"A triumph...This is truly a groundbreaking book! The narratives demonstrate how nurses make transformative differences in patient care through noticing patient/family strengths, and encouraging and empowering those strengths. I enthusiastically recommend this book for every introduction to nursing course, and equally for graduate nurses in Advanced Nursing Practice Master’s programs and practice. This book is one of those rare treats that puts into words what expert nurses come to know and experience over time in their best practice. By giving clarity, insight, and rigor to a central, but poorly understood value in nursing practice, Dr. Laurie Gottlieb has given nursing back a stronger, clearer self and social grasp of the best nursing has to offer."

—PATRICIA BENNER

This is the first practical guide for nurses on how to incorporate the knowledge, skills, and tools of Strength-Based Nursing Care (SBC) into everyday practice. The text, based on a model developed by the prestigious McGill University Nursing Program, signifies a paradigm shift in nursing care from a medical model based on deficits to one that focuses on individual, family, and community strengths as a cornerstone of effective nursing care. The testimony of 46 nurses demonstrates how SBC can be effectively used in multiple settings across the lifespan.

The book examines the theoretical foundations underlying SBC, promotes the acquisition of fundamental skills needed for SBC practice, and offers specific strategies, techniques, and tools for identifying strengths and harnessing them to facilitate healing and health. According to the SBC model, the text describes how one becomes a nurse through retraining the senses, developing observation skills, and reforming interpersonal and communication skills for clinical judgment and decisionmaking. The text includes an instructor’s guide. Author Laurie Gottlieb has been the recipient of the prestigious Centennial Award of the Canadian Nurses Association, the only award to recognize the 100 most influential nurses in Canada.

**KEY FEATURES:**

- Provides the first complete, foundational, and practical textbook on Strength-Based Nursing Care
- Teaches how to identify, engage, and nurture existing and new strengths to enhance health and healing
- Integrates testimony and clinical insights from 46 nurses using SBN in clinical practice
- Emphasizes clinical and critical inquiry, clinical grasp and judgment, decision-making, and evidence-based practice
Strengths-Based Nursing Care
Laurie N. Gottlieb, RN, PhD, is a professor at the School of Nursing, McGill University, Montreal, Canada, where she also serves as the Flora Madeline Shaw Chair of Nursing. She is editor-in-chief of the Canadian Journal of Nursing Research (CJNR) and was recently named Nurse-Scholar-in-Residence at the Jewish General Hospital, a McGill University teaching hospital. She is the recipient of prestigious awards, including the Centennial Award, the first and one-time-only award from the Canadian Nurses Association recognizing the 100 most influential nurses in Canada; the L’Insigne du Merite in 2009, the highest recognition accorded to a nurse from the Order of Nurses of the Province of Quebec; and the Prix du Conseil Interprofessionnel du Québec (CIQ). Laurie Gottlieb has further developed, researched, lectured, and published extensively on the McGill Model of Nursing. With her husband, Bruce Gottlieb, a geneticist, they developed the Developmental/Health Framework, an important elaboration of the McGill Model of Nursing and of Strengths-Based Care. Her books include A Perspective on Health, Family, Learning and Collaborative Partnership (co-edited book on the early writings of the McGill Model of Nursing), A Collaborative Partnership Approach to Care (with translations in French and Japanese), and Dreams Have No Expiry Date: A Practical Way for Women to Take Charge of Their Futures (with translations in Spanish, Dutch, Korean, and Portuguese). Dr. Gottlieb is currently collecting stories of nursing practice for a book on “exquisite” nursing.

Collaborator:
Bruce Gottlieb, PhD, is a geneticist and a project director at the Lady Davis Institute of the Jewish General Hospital in Montreal, Canada. He is an adjunct professor in McGill School of Nursing and a member of McGill’s Department of Human Genetics. His research focuses on the genetics of cancer.
Strengths-Based Nursing Care

Health and Healing for Person and Family

Laurie N. Gottlieb, RN, PhD

In collaboration with Bruce Gottlieb, PhD
To my twin sister, Linda
“Born together, friends forever” (Author unknown)

And to my family, Bruce, Michah, Arielle, Ilana, Gabriella, Jordanna, and Itai
“I sustain myself with the love of family” (Maya Angelou)
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Our Expert Consultants

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Foreword

I'm looking for the light; those little glimmers that make me think there's something there. I am looking for people's gifts of what they've got going for them.
—Nurse Heather Hart

Dr. Laurie N. Gottlieb has written a landmark book that should be required reading for all undergraduate and graduate nursing students and essential reading for all those involved in trying to redesign health care systems, reduce health care costs, and improve the health of people in any society. I cannot think of a better way to introduce student nurses, or others, to learning to think and act like a nurse than by referring them to this book. Dr. Gottlieb has articulated a commonly held stance and practice in nursing since Nightingale (Notes on Nursing, 1860). Nightingale was against a single factor: causal germ theory. Today, her more ecological stance of considering the person’s own strengths, and the body’s ability to repair itself when the environment is conducive to health, has much stronger evidence and validation than any single causal theory of disease. It turns out that Nightingale’s more ecological model best fits the current social epidemiological scientific understanding of health and disease.

In the enlightening stories of wise nurses throughout this book, we learn about Strengths-Based Care (SBC), which seeks out the person’s/family’s strengths and helps people, families, and communities build on those strengths, marshalling them to cope with an illness or injury and recover so that they can resume their lives. This is truly a groundbreaking book! No one has written so clearly on the long-standing but underdescribed, poorly understood nursing goal and pervasive understanding of one’s self and practice to work with patient/family strengths.

As Dr. Gottlieb points out, Nightingale did this work for her generation, but the forces for diagnosing deficits came to dominate health care discourse. The power to define and diagnose deficits became the received truth of the medical establishment’s discourse. This book’s narrative descriptions from nurses who practice SBC bring immediacy and clarity to SBC and to why it is an essential ingredient to health promotion and recovery. The nursing narratives demonstrate how nurses make transformative differences in patient care through noticing patient/family strengths and then encouraging and empowering those strengths. Students and nurses will read this
work and find that it is almost impossible not to integrate its powerful message into their own work and life.

My own work in articulating knowledge embedded in nursing practice resonates with the pervasive nursing practice of looking for person’s strengths, what matters to patients and families, and what works to support and encourage recovery and healing. Dr. Gottlieb clearly articulates what most nurses continue to claim in their practice, even when they lack good language to articulate and defend their approach, in the context of the dominance of a deficit-oriented, diagnosis-driven, and biomedical model in health care.

Nurses report in this book that they look for patient and family strengths and support those strengths in promoting well-being and assisting patients in their self-care and recovery. As Dr. Gottlieb states in Chapter 7: “Nurses who practice SBC are always responsive to the situation and never prescriptive.”

This book is not doctrinaire, and Dr. Gottlieb makes it clear that she does not refer to, or intend to imply the “power of positive thinking” or ideologically static notion that “thinking makes it so” (variants of wishful thinking). SBC focuses on the patient, family, and community strengths in the moment and the context of the situation. SBC in nursing is about finding the situated possibilities of particular patients/clients/ families at particular points in time, in the midst of being confronted with particular challenges. Nowhere does Dr. Gottlieb imagine that patients, clients, or nurses have radical freedom to overcome any obstacle or challenge; instead, she carefully shows, in many clinical examples, patient-/client-/family-situated resources and possibilities. Dr. Gottlieb’s goal is to enable student and clinical nurses to overcome the cultural and professional press to look only for deficits—that is, how far short the patient or family falls below normative expectations for performance or health. By accepting the inevitable vulnerabilities of being human and encountering injuries, illnesses, and situational and developmental challenges, Dr. Gottlieb guides the nurse to exercise the Nightingale tradition with new insights and skills. Throughout this book, she demonstrates how nurses look for strengths that currently exist in the person’s and family’s responses and then strengthen those resources through nursing skills of perception, relating, assessing, thinking, and action. This is thinking and acting like a nurse at its very best. In addition, one of the strengths of this book is in the detailed guides it offers, and its articulation of engagement, observation, and relational attunement skills.

I have no doubt that reading this book will spark the development of real skills and clinical imagination for the relational nature of nursing care. At the same time, Dr. Gottlieb has honed the guidance and message of this book over her entire research career; thus, it is a wise, seasoned, and unusually clearly written book.

SBC can only come from understanding the patient/client/family/community experience and a grasp of the situation . . . its meanings, challenges, threats, and felt resources and possibilities for meeting the challenges encountered. As Dr. Gottlieb writes in Chapter 4,

A focus on strengths is not about ignoring weaknesses or downplaying a person’s vulnerabilities. Moreover, it is not about reframing problems and weaknesses in terms of strengths. It is not about whether the glass is half-empty (i.e., weaknesses) or whether it is half-full (i.e., strengths); instead, it is about
understanding the whole. It is about finding strengths and recognizing that strengths coexist with weaknesses; about striking the vital balance between the two; and about understanding how strengths and weaknesses interact to promote health, recovery, and healing. A focus on strengths is about appreciating and discovering human strengths in the midst of problems and weaknesses and about how to work with strengths to mitigate vulnerability.

In the same chapter, one of the nurse clinicians backs up this message:

Because I have seen in my practice that nurses can be a little overenthusiastic with our understanding of people’s strengths and resources.... I think we have to remind ourselves that a strength two weeks ago in today’s context might not be considered a strength anymore. That’s where we try to figure out the balance.

Appropriate contextualizing caveats clarify the situated wisdom of SBC and its relational and contextual nature. For example, in Chapter 4, another nurse states: “When I talk about strengths, one of the caveats I have is, ‘Be careful.’ A person needs permission to say, ‘Enough already! What worked in the past is just not sufficient now.’ ”

SBC is richly exemplified in nurses’ first-person experience accounts of actual practice. This book is at once accessible and easy to read, but it requires much personal and professional reflection to put the rich wisdom and contextualized assessments and relational skills into practice. In this way, it is not a “one time only” read but what, in the heart of nursing practice, we understand what nursing practice is.

I enthusiastically recommend this book for every introduction to nursing course, and equally for graduate nurses in advanced nursing practice master’s programs and nurses currently engaged in practice. This book is one of those rare treats that put into words what expert nurses come to know and experience over time in their best practice. By giving clarity, insight, and rigor to a central but poorly understood value and wisdom embedded in the best of nursing practice, Dr. Gottlieb has given nursing back a stronger, clearer self-understanding and social grasp of the best that nursing has to offer: SBC that can inform all diagnoses and health care design and implementation.

Patricia Benner, RN, PhD, FAAN
Professor Emeritus
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Ideas, like everything else, find their moment to emerge and the right time to take hold. Focusing on and working with strengths rather than just on problems and deficits is an idea whose time has come. This idea has existed in some form for some time; however, in recent years this new way of thinking has moved from backstage, embraced by a few, to center stage, embraced by many. Focusing on person, family, and community strengths has always been an important value in nursing since the time of Florence Nightingale, but it has never been fully developed, that is, until now.

The strengths idea is gaining momentum. From such diverse fields as nursing, social work, psychology, education, community development, and the like, each field is developing its own understanding of why it is important to adopt a strengths-based perspective. The common thread that binds strengths-based work in different fields is that focusing on strengths brings hope because it engenders in people a sense of empowerment. People come to believe they have the power within to bring about change, exercise some control over their lives, and redefine the past to create a more desirable future.

Strengths-Based Care (SBC) represents a new way of thinking in nursing. It considers the positives, those things that are best, those that are working, and those areas that show potential. This does not mean that a strengths approach ignores problems, pretends that deficits do not exist, or turns a blind eye to weaknesses; instead, it is about finding the right balance between focusing on strengths while dealing with problems and deficits. It is about using strengths to minimize the deleterious effects caused by problems. It is about giving clients, patients, families, and communities the tools to improve their health. It is about knowing the individuals and their situation, placing their problems in context, and knowing their strengths in order to understand how to capitalize and mobilize them to support health, alleviate suffering, help in recovery, and restore wholeness through acts of healing. In other words, it is about working with strengths to tackle new as well as long-standing problems and then finding new ways to deal with them.

A strengths approach requires that new principles be articulated, a different set of structures and relationships be put in place, and a new language be developed to communicate this new orientation that is consistent with nursing values. A strengths approach, which on the surface appears to be a relatively simple idea, requires a
profound shift in thinking about how we as humans relate to one another, whether it is in our own families, communities, and places of work, in different roles and capacities, or in our relationship with others on a global level.

A strengths approach reveals much about the nurse herself and how she chooses to express her humanity. As the famed late fashion designer Alexander McQueen said about himself, but could apply to anyone—“What you see in the work is the person himself.”

**STRENGTHS-BASED CARE IN HEALTH CARE AND NURSING**

After many years of focusing on deficits and trying to fix problems, the results have been limited and, in many cases, disheartening. The deficit approach has yielded short-term solutions that often have proven to be nonsustainable in the long term. People have difficulty maintaining change when motivated by fear and when reminded of their weaknesses, what they are missing, and what is malfunctioning or dysfunctional. In fact, the opposite is the case: People often become depressed and demoralized by hearing repeatedly that something is wrong, missing, or lacking in their lives or health. In contrast, individuals, families, and communities are more likely to take charge of their lives and build a sustainable future for themselves and their children when they believe in themselves; focus on the positives in their situation; are treated with respect; and are given the help, support, and resources to come up with their own solutions to their problems. It is this philosophy about people that is transforming their everyday lives and bringing hope and renewal. Consider what happened when nurses working with high-risk teenage mothers during the first year of their infant’s life focused on these young mothers’ strengths. The turnaround was startling. These mothers, who were fortunate to receive such care, were able to get jobs, had fewer subsequent unplanned pregnancies, and their children had fewer behavioral problems. This early dose of nursing had a long-term sustaining effect on the mental health of both mothers and children (Olds et al., 1997).

In health care, the deficit model still remains the dominant model of care. This is hardly surprising given that health care professionals are trained to treat problems, correct weaknesses, and minimize deficits. Diagnosis is about interpreting and labeling the problem, whereas treatment is about removing the pathology, unblocking the obstruction, minimizing or eliminating the pathogen, and cutting away the diseased parts. But this is just one aspect of the healing process.

