Tools for Strengths-Based Assessment and Evaluation
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Tools for Strengths-Based Assessment and Evaluation

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This book is dedicated to
Jeffrey and Alyssa.
May you always measure others by their strengths.
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As Sir Winston Churchill wryly observed, “However beautiful the strategy, you should occasionally look at the results.” To do this, practitioners and researchers in the helping professions need psychometrically sound, yet practical measures that suit their purposes.

The good news is that hundreds—if not thousands—of measures have been developed, tested, and published that allow practitioners, researchers, and educators from diverse helping professions to “look at the results.” The bad news is that the number of available measures has become so large that oftentimes it is difficult for busy practitioners and researchers to sift through the many available measures and select the ones that are psychometrically sound, practical, and best for their purposes.

Fortunately, in the past 20 years, numerous books have been published that review, critique, and sometimes reproduce measures for practice and research (see Outcome-Informed, Evidence-Based Practice for a comprehensive list of these books published since 2000: Orme & Combs-Orme, 2012). Some of these books focus on particular problem areas (e.g., alcohol problems, eating disorders, anxiety). Others focus on areas of practice (e.g., mental health, rehabilitation, health care). Some focus on particular populations (e.g., children and adolescents, the aging). Still others focus on particular professions or disciplines (e.g., social work, psychiatry, psychology). Such books provide rich resources for busy practitioners and researchers.

Unfortunately, although most helping professionals recognize the importance of client strengths, resources, capabilities, and other positive qualities, it can be difficult to find and select measures of these important constructs. This can be especially difficult because measures of these constructs have been developed by researchers working in diverse disciplines, and strengths-based measurement is a relatively new area in some respects. Very few, if any, books have systematically pulled these measures together in one place and provided a framework for selecting and evaluating them. Tools for Strengths-Based Assessment and Evaluation fills this important gap.

A cornerstone of evidence-based practice, the new holy grail of social work, is to employ the methods and measures shown by evidence to be the most effective. Up until the publication of this book, the social worker who has wanted to document his or her clients’ strengths has faced a difficult and labor-intensive process in locating the most appropriate measures, let alone evaluating the evidence for their reliability and validity. Clearly, the realities of 21st-century social work practice make this a formidable task.

Now, Drs. Simmons and Lehmann have given all of us in the helping professions—practitioners and researchers alike—a comprehensive resource for finding and selecting psychometrically sound, practical strengths-based measures that we can use not only to “look at the results,” but to do so in a way that we “measure others by their strengths.” We
look forward to seeing this invaluable resource take its place with other must-have tools on every social worker’s desk in the coming years.

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Foreword

Why We Need a More Positive Social Science in These Troubling Times

All social sciences—sociology, anthropology, economics, political science, and social work—have included what could be described as the study of the pursuit of well-being (i.e., happiness, a good or better life, justice, and equality). However, until very recently, most research equated this well-being with the absence of illness, disease, injustice, or inequality.

Of all social sciences, sociology and social work have a “social problems” focus that seeks to understand how and why certain groups of individuals in a society bear the brunt of inequality and injustice. In seeking to understand the causes of injustice and inequality, sociology and social work aim to provide practitioners with the tools to alleviate these social problems and the suffering that comes from being in their grip. This focus on social problems is laudable and justified—people who are exposed chronically or more frequently to it live shorter lives, live those shorter lives with more physical disease and mental illness, and are more likely to experience a litany of indignities (e.g., racism, sexism, etc.) and maladies (e.g., violence, substandard housing, unemployment or underemployment, etc.). Worse yet, all indications are that (income) inequality has been increasing in the United States and various nations around the globe. This means that more people suffer the indignities of being at the lower end of inequality.

Today, the “ethical” social sciences—that is, those driven by the ideals of justice and equality for all, such as sociology and social work—are needed more than ever because there are more social problems in number, or at least in the degree of disparity between the richest and poorest. Put another way, we need to focus on social problems, and that is the reason I want to also include a greater focus on well-being as being more than the absence of bad things. The reason is simple: Inequality and injustice create illness, disease, disability, and shorter lives by “robbing” people of their innate strength, capabilities, well-being, hope, and dignity.

Let me make the point from three of my recent pieces of published research. The first showed that losses of positive mental health over a 10-year period in U.S. adults resulted in increased risk of mental illness, while gains in it resulted in decreased risk of mental illness. Next, and most recently, we published research showing that adults in 1995 who had less than “flourishing” well-being had just over a 60% increased risk of premature mortality over the subsequent 10-year period, controlling for age, sex, education, race, body mass index, any cancers, heart disease, HIV/AIDS, stroke, smoking, and lack of exercise. At all ages and for both males and females, adults who were “flourishing”—which is the combination of higher emotional well-being, such as feeling satisfied with life, combined with a higher level of functioning well in life (e.g., more integrated, a greater purpose in life)—had reduced risk of death. Last, the Black population (i.e., African Americans and Caribbean Blacks) has a lower rate of “common” mental disorders, such as anxiety and depression, than the White (non-Hispanic) population. Most would predict that Blacks,
who suffer more inequality and discrimination, would have higher rates of mental illness than Whites—they do not. The reason for this paradox appears best explained by the fact that we find that Blacks are more likely to be flourishing than Whites, and that is before adjusting for inequality and discrimination. After adjusting for inequality and discrimination, Blacks had an even higher level of flourishing than Whites.

What does this mean? First, the Black population is exhibiting a form of resilience in the face of adversity. Were it not for this mental resilience in maintaining flourishing in the face of inequality, more Blacks would be at risk for mental illness and premature mortality. Second, inequality and discrimination erode well-being; greater inequality and more discrimination prevent more Blacks from having even better mental health. In other words, if it were not for greater inequality and discrimination faced by racial minorities in this country, especially and historically Blacks, more Blacks would be flourishing in life.

So, the focus on well-being (i.e., the presence or absence of good feelings and good functioning) allows us to discern stories of strength and resilience. Such stories do not justify a government and its people doing nothing about the structural forms of inequality and racism. Instead, it means we all can learn about our shared human capacity for strength even in the worse of circumstances, and such stories are as important to tell for racial and ethnic minorities as it is to remember Victor Frankl’s story—in his book, *Man’s Search for Meaning*—of strength and resilience, which he witnesses in himself and his fellow Jews who survived the horrors of the Nazi extermination camps. The second implication is that the focus on well-being allows scientists and practitioners to focus on all of the things that are being taken from people when they must suffer inequality and injustice. If happiness in the form of flourishing is what we as a people have the right to pursue, then a nation cannot tolerate policies that permit inequality and discrimination that prevent it from happening.

