The Strengths perspective: How clinical social workers view its usage for facilitating change in mental health settings

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A major challenge faced by mental health professionals is finding interventions that provide therapeutic change for clients in care. One popular approach is the strengths-based model which is a shift in philosophy from emphasizing deficits and pathology to focusing on individual strengths as a change agent. Students in a Master of Social Work (MSW) research class interviewed licensed clinical social workers to determine how they view strengths-based practice and the impact it has on client change. Other popular approaches to practice are discussed along with differences as to whether one modality is more prevalent for change than the strengths perspective. This paper, though non-conventional, will add critical information to the literature on how social workers view the usage of strengths-based practice in clinical practice with clients. There is a paradigm shift in mental health practice, which has called for renewal of the perception of the clients' deficits. More importantly, many mental health professionals find it essential to view a client’s strengths as a source to build therapeutic relationships as well as to empower the client to make positive therapeutic change by relying on resilience, internal strengths and resources that clients sometimes inherently have but due to their life circumstances clients and practitioners may overlook the clients strengths and internal resources.

Key words: Strengths based practice, theory and practice, positive psychology, motivational psychology, solutions focus approach.

INTRODUCTION

One of the major challenges that clinical social workers face in the mental health setting is finding interventions that provide therapeutic change in their clients’ behavior. There are many models or theoretical orientations used in social work practice. Some of the more popular theories of practice include cognitive-behavioral approaches, dialectical behavioral therapy, and the strengths perspective approach to treatment (Hurdle and Stromwall, 2003). Typically, clinical social workers employ more traditional models and approaches in the treatment of clients with mental disorders. However, the strength-based model is gaining popularity as a preferred method for treatment (Wahl and Aroesty-Cohen, 2010).

Strength-based practices have been growing in recent years as a shift from the pathological perspective transpires (Laursen, 2000). This model is a shift in philosophy from emphasizing clients’ problems, vulnerabilities, and deficits to focusing on their individual strengths and resources (Devore and Schlesinger, 1999).

This study uses a qualitative approach to examine practice models or theoretical orientations that clinical social workers employ in an effort to facilitate change in the lives of their clients. Students enrolled in Master of Social Work (MSW) research class at a southeastern university interviewed licensed clinical social workers to determine whether they incorporate a strength-based model in their work with clients. The purpose of the study was to explore the use of the strengths perspective orientation and the prevalence of its use among clinical social workers as an effort to facilitate change in the lives of their clients.

Literature review

The evolution of social work practice in the United States
reflects centuries of an ongoing response to rapid economic and social change. The roots of social work in the United States dates back prior to the American Revolution, when formal systems of poor relief, child welfare, and even mental health services had a dual role of empathy and protection to aid poor individuals and families. In the early 19th century, private benevolent societies and self-help organizations began to play an intricate role in addressing this growing societal issue. By 1898, social work training programs were established and as a result, casework became a unique area of practice (Barusch, 2002).

The profession of social work experienced profound changes throughout the 20th century. Today, social workers comprise the largest percentage of professionals working in the fields of mental health and family services. (Tannenbaum and Reisch, 2001) It is estimated that by 2015, there will be approximately 650,000 social workers, more than a 30% increase over 10 years. National Association of Social Workers (NASW’s) Code of Ethics (1999) identified the primary mission of the social work profession as enhancing well-being and meeting the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. As a result, the profession has focused on advocating for the needs of the most vulnerable individuals within society by challenging social injustice, respecting the dignity and worth of the person, and seeking to improve the client’s well-being.

In an attempt to address the challenge of promoting social justice, a variety of practice models and theories emerged. These models and theories provided the direction and guidance necessary for developing intervention strategies to the social work profession. Some of these models and theories include addiction models, crisis intervention, family preservation, family therapy, dialectic behavioral therapy, narrative therapy, problem-solving models, solution-focused therapy and the strengths perspective.

