

Scottish Recovery Network

Recovery and Strengths Based Practice

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John McCormack, Glasgow Association for Mental Health
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About the Scottish Recovery Network and this series

The Scottish Recovery Network (SRN) is funded through Scottish Government's National Programme for Improving Mental Health and Wellbeing to:

- Raise awareness of recovery from long term mental health problems.
- Develop understanding about the things that help and hinder recovery.
- To build capacity for recovery by supporting local action and highlighting and encouraging innovation in services.

This is the sixth in a series of discussion papers designed to help generate debate on how best to promote and support recovery from long-term mental health problems in Scotland. A number of source materials were used to inform its development. Contact the Scottish Recovery Network for more details on the series.

For more information on the Scottish Recovery Network visit www.scottishrecovery.net. For more information on the National Programme for Improving Mental Health and Wellbeing visit www.wellscotland.info.

About the author

John McCormack is Training and Development Manager with Glasgow Association for Mental Health (GAMH).

John's experience as an addictions counsellor, and subsequently working in the fields of homelessness and mental health, has led him to firmly believe in the inherent strengths and resilience of people who have complex needs.

John is committed to supporting recovery and the training and consultancy he delivers on behalf of GAMH is designed to help others realise their full potential.

Summary

This paper discusses the role of strengths in recovery and strengths based practice describing Solution Focused Therapy (SFT) as one particular model. Strengths based practice is a paradigm shift in mental health and has been implemented widely in the design and delivery of services in New Zealand, Canada, North America, Japan and increasingly so in the UK.

The concept of recovery is integral to strengths based practice. The values of the approach include the belief that people with mental health problems have resilience and other inherent resources which can be amplified and utilised to support their recovery journey.

This discussion paper contrasts a deficits approach with a strengths approach, and explores the meaning of strengths and from this how to assess for strengths as well as needs.

The solution focused approach is offered as a model of how to implement strengths based practice.

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Introduction

Taking a strengths based approach to the promotion of recovery involves looking at people with mental health problems with fresh eyes and noticing appreciatively qualities which were previously seen as only peripheral to the recovery journey.

As with all approaches and perspectives it has assumptions, beliefs and values which underpin practice and this paper will provide a basis for considering the implications of these values and assumptions in terms of how these can assist or hinder recovery.

A strengths based perspective does not deny that people can suffer appalling and prolonged mental distress; this proposition is accepted as a human given. The strengths based practitioner accepts this reality and offers compassionate empathic support whilst being vigilant and mindful of other qualities that coexist beside and within human suffering.

A brief look at models of mental health

As in all areas of life where there are competing philosophies and theories, views can become polarised and much heat generated. It is not the aim of this paper to contribute to the ‘what is mental illness?’ debate, but merely to offer a description of the strengths based approach in the hope that it can offer something useful to everyone, in terms of recovery.

Traditionally mental health professionals have tended to focus on symptoms, illness and dysfunction. Very influential publications such as The Diagnostic and Statistical Manual of the American Psychiatric Association (DSM 1V), and the International Classification of Mental Disorders (ICD-10), have categorised, codified and listed descriptions of a very wide range of emotional or mental problems. These books describe the symptoms and deficits associated with each disorder. For example one symptom of a Major Depressive Episode is “depressed mood, most of the day, nearly every day” (APA 2000 p168).

Given the influence and status of such literature it is hardly surprising that mental health assessments are thematically built around the signs and symptoms, problems and deficits people might have.

Similarly, Social Models of mental health might attribute mental health problems more to such factors as domestic violence, poverty, poor housing, unemployment and so on but again might be naturally drawn more to deficits than strengths.

Counsellors and psychotherapists on the other hand may take the view that some mental health problems are caused by the thoughts, attitudes and assumptions held by the individual and may work with the person to challenge negative beliefs or ‘faulty thinking’. Evidence based treatments like Cognitive Behavioural Therapy (CBT) work on this basis. Again the emphasis is on ‘faulty thinking’ rather than being especially curious about why the client has some thought processes and strategies that actually work rather well.

