Strengths-Based Social Work Assessment: Transforming the Dominant Paradigm

by Clay Graybeal

Abstract

This is a review of some of the conflicts between traditional problem-based assessments and alternative, strengths-based approaches. It offers useful tools and strategies for incorporating client-centered, strengths-based practice in settings where social workers are required to use assessment processes based on the medical model and deficit-based language of psychopathology and the DSM. It also promotes a process of infiltrating, influencing, and transforming the of assessment process so that it reflects a more holistic and strengths-based social work perspective. Examples are provided for incorporating the strengths perspective in practice.

IN THEIR DAILY WORK, many social workers experience a tension between conflicting paradigms. On one hand, there is a rich history of social work knowledge derived from understanding the complexities and resources of the bio-psycho-socio-spiritual environment (Cowger, 1994; Franklin, 1992; Gutheil, 1992; Rodwell, 1987), as well as the remarkable stories of those individuals and families that not only endure, but thrive in the face of great adversity (Bass & Thornton, 1983; Rothenberg, 1997; Rubin, 1994). There is also a growing emphasis on the strengths perspective, and the unique strengths, skills, and abilities of persons who surprise us by not fitting neatly into any category and who create solutions where none seem possible (Weick, Sullivan, & Kisthardt, 1989; Saleebey, 1992, 1996).

On the other hand, there is the dominant medical model world view, primarily based on the concept of disease process and a deficit-based understanding of human behavior as exemplified by psychopathology and the DSM (American Psychiatric Association, 1994; Hersen & Turner, 1991; Maxmen, 1986). This paradigm can influence one's view of all behavior, and have a profound effect on how services are provided, especially through the dichotomization of all behavior into medical and non-medical polarities, and through the mechanism of insurance coverage and reimbursement (Berlin, 1992; Kirk & Kutchins, 1992). It can control access to services, what services can be provided, and how both clients and service providers see themselves in the world, (Kutchins & Kirk, 1997).

The author finds that this tension is often either dismissed as unimportant, or avoided because of the disturbing or threatening consequences of addressing it. That is, the exigencies of getting work done, within the dominant paradigm, tend to reduce the attention paid to possible alternatives, leading to a sense of powerlessness in both practitioners and consumers. Once, in a training session with 55 masters-level social workers, a participant said to the author in a hopeless tone: "What can we do about it?" As other people nodded, the author made the observation that if 55 trained social workers could't effect any systemic change, these are certainly desperate times. Failing to attend to these issues also obscures serious ethical questions (Goldstein, 1990; Kutchins & Kirk, 1987, 1988).

Social work has a great opportunity to provide leadership in transforming practice theory and methodology. This does not require a wholesale abandonment of the medical model, which would be naive and inappropriate. "Schizophrenia is real. Child sexual abuse is real. Pancreatic cancer is real. Violence is real. But in the lexicon of strengths, it is as wrong to deny the possible as it is to deny the problem" (Saleebey, 1996, p. 297). While there have been continuing advances in our understanding of biomedical bases for some behavioral and emotional difficulties, there has likewise been

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a not-so-subtle turning of a blind eye to the mechanisms of institutionalized prejudice and oppression. The important thing is not to lay blame or point fingers, but to establish as broad and inclusive a perspective as possible. This will require a re-assertion of social work knowledge, and placing medical-model understanding within a more holistic understanding of human behavior (Weick, 1986.) In psychiatry, more than any other medical specialty, what one looks at, and how one looks at it, are influenced by perspective as much or more than empirical science:

> *You cannot draw someone's blood, stick someone into a magnetic resonance imager, or take any medical reading that will tell you definitively whether that person is depressed or not. So it matters a great deal how a psychiatrist is taught to look at mental illness, because the "how" cannot be clearly separated from the "what" of the disease. To understand psychiatric ways of seeing, we have to proceed knowing that what counts as "fact" is a tinted window onto a world you cannot step outside to see. (Luhrmann, 2000, p. 10)*

