Strengths-Based Case Management: Individuals' Perspectives on Strengths and the Case Manager Relationship

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Strengths-based practice in social work has a strong theoretical foundation as an effective helping strategy that builds on a person's successes. Although there is growing empirical evidence informing outcomes associated with strengths-based approaches, missing from the literature is an understanding of how individuals who receive these services view their experiences. Qualitative data collection methods were used to gather individuals' experiences of participating in strengths-based case management implemented in a substance abuse aftercare program. The research questions that guided the study were "What are individuals' perceptions of strengths-based case management?" and "How do those perceptions compare and contrast to the key principles of strengths-based case management?" The emerging themes centered on individuals' responses to a focus on strengths (acceptance of strengths; holding on to strengths and deficits simultaneously; and initial mistrust of the approach) and to the relationship with the case manager (acceptance of the relationship; guilt when success is not achieved; and not needing the relationship). Implications for social work practice are discussed.

Key words: *case management; qualitative research; strengths perspective; substance abuse*

The continually evolving strengths perspective of social work has provided practitioners with an alternative to practice models that stress pathology and sickness. The theoretical foundation of the perspective has been invigorated by work in areas such as developmental resilience, healing and wellness, and constructionist narrative (Saleebey, 1996). Furthermore, a sizable body of literature has detailed the practical considerations involved in implementing the intervention (Cowger, 1994; DeJong & Miller, 1995; Kisthardt, 1993). Recently, empirical analyses have begun to suggest that the value of strengths-based case

management may lie in encouraging clients to stay involved in treatment programs and thereby avail themselves of the services available there (Rapp, Siegal, Li, & Saha, 1998; Siegal, Rapp, Li, Saha, & Kirk, 1997). Although each of these areas is important in evaluating and shaping strengths-based practice, surprisingly little attention has been paid to what individuals who receive these services say about strengths-based practice.

Social workers and other strengths-based practitioners have been cautioned: "One of the characteristics of being oppressed is having one's stories buried under the forces of ignorance and stereotype" (Saleebey, 1996, p. 301). In response, strengths-based practitioners have been trained to uncover individuals' stories. These stories reveal assets and strengths that aid in facing life challenges such as mental illness and older age, challenges that put them at a disadvantage relative to the larger society (Holmes & Saleebey, 1993; Pardeck & Murphy, 1993). These stories should include individuals' perceptions of a strengths-based intervention whose raison d'être is a commitment to helping individuals achieve a sense of personal power and efficacy. Proponents of the strengths perspective risk being one of the oppressors themselves if they do not systematically and consistently seek the opinions of individuals receiving strengths-based services. In not doing so they hold themselves liable to the charge that the strengths perspective is not open to critical analysis by the very individuals who receive services, a charge frequently made about disease- and pathology-oriented models of treatment (Mishler, 1981; Segall, 1976).

The study reported in this article presents themes that emerged from interviews with 10 individuals participating in strengths-based case management. Two research questions guided the inquiry, the first, "What are the perceptions of individuals participating in strengths-based case management about the intervention?" A companion question sought to establish, "How do individuals' perceptions compare and contrast to the basic principles of strengths-based case management that guide the intervention?" Qualitative methods for gathering these perceptions were selected as the most appropriate set of methods for collecting data, given the desire to obtain individuals' stories in their own words. The implications of the themes that resulted from these interviews are discussed as they apply to social work practice.

Strengths-Based Practice—Concept and Practice

The strengths perspective is based on the belief that individuals possess abilities and inner resources that allow them to cope effectively with the challenges of living (Rothman, 1994; Weick, 1983; Weick & Pope, 1988). Even individuals normally seen as hopeless, intractable, and resistant to accepting assistance are assumed able to make significant strides in facing difficult challenges when assisted in rediscovering their abilities. Furthermore, these individuals are allowed to retain control of their lives to activate personal strengths. The strengths perspective holds that when a helping agent focuses on pathology and deficits they cripple the individual's ability to transcend life challenges (Holmes & Saleebey, 1993). Strengths-based case management is a specific implementation of the overall strengths perspective, combining a focus on client strengths and self-direction with three other principles: (1) promoting the use of informal helping networks, (2) offering assertive community involvement by case managers, and (3) emphasizing the relationship between client and case manager. Each principle supports the resource acquisition activities that characterize case management (Rapp & Chamberlain, 1985; Siegal et al., 1997).