Few studies examine the child welfare social worker’s practice approaches as they relate to their effectiveness in family change (Smith and Donovan, 2003). Social workers are frequently urged to use best practice models that prove effective with clients; however, few studies have proven what models affect change in clients (Blythe and Briar, 1985). Clients are becoming more diverse and practice models are overwhelming in number; therefore, it is difficult to view a single approach as best practice (Meyer, 1979).

Gorey et al. (1998) reported finding evidence that when the target of “change” is more progressively defined as some element of the environment or the structures of society, then social work models such as generalist problem solving, task-centered, systemic, and radical ones are significantly more effective that cognitive-behavioral ones. Beyond practice models and theories, the literature points out that relationships are a key feature in the therapeutic process (McCamey and Murty, 2014). A characteristic of psychodynamic work “is to recognize how the quality, care and integrity of the worker’s response can enable development, maturation, and therapeutic progress. One of the core components of social work in this context is the social worker’s ability to respond to people’s emotional needs, to their impulse for emotional development, and to the difficulties they experience in forming or maintaining relationships” (Sudbery, 2002).

**Traditional approaches**

In the past, increased attention was given to defining the problems and identifying weakness and pathology in a person’s life so that a rational intervention could be pursued. The scientific belief that a cause must be found before a result could be achieved led to a diagnosis being provided for each individual, after which treatment could proceed. Clinical diagnosis focused on a "human lack or weakness" (Weick et al., 1989) ranging from the relatively benign to the severe. Psychoanalytic theory and problem solving theory have been used in this pursuit. Human weakness was sought as the critical variable in understanding human problems. Virtually all schools of therapeutic thought rested on the belief that people needed help because they had a problem. This problem implied, to some level, who they were. The belief in the problem-solving theory is that an accurate naming of the problem will lead to an appropriate intervention.

Mary Richmond (1917) used social diagnosis as the primary approach in social work practice. The focus of this approach is to discover the deficiency, defects, and inadequacy of clients and use a problem-solving approach for intervention. The problem-solving approach views problems as part of the human condition. The goal of this approach is not psychological change but rather to enhance problem-solving capacities. It assumes that inability to cope with problems is due to lack of motivation, capacities, and opportunities to resolve problems (Turner and Jaco, 1996). The goal of problem-solving is to provide external and internal resources to restore equilibrium and functioning of the individual.

The psychosocial approach to define people’s problems was introduced in 1930 (Schrive, 2001). This approach stresses the interplay of individual and environment. The goal of this approach is to help people achieve psychosocial functioning by developing human relationships, available material, and service resources. It assumes that involvement in therapy sessions may affect changes in cognitive, emotional, and behavioral aspects of the individual and alleviate the suffering of the individual (Turner, 1974).
Alternative theoretical approaches

For many years, the focus on human failure was the mindset of much of society and such negative views continue to plague society today. The profession of social work, however, took a somewhat different stance. In 1958, the Commission on Social Work Practice included as a main objective to the field to "seek out, identify and strengthen the maximum potential in individuals, groups and communities" (Weick et al., 1989).

Implementing effective social work practices or approaches within the social work field is extremely important to help promote change among client systems. Social workers utilize numerous approaches, theories and practices that are designed to facilitate change among clients. A few of the models include the strengths-based model, the ecosystem approach, Golan’s theory of crisis intervention, cognitive-behavioral therapy, brief therapy, solution-focused therapy, and the holistic approach.

The strengths perspective is a contemporary approach widely used in social work practice. The strengths perspective focuses on an individual’s growth, function, and healing (Chapin, 1995). It is based on the assumption that human beings are resourceful and resilient. It emphasizes the individual’s strengths and capabilities. The major focus of the strengths perspective is collaboration and partnership between the social worker and client (Saleeby, 2009). The role of the clinician using a strengths-based approach is to help clients acknowledge and understand what it is that needs to be changed in their life. It draws on the belief that all clients possess the inner strength to overcome obstacles that have blocked their ability to resolve their own crises (Probst, 2009; Rapp and Goscha, 2011). It strives to motivate clients by giving them the energy to want to change. It creates opportunities for competencies and advocacy (Francis, 2014).