The strengths perspective (Saleebey, 1992, 1997; Weick, Sullivan, & Kisthardt, 1989) offers a set of guiding principles that shape the lens for viewing human behavior in a very different way. The fundamental premise is that individuals will do better in the long run when they are helped to identify, recognize, and use the strengths and resources available in themselves and their environment. This seems harmless enough, but as the author and his colleagues have witnessed, this simple idea can be seen as very threatening by some (Graybeal, Moore, & Cohen, 1995). Anecdotal information suggests that many have seen the strengths perspective as naive and simplistic, or that it denies advances in the understanding of psychopathology and a biomedical knowledge base and practice models (Saleebey, 1996.) This is an unfortunate response, as the identification of strengths is not the antithesis of the identification of problems. Instead, it is a large part of the solution.

This article addresses only one aspect of this issue, the process of conducting psychosocial assessments. Many social workers are required to use structured assessment forms that lead inexorably toward problem lists, pathology, and psychiatric diagnoses. While some of these forms include attention to strengths, they often do so as an aside, or as an afterthought. Typically, the structure and content of the form is dictated by policy or insurance guidelines. The PIE system attempts to broaden the perspective, by placing psychiatric problems in a much broader context of social problems and challenges (Karls & Wandrei, 1994). This is a step forward, as there is some attention to strengths in this model. It cannot be said to come from a strengths perspective, however, which would seem to require a greater transformation and shift of focus. This article offers suggestions for how to use problem- and pathology-based assessment forms and procedures in ways that reflect client strengths and resources. In addition, though not the primary focus of this article, suggestions are provided for initiating a process for changing assessment forms and policies, and helping agencies move toward more client-centered practice.

The Traditional Model for Psychosocial Assessments

Table 1 reflects the typical headings and content areas for traditional psychosocial assessments. Though there are many variations, they are mostly in style rather than in substance. This format leads to a thorough history of the client's current and past functioning, symptoms and problems, historical milestones, current and past treatment, and concludes with diagnostic impressions and treatment recommendations. In some settings, the social worker does not offer a diagnosis, but in many they not only offer one, but determine it. Despite the development of the multi-axial system of diagnosis, axes IV and V are often not used, or when used, receive scant attention.

Transforming the Traditional

The word "transformation" is used here specifically to avoid splitting practice into useless dichotomies. When done well, a traditional psychosocial assessment provides information that is highly useful to both client and practitioner. The goal here is to transform that model by including additional information, gained through asking alternative questions that will expand the sense of understanding of the client's life and circumstances. This transformation should also have the effect of influencing how the client experiences the process, and the sense of hope and possibility they have upon its conclusion (Cowger, 1994; DeJong & Miller, 1995).

Assessment is Intervention

Though typically seen as distinct phases of practice, it is critically important to understand that there is

Table 1. *Content Areas in a Traditional Assessment Format*

Typical Content Areas	Traditional Information
Presenting Problem	Detailed description of problem(s). List of symptoms Mental status Coping strategies
Problem History	Onset and duration Course of development Interactional sequences Previous treatment history
Personal History	Developmental milestones Medical history Physical, emotional, sexual abuse Diet, exercise
Substance Abuse History	Patterns of use: onset, frequency, quantity Drugs/habits of choice: alcohol, drugs, caffeine, nicotine, gambling Consequences: physical, social, psychological
Family History	Age and health of parents, siblings Description of relationships Cultural and ethnic influences History of illness, mental illness
Employment and Education	Educational history Employment history Achievements, patterns, and problems
Summary and Treatment Recommendations	Summary and prioritization of concerns Diagnosis: DSM-IV, PIE Recommended treatment strategies

not, and cannot be, a distinct demarcation between assessment and intervention in social work practice. The reader will no doubt be familiar with agency or governmental policies requiring a one-to-three-session assessment process, followed by treatment planning, and intervention. Though it makes sense on the face of it, this idea is problematic. For example, it precludes the possibility that the client may be effectively helped in a briefer time-period, and as Talmon (1990) has documented, a significant percentage of all outpatient clients terminate, and report satisfaction, within one to three sessions.