Beginning in the early 1980s, strengths perspective case management was implemented in community mental health centers and eventually

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in a statewide system of psychiatric institutions, beginning a systematic new approach to working with clients (Rapp & Chamberlain, 1985). In those settings the intervention was designed to help people identify their strengths and abilities as the starting point for functioning successfully in the community. Since that time the strengths perspective has been implemented in other practice settings, including long-term care facilities for older adults, public social services agencies, and residential substance-abuse treatment programs (Bricker-Jenkins, 1997; Fast & Chapin, 1996; Siegal et al., 1995). The usual starting point for strengths-based case management practice is an assessment designed to prompt the individual and worker alike to identify capabilities and assets the individual can mobilize to respond to the challenges of living they are facing (Cowger, 1994; DeJong & Miller, 1995; Rapp, 1998). Goal identification and development of a treatment plan, led by the individuals' perceptions of what they need, serve as the blueprint for the work that follows. The specific activities used to accomplish these activities are flexible, tailored to meet the needs and strengths of individuals (Kisthardt, Gowdy, & Rapp, 1992; Rapp, 1997).

Despite the apparent compatibility of strengths perspective principles with social work's code of ethics and the similarity between strengths-based practice efforts and the social work commitment to person-in-environment, there are concerns about the strengths perspective. These concerns are rooted in both the overall assumptions of the perspective and its implementation in various contexts. The perspective has been accused of being merely a mantra to encourage positive thinking, a thinly disguised attempt to reframe misery and as extremely naive or "pollyannaish" (Saleebey, 1996). Perhaps most seriously, the perspective has been criticized as ignoring objective reality. The seriousness of individuals' presenting problems and the absence of sufficient community resources available to address the problems are cited as evidence of this latter criticism.

Method of Inquiry and the Strengths Perspective

Several studies based on quantitative methodology have suggested beneficial outcomes related to strengths-based case management among people with substance-abuse problems. Data from a cluster analysis conducted with 632 substance abusers suggested that providing strengths-based case management was associated with retention in aftercare treatment for more than one-third of the group (Siegal et al., 1997). Furthermore, a relationship among case management, improved retention, and lessened drug use severity among people with substance-abuse problems was found among the same group (Rapp et al., 1998). Other outcomes, such as improved employment functioning, also have been associated with strengths-based case management (Siegal et al., 1996).

Although the foregoing findings suggest a place for strengths-based case management in working with substance abusers, their reactions to the intervention are left unexplored. Concern about the perceptions of individuals receiving the service is more than altruistic or a prerequisite for ensuring compliance with social work's code of ethics. Gathering empirical data on the reactions of individuals to the intervention assists in tailoring the intervention to address client needs more effectively and thereby improving outcomes. This is especially likely to be the case with interventions, such as the strengths perspective, that promote an empowerment agenda. The neglect of qualitative methodologies that engage clients has been suggested as

> one of the reasons for the dominance of person-blaming interventions [because] . . . the people we seek to help have not been judged to be important informants or collaborators in the execution of the research. Entire areas of psychiatric rehabilitation exist in which little or no research has been undertaken querying consumers about their experiences, perspectives, and recommendations. (Rapp, Kisthardt, Gowdy, & Hanson, 1994, p. 384)

Support can be found for the contention that there has been little inquiry into the views of consumers. In a study analyzing the reasons why qualitative research was used, the most common reason cited in 54 studies of social services interventions was that researchers wanted

to understand the lived experiences of individuals receiving those services (Brun, 1997). In many instances the existent literature pertaining to a particular social services intervention was supported with little or no data collected directly from the individual's perspective, often to the detriment of the people intended to benefit from the intervention.