Thus it could be argued that the mental health professionals’ default mode is to assess around deficits, problems and disabilities. Furthermore, structurally there can be in-built rewards for taking this approach. For example if a worker is supporting someone to apply for income benefits, clearly that process encourages both the worker and the service user to describe problems in their starkest and most acutely distressing terms. Obviously an ethical professional will not go as far as to misrepresent the situation, but equally there is no incentive to describe the service user as they function at their best. The reality is that all supports and services are finite and as a result they tend to be offered according to greatest need.

It can be argued that psychiatry and psychology both operate in a culture wherein taking a deficits view is so much a part of our way of living that it is almost an unconscious process. For example many of us recognise that whether at school or at home with parents, we generally get a lot more feedback about everything that we did wrong, in contrast to limited feedback on what we were doing well. Indeed the feedback given when one makes an error is usually immediate, specific and sometimes even delivered with relish.

In practice Graybeal (2001) notes that trying to work in any other way than within deficit led models is very difficult because “the exigencies of getting work done, within the dominant paradigm, tend to reduce the attention paid to possible alternatives, leading to a sense of powerlessness in both practitioners and consumers.”

Recovery as delineated in *The Strengths Model* (Rapp & Goscha 2006) describes mental health case management from a strengths and resilience perspective, which "allows for new and creative ways to work with clients that honour their skills, competencies, and talents as opposed to their deficits." Their approach firmly locates this practice within the recovery framework.

The strengths based approach to recovery could be described as agnostic, and need not be in dispute with, or subscribe to, any particular model or theory of mental health. Instead the strengths based approach seeks to answer some quite different questions like:

- Why do people survive the problems of life at all?
- What resources do people draw on that would account for their resilience?
- Why do a significant majority of people diagnosed with mental health problems not just survive but often live well despite their problems?
- What are the protective factors that support recovery?
- What meaning do individuals ascribe to their experiences, their suffering, and their triumphs?

Taking a strengths based approach involves moving away from a focus on deficits and therefore represents a paradigm shift. Assumptions on “treatment” are challenged and the role of the service user is transformed from passive recipient of treatment into active collaborator or indeed director of their own recovery.

This shift from deficits to strengths is more challenging and fundamental than it might first seem. It can be argued that many people simply do not have a vocabulary for strengths and abilities. One of the few times in people’s lives that they are asked to describe their strengths is at a job interview!

In the recovery oriented training I deliver to professionals in social care in Scotland on the subjects of Solution Focused Therapy, Motivational Interviewing and strengths based practice, I invite the participants (who are all workers, often involved in very challenging areas such as substance misuse, homelessness and supporting people who have been through trauma) to do a thought experiment in two parts.

Part 1.
The participants are asked to think about all the deficits, failings and things they don’t like about themselves, and to silently count these. There is no confessional aspect to the exercise; the group does not wish to hear what these deficiencies are. The group can do this exercise without any difficulty and can easily reach a dozen or more deficits.
I then ask them to rate their self esteem subjectively on a scale of 1-10. Again there is no need to share this information.

Part 2.
I ask them to try and name the strengths, skills and abilities they possess. In effect a mini self-assessment of their own repertoire of strengths. Again they are not required to state them out loud to the group. Having counted strengths and abilities I would again ask people to subjectively rate their self-esteem on a scale of 1-10, and inevitably this figure had improved, simply by the act of reflecting on positive attributes.

Perhaps as you read this you might like to try and name your own strengths and count them… How many did you count? More than a hundred? Typically the skilled professionals at these training sessions report on average about seven or eight strengths. A surprisingly large number cannot name more than five and rarely someone can recall ten or twelve strengths but this is exceptional.

The participants are then given a handout which describes 38 strengths that any one of us might possess, for example:

- I can be a creative person.
- I am willing to learn and adapt.
- I am usually in control of my impulses.
- I am able to love other people.
- I can enjoy being alone.
- I can think about my mistakes and learn from them.

