

**THE STRENGTHS PERSPECTIVE: RELEVANCE AND
APPLICATION TO MENTAL HEALTH NURSING AND CRISIS
RESOLUTION WORK**

By

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ABSTRACT

This research paper aims to explore the contribution of the Strengths Perspective (hereafter known as S P) to mental health nursing practice. The S P emerged from the area of social work and is primarily concerned with emphasising the strengths and resources of the person, as they define them. The premise is that if a person is able to identify and call on those strengths then he or she is able to improve the quality of their life. The paper outlines the historical, philosophical and moral foundations of the Strengths Perspective and discusses the humanistic approach to mental health nursing. The aim is to demonstrate that the S P and mental health nursing have a strong alignment, particularly with regard to a person-centred approach to care. The influence and constraints of the biomedical model on both mental health nursing and strengths based practice is a theme of the paper. The contention is that the biomedical or pathological approach to care can often disable, not enable consumers of health care, whereas an approach that centres on a person and their strengths is more likely to empower and liberate. The paper concludes with a discussion of themes that emerged from reflection on the literature and propositions are then made about how mental health nurses might orientate their thinking and practice to utilise the S P to augment their clinical work.

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BACKGROUND INTEREST

The purpose of this paper is to explore how the Strengths Perspective (hereafter referred to as SP), originating from the social work domain, can be a useful adjunct to mental health nursing practice.

The S P emphasises the strengths of a person, as they would define them. The premise is that noticing and affirming a person's strengths has the potential to improve the quality of their life. It has much in common with humanistic nursing in that it is person centred and collaborative in style, and shuns the notion of the outside expert. The belief is that the person is able to call on their own resources.

The aims of the aims of this investigation are as follows: to extend my knowledge and understanding of the S P; to reflect on how the S P and a particular strengths based model, Solution Focused Therapy (SFT), can be used by mental health nurses in short term crisis, assessment and resolution; and to identify and explore the inherent tension between the pathological/biomedical model and the S P. My hypothesis is that the S P and the SFT model are useful approaches that will complement other approaches used in mental health nursing.

Key sources

To explore the contribution of the S P to nursing work literature searches were conducted in CINAHL, Medline and Proquest databases. Additional literature was sourced from recommended readings made available on the University of Kansas, School of Social Welfare website.

The key sources for the S P were primarily De Jong and Miller (1995), Saleebey (1992), Rapp (1998), Kisthardt (1997), and Goldstein (2002). De Shazer (1988) is noted for development of solution-focused therapy.

Key nursing authors were Peplau (1952), Forchuk and Brown (1989), Forchuk (1994), Crowe (2000), Webster (1990) and Webster and Vaughan (2003).

In this paper section one reviews the historical, philosophical and moral foundations of the S P and discusses the elements and language of the strengths perspective. The emergence and current place of the predominant medico-scientific (deficit) approach provides a background to the discussion of the S P. It is important to place the model in this context because the biomedical model, I contend, currently constrains mental health nursing practice and the implementation of strengths approaches.

The section concludes with limitations and criticism of the perspective.

Section two discusses several central mental health nursing concerns. The aim is to show that mental health nursing has a strongly developed person-centred approach to care which would be well augmented by the strengths approach. The impact of the predominant biomedical model is discussed in relation to both mental health nursing work and the strengths perspective. Preliminary comparisons between nursing work and the S P are made.

Section three describes the broad implementation of the S P and provides a context for a discussion on a specific strengths model, solution-focused therapy. I have chosen to emphasise solution-focused therapy (SFT) because of the relevance to my particular areas of interest: mental health nursing and conflict resolution. A rationale for the choice of SFT and a description of the process of working with this therapy will be made. Parallels are drawn to other intervention models (Peplau's therapeutic relationship and Robert's crisis intervention model). The section

highlights the contribution of SFT to my practice and limitations of the therapy.

Section four provides a reflective response to literature and themes that have emerged from a personal perspective (mental health nursing and the biomedical model, the interpersonal relationship and caring, hope, connecting with community). I will consider constraints to practice and propose some ideas as to how mental health nurses might orient their thinking and utilize the S P to augment their nursing work. The emphasis is on how mental health nurses might support a person-centred approach to care in the context of a disabling system of service delivery.

My practice using a strengths based approach has been very limited; however, my reflective response to the literature has led me to consider how mental health nurses might orient their thinking and practice to utilize the S P to augment their practice. The following themes have emerged from this process.

My nursing position

A recent discussion with nurse lecturer, Marg Connor, alerted me to two aspects of my nursing practice: my nursing orientation and approach and a current dilemma of practice. Marg said that ‘the moral endeavour of nursing is to respond to the person of the patient’ (Connor, personal communication, August 15, 2003). This comment struck me as particularly salient because it aligned with what I consider to be the purpose of my nursing relationships over many years. People have been at the heart of my practice and this has been enacted in the interpersonal therapeutic relationship. Taylor (1994) suggests that illness has the tendency to alienate and create uncertainty and feelings of despair with many people experiencing illness as a ‘lone’ journey. From practice, my experience of illness and crisis would align with this view and I try to

walk alongside people in a collaborative therapeutic alliance, being with people in the moment, but always mindful of future possibilities and the growth of hope.

I have adopted a narrative approach to practice. By this I mean that I listen to people's stories. I believe it validates them and their experience and enables me to understand the meaning of illness in their lives and to discern what is important to them.

Her second comment that 'nursing is stuck in a medical discourse, an illness not health discourse' (Connor, personal communication, August 15, 2003), though certainly not a new idea, highlighted again for me the dilemma of trying to maintain a nursing approach to practice when the helping environment is so deeply immersed in a pathological biomedical and problem orientated model.

Two years ago I recommenced work in mental health nursing practice after twelve years teaching in under-graduate nursing education. I chose to work in crisis intervention and resolution, as a community nurse. In my teaching practice I became very familiar with a humanist nursing approach and theories and models of humanist nursing practice. Applying this approach to nursing practice, in the 'real world' of mental health care, that has a predominant predisposition to a pathological biomedical paradigm, is certainly a challenge. It requires an expertness and confidence in your nursing philosophy, orientation and practice and an ability to maintain the client, with their concerns, needs, hopes and aspirations, as the core of your practice. These endeavours are easily waylaid in the current fiscally driven and politically motivated health care environment that, in stress, has gone back to what it knows best; the biomedical model.

Since returning to clinical I have been introduced to the SP and I see how it might contribute to my personal mental health nursing practice.

My introduction to the SP

My first experience with the SP (Saleebey, 1992) occurred when I participated in a co-joint crisis assessment with a social worker in our team. She employed a strengths based practice framework and as part of that process used a form of questioning, particular to the strengths approach, *the miracle question*. This question is asked in many ways, but typically a therapist might ask ‘if tonight while you were asleep a miracle happened and it resolved all the problems that bring you here what would you be noticing different tomorrow’ (Iveson, 2002, p150). Iveson (2002) suggests that the practice of miracle questioning allows the person to draw on their creative thinking in order to create a solution.

From this initial experience I noticed that the client was able to envisage how the quality of their life might alter. It appeared, from my perspective, to extend her current thinking to encompass possible future options. From this encounter I began to see how a strengths-base intervention could readily be incorporated into short-term crisis work.

Overview of the strengths perspective

The strength perspective is concerned with change in the present through exploration of the future, despite the fact that it has not occurred. It is by listening to a person’s story that their assets and strengths are discovered enabling them to face life challenges such as mental illness (Brun & Rapp, 2001). More traditional psychotherapeutic approaches tend to base the present situation on the history of the person, whereas the strength-based approach looks at future potential shifts within a person’s life and experience and in so doing invokes the possibility of hope. The S P views the person as resourceful and assumes that they

have everything, personally and in their communities, to solve their problems. This way of working values the notions of resilience, rebound, possibility and transformation as central tenants (Saleeby, 1996).

S P is a future orientated approach with philosophical principles that centre on the liberation and empowerment of people who often have very adverse and complex realities. It seeks to foster the notion of hope and a belief in what is possible as a central tenet in this liberation, however modest and unassuming that liberation may be (Saleebey, 2002).

The strengths perspective maligns the biomedical response that sees people as deficit and in the grip of problems and disorders that are a product of past experience. It does not disregard the real pains and struggles of individuals, families and communities, or deny the realities of abuse and addiction, but it does, however, challenge the ascendancy of psychopathology as society's civic, moral and medical imperative (Saleebey, 2002a). Similar concerns have been expressed in mental health nursing literature about a biomedical response to care (Peplau, 1952; Crowe, 2000a & 2000b; Connor, 2003). Peplau, a seminal writer in the area of interpersonal relationship in nursing, stated in a discussion with Phil Barker that

if nursing is to ever become the holistic, person-focused activity which it believes it is already, then it must reject the notion of packaging people and their care according to medical diagnostic criteria...the focus of nursing is quite clear: we have no real interest in people's diseases or their health for that matter, nurses are interested in people's relationships with their illness, or with their health (Barker, 1999, p.46).

The S P would contribute to nursing practice as it addresses the focus postulated by Peplau.

Possible contribution of the SP to mental health nursing practice in an acute crisis setting

There are several aspects of the strengths perspective that I believe will contribute to nursing practice: Firstly, the perspective emphasises the importance of the quality of the helping relationship; and secondly, it is aligned with the thinking and practice of crisis resolution work (Roberts, 2000; Green, Lee, Trask, & Rheinscheld, 2000); thirdly, it has several ideas, skills and techniques that can be readily used in busy settings and as short term interventions (Mason, Breen, & Whipple, 1994; Hagen & Mitchell, 2001); and fourthly, it affirms and cements a focus on people, their strengths and future possibility, potentially strengthening the mental health nursing discourse and a movement away from the predominant biomedical paradigm (Rapp, 1998; Saleebey, 2002a; Kisthardt, 2002; Goldstein, 2002).

I will address the above points as they relate to nursing practice and my particular practice.