Simply put, inequality and injustice create many of the negative things in our lives—premature death, mental illness, and so on—when they have stripped us of our reasons for living, our well-being, that which makes life and the struggle for it worthwhile. If inequality and discrimination were created, if only in part, by the policies of a government (e.g., taxation policies), the study of well-being has shown that the government has become destructive of the inalienable right to pursue well-being (aka, “happiness”). After declaring the pursuit of happiness as an inalienable right, the founders of this country went on to say:

> That to secure these rights, Governments are instituted among Men, deriving their just powers from the consent of the governed—That whenever any Form of Government becomes destructive of these ends, it is the Right of the People to alter or to abolish it, and to institute new Government, laying its foundation on such principles and organizing its powers in such form, as to them shall seem most likely to effect their Safety and Happiness.

It took a long time to get to a place where the social sciences were comfortable with colleagues studying well-being or happiness (in truth, I cannot be certain my colleagues are really comfortable with it just yet). Yet, it is important to understand what has brought us to this point in history. Several social and scientific trends over the past 50 years have helped to change the course of research on human well-being, culminating in what I would call *positive social science*, defined simply as the scientific field devoted to the study of optimal human functioning and the conditions that allow all people to pursue it.

First, the study of stress and health matured to include models of individuals’ perceptions of stress and their coping strategies. People are not helpless in the face of stress; some cope well with it. Second, the research field of gerontology matured, along with the increasing life expectancy of the population, to include the study of successful aging, which provided conceptions of positive human development in the face of aging. In other words, aging is not all downhill. Third, the period of humanism and social welfare that
characterized the 1960s and 1970s provided a strong rationale for the study of how individuals view the quality of their lives and how to improve it. In other words, our response to World War II was to take individuals’ perspectives on their quality of life more serious. Fourth, the study of resilience emerged during the 1970s and has thrived since the investigation of protective factors and assets that enable usual or exceptional development under conditions of risk and adversity. Put simply, adversity does not make wimps of us all; many of us rise to the occasion and go on to live normal and sometimes extraordinary lives.

Understanding the human capacity—of all humans, regardless of their situation in life—to struggle and sometimes flourish allows all of us to create better environments; indeed, perhaps a better form of government. It also permits us to challenge all of us to be healthier and better people, not only in the face of problems, but even when life is relatively free of the obstacles of injustice and inequality. For these reasons, all of us who labor in the “ethical” social sciences—sociology and social work—should not fear that by shining more light on well-being in these troubling times of growing inequality and disparities, we have lost our soul—it adds to the very ethical quest of social work and sociology.

To that end, Simmons and Lehmann have done a superb job in bringing the perspective and measures of “well-being” to their field of social work. Their book describes why and how to incorporate a person's strengths into social work assessment and evaluation. They assemble over 140 valid and reliable measurement instruments. This volume has made the important work of social work even more relevant to these troubling times.

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Measure what is measurable, and make measurable what is not so.
—Galileo Galilei

In the helping professions assessment is the process of acquiring an understanding of the nature, quality, ability, and/or concerns of someone or something (e.g., Barker, 2006), while evaluation is the systematic investigation into the effectiveness of an intervention (Bloom, Fischer, & Orme, 2006). Both assessment and evaluation use a range of strategies to describe, analyze, categorize, and otherwise understand a particular person, family, group, and/or situation. All of these strategies depend on measurement in some way. In fact, it has repeatedly been noted that measurement is one of the most important components of the behavioral sciences (e.g., Cronbach & Meehl, 1955; Diener, 2009; Fischer & Corcoran, 2007a, 2007b; McDowell, 2006; Orme & Combs-Orme, 2012; Pedhazur & Schmelkin, 1991; Streiner & Norman, 2008). Without measurement, assessment and evaluation are not possible.

Traditionally assessment and evaluation have focused on what goes wrong for clients including their problems, illnesses, and/or pathologies (e.g., Cowen, 1999; Jordan & Franklin, 2003; Tedeschi & Kilmer, 2005). Since most clients come to see helping professionals as those who fix or at least work on their problems, this makes sense. Undeniably, funders are highly interested in the progress made toward this end. For this reason, numerous books, journals, websites, and other resources are available to help practitioners and researchers find tools to measure symptoms, problem behaviors, emotional concerns, deficits, functional difficulties, and pathologies (i.e., Fischer & Corcoran, 2007a, 2007b; Hudson, 1997; Keyser, 2005; Olin & Keatinge, 1998; Spies, Geisinger, & Carlson, 2010). Such resources are important and should not be minimized. However, most helping professionals recognize the importance of also including strengths, resources, capabilities, and other positive qualities in assessment, intervention, and evaluation. Although the previously cited resources include an array of instruments that measure strengths, it is not their primary focus. In fact, only a few resources concentrate on models and instruments designed to measure positive attributes (for two excellent examples please see Lopez & Snyder, 2003 and Parkinson, 2007).

The purpose of this academic text is to expand the resources available to helping professionals who want to measure strengths as part of the assessment and evaluation process. It is not our intent to answer all of the questions practitioners and researchers have about how to incorporate strengths into assessment, intervention, and evaluation. Nor do we present a comprehensive theoretic model that advocates any one approach to assessment and intervention over any other. Instead, the instruments included in this compendium represent a wide range of theoretical approaches and were written by a diverse array of professionals including social workers, psychologists, nurses, physicians, and sociologists.
Instead of presenting one theoretical stance or trying to be all things to all people, our purpose is fairly straightforward: to provide a compendium of instruments that measure a range of positive attributes accurately and objectively, in a straightforward manner that does not require a great deal of additional work. The main focus is to provide tools that give a fairly clear picture of an individual’s strengths while being easy to complete, score, and interpret.

Before using the instruments in this text it is important to define strengths and understand what a strengths perspective is and what it is not. To do this the first chapter provides a broad conceptual overview of the constructs inherent to strengths-based assessment and evaluation. The second chapter discusses the relevance of strengths in a format that highlights the need for a balance and includes a few selected strategies that may be useful. The third chapter reviews the elements of measurement from conceptualization through understanding psychometric qualities and selecting the right tool for assessment and evaluation. For many, the content of the first three chapters will be a review. However, for some, the concepts will be novel and fresh. To both groups, the 140 plus instruments included and discussed in the subsequent 12 chapters will likely be helpful resources to strengths-based research and practice.

