Seeing people, not patients: a strength-based approach to health and healing through asset mapping

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Abstract

A deficits model is the cornerstone for health professions education, practice and scholarship. Focusing on diseases, addictions, social risk factors, and other deficits leads us to see medicalized beings with problems, also known as "patients". This approach does particular harm to those who come from marginalized communities, groups who have always been viewed through the deficits lens by their colonizers/oppressors. When we focus on understanding strengths—including culture, language, resilience, skills, and resources we can begin to see "people" as full human beings possessing the tools necessary for their own healing. This approach, also known as "asset mapping", will allow us to provide more effective, decolonized care, and will open the door to deeper healing for all involved.

Keywords: asset mapping, medical education, appreciative inquiry, strength-based approaches to health, cultural safety

Date submitted: 22-May-2024

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Citation: Nanez J, Fleg S, Covington T, Fleg A. Seeing people, not patients: a strength-based approach to health and healing through asset mapping. Educ Health 2024;37:277-280

Online access: www.educationforhealthjournal.org
DOI: 10.62694/efh.2024.98

Published by The Network: Towards Unity for Health

Introduction

"I am not just a biomechanical meatbox with a problem."
—Stan Cottrell, describing his frustration with the medical care he receives. Stan said this as he ran across the U.S.A. in the summer of 2021. He was 78 years old at the time.[1]

A strength-based approach to health, also known as "asset mapping", is a framework and orientation that looks to identify strengths, resources, talents, etc. as a vehicle for improving health, and can be applied on individual and community levels.[2] It changes the focus from, "What is wrong with you?" and an exclusive interest in mapping out deficits, to centering care on the question, "What is right with you?", mapping out strengths accordingly. Moreover, it allows us to understand a full person and community, utilizing their strengths to address issues of concern.

As a term, asset mapping originated with Kretzmann and McKnight's 1993 Asset Based Community Development (ABCD),[3] aligning with the strength-based perspective in the social work of Saleebey[4] and the Indigenist model of Native women's health described by Karina Walters.[5] It has gained some traction in the fields of social work and public health, but less so in the field of medicine. It is important to state that strength-based approaches exist far beyond the history of academia and are a natural orientation for communities solving problems. In this light, the work we do in scholarship and practice is simply returning to the wisdom that our ancestors knew and practiced so well.

Vignette

The medical student rushed out of the exam room and exclaimed,
"John was not at all who I expected him to be based on my chart review."
My charge to the student before the encounter was simple: meet *John the person*, not *John the patient*.

John the person is a family man who runs his own business. He is the 4th generation of his family to call New Mexico home, and he feels a real connection to the land. John considers spirituality a foundation for his life and expresses this through gratitude for each day. He has a robust meditation practice and also gets outside to walk each day. He describes his community as "one that is tight-knit, where everyone looks out for each other."

John the patient, the version the student "knew" before walking into the room, based on chart review, has diabetes, HTN, CAD, and chronic kidney disease. He is on 12 medications, and had some worrisome labs a week ago. *John the patient* is someone who had missed a few of his last appointments, with notes in his chart implying that he does not take his health conditions seriously. There are also notes that he lives in a community with few resources, high crime, and low SES.

In this one utterance above, the student exhibited a questioning of their deficit-based inclination towards patient care. They were looking for a language to see John as a *person*, not simply as a *patient*. With that question, they were on the path to discovering the importance of strength-based approaches to health and healing.

Reflection questions:

- If you were John, how do you feel your care would be affected by your provider seeing you as *John the person* vs. *John the patient?*
- How do you think the experience of providing care to John differs between seeing *John the person* vs. *John the patient?*
- If John is a member of a marginalized group, will this affect the chances that his medical team sees him as *John the person* vs. *John the patient?*

Why does the deficits-based approach dominate in the health professions?

There are multiple reasons why deficit-based approaches dominate in the health professions. First, the health care systems in the United States (and the wider world) focus on treating disease—with little value placed on an individual's strengths and wellness. Profits and clinical productivity are measured by how much *disease* we document and address—with no interest in mapping and augmenting individual *assets.* We pay clinicians to treat disease as opposed to keeping people well. Given this environment, it is no surprise that health professionals are trained to be experts in mapping deficits, with little attention paid to developing their skills in mapping strengths.

Second, we might consider our neurobiology and the predisposition to focus on negative stimuli as a survival instinct. Known as "the negativity effect", it is described by Kellerman as, "the tendency for negative information to be weighted more heavily than positive information when forming evaluations."[6] This well-documented aspect of the human psyche definitely plays a role in our seeing *patients*, as opposed to seeing *people*, in the health professions.