Health and healing are about wholeness. Health is about creating wholeness, whereas healing is about repairing and restoring wholeness. This is the work of nursing.

Wholeness is about the integration and coordination between and among every aspect of a person, including how he lives in and experiences his environments. It is in healing that the person discovers himself and, in the process, develops, evolves, grows, and is transformed. Health and healing require knowledge and skills that go far beyond the scope of what the deficit model can address. Both require knowledge of the human condition and human responses to a wide range of insults, including illnesses, injuries, and trauma, as well as anticipated threats to well-being. They draw their understanding from diverse bodies of knowledge from the humanities and from the physical, social, medical, and nursing sciences. It is only when nurses recognize the need for different
types of knowledge that come from many sources that they are equipped to deal with patients’ vulnerabilities and frailties and to work with them and their families to restore and recreate a new sense and level of wholeness. In fact, in the Institute of Medicine’s report (2010) *Future of Nursing: Leading Change, Advancing Health*, considered the most significant report on nursing and the future of health care reform to be published in decades, one of the primary recommendations is that nurses “should practice to the full extent of their education and training.” SBC allows them to do this because it requires a broad base of knowledge, education, and training.

Humans respond as whole people. When confronted by challenges and insults, all aspects of the person’s being and many lifeworlds are affected. The only way to deal with the complexity in how humans respond to insults, challenges, and threats is to find ways to support innate health and healing systems. It is within these systems that specific strengths can be found. Thus, SBC capitalizes, mobilizes, and supports innate as well as learned mechanisms of health and healing.

All humans are vulnerable. All humans, at some point in their lives, will need to deal with expected and unexpected challenges, planned and unplanned changes, and ones that are manageable and ones that overwhelm. Yet it is when persons and families are at their most vulnerable and feel the most threatened that the human spirit is revealed. When humans feel, and are, threatened, they mobilize their resources to deal with these threats. Working with strengths is simply an extension of the natural way humans deal with threats by identifying, mobilizing, and capitalizing on existing strengths and developing new ones to help them ward off danger and threats and cope more effectively with their challenges. Nurses and health professionals are charged with the responsibility of helping individuals find their own strengths to deal with both everyday challenges as well as adversities that threaten their integrity, that is, their sense of wholeness as well as the intactness of their lives.

SBC shifts the focus from a narrow perspective on a problem or deficit to a wider perspective on the whole. The person, family, and community are situated in the context and history of their lives with their many facets, layers, and complexities.

SBC is better suited to the changes and challenges of today’s complex and fragmented health care system. Individuals and families are expected to take charge of their health, assume greater responsibility for the health care of loved ones, and be an active partner in health care decisions. They are more likely to take charge when they are treated as partners in their own care, have a degree of self-confidence, and are helped to believe they can do it because they have the required strengths or will be helped to develop the necessary competencies. They are more likely to benefit from the support, teaching, and guidance of nurses when they have a fuller understanding of their own internal strengths and external resources.

This book is for nursing students who are developing their framework of nursing and for experienced nurses who are looking for a new way to practice that honors the uniqueness of each person, places the person and family as the focus and center of care, and understands that problems can best be understood if situated in context and understood within the person’s personal history, culture, belief system, and values of what is important and what holds meaning for them. It is for nurses who want to create environments to support the person’s innate mechanisms of healing. It is for nurses who believe that collaborative partnership is key to helping the patient, client,
and family assume greater control over their health and health care decisions. It is for nurses who subscribe to the belief that focusing and working with strengths hold the key to helping the person and family learn how to become empowered.

**HOW THIS BOOK CAME ABOUT**

Although this book took five years to plan and write, its origins—working with strengths—began many years before. Having spent almost my entire career at the School of Nursing of McGill University in Canada—from an undergraduate and graduate student to researcher, professor, director, and professor once again—I have absorbed the school's values, only to rework and imbue them with new meaning in light of new understandings derived from empirical knowledge, personal experiences, an aesthetic approach to knowing, and an ethical and moral commitment to how nursing should be practiced. I have learned from my students and have benefitted from their experience and wisdom as practitioners. Many of the values in this book are rooted in the history and thinking of professors and graduates of the McGill University School of Nursing as found in Bertha Harmer's book (Harmer, 1922). Bertha was McGill School of Nursing's second director. For the most part these ideas were transmitted through an oral tradition from professor to professor, class to class, from one generation of students to the next. In the mid-1970s, Dr. Moyra Allen identified the six core features that distinguished the McGill approach to nursing, which she called Situation-Responsive Nursing or Complemental Nursing, that became the foundation for the McGill Model of Nursing (for a historical overview, see Gottlieb & Ezer, 2007). The beliefs and values underlying the McGill School of Nursing’s approach include:

- The focus of care is on the person and family over many decades, not the system.
- Nursing is most effective when there is a genuine, deep abiding respect and valuing of the uniqueness of the person.
- Nurses care for patients with the disease and not the disease per se.
- Nurses are learners, and patients and families are the best teachers.
- Nursing requires a broad knowledge base about the human condition, and this knowledge derives from the integration of theory and practice and reflection on practice.
- Nursing is responsive to the needs of the person and family. It is not prescriptive and requires a way of being that is flexible, open, and nonjudgmental.
- People need to find their own solutions and take responsibility for their own health. Nurses create conditions by providing experiences to help this happen. They do so by working in partnership with patients and their strengths.

These values, which have guided the McGill School of Nursing for over 92 years, have also guided my own professional career, which now exceeds 40 years. One of the six core features that Dr. Allen identified was that nurses should work with strengths, not deficits, to plan care (Allen, 1977). However, the least developed and poorly understood feature was working with the person's and family's strengths. It was during my sabbatical in 1992 with Dr. Kathryn Barnard at the University of Washington that my attention shifted to strengths in a more deliberate way. Dr. Barnard underscored the importance of strengths when she called the McGill School of Nursing's approach to nursing as “that strengths
model.” Her comment caused me to ask myself: What did working with individual and family strengths look like in practice? How did strengths interface with deficits? What were its theoretical considerations? How did clients, patients, families, and communities benefit from a strengths approach? Her comment also set in motion a series of events and actions that culminated in my writing of this book, almost two decades later.

I have found that the best way to understand an idea is to teach about it. In 1997, I decided to choose “strengths” as the topic of that year’s doctoral seminar in advanced nursing. The seminar proved to be a turning point. In teaching about strengths, I learned about strengths. The seminars were stimulating as ideas were discussed and debated, and important questions raised. As there was no book on this topic, the experience convinced me that a book on strengths was needed. I then invited expert nurses who had worked with me on a previous book to join me (Gottlieb & Feeley with Dalton, 2006). They enthusiastically embraced the idea of this project and agreed to join me in my latest adventure. To this original group of 10, 11 more expert nurses were invited to participate (see page ix for their photos and biographies). They agreed to first be interviewed by me about their own practice, and then to collect stories from frontline nurses whose nursing had impressed them. Their stories illustrated their understanding of what it means to work with strengths, and proved to be very moving. It was a privilege to hear about such exquisite and sensitive nursing. In fact, it is the stories about their practices and the insights gained from experience of working with strengths that give this book its “heart.” These nurses provided me with the language and reinforced some of my own ideas about strengths that had already begun to take shape. It is their stories about practice that capture the essence of nursing and make these theoretical ideas accessible to nurses and other practitioners, alike.

**ORGANIZATION OF THE BOOK**

Henry Mintzberg (2009), the management guru and professor at McGill University, reminds us in his book called *Managing* that “We need to understand ‘it’ [in our, case SBC] for ‘it’ to be practiced better” (p. 2). This book sets forth to understand “it,” that is, what it means to work with the person’s and family’s strengths to promote health and healing. It is a vision for nursing that blends art and science, formal knowledge acquired through education and practical knowledge gained in practice. It subscribes to the belief that when practice is informed by art, craft, and science, art gives rise to vision and creative insights, craft comes about through experience and practical learning, and science provides the best systematic evidence to guide clinical decision making (Mintzberg, 2009).

This book is organized into three sections: The chapters in Part I lay out the theoretical and conceptual foundations underlying SBC, how SBC is part of a web of other ideas that help the person and family empower themselves to promote their own health and embark on the road of self-healing. Part II examines the tools and strategies required to practice nursing. The chapters in Part III bring together two silos—theory and practice—and describe what working with strengths looks like in practice.

Part I, “Theoretical Foundations of Strengths-Based Nursing Care,” consists of four chapters. Chapter 1, “Why a Strengths-Based Approach to Care?” places SBC in context. It examines the past and current health care systems, the shortcomings and
limitations of the deficit approach, and why and how SBC can address many of these shortcomings. It demonstrates how the movements of person-focused care, empowerment, health promotion, and collaborative partnership are tied together by a common underlying substrate, namely, SBC. It provides evidence of how SBC improves quality care for patients and families and holds promise for transforming nursing practice and the health care system.

Chapter 2, “What Guides Practice?,” asks students and nurses to consider this most basic question. The answer to this question reveals much about the values, beliefs, and attitudes that guide nurses’ day-to-day decisions and nursing actions. SBC helps guide practice decisions, but it goes beyond that, to shape a nurse’s professional identity. Chapter 3, “Values Underlying Strengths-Based Nursing Care,” identifies and describes the eight core values specific to SBC. It reviews the different ways to conceptualize each value and then offers the way they are conceptualized in SBC. Taken together, they create a comprehensive and coherent orientation to practice. Chapter 4, “What Are Strengths? Characteristics of Strengths,” sets out to define strengths and their characteristics. Consistent with a nonprescriptive approach to nursing, this chapter does not list specific strengths. It does provide examples of different classifications of strengths and why a discipline or profession has selected a specific set of strengths to achieve its goals. Most important, it describes nine key characteristics of a quality that makes it a strength. It draws examples from biological, psychological, and social strengths.

Part II, “The Essential Toolbox: Basic Skills Required to Practice Strengths-Based Nursing Care,” comprises four chapters. In becoming a nurse, learners must acquire formal and practical knowledge and skills to meet that profession’s focus, fulfill its role in the health care system, and meet its mandate to society. Nurses need to develop a broad repertoire of clinical and critical inquiry skills for clinical judgment and clinical decision making. All four chapters of Part II offer strategies and techniques that illustrate how one can develop the strengths and skills that transform the learner from a layperson providing care into a professional nurse. Chapter 5, “Essential Nurse Qualities Required for Strengths-Based Care,” shifts the spotlight from the person to the nurse and the strengths that nurses must have, or need, to further develop in practicing SBC. It describes four categories of strengths with their specific subcategories (e.g., Category: Mindset Strengths, Subcategory: Open-mindedness). It describes each strength and why it is needed to practice SBC. It also offers suggestions on how to develop or acquire a particular quality to be used as a strength. Chapter 6, “Retraining the Eight Senses for Nursing Practice,” examines eight senses, namely, the five traditional sensory systems (i.e., sight, hearing, smell, taste, touch) and three senses, required for practice, that monitor internal bodily sensations, thoughts, and feelings that are required for practice. This chapter examines what is involved in retraining the senses for practice and provides specific strategies, based on knowledge from the neurosciences, for how to retrain the senses. Chapter 7, “Nursing’s Professional Gaze: Observations for Clinical Judgment and Decision Making,” reviews why observation remains the cornerstone of practice and how observation is central to clinical grasp, a precursor of clinical judgment, clinical reasoning, clinical decision making, and nursing action. It provides readers with the knowledge underlying observation, the reflective and thinking processes involved, and the criteria for assessing quality observation, as well
as specific strategies and techniques to improve observation. Chapter 8, “Reforming Skills of Social Involvement: Attunement, Authentic Presence, Attentive Listening, and Clinical Conversation,” covers the skills involved in creating and maintaining the nurse–person/family relationship. It is during an encounter that the nurse develops a relationship, gets to know the person, works with her to promote health, and accompanies her on her journey from diagnosis and treatment through recovery and healing. This chapter focuses on adding to the nurse’s toolbox by showing the importance of attunement, authentic presence, attentive listening, dialoguing, and questioning and provides the tools to develop these fundamental relationship skills.

Part III, “Strengths-Based Nursing Care in Practice,” consists of two chapters that bring together all the threads that were set forth in the previous chapters. Chapter 9, “The Spiraling Process for Uncovering and Discovering Strengths,” describes a four-phase process in the nurse–person relationship during which strengths are uncovered and discovered. Each phase of the process is described, along with specific approaches and techniques for nurses to use in uncovering and discovering strengths from getting to know the person and family to evaluating and reviewing care. Chapter 10, “Approaches for Working With Strengths,” describes, in detail, approaches and techniques to create the conditions for SBC. It outlines how to work with existing strengths to deal with problems and concerns. It also details ways to develop new strengths by developing potentials into strengths, by transforming deficits into strengths, and by minimizing deficits.

FEATURES IN CHAPTERS OF THE BOOK

All chapters begin with Learning Objectives to help readers situate themselves in the content of the chapter and to guide them in what to attend to as they read through a chapter. At the end of each chapter are Key Summary Points, a quick synopsis of the major content covered in the chapter.

Every chapter contains tables and exhibits to help summarize and synthesize complex material to make it more accessible and understandable, and to facilitate recall, as well as figures to illustrate concepts and their interrelationships. Within the text, ideas are presented in list format to help capture, summarize, and communicate the material.

Each chapter has at least three other display items: an Empirical Study, a Personal Experience, and a Reflect and Connect exercise. These three represent approaches to how knowledge is learned and then constructed: use of the scientific literature (evidence-based practice), relating concepts to narratives or stories of actual patient experiences (narrative pedagogy), and reflecting on practice and connecting it to theoretical ideas or reflecting on a theoretical concept and then connecting it to practice or to a personal experience (reflective practice).

Concepts and ideas are brought to life with stories from the rich clinical experiences of our expert consultants and frontline nurses. These clinicians were asked to recall an experience with a patient/client and family that profoundly affected them and transformed their approach to practice. Years later, their experiences with these people remain vivid in their memories. Nurses could describe their patients and the experiences in minute detail because they touched something very deep within them.

In this book, the actual nurses’ names are used. These are real nurses telling about real patients that they nursed. However, the first and last names of patients, clients,
and family members have been changed to protect their confidentiality. Some details of their stories also have been altered for the same purposes.