The chapters are grouped according to similarity of the constructs measured. Although different theoretical approaches label and group these constructs differently, we chose to cluster instruments based on the framework outlined in Chapters 1 and 2 of this book. To aid the reader, and improve the usefulness of this text, many of these instruments are also digitally available from Springer Publishing Company at www.springerpub.com/simmons-instruments. It is our greatest hope that this resource will be a helpful addition to the libraries of researchers, educators, and clinicians who want to incorporate strengths into the assessment and evaluation process.

Catherine A. Simmons

REFERENCES


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Catherine A. Simmons

To Peter Jaffe, PhD, father, husband, officer for the Order of Canada, teacher, practitioner, mentor, and strengths-builder; to Delphine, Daley, and Rory—forever strong shoulders I can always count on.

Peter Lehmann
Strengths and Psychotherapy
Catherine A. Simmons and Peter Lehmann

Use what talents you possess, the woods will be very silent if
no birds sang there except those that sang best.
—Henry Van Dyke

Drawing attention to strengths, health, and those things that are going right with clients has been and continues to be a departure from traditional thinking within the helping professions (e.g., Cowen, 1999; Maddux, 2008; McLaren, 2010a; Orlinsky, 2006; Tedeschi & Kilmer, 2005). Although seen as foundational to positive psychology and strengths-based social work, a focus on positive attributes is broader in origin, more encompassing, and far more critical to the helping professions than just these two movements. Without question, there is an interest at a global level (see the burgeoning literature on social capital and human strengths: e.g., Scheufele & Shah, 2000; Yip et al., 2007) to move away from a focus on human deficits toward a convergence of well-being and individual strengths. In this chapter, an overview is presented that encompasses multiple fields and models that share one common thread, an interest in strengths. To start this discussion, it is important to provide a definition.

STRENGTHS DEFINED

The word strength represents a construct that has a wide array of meanings in the English language. To illustrate, the Oxford online dictionary provides a lengthy definition that includes (a) “a good or beneficial quality or attribute of a person or thing,” (b) “physical power and energy,” (c) “the emotional or mental qualities necessary in dealing with situations or events that are distressing or difficult,” (d) “the capacity of an object or substance to withstand great force or pressure,” and (e) “the influence or power possessed by a person, organization, or country” (Strength, n.d.). From these nontherapeutic definitions, helping professionals have expanded and used the word to encompass a range of positive attributes. A few of these include:

- A person’s strengths are a combination of his or her talents, knowledge, and skills. “Talents are naturally recurring patterns of thoughts, feeling and behavior . . . . Knowledge consists of facts and lessons learned . . . . Skills are the steps of an activity” (Buckingham & Clifton, 2001, p. 29).
- “. . . a strength is a pre-existing capacity for a particular way of behaving, thinking, or feeling that is authentic and energizing to the user, and enables optimal functioning, development and performance” (Linley, 2008, p. 9).
- “Strengths are natural predispositions that each of us have—so natural, we argue, that they are evolved adaptations” (Linley & Burns, 2010, p. 4).
- “Strengths can be defined as people’s intellectual, physical, and interpersonal skills, capacities, interests and motivations” (Mallucio, 1981 as cited in McCashen, 2005, p. 7).
- “Resources in people’s environment such as family, friends, neighbors, colleagues, material resources and so on are also considered strengths. Often overlooked when
defining strengths, however, are people’s dreams, aspirations, and hopes” (McCashen, 2005, pp. 7–8).

“Character strengths can be defined as positive traits reflected in thoughts, feelings, and behaviors. They exist in degrees and can be measured as individual differences” (Park, Peterson, & Seligman, 2004, p. 603).

Each of these definitions conceptualizes a person’s strengths in different, yet strikingly similar, ways. Overriding commonalities are that strengths are multifaceted; related to inner power, unique to each individual; and include positive attributes, abilities, thoughts, behaviors, and resources. Strengths are vital components of the human condition, which should be considered when working with people in any capacity (i.e., work, education, interpersonal relationships, psychotherapy, etc.).

FOCUSING ON A PERSON’S STRENGTHS

Focusing on a person’s strengths is not unique to a single therapeutic theory, nor is it a model that attempts to explain, describe, or logically represent a particular aspect, situation, or occurrence within the social sciences. Instead, focusing on strengths should be thought of as a perspective—an overarching way to view the helping process. Saleebey (2006) eloquently states that using a strengths perspective “provides us with a slant on the world, built of words and principles . . . it is a lens through which we choose to perceive and appreciate” (p. 16). It is an orientation that emphasizes a person’s resources, capabilities, support systems, and motivations to meet challenges and overcome adversity (e.g., Barker, 2006). Focusing on a person’s strengths is not about ignoring the existence of real problems or illnesses (Saleebey, 1992, 1996, 2001, 2006, 2008, 2011). Instead, a strengths perspective emphasizes abilities, social networks, positive attributes, knowledge, skills, talents, and resources to help achieve and maintain individual and social well-being. Utilizing a strengths perspective in practice starts by assessing the inherent strengths of a person, a family, a group, or an organization, then builds on these strengths to aid in recovery and empowerment. Saleebey (2006) describes the process as being uncomplicated yet not easy:

The formula is simple: mobilize clients’ strengths (talents, knowledge, capacities, resources) in the service of addressing their goals and visions and the clients will have a better quality of life on their terms. Though the recipe is uncomplicated, as you will see, the work is hard. (p. 1)

The simple recipe for incorporating strengths into the language of change, growth, and understanding is prevalent across a wide range of helping professions. As an example, the social worker Saleebey (1996) conceptualizes strengths as building blocks that help us make a swing away from deficits toward competence. The psychologist Strümpfer (2005) notes that the idea of human strengths has a place because we cannot understand normal and extraordinary function within a problem-oriented framework. The sociologist Keyes (2006) identifies well-being as a form of human capital, while physical and mental health are “viewed among the greatest sources of wealth . . . tied to the growth and development of nations” (p. 5). The World Health Organization (WHO, 2005) focuses on the promotion and advocacy of healthy behaviors that help people realize their full potential. From each of these disciplines, finding ways to incorporate strengths into the equation is helping to broaden understanding about the complexity of human behavior and identify effective ways to improve the human condition. Interestingly, such concepts are nothing new.

