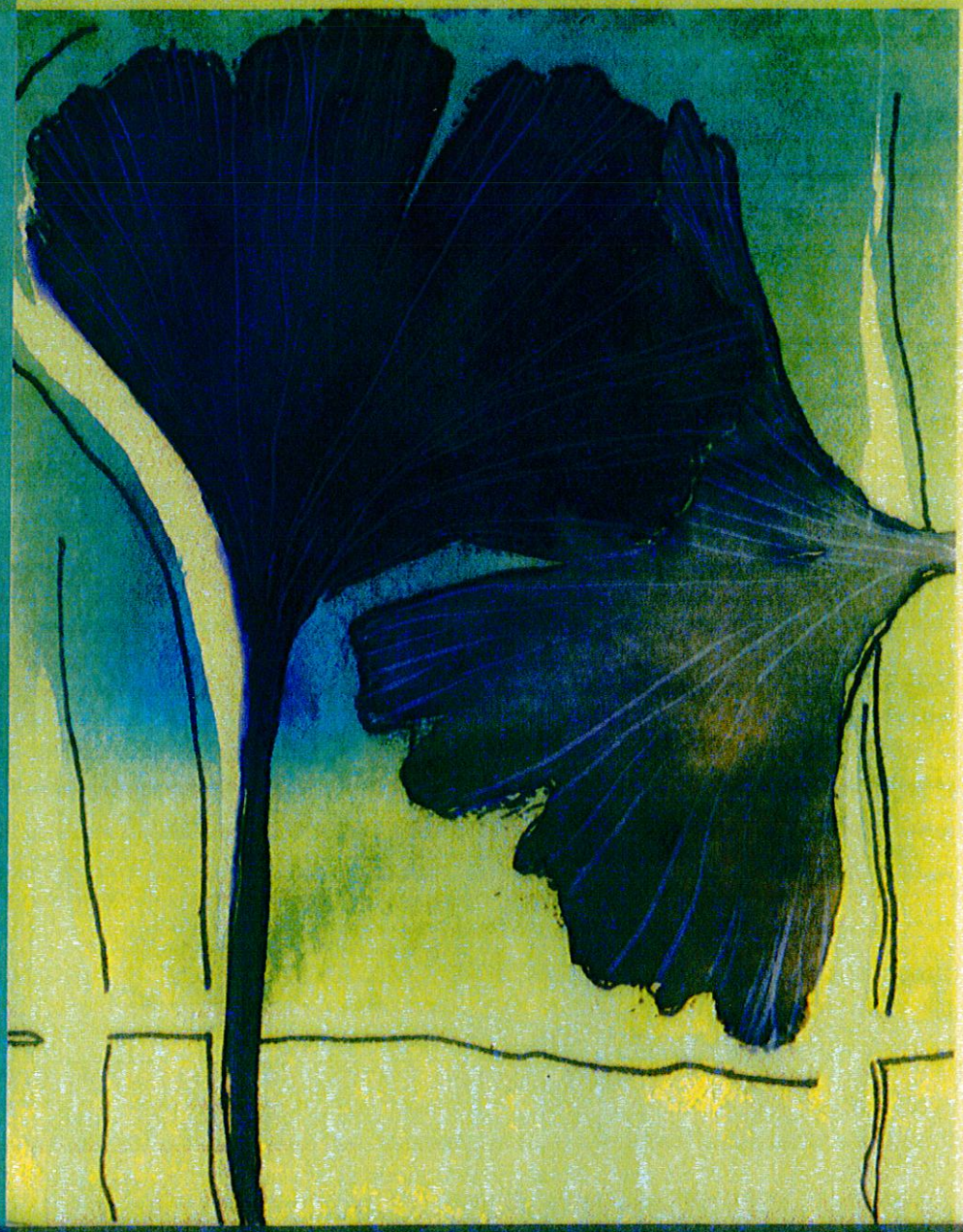
Positive Communication *in* Health *and* Wellness



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• CHAPTER FOUR •

The Social Construction of Hope through Strengths-Based Health Communication Strategies: A Children's Mental Health Approach

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I crossed the street in front of a burned-out church building, walked past the group of pot smokers, and rang the buzzer at the group home door. The case manager, Irene,[1] greeted me warmly and led me in. Roger, from the local community center and Brisa, the house manager, shook my hand as I introduced myself. Within a minute Maria, the youth with whom the team was working, slouched in.