In an exception to the reliance on quantitative methods to explain strengths-based interventions, 19 consumers of mental health services participated in ethnographic interviews that informed research into the process of strengths-based case management (Kisthardt, 1993). Consumers said that several areas of the strengths process were valuable, including the strengths assessment itself, the assistance with goal planning, and the overall importance of the relationship between themselves and their case managers. Three primary conclusions were drawn from the interviews. First, consumers of mental health services placed a high value on the relationship they had with their case managers. Second, these individuals generally were willing to participate in case management services when those services were concrete and clearly grounded in their own interests. Third, advocacy to influence potentially valuable resources was seen as an especially important aspect of case management.

Method

Setting

The individuals participating in these interviews were part of a research project funded by the National Institute on Drug Abuse and implemented by Wright State University School of Medicine and the Veterans Affairs Medical Center (DVAMC), Dayton, OH. The Case Management Enhancements Project (CME) has the goal of examining the effect of community-based aftercare and strengths-based case management on retention and outcomes related to treatment (Siegal et al., 1995). Veterans completing primary treatment were assigned to one of two groups: (1) standard aftercare services on medical center grounds or (2) enhanced aftercare services at a community site with strengths-based case management.

Sample

The strengths assessment conducted in the CME is a specific activity that covers functioning in the following nine life domains: life skills, finance, leisure, relationships, living arrangements, occupation and education, health, internal resources, and recovery. Within each life domain, case managers asked individuals to recount specific instances when they successfully demonstrated skills and abilities relative to that area. The case managers probed for success on the basis of a list of at least 15 specific situations within each life domain. After the strengths assessment, and continuing throughout their relationship, case managers engaged individuals in a structured goal-setting process, which was developed into a case management plan (Rapp, 1997). Goal setting entailed individuals articulating their own goals and, with the assistance of the case manager, setting measurable, specific objectives and strategies. All objectives and strategies included target and review dates, which served as a device for prompting individuals to action and as a point of discussion for the individual and the case manager as they reviewed the case management plan (Siegal et al., 1995).

The individuals enrolled in this study were veterans who participated in the case management component of the CME during a two-month period. All 10 individuals were men, ranging from ages 25 to 53. Six men were white, and four were African American. All but two had been in substance abuse treatment previously. Project case managers were women, one white and one African American.

Seven of the 10 individuals were still involved with the CME case managers three months after discharge from the residential treatment program. Of the remaining three, two could not be located because they had moved out of the local community, and one had entered another residential substance abuse program. Six months after discharge one additional individual could not be located.

The status of the six men still involved with CME six months after discharge varied greatly. Two were living alone, three were living with family members, and one was living with his girlfriend. Three found employment, two received

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support from family members, and one had been living in semi-independent housing on the DVAMC grounds.

Each individual discussed social support goals as well. One consciously moved to a neighborhood away from his past "drinking buddies"; one withdrew his contact with CME when his mother died of cancer, and another individual's wife also was receiving substance-abuse recovery services. A fourth individual was concerned about moving in with his brother, who was a substance user. The fifth individual had conflicts with his girlfriend during his relapse, and the sixth had conflicts with his siblings, who were also his business partners.

Three men remained alcohol and substance free for the six-month period. Three admitted drinking alcohol: one relapsing around two months but not drinking at six months; a second did not relapse until four months after treatment, at which time he admitted himself to a residential treatment program; and the third drank occasionally but felt the drinking was not a concern.

Procedure

The current study used a qualitative method to analyze strengths-based case management from the standpoint of the individuals receiving services. Chronicling the perceptions of individuals with substance-abuse problems allowed researchers to assess whether strengths-based case management was implemented in a manner consistent with the five principles described earlier. This information is important both in informing theoretical discussions about strengths-based practice and in practical considerations of how substance abusers perceive the intervention.