The caring relationship

My practice, like that of most mental health nurses, emphasises the therapeutic value of the relationship between the carer and person using mental health services. The therapeutic relationship is placed at the heart of mental health care (Watkins, 2002, Barker, 1999, Horsfall, Stuhlmiller, & Champ, 2000). Sullivan (1998) and Whitehall (2003), however, contend that current practice in mental health nursing does not reflect these ideals as in many situations there is limited contact and therapeutic interaction between nurses and people in their care. While I believe I had sufficient contact and for the most part good therapeutic

interaction, I wanted to improve the quality of the engagement with clients and focus my activity on the person's innate strengths and resources.

Crisis intervention and resolution

I currently work with people who have acute mental health issues in home-based treatment. We practice from a crisis intervention and resolution perspective and employ the Robert's model of crisis intervention (Roberts, 2000a). I will not elaborate on the specifics of the model here as it will be described and compared to Peplau's interpersonal relationship framework and a strengths model, solution-focused therapy, in section three.

The strengths model is recommended in both nursing and crisis literature (Webster, 1990; Hawkes, Wilgosh, & Marsh, 1993; Webster, Vaughan, Webb, & Playter, 1995; Hillyer, 1996; Roberts, 2000; Green, Lee, Trask & Rheinscheld, 2000; Hagan & Mitchell, 2001; Webster & Vaughan, 2003). It has been shown to be an effective treatment for a wide spectrum of client issues (Saleebey, 1996; Rapp, 1998; McKeel, 1999; Brun & Rapp, 2001).

The purpose of crisis intervention is resolution of the most important issues for the person in a one to twelve week period (Roberts, 2000a). Parad (as cited in Roberts, 2000a) notes that it is not the crisis situation in itself that is the issue; it is the person's "perception and response to the situation" (p.197).

The S P is, therefore, well utilised in crisis work because it is a person centred approach and has some interventions that are short-term in nature. The perspective does also emphasise the building of future possibility and inspiration of hope.

The rationale for the use of solution-focused therapy, a particular strengths approach will be elucidated in section three.

Ideas, skills and techniques

There is some disagreement in nursing as to whether the nurse's work needs to have a process or is skills orientated. Some nurses argue that nursing conceptual models lack the degree of specificity needed for intervening in discreet individualised clinical situations (Johnson, 1992), while others believe that nurses are often obsessed with acquiring skills and technique (Michael, 1994). I tend to align with both points of view. I work in a process way, but would like to augment my kete (bag) of nursing tools. My belief is that nursing practice is promoted and enlivened and consequent client outcomes improved, if nurses continue to augment and strengthen their approach with the acquisition of new skills.

Maintaining a focus on people

From a broader viewpoint, however, the SP would serve to strengthen my mental health nursing practice. It will train my practice eye in the direction of the person, my listening ear to what they say are their issues, concerns, understandings and future possibilities.

My tendency is to move toward the predominant pathological paradigm when I experience stress and overwhelm. The dominating spectre of people's all-encompassing problems, as defined by those outside of them, becomes the focus of my work. It is easier to posit a view about a problem and act on that view rather than continue in a nursing process, with the person, particularly when you are not confident of yourself or the outcome. The biomedical psychiatric discourse can often be a default position that nurses move to, consciously or unconsciously.

I would like to further ground my nursing thinking in possibility rather than pathology, by implementing a particular strengths practice in my current crisis resolution work. My aim would be to build on my existing practice, so that my default position has strengths rather than a deficit/pathological orientation.

Conclusion

The current mental health-nursing environment appears to be very constrained by the predominance of a biomedical paradigm that dictates the treatment of people with mental health issues. The ability to care for people in the tension between the pathological model and a humanist, person-centred approach is something that confronts many nurses daily. This section has highlighted my nursing beliefs and philosophical position as a way of justifying the choice of the strengths perspective for nursing work. My thinking has been briefly explored in relation to nursing literature and parallels have been drawn between my initial understanding of the strengths perspective and these nursing views. The next section will explore several themes that have emerged that, from my perspective, are central nursing concerns. The themes will be situated in nursing literature and related more specifically to the strengths perspective. This will serve to background a fuller description of the strengths perspective in section two.

Section one

THE STRENGTHS PERSPECTIVE

This section reviews the historical, philosophical and moral foundations, and elements and language of the strengths perspective. A brief outline of the emergence and current place of the predominant medico-scientific (deficit) approach provides a context for discussion of a strengths approach to professional helping. This section concludes with a brief synopsis of the limitations and criticism of the perspective.

The two approaches to helping

In considering this inquiry there are two relevant perspectives on or interpretations of the human situations encountered when working with people in practice. The first is the medico-scientific or psychosociological (pathological), often described as the deficit approach. This approach is preoccupied with problems, human deficits, what is wrong with people and society. The second approach, the strengths approach, acknowledges the wholeness of clients, but needs to be considered in context of the larger system of health care, enmeshed in the medico-scientific perspective, that is often diametrically opposed to this approach. Structures, policies, programmes and the preferred language replace the client's own lexicon with the vocabulary of problem and disease (Goldstein, 2002; Rapp, 1996 & 1998; Saleebey, 1992, 1996, 2002a); Cohen, 1999; Blundo, 2001; Weick & Chamberlain, 2002). Following a strengths approach based on the notions of resilience, rebound, possibility and transformation is difficult, because strangely enough, it is not familiar to the world of helping and service (Saleebey, 1996).

The deficit approach

The helping professions discarded the notion that human failings were a consequence of moral failure in the 1930s when the developing fields of psychiatry and psychology portrayed human actions as mysterious, complex, deep seated and rarely as they seemed. 'Truth' could only be discovered by looking at underling and hidden meanings, making causal links in some sequential order to the 'cause' of it all (Blundo, 2001; Cohen, 1999).

This psychologising of human behaviour powerfully shifted the helping process as outside experts became the interpreters of what the person was feeling and why. It removed the behaviours from the larger social context, creating unique failures and problems, rather than bewildering and perhaps frightening, parts of normal human life (Weick & Chamberlain, 2002). Human failure and human problems became the focus of professionals work. This viewpoint has increasingly been articulated in sophisticated professional language with phrases that emerge from complex theory-driven taxonomies or differential diagnosis of pathological states. As an example, the *Diagnostic and Statistical Manual of Mental Disorders IV* (American Psychiatric Association, 1994) has twice the volume of text on disorder, despite being only seven years removed from its predecessor (Saleebey, 2002a).

Limitations, weaknesses, problems and failures remain the filters through which many professionals continue to view their clients. The tendency, when working from this perspective, is for professional to construct a discourse from the basis of deficit and to perpetuate this as the building blocks of the helping relationship (Cohen, 1999). The pivotal position of problems and pathology that underpin the deficit model is one the S P is endeavoring to counter (see Table 1).

The strength approach/perspective

Goldstein (2002) views the S P as an organising construct that embraces a set of beliefs and attributes about health and potential. The S P lays out the assumptions, values, and principles of the use of strengths in practice. The strengths model/s refers to how these are applied in practice (University of Kansas, 2004).

The S P is a multifaceted approach whose tenets are deeply rooted in social work history with Weick, Rapp, Sullivan and Kisthardt first used the words 'strengths perspective' in a seminal article in 1989. This article highlights social work's past emphasis on pathology and problems and the impact that this had on effective social work practice. It proposed the elements of an alternative strengths perspective that would provide an overarching conceptual metaphor for practice (De Jong & Miller, 1995; Kisthardt, 2002).

Subsequent to this many social work educators, providers and administrators have refined the perspective, provided clarity about its complex and diverse application and evaluated its effectiveness (Kisthardt, 1997; Rapp, 1998 & 2002; Saleebey, 1992, 1996, 2002 a& 2002b)

The School of Social Work at the University of Kansas has been pre-eminent in this development and on their website the S P is introduced in the following manner:

The strengths perspective arises from the profession of social work's commitment to social justice, the dignity of every human being, and building on people's strengths and capacities rather than exclusively focusing on their deficits, disabilities or problems. As an orientation to practice, emphasis is placed on uncovering, reaffirming, and enhancing the abilities, interests, knowledge,

resources, aspirations and hopes of individuals, families, groups, and communities. This approach assumes that the articulation and extension of strengths and resources increases in likelihood that people will reach the goals and realize the possibilities they have set for themselves (University of Kansas, 2004).

Over recent years there has been an increased interest in developing strength-based approaches to practice, in particular, case management with a variety of client groups in practice. Adults with severe and persistent mental illness, children and their families with severe emotional disturbance, people with addictions, the elderly, children and adults in the justice system. It has been implemented in small and large communities and used as a framework for policy analysis, and for understanding and acting upon women's concerns (Saleeby, 1996 & 2002a).

The notions underpinning the strengths perspective are an attempt to correct an overwrought and, and in some cases, destructive emphasis on what is missing, what is wrong and what is abnormal. Practicing from this perspective does not ask workers to ignore the real troubles that impact people and their sense of future possibility. But in "the lexicon of strengths, it is as wrong to deny the possible as it is to deny the problem" (Saleeby, 1996, p.297).

Elements of the strengths perspective

Kisthardt (1997; 2002) highlights the six principles of strengths based helping: the initial focus in the helping relationship is upon the person's strengths, desires, interests, aspirations, abilities, knowledge, resiliency, ascribed meaning, not on their deficits, weaknesses, problems or needs as seen by others. The participant is the director of the helping efforts and is responsible for their own recovery. The healing process takes

place on many levels with professionals serving as caring community living consultants. All human beings have the inherent capacity to learn, grow and change. The human spirit is incredibly resilient despite hardship and trauma and people have the right to try and the right to fail. The relationship with the person is the essential component of the support process and is characterized by mutuality, collaboration and partnership. A person-centred, strengths-based approach promotes activities that are home and community based; the entire family and community are viewed as a pool of potential resource and naturally occurring resources are considered before segregated or formally constituted resources are used

Saleebey (2002a) further illuminates the notion of the strengths perspective with the following assumptions. Firstly and most importantly, all people, families and communities possess strengths that can be called on to improve the quality of their life. Practitioners need to acknowledge their client's strengths and respect the direction in which clients want to apply them. Secondly, the client's motivation is promoted by consistently focusing on strengths as defined by the client. Client goals and visions are the base for intervention plans. Thirdly, the discovery of strengths is a co-operative process of enquiry between clients and workers; authoritative 'experts' do not have the last say. Fourthly, the focus on strengths moves the worker away from a tendency to 'blame the victim' and towards discovering how people have 'survived' despite very adverse circumstance. And, finally, all environments contain resources.