The stories and direct quotes that appear in the book were interviews that were audio- or videotaped and then transcribed verbatim. They appear as told, with only some minor editing to put ideas into context and to make the transition from the spoken word to written form more readable.

**INSTRUCTOR’S MANUAL**

A companion to this book is the Instructor’s Manual entitled Strengths-Based Teaching and Learning (SBTL). The manual has been developed as a resource for instructors/educators to assist them in transmitting the ideas and values of SBC to students, so that SBC becomes the students’ theoretical orientation in practice. The manual provides instructors with a pedagogical approach to be used both in the classroom and clinical setting. It provides them with an orientation to teaching and learning that is consistent with the values of SBC. It also provides them with the skills to assist them to create a strengths-based learning environment for their students. It is my belief that when students experience a strengths-based approach in their education, they will understand its benefits at a deeper level and will adopt this way of being with patients, clients, and families. It is also hoped that when instructors teach from a strengths-based perspective they will experience firsthand its benefits. They will see how SBTL empowers students to become more engaged and self-directed in their own learning.

The Instructor’s Manual contains two parts: Part I outlines the philosophy, values, and pedagogical principles underlying SBTL. It also contains the following sections: Instructors’ Role in SBTL, Guidelines for Providing Feedback, and Instructor’s Mirroring/Self-Reflection Activities. Part II of the Instructor’s Manual includes specific activities designed to enhance teaching for a chapter. Each chapter begins with an overview of the contents and features contained within that chapter—*Chapter-at-A-Glance*. In addition, there are two enhancement activities that have been designed to engage students in selected content of that chapter’s material. The Instructor’s Manual is available to qualified instructors by contacting textbook@springerpub.com.

**A NOTE ON TERMINOLOGY**

In keeping with a nongendered approach, the terms *person* and *family* are used. *Person* refers to individuals, patients, clients, and consumers. The term *patient* is used to refer to an individual in the hospital, whereas *client* is used to refer to both the healthy and to the sick being cared for at home or in the community. I have tried to avoid using pronouns of *her/his, she/he*. When the sentence has required the singular, I have randomly used male or female.

The terms *clinician* and *practitioner* are used interchangeably. In general, I use *clinician* to refer to nurses practicing in hospitals and *practitioner* to refer to nurses practicing in the community.
A NOTE ON MY COLLABORATOR

Bruce Gottlieb reviewed drafts of this book, helped me sort out ideas, assisted in the research, wrote the boxes on the empirical studies, and worked with me on editing the book. As a biologist and geneticist, he provided many biological examples. He also wrote the feature Chapters-at-A-Glance for each chapter in the Instructor’s Manual.

IN CONCLUSION

This book provides the knowledge and practical tools to practice nursing from a strengths perspective. SBC is not a prescriptive or a formulaic approach to care. It is not about creating standardized nursing care plans or care maps. “One size fits all” contradicts and violates the tenets of SBC. There is no magical formula or quick solutions or easy answers. People are complex, and they live complex lives. Nursing is about promoting health, helping to alleviate suffering, and caring for the sick. Nurses care for people throughout the life span. Nursing is also about caring for families. Health, wellness, and sickness are family events. Families need support to strengthen what they do in promoting the health of its members during all transitional life events; from conception to death and everything in between. They need help in caring for the sick, the injured, and disabled. Nursing is also about understanding communities. Families and health care systems are parts of communities. Communities either provide or lack resources that can make a difference.

Illness and tragedy are always unexpected and never welcomed; however, they do redefine people and reshape their lives. SBC is about understanding the whole person and understanding him in the context of his life. SBC is about understanding the profound effects that transitional events such as illness and tragedy have on people’s lives. SBC is about bringing transformative change to lives that have become disrupted as people try to continue to live and find meaning and purpose in their lives while repairing that which has been broken. SBC is also about celebrations and triumphs that enable individuals and families to mature, grow, and develop. SBC is about honoring the human spirit.

SBC requires that nurses invest in individuals, families, and communities. To care for another person, especially a stranger, requires physical, mental, and emotional investments on the part of the nurse. Such investments yield indescribable dividends.

In today’s health care climate, that which can be measured is most valued—this book bucks the trend. To care for others, be witness to their sufferings, find ways to help them maintain health, alleviate their suffering, and restore wholeness, often cannot be quantified. Such investments elude pricetags and dollar amounts. They may not translate into dollars, but they do translate into the knowledge that one stranger has touched and transformed the life of another. One person, one nurse, has the power to make a difference. The rewards are immeasurable.

SBC has the power to inspire, facilitate growth, and transform. This is true both for the nurse who is giving care and for the person and family who are receiving care. True power is distinguished by a concern for the powerless and the less powerful—the weak, the vulnerable, the ill and disabled, the dispossessed, the immigrant, and the
stranger (Sacks, 2004). True power is the ability to hear the voice of the powerless and give them voice.

Everyone, at some time in their lives, undergoes change, is touched by disease, the ravages of illness, tragedy, and trauma, only to find themselves in positions of dependency and in need of the knowledge and skills of others. Yet this need not be the entire story. SBC helps people understand that although they did not choose to get sick or be touched by tragedy, they do have the power to choose how they will cope with what has happened to them.

Similarly, nurses have the power to choose how they will nurse. They have the power to choose how they will care for people by how they choose to be and what they choose to do. They have the power to choose how they will spend their time—whether they will spend time with their patients or spend time at the nursing station, whether they will monitor patients at their bedside or on a monitor and at a distance.

Nurses have the power to transform the current health care system, to be major players in bringing about health care reform given that they are by far the largest segment of the health care workforce (Institute of Medicine, 2010). They have the power to bring the human touch to a highly sophisticated, technological health care environment, and to touch the lives of many. They have the power to create a new culture, an ethos of caring rooted in values of compassion and knowledge that respects the human spirit and gives dignity to people. They have the power to restore the centrality of the nurse–patient relationship and the person as the focus of care. SBC gives nurses this power.

Laurie N. Gottlieb
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The seed for a book on strengths, as explained in the Preface, was first planted by Kathryn Barnard of the University of Washington. I am grateful to my wise and insightful friend.

I began this book by approaching 10 expert nurse clinicians and inviting them to an initial brainstorming session. They enthusiastically endorsed the idea for this book, and all agreed to be interviewed by me and then to interview nurses who they knew practiced from a strengths-based perspective. I then invited another 11 individuals to become the expert consultants on this book. Dr. Judith Ritchie suggested some of the expert nurses to interview. To help these consultants prepare to become interviewers, I organized a training workshop. Franco Carnevale and Mary Ellen MacDonald graciously agreed to lead the workshop. Our training session took place in the then–newly opened Arnold and Blema Steinberg Medical Simulation Center at McGill University, as did all the interviews that I subsequently conducted with my expert consultants. I am grateful to Linda Crelinsten, Assistant Director of this center, who helped schedule the interviews, and to Robert Peuckert who videotaped them. I thank Sharyn Andrews, who invited me to attend one of her reflective nursing practice groups, and to Lidia De Simone, who allowed me to pilo my interview schedule. These first encounters met with such enthusiasm that they propelled me forward. The proposal for this book received institutional review board approval from McGill University ethics committee.

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The soul of this book are the stories of nurses in practice, caring for patients, clients, and families when at their most vulnerable, yet focusing and seeing their strengths. As nurses shared with me their nursing experiences, I often found myself moved to tears. It was not just the poignancy of what people go through that revealed the human spirit, but the beauty of their nursing that touched me to my very core. These nurses are committed to those entrusted to their care and have a passion for their work. They recognize the importance of working with strengths, not only to empower patients and families but also to be empowered in their work as nurses to make a difference.

I am indebted to Patricia Benner, who wrote the Foreword for this book. When I invited Patricia to do so, I could never have anticipated her reaction to this book. Her understanding has been the best gift. I thank Judith Shamian for recognizing
the importance of these ideas and for championing the book. I am honored that both Patricia and Judith have shared their insights and have situated this book in its broader context.

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_Laurie N. Gottlieb_
Why a Strengths-Based Approach to Care?

Strengths-Based Care (SBC) is an approach that considers the whole person, focuses on what is working and functioning well, what the person does best, and what resources people have available to help them deal more effectively with their life, health, and health care challenges. It is about how nurses can best support what is working in order to help patients, clients, families, and communities cope, develop, grow, thrive, and transform. It represents a reconceptualization of what it means to care for another person. It returns nurses to their roots of caring for another human being by focusing on individuals’ personhood and humanity and by asking them to see their faces, their uniqueness, and not just their diseases or problems. It asks nurses and health care professionals to gain a fuller appreciation of patients, clients, and their families by situating them and their issues in context, considering their situation and circumstances, getting to know their “story,” and accompanying them on their health and illness journeys. It challenges nurses to work with patients, clients, and families in order to make health care decisions that are responsive to their needs and goals and to act in their best interests. Although SBC makes sense, it represents a radical shift in thinking and a new way of being and doing. It requires a new orientation on the part of most nurses, health care professionals, and the current health care system.

We live in a society in which deficit thinking is the norm. We tend to focus on the negative rather than on the positive, on what is wrong rather than what is right,
on what needs fixing rather than what is working, and on the pains and sorrows of life rather than on its joys and celebrations. In short, we look for deficits, and thus we often miss the strengths and the many possibilities and opportunities for improving the quality of patients’ lives.

Current health care systems exist to look for deficits at all levels, from cells to citizens to communities. Instructors in the health care professions train their practitioners to look for pathology to identify and treat problems. For example, microbiologists look for pathology at the cellular and tissue level. Doctors look for disease in organs and bodily systems. Nurses look for problems in individuals’, families’, and communities’ responses to health and illness concerns. This is what they are trained to do, and this is what they should do, but this is not sufficient. By focusing on what is missing or deficient, they miss out on other aspects of the person that are functioning well and that are compensating for what is not working or is working below an optimal level. They often fail to see the person because they are blinded by the pathology, the diseased organ, or the dysfunctional family. They strip and reduce patients to their parts, ignoring their situations and circumstances, rather than seeing them for the unique individuals they are.

Nurses and other health professionals are all part of what is commonly referred to as the helping professions. The term helping implies the desire and willingness to assist, fix, and repair something that is lacking, missing, malfunctioning, or broken. There are, however, many ways of helping. A nurse can help people by focusing on the problem and trying to fix it, or a nurse can work with people and their strengths to help them deal with their concerns, find solutions to their problems, and choose how to live with them. The latter approach to helping is SBC, and it requires that a nurse knows, values, and respects the person and family who strive to live life and to find new meaning and purpose as they cope with the challenges of illness or other tragedies and work to achieve a higher level of health.

Nurse Gillian Taylor told the story of Sarah, who suffered from a severe, debilitating form of juvenile arthritis, previously misdiagnosed, that left her unable to walk; of her 20-year old single mother, Janice; and of Janice’s parents, with whom they live. Gillian first met Sarah and her family when Sarah was 2½ years old: “If I drew just a genogram [a visual depiction of the structure of the family] and wrote some facts about this mother and daughter on paper, any person would say, ‘What a disaster and what misery’—and I would say: ‘What resilience and what gutsiness!’ ” Not only had Sarah not received the proper treatment after she stopped walking, having previously walked for a short time, but her mother also was told that Sarah’s refusal to walk was because she wanted attention. As Gillian reported, “Fortunately, the mom rejected this explanation.” During Gillian’s first home visit, a number of things impressed her about Sarah and her mother.

“The first thing that struck me was Sarah’s drive; her wish to do things on her own was fierce. She scooted around on her bum, asked for help when she needed it, and then pushed everybody away if they tried to do anything vaguely resembling help. She would say, ‘Don’t touch me! I’ll do it myself! I’ll do it myself!’ And I watched how this mom responded. The mom put out a hand and gave her daughter a little help and then pulled away, so that her daughter could indeed say, ‘I’m doing it myself’; and the mom could say, ‘Yes you are!’ Yes
you are!' This was just phenomenal, because this child was very disabled and in a lot of pain. I remember thinking that this mom allowed this toddler her voice and control given a situation that was totally heartbreaking. Frankly, I just wanted to pick her up and take over because it all looked really difficult."

Another thing that Gillian observed was that, even though the grandmother was upset by the misdiagnosis and kept saying, “We should have gotten a second opinion earlier,” Janice refused to feel guilty and disagreed with her mother by telling her that they had seen a second doctor. Gillian was impressed by Janice’s attitude: “I remember thinking she’s struggling to have a version of this story that will allow her, like her daughter, to keep herself feeling OK.” What also impressed Gillian was that this young mother was able to develop a relationship with her and the doctor despite her negative experience with her previous physician and the health care system.

Sarah is now 8 years old. Gillian described the rollercoaster that Sarah and her family have been on together: “From a medical point of view, this has been one of the toughest cases. Sarah has failed to respond to three different treatments. This means that at times her disease is under control and then it flares up and is out of control. She’s tried experimental treatments and Janice has had to give her consent, which involves trust in the team that many families would find challenging.”

After all these years, Gillian continues to be impressed by this family. She described an incident that captures the spirit of this family and the way they work together: “The other day, I was going over how to inject the new medication and the need to rotate the injection site. As I talked about rotating sites, Sarah said: ‘No; I only get injections in my arms because once my mother gave me something in my belly it hurt, so no.’ As the mom was listening to my explanation of why rotating sites would probably be necessary, the mom very quickly said: ‘Well, for today we’ll just do it in the arm and we’ll let you know if we need to rotate.’ Sarah quickly settled and I gave the injection in her arm. And that was the end of that. A couple of days later, Janice called because she just wanted to go over what had happened at our last visit. She said, ‘I am trying to find a balance now that Sarah is old enough to understand some things. I want her to hear why it is important to rotate sites but she still needs to have some control and it is important that I give her as much as I can. And I’ve learned that she will change her mind about something when she has to.’”

Gillian continued with her story: “About two weeks later, they came in for an appointment and Sarah said to me, ‘Now I like my needles best in my belly.’ And so we looked at how that had come about. Sarah very generously said: ‘You were right.’ And that’s a real strength, to be able to make a shift, to look back and say, ‘Well, you know, that was OK.’ And we talked about how it was a challenge to try new things. Janice, knowing her child’s temperament and respecting Sarah in a way that acknowledges her drive and her gutsiness, also recognizes that Sarah is a child who will change when she needs to—when the timing is right. The mom is able to be both advocate and protector.”