More importantly, this dichotomy is based on the illusory idea of therapeutic neutrality or transparency. That is, it assumes the practitioner has little influence on the experience or presentation of the client. I once attended an interdisciplinary treatment planning meeting where the psychiatrist left the room to get the patient, and returned alone, literally screaming, "I'm not bringing that patient in here, she's completely hysterical!" Relational theory (Jordan, et al., 1991) and practitioner experience suggest that it makes sense to expect that the nature of the process itself will have a profound effect on the client. These effects derive from more than personality, mood, style, or setting. Embedded biases and prejudices play a role, as does pressure to collect required data and to avoid meaningful but time consuming tangents. Most powerful of all, the expectation of pathology guides clients into a problem-based world view, and an experience of themselves as central to the origins and maintenance of problems, deficits, and pathology. And if the map contains no directions to resources, strengths, and solutions, the practitioner will not expect them, and is likely to find them only by chance.

In their professional education, social workers are often exposed to a contradiction in knowledge bases and world views. While educated in the dynamics of institutional oppression, they are often simultaneously trained in the field and classroom to look through a traditional lens at individual behavior. In their field placements, they are often expected to be prepared to work directly and primarily with the *DSM* as the lens for assessment, to see individual behaviors as reflective of psychopathology rather than systematic oppression or contextual circumstance. They may even experience a certain impatience from field instructors and other professionals if they question this emphasis and requirement. Social workers can and should offer alternatives, including meaningful questions that will combat the relentless pursuit of pathology, and ones that will help discover hidden strengths that contain the seeds to construct solutions to otherwise unsolvable problems.

A Bio-Psycho-Socio-Spiritual Framework

The first step to more meaningful assessments is in broadening the perspective. Most persons see themselves as a complex constellation of qualities, with many dimensions, some known to others, and some not. All humans are influenced by and exist within at least four major dimensions, biological, psychological, social, and spiritual. Most theories of practice, even in social work, emphasize the first two dimensions, and traditional as-

sessment practices, especially the *DSM*, give little or no credence to the latter two. Interestingly enough, it is in the social and spiritual dimensions that the substance of persons' lives is played out. That is where meaning is constructed and relationships are developed. It is the social dimension in particular where the individual encounters his or her environment, and finds it to be either resource rich or growth enhancing, or oppressive and debilitating. Table 2 summarizes some of the key subject areas for each of these four dimensions.

When is a Client not a Client?

It is helpful to understand that not everyone called a client is a client. For example, I contend that there is no such thing as an uncooperative or mandated client, and that to suggest there is actually creates delusional thinking on the part of practitioners, and guarantees the emergence of "uncooperative" behavior (de Shazer, 1985; Walter & Peller, 1992). This makes more sense when one understands that many of the people one sees are not clients, but something or someone else. There are five types of people that a social worker may see as clients: complainants, visitors, targets, patients, and clients (de Shazer 1985; Pincus & Minahan, 1973):

Complainants are people with a complaint, and they want something, or more typically, someone, to change. Marital and family therapists often find they have one or more complainants, individuals who would like their spouse or child to change.

Visitors are people who are essentially passing through; they offer neither a complaint nor an interest in working on anything. School social workers see many kids that are visitors, at least initially.

Targets are individuals someone else wants to change. Most children in therapy are targets, as are many spouses, and so-called uncooperative, resistant, and mandated "clients."

Patients are recipients of medical care. Social workers do not provide medical care, and calling a client a patient creates a host of epistemological and ethical quandaries.

Clients are defined by two critically important criteria: (a) they have a complaint; and (b) they enter into a contract with the social worker to do something about it.

Understanding whom one is meeting with changes the entire experience and outcome of the assessment process. For example, understanding someone as a target completely alters the socially constructed meaning of the interaction, and the expectations one has for it. "Resistance" or lack of cooperation may be seen instead as the target's way of teaching the provider how to work with her or him (O'Hanlon & Wilk, 1987).

