

Original Research Article

Techniques for Brief Strengths Based Social Case Work

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ABSTRACT

Background: Depression is a debilitating common mental disorder that interferes with a person's functionality and quality of life. The realm of social interventions in the area of depression has been explored in a few settings but is yet to be validated for clinical practice. Almost all of these interventions focuses and deals with the problems that the person with depression faces. The strengths perspective is a dramatic departure from conventional social work practice. A quick review of the existing literature on social work reveals that almost all recent textbooks make a reference to the strengths perspective. However, they lack empirical and practical content.

Materials and Methods: This is part of a doctoral thesis. 9 Key Informants were interviewed and a card sorting method was used to arrive at 3 comprehensive techniques that can be used as strengths based social case work interventions among persons with depressive disorders. These were pilot tested with 6 persons with depression and outcome variables of symptom severity, quality of life and functionality were assessed pre and post intervention.

Results and Discussion: The three techniques include River of Life, Social Network Mapping, and Step Ladder. These techniques have been described in detail and their practical implications discussed. The pilot test shows positive trends and requires further study to arrive at definite conclusions.

Conclusion: This paper introduces and expounds three apparently effective, practical techniques that can be taught to social work students in the area of Mental Health.

Keywords: Strengths Perspective, Social Case Work, Techniques, Depression

INTRODUCTION

Depression is a debilitating common mental disorder that interferes with a person's day-to-day functioning and decrease the overall quality of life of an individual. Depressive disorders are the 2nd leading cause of Disability Adjusted Life Years amongst persons aged 15-44. ^(1,2)

A simplistic categorization of people as either mentally healthy or mentally ill is insufficient and this understanding rests on a concept of mental health and mental disorder as existing on two separate lines or

continua. ⁽³⁾ Mental health interventions are appropriate for people diagnosed with a mental illness.

The bio-psycho-social approach to mental health places importance upon the equal role of biological, psychological, and social factors in the genesis of depression. Therefore, most practitioners combine the use of biological treatments, psychological counselling, and social interventions to address mental illness. ⁽⁴⁾

The current modes of treatment for depression include Electro Convulsive

Therapy, Medications and Psychotherapy. (5) The realm of social interventions in the area of depression has been explored in a few settings but is yet to be validated for clinical practice. (6) Almost all of these interventions focuses and deals with the problems that the person with depression faces.

Several authors have expressed their reservations about the problem-based approach. (7-11) The strengths approach is a major paradigm shift away from the problem-based approach. "The strengths perspective is a dramatic departure from conventional social work practice. Practicing from a strengths orientation means this - everything you do as a social worker will be predicated, in some way, on helping to discover and embellish, explore and exploit clients' strengths and resources in the service of assisting them to achieve their goals, realize their dreams, and shed the irons of their own inhibitions and misgivings, and society's domination." (9)

A quick review of the existing literature on social work reveals that almost all recent textbooks make a reference to the strengths perspective. However, it may be noted that there is little theoretical or empirical content on this topic. And this lacuna is reflected in the social work literature currently available. (12-16)

MATERIALS AND METHODS

After extensive literature review, nine key informant interviews were carried out. The key informants were experts in the field of strengths based work amongst persons with depression. Each of them were faculty level practicing clinicians and academicians working in the area of mental health, amongst persons with depression from a strengths, resilience or positive psychology point of view. These three ideological standpoints were specifically chosen as the areas of work and theoretical and practical bases of these are closely linked as described in literature.

These 9 experts included 3 Psychiatric Social Workers, 2 Generalist Social Workers, 2 Clinical Psychologists

(working in the area of Positive Psychology) and 2 Psychiatrists. They were each asked to narrate a few cases in which they had used either strengths, resilience or positive psychology based interventions among persons with depression. They were asked to suggest specific tools or techniques from their practice which they experienced to be most effective over a short period of time.