One of the criticisms of the strengths perspective is that it ignores the reality of the problem (Schriever, 2001). Saleeby (1996) responded to this criticism, stating “It does not discount the problems of clients.... All helpers should assess and evaluate the sources and remnants of client’s troubles, difficulties, pains and disorders. They must also calculate how clients have managed to survive thus far and what they have drawn on in the face of misfortune” (Saleeby, 1996).

Solution-focused therapy is another alternative model that is closely associated with the strengths perspective. This model emphasizes resources in the environment. It does not focus on categories of pathology or problems. This model assumes that “the discovery of client’s strengths is a process of cooperative exploration between client and helpers, and that focusing on strengths increases motivation” (Lee, 2003).

Cognitive-behavioral therapy recognizes that “thoughts are choices and that the thoughts we choose to have will shape the feelings we have about ourselves, others, and the future” (McQuaide, 1999). This model stresses the effect of cognitive functioning on the behavior of the individual. It suggests that clients need to re-structure their negative thoughts in order to facilitate change in their behavior.

Wellness theory places emphasis on the quality of life rather than the length of life. The wellness perspective recognizes the significant relationships among mind, environment, health, and wellness. Wellness is defined as “a state of harmony, energy, positive productivity, and well-being in an individual’s mind, body, emotions, and spirit” (Jones and Kilpatrick, 1996). The state of wellness also includes family relationships and the individual’s relationships with his or her environment and the larger society.

The empowerment approach involves enabling people to become aware of what needs to change in their lives, community, school, job, or home. The most essential and valuable word in the empowerment approach is “power.” Power provides the strength and the determination to make a change where change is needed.

In summary, while traditional approaches emphasize an individual’s deficiencies and pathology and the provision of resources to alleviate stress or crisis situations, the alternative models seek to enhance recovery or rehabilitation (Weick and Chamberlain, 1997).

METHODOLOGY

This exploratory research project utilized grounded theory and a qualitative research method of data analysis. A semi-structured interview was used to explore the types for practice models or theoretical orientations that licensed clinical social workers were using to facilitate change within their practice setting. The interview guide consisted of a series of practice related questions that were designed to gain an in-depth understanding of the practice model(s) or theoretical orientation clinical social workers used to facilitate client change and the degree to which they incorporate the strengths perspective in their practice.

Study sample and population

Thirty-seven graduate students who enrolled in an MSW program at a major southeastern university participated in a qualitative research assignment as part of an introductory research methods class. The assignment required each student to select one subject drawn from his or her peers, co-workers and professional contacts. The study population was limited to MSW clinicians that
held a licensed clinical social work title and were practicing in either a public or private setting.

For purpose of the assignment, students were placed into one of four separate groups. Each student contacted one subject to arrange a face-to-face interview, which was dependent upon consent. After interviewing the subject, students shared their transcript with the other students in their group for individual analysis. Therefore, each student had approximately nine subjects to use for the data analysis part of the assignment.

The study was qualitative in nature and involved a non-probability sample that does not allow for generalization beyond the subjects participating in the study. A purposive sampling frame was used because only licensed clinical social workers were used to determine the extent and reasoning for their usage of the Strengths perspective (York, 1998; Siegal, 1993).

Data collection procedures

This exploratory study employed a semi-structured interview developed by the professor and designed to measure the extent to which the strengths-based perspective was used by clinical social workers in their practice. The interviews consisted of open and closed-ended questions designed to explore the types for practice models or theoretical orientations that clinical social workers used in practice to facilitate client change. The questions were divided into four sections: demographic questions, practice approach questions, questions asking the subjects to rate their level of agreement with certain characteristics grounded in the strengths-based and two closing questions about their use of the strengths-based perspective as their primary practice approach.