The qualitative methods used in this study followed practices designed to guide the researchers in understanding the individual's construction of strengths-based case management (Guba & Lincoln, 1989; Lincoln & Guba, 1985; Rodwell, 1987; Rodwell & Woody, 1994). The evaluator entered the environments that surrounded the client–case manager interactions. The individuals' constructs or perceptions of the "work" being done were gathered through open-ended interviews and observa-

tions. Individualized lived experiences provided contexts for understanding how the same strengths-based approach was received and carried out with different people. In collecting individuals' stories through qualitative methods, the primary question changed from "Do individuals fit the assumptions of strengths-based case management?" to "Do the assumptions of strengths-based case management fit the individual's experiences of the intervention?" Client stories were taken as the truth with which other truths—the theories held by researchers and clinical staff, prior literature on the strengths perspective—were compared.

A researcher (the first author) trained in qualitative data collection conducted the interviews. This individual was familiar with the principles of strengths-based social work but had no contact with the case managers, respondents, or the actual clinical setting prior to this study. To collect data representative of the entire length of the strengths-based intervention, it was decided that individuals would be interviewed at three points during the course of treatment. The first interview took place between the second and fourth week of residential treatment. Each individual read an informed consent in which they were advised that their participation was voluntary and confidential, that participation or refusal to participate would not affect their treatment, and that they would be paid $30 for their time spent in the interview. The open-ended, audiotaped interview was conducted with individuals in a private office at the substance abuse program and generally lasted one hour. The interview guide developed for this and other sessions was designed to ensure that the same content was covered with all individuals, while allowing the individual to direct the course of the interview (Patton, 1990). General questions about the client's perception of the first meeting with the case manager included What was it like to meet the CME case manager? What was the purpose of the meeting with her? How would you describe your meeting from beginning to end? How are the meetings with the CME case manager different from other workers you have had?

All individuals were sought for a second interview one to three months after discharge

from treatment. Seven of the original 10 individuals were located and interviewed at the CME offices. The interview followed the original interview guide with one addition, "Has case management helped you to stop using substances?" Six of the seven individuals remaining in the study were located for a third interview at six to nine months after discharge from treatment. Four interviews were in the individuals' homes, and two were at the CME offices. The transcript of the first two interviews, along with a two-page summary of those interviews, was mailed to individuals before the third interview. This "member checking" is one method of obtaining credibility of qualitative data (Lincoln & Guba, 1985). The interview guide from the first two interviews was repeated, and individuals were asked to give feedback from the written summaries of the first two interviews.

Data Analysis

Professional transcribers transcribed all interviews verbatim. A research assistant reviewed each tape at four intervals to assess the accuracy and completeness of the transcriptions. Although the transcriptions were an accurate account of the tapes, there were omissions in some interviews resulting from the soft voices of some individuals. The researcher's handwritten notes from each interview confirmed that the most important content was retained in the transcriptions.

Several steps were followed in analyzing the emerging themes grounded from the interview data (Strauss & Corbin, 1990). The researcher hand coded all first interview hard-copy transcriptions by identifying content that stood alone, without further explanation to an outside observer (Rodwell, 1995). The units were identified in the margin with a one- to five-word label. Units that covered the same content were given a category title. An example from one transcription is the category "goals give me choices," which contained the units labeled "she puts it on the table and it's up to me" and "I felt guilty."

A summary of category and unit names from each coded transcript was compiled. The researcher developed a diagram of similar and diverging themes (Huberman & Miles, 1994)

that emerged from the collective review of all coding summaries. Emergent themes were discussed with the coauthor of this study who had access to all transcripts. The researcher further discussed interpretation of the themes with the individuals during the third interview.

Results

Two major themes were derived from individuals' stories, and each one contains three subthemes typified here by quotes from individuals. The first theme, individuals' responses to the strengths-based focus, can be found in "I can make it," "AA puts me on the right level and case management is like a guide," and "I need the truth." The second theme resonates with individuals' responses to the professional relationship as reflected in "I didn't know nobody would care that much," "I let them down," and "I felt I didn't need her."