Most clinicians would focus on Sarah’s arthritis, her deformed joints, the pain, and the fact that her disability has prevented her from walking. They would fail to see Sarah the spunky toddler, who just happens to have juvenile arthritis. What are the things about Sarah and her family that impress Gillian?
Gillian sees a little girl with tremendous drive and an intense desire to do things by herself despite the pain and disability. She sees Sarah’s mother not as a single teenage mother but as a mother who knows her daughter and what is best for her. Janice has a parenting style that meets her child’s needs for autonomy and control, is able to advocate and protect her child, and can trust and work in partnership with the health care team to ensure that her child gets the very best care. Gillian, fully aware of Sarah’s medical condition, sees a family who lives every day with the effects of juvenile arthritis and creates the conditions that enable them to cope and get the most out of life. She practices nursing from a strengths perspective.

The resiliency of the human body and spirit speaks to the human condition and its ability to rally from trauma, illness, and hardship; overcome vulnerabilities; cope and deal with problems; meet life’s challenges, and find meaning in living. It is this recognition and appreciation of the human spirit that are at the heart of working with strengths. Consider how Sarah’s inner spirit shines through despite incredible pain and deformity. Most nurses and health care practitioners, however, because they practice from a deficit perspective, are often blind to the human spirit and how that spirit informs and feeds a person’s strengths. Why is this the case, and how did this come about?

To address these two questions requires an understanding of how the deficit perspective became the dominant approach that most practitioners use to guide their practice.

**BRIEF HISTORICAL OVERVIEW OF THE EMERGENCE OF THE DEFICIT PERSPECTIVE**

What often determines the nature of a profession’s practice is what society expects of it, how the members of that profession meets these expectations, and the rewards society bestows on that profession for meeting these expectations (Sullivan, 2005). Medicine is responsible for diagnosing and treating disease, whereas nursing is responsible for promoting health, caring for the sick, and alleviating suffering. The ways a profession fulfills its roles and societal obligations are affected in part by the social, political, and economic pressures of that period in time. Although nursing is primarily responsible for caring for the sick, the way nursing fulfills its mandate looks very different today than it did 10, 20, 50, and even 100 years ago, as outlined in Table 1.1 (Hallett, 2007; D’Antonio & Lewenson, 2010).

During the 19th and first half of the 20th centuries, health care delivery was radically different from what it is today. Each family had its own family physician who was intimately involved with and knew them well (Howell, 2001). Family doctors and public health nurses were part of the family’s community and accompanied the family through all major life events, from pregnancy, births, illnesses, accidents, and traumas, to death and its aftermath. Doctors and nurses knew their families from cradle to grave. They saw them at schools and visited them in their
homes, and when a family member had to be sent to the hospital it was for a specific medical treatment. They knew each family member’s strengths, weaknesses, vulnerabilities, and frailties. They knew which families had the emotional and financial resources to cope and which ones did not. They knew which family member could provide accurate information and which ones could not. They knew who would comply with treatment and who would not. They knew who was at risk for disease and who was not.

The primary responsibility for health maintenance, prevention of disease, and the care of the sick and dying rested with the family, extended family members, friends, and their community. Nurses visited families in their homes and worked alongside family caregivers in partnership with doctors and other health care workers when patients succumbed to illness (Reverby, 1987). They were the primary health care workers who cared for the population during life-threatening epidemics, such as the Yellow Fever epidemic in the U.S. Deep South (Sabin, 2010) or the major influenza epidemic of 1918 (Keeling, 2010). Health care providers were an important part of the family’s social network. They were called on at the appropriate time when their expertise was needed.

With industrialization and the move to cities, along with the growth of scientific knowledge, the development of new technologies to diagnose, and changes in medical therapeutics, care shifted from family caregivers in the home

<table>
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<tr>
<th>Period</th>
<th>Major Feature</th>
<th>Values and Qualities</th>
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| 15th to 19th centuries | Caritas Era       | Nursing emerges in an era that subscribes to an ethos of caring and self-sacrifice. It is a time of:  
|                     |                    | • Charity  
|                     |                    | • Strong resonance of spiritual love, self-sacrifice  
|                     |                    | • Precursor to modern caring                                                                                                                     |
| 1850s to 1950s      | Heroic Era         | Nursing roles are forged during wartime (Crimean War, the Boer War, World Wars I & II):  
|                     |                    | • Calculated risk taking  
|                     |                    | • Courageous  
|                     |                    | • “Angels”  
|                     |                    | • Compassionate care                                                                                                                               |
| 1950s to 1980s      | Professionalizing Era | Nursing begins to forge its knowledge base with a focus on logico-scientific systems but has difficulty finding acceptance.                        |
| 1980s to the present | Technocratic Era   | Nursing embraces medical technology with its link to status and power and loses its identity and purpose.                                            |

Source: Based on Hallett (2007).
to professional caregivers in hospitals. Beginning with the first world war, and increasingly so during the second world war, hospitals supplanted care in the home, and nurses became primary caregivers (Howell, 2001; Lynaugh & Fagin, 1988; Reverby, 1987).

The division of labor between nurses, physicians, and other health care providers was clear. Physicians were responsible for overseeing the patient’s care, whereas nurses were responsible for carrying out doctors’ orders and reporting to them about any change in the patient’s condition (Barnes, 1961). Nurses came to know their patients by ministering to their physical needs, providing physical care, and listening to their stories (Sandelowski, 2000). Hospitals took care away from families and transformed the illness experience. In the new modern hospitals, family visitation was neither desirable nor acceptable, and families were seen as more of a nuisance than as a help (Barnes, 1961; Markel, 2008). Hospitals made little provision for family members. Often, they did not provide a place even to hang up a hat or coat or a chair on which to sit (Barnes, 1961). Family members were relegated to a visiting role and had limited access to their loved ones. The premise was that this would be “best” for the patient, who would be protected from infection and could direct his energy to healing. Families were tolerated at best, viewed as interfering with treatment at worst, and certainly not treated as partners in care.

A study in the late 1950s of patients’ experiences in hospitals found that they were expected to be passive and submissive (Barnes, 1961). Now that doctors had at their disposal new treatments, surgeries, and drugs brought about by advancements in the biological and physical sciences, they, as well as the general public, saw the medical profession as responsible for curing whatever ails people. Physicians, particularly surgeons, were elevated to the status of gods and considered omnipotent. In exchange for being cured, patients were expected to ask few questions; cooperate with treatment; and submit body, mind, and soul. Often, patients and families were left in the dark, knowing little, and were also expected to ask little (Barnes, 1961).

Patient hospital stays were lengthy, and patients were discharged only when all symptoms had abated and when minimal home care was needed. During the 1950s and 1960s, the average length of hospital stay for commonplace procedures, such as a tonsillectomy, cholecystectomy, or cataract removal, was five to fourteen days. Today, these procedures are routinely conducted in day surgery. Because patients were in the hospital for a relatively lengthy period of time, they were often assigned to the same nurse. Nurses were responsible for caring for three to five patients, of whom only one or two were acutely ill, with the remainder in various stages of recovery. Patients and nurses got to know one another. Direct patient care was only part of a nurse’s responsibility. Although they were the record-keepers, message carriers, caretakers, organizers, and housekeepers of the ward, nurses were expected to give bodycare (bathing, backrubs, and the like) and find time to listen to their patients as well (Barnes, 1961).

In addition to hospital care, community care nursing focused on home visiting, public health education, prenatal and postnatal care, immunization programs, lifestyle counseling, school nursing, occupational health, and the like. Public health nurses visited patients at home to give treatments, educate, and support families in the care of their ill member.
Chapter 1: Why a Strengths-Based Approach to Care?

THE GROWTH OF THE DEFICIT MODEL AND ITS INFLUENCE ON HEALTH CARE PRACTICE

At the present time, the deficit model dominates thinking in the health care system. In part, this is due to the prevalence of the biomedical model, which was developed over the course of many generations to help doctors understand their patients’ medical problems, arrive at an accurate diagnosis, and find the best treatment. Thus, the biomedical model is a method for, or an approach to, systematically collecting, organizing, and categorizing clinical data (D’Antonio & Fairman, 2004). Physicians are attuned to what is wrong and are focused on understanding the cause of the symptom; the underlying pathology; the malfunctioning organ or system; and how to cure, correct, or minimize the problem. There is a downside here: The biomedical model has become a reductionist approach in which patients are reduced to, and thought of, in terms of their body parts: the diseased heart, the malfunctioning lung, the pain in the stomach. Their personhood is ignored, and their strengths go unnoticed.

There are a number of reasons why the biomedical model has come to dominate the health care system and is used by so many other health care practitioners as their orientation to practice. First, patients often seek out medical care because something is bothering them. The medical model has been shown to be a highly effective and systematic approach to address such concerns. Second, the current health care system is primarily a medical one that is devoted to the treatment and cure of disease, not one that primarily promotes health and helps patients heal. Third, the biomedical model provides a common language within the health care system for health care professionals to communicate with each other. However, the unintended consequence of the dominance of the biomedical model is that the culture it fosters in the health care system roots it in deficit-type thinking. Most health care professionals are preoccupied with what is not working and ignore what is working. Finally, medicine has been and continues to be the dominant member of the health team, which garners the most attention in the system. Nurses and others believe that, by identifying with and adopting the medical model they will, by association, elevate their status within the organization they practice in. This observation, which was made in hospitals over 50 years ago (Barnes, 1961), is just as real today.

The power of the powerful to shape others’ thoughts and action should not be underestimated. Harris (1998), through her groundbreaking insights into how children turn out the way they do, alerted readers to the power of the group in socializing an individual to a particular role, a specific way of behaving. At a very early age, children select a group with which to affiliate because there is something in that group that they want or that resonates with them, so they then adopt the ways of thinking and behaving of a group that is perceived to be more powerful. This pattern of socialization continues throughout an individual’s life span. One of the first things a person does when he enters a new environment is scan the environment for the attention structure that is in place; that is, he appraises the different social groups; categorizes the groups in terms of power, status, attention, interests, values and the like; and then decides on the group he would like to join. Shortly thereafter, he quickly learns to behave like the other members of that group (Harris, 1998). In hospitals and the health care system, there is an attention structure as well: the group that gets the attention, the profession to which everyone looks when they are unsure about what to do. Those individuals
who are high on the attention structure often get privileges and rewards that those low on the structure could never dream of having, let alone hope for (Harris, 1998). Medicine has enjoyed being on the highest echelons of the attention structure. This has been going on for a very long time. In fact, a study of the inner workings of hospitals conducted during the 1950s found that nurses derived much of their satisfaction from doctors’ approval of what they did, and things that doctors did not consider important, useful, or proper were not considered important (Barnes, 1961). Although today’s nurses derive their job satisfaction from being given the autonomy to carry out responsibilities that are commensurate with their knowledge and experience, job satisfaction is still related to a positive relationship and clear communication with physicians (Wanzer, Wojtaszczyk, & Kelly, 2009). Attention structure theory may explain in part why nurses and others have muted their voices and diminished their own roles by adopting medical language and the deficit discourse.

CAVEAT

The medical model need not be a deficit model. The two are not mutually exclusive. Physicians can diagnose and treat problems and also have a strengths perspective and practice whole-person care.

WHAT EFFECT HAS DEFICIT THINKING HAD ON PRACTICE?

The first effect of deficit thinking is that many nurses and health care practitioners view their patients through a negative lens. As a result, behaviors that seem unfamiliar or unusual are interpreted in clinical terms, such as abnormal, deviant, pathological, or dysfunctional. Because clinicians focus on problems, there is a tendency to frame a patient’s behavior negatively. Even healthy responses can be labeled pathological. Consider the story of Mrs. Coreen Kennedy, who was diagnosed with advanced rectal cancer when she was in her first trimester of pregnancy. The doctors advised Mr. and Mrs. Kennedy to abort the pregnancy, so that Coreen could start treatment immediately. This couple agonized over what to do and, after much discussion with their minister, family members, and health care professionals, decided to continue with the pregnancy until the earliest date at which time Coreen could safely give birth to a viable baby. She would then have surgery to remove the malignant tumor and begin chemotherapy and radiation therapy. Once the couple had made their decision, Coreen became calmer. The doctors were disturbed by her calmness and interpreted Coreen’s calmness negatively. Christina Clausen, Coreen’s primary nurse, described the medical team’s response: “There were questions among physicians of whether Coreen was coping appropriately because she was so strong. And they’re thinking—‘She must be in denial, someone this positive and this able to manage; well, that just can’t be!’ ” Yet Christina knew this mother was not in denial. She knew what this couple had gone through in arriving at their decision. Christina saw that her role was to support the Kennedys’ decision and advocate for them. She believed that the decision the Kennedys had made was right for them. Both Coreen and her infant daughter survived.
A second effect of the widespread adoption of the biomedical model, with its associated deficit thinking, has been to deconstruct and depersonalize the individual who is seeking care. Part of diagnosing the problem is to identify, locate, and understand symptoms. What becomes problematic is when the process of diagnosing becomes generalized to the person; that is, when the person is reduced to her symptoms, as if symptoms can exist separate from the person, instead of the patient being viewed as a person who is experiencing a symptom or illness. In other words, patients may be referred to and treated as Mrs. Wallis—“the amputee,” or Mr. Roberts—“the stomach ulcer.”

Another reason for this state of affairs lies in the nature of the work. Many medical treatments cause pain. Think of the effects of surgery or invasive procedures, such as taking blood, inserting lines, and catheters and tubing in different orifices (e.g., feeding tubes). Nurses often have to inflict suffering in order to alleviate suffering. Most procedures and treatments cause bodily pain. It is easier to cause pain if the nurse or physician or any health professional is detached from the patient. It is easier on the doctor or nurse to inflict pain on a body part or target a specific symptom, rather than cause pain to a person (Barnes, 1961). Thus, depersonalizing a patient and reducing him to a symptom or bodily part has become a defense learned early in a person’s professional career.