The demographic questions included items such as the subject’s gender, date they received their MSW degree, the university they attended, titles of core practice courses taken in the MSW program, number of years in clinical practice, their area of specialization and type of setting where they were practicing. The practice approach questions included items such as how they would describe the way they practice, if they subscribe to a particular model or theory of practice, the basic assumptions and premises they believe help facilitate client change, and if they think their practice approach(s) have changed in regards to how they work with clients since completing their MSW degree. The strengths-based practice questions included items such as whether or not it is their primary approach to practice, if so, what were the strengths and weaknesses of using this approach. If the subjects were not using a strengths-based approach then what factors contribute to this decision? A final question asked subjects what they thought constituted best practice. One class period was devoted to helping students familiarize themselves with the survey and to demonstrate how using the same questions and probes ensures consistency among interviews. In addition, students practiced role-playing interviews in class.

The interviews either were conducted by a face-to-face or telephone interviewing depending upon the subjects’ preference. Some of the interviews were tape recorded (with consent), and then transcribed and other interviews utilized written field notes. In each case, the students anonymously transcribed their notes as soon after the interview as possible and shared them with the other students assigned to their research group. The interviews times were set at the convenience of the participants and were not time-limited to ensure each participant the time needed to respond to all questions without worrying about time constraints.

Data analysis procedures

Data were collected and analyzed using the grounded theory method that involved continued exchange between the mass of data collected and the development of theory. The purpose was purely descriptive and focused primarily on the search for common themes and patterns among answers. Students were instructed to classify and code the data manually. The concepts used to develop the questions in this study served as the organizing principle for qualitative coding.

Open coding was used to locate themes and assign initial codes to condense data into smaller categories or classifications. Open-coding is defined as the part of analysis that pertains specifically to naming and categorizing phenomena through close examination of data (Rubin and Babbie, 2005; Neuman, 2004; Strauss and Corbin, 1990). During open coding, data are broken down into discrete parts, closely examined, compared for similarities and differences, and questions are asked about phenomena as reflected in the data. Subjective data points were collected to gain insight into the subject’s responses and their actions as promoters of social change.

A computer file was created that formalized the data in a structured list of responses separated by subject. Data were examined in an attempt to recognize and identify patterns or themes. Tables, worksheets, and checklists were compiled and common themes were highlighted and sorted together. For example, demographic information was looked at conjunctively with the practice methods used to see if any relationships between the two existed.

The final phase of data analysis involved a modified triangulation approach. The author examined the filed notes from independent interviews and looked for consistency among the findings reported in the students’ papers.
Table 1. What is your age and level of education?

<table>
<thead>
<tr>
<th>By Age</th>
<th>Male</th>
<th>Female</th>
<th>% Male/Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>25-34</td>
<td>6</td>
<td>26</td>
<td>0.75</td>
</tr>
<tr>
<td>35-44</td>
<td>2</td>
<td>2</td>
<td>0.25</td>
</tr>
<tr>
<td>35-44</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>55-64</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>65 or older</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

By level of education

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>% Male/Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelor’s degree</td>
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<td>0</td>
</tr>
<tr>
<td>Master’s degree (MSW)</td>
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<td>29</td>
</tr>
<tr>
<td>Master’s degree (other)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Professional degree</td>
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<td>0</td>
</tr>
</tbody>
</table>

Table 2. What is your Race?

<table>
<thead>
<tr>
<th>Race</th>
<th>Number</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>African-American</td>
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<td>0.08</td>
</tr>
<tr>
<td>White</td>
<td>32</td>
<td>86</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>0.02</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1</td>
<td>0.02</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

RESULTS

The subjects included 37 licensed clinical social workers, of which 29 were females and 8 were males. Eighty percent graduated from MSW programs located in southern states and worked in predominantly rural areas. The subjects averaged 9.5 years of clinical practice after receiving their MSW, with a range of 30 years (8 months to 31 years). Most worked as private practitioners while others worked as case managers, counselors, program directors, and outpatient therapists. The most common reasons cited for clients coming in for services were behavioral problems, difficulties maintaining personal relationships, severe depression, and recurrent anxiety symptoms (Tables 1 and 2).