Table 1 contrasts the strengths approach with the biomedical pathological approaches.

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 sceptical of personal stories, rationalisations.	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.
Centrepiece of therapeutic work is the treatment plan devised by practitioner.	Centrepiece 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 centred on reducing the effects of symptoms and the negative personal and social consequences of actions, emotions, thoughts, or relationships.	Help is centred on getting on with one’s life, affirming and developing values and commitments, and making and finding membership in or as a community.

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Philosophy of the strengths perspective

Saleebey (2002a) discusses two major philosophical principles that for him set out the claims of the strengths perspective. Those two principles are: *Liberation and Empowerment: Heroism and Hope* and *Alienation and Oppression: Anxiety and evil* (italics added)

Liberation and empowerment: Heroism and hope

Saleebey (2002a) believes liberation is founded on the idea of possibility: opportunities for choice, commitment and action. He believes that within people there is a longing to be heroic, to transcend circumstance, to stand up and be counted and to face adversity down. Too often this is distorted or stamped out to serve the interest of others. Hope and the belief in future possibility are central to the liberation of people who often have very adverse and complex realities.

Paulo Freire (as cited in Saleebey, 1996) wrote: “Hope as an ontological need, demands an anchoring in practice.... Without a minimum of hope, we cannot so much as start the struggle” (pp.8-9). Rapp (1998) refers to research that suggests that hopeful people have goals, the desire or confidence, and a plan for achieving those goals. He believes because hope is so much to do with achievement that it is relevant for the strengths perspective and intervention.

Alienation and oppression: Anxiety and evil

Saleebey (2002a) makes a succinct description of how oppression and alienation occur in our communities. He says that it is clear from our experience that harsh and tyrannical institutions, relationships, circumstances and regimes exist. While the setting of people aside and treating them as the despised other and not fully human, is a quiet act, it is no less devastating than war, slaughter or repression. It is a reminder of the existence of brutality, evil and despotism that exist in the larger

global picture and in the nuance of daily life. However in the small confines of everyday activity people are able to transcend these forces of oppression. They are able to find the capacity to be heroic and allow the emergence of the human spirit.

The impact on practice of the philosophical foundations of the perspective

The theoretical approach professionals choose to use is a “creation of the mind, a shared collection of beliefs and assumptions selectively designed to interpret and explain particular phenomena” (Goldstein, 2002, p.26). When one theoretical approach is favoured over another there is clearly an advanced assumption about the outcome of that approach. Goldstein suggests that the deficit view of human behaviour predicts dire consequences whereas the strengths approach is inherently more hopeful and optimistic. The risk that workers face when they attempt to make sense of the client’s circumstance, by ordering them into one or another assumptive approach, is that they will miss the more subtle moral conflicts and ironies of people’s lives that are expressed in their stories.

It is through the language of people’s stories that practitioners can learn about resilience and strength and the implicit moral persuasions that they call on to become a person. The language of the chosen perspective inevitably dictates the practitioner’s role in relation to the client. Because the language of the biomedical model is the language of the outside expert, ethical questions emerge regarding allocation of power and authority questioning the potential for self-determination of the client (Goldstein, 2002).

Languaging of the perspective: The lexicon of strengths

William James (as cited in Saleebey, 1996; 2002a) who, upon reflecting on Kant's notions about conceptions wrote "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). Saleebey (2002a) believes that workers need to examine the language of helping as words have the power to elevate or destroy. Goldstein (2002) posits that the language of the philosophies, theories and concepts that are used by professionals to explain or classify clients will, by definition, influence the character, style, and goals of the helping process and significantly, the expected roles of the participants.

Saleebey (2002a) describes significant words and phrases that make up his 'dictionary of helping' (Saleebey, 1996, p.298). These are: *empowerment, membership, resilience, healing and wholeness, dialogue and collaboration and suspension of disbelief*. Other strengths writers use similar languaging (Rapp, 1998; Kisthardt, 2002; Goldstein, 2002; & Benand 2002).

Empowerment

Empowerment describes the intent to, and the processes of, assisting individuals, groups, families and communities to discover and expend the resources and tools around them (Saleebey, 2002a). People are supported to define their own worlds, aspirations, problems and strengths as a way of discovering the power within themselves and their communities (De Jong & Miller, 1995). Saleebey reminds us that supporting empowerment means that workers need to trust in people's intuition, accounts, perspectives and dreams, assail the victim mindset, and provide opportunities for connection to people.

Membership

People need to be valued, respected and responsible community citizens. Often people who are consumers of mental health services do not have membership in our communities and consequently risk alienation, oppression and marginalisation (Saleebey, 2002a). The lack of sense of belonging can mean that people are out of touch with their strengths and possibilities. Working collaboratively with people; affirming their perceptions and stories; recognizing their successes and efforts and fostering links to contexts where people can flourish engenders a sense of membership and community, need to be the aims of people working in this model (De Jong & Miller, 1995; Saleebey, 2002a).

Resilience

Lifton (as cited in Benand, 2002) describes resilience as the human capacity of individuals to transform and change, regardless of the risks they face or the challenges they endure. It is an innate 'self-righting' mechanism Werner & Smith (as cited in Benand, 2002).

People have growth capacities to form relationships (social competence), to develop a sense of identity (autonomy), to problem-solve (metacognition) and to plan and hope (a sense of purpose and future). Resilience does not just belong to a chosen few, as individuals have resilient natures that recognize healthy people and messages and are able to save these as a future possibility (Benand, 2002). Literature suggests that that majority of humans have the facility to overcome the harshest of experience and most actually do. The rule, not the exception in human affairs, is that people do rebound from serious and troubling adversity (Rapp, 1998; Saleebey, 2002a).

A common theme in resilience research is that there is one person, often unbeknownst to himself or herself, who shifts the scale from risk to

resilience. These turnaround people are described as having the following attributes that are consistently identified in research as being critical protective factors: caring relationships, high expectation messages, and opportunities for contribution and participation. A professional working from a strengths viewpoint promotes resilience and the need to be caring, compassionate, respectful, non-judgmental and be able to see the possibility for a person outside of himself or herself (Rapp, 1998; Benard, 2002).

Goldstein (2002) views the strengths perspective as an organising construct that embraces a set of assumptions and attributes about health and potential. He says while this may not be a consensual definition, he sees resilience as ‘the attribute that epitomizes and operationalises what the strengths perspective is about’ (p.30).

Healing and wholeness

Healing entails both wholeness and the inherent facility of the mind and body to regenerate and resist when confronted by disease, disorder and disruption. It seems that all humans have the inclination to heal and in a sense ‘know’ what we need to know. This knowledge may not exist in behaviour and thinking, however, unless the environment requires and elicits it. Healing occurs when the worker is able to align with and instigate the power of, the individual to restore themselves (Saleebey, 1996; 2002a).

Dialogue and collaboration

Dialogue necessitates identification with, inclusion of and genuine empathy for other people. To truly hold dialogue with a person requires an exploration and affirmation of the ‘otherness’ of the person.

The notion of collaboration has a more specific focus. To collaborate means to negotiate and consult with the person, the worker's role is not to provide expert answers (De Jong & Miller, 1995; Saleebey, 2002a).

Suspension of disbelief

The ability of workers to shift perceptions of people with mental illness is viewed by many well-known writers and researchers of the strengths perspective as central to this approach (Rapp, 1998, Saleebey, 2002; Kisthardt, 2002).

Rapp (1998) states that in many cases the mental health system has institutionally low expectations, despite evidence to the contrary. Harding, Brooks, Takamura, Strauss, and Breier (1987a & 1987b, as cited in Rapp, 1998) in a 20-year study, found that people with major mental illness will eventually merge into the fabric of community, having, jobs, friends, families and homes. Mental health workers, he states, must have a belief in people and the capacity to better their lives and that the 'practice perspective must reek of "can do" in every stage of the helping process' (p 54). The strengths perspective demands that workers regard their professional work through a different lens. Individuals, families and communities need to be seen in the light of their capacities, talents, competencies, visions, values, and hopes, however broken and distorted by circumstance, oppression and trauma (Saleebey, 1996).

People, viewed from this perspective, have an inherent capacity to grow, learn and change. The upper limit of a person's capacity to do this is not known, so workers need to take individual family and community aspirations seriously (Kisthardt, 1997). This "re-vision" requires professionals to suspend their initial disbelief in clients and be genuinely interested in and, respectful of, client's stories, narratives and accounts,

the interpretative slant they take on their own experience (Saleeby, 1997, p.12).

To shift perspective from the traditional medical model to a strengths perspective, it is first necessary to recognize the frame of reference and then view professional conceptualisations as “hypothesis” rather than “fact”. This enables workers to dissociate themselves from the constructs they currently operate from and examine them from another point of view. There is a tendency towards automatic perceptions and assumptions and to look for what is wrong or broken and then to quickly offer suggestions or answers for the person to follow. The simplest comments can go unnoticed and workers strain to “hear strengths over the noise of problems” (Blundo, 2001, p. 303). Workers, however, may find this difficult to do, particularly if their clients have participated in abusive, destructive, addictive, or immoral behaviour (Saleeby, 1996).

Reservations and criticisms of the strengths perspective

Saleeby (1996; 2002c) reports that the S P has been criticised for ignoring the realities of structural poverty, institutional inequality and the realities of discrimination and oppression. Saleeby (2002c) suggests that the S P, while not ignoring people’s realities, attempts to restore, beyond rhetoric, some balance between honouring the strengths and capacities of people and their afflictions and agonies. He believes that many models and institutions of care dominate and create inequality in the service of safety, service, helping and therapy and that the S P goes some way to promoting equality, justice, and autonomy.