Theme One: Individuals' Responses to the Strengths-Based Focus

Three subthemes compose this theme. "I can make it" describes the individual's acceptance of the focus on strengths; "AA puts me on the right level and case management is like a guide" describes the individual's ability to hold onto a focus on strengths and deficits simultaneously; and "I need the truth" is one person's initial mistrust of the strengths perspective.

I Can Make It. During the first interviews individuals described a positive, hopeful attitude about their plans for recovery and shared much detail about their substance use. Individuals were still in residential treatment and within the preceding seven days had participated in a strengths assessment, their initiation into the strengths approach. Some individuals indicated that the case manager was the first person to have asked them about a time when they were successful in each of the life domains. Individuals were able to recount tangible, specific instances in which they had been successful or competent, including relationships with girlfriends, spouses, parents, other family members, military colleagues, and coworkers; work; leisure, "things I do for fun, like fishing or bowling"; financial affairs; and their spiritual beliefs.

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Individuals described reactions to being asked to remember a time in their life when they were doing well. Individual comments included "I can be creative"; "I'm more confident"; "I can weigh the positives and negatives"; "It gives me my choices back"; "I can be a winner"; "An addict needs to hear he's doing good"; "I haven't been asked about strengths in a long time"; and "It [the strengths assessment] showed what I accomplished."

For example, James's experience captured the optimism that all of the men described after the strengths assessment, "All I know is that I'm more happy and more at ease with myself now than I was before I came to the program. I do feel I can make it. My self-esteem was built up."

AA Puts Me on the Right Level, and Case Management Is Like a Guide. During the first interview individuals described details of using alcohol, crack, or other substances and the specific incidents that led to their current and past relapses.

Talking about the "negatives" was part of the assessment process in the core (non–case management) components of treatment. Individuals attended daily 12-step groups where, as one said, "I start off saying, 'my name is Ben and my life is unmanageable.'" How then did individuals respond to being in treatment that centered on overcoming addiction while being introduced to case management that focused on a time when they did not use substances? The common response was that there was a need and place for both approaches. Grant described AA as "putting me on the right level" and the "case manager is like a guide." The case manager "won't get down on me" and "is not there to kick my butt."

Lane summed this up best with "You have to bring out the negatives in order to start healing. But there's a time to stop all that negative stuff, too. You know treatment is to get you to put it on the table. . . . After it's brought out, you've talked about it, it's kicked around, and it's out in the open, it gets better. You have to get that stuff out before you heal."

I Need the Truth. It takes time to develop a belief in the positives, and several individuals anticipated that after discharge they would face negative situations. For example, Grant knew

he could not live in his old neighborhood, where it would be too easy to be around old drinking friends. Lane felt his business partners would deny him the chance to work with them again. James could not resist wanting to be back with his wife, although she was currently in rehabilitation.

Al even questioned whether the strengths-based approach was worth trusting. He described how his "using buddies would tell me I'm a good person" only so they could manipulate him for drugs. "They would pat me on the back and then be lying." Al stated to the researcher that the case manager's statements about his strengths reminded him of "people I was close to," the same people who lied to him.

Theme Two: Individuals' Responses to the Professional Relationship

A major theme of the second and third interviews was the individuals' impressions of how the individual–case manager relationship prepared them for re-entering community living. First, individuals described specific resources gained with the assistance of the case manager, such as securing housing and employment. Other individual–case manager activities named by the individuals were getting diapers for his children; filling out necessary paperwork for disability benefits or medical assessments; receiving help with legal matters; and phoning contacts with AA sponsors, siblings, spouses, employers, and other social services agency workers to advocate on the individual's behalf.