After considering this list, they come to realise that they have typically got more than 30 strengths but that they had somehow been unable to name them.

How to account for this apparent difficulty in naming strengths, even when the person doing it is in full time skilled employment, has qualifications, relationships, somewhere to live, and is generally living reasonably well? It could be that culturally there is no emphasis on noting strengths skills and abilities. It may be that in mental health (and social care generally) our default mode is to seek out problems, difficulties and disorders as an automatic start point. Whatever the reasons for our apparently limited vocabulary for strengths and virtues, some theorists are attempting to provide a counterbalance. Character Strengths and Virtues (Peterson and Seligman 2004) is a manual in the style of the DSM or ICD-10 which uses equal scientific and intellectual rigour to codify strengths as opposed to disorders. This ‘manual of the sanities’ describes in detail how the various strengths were identified, their universality across cultures and how these relate to the work of others such as Erik Erikson or Abraham Maslow. For example six ‘core virtues’ appear to be consistent across cultures, courage, justice, humanity, temperance, transcendence, and wisdom. By focusing our attention on what is right with people, this book represents a powerful new resource for all types of solution-focused, strengths based practitioners.

Recovery and assessing for strengths

Psychology and psychiatry have for the past 100 years or so been so focused on deficits and disorders that it could be argued that the term ‘assessment’ often really means ‘assessment of problems and difficulties’ e.g. do you have problems with alcohol or other drugs? Have you ever been in care? Thus it has become natural to look for what is wrong with people and what treatment ought to be prescribed and applied. In this context the invitation to professionals to start looking at what strengths and resources people posses can generate resistance and feel counter intuitive. It may prove challenging to relinquish the search for the legendary ‘signs and symptoms,’ and to start looking for the signs and symptoms of wellbeing and bring them to awareness.

Features of a strengths based approach

Like all models and approaches the strengths based approach has its own assumptions and beliefs. One of these is that: **People have strengths, skills, and abilities.**

Strengths based practice uses these skills and personal strengths as the platform on which recovery will be built. Strengths based practitioners do not deny that serious symptoms and problems exist. Suffering, problems, mental distress, and severe difficulties do exist, but they are not the whole story.

Examples:

Problem	**Strength**
Patient misses appointments	Person attends some appointments
Client is homeless	Individual has street survival skills
Client mixes with bad peer group	Person has a network of friends
Client is in perpetual crisis	Person continues to exist despite the stress
Patient is dysfunctional	Person is overwhelmed and is in need of support
Client resists agency intervention	Person believes in using own strategies
Client is co-dependant	Person has a close mutually supportive relationship
Patient is paranoid	Person is afraid and the fear may be justified

One well established and well researched strengths based approach is the Solution Focused Approach also known as Solution Focused Brief Therapy. In taking a strengths based approach workers are not necessarily doing therapy, but the principles used will be identical to those that underpin Solution Focused Brief Therapy.

Solution Focused Therapy, strengths and recovery

The basic principles commence right from the outset. The stance during assessment is yes, to empathically explore the problems, difficulties and hurdles facing the individual, and the greater these problems are, the more amazing it is that the person can be here today to voluntarily participate in assessment at all. This participation alone points to hope and optimism and tells the strengths based practitioner that the person is willing to engage (as much as they can, given their circumstances) in the process of change.

As with all good interventions, the active ingredient is empathy, and so the worker must spend time understanding the person's difficulties and problems and acknowledge vulnerabilities and losses. This process builds rapport and engagement and is experienced by service users as genuinely helpful and supportive.

Nonetheless, from a strengths based standpoint one of the assessment questions that the worker is very curious about is "how did you survive all of that to be here today?"