"We're here to check Maria's progress," Irene began. She looked toward Maria, but Maria's eyes remained downcast, her hands folded in her lap. Irene pointed to the agenda. "First we'll talk about the strengths of Maria and our team. What strengths does Maria have?" "She's tenacious," offered Roger. Irene wrote on the flip chart. "She can follow through on things." He gave a recent example. "Here's one," said Brisa. "Just this morning, I came in the recreation room and she was sitting on the couch, reading. I said 'hello,' and she responded, 'I don't want to talk to you right now.' This is a

1. Names and identifying details have been changed.

strength because instead of getting angry at the interruption, she was honest with her feelings. I really appreciated that." She smiled warmly at Maria, and Maria responded with slight eye contact.

"Good!" Irene affirmed as she wrote on the flip chart. She directed the next question to Maria. "What strengths do you think you have?" Maria shook her head, but Irene gently pressed. "What about yesterday, when you were going to buy that CD but decided it wasn't worth the money? I'd say you were good at decision-making. What do you think?" Maria kept her eyes downcast, but she nodded, so Irene added that to the list before continuing. "What about strengths of the team? What is one strength each of you brings to this team?" "I have good access to resources," Roger offered. "I care about Maria," suggested Brisa. I noticed Maria had begun looking directly at the team members as they spoke.

This opening narrative offers an example of what's called a "strengths approach" as it is used in a children's mental health treatment team meeting within a children's mental health system of care (SOC). In contrast to traditional social service systems that focus on deficits when working with children, a strengths approach is a positive one which concentrates on the family's resources and talents, and uses them as vehicles for positive change as they help families help themselves. This approach takes a similar philosophy to the fields of positive psychology and psychotherapy, which suggest that building on positive things already in a patient's life (positive characteristics, emotions, engagement, meanings, talents, and institutions) rather than focusing on repairing and fixing negative attributes, is a more effective treatment for depression and other pathologies (Seligman, Steen, Park, & Peterson, 2005; Seligman, Rashid, & Parks, 2006; Seligman & Csikszentmihalyi, 2000). The strengths approach also has a philosophy similar to that of positive communication which is defined as "communication that promotes positive emotions and attitudes and benefits interpersonal relationships" (e.g., Socha & Pitts, 2012). However, the use of strengths in children's mental health treatment planning moves beyond both of these perspectives by moving past feelings and thoughts into the realm of using communication to enhance not just mood, satisfaction, and emotion, but the more tangible, day-to-day *functioning* of a person's life.

Thus, this chapter provides a practical understanding of the use of strengths in family service planning in SOC teams. This chapter will first explain the history and characteristics of the strengths approach in the field of children's mental health, particularly as it contrasts with more traditional medical models of care. We will then introduce our research which suggests a typology, or categories, of strengths-based communication strategies and examine the language that service providers use as they follow a strengths approach. We'll next talk about the strengths-deficit dialect and how this

tension problematizes the use of a strengths philosophy when working with children and families. Finally, we'll discuss how strengths discourse can construct hope with children, families, and their providers.

Introduction to a Strengths-Based Approach

The SOC philosophy in children's mental health was developed in the past decade in response to criticisms of the health, social, mental health, and educational systems (Friedman, 1994). Mental health care systems following this approach take a holistic, contextual view of treating the child and family. This philosophy encompasses, among other characteristics, a collaborative interagency planning team which includes the child and family as full team members and—within that team context—a strengths orientation (Lourie, Katz-Leavy, & Stroul, 1996; Stroul & Friedman, 1986).

Practicing in a strengths manner—identifying strengths and using them as part of interventions for change—is an approach to treating children and families that differs significantly from more traditionally based ones, partly because the strengths perspective is a departure from the medical model's reliance on deficit language (Laveman, 2000). Providers practicing in this manner seek to develop the family's strengths by focusing on family talents, skills, possibilities, values, culture, and competencies that promote and enhance family functioning, instead of focusing on deficits and problems (Dunst, Trivette, & Mott, 1994; Durrant & Kowalski, 1993; Saleebey, 1996). When moving from deficiency (what's wrong with the child and family that needs to be fixed) to capability (what's right with the child and family that can be enhanced and built upon) language transcends problems and reframes an individual's (and family's) identity to a more positive one (Bronfenbrenner, 1979; Saleebey, 1996).