Practitioners and students of the S P have expressed a number of concerns about the approach. They believe that it is positive thinking in another guise and reframes misery, is Pollyannaish and ignores reality, and downplays real problems (Saleeby, 1996 & 2002c).

Saleebey (2002c) suggests that the S P is not positive thinking and is not built on the repetition of uplifting mantras. It seeks to build something of lasting significance with people. Practitioners need to use their expertness to capitalize on people's resources, talents, motivation and knowledge as well as environmental attributes. This is not easy, particularly when people are not given to thinking of themselves in terms of strengths or have been inculcated into believing themselves to be deficient and needy.

The strengths perspective demands a reframing of reality; it does not deny it. Practitioners need to develop a language and attitude about the nature of possibility and opportunity and the nature of the person beneath the diagnostic label.

The perspective does not downplay or ignore real problems. Problems are where people begin and what they are compelled to talk about. People need the opportunity to express their anxiety or anger, and recount the barriers to their expression and esteem. It is how workers relate to these problems that is the pivot in the strength perspective. Expression of problems often leads to diagnosis, workers from this perspective need to ensure that the diagnosis does not become the cornerstone to identity. Cousins, 1989, (as cited in Saleebey, 1996) believes that "one should not deny the verdict (diagnosis or assessment), but should defy the sentence" (p.300).

A New Zealand adaptation of the S P has been adopted by Timaru mental health services where they employ a particular strengths model and formalized assessment process in their acute in-patient setting. Mosley (2004), a mental health nurse in this service, contends that a limitation of the strengths model is the inability to use this approach

when people are acutely unwell. The premise is that people need to be able to set appropriate goals and make reality based decisions themselves and are not able to do so when acutely unwell. The locus of control is gradually returned to the person as their mental health status improves. Mosley (2004) suggests that in the acute stages of illness, “strengths model work is minimal” (p.39).

I would draw a distinction between the particular strengths model and assessment framework employed in Timaru and the overall S P approach. I have not used the S P in an inpatient setting, but I have used this approach in the community with people who are acutely mentally unwell. The S P can be employed early in interactions with people as the major premise of the approach is the suspension of disbelief and maintaining a positive regard for the person. This response is not dependant on the level of a person’s wellness. Section three, outlines a particular strengths model, Solution Focused Therapy, and reference is made in this section to successful applications of this model in acute in-patient setting.

Other concerns highlighted in the literature included inadequate research and education into the use of the approach. Brun and Rapp (2001) note that there is very little qualitative research from the perspective of consumers of health care as to the effectiveness of the approach. Goldstein (2002) states that inadequate education means the model could be applied prescriptively. Clearly a pervasive concern, as expressed in earlier in the paper, is the difficulty in implementing this approach in the context of a deficit model and the accompanying negative shrunken expectations of people (Saleebey, 2002b).

CONCLUSION

The proponents of the strengths perspective say that this approach requires a shift in paradigms from a pathology orientation to a strengths and resilience focus. It is more than ‘add strengths and stir’ (Rapp, 1998, p.47). Mental health nursing does not require a big shift; we are already in the same realm. What this perspective does offer, however, is an opportunity for realignment and refreshment and ideas that provoke and awaken thinking. This way of being with people is not new to nursing. The next section will look briefly at the broad implementation of the strengths perspective and then consider a particular strength-based approach, solution-based therapy, that appears to offer some useful techniques and skills that can readily utilised in mental health nursing environments.

Section two:

MENTAL HEALTH NURSING AND THE STRENGTHS PERSPECTIVE: WHAT ARE THE PARALLELS?

I was drawn to the strengths perspective (SP) because it had tenets in common with my nursing practice and resonated with broader nursing ideals. Mental health nursing practice has a strong history of a person centred approach to care and consequently many of the ideas of the SP have deep resonance with themes expressed in current nursing discourse, both in practice and in nursing literature. My purpose, as part of this process, was to build on my current nursing thinking and actions.

The background section outlined my nursing position and the attraction and possible contribution of the strengths perspective to my nursing practice. Several themes have recently emerged that are central nursing concerns: humanistic caring/helping; caring in context of the biomedical/psychiatric discourse; the therapeutic relationship; narrative approaches; and the concepts of possibility and hope as they relate both to crisis intervention in nursing and the recovery of people from mental illness.

The themes, caring, the therapeutic relationship, narrative and hope, will be situated in nursing literature and related briefly and more specifically to the strengths perspective.

Caring in nursing

Many nursing authors (Bevis, 1981; Leininger, 1981; Benner, 1984; Watson, 1985; Swanson, 1991) describe caring as the core of nursing. As a concept and moral ideal caring is considered the foundation for both physical and psychosocial practice. Characteristically caring acknowledges the subjective and personal experience of clients, and promotes holism as a way supporting people, with complex needs and

relationships in an even more complex health care environment (Spitzer, 1998).

Nursing caring has a humanist perspective and focuses, in practice and research, on the exploration of phenomena as a way of understanding human experience and relationship. The belief is that a person is able to interpret their unique circumstance and create meaning of their lives and 'illness' experience. It posits that human beings can potentially understand the nature of human existence, given their daily immersion in it (Benner, 1984 & Taylor, 1994). As such the nursing reality has a human, interpretative character and has the nurse client relationship at the centre (Peplau, 1952; Peplau, 1992; Forchuk & Brown, 1989; Forchuk, 1994 & Jones, 1996). The discovery of and interpretation of personal meanings, which emerge in the context of this caring relationship, is of central importance (Gastmans, 1998).

Barker and Whitehill (1998) propose a philosophy of care for mental health nursing. They describe mental health nursing as an interactive, developmental, human activity, more concerned with the future development of the person and how people overcome and live through distress, than with the origins or causes of their present mental distress. It centres on the person's unique growth and development and aims to provide conditions where people can access and review their experiences. They agree that nursing practice is about helping a person address their human responses to mental illness. Nursing is focused on everyday life and the person's relationship with themselves and others in the context of their interpersonal world. It occurs in the context of a collaborative interpersonal relationship that endeavours to work with people rather than on them.

Caring in context of biomedical paradigm

The biomedical paradigm is modern, positivist, evidenced based and tends to define and solve problems from outside of the person. It has a pathological orientation and theoretically reduces the complexity of human being and their minds to specific body systems. The assumption is that a person with a psychiatric diagnosis has a faulty physical body, brain structure, genes, and/or neurotransmitters (Hall, 1996). The wholeness of the person and their cultural and social context is not accounted for (Horsfall, Stuhlmiller, & Champ, 2000).

In mental health care these claims are underpinned by the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM IV). This manual classifies illness into diagnostic categories dependant upon particular symptomatic criteria. The primary mode of treatment for the person with a psychiatric diagnosis is medication (Horsfall, Stuhlmiller & Champ, 2000 & Saleebey, 1996 & 2002a).

Crowe (2000a & 2000b) argues that the DSM-IV has a broader social function in that it constructs what is to be regarded as normal and also constructs what society can expect as normal behaviour. The DSM-IV represents a psychiatric discourse, which marginalizes other explanations of mental distress in favour of psychiatric diagnosis (Crowe, 2000a).

Mental health nursing texts, education and clinicians have long absorbed medical models of psychiatric aetiology (Hall, 1996) and mental health nursing practice has largely co-opted psychiatric discourse as the basis for practice (Crowe, 2002a). If mental health nurses continue to promote this stance then the inevitable consequence would be that nursing care would consist of dispensing medications, managing behaviour associated

with mental distress until medication takes effect and supporting the person to modify their life to the inevitability of disability of a biochemical dysfunction (Crowe & Alavi, 1999). Clearly mental health nursing has a greater possibility than this and involves skilled interventions to assist people's skill and potential to move through their mental distress (Crowe, 2002a).

The strengths perspective has a similar philosophical alignment to mental health nursing practice and maligns the biomedical response that sees people as deficit and in the grip of problems and disorders that are a product of past experience (Saleebey, 2002). A shift in paradigm from a pathological orientation to a strengths approach allows for a different way of thinking about people. It creates a framework for caring that reveals strengths and individual power within people. It is, however, more than and "add strengths and stir" (p.47) to the existing pathological approach. It is a shift in paradigm that allows for new and creative ways to work with people that pays tribute to their skills, competencies, and talents as opposed to their deficits (Rapp, 1998).

The therapeutic relationship

The caring context of nursing is embodied in mental health nursing in the interpersonal relationship between the nurse and the person (patient). Peplau's (1952) interpersonal relations theory located the therapeutic nurse patient relationship at the centre of mental health nursing practice. People are believed to develop through interpersonal relationships, including nurse-client relationships (Forchuk & Dorsay, 1995). The thoughts, feeling and activities of the client and those of the nurse are at the very centre of the nursing process (Peplau, 1952). Peplau saw nursing as an interpersonal process where the person is given an opportunity within the relationship to explore options and possibilities (Forchuk, 1994). The caring relationship, however, is situated in a

relational and social context with her view of the person stressing a balance between autonomy and self-realisation and fellowship and relationality (Gastmans, 1998).

Many subsequent authors continue to promote and strengthen that position (Wilson & Kneisel, 1996; Barker, 1999; Forchuk & Brown, 1989; Forchuk, 1994; Doncliff, 1994; Watkins, 2002). Barker (1999) states that whatever else might be involved, “nursing is rooted firmly in the interaction of a *person*-called patient and a *person*-called nurse” (p.105).

The therapeutic relationship, as described by Peplau, is characterised by the therapeutic use of self, particularly the development of trust and empathy and involves specific interpersonal processes. The specific interpersonal processes are: communication, pattern integration, the nurse-client relationship and the roles of the nurse (Forchuk, 1994). Originally Peplau described six nursing roles: stranger, resource person, teacher, leader, surrogate, and counsellor (Comley, 1994), but in later writing emphasised the primary role of counsellor (Forchuk, 1994).