Table 2. *The Bio-Psycho-Socio-Spiritual Dimensions of Assessment*

Biological	Basic needs—food, clothing, shelter
	Comprehensive health
	Physical attributes and abilities
	Physical environment
Psychological	Individual history
	Personality style and makeup
	Intelligence and mental abilities
	Self-concept and identity
Sociocultural	Family (through biology, choice, or circumstance)
	Friends
	Community
	Ethnicity
	Social environment
	Political environment
	Economic environment
Spiritual	Sense of self, in relation to the world
	Sense of meaning and purpose
	Value base
	Religious life

Identity, Attribute, and Behavior: or Being, Having, and Doing

The strengths perspective does not ignore or minimize diagnoses or diagnostic skills, but does assert that they must be seen as contextual and part of a larger process. "Having assessed the damage, the social worker needs to ensure that diagnosis does not become a cornerstone of identity," (Saleebey, 1996, p. 303). Thus, another important consideration in the assessment process is understanding the difference between identity, attribute, and behavior. For example, consider how the three following statements might impact both the client's self-perception, and the social worker's perception of them: "She's a borderline." "She has borderline personality disorder." and, "Sometimes she's very kind, sometimes she's very critical." Or, another example: "I'm an alcoholic." "I have a disease called alcoholism." and,

"My drinking creates problems in my life." In each example, the three statements derive from different epistemological and ontological assumptions, and the impact on perception can be subtle but hugely significant, and vary widely with the individual affected. Declaring oneself an alcoholic is a critical turning point for many, while declaring someone else a borderline may set her up for discriminatory reactions from service providers, as well as deleterious effects on her own sense of self.

Social workers should understand how these distinctions impact the way they see and relate to persons in need of services, and how those clients see themselves in the world. Labels have the power not only to explain, but to confine and constrict, to objectify the client in ways that reduce the meaningful facts of their lives to secondary trivia.

Finding Strengths: Use the ROPES

The identification of problems and pathology has a long and rich history, including an enormous literature, methods of practice, and reimbursement structures for those who practice those methods. Recently, a growing literature of strengths, normalcy, resilience, and solutions has begun to emerge (Anthony & Cohler, 1987; DeJong & Berg, 1998; Herman, 1992; Higgins, 1994; Offer & Sabshin, 1991; Saleebey, 1992, 1996, 1997; Weick, et al., 1989.)

What continues to be needed are the practical tools for identifying and utilizing personal and environmental resources and strengths. The ROPES Model (Graybeal, in development,) is one such tool. This acronym stands for Resources, Opportunities, Possibilities, Exceptions, and Solutions. Table 3 summarizes the model. This framework is used to guide both the general perspective and the specific questions of the practitioner. When the practitioner feels stuck, uninspired, or unable to locate useful strengths, ROPES, as a simple mnemonic device, can provide direction.

Making it Real: Incorporating the Strengths Perspective in Practice

The challenge for social workers is to incorporate the strengths perspective, even in settings where there is little understanding, acknowledgment, or acceptance of it as relevant. "Pursuing a practice based on the ideas of resilience, rebound, possibility, and transformation is difficult, because oddly enough, it is not natural to the world of helping and service" (Saleebey, 1996, p. 297). I assert that social work values and ethics should influence this choice, and hold sway over those influences that retain and reinforce dominant paradigm, deficit-based, thinking. This will require advocacy for change at both policy and practice levels. The policy dimension is beyond the scope of this article, which is intended to engender hope and change from the ground up, in current practice procedures.