There is some criticism of the strengths approach to mental illness (Taylor, 2006), including that some adherents of this philosophy oppose the use of accepted diagnostic evaluation measures such as the DSM. However, people practicing this philosophy don't ignore problems, they just look at them a different way: they assess the needs but rather than focusing on them, they focus on strengths as pathways to solutions. While positive psychology advocates suggest that they are supplementing, not replacing, the deficit-based approach, some admit they are "challenging" the deficit model of traditional psychology (Peterson, 2006, p. 5), and Peterson and Seligman (2004) have actually developed their own DSM-modeled book that classifies virtues rather than disorders. Positive psychology advocates suggest what's good about your life is as important as what's bad and a focus on simply alleviating symptoms results in short-lived and less effective outcomes (Peterson, 2006; Seligman, Rashid, & Parks, 2006; Seligman, Steen, Park, & Peterson, 2005). Treating problems as

personal deficiencies contributes to dependence, passivity, and disempowerment. Along with others, we argue focusing on strengths does just the opposite: helps empower and enable children and families (Dunst & Trivette, 1996).

Most children's mental health providers who attempt to follow a strengths orientation do so by conducting a "strengths discovery"—an exercise in which strengths of each team member are elicited and written down in a formal, rote manner. Simply listing strengths can be a good assessment tool, but by itself, does not effectively address family's needs. Providers are most effective when they use strengths to strategically move the family and team forward in a positive direction (Davis, 2006, 2008, 2012). Prior research identified a typology of seven strengths that, when used in child and family treatment planning, yields a strategic use of strengths: child and family talents, child and family resilience, child and family possibilities, available family and team resources, borrowed strengths, past or historical strengths, and hidden strengths (Davis, Mayo, Sikand, Kobres, & Dollard, 2007).

We next discuss our most recent research on how service providers using a strengths approach do so discursively.

Methodology

This research is based on an SOC site for children's mental health services in a major Southeastern city. This site, like over 100 others throughout the U.S., was funded by a grant from the Child and Family Branch of the Center for Mental Health Services (CMHS) in the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) to implement and enhance systems of care (SOC). This site has been a graduated site since 2004, which means that they have completed their six years of funding from this program, and have since maintained the practice of SOC values through training, supervision, and implementation of strengths techniques at the direct service level.

These SOC programs are community-based initiatives intended to integrate mental health, social, and human services for children with serious emotional disturbances (SED) and their families. At the time of the CMHS grant, the children enrolled in services at this site ranged in age from 4 to 18 years, and had a history of psychiatric hospitalizations, physical abuse, sexual abuse, running away, suicide attempts, and substance abuse. Their biological family histories included family violence, mental illness, psychiatric hospitalization, criminal convictions, and substance abuse. Their diagnoses included ADHD, depression, disruptive disorder, adjustment disorder, and other major psychiatric disorders, with many children identified with multiple diagnoses.

Extending from our earlier research which identified a typology of seven strengths that can be used in child and family planning (Davis, Mayo, Sikand,

Kobres, & Dollard, 2007), this study sought to build on those results by correcting some shortcomings of that study's methodology, to validate or amend that typology, and then understand how actual discourse is used in construction of strengths.

The prior research (referenced above) was a longitudinal study measuring outcomes of children and families enrolled in CMHS funded services, which included observation of 118 SOC child and family team meetings and a case review of 65 child and family teams across four different agencies to assess fidelity to SOC principles (Davis, Sikand, Mayo, Kobres, & Dollard, 2007). While the sample was large and extensive, analysis was retrospective and based on field notes gathered for a different purpose, yielding information that was less detailed than ideal and that did not allow for analysis of actual discourse. In the research reported here, we gathered new data by observing and video recording ten recent children's mental health treatment team meetings in the originally studied CMHS-funded community. For this project, we used a volunteer and convenience sample of client families who had children with SED and who were recruited by referrals from case managers. The participants were purposefully chosen to provide a variety of child and family teams.

The ten meetings observed were with one independent case management agency. Two parents were in attendance in five of the meetings, one parent (the mother) in the other four, and one grandparent as caregiver was in one. From one to four youth attended the meetings. Most parents were married, although a few were never married and one was widowed. About half of the families were white (not Latino), and the rest were black (not Latino), Latino, Asian, and Native American. Most parents attending had less than a high school education, and the treated children were in elementary or middle school. About half of the families had been receiving mental health services for less than a year; the rest, from one to nine years.