Respondents were asked what particular practice courses (i.e., skills or theories) they took during their MSW program and the general content of these courses. Although many of the respondents had difficulty remembering the content of the coursework taken in graduate school, many recalled taking classes dealing with children and families and group work. Most of them seemed to recall taking direct and indirect practice courses that introduced the following practice approaches: cognitive-behavioral, client-centered, psychodynamic, person-in-environment and human diversity. However, many recalled that the practice courses were quite eclectic with no predominate theme.

The geographic area served was primarily rural with services involving children (e.g., school, behavior, and home environment issues), mental health (e.g., depression, substance abuse, mood disorders, anxiety) and marriage counseling (e.g., interpersonal relationship building and problem solving). Areas of current specialization included mental health, children, adolescents, and families. The two most common approaches respondents practiced in their agencies were cognitive-behavioral and strengths perspective.

Those working in mental health settings primarily used the cognitive-behavioral approach. In addition to cognitive-behavioral and strengths-based practice approaches, practitioners cited the family systems approach, problem solving techniques, and psychodynamic approach. The participants identified basic social work skills as the most common approach used for engaging with clients. Insight, empowerment, resources, social support, and behavioral modification were identified as to how clients change in therapy (Table 3).
Table 3. What is your theoretical orientation?

<table>
<thead>
<tr>
<th>Clinician theoretic orientation most used</th>
<th>Number</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive behavioral therapy</td>
<td>29</td>
<td>78</td>
</tr>
<tr>
<td>Strength base approach</td>
<td>27</td>
<td>72</td>
</tr>
<tr>
<td>Solution focus therapy</td>
<td>19</td>
<td>51</td>
</tr>
<tr>
<td>Gestalt therapy</td>
<td>10</td>
<td>27</td>
</tr>
<tr>
<td>Wellness</td>
<td>3</td>
<td>.08</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>.43</td>
</tr>
</tbody>
</table>

Strengths-based perspective

The vast majority of clinical social workers interviewed (77%) stated that their approach was strengths based. The remaining 23% stated that although it was not their primary practice approach, they tried to incorporate some of the concepts found in the strengths approach with other practice models they may have been using. Those who used the strengths-based approach as a primary approach thought it was important because it kept them focused on the problem from the clients view and it utilized client’s strengths and resources to alleviate the problem. The following two quotes provide a rational for using the strengths approach:

“I think it is the best way for me to practice with the population I serve. I think it is so important to meet the client where they are and build from their strengths and resources.”

“The strengths approach involves focusing on what the client can do, giving them positive energy, and demonstrating success so that they can build off their experiences.”

Clinical practice varies from client to client and from situation to situation. Therefore, one approach may not be suited for all clients and situations. The following three quotes provide a rational for not using the strengths approach:

“It can sometimes oversimplify the human experience. It may not be where the client wants to ‘be’ and therefore, client does not respond to this type of approach.”

“Working from a strengths perspective is difficult because it challenges traditional therapeutic relationships, as well as systematic infrastructures based on payment and reimbursement for public services. Therefore it is paramount in theory but not always the most practical.”

“I don’t think you can ascribe to any one approach or theory 100% with every client 100% of the time. That would be like assembly line stuff and that is not fair.”

One clinical social worker who stated that they used the cognitive behavioral therapy approach in conjunction with the strengths perspective noted:

“The strength of this approach is that everyone wants to be loved and respected, but a weakness is when an individual is practicing something they don’t understand.”