Individuals described their reactions to the working relationship with case managers in three subthemes. "I didn't know nobody would care that much" illustrated the perceived positive effect of the case manager relationship, whereas "I let them down" described an individual's reaction to the case manager when he did not follow the strengths-based intervention plan. "I felt I didn't need her" summarized the various reasons why individuals stopped contacting the case manager.

I Didn't Know Nobody Would Care That Much. Individual comments about the case managers included "Someone else is seeing what I need to do"; "I don't have to keep it [goals] all in my head"; "She becomes a piece of my

conscience"; "She helps me keep my train of thought"; "Hearing her voice motivates me"; and "I didn't know nobody would care that much."

James shared the effect that the case manager's commitment had on him: "She is like a big sister. She is there checking on me. She says, 'So, you behavin' yourself?' I say, 'Yeah.' She says, 'I haven't heard from you. Are you okay?' That helps that she calls and checks on me like that. I got to keep my nose clean."

I Let Them Down. Several individuals described what it was like to have the case manager continue to accept them even if they did not follow the mutually agreed-on intervention plan. For example, just as Al had questioned the sincerity of the strengths approach, Charlie's example illustrates the difficulty of trusting the acceptance of the case manager:

> The case manager and aftercare counselor received a call from Charlie's girlfriend within two months after Charlie left treatment. Charlie had been drinking, and he and his girlfriend were fighting. Both staff members came to his apartment to help him resolve the situation. Since that time, Charlie left that relationship, moved into an apartment with different friends, and got a job on his own. Charlie said that case management helped him stay away from substances "in a way." But, "I let them down. I don't want to hurt nobody especially them [the case managers]. . . . She came over and said, 'Quit beating yourself up. Everyone makes a mistake.' . . . I felt guilty. They were both so nice."

I Felt I Didn't Need Her. Several individuals commented that goal setting gave them choices. At the same time the individuals described the dilemma when they made choices that were different from their perception of the case managers' preferred choices. David and Lane ended case management while still using alcohol; Grant abstained the entire six months of the study.

During the second interview David stated that the case manager had offered to help him fill out financial aid forms to go to a local community college and work on his GED. She also gave him referrals for jobs. But he knew that "everything is up to me to make choices." Between the second and third interview, he had stopped attending aftercare and stopped contacting the case manager—"I have been taking care of things on my own. I guess in the last few months I didn't need her." His mother died of cancer during this time. He also stopped taking prescribed medication for depression. In one passage he observed:

> I'm sure there's things they [CME staff] say and do that help. With myself it is my personal choice if I get back into it or not. Then I am the one who has to pay the consequences. No one else. In my case, fortunately, I have been completely off drugs or alcohol. I do drink now and then, but I don't seem to get drunk or anything like that.

Lane initially embraced case management with much enthusiasm, stating that case management gave him choices again. He arranged to meet his case manager once a week after leaving treatment. He set his own goals to "stay busy" and call the case manager every day. He described that the focus on his positive traits helped him "be a winner." He commented on how the case manager had called his AA sponsor and intervened with family members. Then he crashed. Between the second and third interviews, Lane readmitted himself to a detoxification and rehabilitation unit. He had talked in all three interviews about "having depression" and being "in a mental state." After seeing the written summary of his first two interviews, he commented, "Reading this every day, or at least part of it, that's the way that my mind is supposed to think, and those are the things I want to do. But it hasn't been my choice. I've been powerless over my addiction because of my depression."

Grant was sober for more than six months— "I hadn't done that before." His goal from the time he was in treatment was to see his son again, but the case manager agreed he "needed to work up to that." "Before seeing my son, I needed to get away from old people, places, and things. Which I did by moving here. I got out on my own away from the VA. I'm depending on myself again." Grant moved into a semi-independent living unit from treatment. While there he attended AA every day and an aftercare group twice each week. He started employment

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based on a referral from the case manager. He secured an apartment through a friend who "keeps me straight." He has stopped attending aftercare because of his job schedule. "I'm not going to AA meetings like I used to because I'm filling up my life with a life instead of just needing. I'm not dependent on needing anymore."