Table 3. *Identifying Strengths: Use the ROPES*

Resources	Personal Family Social environment Organizational Community
Options	Present focus Emphasis on choice What can be accessed now? What is available and hasn't been tried or utilized?
Possibilities	Future focus Imagination Creativity Vision of the future Play What have you thought of trying but haven't tried yet?
Exceptions	When is the problem not happening? When is the problem different? When is part of the hypothetical future solution occuring? How have you survived, endured, thrived?
Solutions	Focus on constructing solutions, not solving problems What's working now? What are your successes? What are you doing that you would like to continue doing? What if a miracle happened? (de Shazer, 1985) What can you do now to create a piece of the miracle?

Faced with traditional assessment forms, it is possible to transform the content by the way it is written, through the questions asked of the client, and the inclusion of responses that come from a place of exception, hope, and possibility. In this section, two examples of an assessment based on a traditional form are provided. The first example is traditional in language and content. The second ex-

Table 4. *Additional Assessment Information From a Strengths Perspective*

Typical Content Areas	Traditional Information	Additional Information
Presenting Problem	Detailed description of problem(s). List of symptoms Mental status Coping strategies	Emphasis on client's language Exceptions to the problem Exploraton of resources Emphasis on client's solution Miracle question
Problem History	Onset and duration Course of development Interactional sequences Previous treatment history	Exceptions: When was the problem not happening, or happening differently? Include "future history"—vision of when problem is solved
Personal History	Developmental milestones Medical history Physical, emotional, sexual abuse Diet, exercise	Physical, psychological, social, spiritual, environmental assets. "How did you do that?" "How have you managed to overcome your adversities?" "What have you learned that you would want others to know?"
Substance Abuse History	Patterns of use: onset, frequency, quantity Drugs/habits of choice: alcohol, drugs, caffeine, nicotine, gambling Consequences: physical, social, psychological	"How does using help?" Periods of using less (difference) Periods of abstinence (exceptions) Person and family rituals—what has endured despite use/abuse?
Family History	Age and health of parents, siblings Description of relationships Cultural and ethnic influences History of illness, mental illness	Family rituals (mealtimes/holidays) Role models—nuclear and extended Strategies for enduring Important family stories
Employment and Education	Educational history Employment history Achievements, patterns, and problems	List of skills and interests Homemaking, parenting skills Community involvement Spiritual and church involvement
Summary and Treatment Recommendations	Summary and prioritization of concerns Diagnosis: DSM-IV, PIE Recommended treatment strategies	Expanded narrative-reduce focus on diagnosis and problems Summary of resources, options, possibilities, exceptions, and solutions. Recommendations to other professionals for how to utilize strengths in work with client

ample incorporates the strengths perspective throughout, adapting the traditional format by incorporating the additional criteria listed in Table 4. In the interest of conserving time and space, both examples are brief.

Example 1: A Traditional Assessment

Presenting Problem: Mary S. is a 28-year-old woman who appears older than her stated age. She complains of feeling depressed and states, "It's just not worth it anymore." She has been experiencing difficulty sleeping, and has poor appetite, weight loss, a loss of interest in things generally, and low energy. She has recurrent feelings of hopelessness, helplessness, worthlessness, and guilt. She has had intermittent suicidal ideation, but indicates no current plans to harm herself. She comes to the clinic because previously, she has been helped by therapy and medication. She left therapy last year due to what she describes as "a difference of opinion" with her therapist, and is not currently taking any medication.

Problem History: Mary describes the onset of her depression as gradual, with a slowly increasing loss of interest and energy. She first experienced depression after deciding to have an abortion at age 21. At that time she was treated with psychotherapy and medication. Since that time she has been treated two more times, once with just psychotherapy, and the second time with medication and therapy.

Personal History: The client describes normal developmental milestones, but says she was generally lonely as a child. She is not aware of any physical ailments. She denies any history of physical or sexual abuse, though she feels that her father was emotionally abusive and demanding. She has few friends and tends to be fairly isolated socially.

Substance Abuse History: Mary indicates she does not smoke and has never used illegal drugs. She drinks four to five cups of coffee per day, and recently has begun drinking more than in the past. This area was explored and she reports often having one to two drinks at night to help her fall asleep. She denies any problems related to her drinking.