Half of the meetings observed were maintenance meetings, that is, meetings with ongoing teams, but two were the initial meeting for the teams, and three were final team meetings, preparing the families for discharge. Most of the meetings were held at the family's home, but one was held at the agency office. The meetings were approximately one hour long, and the transcripts ranged from five to fifty-one pages long. Two of the meetings were conducted in Spanish. On average, the meetings had just five attendees, ranging from four to seven. In addition to the parents and children, meetings were always attended by a case manager (who served as team leader). Two meetings also included a therapist/psychologist, and three meetings also included one or two mentors.

Observers had little interaction with meeting participants and primarily videotaped the meetings from positions in the room removed from the

discussion. The tapes were transcribed verbatim with non-verbal behaviors noted. Meetings conducted in Spanish were translated into English for coding and analysis. Participants gave informed consent and the study was approved by UNC-Charlotte's IRB. Participating team members were paid a stipend for their participation.

Data Analysis

For this research, we conducted a qualitative content analysis and subsequent discourse analysis of transcripts from ten treatment team meetings to identify strengths, validate or amend our original typology of strengths, and understand how actual discourse is used in construction of strengths. For the purposes of this research, we defined "strengths discourse" as *language used which refers to, suggests, or acknowledges something positive in the child, parent, family, team, or environment which can be used to move them forward in a positive direction.*

Qualitative content analysis describes elements in a message based on an existing coding scheme, and for our analysis, we began with the coding scheme of seven types of strengths developed in our prior research (child and family talents, child and family resilience, child and family possibilities, available family and team resources, borrowed strengths, past or historical strengths, and hidden strengths). Although we began our coding process with the existing typology, using an inductive approach to the data we left ourselves open to the possibility of revising categories or identifying additional ones.

To identify strengths and develop the typology of strengths, four coders conducted line-by-line coding of the meeting transcripts, as follows:

1. The first author examined the transcripts to identify instances of strengths discourse (times when strengths were mentioned or discussed). She compared these instances to the original typology, and noted when they did not fit into the proposed categories. From this she proposed a revised typology of 11 categories (see Table 4.1).

2. All four researchers met and jointly coded two transcripts, using the revised typology. They conducted line-by-line coding to identify instances of strengths discourse, then made a second pass through the transcripts to identify the category of the discourse. They conducted a negative case analysis to determine if additional categories should be added or revised, and made revisions to the code book definitions.

3. The four coders split into dyads to code the remaining eight transcripts, with each dyadic partner coding separately then each dyad comparing codes. Rather than attempting to reach a specific percentage of interrater reliability as in quantitative content analysis, taking a social constructionist point of view, we used a collaborative coding process called "peer debriefing" (Harris, Pryor, & Adams, 2012; Lincoln & Guba, 1985) in which individual coding differences were discussed and jointly resolved within the dyads.

Table 4.1. Strengths-Based Health Communication Strategies

Strategy	Description	Example
Identifying/ acknowledging positive child or family skills, talents, or competencies.	Skills, or things in which the child or family (or team members) have excelled in the past, or do excel in the present.	A child's math ability.
Mentioning positive (recent) past behaviors.	Specific behavioral examples of strengths exhibited in the past usually recent past).	When a child buckled down and did well on his assignment.
Finding positive interests for the child/family.	Things a child or family is interested in doing that would move them in a positive direction. (Interest strengths are often manifested in behavioral strengths, if a person is interested in something then does it).	A child's interest in crafts.
Identifying possibilities for the child/family.	Goals or dreams set in the *future* toward which the family and team are working. Goals which are *stated in the positive*— "What will it look like when things are better?"	A new home for the family.
Identifying available resources.	Financial, time, and knowledge resources available to help the family and team achieve their goals.	Assistance budget: re- source provided by com- munity mental healthcare system. Psychological testing: school provides. Other types: environmen-tal, food/clothing, medical, vocational, transportation, educational, recreational emotional, cultural, social resources.
Borrowing strengths.	Positive characteristics taken from another person, or by the strengths of the intervention or treatment itself.	A teacher's intervention borrowed from other work done in other schools.

Continued on next page

Table 4.1. Strengths-Based Health Communication Strategies *continued*

Strategy	Description	Example
Uncovering hidden strengths.	Strengths that, on the surface, look like deficits, but could be turned around into strengths.	A child's aggressiveness could be a positive thing if he learned to channel it in a good direction.
Identifying strengths in the environment.	Positive things in the environment.	The fact that the family has a home with a mother *and* a father at home.
Identifying feelings, attitudes, or values that are positive/ helpful.	Attitudes or beliefs that are helpful for a family (or team member) to have (other than resiliency).	A family's desire to keep their family intact is a value strength.
Pointing out family resiliency.	Personality traits that enable a child or family to have survived so far in the face of difficult life circumstances.	A parent's persistence in obtaining help for her family. A parent's ability to remain calm in the midst of ongoing crisis.