In exploring theses survival and coping skills the strengths based approach seeks to unpack and amplify these skills in ever greater detail. Questions like “and what else do you do that helps you deal with these problems?” help draw out the details of the persons problem solving strategies and other resources so that imperceptibly the dialogue between worker and service user takes on the aspect of a curious worker seeking to understand how the expert client manages to deal with whatever mental health or other problems they may have.

Assessment is conducted in a conversational and engaging manner, and the language used documenting it, is from the service users’ perspective and in their own words, paying attention to the metaphors and images used by the client. Strengths based assessment is viewed as ongoing and evolving.

This leads to another key feature of a strengths based, solution oriented approach; the explicit recognition that the client is the expert. This approach respects and honours the individuals lived experience and involves the worker in relinquishing the role of expert or teacher in favour of that of collaborator working towards recovery in partnership with the service user. This allows the worker to be open, respectful and curious, thus avoiding a prescriptive or dogmatic approach.

WORKER AS EXPERT	**WORKER/CLIENT AS COLLABORATORS**
Thinks in terms of problems and mental illness	Thinks in terms of solutions and mental health
Use of technical expert language	Uses person’s language and metaphors
Use of diagnostic labels Pathologises	Aware of labelling and avoids it De-pathologises.
Can set goals unilaterally	Co-constructs goals
Can impose interventions	Negotiates joint action plans
Thinks illness is ‘severe and enduring’	Recognises that recovery is a real possibility

In using a strengths based, solution focused approach the basic building blocks of good recovery practice are taken as being fundamental:

- Belief that recovery is a possibility
- Respect
- Encouragement
- Optimism
- Empathy
- Anti-oppressive practice
- Self awareness and reflective practice
- Understanding the principles of recovery
- Clear boundaries
- Accepting the persons definition of the problem
- Objectifying not personalising the person’s behaviour

Rapp & Goscha (2006) propose six ‘recovery principles,’ these being:

1. People with psychiatric disabilities can recover, reclaim, and transform their lives.
2. The focus is on individual strengths rather than deficits.
3. The community is viewed as an oasis of resources.
4. The client is the director of the helping process.
5. The case manager-client relationship is primary and essential.
6. The primary setting for the work is the community

Regaining the vision and aspirations

Traditionally therapy has often been seen as having something to do with getting to the root of problems, expending great effort looking back to the past and trying to analyse the origins of the mental distress or other presenting problems. Whilst a strengths based, solution focused approach does not consider this to necessarily be unhelpful, it does not regard it as the main focus of the process. There is rather more of a future oriented emphasis involving trying to elicit the service user's sense of a 'preferred future'. This can involve the use of various 'what if' questions designed to rekindle a sense within the service user of having permission to dream of an attractive inspiring future. To help this, the worker will try to enlist the internal motivations within the person; 'If all the problems that brought you here today just disappeared what would you be doing differently?' 'Where would you be?' 'What would you be doing?' 'How will that be better?'

A well established variant of the kind of question that gives people permission to visualise their preferred future is the 'Miracle Question' which goes along the following lines *'Suppose tonight when you go to sleep, a miracle takes place. The miracle is that all the problems that brought you here to talk to me, all disappear. You don't know that the miracle happened because you were asleep. What's the first thing you will notice in the morning that will tell you a miracle has happened*?'

The answers to this question are amplified by the worker and developed using simple 'and what else?' questions and by asking from different perspectives. For example, 'What is the first thing that your partner will notice that will tell them that you have changed?' Thus one of the aims of this type of approach is to enable people who have been facing distress and difficulties to look beyond their immediate very real problems and dare to dream of a future that inspires them, providing hope and the possibility that things can improve.

Workers may have some concerns about this, wondering if it will create disappointment after the exercise is over, or in some way making the person feel worse as they come back in their mind to their reality. In practice service users know it is a 'what if' exercise and report that they have enjoyed the chance to think about their preferred future. Some questions invite the person to project forward in time; 'If I was to see you in six months time and things are better than they are now, what was it that you did that made the difference?' Note that this type of question is presuppositional, meaning that it has a built in hidden assumption that things WILL get better. It appears that this type of use of language subtly helps the person see that the worker believes in them and in their self-efficacy and capacity to change.