Strengths and weaknesses

The clinical social workers interview in this study identified various strengths and weaknesses associated with using the strengths based approach in practice. It was thought that its primary strength lay in its ability to empower clients to utilize their personal strengths and resources to overcome problems. This premise was based on the idea that when clients take responsibility for changing it creates positive energy. Other strengths were identified such as its belief that clients are not perfect and need help, it utilizes a strategy for helping clients focus on what it is they want to do. In addition, it is founded on the belief that clients have the ability to deal with their own problems and if you start where the client is and reframe the situation into more hopeful-optimistic terms then they can be empowered to change.

The weaknesses of strength-based approach seem to share a common theme in that the more attention given to the client’s own solutions, the more overwhelming their life can be. Some participants view the approach as taking the focus away from the real cause of the client’s problem and could foster a sense of denial. As one clinician stated:

“Sometimes the client simply has to come to terms with why they did what they did, before they can find the solution to the problem”

Many of the subjects believed they needed to use a more holistic approach rather than relying on a single approach. For example, a number of mental health clinicians identified using a multiple treatment approach that may include CBT, the use of medication and a strengths-based approach. In addition, they thought the strength-based approach often over-simplified human experience by constantly asking clients to know themselves, by being aware of their blind spots and to think only in terms of strengths and limitations could become overwhelming.

Client change

The majority of clinicians interviewed acknowledged that
clients change when they become empowered which helps increase their self-esteem and self-confidence. Thus, change occurs when clients gain insight about their behaviors and learn that they have the ability to change. Clients need to feel in control and once they get control in their life they begin to change. Two respondents stated:

“Therapy encourages self-esteem thereby increasing positive coping skills, confidence in their abilities, contemplation and often time’s sobriety.”

“I think they change with unconditional positive regard, acceptance, of where they are, [there’s the] importance of mirroring for people what their strengths are and allowing them to work on their weaknesses.”

It was also recognized that the change process for each client is individualized and sometimes the process is slow. One respondent said:

“The reality is that some people never do change. It’s, like the joke, how many social workers does it take to change a light bulb? One but the bulb really needs to want to change.”

**Facilitating change**

The first assumption clinicians must make is that everyone affected by a problem wants to change. A number of practitioners believe that clients change at their own pace and that it is important to start where the client is. Others believe the power to change lies within the client. One clinician stated that:

“It is important for therapists to show unconditional regard, no matter what they say to facilitate change and that the client must consider how external stressors affect their problem before change can be made.”

Many of the respondents maintain that change can only occur when a mutually positive environment is constructed between the client and the therapist. Thus, it is important that clinicians utilize techniques that foster this relationship. One respondent stated:

“I believe it is most important to first develop a connection with the client or clients. Without that connection, the intervention process can be more challenging. Getting to know the client is very important.”

One of the interview questions asked the respondents to present their views on the basic assumptions and premises that they believe facilitates change within the client. It was thought that for the most part, clients seek the help of therapists because they want something in their life to be different. Therefore, the role of the practitioner is to be an enabler to empower clients to help themselves. One practitioner summed up this premise by saying:

“I believe that people have solutions to their own problems. They may need coaching and strategies to help them solve their problems.”

Two alternate themes emerged: building trust and establishing rapport. The majority of respondents reported that a strengths-based approach was a powerful tool for building trust and establishing rapport because it reinforces a mutual relationship between the client and practitioner. One respondent said:

“I’m a big believer in Carl Roger’s approach that, if you show them you care and want to hear them, they will start to feel confident and when confidence is built, the client feels empowered and in-control, reaching acceptance, and insight.”

When the respondents were asked to describe how they go about working with clients, most expressed rapport building as an important step in practice delivery. They reported that helping facilitate change among clients is centered on respect for the client and empowerment. Two subjects stated:

“Establishing therapeutic alliances and development partnerships with clients, meeting clients where they are, develop connection with client(s), exploring strengths, help clients feel at ease”

“Mutual respect, building on resiliency and their strengths, utilization of resources, working together, giving them hope, and believing in client are important ingredients for creating change”.