Discourse analysis studies the content, delivery, and context of discourse, to understand how people use language to construct meaning. To conduct the discourse analysis, once the discourse was categorized into the revised typology (themes), we analyzed how language was used to construct meaning within each theme.

Results and Discussion

Typology of Strengths-Based Communication Strategies

In this research, we've revised and expanded the original typology of seven types of strengths and have now identified eleven tangible ways team members (including family members) enact a strengths approach to family services. Reminiscent of the "three pillars" of positive psychology, "positive emotion," "positive traits," and "positive institutions" (Seligman, 2002, p. xiii), together these categories comprise a preliminary typology of what might be called strengths-based health communication strategies. Overlap and interaction across the eleven identified strategies exists, yet this typology provides a framework with which we can approach training of case managers and other healthcare providers and from which we can develop and further test communication-based hypotheses. We will next discuss each theme, give

a description and examples of each, and discuss how discourse is used to construct a strengths approach.

Identifying positive talents, competencies, or skills. The first theme, or strength-based communication strategy we identified, is to acknowledge positive talents of the child or family members. Talents include, for example, scholastic, musical, and sports talents (Dunst, Trivette, Davis, & Cornwell, 1994). Focusing on competencies supports the value that children and families are greater than their problems, and gives a foundation upon which to build goals and plans. Related to Csikszentmihalyi's (1990, 1999) concept of "flow," acknowledging their competencies provides opportunities for families and youth to use their talents, have enjoyable experiences, and feel in control. This communication strategy is the one most frequently identified in team meetings, and is elicited typically through a formal "strengths discovery" process in which the case manager goes around the table and asks each participant to list a strength of each other participant. With this strategy, the rote listing of strengths certainly has "feel good" qualities but does not appear to contribute much to positive progress.

> Case Manager: I guess grandma can read [Youth's] strengths.
> Grandmother: helpful, smart.
> Case Manager: Especially in—
> Grandmother: Especially in math.
> Case Manager: Yeah.
> Grandmother: Quick learner, good at video games. . .

Giving specific examples of positive behaviors. The second strengths-based communication strategy is to mention specific behavioral examples of positive things a family member, usually the "targeted" child, has done in the recent past. This type of strategy is a way team members tangibly reinforce actual behaviors, often of the youth, and frequently do so in "real time" as it occurs in the team meeting. This example shows how pointing out specific positive behaviors soon after they occur reinforces and acknowledges them:

> Therapist: I want to say [youth] has done an amazing turnaround since last Friday. ...We're seeing some changes and I was talking with [school counselor] today and she said you were much more receptive to talking to her. [Addresses youth] You were willing to talk to her. She...told me there was a problem in class today where one of the kids was trying to give you a hard time and you were [trying] to step away from it....I just think that's wonderful. I've seen some real big changes in that area. I think you're moving in the right direction. I'm really proud of you and I want you to know that.

Finding interests that move children or families in a positive direction. The next strengths-based communication strategy is to find things a child or family is interested in doing that would move them in a positive direction, such as having an interest in playing or watching sports. Interests are often manifested in talents or specific positive behaviors as a person interested in something is likely to do it. Distinct from possibilities (mentioned next), interests are short term or immediate things a person might want to do, as opposed to bigger picture, longer term dreams. While not goals or dreams, interests may be turned into goals that might lead a child or family toward a possibility or dream.

Identifying possibilities for the child or family. The fourth strengths-based communication strategy is to identify possibilities. Similar to "solution talk" (Berg & DeShazer, 1993; Fanger, 1993), this refers to goals or dreams set in the future toward which the family and team are working. This type of discourse uses imagery to orient the family toward what they have to look forward to, or what they can accomplish (Fanger, 1993). In this example, the mentor uses future tense language to move from the youth's problems to a vision of what life like will look like when those problems are improved.

> Mentor: When you start a family, you will know how to lead and guide your family in a positive way so that you will be able to provide what's best for them....One day you are going to be a man, you're going to have a house, you're going to have a wife, you're going to have children, and that those are things that you're going to have to learn to do.