These questions invite the person to reflect on possibilities instead of on intractable problems. The person's current problems are not ignored or discounted, when the individual feels the need to talk about their pain or any difficult experiences from the past, they are offered active listening, empathy and support, however, the worker does not seek to lead the person into repeated recounting of the narrative of suffering. The worker is attentive not just to the person's difficulties but also how they manage to deal with them. Ultimately the individual is invited to attribute survival and recovery to their own internal capabilities, thus enhancing the sense of self-efficacy.

Having empowered them to gain a vision of their ideal future the next step is to help the person state what the first very small step they would like to take is. This will tell them that they are moving towards their preferred future even in a small way.

Experience shows that having had some sense of inspiration people are motivated to set their own goals toward a target which has sprung from their own imagination.

Seeking exceptions to promote hope

Another element in the strengths based, solution focused approach to recovery is the focus on 'exceptions', these being those times in the past when the problem was either:

- Not happening.
- Was happening but was under control.
- Was there but was not so prominent.
- Was there but somehow was being coped with more effectively.

Almost all problems and difficulties have exceptions; primarily because nothing in life is static, even chronic problems have their variations. For example mental health problems are known to vary over time. There can be times of great distress, times of relative stability and times where a sense of recovery is experienced. Too often a deficit led approach explores the periods when things were at their worst and seeks to analyse these, to analyse the factors and triggers that caused the bad times. This is of course reasonable and might well shed light on things to be avoided. However, by looking equally at times when things were better, the person can see that change is possible (and inevitable) and that they had some responsibility for those times when things were better. The ongoing assessment is geared towards helping the person see that they are not stuck, and the strategies and behaviours they used in the past could be redeployed, perhaps with some fine tuning to gain improvement in the present and future.

Sometimes elicited exceptions are very significant indeed. "For ten months two years ago I was completely well and happy" - a quote from a homeless woman who described herself as "chronically depressed" but who had not noticed the significance of the fact that two years ago when she spent ten months on a friends farm in Ireland her depression lifted, only to return when she came back to her circumstances at home. From this realisation she suggested that she should perhaps go back to Ireland, which was in fact a possibility and ultimately it was what she chose to do. A very simple example, but if the focus had been on deficits alone, would such a solution have emerged from her? One can only speculate.

Other exceptions may not be so dramatic, but reflecting on them may yet generate clues as to why in the past they had coped somewhat better with their problems.

Change is constant and inevitable

The fundamental belief that change is constant and inevitable underpins recovery and the strengths based, solution focused approach. If we reflect on our lives, are we the same as we were five years ago? One year ago? Six months ago? Inevitably our circumstances change (not necessarily for the better) our health changes, our income changes, everything changes, so how can things ever really be stuck? Acknowledgement of the transient and temporary nature of everything helps service users to notice that even suffering changes. Thus terminology like 'severe and enduring mental illness' loses some of its pessimistic power if the inevitability of change is given prominence.

Hawkes and Hingley (2007) have described the tendency to be "stuck in a professional conceptual rut" as the "Groundhog Day Effect in Mental Health Care". Hawkes and Hingley note that "*We cannot **not** change… the assessing nurse is not encouraged to take time to notice those variables that may make a difference. The intricate richness and complexity of the one occasion when the person surprised themselves and went out despite their problems, is lost in favour of a list of symptom behaviours.*"

The emergent imagery of strengths and resilience begins to replace the deficit focused discourse and the self image can begin to shift from one of hopelessness to competency. As

this process continues both worker and service user get habituated to noticing and discussing strengths, resilience and coping skills as a matter of routine.

Scaling questions

The use of scaling questions, wherein the service user rates their own subjective feeling states such as confidence, motivation, satisfaction with life, mental health and whatever other matters feel relevant to the client, are powerful tools for helping the service user to take control of the process and direct their energy onto the issues they feel to be most salient.