Family History: The client is the younger of two sisters, and indicates that her older sister was the star of the family. Her older sister is 31, married, with two children, and a successful artist. Her parents divorced when she was 18. She describes her father as emotionally distant and rarely home due to his work as a traveling salesman. Two years ago, her father died of a heart attack at age 57. Her mother, 54, lives nearby, and calls daily to "check up on" her. She feels that her mother means well, but is generally too demanding, and is hard to be around. She indicates no history of mental illness in the family.

Employment and Education: Mary completed high school and attended technical college where she received training in office management. She is currently employed full-time as a secretary for a small heating and air conditioning business. She has been there for three years, and finds it to be difficult due to the stress and noise. She would like to work somewhere else, but hasn't been able to get motivated to look for another position.

Summary and Treatment Recommendations: Mary S. is a 28-year-old woman who complains of depression. She states that she would "like to feel better," and that she has been helped in the past by psychotherapy and medication. She is worried, however, that she is worse than before and often feels hopeless that she will ever get better. She is employed and has contact with her family. Though she is interested in changing jobs, her perspective may be influenced by her depression and she was encouraged not to make any major changes until her depression has been treated.

Diagnosis: Major Depression, Recurrent

Treatment Recommendations: Weekly individual psychotherapy to deal with depression and low self-esteem. Evaluate for antidepressant medication.

Example 2: A Transformed, Strengths-Based Assessment Using Traditional Format

Presenting Problem: Mary S. is a 28-year-old woman who complains of feeling depressed and states, "It's just not worth it anymore." She notes that recently a close friend moved away and she has been feeling lonely. She has also been experiencing difficulty sleeping, and has poor appetite, weight loss, a loss of interest in things generally, and low energy level. She has had intermittent suicidal ideation, but indicates no current plans to harm herself. She reports positive experiences in the past with therapy and medication. She finds her mood is better when she is at work, and when her friend calls her. When this problem is solved, she imagines that she will have more energy, and will be planning more activities outside of work.

Problem History: Mary describes the onset of her depression as gradual, with a slowly increasing loss of interest and energy. She first experienced depression after deciding to have an abortion at age 21. She notes that things improved a great deal when she got her current job, thought that seems to no longer be true. Psy-

chotherapy and medication have helped in the past. In the future, she would like to be able to get help from friends instead of therapists.

Personal History: The client says she was generally lonely as a child. She thinks of herself as a strong person, physically, and used to enjoy exercise. She indicates she has not experienced physical or sexual abuse, though she feels that her father was emotionally abusive and demanding. She has not had many long-standing relationships, but reports this is not a concern for her. Her one close friend who recently moved away, but calls her regularly on the telephone. She describes herself as a very creative person, and she has sometimes been able to use her creativity to feel less lonely, by imagining she is taking part in great adventures. She is an avid reader.

Substance Abuse History: Mary indicates she does not smoke and has never used illegal drugs. She drinks four to five cups of coffee per day, and finds she needs this much to feel energetic. She recently has begun drinking more than in the past. This area was explored and she reports often having one to two drinks at night to help her fall asleep. She reports that when she drinks she feels less lonely, and more creative. She believes that drinking has been helpful to her, though she would like to find more interesting things to do.

Family History: The client is the younger of two sisters, and indicates that her older sister is now 31, married, with two children, and a successful artist. Her parents divorced when she was 18. Her father died of a heart attack two years ago at age 57. He was a traveling salesman. She notes he often seemed distant but always made a point of being home for Sunday dinner, which she loved because he would bring her presents, and they would watch television together. Her mother, 54, lives nearby, and calls daily to "check up on" her. She feels that her mother means well, but is generally too demanding, and is hard to be around. She has a favorite aunt, Janice, who also lives nearby, but she has lost touch with her. She would like to re-connect with Janice. She indicates no history of mental illness in the family.