Identifying available resources in the family, team, and community. The fifth strengths-based communication strategy is to point out financial, time, and knowledge resources that are available to the family, either from within the family unit, the team, or the community. Resources mentioned in the meetings include educational tools, information, recreational activities and organizations, community resources, formal supports (therapist, school counselor, police), and informal supports (mom, dad, grandma, step-parents, siblings). Recent research reports expansion of family resources (such as informal support and community resources), enhances the parent-child relationship, and reduces parenting strain (Cook & Kilmer, 2010; Kilmer, Cook, Munsell, & Salvador, 2010). Positive psychology (Peterson, 2006) suggests that "enabling institutions" (pp. 275-303) contribute to the fulfillment, purpose, safety, fairness, humanity, and dignity (p. 298) of the people with whom they are working. Of course, "supportive communication" within these institutions is what makes them a resource—providing instrumental support such as advice, for example, that is high in person-

centeredness (acknowledgment of feelings in a sensitive manner), politeness, and appropriateness for the situation (MacGeorge, Feng, Wilkum, & Doherty, 2012). Teams often mention resources as part of goal setting—as a listing of what resources are available or needed in order to move toward the goal. Family members can serve as resources for other family members, which is an empowering acknowledgement.

Borrowing strengths. The sixth strengths-based communication strategy is to borrow strengths from an exemplary other person, or by the strengths of the intervention or treatment itself, such as in medical treatments (Groopman, 2004). This strategy differs rhetorically from simply listing a resource by actually lifting elements or characteristics of that resource and holding them up as an example, suggestion, or lesson. So, for example, strengths can be borrowed from the successes, failures, or mistakes of a mentor, another child or family who has overcome similar circumstances, or from a service provider. A teacher's intervention in a classroom could be borrowed from other work he or she had done in other schools, and a school staff's success in controlling a child's behavior could be borrowed from their experience with other children at their school. Strengths can be borrowed from a person who has overcome similar experiences, such as in the example below:

> Therapist : The other thing I asked (father) to do – and he has been doing it – is to talk about when he was a young man and people tried him or said things to him to try to get him going. How did he ignore it? How was he able to walk away from it and still have his pride intact and everything? So he's also been addressing that.

Remembering past or historical strengths. The seventh strengths-based communication strategy is to remember past or historical strengths. These are events or memories that are actually borrowed from the family's own history, such as "coming from a home that was stable," and "we stayed in one place." This category differs from the previous one—borrowing strengths from a person's past experiences in that—in this category—the past strengths are from within the family itself. This distinction is important, because past strengths help remind the family how they came to have their current strengths, what they did to achieve their goals and successes, and that these skills can generalize to the future. The following example is an exchange between two parents and the case manager reminiscing about what the family has done in the past to remain close despite their problems:

Parent 2: We normally have this big Easter thing that we do, our family is so big with all of my kids and grandkids. We do relay races. All kinds of fun things. I've got videos that you cannot believe, doing three-legged races together, and stuff.

Case Manager: And that goes back to the culture thing too of your family. Those are things that you remember.

Parent 1: It's just one big happy family, if one needs something the other one's right there, it's all tight-knit.

Uncovering hidden strengths. The eighth strengths-based communication strategy is to uncover hidden strengths—strengths manifested, at least apparently, through undesirable behaviors, or which are hidden by negative behaviors or communication. The challenge is to identify these strengths and help the child channel them into more productive activities, or identify how the traits manifesting these undesirable behaviors can be redirected to become constructive. The opening narrative in the introduction to this chapter gives an example of a hidden strength. The youth said "I don't want to talk to you right now" and, rather than labeling this as antisocial behavior, the service provider acknowledged it as a strength. ("This is a strength because instead of getting angry at the interruption, she was honest with her feelings").

In this next example, this parent tells a story of resisting a teacher's attempt to label her child as learning disabled. She reframes the situation as one of the child being intelligent but not manifesting (hiding) those strengths because the youth is exhibiting resistance behavior.

Parent: [The teacher] was very frustrated that she doesn't think [youth] was placed right....[Youth]'s placed just fine, she's very intelligent, and she could do the work, she's just not doing for her, because she's resisting because the teacher's demeanor.

Sometimes past strengths are hidden when—due to current difficulties—people have forgotten about strengths exhibited in their past. In one specific instance, reminding a woman of her past strengths re-energized her and helped her achieve progress toward her goals.