Such user led self-assessment helps restore some balance in the power differential that exists between service user and service provider. It helps both parties notice change over time from the baseline ratings and helps the service user move towards being a service director.

Scaling is a deceptively simple technique which, if skilfully employed, can help the service user transform nebulous mood states into very specific and measurable components that either show that change is happening already, or enable the person to see what changes need to take place to let them know they are making progress.

How scaling works in strengths based, solution focused practice

Let's assume that the issue of motivation has arisen. The comment 'I don't really feel I have the willpower to make that change' may have been uttered. To use the scaling tool the worker might ask 'on a scale of one to ten, with ten meaning that you are totally 100% committed to making this happen, and with one meaning that you have no motivation to change, what number would you rate yourself at just now?'

Now whatever number the person rates themselves at, the strengths based worker can utilise it by inviting the service user to:

- Wonder why the number isn't lower (if already at 1, why has it not gone negative?)
- Visualise moving up one number.
- Describe what needs to happen that will tell them they've moved up a number.
- To notice what's different now that they have moved up a number.
- To visualize being at 10, they don't need to do any work to get to ten, just enjoy visualizing it and describing the preferred state.

Scaling will be combined with presuppositional language in a skilful manner so that the worker might ask: 'How will it feel when your self esteem has risen by 1 point?' thus implicated in the question is the belief that this change is achievable.

Scaling can be done creatively using a line of chairs in a room to represent the scale, or it can be a line that the person takes steps along to help them visualise change. This might suit some service users who are more visual than numerical in their thinking style.

Recovery goals and outcomes

Following the self-assessment the service user will be encouraged to set their own SMART objectives (Specific Measurable Achievable Relevant and Time limited). Negotiating small measurable goals allows for early success to take place and this helps foster motivation toward the next small goal. Having set the goal for themselves the person can see the purpose and meaning of the objective and how it fits with the vision of their preferred future.

Small goals are much better than big goals; small goals can create feelings of success and efficacy whereas big goals feel too difficult.

These goals will be regularly jointly reviewed and serve to help both worker and service user to jointly notice areas of progress and areas of 'stuckness' and to adjust the action plan accordingly. This also allows the service user to identify if appropriate an exit strategy from the support should they feel that they have achieved all the objectives they wanted in collaboration with the service provider. Again this helps maintain a better balance of power and helps prevent creating a dependency.

Subsequent sessions

All sessions following assessment utilise scaling and the other approaches already described. In order to keep the focus on change and recovery it is useful to ask service users at subsequent sessions, 'what's better since we last met?' To this apparently risky question there are only really three broad answers:

A. Something (and it gets described).
B. Nothing, everything is the same.
C. Things are worse.

If it is answer A then the credit for improvement is attributed to the service user.
If B, we might be curious about how they managed to maintain stability and avoid crisis or chaos. If C we might empathise with the situation before being curious about how they manage to cope and deal with a deteriorating situation yet still be able to have this conversation with a worker.

Related developments

The values and working assumptions embodied in strengths based practice and Solution Focused Brief Therapy are aligned with those of the recovery agenda. These ways of conceptualising best practice in mental health have been around now for more than 25 years and are becoming ever more widely adopted. Indeed the Tidal Model which uses many of the principles of the solution focused approach has been successfully rolled out across a range of statutory mental health services and in Glasgow the NHS has introduced 'Solutions Groups' based on ideas similar to the recovery principles described in this paper, a leaflet on this can be found on the tidal model website (www.tidal-model.co.uk).

Elsewhere the development of the Scottish Recovery Indicator as outlined in Delivering for Mental Health (Scottish Executive 2006) creates an expectation that assessment, care planning and delivery will take account of, and promote, strengths.