A HISTORICAL CONTEXT

Academic discussion about the importance of individual strengths, including virtuous character, doing good things, and leading fulfilling lives, has a long historic tradition.
Walsh (2001) noted more than 2,000 years of practical and theoretical exploration into optimal human functioning going back to ancient Greek and Roman philosophers, as well as early scholars of Christianity, Buddhism, Yoga, and Chinese medicine. For example, in the *Nicomachean Ethics*, the ancient philosopher Aristotle (1998/1925/350 BCE) emphasized the importance of developing a virtuous character and the ability of humans to do so. Over 1,500 years later, the Christian scholar Thomas Aquinas (1981/1920/1265–1274) wrote extensively about virtue and the ability of humans to do and promote good. Ancient Chinese healers viewed health as the natural order, while their role was to increase natural resistance and resilience (Strümpfer, 2005).

More recently, the origin of modern psychology discusses the part that transcendent experiences play in optimal human functioning (James, 1902/1958), that basic life tendencies work toward the fulfillment of life (Bühler, 1935), and how the concept of individuation and self-realization helps people achieve their potential (Jung, 1933, 1938). In the mid-20th century, the World Health Organization defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 1946, p. 1). Jahoda (1958) drew on all of these ideas to spell out the positive components of mental health in a manner that sharply contrasted the prevailing (and strongly Freudian) explanation of mental health as the absence of negative symptomatology such as depression, anxiety, and neuroticism.

As the fields of modern psychology and mental health have emerged, similar themes have been addressed by the humanistic movement’s idea of inherent potential (Bugental, 1964), Frankl’s (1967) concept of self-transcendence, Maslow’s (1943, 1968) self-actualization, and Rogers’ (1961) ideas about the fully functioning person. Such changes have included the introduction of new vocabulary to explicate positive qualities. For example, Hollister (1967) introduced the concept of *strenso* to describe experiences that enhance or strengthen people in education. Likewise, Antonovsky (1979) used the term *salutogenesis* to describe the processes that contribute to healthy physical and psychological outcomes, which is the opposite of a focus on dysfunction called *pathogenesis*. Despite the attention paid by many of the great scholars to human potential, little integration has existed between helping professionals and academics operating from these paradigms, until recently (Linley & Joseph, 2004). Only with the emergence of movements such as strengths-based social work (e.g., Corcoran, 2005; Saleebey, 1992, 1996, 2001, 2006, 2008, 2011) and positive psychology (e.g., Seligman, 1998, 2002; Seligman & Csikszentmihalyi, 2000) has the mental health profession been challenged to focus on positive attributes as a means to elevate those that are problematic.

**STRENGTHS-BASED SOCIAL WORK**

There is perhaps no stronger ally in the demarcation of strengths than that found within the field of social work. The historical identification of strengths within social work practice dates back to the early settlement house movement. For example, Rapp, Saleebey, and Sullivan (2005) dated early references to strengths in quoting Jane Addams (1902), one of the founders of social work:

> We are gradually requiring the educator that he [sic] shall free the powers of each man and connect him with the rest of life. We ask this not merely because it is the man’s right to be thus connected but because we have become convinced that the social order cannot afford to get along without his special contribution. (p. 178)

The writing of Jane Addams provides an early account of the emphasis social work places on strengths. Building on the work of Jane Addams, the authors McMillen, Morris, and Sherraden (2004) further traced an early generation of practitioners who identified the importance of constructive growth experiences (Robinson, 1930; Smalley, 1971), the need to
work with human capacities using client-centered casework (Towle, 1954), supporting personal growth (Hamilton, 1940), capacity building in environments (Compton & Galloway, 1989, 1999), the early promising model of solution-focused brief therapy (De Shazer, 1985), and the more current strengths and skills building model (Corcoran, 2005).

Development of a strengths-based approach within social work has been popularized by Saleebey’s edited collection of readings titled *The Strengths Perspective in Social Work Practice* (1992; 2nd ed., 1996; 3rd ed., 2001; 4th ed., 2006; 5th ed., 2008; 6th ed., 2011), which has become a mainstay of the profession. Indeed, strength building is considered an integral part of the deeply embedded values of social work that continues to the present day (e.g., McMillen et al., 2004; Rapp et al., 2005; Weick, Rapp, Sullivan, & Kirsthardt, 1989).

In spite of the distinguished history and popularization of strengths-based social work, it purposefully defies a need to develop a theory or pursue identifying itself as a model. To this end, the strengths approach identifies itself as a perspective (Saleebey, 1992, 1996, 2001, 2006, 2008, 2011) and an attitude/frame (Blundo, 2001) that to some extent has become a set of underlying assumptions used to guide social work practice. Regardless of the criticisms directed toward the strengths-based perspective (mostly for it’s lack of empirical support: e.g., Gray, 2011; Staudt, Howard, & Drake, 2001), the popularity of using strengths is almost at a consensus level among professionals in all facets of social work practice, accrediting bodies, and schools of social work around the world. What appears to have evolved is a model of practice that has been summarized by the six practice hallmarks illustrated in Box 1.1 (Rapp et al., 2005). These hallmarks are uniquely adapted to the context of the social work profession and remain close to the historical foundation from which they were developed. Indeed, strengths-based practice is so integrated into the profession that it is likened to a value stance that represents “good basic social work practice” (Staudt et al., 2001, p. 18) and not a unique practice model.

**POSITIVE PSYCHOLOGY**

Positive psychology developed largely in reaction to the proliferation of the disease model within psychology and psychiatry professions (Maddux, 2008; Seligman, Steen, Park, & Peterson, 2005a, 2005b). The decisive change began in 1998 when the newly elected president of the American Psychological Association, Martin Seligman, announced that one of his presidential initiatives was to spearhead the empirical study of “what actions lead to well-being, to positive individuals, to flourishing communities, and to a just society” (Fowler, Seligman, & Koocher, 1999, p. 560). In his presidential address, Seligman pointed out that since World War II psychology has focused largely on pathology, not well-being. Although focusing on the identification and treatment of mental illness has resulted in effective treatments and even cures for a range of psychological diseases, Seligman argued that healing disease is only part of psychology’s mission. More broadly, psychology is about making the lives of all people better. In a special issue of the journal *American Psychologist* devoted to positive psychology, Seligman and Csikszentmihalyi (2000) stated that psychology was not producing enough “knowledge of what makes life worth living” (p. 5). They called for a revolutionary change within the field, one that would make positive psychology an object of intervention and scientific study. Since then, the mission of positive psychology has centered in three domains of optimal development: (a) positive subjective experience (happiness, pleasure, gratification, fulfillment), (b) positive individual traits (strengths of character, talents, interests, values), and (c) positive institutions and communities (families, schools, institutions, businesses, societies) that support the first two (e.g., Seligman & Csikszentmihalyi, 2000; Seligman et al., 2005a, 2005b).