Although the solution-focused approach was frequently mentioned as a good approach to practice, there was some caution that this approach works well in certain situations. It was believed that the strengths approach was a powerful assessment tool that empowers clients to be in control of their own treatment. However, many respondents felt that at some point you have to move beyond “self-talk” and into treatment and that at some point clients have to come to an understanding of why they did certain behaviors before they could move on to treatment. Thus, other practice theories such as cognitive-behavioral, bio-psycho-social were identified as being equally important in facilitating change among clients. In some instance, it was pointed out that a combination or holistic approach that uses a strengths-based approach with other treatment modalities as being the best approach for facilitating change.

**How therapists change**

The clinicians were asked if they felt they had changed in regards to working with clients since completing their highest degree and to describe how their practice might have changed. Although a number of reasons were given
as to why therapists change their approach, most reported improving their practice skills and self-growth skills as the primary reasons why they changed. Some of the examples cited were learning to set boundaries, gaining trust and respect, learning how to be humble, placing more trust in self, and realizing that you do not have all the answers.

The prevailing reason stated for self-change was practice experience. As clinicians became more experienced they reported being "less judgmental", "more flexible", "better understanding of different diagnosis", and "taking less responsibility for personal changes".

“I am increasingly more aware that people don’t always create their own chaos, sometimes people do everything they are supposed to but chaos still happens”.

“Experience has been a wonderful teacher”, [through experience] this interviewee learned to “allow the therapeutic process to grow without forcing it”.

Others felt that they changed when they set boundaries with their clients that make them responsible for their own growth. They also attributed personal growth to their experiences and their continual learning. One respondent stated:

“I think that if you spend your life trying to fix your clients’ problems for them, you’ll begin to realize how just burned out you can get.”

Many respondents stated the strengths approach made them feel more relaxed in their work and become more patient with their clients. It also helped them recognize when they are resorting back to a more confrontational approach. One member of the sample made the point that:

“Therapist must work very hard on their own issues and recognize ineffective practice approaches if they want to help their clients.”

Self-reflection is another critical factor for improving practice. Clinicians must become aware of their own biases. One person stated:

“If you are not aware of your own personal biases, you are more likely to become less tolerant of client input and projected a certain level of arrogance. Clients will interpret your behavior as an invitation that they do not know what is best for them and that the therapist knows. This is a destructive message that inhibits client involvement.”

A variety of other factors for self-change were mentioned. Some stated that they changed when exposed to other practice methods, receiving appropriate guidance from supervisors, changes in technology, or the recognition that practice style may be too direct or literal. Others changed because of a strong desire to help other individuals and to make a difference in people’s lives. Nearly everyone saw the need for continued professional development and to improve their practice techniques which would make them better practitioners.

Best practice

Although best practice was defined in a variety of ways, most agreed that it is a process that involves the clinician and client coming together to create change. This approach can be troublesome for clinicians who have strong desires to help clients make change by telling them what they think they should do rather than listening to what the client wants to do. Utilizing the strengths perspective as a practice approach helps ensure a client/practitioner environment that is built on mutual respect. It is then and only then that best practice is created. The following quotes support the need for mutual relationships:

“Make sure all the time that your own value systems and judgments don’t filter into your treatment practices”.

“You need to really care about people, you need to really want to help people... accept people for who they are... where they’ve come from and where they are going”.

“The main thing is to know your own limitations and biases, be compassionate and caring follow the Code of Ethics, and be a professional”.

“Best practice is by caring professional, developing opportunities for increased experiences, ongoing education, application of new methods and evidence-based research”.

Finally, a few respondents pointed out how best practice begins with NASW’s Code of Ethics that mandates the provision of competent services and respect for the dignity and self-worth of all individuals. This is accomplished when clients are empowered by clinicians who are open-minded and non-judgmental. One person summed it up best when they said, “it’s like planting a seed and watching it grow into a beautiful flower”.