Discussion

The findings of this study should be interpreted within the context of two cautions. The first relates to the effect that the researchers have on this study. Commonly recognized steps—open-ended questioning, and diagramming similar and diverging themes—were used to recognize bias introduced by the researchers. Arguably, the final arbiter of whether the data are interpreted accurately must rest with participants themselves. In this study participants had the opportunity to review summaries of their interviews that eventually led to the formation of the themes presented. The second caution is that the themes do not represent an exhaustive theory of practice with people who have substance-abuse problems. The intent of this study was to address the questions of how individuals receiving strengths-based case management perceive the intervention and whether these perceptions reflect the intervention's underlying principles.

The emphasis on individuals' strengths and abilities is the most important principle of strengths-based work and emerged frequently in individuals' stories, although "strengths" became "positives" in the lexicon of these individuals. At the same time positives were not always readily accepted by these individuals, although for a different reason than previously anticipated. A practice implication is that strengths-based practitioners generally have assumed that individuals would be uncomfortable with looking at evidence of their own abilities because of guilt and a lack of familiarity with considering their strengths. At least one individual suggested that trusting the positive things that someone says may leave one vulnerable to being taken advantage of by people in a drug-using culture.

In describing their treatment experience, individuals found room for a discussion of both

negatives and positives, of pathology and assets. Although the remaining presence of pathology in individuals' perceptions about themselves may be disconcerting to strengths-based practitioners, individuals suggest otherwise. The balance that comes from the presence of both approaches—strengths and disease—results from what one client related was the ability to heal after "put[ting] it [negatives about one's use] out on the table." A practice implication is that it is possible that strengths-based staff underestimated the useful role that reflecting on problems, at least problems related to the use of substance abuse, may play in the treatment process.

The second important principle of the strengths-based intervention discerned in this study was the importance of the professional relationship between individuals and the case managers. References to the case manager as a "big sister" who will "check on me" cast the relationship in friendly, intimate terms. Individuals in this study, like consumers of mental health services noted by Kisthardt (1993), indicated that the relational aspects of case management were important in helping them make changes in their lives. Even individuals who were not doing well had positive feelings about the assistance they had received from their case managers.

An appreciation of the strengths process and sense of a strong positive relationship with their case managers combined at times to create a personal dissonance for individuals. On the one hand they wanted to embrace their own strengths and the relationship with their case manager while, at the same time, they were being pulled away from both by internal and external pressures. Internal events, such as depression and substance abuse, combined with external forces, such as friends and family, can wear away the gains made early in the process.

The three findings noted here—individuals' recognition of the strengths process as valuable, an emphasis on the relational aspects of the intervention, conflict between recognizing these elements and effectively implementing them— all have significant implications for social workers who practice strengths-based case management. Perhaps most significant is that social workers need to re-examine the professional

detachment that frequently characterizes the relationship between social worker and client. There is no reason to believe that the warm, genuine, and mentoring relationship noted by individuals in this study cannot be maintained within the context of appropriate professional boundaries and the realities imposed on social work practice in contemporary settings.

Social workers implementing strengths-based practice must persist in emphasizing strengths throughout the relationship. It is not enough to conduct a strengths assessment early in the intervention and expect that it will effectively support individuals through challenges to their perceptions of personal competence and effectiveness. Social workers should be prepared to integrate the emphasis on strengths into all interactions with individuals, especially during the course of goal-setting activities. The most effective means of maintaining the focus on strengths lies in social workers examining the fundamental aspects of personal and professional beliefs about the individuals we typically refer to as difficult and resistant.

The two themes that emerged from individuals' stories—(1) the value of the helping relationship and (2) a focus on personal strengths—begin to establish a link between the principles of strengths-based practice and the implementation of the intervention. Additional research will be necessary to examine the question of whether these characteristics of strengths-based practice are related in some meaningful way to outcomes such as retention in treatment and improvements in important areas of functioning. ■

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