Employment and Education: Mary completed high school and attended technical college where she received training in office management. She is employed full-time as a secretary for a small heating and air conditioning business. She has been there for 3 years, and finds it is no longer challenging to her, and is stressful and noisy. She feels that her skills would warrant a better position, and that changing jobs would help her to feel much better.

Summary and Treatment Recommendations: Mary S. is a 28-year-old woman who complains of depression. She states that she would "like to feel better," and that she has been helped in the past by psychotherapy and medication. Her depression is better when she is active. She is employed and has some contact with her family. She would like to change jobs to better utilize her skills, to re-connect with her aunt, Janice, and to find a way to meet some more people since her best friend moved away. She is a creative person, and an avid reader, but has few outlets to express herself and would be interested in finding out what other kinds of creative activities might be available. She would like to find help from friends instead of from therapy. This client responds well to positive re-enforcement, and a change in her mood was noted during the assessment session, with more energy noted as she discussed making changes for herself, and considered options and alternative to traditional therapy.

Diagnosis: Rule/out: adjustment disorder
Major Depression, recurrent

Treatment Recommendations: One to three sessions to explore options, including locating support group, employment planning, social activities, and/or psychotherapy. If no improvement noted in 1 month, request evaluation for antidepressant medication.

Discussion

The first example uses the fairly standard language of a mental health agency assessment. Through its structure and design, and the nature of the information sought, it tends to lead to a compilation of problems, symptoms, and diagnoses. In the service of that goal, it is efficient and professional. The second example uses the same form, but through a change in focus, the worker guides a conversation in search of resources, options, possibilities, exceptions, and solutions. The client experiences this process quite differently, and there is even a change in affect noticed by the worker. This is not magical or wishful thinking, but a fairly realistic description of what often happens.

It is important to understand that a client may be participating in the assessment process on one of the worst days of his or her life. She or he may be experiencing loss, trauma, alienation, poverty, abuse, malnutrition, and psychosis. He or she may have never had to ask for help before, and feel shame, guilt, and/or incompetence. The questions the social worker asks are critical. They may reinforce the worst of external conditions and internal experience, or they may guide the client to recognition and acknowledgment of their own sense of

self-worth and possibility. And the most important discovery for the social worker is that such questions do not ignore problems or pathology, but instead place concerns in the context of the belief that the client also holds the clues and creativity that will lead to solutions. Learning to ask questions that open up possibilities is an art form that takes practice. Luckily, there are a growing number of sources for such questions, (Tomm, 1987; Cowger, 1994; DeJong & Miller, 1995; DeJong & Berg, 1998). Social workers are encouraged to devote at least equal time to these skills as to training in pathology-based diagnostic skills.

The current structure of traditional assessment forms is often dictated by requirements of government regulations and insurance reimbursement practices. It is also influenced by the overwhelming hegemony of the medical model in mental health practice, with its emphasis on problems, pathology, and diagnosis. Experience suggests, however, that it is not only possible to use the traditional format in a different way, but to initiate change at the agency level. I have a number of students and colleagues who have re-written agency assessment forms and are using them effectively to influence practice in the direction that embodies the strengths perspective.

Conclusions

There are many related topics that need further exploration and development, including more advanced training in the skills of strengths-based practice, and advocacy for transforming agency policy and constrictive assessment practices. What is also needed is the exploration of alternatives to reimbursement structures and deficit-based practice models that lead social workers inexorably towards defining social problems as personal pathology. Finally, social workers and social work students who attempt to implement a strengths perspective often need ongoing support and encouragement in their efforts to challenge dominant paradigm thinking.

This article has explored the process of social work assessment. Recommendations have been made for ways to change the emphasis of psychosocial assessments from one of problems and pathology to one of strengths, solutions, and possibilities. I have made some suggestions and offered tools to help with this transformation. Social workers have a great opportunity to become leaders in this area, as strengths-based assessments exert influence well beyond the worker and client. They have the potential to change the perceptions of other current and future providers, and plant seeds for those providers to see clients as resources in their own process, whether that process is called treatment, therapy, recovery, personal growth, collaboration, or social work.

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