Identifying strengths in the environment. The ninth strengths-based communication strategy is to uncover acknowledge positive things in the family's own environment or culture. Characteristics such as "stable household" and "solid home," living in a community with resources, and being on a team with caring people remind team members, including family, there are beneficial things in their lives that can be built upon. In an environment where children can be removed from the home if child welfare (frequently involved in these teams) deems the home environment to be

unsuitable or unsafe, acknowledging strengths in the environment is a very powerful statement.

Identifying positive feelings, attitudes, or values. The tenth strengths-based communication strategy is to identify positive feelings, attitudes, beliefs, values, "virtues" (Seligman, 2002, p. 133), or "character strengths" (Peterson, 2006, p. 142) helpful for a family (or team member) to have because they contribute to feelings of well-being, as well as eudemonic and hedonic happiness (see Socha & Pitts, 2012), and lead to future positive actions (Peterson, 2006), and perhaps therefore, a longer life (Seligman, 2002). Usually listed in the strengths discovery process, these include attributes such as "loves her family," "loving, genuine, concerned, and spiritual," "trusting," "generous," "motivated," and "he always puts his family first." Seligman (2002) and Peterson (2006) suggest the helpfulness of developing a grateful outlook on life, a will to be happy, and an attention to the positive.

Reinforcing family resiliencies. One specific positive attitude is called resiliency, and the final strengths-based communication strategy is to point out a family's resiliency. Resiliency is a personality trait that enables a child or family to have survived so far in the face of difficult life circumstances (Dunst, Trivette, Davis, & Cornwell, 1994; Richardson, 2002), such as the ability to survive in the face of chronic stressful situations, a sense of humor, a mother's desire to keep her family intact, a parent's persistence in obtaining help for her family, and a strong spiritual or religious faith. While life circumstances play a role in individual happiness, it resiliency in the face of negative circumstances that has been shown to have a powerful and positive impact (Socha & Pitts, 2012).

In the following example, family resilience is mentioned conversationally, as justification for believing the family's situation will get better, rather than in a rote listing. This conversational tone embraces the strengths orientation rather than simply complying with a mandate, and thus, is a more positive acknowledgment of the family.

> Case Manager: It's because of all these strengths that you guys have gotten through some rough patches. Because...you guys are very stable; if you weren't as stable as you are, it might be a little harder road.

Strengths-Deficit Dialectic

Evident in our past research about children's mental health treatment teams (e.g, Davis, 2008, 2012), and reinforced in the current study, is the struggle with the strengths-deficit dialectic. Dialectical theory says that individuals struggle with dialectical contradictions, relational phenomenon that are

interdependent yet functionally incompatible (Montgomery & Baxter, 1998). This tension problematizes the use of a strengths philosophy when working with children and families. Team members, frequently including family members, have difficulty moving away from the child's problems. This makes sense, if strengths are seen as a rote listing of "nice things" that a parent who has come for help with a child might wish to move quickly through in order to address the presenting problem(s). This next example shows how difficult this shift can be for team members who are ensconced in a deficit paradigm—frequently, strengths language is cancelled out by deficit language, often in the same breath.

> Behavioral Analyst: [Youth] has exceptional skills.
>
> Case Manager: I know [youth] has exceptional skills. His want is lacking but he has exceptional skills.

In this next example, the parent both acknowledges a strength of the child and a deficit in the same sentence.

> Parent: He's smarter than he lets on, but a lot of stuff he thinks he knows 'cause he don't like learning new things.

In another strengths-deficit dance, this parent is stating a child's strength (being naturally intelligent and getting good grades) negatively as a deficit:

> Parent: One of his problems when he was at [school] was that he was not doing class work. The only reason he kept his grades up was because he can ace the test. He didn't do his homework, they didn't get turned in, he didn't participate in class work, but when it came to the test he would ace [it] which kept his grades up. So he's smart, he just wasn't always doing, if he had done the work he'd be a straight A student.

The following conversation is also interesting as the case manager seems to be scaling back the dream the child and family have by reducing the goal from "going to college" or even "graduating" to just "finishing school."

> Case Manager: Now what goal can we attach to be successful?...I think that you had just mentioned to graduate, to finish school.
>
> Parent: He wants to graduate. He wanted to go to college; he told me forever ago that he wanted to go to college.
>
> Case Manager: Okay, so [to] be successful...the goal would be to finish school.
>
> Parent: (As Case Manager writes "to finish school" on board) To graduate.