The key informants, based on their experiences listed 32 techniques for intervention for persons with depression as follows:

Table 1: Techniques suggested by Key Informants

Sl. No.	Technique
1	Reframing
2	Resource mapping
3	Resilience development
4	Coping Skills Training
5	Environment manipulation
6	Free listing
7	Motivation Enhancement
8	Goal Setting
9	Step ladder
10	Sociogramme
11	Social Network Mapping
12	Transect Walk
13	Mood Charting
14	Past History Analysis
15	Avoiding routine
16	Cognitive retraining
17	Self awareness training
18	Miracle Questioning
19	Gratitude Diary
20	Physical exercise
21	Support group formation
22	Varying pleasurable activities
23	Insight Facilitation
24	Thought Diary
25	River of Life
26	Spirituality training
27	ROPES assessment
28	Cognitive restructuring
29	Adherence Counselling
30	Systemic Understanding
31	Behaviour manipulation
32	Yoga

Evidently, some were eliminated as they pertained to generalist social work practice and not specific to strengths based work.

The remainder of the techniques and methods suggested by the key informants, were collated into a set of cards, a panel of 5 experts were asked to sort the cards out based on

- Utility (does it help the clients identify and develop their strengths?),

- Client feedback (how do the clients appreciate the intervention) and
- Brevity of implementation (can it be done over 8 sessions?)

The experts were explained in detail what each of the intervention strategy involved based on key informants reports and literature review. The top 3 intervention strategies were decided as per the consensus of the 5 member panel that would enable the worker to intervene with the entire gamut of client system. These three interventions were then tested on a pilot sample of 6 persons as an adjunct to treatment as usual. Special care was taken in choosing these participants and were selected based on the inclusion criteria (which included person diagnosed with depressive disorder as per ICD 10 criteria, having been on at least one month of pharmacological interventions for the same, having residual depressive symptoms with a score of at least 10 on the Montgomery-Åsberg Depression Rating Scale at the baseline) as well as their abilities to articulate their experiences. This was done in order to gather their experiential feedback after each session and at the end of interventions.

The brief strengths base social case work was initiated with these persons as an adjunct treatment to the regular treatment. The Case Work interventions comprised of eight sessions each. Parts of the first, fourth and the last sessions were used for assessments. Since it was a pilot test, verbal feedback after each session was sought from each of the participants. The outcome variables of quality of life functionality and symptom severity were assessed using the WHO QoL – BREF, (17) WHO DAS 2.0 (18) and the MADRS (19) was used respectively. Each of these 6 persons was orally informed about the study and written informed consent was sought. The entire study has received ethical clearance from the NIMHANS Ethics Committee.

RESULTS AND DISCUSSION

With regards to utility, all six persons with depression on whom the

interventions were pilot tested, after the intervention had shown improvements. A paired sample Wilcoxon Test was run on the results in order to ascertain the statistical significance of these changes observed qualitatively.

Table 2: Quantitative Analysis of Data

Variable	Median	Median Deviation	Paired Sample Wilcoxon Test
QoL Pre	47.5	7.34	V = 0
QoL Post	61.586.6	6.2	P = 0.3125
MADRS Pre	22.36	1.414	V = 21
MADRS Post	6.167	1.16	p = 0.3501
DAS Pre	52.33	13.01	V = 21
DAS Post	45.5	7.34	P = 0.261

Table 2 shows the results of the Wilcoxon Test done on the pilot sample. It can be seen that the changes cannot be considered statistically non-significant across all the outcome variables. Nevertheless, these results indicate, although not conclusively, that the selected three techniques had fairly uniformly helped in improving the outcome variables in all the participants of the pilot study. The qualitative experiences, as will be discussed further in this section, the magnitude and consistency of change observed at a clinical level was compelling evidence regarding the utility of the techniques to continue with the same.

With respect to client feedback, the following quote from one of the participants of the pilot study reveals that the participants were grateful and received the interventions with ease and eagerness.