A third effect of the dominant medical model is that nurses who practice deficit thinking have relinquished many of their traditional roles of caregiving in favor of taking on more medical tasks and functions. Traditional caregiving roles gave nurses their distinct role in the health care system. Many of the relinquished tasks (e.g., bed baths, backrubs, patient positioning) involved caring for the person by caring for the person’s body and attending to her bodily needs. It was in the act of doing these tasks that nurses came to know their patients as individuals and could assess at close hand their health and healing status (Wolf, 2009).

Finally, the focus on disease and problems has stimulated the invention of ever-more-sophisticated technologies to help practitioners diagnose and treat medical conditions. In short, health care systems tend to be problem centered rather than person centered, yet they can be both. The focus needs to be on understanding the disease, its cause, and how to cure it, or at least manage it. The approach to healing patients needs to focus on the persons and use their strengths and capabilities to manage their problems. These two approaches can be compatible, as I describe in more detail in Chapter 3, Exhibit 3.6.

**EMERGENCE OF THE TECHNOLOGICAL ERA**

Beginning in the 1960s, with the advent of new technologies for diagnosis and treatment (e.g., imaging scans) and advances in pharmaceutical technology and therapies, the health care system underwent radical changes. Intensive care units were created to
deal with the most seriously ill patients. Health care became more specialized; services became more technologically driven; and traditional health care professions, such as medicine and nursing, had to rethink their roles as new groups of health care technicians and therapists were trained.

New technologies have ushered in a new era of treating diseases, extending life and, for many, improving the quality of their life. Such advances, among them noninvasive surgeries, have minimized the trauma of major surgery, have reduced complications, and enabled individuals to resume their normal activities within a relatively short period of time following treatment. A case in point is cholecystectomy surgery. Until the early 1990s, the removal of a gall bladder required a five- to ten-day hospital stay because the surgery was invasive, requiring a large incision in the abdominal wall. The development of laparoscopic surgical equipment offered general surgeons the ability to complete cholecystectomy surgeries and send patients home the very same day. Patients often resume their normal routines within the week.

Nurses have identified both positive and negative effects of technology on their practice (Zuzelo, Gettis, Hansel, & Thomas, 2008). On the positive side, nurses have reported that technology has increased their efficiency and saved them time, as well as helped them keep their patients safe by detecting subtle changes in their patients’ condition so that they could intervene early to prevent deterioration, injury, complications, and infection. Technology also contributed to shortened hospital stays by promoting healing and helping nurses prepare patients for discharge. In addition, the new technologies better prevented nurses from injuring themselves while providing care. However, there are negatives associated with the new technologies, such as the challenges associated with broken equipment, how to operate/use complicated equipment, and how to keep up to date with changing technologies. Another downside of technology is that it can be addictive. Professionals and the public have come to believe that technology can solve all problems.

We live in a culture fascinated with new technology, almost to the point at which there is overconfidence in what technology can achieve and an overreliance on its use. Many people believe that technology can address and correct what is wrong, repair what is broken, and cure what ails us. Health care professionals are increasingly reliant on these technologies as their primary source of information. At times, technology has diverted nurses’ attention away from the patient as a person (Barnard, 2009). In other words, nurses often find themselves watching a machine instead of observing, interacting with, and developing a relationship with the person who is attached to the machine. Direct care of the patient has been replaced by care of the patient via a machine! When nurses view patients in this way, what patients and their families have to say can be more easily ignored or discounted.

Doctors, nurses, and other health care professionals have come to believe that they alone are responsible for curing the patient and that the patient plays a minor role in their own recovery. This assumption is clearly erroneous. As Florence Nightingale, the
founder of modern secular nursing, observed in the first book ever written on nursing, *Notes on Nursing*, back in 1860,

> It is often thought that medicine is the curative process. It is no such thing; medicine is the surgery of functions, as surgery proper is that of limbs and organs. Neither can do anything but remove obstructions; neither can cure; nature alone cures. Surgery removes the bullet out of the limb, which is an obstruction to the cure, but nature heals the wound. So it is with medicine; the function of an organ becomes obstructed; medicine, so far as we know, assists nature to remove the obstruction; but does nothing more. And what nursing has to do in either case is to put the patient in the best condition for nature to act upon him. (p. 133)

Nightingale’s observation is no less true today than it was in 1860. Ultimately, the ability to rally and recover from disease and trauma resides in the person, and the role of the nurse (as well as that of other health care professionals) is to create the conditions that encourage and support the person’s health and natural healing processes. Creating the conditions for health and healing can best take place when nurses develop a relationship with their patients. SBC is about “putting the patient in the best condition” by capitalizing on the person’s strengths and supporting those areas that are functioning to allow the body and mind to heal.

**THE CURRENT HEALTH CARE SYSTEM: A SYSTEM IN CRISIS**

The past 20 years have been a period of major upheaval in health care systems worldwide. With escalating medical costs primarily brought on by the high demand for costly technologies and an increase in chronic care services due to an aging population, health care costs are spiraling out of control (Rachlis, 2004). Regardless of whether health care is publically funded, as in Canada, the United Kingdom and France, or partially government funded (e.g., Medicaid, Medicare), as in the United States, the challenge for all governments and health care systems has been how best to contain costs while meeting increasing expectations and demands on the part of their citizens for the latest medical technologies and providing quality health care.

Many hospital administrators have even turned to business models to find solutions to control and contain escalating costs. During the 1990s, hospitals merged to reduce duplication, eliminate waste, and consolidate services. Because nursing accounted for the largest portion of hospital budgets, nursing management and front-line nursing positions were slashed as hospitals downsized and merged and many services were transferred from tertiary hospitals (a hospital with a full complement of services) to community facilities or to home care (Rachlis, 2004). The effects were devastating on both patients and the nursing workforce. The loss of nursing expertise put patients’ safety at risk, as reported in a landmark nursing study conducted by Linda Aiken and her colleagues at the University of Pennsylvania (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). They surveyed 10,000 staff nurses and 232,000 surgical patients. When the nurse:patient ratio went above four (i.e., when a nurse was assigned to care for more than four patients), for each additional patient cared for there was a 7% increase in the odds of a patient dying within 30 days. Moreover, nurses were more likely to
experience burnout and job dissatisfaction. Six years after this study was published, Aiken and her group reported more specific features of the care environment on which the quality of patient care depends (Aiken, Clarke, Sloane, Lake, & Cheney, 2008). This study is described in Exhibit 1.1.

Patients and families became numbers and statistics. Health care services and professional values shifted from a focus on patients to a focus on the bottom line, the financial cost of care (Weiss, Malone, Merighi, & Benner, 2001).

Another measure taken to contain costs was to shorten hospital stays and send patients home early. Hospital stays are expensive when the costs of salaries, housekeeping, equipment, and food are all factored in. Administrators reasoned that

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**EXHIBIT 1.1**

**Empirical study**  
*Downsizing and mergers of hospitals: Effects on nurses and patients*

**The Problem**  
Does the environment in which a nurse practices make a difference to nurse and patient outcomes?

**The Issues**  
It is known that the environment in which nurses practice can have a profound effect on both them and their patients. In particular, do management skills and their effects on staff relationships make a difference?

**The Study**  
Aiken et al. (2008) collected data from more than 10,000 nurses and more than 230,000 surgical patients in 168 Pennsylvania hospitals. The care environments were classified according to the following two criteria: (a) quality of staff development and management and (b) interpersonal relationships. They then measured and analyzed outcomes that included nurse job satisfaction, burnout, intent to leave, and reports of quality of care, as well as mortality and failure to rescue in patients.

**The Findings**  
Nurses reported more positive job experiences and fewer concerns with care quality in better practice environments. In these environments, there were significantly lower risks of death and failure to rescue. The care environment elements that had a positive effect on nurses and their nursing included staff development and the quality of management, nurse manager abilities, support given by management to nurses, and the collegial quality of the nurse–physician relationship.

**The Bottom Line**  
The quality of patient care depends on the care environment in which nurses practice. In particular, the leadership and management of the nursing staff as well as their interactions with physicians can have a profound effect.

*Source: Adapted from Aiken, Clarke, Sloane, Lake, & Cheney, (2008).*
hospitals could save significant amounts of money by discharging patients home early or sending them to less expensive facilities, such as rehabilitation or convalescent institutions.

For the most part, people do recover faster and without complications in the comfort of their own surroundings, particularly when they and their families have access to professional support and advice. However, this is not always the case. When patients are sent home to be cared for by family members who feel ill prepared or have inadequate support, family caregivers often feel stressed and burdened themselves (Bull, 1990; Scherbring, 2002).

These are some of the changes that people have been dealing with as the health care system transforms itself. Although many of these changes have brought about improvements, they have also resulted in citizens experiencing high levels of dissatisfaction and frustration with the health care system and health care professionals.

**Indicators That Something Is Amiss**

There are many indicators that something is amiss within the current health care system. These indicators range from job dissatisfaction and nurse burnout, concern for patient safety, difficulties in patient–professional communication, increase in litigation suits, and an overall deterioration in quality care. A sample of studies illustrating that something is amiss is summarized in Table 1.2.

**What do these responses have in common?**

Many of these responses are primarily the result of health care professionals’ failure to establish a connection with their patients and families and to work with them in ways that are meaningful to them. For professionals who care about patients and want to get to know them, the failure to develop a relationship with patients and advocate on their behalf have given rise to a new condition health professionals suffer. *Moral distress*, as it is called, surfaces when doctors and nurses feel trapped by the competing demands of the health care system and are unable to do what they believe to be right for their patients (Chen, 2009). In other words, the health care system puts system needs first and patient needs further down the priority list, causing health professionals to experience a sense of helplessness because they are unable to do what they believe is right for their patients.

By depersonalizing people, and treating them more as symptoms or numbers than as human beings, the health care system has unduly put people at risk rather than safeguarding and protecting them (Kohn et al., 2000).

**How Have People Responded to the Effects of a Deficit-Dominated Health Care System?**

In response to the growing dissatisfaction with and mistrust of health care providers and the deterioration in the quality of health care services, citizens, professionals, organizations, and governments have organized to lobby for a different type of health care system based on a different set of values. Although many proposals have been
TABLE 1.2
Evidence that something is amiss in the health care system

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Study</th>
<th>Sample</th>
<th>Findings</th>
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<tbody>
<tr>
<td>Nurses’ job satisfaction</td>
<td>Aiken et al. (2001)</td>
<td>43,000 nurses in 500 hospitals, five countries</td>
<td>Widespread dissatisfaction among nurses. High demands on nurse workforce, with reports of nurses having insufficient time to teach and counsel patients and families.</td>
</tr>
<tr>
<td>Patient safety</td>
<td>Kohn et al. (2000)</td>
<td>Meta-analysis of U.S. studies; Washington, DC</td>
<td>Between 44,000 to 98,000 people die each year as a result of preventable medication errors, compared with fewer than 50,000 people who die of Alzheimer’s disease. About seventy thousand (7.5%) of hospitalized patients experience preventable adverse events (estimated 9,000–24,000 preventable deaths in Canada annually due to error).</td>
</tr>
<tr>
<td></td>
<td>Baker et al. (2004)</td>
<td>The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada</td>
<td></td>
</tr>
<tr>
<td>Patient–practitioner communication</td>
<td>Levinson et al. (1999)</td>
<td>Focus group of the frustrations among patients and physicians with managed care organizations American patients in hospitals</td>
<td>Disagreements between physicians and patients involved three areas: (a) allocation of resources, (b) access to care, and (c) financial arrangements. Patients expect a level of quality care that physicians cannot provide. Patients and physicians are not communicating, leading to patient and physician frustration. Fifty-five percent of patients are not getting treatment for which a sound evidence base exists, and approximately 10% are getting inappropriate treatments linked to problems in system design and provider–patient communication.</td>
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<td></td>
<td>McGlynn et al. (2003)</td>
<td></td>
<td></td>
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<tr>
<td>Quality of patient care</td>
<td>Jha et al. (2008)</td>
<td>Patients in U.S. hospitals, perceptions of care</td>
<td>Patients expressed need for improvement in nursing care, communication about medications, pain control, and provision of clear discharge instructions.</td>
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Chapter 1: Why a Strengths-Based Approach to Care?

advanced to address these problems, the four key approaches to reorient health care service delivery are as follows:

1. Patient/person/family/relationship-centered care
2. The patient/person empowerment movement
3. Health promotion, illness prevention, and self-care
4. Collaborative partnership care

Although each approach is discussed separately, it is important to keep in mind that they are interrelated (see Figure 1.1). They are derived from many of the same beliefs and core values about the person, a person's role in the health care system, and a person's relationships with health care providers.

CAVEAT

Patient/Person/Family/Relationship-Centered Care

Person-centered, patient-centered, family-centered, and relationship-centered care are buzzwords being touted by health care institutions and practitioners to signify a “new” approach to care that is sensitive and responsive to patient needs. Person-centered care is about practitioners and the health care institution holding the patient's “personhood” central in clinical decision making (McCormack, 2003). Personhood is the right of people to have their values and beliefs respected. Each profession has its own concept of what person-centered care means.

Patient-Centered Medicine. In medicine, patient-centered care was proposed as a model to redress the public’s dissatisfaction with the care they received from physicians, a dissatisfaction that arose because of physicians’ education and training in the

FIGURE 1.1

Interrelationships among the four approaches.
biomedical model, which focuses almost exclusively on the disease or problems rather than on the person who is dealing with the disease or problem (Stewart et al., 2003). The patient-centered model of medicine was developed to transform physicians’ clinical method of practice and to incorporate ways to improve how they communicate with their patients. Patient-centered medicine, as conceptualized by Stewart and her colleagues, incorporates six interactive processes into medical clinical practice:

1. Exploring disease as well as the illness experience
2. Understanding the person at the personal level (i.e., life history), proximal level of influence (i.e., family, social support) and distal level (i.e., culture, community)
3. Finding common ground.
4. Enumerating problems, priorities, goals of treatment and/or management of the disease
5. Incorporating prevention and health promotion
6. Enhancing the patient–doctor relationship
7. Being realistic

*Person/Family/Relationship-centered care in nursing.* In nursing, person-centered care is not a new idea. The term has been around for over 50 years. It was coined in the 1960s by early nurse theorists, such as Faye Abdellah and Ernestine Wiedenbach, to shift the focus of nursing away from tasks and techniques to the patient or family as the center of the nurse’s attention and their care (Abdellah, 1960; Wiedenbach, 1964). Dr. Myra Levine, another early nurse theorist, used the term *patient-centered nursing care* to refer to individualized nursing or care that was tailored to the unique needs and concerns of each patient (Levine, 1973). Patient-centered or individualized care required that nurses know their patients as unique human beings in order to be able to promote their recovery and help them return to a better state of health (Dunphy, 2009). In fact, hospital life during this period was fraught with some tension on the wards between the head nurse and her nursing battalion and the doctor-in-chief and his physician battalion. As Barnes (1961) summed up, the tension between these two factions was due to a difference in orientation: “Patient-centered nursing techniques and interest in human needs versus disease-centered medical techniques and interest in pathology” (p. 50). Moreover, nurses regarded the patient and human problems as their special domain of practice.