In spite of its long list of detractors (e.g., Coyne & Tennen, 2010; Coyne, Tennen, & Ranchor, 2010; Ehrenreich, 2009; Held, 2002, 2005; Kristjánsson, 2010; Lazarus, 2003),
BOX 1.1 ■ The six hallmarks of strengths-based social work practice.

Strengths-based social work practice…

1. Is goal-oriented
2. Utilizes systematic assessment of strengths
3. Sees the environment as rich in resources
4. Uses explicit methods for incorporating client and environmental strengths in setting and attaining goals
5. Views the therapeutic relationship as accepting, purposeful, empathetic, and hope-inducing
6. Makes it central to provide meaningful choices to the client and give them (the client) the authority to choose

Adapted from Rapp et al. (2005).

the importance and relevance of positive psychology cannot be underemphasized. The empirical study of positive psychology has since rapidly grown to involve hundreds of researchers around the world. To illustrate, this accumulation of worldwide information between 1999 and 2010 grew to include at least 17 special journal issues, millions of dollars devoted to research/development, annual conferences, hundreds of journal articles, and both graduate and undergraduate courses and degree programs specializing in positive psychology (e.g., Gable & Haidt, 2005; Wood & Tarrier, 2010).

The early mission of positive psychology is very much within reach. The swift and early acceleration of the growing field sometimes labeled “happiology” (Peterson, 2006, p. 7) has been replaced by vibrant, cutting-edge approaches that offer an alternative perspective of the human condition. The shift has led to a sizeable body of theoretical models with strong empirical support. Such conceptual advances are found in the areas of happiness (e.g., Linley, 2008; Peterson, 2006; Seligman, 2002), gratitude (e.g., Bono, Emmons, & McCullough, 2004; Wood, Froh, & Geraghty, 2010), hope (e.g., Gallagher & Lopez, 2009; Lopez et al., 2004; Weis, 2010), positive emotions (e.g., Cohn, Fredrickson, Brown, Mikels, & Conway, 2009; Fredrickson, 2006, 2008), resilience (e.g., Ungar, Toste, & Heath, 2010; Yates & Masten, 2004), optimism (e.g., Gallagher & Lopez, 2009), forgiveness (e.g., Miller & Worthington, 2010; Schultz, Tallman, & Altmaier, 2010), forensics (e.g., Gredecki & Turner, 2009), subjective well-being (e.g., Diener, Ng, Harter, & Arora, 2010; Keyes, 2009a), and self-efficacy (Bandura, 2006, 2008; Benight & Bandura, 2004), to name a few.

From these considerable theoretic and empirical advances, the positive psychology practice field has been deluged by new and innovative perspectives that move many of the research-focused principles of positive psychology toward a clinical framework (e.g., Burns, 2010; Joseph & Linley, 2006, 2008; Linley & Joseph, 2004; Magyar-Moe, 2009; Seligman & Fowler, 2011). For their part, Wood and Tarrier (2010) made a strong argument that development of positive clinical psychology will advance the clinical field by balancing the positive and negative in the clinical environment. Such advances have the potential to rapidly expand the scientific knowledge base of the profession and can be used to improve people’s lives (Wood & Tarrier, 2010).

ON THE SHOULDERS OF GIANTS

Although an interest in human strengths is evidenced throughout the origin of modern psychology, historically, the helping professions have placed their primary emphasis on illnesses, problems, and those things that go wrong with the human condition. Moving
beyond a unitary view that mental health is illness based, to a more inclusive view that includes strengths, requires us to place it within a historical context. In detailing the transition, Strümpfer (2005) highlighted the fact that, while focusing on a person’s strengths may seem like a new paradigm, it is, instead, a rather old idea that is only recently becoming evident in Western psychology and other professions. Strümpfer (2005) quite elegantly stated that “some of the predecessors were perhaps just courageous foot soldiers, but some were indeed giants—and today we can stand on the shoulders of all of them” (p. 22). From the shoulders of giants, the current state of psychotherapy is shifting away from a medical model with an illness analogy to one that recognizes, measures, emphasizes, and utilizes a person’s strengths.

THE STATE OF PSYCHOTHERAPY

In their chapter about the importance of “strengthspotting” (i.e., recognizing strengths in yourself and others), Linley and Burns (2010) asked two captivating questions about the current state of psychotherapy:

1. “Is psychotherapy a place where clients would consider going to talk about their strengths?” (p. 4)
2. “Is psychotherapy a place where therapists would routinely inquire about a client’s strengths?” (p. 4)

At present, most professionals who have contact with client populations are likely to offer a resounding yes to both questions. Apparent throughout the helping professions is recognition that it is important to measure and capitalize on resources, health, and those things that are going right, not simply focus on deficits, problems, and those things that are going wrong. However, this has not always been the case. Indeed, if we were to ask the same question as short as a decade ago, the response might have been maybe or, for some, even no. Such cautious responses could have been a function of a field mired in the dominant illness language of the times (i.e., medical diagnoses, biological disorders, and prescriptive clinical treatments). In some ways, these responses represent the last 50 years of the history of psychotherapy research, ruled by what Orlinsky (2006) described as a widely accepted and largely unquestioned “normal science” (Kuhn, 1970). In this, the “standard model involves the study of (a) manualized therapeutic procedures (b) for specific types of disorders (c) in particular treatment settings and conditions” (Orlinsky, 2006, p. 2).

An Illness Analogy

The summary of Orlinsky (2006) echoes the compelling position that psychotherapy, for the most part, has existed in a vacuum where the “illness conception” or “illness analogy” (Maddux, 2008, p. 56) exists. Also referred to as the “medical model” and “medical analogy” (Maddux, 2008, p. 56), most psychotherapy replicates the language of medical science (e.g., pathology, illness, disease, disorder, symptom, comorbidity, etc.), leading to a focus on what and where we should be looking based on an “illness ideology” (Maddux, 2008, p. 56). Essentially, the illness ideology is a narrowed focus where pathology is a function of biology and intrapsychic forces, mostly beyond one’s control, and the human condition is divided into categories such as normal/abnormal and clinical/nonclinical. Maddux’s view represents a social constructionist view of mental illness, one of assumptions and values that were typically cocreated by those who have the power and privilege to promote a particular view. Maddux suggests that there is no stronger socially constructed view than that of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification
of Diseases (ICD). In this case, they represent the “heuristic social artifacts” (Maddux, 2008, p. 63) serving the social order and echoing the social value judgments of our culture.