“Thank you very much for telling me what all is good with me. Everyone, including the doctors have been telling what I have been doing wrong and suggesting ways to correct it. You are the first person in 15 years of taking these medicines, who has told me what I have done correctly and encouraged me... I now know that I have not been all wrong and that I need to change a few things and I have the ability in myself and those around me to help me...”

- 48 year old female

Brevity was accomplished when all participants of the pilot study were able to complete intervention in 8 sessions each.

The techniques thus selected included

1. River of Life
2. Social Network Mapping
3. Step Ladder

River of Life

Although the original developer is unknown, it was popularized through the Kawa River model informally developed for Occupational Therapists by Michael Iwama in 2000. (20) It is often quoted among NGO circles dealing with sexuality, adolescent development and play therapy. (21-23) This has also been tried in mental health settings. (24-27)

River of life is a visual narrative exercise in which a client is able to share about his/her past, present or future with the help of the visuals that they are creating for themselves. In an average situation, after an initial intake, this is a tool to help the client make assessments about their Resources, Options, Possibilities, Exceptions and Solutions (ROPES). (28) The client is asked to draw a river with its various highs and lows depending upon the life of the client. It is a narrative experience wherein the client draws in from his/her past experiences in order to understand or give meaning to his/her current experiences and plan ahead for the future. Since the population of the study is undergoing a mood disorder a simple mood chart based on a visual analogue scale was used to mark the highs and lows. The visual analogue scale ranged from a simple three point scale to a more complex 10 point scale. The five predominant questions that guide this session are:

1. Please narrate some of the major good things that have happened in your life
2. Please narrate some of the major not so good things that have happened in your life
3. Please narrate some of the problems you are having now
4. Please narrate some of the good things that are happening to you now
5. Where do you want/plan to be in the

future?

Each question is fortified with necessary probes and channelizing questions. The sixty minute session is divided into five un-equal sections of time giving more importance (time) to the present and the future. The therapist takes a supportive stance when talking about the negative experiences and facilitates ventilation. While talking about the positive experiences, the therapist gathers a more encouraging stance and facilitates enthusiasm.



Figure 1: Sample of a River of Life

As feedback to this session one participant commented, *“it is so nice for me to know that my life has had so many good things. It is nice to see my river... it has had so many up times... ..The present time is filled with troubles and that is why I am not able to see any goodness. But, I have great things to look forward to. I have some hope.”*

- 32 year old female

This quote emphasizes the point that engaging with a person positively while providing support at negative instances helps in building hope in the person.

This is supported by other studies in the same area. Brun and Rapp (8) describe in detail how narrative techniques used as part of strengths based case management help clients with chronic problems. Another recent study dealing with students with depressive behaviours (specifically self

harm) enlightens the usefulness of engaging positively with persons surrounded with negative experiences. (29,30)

Social Network Mapping

Originally developed by Tracy and Whittaker in 1990, (31) it has since then been cited in at least 231 times in indexed peer reviewed journals for a wide variety of issues. The Social Network Mapping is an exercise wherein the client is able to visually recreate his/her otherwise invisible and often intangible social support systems. (32,33)

The client is asked to draw himself at the centre of a page. The portrait need not be perfect, it can be just a circle or a square or some definite shape. The person is then asked to mark persons or systems that he or she meets or interacts with on a daily, weekly, monthly or annual basis at varying distances from the client. The client is then asked to mark those persons or systems that he/she perceives as supportive and those who are impediments to them achieving their goals/solutions. The person is additionally asked to map the interactions that all the key points that they have drawn in order best indicate routes of receiving direct or indirect social support. The predominant questions that guide this session are

1. With whom all do you have to meet or interact with on a daily, weekly, monthly or annual basis?
2. Who of these are supportive to you?
3. Who of these are not so supportive of you?
4. How do you interact with these people and they interact with each other?
5. How best can you get the support of these people in your life?