These approaches seek to promote recovery and treat people with mental health problems in exactly the way anyone receiving a service would want to be treated. Workers adopting this approach to recovery have to fundamentally believe that the service users lived experience represents the expertise that will be crucial to the recovery journey.

It is interesting to notice how these concepts and ways of working have been adopted and reconfigured across a spectrum of human endeavours. The world of business and commerce increasingly employ solution focused strategies in management coaching. In organisational development the approach goes under the name Appreciative Inquiry, which is located within the positive psychology movement, which again like strengths and solution based approaches focuses on peoples exceptionality, their unique gifts and then uses these as leverage in the pursuit of good outcomes (http://appreciativeinquiry.case.edu/).

Similarly Positive Deviance www.positivedeviance.org takes the same philosophical and practical approach to community problems; i.e. the solution to the community's problem lies within the exceptions (or positive deviance) that inevitably exists within the community. All of these variants of strengths based-solution focused practice are primarily concerned with recovery.

Conclusion

Solution focused strength based practice is not just about asking some new interesting questions or recording a service users skills during assessment, it is a mind set, a lens through which everything is viewed and everything is changed. It is a world of possibilities, of curiosity, of new expectations. It reveals perspectives that were previously invisible.

Practitioners may begin to wonder if every aspect of human behaviour contains a hidden strength. Does that poor personal hygiene actually protect some people from unwanted attention? Is that chaotic drug use actually the solution to intrusive thoughts? Is that person's 'paranoia' actually a justified fear based on having experienced violence from people who should be benign?

Ultimately the strengths based philosophy seeks to promote self-efficacy, giving individuals a belief in their own abilities and competencies. The client is helped to begin the transformative journey from service user to service director. Taking control of the goals they wish to achieve leading towards their overarching preferred future. This approach also has the advantage of helping to defend against the unwelcome possibility of the service user developing feelings of dependency towards the worker.

Perhaps the last word should go to someone with the lived experience of mental health problems, who had first been hospitalised and put on major psychiatric medication as a teenager. Patricia Deegan writing in the foreword to Rapp & Goscha (2006) states that strengths based practice is "a powerful antidote to the high cost of the deficits approach. In this model, strength is not constructed as some superheroic state of invulnerability. Rather, we learn that even when people are present with obvious vulnerabilities, they also have strengths. Their strengths are in their passions, in their skills, in their interest in their relationships and in their environments. **If mental health practitioners look for strengths, they will find them."**

Commenting and finding out more

If you have any comments to make on this discussion paper, would like to contribute to the work of the Scottish Recovery Network or would like to join the mailing list then email info@scottishrecovery.net or visit www.scottishrecovery.net.

BIBLIOGRAPHY

American Psychiatric Association (2000) *Diagnostic Criteria from DSM-IV-TR.* (Washington, APA,)

Benard, B. (2004). *Resiliency. What we have learned*. San Francisco: WestEd.

Barry, L. D., Hubble, M. A., & Miller, S. D. (1997). *Psychotherapy with "Impossible" Cases. The efficient treatment of therapy veterans*. New York: W.W. Norton & Company.

Canda, E. R., & Smith, E. D. (2001). *Transpersonal perspectives on spirituality in social work*. New York: Haworth Press.

Chapin, R. (2006). *Social policy for effective practice: A strengths approach.* Boston, MA: Mc Graw Hill.

Corcoran, J. (2005). *Building strengths and skills: A collaborative approach to working with clients*. New York: Oxford University Press.

Csikszentmihalyi, M., & Csikszentmihalyi, I. S. (2006). *A life worth living: Contributions to positive psychology*. Oxford; New York: Oxford University Press.

Davis, L. V. (Ed.). (1994). *Building on women's strengths: A social work agenda for the twenty-first century.* . New York Haworth Press.

Duncan, B. L., & Miller, S. D. (2000). *The heroic client. Doing client-directed, outcome informed therapy*. San Francisco: Jossey Bass.