McLaren (2010b) furthers these views with the argument that psychiatry has never been able to articulate “a model of mental disorder that, ab initio [from the beginning], dictated the borders and contents of mental disorder” (p. 193). Instead, psychiatry has relied on a reductionist stance that views disorders as a disease of the brain (e.g., Bennett & Hacker, 2003; Guze, 1989; McLaren, 2010a,b), emphasizing poor adjustment over healthy adjustment, abnormality over normality, and sickness over health (e.g., Maddux, 2008; McLaren, 2010b). These views are seen in the ominous writings of many who agree that the current process is unlikely to change with the advent of the fifth edition of the DSM in 2013 and the 11th edition of the WHO’s ICD in 2014 (e.g., First & Wakefield, 2010; Frances, 2009a, 2009b; McLaren, 2010a,b; Wakefield, 2010). As McLaren (2010b) notes “trying to derive a classification of mental disorder when we do not even have a model of how it arises is totally back to front” (p. 193). From an illness ideology, mental disorder must be categorically distributed. However, most in the field recognize both mental disorder and mental health as multidimensional, existing on a continuum, and dependant on individual, culture, and context.

Times They Are a Changing

Let’s return to the question, what is the current state of psychotherapy? In the simplest terms, Hubble, Duncan, Miller, and Wampold (2010) report that “the field is maturing” (p. 24). Throughout the helping professions “the times, they are a changing” (Strümpfer, 2005, p. 22). The field has begun to reinvent itself against the past 50 years of illness ideology, allegiance with managed care, and medicalization of mental health (Becker & Marecek, 2008). This reinvention seems to be away from a deficits paradigm of client dysfunction/frailty to one where client strengths, resources, and competencies are part of the focus for change. Indeed, exploring the strengths of individuals is hardly new and we believe the field is headed over and beyond the popular cultural zeitgeist as it has been characterized (e.g., Held, 2002; Strümpfer, 2005). To paraphrase Maddux (2008) once again, an important strengths ideology has emerged, which is not focused on a categorical framework (you either have strengths or you do not), but instead takes a multidimensional view of mental health (i.e., there are all shapes and sizes of one’s strengths, some big, some small, all worthwhile).

A MULTIDIMENSIONAL VIEW OF WELLNESS

Following the definition and history of strengths, we next move toward an expansive view of mental health that can be translated into clinical practice. Of importance is the need to move away from an illness and deficit point of view with which much of the helping professions have traditionally been conceived. As stated previously, the history of debate about the categorical distribution of mental health is long and not likely to be resolved with the forthcoming application of the DSM-5 (e.g., First & Wakefield, 2010; Frances, 2009a, 2009b; McLaren, 2010b; Wakefield, 2010). However, as Mechanic (1999) aptly stated, “although the concept of positive mental health is one worth keeping in mind, it is not very helpful in classifying different persons, groups, or populations” (p. 2). Within this context, a number of authors have put forth ideas that an inclusive, multidimensional view seems warranted; one that is inclusive of both strengths and illnesses (e.g., Antonovsky, 1979, 1987; Keyes, 2007, 2009b; Keyes & Magyar-Moe, 2003; Ryff, 1989; Ryff & Keyes, 1995).

More Than the Absence of Illness

Conceptualizing mental health has generally focused on the pathogenic model that views health (or complete health) as the absence of disease, a term that is consistent with the
illness ideology stated previously (e.g., Keyes, 2007, 2009b; Maddux, 2008; McLaren, 2010a, 2010b; Orlinsky, 2006). Mental health treatment, therefore, usually consists of attempts to reduce symptoms, prevent relapse, and provide treatment after the problem has occurred. Building on the theoretical pathogenic approach, Keyes (2002, 2003, 2005, 2007, 2009a, 2009b, 2010) argued the de facto perspective of mental health is that a person is either ill (i.e., mentally ill) or well (i.e., not mentally ill), thus supporting a fixed assumption of either/or. On the other hand, a compelling body of work articulates the idea that health is not merely the absence of illness or something negative, but instead is the presence of something positive. This perspective is illustrated in the World Health Organization (2005) definition of mental health as “a state of well being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (p. 18).

A Two-Continua Model

A growing body of evidence demonstrates that the absence of mental illness does not imply the presence of mental health, and inversely, the absence of mental health does not imply the presence of mental illness. Consistent findings with adults (Keyes, Shmotkin, & Ryff, 2002; Keyes et al., 2008; Westerhof & Keyes, 2010), adolescents (Keyes, 2005), and college samples (Robitschek & Keyes, 2009) show mental health and mental illness are often-times present along different continua with the exceptions residing at the extreme of either range. Thus, categorical descriptions do not represent the normal state but are instead the extreme cases.

In contrast to this either/or view, Keyes (2002, 2005) and others (Headey, Kelley, & Wearing, 1993; Keyes & Ryff, 1999; Westerhof & Keyes, 2010) have taken the position that mental health and mental illness are related, but represent distinct dimensions (Keyes, 2002, 2005) existing along two different continua. Illustrated in Figure 1.1, one continuum represents mental health (including emotional, psychological, and social well-being discussed below), while the other represents mental illness (under which one can include symptoms, pathology, and illness). Anchoring both continua are the functional components flourishing (defined as the highest levels of positive emotions) and languishing (defined as emptiness, despair, and stagnation) (e.g., Keyes, 2002, 2005; Westerhof & Keyes, 2010). The extremes of each range represent (a) the presence of mental health and the complete absence of mental illness (i.e., complete flourishing) and (b) the presence of mental illness and the complete absence of mental health (complete languishing). Within this model, it is entirely possible for mental health and mental illness to exist simultaneously. Similarly, one can be mentally healthy, yet languishing; or mentally ill, yet flourishing.

**Figure 1.1** The two-continua model takes the position that mental health and mental illness are related, but distinct dimensions existing along two continua.
Health and illness are not either/or propositions, but instead are variations that can exist concurrently along the two separate continua.

The work of Keyes et al. (2008) and Westerhof and Keyes (2010) found that the largest proportion of the population exhibit degrees of mental health, while also experiencing a range of problems. It is only at the polar ends that one finds opposite extremes of complete mental illness (i.e., complete languishing) and complete mental health (i.e., complete flourishing). These findings indicate mental health is more normally distributed across the continuum than existing in an either/or state. One way to illustrate these differences is by considering the distribution of responses military members have when faced with combat (Seligman & Fowler, 2011). In the face of life-threatening adversity only a very small minority collapse (languish), while most combatants (i.e., the majority) are in the middle (resilient, returning to normal levels of coping despite the disruption) or grow after adversity; in other words, they flourish (Seligman & Fowler, 2011). As mental health professionals, the goal then is to move people along the continuum by focusing on their positive attributes and strengths in a way that will “build more positive emotion, engagement, and meaning, and better relationships among all people” (Seligman & Fowler, 2011, p. 86).