Peplau proposed a framework for the nurse-client relationship that evolved through overlapping phases and continued through the duration of the nurse client interaction: *orientation*, *working* (subdivided into *identification* and *exploitation*) and *resolution* (Peplau 1952). It is a person-centred and initiated process and the person and the family are considered potential clients.

A brief overview of the phases here will background further description in section two, where I will draw comparisons between the phases of the Peplau’s therapeutic relationship, the Roberts conflict resolution model and a strengths perspective approach, solution-focused therapy.

The *orientation phase* is characterised by the client or their family perceiving a 'felt need' and seeking professional support. The nurse and client work together to recognise, clarify, and define facts related to need. This process is ongoing throughout the phases. The nurse actively listens to facilitate this process, to focus the client's energies and to allay anxiety and distress (Peplau, 1952).

The *working phase* includes the phases of *identification* and *exploitation*. During the *identification* phase the client selectively responds to people who they feel can offer help. The nurse supports the client to explore and express feelings and identify needs and understand problems (Peplau, 1952).

The *exploitation* phase is characterised by the client actively seeking what is available in the nurse client relationship. The client makes full use of services and concurrently identifies and develops new goals. The nurse clarifies, listens and is accepting of the client (Peplau, 1952).

The *resolution* phase sees the client abandon old needs and aspire to new goals. They are able to apply new problem-solving skills and maintain changes in their style of communication and interaction. There is a positive change in their view of self and a growing ability to stand-alone. The nurse continues to facilitate goal setting and promotes family, social and community relationships (Peplau, 1952).

Peplau's theory recognises that an awareness of self and self-reflection on the part of the nurse is as important as the assessment of the client's situation. The nurse needs to be aware of how she influences the therapeutic relationship. Forchuk (1994) highlighted particularly the concept of preconceptions, and its relative importance in the evolution of

the therapeutic relationship. Her research supported the belief that both the client's and the nurse's preconceptions had a significant impact on the development and ongoing quality of the therapeutic alliance.

Several eminent writers and researchers of the strengths perspective value this notion and view the ability of workers to shift perceptions of people with mental illness as a primary concern. The ability of workers to *suspend belief* is a central tenet of the work in this approach (Rapp, 1998, Saleebey, 2002a & Kisthardt, 2002).

The quality of the helping relationship is something that is also pivotal to the work of the SP. The approach emphasises the impact of the helping relationship and the use of self as the medium for growth and change and stresses the importance of the developing of a truly collaborative relationship. It does; however, appear to lay far greater emphasis on extra therapeutic factors such as strengths, assets and resources in the individual, family and the ambient community (Saleebey, 2002b).

Narrative approaches

Nurses know how they might care for a person and what is important to that person by listening to their stories and asking questions. The narrative approach is one that is widely valued in nursing practice, research and education (Benner, 1984; Swanson, 1991; & Diekelman, 2001). This emerges from a humanistic approach to helping in nursing that is rooted in phenomenology. From this point of view knowledge and understanding can only be explored through exploring the subjective experience of people. The task, then, of therapeutic helping is to enable people to report and describe their reality, through narrative, without interpreting or trying to fit them into some classification system (Watkins, 2002).

The postmodern perspective has led to a resurgent interest in narrative approaches. This view posits that that truth is not 'out there' waiting to be discovered and measured, but is something that is constructed by people interacting with their environment; it is always provisional and contingent on context. Postmodern literary theory posits two perspectives on the creation of accounts or narrative, have emerged: constructivism and social constructivism. The first emerges from the individual attribution of meanings to events and the creation of a story to unfold and explain personal experience. The second focuses on social perspectives and how meanings are negotiated with a person to create a story that is co-constructed by the individual interacting with those around him (Roberts, 2000b).

Nursing favours a narrative approach as a way of being in peoples lives that supports, but does not suppress peoples aspirations, hopes and possibilities. This strongly resonates with the S P where practitioners are encouraged to respect and engage the person's way of viewing themselves and their worlds in the therapeutic process. The clients 'meaning' must count for more in the helping process than scientific labels and theories (De Jong & Miller, 1995). The clinical account is an active creation of illness meaning created in dialogue with the person. It is an attempt by people to explain and define themselves and their world. Practitioners using this approach are trained to uncover stories (Roberts, 2000b; Goldstein, 2002).

Hope

The essential element in the spirit of recovery from mental illness is the courage to hope and the willingness to try (Deegan, 1996; Watkins, 2002). Engendering hope is the goal of good nursing practice (Swanson, 1991; Watkins, 2002; Cutcliffe, 2003) and fostering this possibility means

that nurses need to be concerned more with the growth of people than with ultimate cure (Watkins, 2002; Rapp, 1998).

Crisis nursing, often involves caring for people who are potentially at risk of suicide or self-harm. *Inspiration of hope* is one of two linked interpersonal processes that are the key to working with people who have suicidal intent. The other process is *engagement*. *Engagement* centres on the interpersonal relationship, with a particular emphasis on compassion, trust, unconditional acceptance of, and tolerance for, the suicidal person, which is conveyed in a genuine manner (Cutcliffe, 2003).

The evidence suggests that hopelessness is the key clinical predictor of whether a person will complete suicide rather than just considering it (Calvert & Palmer, 2001; Cutcliffe, 2003). Cutcliffe (2003) believes that inspiration of hope is not a primary clinical consideration in nursing and that there is no specific theory or research that informs nurses of the process of hope inspiration. He does note, however, that research into inspiration of hope with a variety of disparate client groups emphasises the relational aspect to hope that is inherent in caring practices. The presence of another human being, who is able to demonstrate unconditional acceptance, tolerance and understanding, as he/she enters into practice, simultaneously inspires hope. It is not what the person does, but who they are being in the caring relationship that inspires hope.

Clearly the interpersonal relationship, as first described by Peplau, is one that inspires hope. Further to this Russinova (1999) suggests that while the development of a trusting relationship is paramount, the presence of a professional who believes in positive outcomes even when the people do not believe in themselves is equally important. Swanson (1991), a nursing theorist, in her 'middle range theory of care', illuminates five caring processes: *knowing, being with, doing for, enabling and maintaining belief*. The last process, *maintaining-belief*, supports this

notion of the nurse standing outside of a person and sustaining faith in a person's ability to get through an event or transition and face a future with meaning. The nurse must regard the person with esteem and maintain a hope-filled attitude.

Similarly a central notion of the S P is the fostering of hope and a belief in what is possible. It has a future orientation that has people think beyond their current circumstance (Saleebey, 1996 & 2002a).

Cutcliffe (2003) as previously stated, suggests that there is no specific theory or research that informs nurses about the process of hope inspiration. I believe that strengths approaches can provide one process for nurses to follow that may lead to a more hopeful perspective for people.

Finally it would appear that nursing and the strengths perspective are aligned from a philosophical perspective, in that we aim to work with people in collaborative and facilitative ways that maximise self-help and autonomy, with the professional helper as the broker not the originator of change (Watkins, 2002). From both perspectives there is also an emphasis on the caring interpersonal relationship that conveys loving support and respect for people (Peplau, 1952; Benner, 1984; Watson, 1985; Swanson, 1991; Benard, 2002; Watkins, 2002).

Conclusion

The interpersonal relationship is the cornerstone of mental health nursing work and it is the discovery and interpretation of meaning that arises through people's narrative accounts, in the context of this caring relationship that is of central importance. This section has described a person-centred approach to care that is familiar to both nursing and the strengths perspective. It has been postulated that the strengths approach

allows for the creation of a future beyond the present and belief in the presence of hope and is therefore aligned with the notion of recovery. While this approach to care is valued by both consumers of mental health services and clinicians alike, its true expression is often stifled by the dominant biomedical paradigm.

This section has described the current circumstances and has not provided insight into what might contribute to a change in the current environment. The next section provides an outline of the strengths perspective that seeks to show how it might add to the practice of mental health nursing. The purpose is to provide insight into how a shift in thinking that comes with an orientation to a strengths approach can impact nursing practice in the context of the current pathological model.

Section three

IMPLEMENTING THE STRENGTHS PERSPECTIVE

This section begins with a description of the broad implementation in mental health nursing of the S P and will provide a context for a larger discussion on a specific strengths model, solution-focused therapy.

I have chosen to emphasise solution-focused therapy (SFT) because of the relevance to my particular areas of interest: mental health nursing and conflict resolution. Solution-focused therapy has been applied in both mental health nursing (Webster, Vaughan, Webb & Playter, 1995; Webster & Vaughan, 2003) and in crisis resolution work (Green, Lee, Trask, Rheinscheld, 2000). The rationale for the choice of SFT and a description of the process of working with this therapy will be made. Parallels will be drawn to other intervention models (Peplau's therapeutic relationship and Robert's crisis intervention model).

The strengths perspective in practice

The strengths perspective lays out the assumptions, values, and principles of the use of strengths in practice. Strengths models practically apply the S P in practice (University of Kansas, 2004).

Strengths

Strengths can be almost anything dependent on circumstance; however, some capacities, resources, and assets commonly appear on a roster of strengths. These include: personal qualities, virtues and traits; what the person has learnt about themselves, others and the world; what people know about the world around them from education or life experience; the talents people have; cultural and personal stories and lore; peoples

'survivor' pride; the community and informal and natural environment; spirituality that involves the essential and holistic quality of being and spirituality as it reflects the struggle to find meaning (Saleebey, 2002b). Saleebey (2002b) suggests that strengths are found by looking around for evidence of the person's interests, talents and competencies and by listening to their stories. Survival, support, exception, possibility and esteem questions are used when trying to discover the strengths within and around the person.

