are sanitized and less threatening to self and others. In this way, schizophrenia, for example, becomes an exquisite sensitivity to the motives and meanings of others. The strengths approach honors the reality of schizophrenia and the damage this neurobiological, psychosocial disorder can do.

The strengths perspective does not deny reality; it demands some reframing, however, to develop an attitude and language about the nature of possibility and opportunity and the nature of the individual beneath the diagnostic label. The work involves creating access to communal resources so that they become the ticket to expanded choices and routes to change.

Pollyannaism

Another criticism is that the strengths approach is Pollyannaish, that it ignores how manipulative and dangerous or destructive certain clients and client groups can be. The argument is, apparently, that some people are simply beyond redemption. Clearly, there are individuals who commit acts that are beyond our capacity to understand, let alone accept.

But the strengths perspective demands that practitioners ask what useful qualities and skills or even motivation and aspirations these clients have, how they can be tapped in the service of change, and in what more salubrious ways these individuals can meet their needs and resolve their conflicts. Social workers cannot automatically discount people. There may be genuinely evil people, beyond grace or hope, but it is best not to make that assumption first.

Ignoring Reality

A very serious criticism is that the strengths perspective ignores or downplays real problems. The

strengths approach does not discount the problems of clients. Often, these problems are where clients begin, what they are compelled to talk about, what are most urgent. The individual or group may need the opportunity for catharsis, for grieving and mourning, for the expression of rage or anxiety, for the recounting of barriers to satisfaction and esteem (Wolin & Wolin, 1993).

All helpers should assess and evaluate the sources and remnants of client troubles, difficulties, pains, and disorders. As Cousins (1989) suggested, one should not deny the verdict (diagnosis or assessment) but should defy the sentence. Having assessed the damage, social workers need to ensure that the diagnosis does not become a cornerstone of identity. To avoid that possibility, they calculate how clients have managed to survive thus far and what they have drawn on in the face of misfortune. What part of their struggle has been useful to them, and what positive or constructive learning has it yielded? People are not often thought to think of the afflictions of circumstance, context, or character in this way, but with encouragement, they can. Whatever else symptoms are, they may also be a sign of the soul's struggle to be alive, responsible, and involved (Moore, 1992). For helpers, the goal may be not the heroic cure but rather the constancy of caring and connection and collaborative work toward improving the quality of day-to-day living.

Yes, but . . .

Many social workers and agencies argue that they already abide by the strictures of a strengths orientation. A review of actual practices reveals that they often fall short of full endorsement and application of a strengths-based practice. For example, in many mental health agencies around the country, individual service plans (ISPs) are devised to "incorporate" the strengths of client and family in assessment and planning. But many ISPs the author and other colleagues have examined are rife with diagnostic assessments and elaborations, narratives about decompensation, and explorations of continuing symptomatic struggles and manifestations. Axes I and II of the DSM are usually prominently featured. Often, the strengths assessment is consigned to a few lines at the end of the evaluation and planning form. The accountings rendered on these forms are, for the most part, in the language of the worker and use the mental health system lexicon.

Conclusion

The strengths perspective honors two things: the power of the self to heal and right itself with the help of the environment, and the need for an alliance with the hope that life might really be otherwise. Helpers must hear the individual, family, or community stories, but people can write the story of their near and far futures only if they know everything they need to know about their condition and circumstances. The job is to help individuals and groups develop the language, summon the resources, devise the plot, and manage the subjectivity of life in their world.

In a strengths approach, how social workers encounter their fellow human beings is critical. They must engage individuals as equals. They must be willing to meet them eye to eye and to engage in dialogue and a mutual sharing of knowledge, tools, concerns, aspirations, and respect. The process of coming to know is a mutual and collaborative one. The individuals and groups the profession assist, also must be able to "name" their circumstances, their struggles, their experiences, themselves. Many alienated people have been named by others—labeled and diagnosed—in a kind of total discourse. The power to name oneself and one's situation and condition is the beginning of real empowerment.

The American philosopher Susanne Langer (1963) wrote, "The limits of thought in any age are set not so much from the outside by the fullness or poverty of experience . . . as from within by the power of conception and the wealth of formative notions with which the mind meets experience" (p. 8). The strengths perspective is a standpoint. Supporters believe that it offers a new way of thinking and acting professionally. Clearly, it is not a theory. But its emerging body of principle and method does create opportunities for professional knowing and doing that go beyond the boundaries of the "technical–rational" approach (Schön, 1983) so common today.

Some social work practitioners may find little in this article that is "new" and may regard these ideas as simply good social work practice. However, it is the experience of those who have worked to develop it that a strengths-based practice does provide a richness of thought and an array of actions that go far toward serving well those who seek help from the profession (Chamberlain & Rapp, 1991; Sullivan & Rapp, 1994;

Weick et al., 1989). 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. . . . The worker creates a language of strength, hope, and movement. (p. 53)

In the end, it is that kind of rhetoric that preserves the possibility and promise of our clients. ■

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