It is important to note that person-centered care can also be practiced from a deficit lens when the practitioner solely focuses on problems or weaknesses without considering or balancing the problems and deficits with the person’s strengths. The appeal of person-centered care is that it brings the person to the forefront. The person’s problem is understood within the context of his circumstances, past experiences, relationships, different environments, and lifeworlds.

**Patient/Person Empowerment Movement**

The idea of empowerment derives from the social action movements of the 1960s and the self-help ideology of the 1980s. Empowerment movements such as those seeking equal civil rights for women, gay men and lesbians, and members of racial/ethnic
minority groups were borne out of frustration; a lack of control; and feelings of powerlessness, helplessness, hopelessness, and oppression. These groups felt marginalized and silenced at many levels of society.

The patient empowerment movement traces its roots to the rise of the consumer movement of the 1960s. Ralph Nader, an American lawyer and early consumer activist, was the David who took on Goliath, the giant automobile industry, to advocate for safer cars. His actions resulted in legislation that mandated the use of many safety devices in cars that we now take for granted, such as seat belts. Nader showed that one man could change a system to make it more responsive and accountable to the needs of its citizens. The idea that citizens could empower themselves to create change spread to other sectors of society, including the health care system (Sullivan, 1998).

Empowerment movements are grassroots or “bottom-up” movements whereby individuals and communities come together, find their voice, and organize themselves to change the status quo. Citizen empowerment movements advocate for better care in dealing with specific diseases, for the right of individuals to be treated with respect and dignity, to choose treatments, and to participate in decisions affecting their own health. Consider one of the earliest patient empowerment movements, the breast cancer movement, which showed how citizens could empower themselves to advocate for changes in their own health care as well as change in the health care system itself (see Exhibit 1.2).

**What is meant by personal “empowerment”?**

*Empowerment* is “a social process of recognizing, promoting, and enhancing people’s abilities to meet their own needs, solve their own problems, and mobilize the necessary resources in order to feel in control of their own lives” (Gibson, 1991, p. 359). Thus, empowerment is the process of helping people help themselves to assert control over the things that matter to them and affect their health. Empowerment requires a number of qualities in order to be effective (Chamberlin, 1997), including

- access to information to help people make decisions,
- having a range of options from which to choose,
- assertiveness to express ideas and to stand up for oneself,
- the belief that one can make a difference, and
- learning to think critically.

Empowerment is premised on the belief that every person, family, and community has the capabilities, capacities, skills, competencies, and potential to assume responsibility for their own health as well as to gain some mastery over their own lives. It encompasses the belief that people, not health care professionals, empower themselves. Health care practitioners create the conditions that enable people to acquire the skills to foster their own empowerment (Gibson, 1991). Again, this approach requires an emphasis on the inherent and acquired strengths residing in individuals, families, and communities.

**Health Promotion, Illness Prevention, Self-Care Culture**

The current health care system is a misnomer. It is not a health care system but rather a disease care system. The majority of health care dollars are spent on diagnosing and treating disease; the sum is vast compared with the amount of money spent on
History The rise of the breast cancer movement

The breast cancer movement that arose in the 1970s in the United States is an excellent example of patients seizing the initiative for their own care. Up until then, it was virtually unheard of for a patient to challenge the opinion of a physician, because it was always assumed both by patient and doctor that all the relevant diagnostic and treatment data were solely in the possession of the physician.

This changed in 1975 when a young journalist named Rose Kushner questioned why she had to undergo a radical mastectomy procedure known as a Halstead, when data showed a modified procedure that involved only a partial mastectomy had been proven to be just as effective. Following her own diagnosis with breast cancer, she had to go to nineteen different surgeons before she found one who would consider this procedure. She then conducted extensive research that culminated in her publishing Why Me? What Every Woman Should Know About Breast Cancer to Save Her Life. This book proved to be the impetus that launched a patient-based movement that totally changed the dynamics of the patient–doctor relationship.

Within a short period of time, Kushner helped found the Breast Cancer Advisory Coalition (now known as the National Breast Cancer Coalition), which became not only a powerful advocate for breast cancer patients but also a key player in determining research funding and policy in the United States. This coalition included breast cancer patients as well as politicians, physicians, nurses, members of Congress, and media personalities. Together, they raised the public profile of breast cancer.

Ironically, when Rose Kushner first addressed a meeting of oncologists in 1976 she was booed off the platform. When she died in 1990, the American Medical Association gave her fulsome praise as a fighter against the war on breast cancer. Her activism provided a model for other patients suffering from high-profile diseases, such as heart disease, and stigmatized diseases, such as AIDS.

Source: Adapted from Casamayou (2001).

promoting health or preventing illness. Health promotion and disease prevention programs, such as parenting programs, school health, and safety and injury prevention, receive a relatively small proportion of the total health care budget. In the United States, for example, less than 5% of health care expenditures are dedicated to health promotion and illness prevention (Jacobs & Rapport, 2004).

A new culture of health promotion is starting to take hold. The cost of preventing a disease is significantly lower than the cost of treating the disease once it has occurred. Advocates of health promotion use the arguments that are captured in the phrase “PAY A SMALL AMOUNT NOW OR PAY A LOT MORE LATER.” In other words, invest now in health education and the determinants of health that affect people’s lifestyle choices with respect to diet, physical activity, sexual behavior, substance abuse,
coping with stress, and the like in order to save money and lives later (McGinnis, Williams-Russo, & Knickman, 2002).

Take, for example, the diseases associated with smoking, such as lung cancer and heart disease. Consider what the costs of treating lung cancer and heart disease are. Now compare these costs with the costs of educating young people about the dangers of smoking; supporting smoking cessation programs; or getting at some of the root causes of smoking, such as stress, poverty, low self-esteem, and peer pressure. Also, consider the cost of treating car injuries caused by a failure to use seat belts. What is the cost of intensive care and rehabilitation for a person involved in a car crash versus the cost of educating people in the proper use of car seats and safety belts?

**Self-Care**

Self-care is an important aspect of health promotion that is concerned with issues of autonomy, self-determination, and independence. In the 1970s, knowledge about self-care reached a broader public because of the wellness and self-help movements. It stressed that people “should gain confidence as health care consumers and that there were many options on the road to health and within medical treatment” (Kickbusch, 1989, p. 125).

In Canada, self-care was proposed as one of three key mechanisms in a health promotion framework aimed at achieving health for all Canadians, commonly referred to as the *Epp Report* (1986). This report defined health promotion, using the World Health Organization definition, as “the process of enabling people to increase control over, and to improve, their health”. In addition to self-care, mutual aid, and the creation of healthy environments were the mechanisms advanced to promote health. In this context, *self-care* referred to “the decisions and actions individuals take in the interest of their own health”. The Canadian self-care framework involves supporting the person, sharing knowledge, facilitating learning and personal development, helping the person build support networks, and providing a supportive environment (see Table 1.3; Health Canada, 1997).

A culture of health promotion, illness prevention, and self-care is premised on the belief that people can change their health behaviors and that they possess within themselves the power to change. It requires that people make better lifestyle choices for themselves. It also requires a different mindset on the part of individuals, families, communities, and government. People at each level need to rethink how to build and make better use of their strengths and assets. It also requires communities to provide environments that support health. For example, consider the recommendation that a healthy diet includes daily portions of fruits and vegetables. Fulfilling this requirement may be difficult for low-income families if they live in neighborhoods where there are few stores that sell fresh fruits and vegetables (Kawachi & Berkman, 2003). Although the change toward health promotion is primarily economically motivated to relieve the burden on the health care system by keeping people healthy, the culture of health promotion also requires a change in attitude on the part of many including communities, policy makers, and local and federal governments. However, most important it requires a change in attitude on the part of both the person and the health care professional. It requires that people want to assume greater responsibility for their health and make better lifestyle choices. It also asks nurses and health care professionals to make health promotion an integral part of their practice.
Collaborative Partnership

Changes in the health care system have necessitated that roles and relationships between the person and health care provider be redefined. With the shift in care from hospital to home, individuals and families have had to assume greater responsibility for their own health care decisions and the management of their own care.

A collaborative partnership signifies a different relationship between the person and nurse and redefines the boundaries between them. Rather than the person being a passive recipient of care, she becomes a partner in her own care. This new relationship replaces the traditional hierarchical (paternalistic) relationship in which the health care provider is the expert, knows what’s best for the person, and expects the person to comply with the prescribed treatment regimens. In contrast, the collaborative partnership approach to care requires, among other things, a willingness on the part of the nurse to share power with the person and to work together on mutually agreed upon goals (Gottlieb & Feeley, 2006). This approach recognizes and respects the experiences and expertise of both partners. It does not mean that the nurse relinquishes responsibility to the person. It does mean that the nurse listens to the person, recognizes the person’s

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**TABLE 1.3**

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<td></td>
<td>• Conveying acceptance</td>
<td>• Recognizing the experiential knowledge of the person</td>
<td>• Helping the person understand and name problems</td>
<td>• Helping the person identify sources of support</td>
<td>• Providing an environment that is supportive in terms of its psychological, organizational and physical aspects</td>
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<td>• Creating a climate of trust</td>
<td>• Providing information</td>
<td>• Helping the person set goals</td>
<td>• Facilitating roles of natural caregivers and family members</td>
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<td></td>
<td>• Listening</td>
<td>• Teaching skills</td>
<td>• Going at the person’s pace</td>
<td>• Suggesting programs that provide support, e.g. support groups and self-help groups</td>
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<td>• Focusing on the person’s strengths</td>
<td>• Suggesting resources</td>
<td>• Dividing learning into small steps</td>
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<td>• Helping the person build self-confidence</td>
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<td>• Encouraging the person to try things out</td>
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<td>• Being accessible</td>
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<td>• Modeling ways of approaching health problems</td>
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<td></td>
<td>• Developing a relationship over time</td>
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<td>• Focusing on strategic moments and key transitions</td>
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expertise, and together they work out a plan of care that is tailored to the person and family’s goals, needs, lifestyle preferences, and circumstances.

This relationship encourages individuals to become more involved and to take greater responsibility for their care. People feel empowered when they are encouraged to express themselves and to believe that they have the capacity to find solutions to their own problems. Collaborative partnerships also encourage people because it enables them to get the help that best suits them.

Dr. Mary Grossman (2011) narrated the story of Eleanor Johnson, who was diagnosed with a very aggressive, Stage IV form of breast cancer. When Eleanor was given the diagnosis, she believed she would surely die. Eleanor was lucky to find an oncologist who saw her as a person with an illness and not just a case of breast cancer that needed to be treated. In Exhibit 1.3, Eleanor tells how her doctor entered into a collaborative partnership with her and how this partnership made all the difference in how she coped with the diagnosis. Eleanor’s doctor made a difference in how Eleanor faced the long journey that awaited her: Fear and anxiety were replaced with feelings of calm and being in control.

WHAT DO THESE FOUR APPROACHES HAVE IN COMMON?

SBC brings these four approaches together under one umbrella. At the heart of person-centered care, the empowerment movement, the culture of health promotion, and collaborative partnership is the belief and valuing of the person and their strengths (see Figure 1.1). These approaches aim to create a more humane health care system that puts people first and is responsive to their needs. Although these four approaches may differ in focus, they share many common elements:

- A shift from illness, problems, and disease to health, coping, and development
- A shift from a disease model to a process model of a person living with an illness or condition
- A shift in focus from the practitioner and organization to the person and his personhood
- A rebalance in the power between practitioners and persons
- Recognition that the person, not the practitioner, is ultimately responsible for his own health.
- Recognition that a person is a unique human being who has the right to be treated with respect and dignity.
- Recognition that within every person, family, and community reside actual and potential strengths.

WHAT IS STRENGTHS-BASED CARE?

SBC is an orientation to guide practice:

- SBC places patients at the center of their own care (person-centered care).
- SBC empowers persons to achieve their own goals and find new meaning in their lives (empowerment movement).
• SBC is a prerequisite for change, a requirement for self-care that encourages a person to take charge of and be responsible for her own health, recovery, and healing (health promotion and illness prevention, self-care).
• SBC requires a collaborative relationship between the person and health care provider (collaborative partnership).
• SBC works with biological, intra- and interpersonal, and social strengths (resources, assets) to help the individual deal with challenges, meet goals, and function as integrated, whole person.
• SBC is a commitment to the person’s development.

EXHIBIT 1.3

Personal experience  The story of Eleanor Johnson: The visible woman

Eleanor Johnson had never been sick a day in her 45 years. So when her arm accidentally brushed against a solid lump lying along the outer aspect of her left breast, during her exercises that evening, she was momentarily incredulous but also knew instinctively that she was in trouble. When the doctor removed the aspiration needle from the center of the huge lump the next morning, she did not need to be told the significance of the empty syringe. A swell of anxiety and fear overcame her normally collected composure. She was going to die. “You know what this means,” the doctor said, oblivious to the fact that she was struggling to concentrate on what he was saying, “You have cancer. You need a biopsy. You’ll need to be booked for surgery and then chemotherapy. Come back in a couple of weeks for the biopsy results.” And that was that.