The strengths working process

Benard (2002) recommends a simple strengths-based process that she employs in her work with adolescents. This process involves: *listening to their story; acknowledging their pain; looking for strengths; asking questions about survival, support, positive times, interests, dreams, goals, and pride; pointing out strengths; linking strengths to client's goals and dreams; linking client to resources to achieve goals and dreams; and finding opportunities for client to be a teacher/paraprofessional.* Similar processes are replicated in most strengths models (Rapp 1998; Saleebey, 2002 b; Goldstein, 2002, Kisthardt, 2002). It is important to note that the initial stage of the process 'begins where the person is' by listening to their story and acknowledging their pain. Working with people from the strengths perspective does not mean denying the existence of problems or talking people out of their authentic feeling of distress (Cohen, 1999).

Acknowledging people's pain and in some instances exploring the roots of trauma in family, community and culture may be useful, but the purpose of this perspective is always to look for the seeds of resilience and rebound, the lessons taken from adversity (Cohen, 1999; Benard, 2002; Saleebey, 2002b).

Solution focused therapy

Solution-focused therapy is a strengths model that has an implicit and enduring interest in the strengths of individuals and families (De Jong & Miller, 1995). SFT is a therapy or therapeutic technique that does not emphasize the problems of the person, but prefers to focus on: the strengths or positive attributes a person brings to the therapy; a working relationship between the therapist and the person; the construction of future-orientated and positively worded goals; and the actions necessary to reach those goals (Mason, Breen & Whipple, 1994).

SFT was developed by de Shazer and his colleagues at the Brief Family Therapy Centre in the early 1980's (de Shazer, 1988). It operates from the premise that not only is focusing on solution more important than a problem focus, but that it is conceivable that you can arrive at the solution(s) without necessarily understanding the problem, how it emerged or how it is maintained (Hillyer, 1996).

Assumptions

The assumptions of SFT mirror those of the strengths perspective and centre on the role of change brought about by people who have found a goal and an approach to a solution that is important to them (Webster & Vaughan, 2003). The therapists, rather than seeing themselves visited by people with problems, view themselves as visited by people with solutions seeking expression (Drury, 2000).

SFT is a rhetorical process, which encourages people to talk themselves into solutions on the assumption that people experience continual change and solutions are already present as exceptions to the problem-saturated stories. As solutions are already happening then it must be the person who is doing it. This allows the practitioner to attribute change for the

better to the person and failure to enhance recognition of change to the practitioner. This moves the thinking away from the notion of client resistance (Drury, 2000). Solution-focused therapists view the concept of resistance as a problem that the therapist has with hearing the person, rather than the person being unwilling to accept the therapist's interventions (Webster & Vaughan, 2003).

The use of language, is an important aspect of the broader strengths perspective, and plays an important part in SFT. People often come into therapy with a well-developed problem vocabulary and the therapist has the challenge of shifting the person's language and supporting them to describe, in their language, the absence of a problem (Webster & Vaughan, 2003)

The value of the interpersonal relationship is central to this model. Clients value the relationship between themselves and the practitioner (Brun & Rapp, 2001). Webster and Vaughan (2003) suggest that the development and maintenance of an egalitarian, collaborative interpersonal relationship is paramount in SFT. The person is viewed as expert in their own situation with the therapist supporting them to discover solutions.

Rationale for use of solution-focused therapy in mental health nursing

SFT has been applied in both mental health nursing (Webster & Vaughan, 2003) and in crisis resolution work (Green, Lee, Trask, & Rheinscheld, 2000) and would clearly be a useful approach in my current practice.

User friendly

Research indicates that users of the mental health services found several aspects of a strengths approach useful (McKell, 1999; Brun & Rapp, 2001). These aspects included: the strengths assessment and inquiry; the assistance of goal planning; the overall value of the relationship between themselves and the practitioner and services that are concrete and clearly grounded in the person's interest. Additionally the role of advocacy in that relationship was seen as especially important (Brun & Rapp, 2001).

Congruent with nursing values and practice

SFT is congruent with a person-centred approach to nursing relationship concerns including collaboration, emphasizing hope and supporting people's strengths and focusing on health rather than pathology (Webster et al, 1995; Hillyer, 1996; Hagan & Mitchell, 2001; Webster & Vaughan, 2003). Mason, Breen and Whipple (1994) discuss the merits of SFT for nursing relationships, suggesting that it promotes nursing staff cohesion, encourages greater nurse-client collaboration, and increases co-operation between nurses.

Effective in short time span

Treatment outcome studies suggest that much progress is possible in the first sessions, with large gains being made during the initial six to eight sessions (Schaefer, Koeter, Wouters, Emmelkamp & Schene, 2003). SFT, is an example of a short time-framed therapy that, on average, takes about five sessions, each of which need not be more than forty-five minutes. As progress occurs the time between sessions extends, often to several months (Iveson, 2002). The short time frames of this intervention make it useful for inpatient and community mental health settings as well as crisis intervention and resolution (McKeel, 1999; Mason et al, 1994).

Effective for broad range of mental health concerns

While SFT was originally utilized in counseling settings an increasing number of practitioners are advocating the use of SFT by nurses in mental health settings. Research indicates that SFT is an effective treatment for a broad range of client problems including, depression, and suicidal ideation, and sleep problems, parent-child conflict, relationship issues, sexual problems, sexual abuse, family abuse and self esteem problems (McKell, 1999). It has also been shown to be useful with people who experience thought disorder (Mason et al, 1994; Hagen & Mitchell, 2001; Rhodes & Jakes, 2002).

SFT has also been shown to be useful as a complement to other therapies, such as family and medical therapy (Iveson, 2002). A brief description of how SFT might be employed in mental health nursing practice, in the context of a psychiatric biomedical model, will conclude this section.

Solution-focused therapy in action

A model for practice

SFT is a complex therapy that requires years of training to master. This review of a process for SFT is not exhaustive and is not intended to act as a guide for actual practice. It is designed to provide an insight into the process of SFT and to create an interest in the approach.

Green et al, (2000) have developed a process for SFT that specifically relates to crisis resolution work. Other authors (De Jong & Miller, 1995; Hagan & Mitchell, 2001; Iveson, 2002; Rhodes & Jakes, 2002;

Webster & Vaughan, 2003) appear to have very similar designs that are used in other clinical areas.

The process highlighted by Green et al (2000) has the following phases: *joining; defining problems; setting goals; identify solutions; development of an action plan; and termination and follow-up* (p.36-46).

Table 2 makes a comparison between and Peplau's interpersonal theory (Forchuk & Brown, 1989), the Robert's model of crisis intervention (Roberts, 2000) and solution-focused therapy process (Green, Lee, Trask, Rheinscheld, 2000).

Table 2

Comparison of three models of care

Peplau's interpersonal theory	Robert's model	Solution-focused therapy
<p><i>1.Orientation</i> Person perceives 'felt need' Nurse and client work together to recognise, clarify and define facts in relation to need Nurse practices non-directive listening to reduces anxiety and tension; clarifies preconceptions and expectations; focuses persons energies <i>Initial problem identification</i></p>	<p><i>1. Plan and conduct crisis assessment (assessment of lethality and dangerousness to self and others, & immediate psychosocial needs and mental status)</i> <i>2. Establish rapport and rapidly establish relationship</i> Convey genuine respect and acceptance for the person. Active listening to hear persons perception of difficulties</p>	<p><i>1.Joining</i> Establish positive working relationship- by identifying, reflecting feeling, accepting and using clients language Accept client as the expert on their situation Collaborative/egalitarian focus Ongoing risk assessment through phases</p>
<p><i>2. Identification (working phase)</i> Identification of problems Selective response to person who they feel can offer help (client) Support expression of feeling and identify needs and problems Unconditional acceptance Collaborative focus</p>	<p><i>3. Examine dimensions of problem in order to define it I including 'last straw' or crisis precipitants.</i> <i>4. Deal with feelings and emotions (including active listening and validation)</i> Extensive use of questions</p>	<p><i>2.Defining problems</i> Specific definition of issues that are concrete and behavioural Prioritise issues Move to define goals Begin solution talk when person ready Establish concerns/issues</p>
<p><i>3. Exploitation (working phase)</i> Supports self direction, problem solving, interpersonal skills Clarification, active listening and acceptance (nurse) Meet emerging needs Support identification of new goals Attempts to attain new goals Demonstrates changes in communication Initiate rehabilitative plans Self directing Collaborative focus</p>	<p><i>5.Generate and explore alternatives</i> Explore alternative coping methods and partial solutions Collaborative focus</p>	<p><i>3. Setting goals</i> Emphasise above defining problems Use of questions (the miracle question, dream question and relationship question) <i>4. Identify solutions</i> Use of questions (exception question, coping question, scaling question) Use of compliments Collaborative focus <i>5. Develop and implement action plan</i> Person identifies solutions and/or does more of them Promotes community and family participation</p>
<p><i>4. Resolution</i> Promote family and community participation Continue goal setting and achievement Teach preventive measures Promote self care</p>	<p><i>7. Establish follow-up plan</i> Offer urgent follow-up if client feel need</p>	<p><i>6.Termination and follow-up</i> Support review of achievement of specific goals and readiness for termination; anticipate possible future setbacks; promote community and family participation Use of scaling questions</p>

Table 2 was created to support clarification of my thinking with regard to the three models of care that I currently employ in my mental health nursing practice. The table highlights the specific actions in each phase of the three approaches. There are basic similarities between all three models. All are sequential and focus on therapeutic interactions. All utilize problem solving and solution finding activities that the nurse and client collaborate on, with an end purpose of meeting client needs.

Belcher and Fish (1985) compare the nursing process and Peplau's phases of the interpersonal relationship. The focus on nursing work when Peplau developed her model in 1952, tended to relate to individual variables such as needs, frustrations, conflict and anxiety. A broader view of nursing care has developed over time that includes these individual variables, but extends to other variables such as: intra-family dynamics, socioeconomic forces, personal space considerations and community resources. There is also a focus on the extended nursing role and emphasis on health maintenance and promotion.

The Roberts model and SFT, like the nursing process, has a holistic, family and community focus, that extends beyond the nursing process to not only consider personal, but institutional issues of power.