Strengths Discourse as Hope-Building

In this last section, we'll discuss how strengths discourse can help construct hope with children, families, and their providers. Hope can be defined as the ability to see beyond limitations toward dreams, possibilities, and desired goals, and to imagine one's ability to reach those desires (Kearney & Griffin, 2001; Snyder, 2002). We suggest teams—including family members and youth—use the language of strengths to construct hope for each other and themselves (see Davis, 2012). Hope theory (Snyder, 2000) sees hope as types of thoughts and suggests that hope results from the combination of motivation to move forward (agency) and the ability to find ways to reach goals (pathways). Hope theory also suggests that positive thoughts result in pursuit of goals and then positive emotions, and the more alternative paths people have to reach their goals, the more hope they have. We suggest that hope is not only a way of thinking but a way of communicating, and strength-based communication strategies construct hope because they discursively contribute to agency thoughts (resiliencies, possibilities, past strengths, positive feelings/attitudes/values) and pathway thoughts. Taken together, our array of strengths-based communication strategies reflect "pathways thinking"—the practice of "attach[ing] oneself to positive outcomes or goals" (Snyder, 2000, p. 6) by constructing visions of a positive future and creating ways to reach them. They move the attention from the past and present (away from problems or deficits) to the future, toward positive, concrete alternatives, options, and solutions (Lipchik, 1994).

Hope theory suggests that hope is learned (Snyder, 1994) and we suggest that strengths-based language contributes to the lesson: strengths-based language shows the child or family is good at something (or multiple things) they can use to help themselves and develop alternative pathways; is a reminder the situation is not completely bleak; moves the family out of a present-time focus—which is often problem and deficit laden—into a future-time focus; reminds everyone working with the family they're not in this alone—there are resources they can all rely on for help; and reminds everyone the family accomplished something before, therefore they can do it again. Borrowing strengths is hopeful because this also borrows hope—someone else could do this; this helped in another situation, therefore this will help here. While deficits and problems frequently reside in the past and present, hope resides in the future, and hope discourse resides in the future also. Hope moves children with mental illness and their families forward (Kearney & Griffin, 2001; Snyder, 1994, 2000, 2002).

Discussion

As this analysis shows, fully adhering to a strengths approach in providing services for children and families is quite a challenge. In the "real world," attempts to do this are derailed by problem-saturated language and the difficulty in seeing family and child strengths in the midst of the deficits, problems, and challenges with which the team is bombarded. Child and family teams exist because of the family's problems, but if those problems remain the main focus of the team, positive psychology suggests help will be fleeting.

We suggest using strengths language can help families construct hope by introducing ways of reframing problems and challenges. Our characterization of 11 strengths-based health communication strategies suggests useful ways providers can focus on family strengths. Overlap and interaction across the 11 identified strategies exists, and in fact, many of these strategies can lead to others. For example, interests lead to talents which lead to positive behaviors and goal attainment. This suggests that starting somewhere—beginning to identify and build upon strengths of some sort—is the key to constructing hope for the family. Focusing on a positive future leads to hopeful feelings, which leads to forward momentum, positive motivation, and more hopeful feelings (Averill, Catlin, & Chon 1990; Groopman, 2004).

Strengths language can be thought of as "hope discourse." Effectively used, strengths direct the team toward a future where hope resides; they provide resources, ideas, and suggestions the family and team can use; and they remind everyone positive change is possible. Focusing on strengths reminds everyone they are greater than their problems and provides a foundation on which to build goals and plans. Positive psychology suggests thinking constructs reality (Kelley, 2004), and people feel less stressed and more positive about problems or challenges when they know what they are working toward and believe they have the traits, capacity, and resources necessary to deal with the problems (Aspinwall & Tedeschi, 2010; Csikszentmihalyi, 1993; Seligman & Csikszentmihalyi, 2000). In fact, research has found positive beliefs and self-affirmations can actually be induced by others in people who do not already have them (Aspinwall & Tedeschi, 2010). We suggest strengths discourse constructs hope.

Implications

After ten years, many of the SOC sites throughout the United States have progressed toward a strengths-orientation. An SOC approach has become a standardized philosophy, and in some child-serving systems, has even

become institutionalized. However, most case managers still are operating from a deficit approach and require reframing to a strengths orientation. This is a paradigm shift not only for the professionals but also for the families who are accustomed to their traditional "sick" roles. Our typology of strengths-based health communication strategies is being effectively used in training of case managers and other mental healthcare providers. Re-training a strengths approach sets up a positive experience for training participants as well as the families that will eventually be served by them.

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