Each of these main questions is supported with qualifying or probe questions in order to help the client achieve his/her goals. The therapist takes on a facilitative stance during the course of the session thereby not only exploring social facets of the client's life but also suggesting certain social maneuvers to help the client

attain his/her social and other goals. Therefore this session is ideally undertaken in the client's social context such as his/her home or workplace. During such a session, the client's significant others may be able to help in or need to be helped to understand the client's goals and support systems.

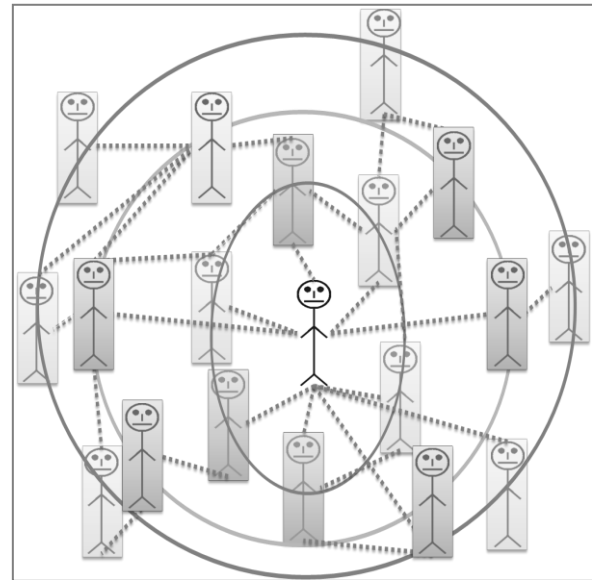


Figure 2: Sample of Social Network Map

At the end of this session, one of the participants stated, *“There are so many people I know and who mean me well. Over these past two months, I have been so negative towards all of them especially some whom I meet daily... my husband... yet he has been so supportive of me through all of this. It was important for me to see this positive side of my people today because otherwise, I would just go back to grumbling about my sad life. I can see help coming from so many places in my life.”*

- 36 year old female

This quotation points in the direction that helping a client identify social resources is important in building a sense of joint efforts towards the client's solutions. It is important to tap into these community based strengths while working with a person with depression. The client is able to develop a sense of helpfulness from this technique.

This finding is generally supported by other literature in the area of strengths based practices. Brun and Rapp (8) emphasises on the relationship between the

care giver and receiver being key in the client feeling helped. Four studies spanning over two decades highlight the role of assessing the client's social support networks as part of a strengths based assessment as being both helpful in understanding the client as well as therapeutic for him/her. (30,34-36) Smith (11) in the handbook of social network analysis points this technique out as strength and emphasises on the role of community in general to make a person feel helped. Saleebey (9) himself states that one of the core principles of strengths based practice is that care giving and care receiving is a right of a person and happens in the social community context of the person.

Step Ladder

Developed originally as a management group problem solving tool, (37) it is widely used in motivation enhancement, scholastic backwardness, social support assessment, etc... (38-40)

It is often seen that one has rather high expectations from oneself and the cognitive dissonance from the reality of achievement of these expectations lead to a sense of worthlessness about oneself. If a person is able to see micro gains in the person's life and chart his/her trajectory of development, they would be able to appreciate themselves better. (41) In order to achieve this, it is important that a person sets Specific, Measurable, Attainable, Resourceful and Time-bound (SMART) goals. (42) Along with that, it is also important that the person realises that the goal is only the final destination and that there are several sub goals that the person needs to attain in the process and that the person needs to be able to identify them.

Although this session is predominantly a future based session with lots of planning involved, it most often begins with the acceptance of the person's present reality. This is attained using the 'miracle' question. What would it be like if your current 'problems' were to magically or miraculously go away? (43) A logical framework approach is taken by the

therapist help the client understand that the solution is attained by a series of smaller steps.

Then, scaling questions are used to make the client understand that there are various levels of solutions and each of them is important to achieve. The questions that help the scaling of the questions are with respect to a time frame e.g. when would you like this particular goal in your life attained? (43) A visual step ladder is then drawn on a piece of paper with as many steps as the time frame that the client requires. Once the client is able to lay out specific and time-bound goals, the client is then enabled by the therapist to seek out ways in which if the specific sub-goals have been attained, the resources that are needed to make it happen and attain those sub goals.