The two-continua model has a wide range of possible applications within the field of psychotherapy. Prevention of mental illness can be supplemented with promoting well-being through the development of individual strengths. It can be argued that the concept of promotion (i.e., moving toward mental health) increases the possibility that an individual will engage in behaviors that further mental health and subjective well-being. To promote mental health through an examination of strengths assumes that one identifies the capabilities, characteristics, and/or traits of the individual, as opposed to a more narrow or constricted view. Consequently, there is room to focus on internal and external resources that can lead to an increase in desired outcomes and a more hopeful future for clients. To better understand the various components of psychological health, it is helpful to consider some of the literature providing a framework for physical, mental, and social well-being.

### Physical, Mental, and Social Well-Being

In an attempt to develop holistic models to explain the underlying dynamics of psychological health and well-being, a number of authors (e.g., Christopher & Campbell, 2008; Joseph & Linley, 2006; Keyes, 2006; Richardson, 2002; Strümpfer, 2005) have made efforts to find common ground among the large number of strengths-based and strengths-inclusive models. Yet, to date, no general agreement exists that provides a coherent theoretical framework for explanation and/or prediction (Wissing & Temane, 2008). Despite the absence of consensus within the field, a number of theoretical approaches can be combined to provide a conceptual framework that incorporates physical, mental, and social well-being.

### Conceptual Framework

The framework used to guide development of the current text was created by integrating the work of a few key theorists (Diener, 2008; Keyes, 1998; Keyes & Magyar-Moe, 2003; Ryff, 1989) into the World Health Organization (1946) definition that health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Illustrated in Table 1.1, the resulting multidimensional framework integrates components of the health triangle (i.e., physical, mental, and social well-being) into definitional knowledge related to subjective well-being. From this, mental well-being is further apportioned into the lower-order components of emotional well-being and psychological well-being. Together with the physical and social well-being components, each includes multidimensional constructs that are important to the overarching idea of subjective well-being. When reviewing this framework, it is important to note that it is not intended to be explanatory or all encompassing. Instead, it is presented as one possible way to conceptualize the multiple areas that can be considered when incorporating strengths into clinical practice.
**Table 1.1** A Conceptual Framework That Provides a Multidimensional View of Mental Health Using the Construct Subjective Well-Being to Link All of the Parts

<table>
<thead>
<tr>
<th>Physical Well-Being&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Mental Well-Beings</th>
<th>Subjective Well-Being&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Social Well-Being&lt;sup&gt;4&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health:</strong> The level of functional and metabolic efficiency of a living being.</td>
<td><strong>Mental Well-Beings</strong></td>
<td><strong>Life satisfaction:</strong> A global judgment that people make when they consider their life as a whole.</td>
<td><strong>Social integration:</strong> The evaluation of the quality of a person's relationship with society, including the extent to which a person feels they have something in common with other people and that they belong to a community and society.</td>
</tr>
<tr>
<td><strong>Wellness:</strong> A way of life that equips the individual to realize the full potential of their capabilities; a lifestyle that recognizes the importance of nutrition, fitness, stress reduction, and responsibility (self and civic).</td>
<td><strong>Self-acceptance:</strong> Acknowledgement, acceptance, and a positive attitude about multiple aspects of the self, including past life and unpleasant personal aspects.</td>
<td><strong>Positive feelings (affect):</strong> Spontaneous and subjective reflections of pleasant emotions in the individual's immediate experience—their avowed happiness right now</td>
<td><strong>Social contribution:</strong> Evaluation of one's social value, including a belief they have something to contribute and that the community and society in which they live value this contribution.</td>
</tr>
<tr>
<td><strong>Health-related quality of life (HRQoL):</strong> A subjective assessment about the impact that health and health care has on an individual's quality-of-life, including the ability to care for oneself, perform daily tasks of living, freedom from pain, and ability to see, hear, and think normally: An individual's perception of illness and wellness.</td>
<td><strong>Positive relations with others:</strong> The ability to empathize, cooperate, compromise, and be concerned about the welfare of others and to cultivate meaningful relationships</td>
<td><strong>Environment mastery:</strong> The ability to manage everyday affairs, control a complex array of external activities, make effective use of surrounding opportunities, and take an active role in getting what is needed from the environment</td>
<td><strong>Social coherence:</strong> Appraisals that society is discernable, sensible, and predictable. The person not only cares about their world but feels they can understand what is happening around them.</td>
</tr>
<tr>
<td><strong>Social integration:</strong></td>
<td><strong>Social acceptance:</strong> A trust of others, favorable view of human nature, and feeling comfortable with other people</td>
<td><strong>Social actualization:</strong> The belief that society has the potential to evolve and realized through its citizens and institutions</td>
<td><strong>Social actualization:</strong></td>
</tr>
</tbody>
</table>
Subjective Well-Being

Subjective well-being is a broad concept that is often used to describe a combination of cognitive judgments about the quality of and satisfaction with one's life. Although a broad range of definitions have been presented in the literature, most professionals and laypersons conceptualize subjective well-being as multifaceted in nature with affective, cognitive, and social components (e.g., Diener, Suh, Lucas, & Smith, 1999; Keyes & Magyar-Moe, 2003; Ryff, 1989). Because well-being is inherently subjective, measurement should always allow the client to determine his or her own criteria for inclusion and to weigh these criteria in a manner he or she chooses (Pavot & Diener, 2008). The resulting understanding can help gauge the quality of an individual's life, regardless of the circumstances in which he or she presents to intervention. Therapeutically, the importance of this understanding is supported by a large body of research demonstrating that an individual's reported well-being is directly and indirectly related to resilience, self-efficacy, self-esteem, adaptation, physical health, mental health, workplace success, social skills, energy, values, positive mood states, low anxiety, low depression, and reduced suicide ideation/attempts (for reviews please see Lyubomirsky, King, & Diener, 2005; Pressman & Cohen, 2005). Subjective well-being was selected as the overarching construct linking all the parts of the presented framework because it encompasses all aspects of physical, mental, and social well-being.