Peplau's theory was not as concerned with the assessment of risk which is a more explicit requirement in the current environment. The focus on risk assessment and containment of risk from a service position appears to have come about because of de-institutionalization of people in psychiatric care, with a move from physical containment to community care and the threat of litigation and increased public pressure fueled by the media. Douglas (1994, as cited in Crowe & Carlyle, 2003) suggests that risk has become a societal not individual issue and has become a calculation of economical, political, social, and physical danger. In our

current society danger is defined to protect the public good and the incidence of blame is a bi-product of persuading fellow members of that society to contribute to it. From this view, if a clinician fails to make an accurate risk assessment then he or she is regarded as negligent and has in essence endangered the public good (Crowe & Carlyle, 2003).

This has significant implications for mental health nurses who personally feel the pressure of this public accountability. Managing organizational risk appears to have taken precedence over individual risk benefit analysis. The focus on organizational need, I believe, substantially adds to the stress that mental health nurses currently face in the workplace. Interestingly, Crowe and Carlyle (2003) suggest that the positioning of social concerns has taken precedence over clinical judgment and that attempts to control the actions and behaviors of consumers is more an attempt to manage the fiscal needs of organizations.

Practice activities of SFT

While the SFT process is described as a linear one, setting *goals*, and *identifying solutions*, occur simultaneously and in a cyclical way and there are *practice activities* particular to each phase.

The practice activities of the solution-focused approach are the development of *well-formed goals* with the person, within their frame of reference and the development *solutions*; based initially on what the person is already doing that has the potential to achieve (Iveson, 2002). Examining *exceptions*, which are those times in the person's life when the problem might have occurred but did not, supports the development of solutions (De Jong & Miller, 1995).

Well-formed goals have the following characteristics. They are: important to the person; small and achievable; concrete specific and behavioral; express a presence rather than an absence of something; have beginnings not endings, conceptualizing first steps to desired ends; realistic within the context of the person's life; perceived by the person as involving hard work, this preserves dignity if the achievement is noteworthy (De Jong & Miller, 1995). The interviewing for well-formed goals and interviewing for people's strengths go hand in hand (De Jong & Miller, 1995; Green et al, 2000; Webster & Vaughan, 2003).

Additionally, *identifying the concern issue or problem that is of most concern to the person* is an important initial consideration. The solution-focused approach begins by asking the person to identify the most important issue or problem from their perspective. This can be a significant shift for professionals, focusing on a problem that the person feels is important, rather than what the professionals feel is important. The person is asked what issues of all the challenges they are facing needs to be solved first. Once the person has experienced success-finding solutions to their most pressing problem, they can then apply the same strategies to the next important problem, and so on (Hagan & Mitchell, 2001)

Solution-focused questions

There are many *solution-focused questions* that are particular to SFT and support the development of well-formed goals and the seeking of solutions. This description will confine itself to those questions that most commonly occurred in the literature (*the miracle question; relationship questions scaling questions; exception and difference questions; coping questions; and scaling questions*).

The *miracle question* is another way of identifying exceptions by projecting a possible future where the person's problem does not exist and as previously stated was my first introduction to the SP. The question is a little unusual, so the language used needs to take into account the person's background and beliefs (Hillyer, 1996; Green et al, 2000; Hagan & Mitchell, 2001; Webster & Vaughan, 2002). This question is often used early in therapy to promote creative thinking.

Relationship questions account for the fact that the person exists in a broader social system. This question has the person postulate as to what others may think about their situation. Developing multiple indicators of change helps the person develop a clearer vision of the future appropriate to their real life context. A therapist might ask 'What would your partner notice about you that is different about you if they didn't know that a miracle had occurred' (Green et al, 2000, p.40).

Exception questions centre on times when the problem is not occurring or when it is different or better (*difference questions*) (Green et al, 2000; Hagan & Mitchell, 2001; Webster & Vaughan, 2002). Typically the therapist might ask the person: 'Can you tell me about a time when this issue was not present and it might have been?' 'What was different about those times' (Webster & Vaughan, 2002, p.189).

Coping questions acknowledge and build on strengths that are not always visible to the person. Questions might include: 'What keeps you going?' 'How did you manage to get yourself up this morning?' (Webster & Vaughan, 2002, p.190).

Scaling questions support the person to notice the small steps that lead to greater change. Scaling can be done at any point and for different purposes. As an example, scaling can be done to measure progress

towards solutions, to determine commitment to working toward solutions and to know whether progress will be maintained (Webster & Vaughan, 2002). Scaling questions allows the person to quantify their problem or goal (Green et al, 2000; Hagan & Mitchell, 2001; Iveson, 2002; Webster & Vaughan, 2002).

Research by Shilts, Filippino & Nau, 1994; Beyebach, Morejon, Palenzuela, & Rodriguez-Aries, 1996; Metcalf, Thomas, Duncan, Miller, & Hubble, 1996 (as cited in McKeel, 1999) indicates that clients appreciate the questions asked by their therapists in SFT and found that the focus of questions on strengths, noticing differences, and amplifying what works useful as strategies.

Other SFT processes

Compliments involve the active encouragement and affirmation for success, based on the progression of goals and at a time when the client appears ready to hear positive feedback (Webster & Vaughan, 2002). Being curious about how people cope, affirming courage and ability to hang on despite adversity, is another occasion where genuine praise can be invaluable (Iveson, 2002).

Homework assignments are based on the client's own information about what has been working. For example, clients who know how to create exceptions will be directed toward sustaining that behaviour and noticing what difference it makes to themselves and others. The person becomes actively involved in treatment and begins to notice small pieces of life without the problem (Hagan & Mitchell, 2001; Webster & Vaughan, 2002).

Application to my practice

I have had no training in SFT, but have been able to employ some of the practices in my work. I now frequently ask clients what the issue is that is causing them the most concern as a way of bringing the focus back to them and away from my interpretation of what needs immediate attention. I have also used the miracle and scaling questions. In response to the miracle question, one client said that if he woke up in the morning and did not feel so overwhelmed or had the thought of suicide at the front of his mind then he would know that he had made significant improvement. I reflected back that he might feel lighter. He concurred that this would be his experience. From this I was then able to employ the scaling question. On a scale of one to ten, ten would be the lightest he could possibly feel and one would be the heaviest. He said that he was a four. At the beginning of my involvement he was at zero. He thought the change was significant. I then was able to use the scaling question in later interviews to gauge change.

What I find particularly exciting is the orientation of the questions in SFT. Questions focus the person towards improvement and future possibility rather than on symptoms. An emphasis on the person's symptoms tends to have the impact of amplifying them (Iveson, 2002). Iveson suggests that SFT can be used to complement medical treatment with questions designed to construct signposts to success. This approach would support mental health nursing work, in the current medical paradigm, where medication is the predominant treatment. Questions about the effectiveness of medication, for example, might include: *If the antidepressant is working, how will you know? What would be the first sign that your mood is lifting? If we were to begin reducing your medication what would tell us we are going in the right direction?* Iveson suggests that questions framed in this manner ask people to

participate and contribute their expertise to their treatment (Iveson, 2002).

In contrast, the professional, asking questions in relation to the impact of medication on symptoms, calls on an outside expertness and subtlety and pervasively reduces the power of the client. Saleebey (2002c) makes the point that in the service of helping we have “impoverished, not empowered” people. The way we ask people to contribute is an example of this and a simple shift in how we ask questions creates the possibility of a more even distribution of power in the interpersonal relationship. In my own practice I notice that this is the way that I frame questions and can see that the continued attention to this practice, though a small part my relationship with clients, can have an impact in conjunction with other person centred practices.

Hagan and Mitchell (2001) were “struck by the extent to which SFT forces one to immediately move past disease and psychiatric symptomatology, and instead see the individual as a collection of strengths and coping strategies” (p. 92). They also noted that it engaged all of a nurse’s communication, interviewing and problem-solving skills and consequently stimulated and enriched their practice. In my preliminary use of the model I notice that I too am enlivened by the process and my perceptions of what is possible for people has been changed.

Limitations

Saleebey (2002c) states SFT is congruent with the S P and has an implicit and abiding interest in strengths for individuals and families. He is, however, concerned that it does not concentrate sufficiently on resources and solutions in the environment. Saleebey (2002c) contends that this may limit possible options for the person because access to

community resources provides “the ticket to expanded choices and routes to change” (p.270).

Webster and Vaughan (2003), from their extensive clinical work, note several limitations of SFT including: short intervention time, inappropriateness of verbal therapy, incongruence of risk assessment with SFT, and the inability of client to generate solutions.

Longer-term intervention may suit both the therapist and client better. A long term, more intermittent approach, for continuing issues, that may require several interventions, may suit some clients. Conversely some therapists struggle with the short-term nature of the work, particularly if they derive much of their professional reward from working with clients over time and seeing the growth and change (Webster & Vaughan, 2003).

Verbal therapy might have a limited role in certain populations. For example: clients who are acutely psychotic, severely regressed, or have serious cognitive impairment may not benefit from an approach that requires active participation in defining goals, strengths, alternatives and progress (Webster & Vaughan, 2003).

Risk assessment is an area that appears to counter solution focused principles, in that safety may not be an area that is defined by the client as a concern. Where the therapist identifies safety, as a concern, it can be scaled, but the client would need to be aware that it is the therapist’s goal (Webster & Vaughan, 2003).

Limited life experience or access to information and resources means that some people are not able to generate a wide range of possible solutions. This can be countered by having people work in groups where

they are exposed to a larger pool of possible solutions or by engaging in 'modeling and role-modeling' (MRM). This nursing theory provides psycho education in areas that the client indicates a desire for further information (Webster & Vaughan, 2003).

McKeel (2001) in a selected review of SFT research, states that experimental outcome research using established measures is noticeably absent from solution-focused therapy research. He believes the following issues need to be addressed in this area of research.

SFT needs to be defined and studies need to provide information about the model practiced by therapists in the study. de Shazer and Berg (as cited in McKeel, 2001) urge researchers to ensure that the model of therapy being tested is actually the model used by the therapists in the research study.