This exercise is usually the final intervention session and provides the client with a roadmap to recovery and builds a sense of worth in the client.

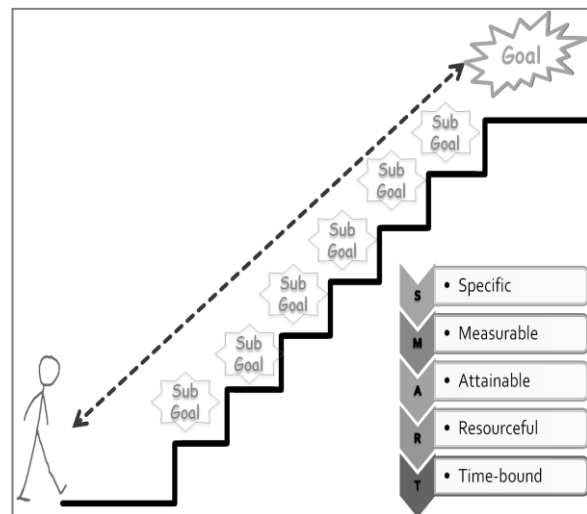


Figure 3: Sample of Step-Ladder

At the end of this session, one of the participants of the study stated, "I was very happy with all things we were discussing when we met. But when I went back home, the problems still remained and I could not see myself ever getting out of it. So, I was getting unhappier by talking to you and thinking that you are only saying things to make me feel happy. Today, I am able to see myself being able to climb out of this hole that I am in. I know it is not an easy or a quick process... but I know I can..."

This quote indicates that this technique enables the self - worth of the client. It also emphasises that the case work sessions do not end in the specific place and time but, empowers the client to attain the goals that the client has set for him/herself by building a roadmap for recovery and attaining those goals.

Support for this is indicated in literature. It is not sufficient that a person coming into therapy feels helped and supported at that time but must be empowered enough so that when they go back to their realities, they may be able to handle the pressures within. ⁽⁴⁴⁾ Even while working with families, two studies ^(45,46) found out that empowerment and the worth of family systems as a whole is central to the recovery and inclusion of persons in society. Increasing the self worth of a client is central to the interventions provided by a therapist to a person with depression as it helps a person towards recovery and empowering them to make their own decisions. ⁽⁴¹⁾ Jaganathan and Sekar ⁽⁴⁷⁾ highlight the usefulness of terminating strengths based work with persons with mental illness with a plan to handle contingencies and a roadmap to recovery.

CONCLUSIONS AND IMPLICATIONS

The findings of the current study have profound implications primarily for clinical training, practice and research in the area of common mental illnesses in general and depression in particular.

While teaching case work to students, a predominance of problem focussed schools is present. This is often justified as being used in the cliché that while helping clients, the objective is to 'minimize the problems and to maximize the *strengths*'. ⁽¹⁶⁾ This paper brings to light three apparently effective, practical techniques that can be taught to students working psychosocially with persons with mental illness as part of the link between theory and practice. It can easily be monitored by supervisors as there is visual/graphic snapshot evidence of the

sessions and in itself becomes part of a process record. It requires minimal materials for preparation and can easily be tweaked to suit the needs of various client groups... not only persons with depression or other mental health issues.

The strengths based approach is eclectically integrated into the day-to-day clinical practice of a professional working with mental illness at a superficial level. This paper details the processes involved in practicing from a strengths perspective.

This paper is a starting step in further research that needs to be done in this area to further the knowledge of the use of strengths based approaches from a culturally sensitive standpoint. These techniques require repetition to arrive at some level of standardisation for at this point this paper is limited to the experiences of a very minute sample and cannot be generalised to all persons with depressive disorders. However, with the sound theoretical backing and promising empirical evidence from around the globe, this paper is worth exploring further.

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