Eleanor took control over her own health care by deciding the type of oncologist she wanted and seeking out one that would fit her way of doing things. When Eleanor received the biopsy report, she learned that the news was extremely grim, stage 4 of an extremely aggressive tumor that had a poor prognosis. She made the decision to find an oncologist with a team approach. “Yes, it is aggressive but there are things we can do. Remember that a prognosis is about the natural trajectory of the illness before the medical intervention. Statistics say nothing about how you personally will respond to treatment.” With that, the load of fear and anxiety started to lift. “Don’t forget,” the oncologist added, “there is a whole team behind you. We have an idea of what we want to do- but we also are consulting with colleagues at several leading cancer centers.” For the first time, Eleanor began to feel safe. But there was still something else she needed to understand. “But I don’t fit a protocol? Her anxiety soared again. “True, but we have something else- your cancer to help direct us to the best combination of treatments. We think the surgery should be delayed until we try to make the tumor smaller- and then we can monitor its response to the chemotherapy.” “Ok” she persisted. “But I have a hard time just doing nothing.” “Who says you have nothing to do? Your work is to eat healthy food, stay calm, and walk everyday. My job will be to take care of your treatment.” He could see she was hesitating, not
The SBC approach varies from discipline to discipline. For example, the positive psychology movement uses the word *positives* to refer to qualities that work best (i.e., strengths). Its focus includes the mental processes involved in happiness, well-being, quality of life, self-actualization, flow and personal growth, and it looks to those positives within the person so that the person can better enhance them (Snyder & Lopez, 2002).

The field of social work uses a strengths perspective to develop strengths and resilience to help persons, families, and communities overcome adversity (Saleebey, 1996; Saleebey, 2008; Walsh, 2006).

Counseling psychology professionals and early childhood special educators have as their overriding goal the facilitation of growth by focusing on individuals’ innate strengths and the promotion of social change (Smith, 2006). They often use strength-based interventions to support families in which children are at risk for psychopathology and delinquency. These programs target families who may be experiencing pervasive poverty, a history of family and community violence, inadequate health care, substance abuse, and the like (Powell, Batsche, Ferro, Fox, & Dunlap, 1997). Counseling psychology and early childhood education professionals focus on strengthening families to create health-promoting environments for its members, particularly young children.

Medicine uses a strengths perspective when subscribing to whole-person care. Physicians who practice whole-person care continue to diagnose and treat patients through a biomedical lens; however, their focus is on treating the whole person and that person’s medical condition in the context of her life. They consider the impact of the medical condition on the person and are sensitive to patients’ suffering and their personhood and how these relate to their health care (Hutchison, 2011; Mount, 1993).

For nursing, working with the person’s and family’s strengths allows patients to maximize and support their responses, in order to deal with everyday events and difficult life challenges (including illness, injury, disability and trauma) and to meet their goals (Allen, 1977; Feeley & Gottlieb, 2000). This approach has also been used in health promotion, to enhance wellness and well-being (Leddy, 2006). Strengths can be biological, intra- and interpersonal, and social. Biological strengths are related to the biochemical, genetic, hormonal, and physical qualities within each individual. Intrapersonal and interpersonal strengths reside in the person and define his personhood and are considered a part of a person’s inner resources. Social strengths, commonly known as resources or assets, reside in the person’s environment and are available to him.

Working with strengths enables a person to get the most out of living in order to cope, recover, heal, and discover new purpose and meaning in living. SBC is an
approach to care in which the nurse identifies and develops the person’s and family’s strengths. The nurse, in collaborative partnership with the patient and family, then works with their strengths to help them deal with their problems to achieve their health goals. As Nurse Andra Leimanis explained: “Working with strengths is the major part of what I do. You want to build on those strengths, to work through those problems areas, to work through that dark cloud. As a nurse, you need to ask yourself ‘What’s going to be the driving force? What’s going to support you (during these dark periods)?’ It’s fundamental to gain awareness of those positives and work with them because it is the person’s strengths that will help them to face their dark clouds.”

SBC does not ignore or negate problems; neither does it turn a blind eye to weaknesses or deficits. Instead, it uses strengths to balance or overcome them. SBC, at its core, is about looking for what is working and capitalizing and mobilizing those areas within the person, and in the person’s life, that are working. In SBC, the conversation shifts from “What is wrong?” to “What is right?” and “What has happened or is happening?” to “What is working?” This change in thinking places the problem within the context of what else is happening in a person’s life that may directly or indirectly affect how the patient and family are responding to and coping with their challenges.

Practitioners who subscribe to SBC begin with an appreciation of the complexity of the human being and the innate strengths of the human spirit. They have the knowledge, judgment, and skills to recognize, support, and develop the person’s strengths—which can be biological, psychological, and/or social in nature—to achieve better health outcomes.

Nurse Sophie Baillargeon summarized what SBC is: “Every person has some kind of strength within them. It is there for the nurse to find. It is how the nurse can help them work within their situation to deal with their concerns. Some issues are difficult. Some situations may not be going well, but it is how the person goes through the situation and the way they cope with it that is important. That’s the strength. As nurses, we are here to help them see that they can cope. We help them build on what they have and give them other ways to get through difficult situations.” Sophie continued: “…Strengths are the person’s tools to help them work around their more problematic issues. If you only work at problematic issues, you deplete the person’s energy. By bringing strengths, people come to believe in themselves. And then as a nurse you can help them figure out other ways to work through their more difficult issues.”

How Does Deficit-Based Care Compare to Strengths-Based Care?

The major features of SBC are summarized and compared with deficit-based care (DBC; Table 1.4) and are briefly described below.

The primary focus of DBC is to understand what is not working (deficits) and how to correct or “fix” it. In contrast, the primary focus of SBC is to understand what is working and to use what is working, what the person is capable of doing, as a means to minimize symptoms and find solutions to help the person develop—and, in the case of
### TABLE 1.4
Comparison of the deficit-based care and strengths-based care

<table>
<thead>
<tr>
<th>Distinguishing Features</th>
<th>Deficit-Based Care</th>
<th>Strengths-Based Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary aim</strong></td>
<td>A focus on problems, what is missing (deficits), not working, malfunctioning and dysfunctional.</td>
<td>A focus on what is working, what capabilities the person has while dealing with concerns and problems.</td>
</tr>
<tr>
<td><strong>Context</strong></td>
<td>Context-striped: Problem is viewed in isolation with little or no consideration of the person’s situation, past experience, or current circumstances.</td>
<td>Context is critical to understanding the person’s concerns and goals. All issues are “situated.”</td>
</tr>
<tr>
<td><strong>Relationship</strong></td>
<td>Traditional hierarchical relationship; “practitioner-knows-best” model. The person is expected to assume a passive role, as a recipient of care.</td>
<td>Collaborative partnership in which the nurse, the team, with the person and family jointly make decisions, create the plan, and work together to find solutions.</td>
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<tr>
<td><strong>Primary source of information</strong></td>
<td>Values objective data over subjective data. Focuses on the medical and health status. Nurses use multiple sources of information but rely heavily on technological equipment and machines for information, such as laboratory tests, biopsies, X-rays.</td>
<td>Values subjective information: what the person feels, thinks, and experiences. Focuses on the person’s health and life. The person and family are primary sources of information. Importance is placed on the person’s story, narratives, reflections, experiences as gained during clinical conversations.</td>
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### TABLE 1.4
Comparison of the deficit-based care and strengths-based care  
*(Continued)*

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<thead>
<tr>
<th>Distinguishing Features</th>
<th>Deficit-Based Care</th>
<th>Strengths-Based Care</th>
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<tbody>
<tr>
<td><strong>Basis for decision-making: Plan of care</strong></td>
<td>Differential diagnosis, diagnostic reasoning, and problem-based approaches to diagnosis are the tools for decision making. Plan of care is based on what needs “fixing.” Prescriptive: One size fits all. Nurses carry out doctors’ orders when plan is medical. In decisions governing nursing action, nurses diagnose the problem and use a standardized care plan to fix or correct the problem.</td>
<td>Knowledge is derived from formal education and practical experience and is created through experience and reflection. Knowledge is derived from a complex process of clinical reasoning and clinical judgment. Plan of care is built on the person’s strengths. Situation responsive; one size fits no one. The nurse works in partnership with the team and the patient/client/family to plan and manage care. The plan is customized to the uniqueness of the person and family and their situation.</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Measured in terms of how well the practitioner was able to “fix” the problem. A dead end. If the problem is not satisfactorily resolved, the nurse and team may feel they have run out of options.</td>
<td>Person and family determine outcomes: what is important to them including subjective well-being and their quality of life. Focus is on strengths, possibilities, empowerment, engagement, and energizing the person. Effects can motivate; energize; increase self-awareness; promote self-discovery; improve rallying, rebounding, and recovery; create hope; empower; and promote development through growth and transformation.</td>
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A patient, to recover and heal. For example, in treating pain, a nurse who uses DBC may give a medication without exploring other ways to treat the pain. On the other hand, a nurse who uses SBC may know her patient and has learned that this patient enjoys music. The nurse knows that the patient’s hearing is intact (a capability or strength) and may suggest that the patient listens to music as a way of distracting her when the pain is most acute and before the medication has had time to reach its peak effect.

Nurses who practice from a DBC perspective believe that the problem can be understood in its own right without placing the problem in context; that is, without reference
to or knowledge of the person’s situation, history, or circumstance. For example, a nurse may find that a patient is rude and withdrawn. She may interpret the patient’s behavior as negative and label the patient as antisocial, disturbed, or difficult. In contrast, SBC nurses believe that the patient’s behavior can best be understood by knowing that person, her situation, and the circumstances affecting her. The nurse looks for patterns of response. Is this patient’s behavior unusual? In taking the time to talk with the patient, the nurse comes to learn that the patient has recently lost her grandson in an automobile accident and that today is the 6-month anniversary of his untimely death.

These two approaches also differ in the language they use. In DBC, clinicians often use a lot of “D” words as part of their vocabulary, such as disaster, deficit, detrimental, dysfunction, and so on. It is language that is associated with criticism and blame. This language sets a tone for confrontation that often leads to fear and despair (another D word!). For example, when a patient does not improve, the patient may be “blamed” for not following the medical regimen or for not taking the medication as prescribed. On the other hand, SBC language is more positive in tone and uses language that communicates hope. The nurse looks to encourage and reinforce what the person does well, what is working. He seeks to understand the patient’s capabilities and capacities. SBC language uses words that communicate growth, energy, transformation, possibilities, and opportunities.

In DBC, the practitioner tends to view the person as a “case” or “disease,” not as a person who has experience, knowledge, and capabilities and who is competent to make decisions. DBC practitioners believe they have to do for the person rather than with the person. In SBC, the relationship is collaborative. The person and nurse respect each other’s expertise and trust each other’s judgment. Nurses see themselves both as learners as well as educators. They knows that patients are their best teachers and that they have much to learn from them. They also see themselves as educators and teachers, guiding patients in making decisions in matters of health and health care.

DBC and SBC both rely on multiple sources of information, including the results of objective testing (e.g., laboratory reports, X-rays), visual images, empirical research, and the like to understand the problem. In addition to objective, technical information, SBC nurses place high value on the person’s subjective understanding of how they view themselves and what is happening to them by talking, listening, and piecing together their narratives.

In DBC, creating the person’s treatment plan and making decisions is primarily the responsibility of the practitioner, whereas in SBC the nurse and person, where appropriate, devise a customized plan that capitalizes on the person’s strengths and capabilities. Together, they fashion a plan that is responsive to the person’s situation because such a situation-responsive plan is believed to have the best chance to succeed. When patients have a say, they devise plans that take into account their realities and that which they realistically can follow. In contrast, DBC practitioners give patients plans that are prescriptive. In other words, every patient with that condition is prescribed the same, one-size-fits-all treatment that in reality

When nurses capitalize on the person’s strengths, they are creating conditions that support and encourage the person’s innate health and natural healing processes.
fits no one. It does not take into account the possibility that the person’ has a unique way of responding physiologically, psychologically, and behaviorally.

The effects of focusing on deficits can be demoralizing and lead to a sense of frustration for both the nurse and the person. This sense of frustration results when clinicians play on patients’ fears, intentionally or unintentionally, to convince them to comply with what they believe to be is in the patients’ best interest. Often one hears a well-intentioned nurse warn patients of the dangers of their actions, thereby playing to their fears: “If you don’t lose weight, you will have a heart attack.” They can often reach a dead end when all options to resolve a situation have been exhausted. In contrast, working with strengths may require more effort, yet it also opens up more possibilities. Together, the nurse and the person can explore different treatment options. Looking for different solutions often generates hope, and hope is in and of itself often empowering.

Nurse Danielle Beaucage clearly identified the effects of SBC on both the nurse and patient: “[SBC] works because if somebody focuses on your strengths you tend to trust that person more. There are strengths in every individual. It makes nursing more relevant and more fun. Working with a person’s strength helps to establish a collaborative partnership. It also helps the patient and nurse to have more realistic goals because you’re building on something together. Even to acknowledge strengths is in and of itself an extremely valuable nursing intervention.”

Danielle describes caring for a patient with whom other nurses had difficulty dealing: “Once I reframed his stubbornness as a strength, as a positive side of his personality, I saw him differently. I often thought, ‘If he did not have this personality he would be dead.’ It really helped me to take care of him.”

Now reread the story told earlier in this chapter by Nurse Gillian Taylor, who cared for Sarah and her family. Reflect on the features of SBC and then connect them to Gillian’s care of Sarah and her family. Take a few minutes to complete the exercise in Table 1.5.