Quantitative outcome research needs to include comparison control groups. The comparison might be between the experimental group (SFT) and a control group, who are employing a different model of treatment. The comparison might also be between two components of the SFT model to see which are necessary or sufficient for success.

There needs to be an improvement in outcome measures where researchers use multiple outcome measures, rather than relying solely on client's perceptions. McKeel (2001) believes that success ratings from the therapist and an observer may be beneficial, especially when the client has violence and substance abuse issues.

Conclusion

Solution-focused therapy is a strengths model that appears to be well suited to the mental health nursing practice and aligned to the values of the profession. It is clearly a model in keeping with the S P because of its implicit and abiding interest in strengths of individuals and families (Saleebey, 2002c).

This section highlighted one approach, SFT, to working with the strengths perspective that is based on the understanding of language and dialogue as creative processes. The central focus is on future, with no framework for understanding problems, preferring instead to focus on change that can be brought about by creation of goals and the seeking of solutions. In the next section, I propose to reflect on the process of writing this project and how it has contributed to and reinforced my nursing thinking. I will consider how I might work in the current biomedical paradigm from a strengths perspective..

Section four

REFLECTIONS AND IMPLICATIONS FOR NURSING PRACTICE

This paper began by considering the concept of humanistic caring in mental health nursing and drawing some beginning parallels to the strengths perspective. It considered the difficulties inherent in endeavoring to follow a person-centred, humanist, and strengths based approach in the context of a deeply entrenched biomedical model. The development of an understanding of a strengths orientation to practice that this paper has undertaken demonstrates that the S P easily aligns with a mental health nursing practice that centres on the interpersonal relationship. The process of research and writing for this paper has supported my ability to work in an environment that has a different philosophical bias to care. My thinking and focus on humanistic caring in nursing has been reenergised.

D. Saleebey (personal communication, June, 2004) responded to an inquiry when I first started work on this paper. He said that “nursing and social work share common ideas and roots...and that it is appropriate to engage in dialogue and reflection because that is one of the ways that we begin to understand how clients see their situation and the way to progress to a better life by employing their assets”. It is apparent to me, now that I am nearly complete, that mental health nursing and the strengths perspective clearly share the same paradigm.

The process of reflection that this work has engendered has firmed my belief in the power of the nursing discourse, particularly the ability of nurses to stand in their own knowledge and be able to not only distinguish it as different from the biomedical pathological discourse, but to have

confidence and pride that nursing provides something of equal value or better for consumers of mental health care. It has considerably bolstered my faith in the way I and many other mental health nurses work.

The strengths perspective's emphasis on successful coping strategies and strengths and a future that can be accessed through creative conversation and language, is one that draws you away from disease and psychiatric symptomatology. This orientation to practice, while not new to mental health nursing, adds value to our work.

My practice using a strengths based approach has been very limited; however, my reflective response to the literature has led me to consider how mental health nurses might orient their thinking and practice to utilize the S P to augment their practice. The following themes have emerged from this process.

Mental health nursing and the biomedical model

Mental health nurses work in an environment that promotes a deficit model of care. Current clinical documentation requires that our clients are given a DSM IV diagnosis and often outcomes of care do not reflect consumer concerns, but organizational outcomes. The medical practitioner, while not accountable for nursing practice, often takes lead roles in care.

Saleebey (2002c) suggests that it is relatively common, in agencies that promote a deficit model of care, to hold negative expectations of clients, to work in ways that control damage, to define clients in terms of their degree of manipulation and resistance, and not surprisingly, have health workers who are compromised. He does, however, believe that while clinicians may feel cynical, angry and disappointed, they can exercise choice. Clinicians can choose how they respond to people, what

information is sought and how that information is interpreted. Saleebey further agrees that choice can be exercised about how clients are regarded and an effort can be made to discover the resources within the client and in the environment.

The notion of choice as expressed by Saleebey (2002c) spoke powerfully to me. I have a sense of feeling compromised and sometimes impotent and cynical in my workplace where the predominant biomedical paradigm prevails. It reminded me that I have a responsibility to choose how I speak to and about a person and what I take from conversations with people. My role is not to interpret the client's experience, but to be witness to and mirror that experience back to them. The aim is to provide a different view of their world for the person.

The interpersonal relationship and caring

The caring practice of nursing and how that is expressed in the interpersonal relationship between the nurse and the client has been the major thread of this paper. I have always known that this is where caring occurs. The strengths perspective has augmented this belief and has provided both the same and a different place to view my practice.

Peplau (1952) defined nursing as

...a significant therapeutic, interpersonal process. It functions cooperatively with other human processes that make health possible for individuals in communities... Nursing is an educative instrument, a maturing force, that aims to promote forward movement of personality in the direction of creative, constructive and productive, personal and community living' (p16).

She further notes that the interactions between the thoughts, feelings, and activities of the client and of the nurse are at the very centre of the nursing process.

These interactions between the client and the nurse have a particular quality. Studies of the perceptions of consumers of mental health care highlight the importance of the therapeutic relationship. The qualities that clients found were most essential were: the ability of the worker to be respectful, to take time to listen and to hear and understand the person (Shilts, Rambo & Hernandez, 1997; & Odell, Butler, & Dielman, 1997, as cited in McKeel, 1999). The instillation of hope is a primary function of the interpersonal relationship. The qualities of the relationship that clients found important appear to parallel the potential to inspire hope. Clients find the presence of another person who is able to demonstrate unconditional acceptance, tolerance and understanding as pivotal to this process (Cutcliffe, 2003). As previously stated, it appears that when the nurse is more concerned with who they are being rather than what they are doing, then hope is inspired.

Hope

Hope is something that is engendered when the nurse can stand outside of the person and believe in positive outcomes even when the person does not believe this for herself (Russinova, 1999). The strengths approach has particular emphasis on this external perception and commitment to people. Practitioners need to be able to suspend disbelief and have a respectful regard for people and their inherent capacity to grow, learn and change (Rapp, 1998; & Saleebey 2002). The worker needs to have an unmistakable belief in the person and a 'radical acceptance' for the client's expertise and endeavours (Webster & Vaughan, 2003). The psychiatric system is so saturated by negative perceptions of people with mental illness that it is sometimes difficult to 'hear the strengths over the noise of problems' and pathology (Blundo, 2001, p. 303). While there is a tendency for clients to express their concerns in a problem oriented way, there is as much of a tendency for nurses to choose to see only people's pathology, not their possibility.

Nurses need to draw on their particular knowledge and strengths to infuse some hope into nursing relationships. The strength perspective's orientation to caring work has been one such infusion for my practice. The strengths approach is not the sole contributor to a potential shift in my response to nursing, but acts in a synergistic way with what I already know about caring in nursing.

Connecting with community

Peplau (as cited in Forchuk & Dorsay, 1995) defines the client as individual, couple, family or community, however the application of the theory has tended to focus on the individual. The strengths approach has a keen interest in aligning the strengths of individuals with assets and resources in the environment (Saleebey, 2004, personal communication, June, 2004). In solution-focused therapy, conscious efforts are made to identify important relationships outside therapy (family, friends, community resources) and clients are encouraged to develop these 'natural' connections that will endure after the immediate need for therapy has been met (Webster & Vaughan, 2003).

One of the observations I have made in this writing is that our tendency in mental health services is to draw people into the mental health service community, rather than supporting reintegration into their existing communities. This is by admitting people to hospital and by referring people to community mental health teams. This often happens in the first instance, before health professionals have explored with the person the possibility of resources in their own communities. The inclination to this course of action by professionals is strong because, for the most part, free service is not available without an admission to a community mental health team and admission to a community mental health team can often only be assured with a DSM IV diagnosis. The pathological model has

become more, not less, entrenched in the systems of managing people with mental health issues. Nurses need to be able to ameliorate the impact on the biomedical model as a sole response to people with mental illness, as the orientation of this system is not towards healing and the best interests of the person, but to the successful management of large groups of people in an even larger system.

Mental health nurses need to be able to train themselves to think outside of the 'biomedical square' and consider other community resources like family, consumer movement support services, community groups, friends, family, community counselors, self help groups, to name a few. The majority of mental health nurses work inside large organizations that are committed to the biomedical approach and a predictable pathway of care. It is impossible to ignore the authority and influence of these organizations. However, if nurses are aware that the current model of popular care is only one alternative, then they can consciously drive alternative options, such as the S P, that clearly have the interests of mental health consumers at heart. The S P can easily work alongside the biomedical model and may ease the dissonance that nurses may feel when they are forced to conform to an ideology that is inconsistent with humanistic nursing practice.

From my perspective, working in a crisis intervention and resolution team, I would need to have sufficient confidence in my practice and the practice of my team, to manage the risk of self harm and suicide, while I worked with the person and supported them to call on their community resources.

CONCLUSION

The purpose of this paper has been to develop a greater understanding of the S P and to consider the possible contribution of the S P to mental health nursing practice. My personal response to nursing and beliefs about the art and science of mental health nursing practice as articulated in the literature, gave a background and a connection to the philosophy and practice of the S P. Mental health nurses in practice are strongly influenced by the current predominant biomedical paradigm. It, therefore, was important to contextualise the discussion on nursing thinking and practice and the philosophy and practice of the S P in relation to this influence.

This paper attempts to not only provoke thought, certainly mine and perhaps others, but highlight some practical ways that mental health nursing practice might be augmented by the philosophy and practice of the S P.

A person-centred mental health nursing philosophy that underpins practice provides the key to working with people with integrity and continued vision. The S P and humanistic mental health nursing have a consistent view of human caring. This view of caring is well articulated by Rogers (as cited in Watkins, 2002) when he describes the heart of humanistic helping as

a belief in the trustworthiness of the person seeking help, as someone capable of evaluating their inner and outer world, understanding himself in it's context and make choices as to the next step in life and acting on those choices (p. 77).

From this perspective the person already knows what they need to know and is capable of making choices that will create forward momentum in their lives. Our role is to facilitate that choice.

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