Graybeal, Clay (2001) *Strengths-based social work assessment: Transforming the dominant paradigm* Families in Society,

Hawkes, D. Hingley, D. (2007) Recovery Intelligence and "Groundhog Day" Effect in Mental Health Care: Mental Health Nursing 27(4): 18-19

Hope, R (2004). *The Ten Essential Shared Capabilities*. *A Framework For The Whole Of The Mental Health Workforce* London: NIMHE

Hubble, M. A., Duncan, B. L., & Miller, S. D. (2002). *The heart and soul of change. What works in therapy*. Washington D.C.: American Psychological Association.

Lieberman, A. A. (1998). *The social workout book: Strength-building exercises for the pre-professional*. Thousand Oaks, Calif.: Pine Forge Press.

Linley, A. (2006). *Counselling Psychology's Positive Psychological Agenda: A model for Integration and Inspiration*. The Counselling Psychologist 34:313: Sage.

Mills, R. (1994). *Realizing mental health*. New York: Sulzburger & Graham.

Norman, E. (Ed.). (2000). *Resiliency enhancement. Putting the Strengths Perspective into social work practice*. New York: Columbia University Press.

O'Connell B., Palmers,S. (Ed.). (2000). *Handbook of Solution Focused Therapy* New York: Sage Publications: London

Peterson, C., & Seligman, M. E. P. (2004). *Character strengths and virtues: A handbook and classification*. Washington, DC: American Psychological Association: Oxford University Press.

Rapp, C. A., & Goscha, R. (2006). *The strengths model: Case management with people with psychiatric disabilities* (2nd ed.). New York: Oxford.

Rapp, C. A., & Poertner, J. (1992). *Social administration: A client-centred approach*. New York: Longman Publishing Company.

Ridgway, P., McDiarmid, D., Davidson, L., Bayes, J., & Ratzlaff, S. (2002). *Pathways to recovery: A strengths recovery self-help workbook*. Lawrence, KS: School of Social Welfare, University of Kansas.

Saleebey, D. (1997). *The Strengths Perspective in social work practice* (2nd ed.). New York: Longman.

Saleebey, D. (2006). The strengths approach to practice. In D. Saleebey (Ed.), *The Strengths Perspective in social work practice* (4th ed.). Boston, MA: Allyn & Bacon.

Scottish Executive. (2006). Delivering for Mental Health. Edinburgh

Sharry, S., Madden, M., Darmody. M. (2003). *Becoming a Solution Detective: Identifying Client Strengths in Practical brief Therapy.* New York: Haworth Clinical Practice Press

Shazer, S. de. (1991). *Putting difference to work*. New York: W.W. Norton & Company.

Snyder, C. R., & Lopez, S. J. (Eds.). (2002). *Handbook of positive psychology*. NY: Oxford University Press.

Snyder, C. R., & Lopez, S. J. (2007). *Positive psychology : The scientific and practical explorations of human strengths*. Thousand Oaks, Calif.: SAGE Publications.

Vaillant, G. E. (2002). *Aging well: Surprising guidelines to a happier life*. Boston: Little, Brown & Co.

Van Wormer, K., & Davis, D. R. (2003). *Addiction treatment; a Strengths Perspective*. USA: Wadsworth Publishing Co.

Van Wormer, K. S. (2001). *Counselling female offenders and victims: A strengths-restorative approach*. New York: Springer Pub. Co.

Van Wormer, K. S., Wells, J., & Boes, M. (2000). *Social work with lesbians, gays, and bisexuals: A Strengths Perspective*. Boston, MA: Allyn & Bacon.

Walter, J. L., & Peller, J. E. (1992). *Becoming solution-focused in brief therapy*. New York: Brunner/Mazel Publishers.

Wolin, S., & S., W. (1993). *The resilient self: How survivors of troubled families rise above adversity*. New York: Villard.

World Health Organisation (1992) *The ICD-10 Classification of Mental and Behavioural Disorders; Clinical Descriptions And Diagnostic Guidelines*: Geneva, WHO