THE EVIDENCE THAT STRENGTHS-BASED CARE BENEFITS PERSONS AND FAMILIES

Focusing on strengths has been found to be effective with different populations (e.g., adolescents, parents, elderly individuals), in dealing with a wide range of problems and conditions (e.g., acute and chronic illness, mental health, health promotion), and in different settings (hospital, ICU, community, workplace; for relevant review articles and book chapters, see Hodges & Clifton, 2004; Powell et al., 1997; Snyder & Lopez, 2002). Studies have found that persons cared for by practitioners who focus on positives and strengths have shown improvements in their health and quality of life (Bluvol & Ford-Gilboe, 2004), better subjective well-being (King, 2008), improved resiliency (Walsh, 2006), greater personal growth, more positive relationships (Fredrickson, 2008), and increased control and self-efficacy (a can-do attitude; Maddux, 2002b). Moreover, health care professionals who subscribe to a strengths-based philosophy have developed therapies that cultivate specific strengths, such as hope (Worthington et al., 1997), optimism (Carver & Scheier, 2002; Seligman, 2006), subjective well-being (King, 2008), positive emotions (Fredrickson, 2008), better mental health outcomes (Klausner, Snyder, & Cheavens, 2000), and improved couple relationships (Worthington et al., 1997). Consider the strength of hope. Klausner et al. (2000) found that a hope-focused group intervention conducted with depressed elderly individuals
### TABLE 1.5
Reflect and connect: Strengths-Based Care in practice

<table>
<thead>
<tr>
<th>Distinguishing Features</th>
<th>Strengths-Based Care</th>
<th>Nurse Gillian Taylor and Sarah and Her Family</th>
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<tbody>
<tr>
<td>Primary aim of care</td>
<td>Focuses on what is working, what is best, while dealing with concerns, problems, illness, and disability. Focus is on how the person copes or deals with adversity and rallies from insults. Avoids labels and categories and focuses on the person and her personhood. Uses strengths to build confidence to deal with concerns. Looks for solutions instead of dwelling on problems. Supports and facilitates coping, healing, and development.</td>
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</tr>
<tr>
<td>Context</td>
<td>Context is critical to understanding the person’s concerns and goals. Health and illness are understood in light of the person’s situation, past and current experiences, culture, relationships, and the social/economic/political environment.</td>
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</tr>
<tr>
<td>Language</td>
<td>Language is positive, associated with words such as strength, energy, challenges, opportunities, possibilities. Language of hope.</td>
<td></td>
</tr>
<tr>
<td>Relationship</td>
<td>Collaborative partnership in which practitioner and person jointly make decisions, create the plan, and work together to achieve the person’s health goals.</td>
<td></td>
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<tr>
<td>Primary source of</td>
<td>The nurse’s primary source of information is the person and family. Values subjective information: what the person feels, thinks, and experiences. Importance is placed on the person’s story, narratives, reflections, and experiences as gained during clinical conversations. Values multiple sources of information, including objective data from laboratory tests, biopsies, and X-rays. Values, appreciates, and requires different ways of knowing, including empirical data, personal experience, moral/ethical comportment, and aesthetics to understand the whole person. Knowledge is derived from formal education and practical experience and created through experience and reflection.</td>
<td>information</td>
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(continued)
TABLE 1.5
Reflect and connect: Strengths-Based Care in practice  (Continued)

<table>
<thead>
<tr>
<th>Distinguishing Features</th>
<th>Strengths-Based Care</th>
<th>Nurse Gillian Taylor and Sarah and Her Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basis for decision making: Plan of care</td>
<td>Knowledge is derived from a complex process of clinical reasoning and clinical judgment. Plan of care is built on the person’s strengths. Situation responsive; one size fits no one. The nurse works in partnership with the team and the patient to plan and manage care. The plan is customized to the uniqueness of the person and his situation.</td>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
<td>Focuses on strengths and possibilities that empower, engage, energize, motivate, energize, increase self-awareness, promote self-discovery, improve rallying and recovery, create hope, and promote development through the person’s growth and transformation.</td>
<td></td>
</tr>
</tbody>
</table>

Reflect and Connect Instructions:
1. Reread Gillian Taylor’s nursing of Sarah and her family.
2. Reflect on the features of SBC and then connect them to Gillian’s care of Sarah and her family.
3. Identify the behaviors that illustrate these features.

- reduced mild depression and anxiety and promoted adjustment. When used with couples, hope-focused therapy enhanced the couples’ relationships by improving relationship satisfaction and quality-of-couple skills (Worthington et al., 1997). Moreover, when practitioners direct therapy to cultivating positive emotions, the effects of this therapy not only counteract negative emotions but also build on personal resources that enable people to cope with and optimize their own feelings of health and well-being (Fredrickson, 2000).

One of the only nursing intervention studies to use a strengths-approach was a randomized controlled trial that examined whether children with chronic physical disorders had better psychosocial adjustments if they and their family received care by nurses whose nursing was guided by the McGill Model of Nursing (Pless, Feeley, Gottlieb, Rowat, Dougherty, & Williard, 1994). (The McGill Model of Nursing focuses on understanding the person, family issues, and working with strengths within a collaborative partnership; Gottlieb & Rowat, 1987.) The results of this study are summarized in Exhibit 1.4.

As part of the study described in Exhibit 1.4, some of the parents were randomly selected from families who had received the specialized care (i.e., SBC) for an in-depth interview about their experiences (Ezer, Bray, & Gros, 1997). Parents assigned to the intervention group were asked to describe what they thought about the nursing they had received. Parents reported positive child- and family-related changes following the intervention. Almost 89% of families reported that their children took more responsibility
Chapter 1: Why a Strengths-Based Approach to Care?

Empirical study  The effects of specialized nursing (strengths based/collaborative partnership) on children with chronic physical disorders

The Problem
Could specialized nursing care (strengths-based care) help prevent or reduce psychosocial problems among children with chronic physical disorders?

The Issues
Children with chronic physical disorders often suffer from psychosocial problems. Does specialized nursing care help prevent or reduce psychosocial problems?

The Study
Pless et al. (1994) investigated whether a strengths-based form of nursing care could help prevent or reduce psychosocial problems among children, aged four to sixteen years, with chronic physical disorders. A randomized clinical trial was conducted in which 332 children and their families were randomly assigned either to receive this specialized nursing for a one-year period or to remain in the control condition. Three measures of psychosocial functioning administered before and after the intervention were the basis for assessing its efficacy.

The Findings
Statistically significant positive differences were found in those families who received the nursing intervention: The children were reported by their parents to be less anxious and/or depressed after the intervention, and their scholastic competence and behavior improved, as did their global self-worth.

The Bottom Line
Specialized nursing intervention (Strengths-Based Care) can help children with chronic disorders deal with their medical conditions by preventing or reducing any psychosocial problems they may have.

Source: Adapted from Pless et al. (1994).

for their health. Moreover, parents noted improvements in almost all aspects of their child’s life, as reflected in the following themes from the interviews: “doing better at school,” “having greater self-confidence,” and “spending more time as a family.” Parents also reported that they liked the approach that nurses took with them. They felt that the nurses treated them as unique individuals and gave them “time to discuss all kinds of things,” which made them feel that they were “more than just a number.” Families explained that when nurses focused on strengths, it helped them to see themselves in a new light and proved to be an important first step in considering what to change. For many of these parents, who were not used to hearing what they were doing right, they said that it was good to “[hear] that we were doing something right.”

Consistent with these findings, in another study that evaluated the effects of a family systems nursing intervention that included commendations (i.e., nurses noting what
families were doing well) for families found that families reported that focusing on strengths was very therapeutic (Robinson & Wright, 1995). In a more recent, small qualitative study of adolescents who were at risk for suicide, patients were asked what nursing interventions they found to be most helpful (Gros, Jarvis, Mulvogue, & Renaud, 2011). Of the many things that these adolescents reported about the nursing they had received, what they found most helpful was when the nurse focused on their strengths. These adolescents commented or advised the following: “Focus on the positive,” “Notice the parents care . . . that will help so much, cuz . . . if you’re going to therapy, you’re saying your problems. It’s negative, negative, negative.” Another patient linked nursing action to patient outcome and in so doing sent a powerful message: “Pointing out the things you’re good at makes you want to live. It really does. It makes you think that you’re not completely worthless.”

Our consultants and front-line nurses provided further validation of the effectiveness of SBC from the feedback they have received from their patients and clients. Many felt that focusing on the person and family strengths played an important role in helping patients find new directions and helping them take greater responsibility for their own health. Some of their patients credited their nurses with helping to improve their self-confidence and to feel more empowered.

The following insights are a selection of statements from some of the expert consultants’ interviews of why they value and have adopted SBC as their nursing orientation and approach.

Nurse Lidia De Simone explained her rationale for using a strengths approach: “It is important not to lose sight of a person’s strengths because if you lose sight of their strengths, their unique qualities, the person’s confidence goes down and they won’t have the energy to deal with whatever it is that they are dealing with.”

Nurse John Kayser told of the feedback he has received from the patients he works with on addiction issues: “My patients tell me: ‘You believed in me when I didn’t believe in myself and your belief in me raised doubts in my own mind that if you think I can, well maybe I can,’ and that moves them forward.”

Nurse Catherine Gros summarized why this is an important approach for the person: “Not listening, not tuning in to that person can be very damaging. I have never had a case in which understanding and working with someone’s strengths has had a bad outcome. Even when the person is dying and may not survive, there is a good outcome in terms of the relationship I am able to develop with them.”

The Benefits of Strengths-Based Care for Nurses

Clinicians who choose to practice from a strengths perspective reveal something about themselves, their values, and what they feel committed to and passionate about, what they oppose and what they are willing to advocate for. As Charles Taylor (1991), the renowned philosopher observed that we become what we are by virtue of how we decide to look at others as well as ourselves. Nurse Sharyn Andrews, one of our consultants, affirmed Taylor’s observation. She reported that nurses who practice from SBC have told her, “I feel good about myself when I work with families in this way.” In working with strengths, nurses reveal and find expression of their own humanity.

Nurses who see the person rather than the disease or condition learn about the human spirit. They come to appreciate that people find courage even when tragedy
Chapter 1: Why a Strengths-Based Approach to Care?

It is working with people during periods of vulnerability that nurses find themselves admiring and being inspired by their patients. This type of respect at times borders on awe. It brings nurses great satisfaction and fosters a special connection between them and their patients. Nurses have used phrases such as “amazing people” and “I feel honored and privileged to care for them” to describe their patients.

Nurse Charlotte Evans cared for Diane, a woman suffering from the debilitating neuromuscular condition, amyotrophic lateral sclerosis, during the final weeks of an eight-year battle. Charlotte summarized her feelings of admiration for Diane, who handled herself with great dignity, continued to protect her husband despite her own rapid deterioration, and remained involved in all the decisions concerning her care up until death. Nurse Evans: “I know this sounds cheesy, but she was very strong. She was an amazing woman, really an amazing woman. I think I was so privileged to have known her and cared for her.”

Nurse Margaret Eades believes that SBC is the key that fosters the nurse–patient relationship and facilitates the health work that they do together: “Using a strengths approach helps me get right to the heart of where I can begin to work because whatever I do is of no consequence unless the person is interested in what I have to offer. And I have to find that kernel (key) to build the relationship. Focusing on the person’s strengths is that kernel.”

Nurse Caroline Marchionni summed up what focusing on strengths “buys” her that a deficit approach just doesn’t: “I use strengths because what else are you going to focus on, the negative? ‘You didn’t get out of bed today?’ or ‘We don’t have your pain under control.’ Then why bother? . . . Positivity breeds positivity in the same way that negativity breeds negativity. When you’re around somebody who’s in a bad mood, then you often find yourself in a bad mood. Positivity is contagious, too.”

Nurse Lidia De Simone described how SBC has added value to the way she nurses: “I learned that focusing on people’s strengths was really going to help them use what tools they have. I remember saying ‘I can do more with this interaction, but I didn’t know what to do or how to do it.’ Working with strengths was the key. I could continue the conversation with people. I didn’t focus on deficits and I didn’t say to them everything that was wrong or what they couldn’t do. Working with their strengths either gave them some ‘gas’ because they felt good about themselves and they would say to me, ‘Oh yeah, you know, that’s true; maybe I could do that if I approached it in this way.’”

Nurses are in a privileged position because they often are privy to the inner world of the person who is suffering. If they are able to connect with their patients and create a relationship of trust, patients will share their most intimate thoughts and feelings of vulnerability as well as their dreams and goals for the future.

Health care practitioners have generally measured the effectiveness of their work in terms of morbidity and mortality outcomes. There is some recognition that these outcomes do not capture the things that are important to patients. If the aim of patient-centered care is the patient’s health, helping the person recover and heal, and to find new meaning and purpose in living, then different outcomes must be considered in addition to morbidity and mortality. There is a need to shift from solely measuring health status via the body to those outcomes that concern the patient’s quality of life and whatever is important to them (Sullivan, 2003). As Sullivan (2003) astutely observed,

Each step in this direction (towards measuring outcomes in terms of health or patient’s life rather than in terms of outcomes of the body) brings medicine
Part I: Theoretical Foundations of Strengths-Based Nursing Care

(medicine being used here in its generic sense to encompass all health care practices) closer to pursuing “what really matters to patients” and also brings greater scientific, ethical, and social complexity. Subjective health is more meaningful to patients than objective health measures such as coronary artery stenosis or joint space narrowing. But it introduces many complex factors into the core of medicine beyond tissue diagnosis or organ impairment. Now medicine must concern itself with the perceiver of ill health as well as the ill body. (p. 1602)

SBC is an approach to care that enables nurses to broaden their scope of practice and sphere of influence by improving the lives of the person and family with whom they are called to care for, regardless of whether it is during normative life transitions or during unexpected, unplanned and often unwelcomed and undesirable life events.

Key Summary Points

• SBC is an approach to care that focuses on and works with a person’s and family’s strengths to promote health, recovery, and healing.
• The medical model is a systematic approach to diagnosis and treatment of disease that, when used to reduce the person to a diseased body part rather than to understand the person as a whole, has contributed to DBC.
• Although the growth of technology has improved medical diagnoses and treatment, it has also contributed to a distancing between the nurse and the patient.
• Patient/person-centered care, the empowerment movement, health promotion/self-care, and collaborative partnership have been proposed to address the shortcomings of the current health care system. The underlying foundation of these four movements is a focus on a person and family’s strengths.
• SBC restores the person to the center of care and helps empower patients to take greater control over their lives and their health care decisions.
• SBC places illness care in the context of knowing and appreciating the whole person situated within their own context and lifeworlds.
• SBC works with what is working and what is functioning best. Strengths can be biological, intra- and interpersonal, and social (resources and assets) that enable people to deal with challenges and function as integrated whole human beings.
• SBC differs from DBC in terms of its purpose, consideration of context, use of language, nature of the nurse–patient relationship, source of information, how decisions are made, and types of outcomes considered important.
• Nurses and health care practitioners who practice SBC look to discover potentials, possibilities, and opportunities to help people manage their illness and deal with life events.
• SBC is a rewarding approach for both the person who seeks help and for the nurse who gives care.
• SBC helps to define nurses’ professional identity by how they care for others, how they see themselves, and how others see them.