Physical Well-Being

Physical well-being is a person's subjective report that he or she feels healthy, energetic, and physically robust, and does not feel lethargy, weakness, or in ill health. Distinctly different from mind, spirit, and social aspects of a person's life, physical well-being is related to perceptions about the biological functioning of the human body and includes health, wellness, and health-related quality of life (HRQoL). Leddy (1996) defined health as “a dynamic process that manifests the pattern of the unitary human being” (p. 25). Health includes the level of functional and metabolic efficiency of a living being. Wellness is a dynamic state of well-being that includes a lifestyle that recognizes the importance of nutrition, fitness, stress reduction, and self-responsibility. Wellness equips the individual to realize the full potential of his or her capabilities. HRQoL is a subjective assessment about the impact that health and health care has on an individual's quality of life, including the ability to care for oneself, perform daily tasks of living, live free from pain, and have the ability to see, hear, and think normally. Inherently subjective, HRQoL is an individual's perception about how his or her personal state of wellness and illness affects day-to-day living.

Emotional Well-Being

Emotional well-being is a dimension of mental well-being that includes individual life satisfaction, positive feelings, and the balance of positive-to-negative affect (e.g., Bradburn, 1969; Diener, 2009; Diener et al., 1999; Gurin, Veroff, & Feld, 1960). Life satisfaction is a global judgment about one's own life, including whether the person is content with his or her life overall and how satisfied he or she is. Measured using a number of different methods, instruments designed to assess life satisfaction generally assess a respondent's personal judgments (i.e., appraisal) about life events, circumstances, and themselves. Positive feelings, conversely, are based on spontaneous and subjective reflections of pleasant emotions in the individual's immediate experience, his or her avowed happiness and/or joy. Also referred to as positive affect, measuring these positive feelings generally includes the frequency and/or degree of emotional reactions which the person considers pleasant and pleasurable. The specific focus of positive feelings (i.e., positive affect) is on the up side of the emotion scale.

Moving affective measurement beyond pleasant feelings alone, the balance of positive-to-negative affect taps into the frequency that a person reports both positive affect (i.e., being cheerful, in good spirits, calm/peaceful, satisfied, etc.) and negative affect (i.e., being sad, restless/fidgety, hopeless, nervous, worthless, etc.) (e.g., Bradburn, 1969; Diener, 2009; Diener & Emmons, 1985). The balance is usually reported as a formula (or the results of a formula), whereby the unpleasantness (negative affect) is subtracted from the pleasantness
Unfortunately, the nature of this balance is not well understood with some researchers concluding that the two are different ends of the same continuum (e.g., Feldman-Barrett & Russell, 1998; Russell & Carroll, 1999) and others proposing that, although they are moderately related, positive and negative affect represent two distinct dimensions (e.g., Bradburn, 1969; Diener, 2009; Diener & Emmons, 1985). Despite this current state of disagreement, inclusion of an individual’s balance of positive-to-negative affect in explanations of emotional well-being is certainly warranted. Taken with life satisfaction and avowed happiness, these three constructs serve to explain emotional well-being.

**Psychological Well-Being**

Psychological well-being is a dimension of mental well-being that focuses on the individual and has historically included personality, successful resolution of developmental milestones (Erickson, 1959; Neugarten, 1973), being mentally healthy (Jahoda, 1958), self-actualization (Maslow, 1943, 1968), and becoming a fully functioning person (Rogers, 1961). To expand theoretical understanding about psychological well-being, Ryff (1989) proposed a six-part model that encompasses self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth. Illustrated in the third column of Table 1.1, this model encompasses the areas of psychological well-being that include (a) a positive self-evaluation, both now and in the past, (b) a sense of personal growth and development, (c) a belief that one’s life has purpose and meaning, (d) the ability to have quality relationships with other people, (e) the capacity to effectively manage one’s life within the context of the surrounding world, and (f) a sense of determination and authority (Ryff, 1989; Ryff & Keyes, 1995).

**Social Well-Being**

The subdimension social well-being focuses on the relations the individual has with others and originates from the classical themes of alienation and anomie (e.g., Mirowsky & Ross, 1989; Seeman, 1959), social psychology (Keyes, 1998), and social work. Describing the components of social well-being, Keyes (1998) proposed a five-part model that encompasses social integration, social contribution, social coherence, social acceptance, and social actualization. Further defined in the fourth column of Table 1.1, these five components focus on social tasks encountered by all people. Measurement of these components provides information about the degree to which a person is functioning in his or her social world (i.e., as family members, friends, neighbors, coworkers, and citizens) (Keyes, 1998).

**A Sum of Its Parts**

Subjective well-being, then, is a sum of its parts. These parts represent a diverse range of factors that, when taken together, converge to create a comprehensive understanding about what positive attributes are and, conversely, what they are not. Underlying the conceptual model used to develop this text is the implicit theory that subjective well-being includes elements of physical well-being, social well-being and the psychological and social components of emotional well-being. The constructs measured by this book’s instruments are essential to this model and include happiness, subjective well-being, health, wellness, HRQoL, mindfulness, acceptance, situational effect, hope, optimism, humor, resilience, coping, aspirations, goals, values, self-efficacy, empowerment, emotional intelligence, social support, social relationships, intimate relationships, and family relationships. The utility of measuring these constructs in clinical practice lies in a better understanding of the strengths and resources that can help the client achieve his or her therapeutic and personal goals. To this end, the instruments included in Chapters 4 though 15 of this book encompass these strengths-based constructs. Taken together, these constructs link to the elements of the above-described conceptual framework and represent strengths that can be incorporated into strengths-based research and clinical practice.
IN TRANSITION

A shift is occurring throughout the helping professions, which we believe is moving psychotherapy away from a deficit or illness model to one that focuses on strengths, resources, competencies, and the positive. These changes represent an evolution within the professional field that encompasses historical and current theoretically driven strengths-based and strengths-inclusive models, and a long-standing dissatisfaction with a problem-focused approach to understanding the human condition. What has emerged is a resounding swing in the landscape of psychotherapy, particularly with the emergence of positive psychology and the strengths perspective in social work. While fresh and inventive in design, these changes are grounded in historic ideas spanning from ancient philosophy to the origins of modern psychology.

From this historical discussion, practical questions arise about how to incorporate strengths into the assessment and evaluation processes. In closing this chapter about incorporating strengths into psychotherapy, it is important to acknowledge that there is a very real need to strike a balance between what is right with what is wrong in the assessment and evaluation process. Research documenting client factors and how clients change highlights the importance of enhancing collaboration, alliance building, and selecting appropriate targets for change. To this end, the next chapter of this text discusses the need to strike a balance between problems and strengths in the assessment and evaluation process.

REFERENCES