Although other practice themes and approaches such as the Cognitive Behavioral, Eclectic, Solution-Focused, and Strengths Perspectives emerged, subjects recognized the role that basic social work skills play in engaging clients in the process. Basic social work skills like insight, empowering the client, advocating for resources, developing social support, and behavioral modification were identified as requirements for assisting client change.

Conclusions

Although most of the clinicians interviewed in this study
reported utilizing more than one practice model, they recognized the importance of the strengths perspective in working with clients, which is consistent with related research and previous studies conducted on this important topic. Most cited that factors such as meeting the client where they are, seeing clients learn self-confidence, building on the clients’ strengths, establishing mutual therapeutic relationships, and keeping their professional boundaries intact were important in producing positive results.

A number of respondents working in mental health settings identified the use of a Cognitive-Behavioral approach as a primary method for working with clients. However, many of them also reported the need for using a more eclectic approach when working with clients in a therapeutic setting. Even though they believed the “Strengths Perspective” is an important and integral aspect of therapeutic intervention, it may not be appropriate to all circumstances. This overarching theme is consistent with the literature with posits the “Strength’s Perspective” as being a central component and a foundation to provide intervention while being augmented with other therapeutic interventions. Those who supported the strengths approach referenced using clinical skills that focused on the helping process, built a collaborative effort, being non-judgmental, focused on client strengths and less on diagnoses, and keeping focused on future outcomes rather than dwell over past problems. Other positive remarks suggested that the strengths approach empowers clients to take control over their own decisions and how it can be a catalyst for motivating clients to participate in the change process.

It is likely that the strengths approach to clinical practice will continue to gain more popularity as one of the primary approaches for client-centered practice. Embedded in NASW’s Code of Ethics is the professional obligation for social workers to continue to develop stronger approaches that incorporate client involvement in the change process. The belief is that clients are generally more receptive to change when they have input and the strength-based perspective strongly encourages the clients input.

Implications for practice

The findings in this study indicate that most clinicians view the strengths perspective as a valuable tool in the therapeutic process and that it is a powerful approach for helping clients realize their potential. However, clinical social workers should recognize that no single approach to practice works best for everyone and other methods may work as well with certain types of clients. Therefore, clinical social workers need to be flexible and use a variety of clinical methods when assisting clients with change. Best practice was conceptualized as utilizing whatever technique works best for that client. As one therapist put it, “I truly think there is no perfect model yet and that you have to borrow from different ones to be helpful.”

Although the sampling method used in this study does not lend itself to generalizing the findings to all clinical social workers, it does suggest several provisional implications that constitute best practice principles:

1. Clinical social workers should understand and develop a variety of practices methods in treatment rather than relying on a single approach.
2. The agency setting where a clinical social worker practices has an impact on the type of practice models they will use.
3. Practice experience and continued education appears to be as important in working with clients as any practice model or theory.
4. A strengths-based approach, despite its few limitations, is highly regarded as a viable approach for best practice.

Study limitations

It is important to note that most of the clinical social workers in this study learned to practice in a mental health setting which may have had a profound effect on the practice models and theoretical orientation clinical social workers utilize. For example, clinicians working in mental health settings thought that the best approach for facilitating change among clients was through Cognitive-Behavior therapy because clients had to recognize the factors that contributed to their behaviors before they could be asked to generate solutions for solving their own problems. They further suggest that once the client comes to terms with the cause of their problem, then a strengths-based approach can be helpful in facilitating change.

Recommendations for future research

One recommendation for future studies would be to develop longitudinal studies for comparing the effectiveness of strengths-based approaches to other practice methods in facilitating change among clients. The strengths perspective needs to be tested for its long-term effect on facilitating change to ensure that it is more than just helping a client become empowered. It may be possible that the results achieved through empowerment will be short lived after the therapist steps out of the picture. Therefore, questions like “how long does personal growth achieved with this approach stay with the client” or “has the client developed any new skills to help solve future problems” need to be answered before
the strengths-based approach is considered the “best practice” approach.

REFERENCES