A third reason for deficit-based thinking comes from taking a look at Individuated versus Integrated cultures in work developed by Chavez and others.[7] Individuated systems stemming from Northern Europe dominate the pedagogy of health fields and Western education, "characterized by individual, discrete, abstract, and specialized learning."[8] In contrast, Integrated systems that stem from non-European populations, "value collaborative, holistic, connected, contextualized learning." Health professionals in the Individuated system serve to provide knowledge, whereas in Integrated systems they would serve as facilitators more interested in eliciting wisdom from their clients. Individuated thinking predisposes to deficit thinking, whereas integrated thinking allows for strength-based approaches to thrive.

Finally, colonization predisposes Black, Indigenous, People of Color, and other marginalized communities to being seen disproportionately through the deficits lens. White supremacy, defined as the "beliefs and ideas purporting natural superiority of the lighter-skinned, or 'white', human races over other racial groups[9]," underlies the colonization efforts of European countries and helps to explain the world's un-even distribution of resources. Non-white communities have been deficit-mapped from the moment Europeans encountered them. It was and is a way to dehumanize and justify "manifest destiny", enslavement, genocide, and resource extraction from these populations. Our medical institutions are built within this foundation of white supremacy, whereby European culture and its norms are the standard. For instance, a patient who only speaks Spanish or their Indigenous language is labeled "low English proficiency" as opposed to labeling the system itself as "deficient in our ability to care for persons not speaking English". Similarly, a person who has a 3rd grade formal education but

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who has studied 30 years to become an herbalist in their Indigenous tradition is labeled "low educational attainment" since formal education is recognized and valued over Indigenous knowledge/ education systems.

Re-Envisioning Care Using a Strength-Based Approach

Having covered the background on asset mapping and this discussion of factors that have led us to the dominance of deficit-based care, we will share four examples of re-envisioning care using a strength-based framework.

Re-envisioning care: Asset mapping and SDOH

With more attention paid to social determinants of health (SDOH), we see poverty, low SES, low educational status, and other risk factors as the focus, without similar attention to protective SDOH such as resilience, involvement in one's culture/ traditions, family support, etc. Moreover, whereas a medical provider may list multi-generational housing as an SDOH risk factor, they may completely miss the cultural importance to having elders in the home to pass on language and traditions. Indeed, this housing situation may actually be more a strength than a risk factor with regard to SDOH.

Re-envisioning care: Trauma-informed frameworks and Cultural Safety – examples of asset-mapping applied to traumatized people and communities

We also can't acknowledge the impact of white supremacy without the trauma of white supremacy on populations of color. Trauma-informed care frameworks take a strength-based approach that promote collaboration and mutuality; empowerment voice and choice; along with recognition of gender, cultural and historical issues as primary tenets in a trauma-informed system of care, all while seeking to reduce re-traumatization through actions or organizational policies and processes.

If we move a step further in our trauma- informed care and strength-based approach, we can begin to enter into the Cultural Safety framework of care. The concept of Cultural Safety was developed in the nursing field by Irihapiti Ramsden,[10] a Maori nurse researcher. Cultural Safety actively engages the individual receiving services to help define what is culturally safe, culturally appropriate, culturally engaged care. It centers *the individual, their culture(s) and the lived experience of that person and their community*; In doing so, the goal becomes to create systems that support centering that experience. This framework, developed from an Indigenous perspective, seeks to be inherently anti-racist in its construct; and actively works to promote justice, access and equity. Cultural Safety seeks to center these assets for both individuals and their cultural community. Interestingly enough, Cultural Safety as a healthcare framework has been adopted in countries globally, including Canada, United Kingdom, Australia, and in New Zealand. It is only now being introduced in the United States.

Re-envisioning care: From sick-care to wellness-care

Understanding the many factors that predispose health professionals to focus on deficits, we can imagine small, concrete steps to shift the focus toward strengths and assets. For instance, begin your note template with "Wellness" to prompt you to make that the *beginning* part of each clinical encounter. It would serve as a natural way to see *people*, not *patients*.

Re-envisioning care: Asset mapping our students

For those of us privileged to teach health professions students, we have an opportunity to know them far beyond their grades and assignments. Developing a practice where you take a deep dive into who this person and their story is, before they entered into the academic realm, changes everything. They will see that your interest in them is *more* than about their ability to master your material, aligned with the Integrated approach mentioned above (e.g. How does this course I am teaching fit into this student's life story? How can I make *the way I teach* and *what I teach* most relevant to them?). It will also give you insights that can be critical if that student struggles academically; you may encourage them to use their resilience, cultural strengths, etc. to overcome their academic issues.

Conclusion

I am well. I am healthy. I have everything I need and I am grateful for what I have. If I was only living to walk again, I 'd not be able to focus on what I can do when I am not walking.
—Peter Berry, a high-level wheelchair basketball player who was paralyzed at age 9 from a MVC

When we focus on understanding strengths, including culture, language, resilience, skills, and resources we can begin to see "people"—full human beings possessing the tools necessary for their own healing. This approach, also known as asset mapping, will allow us provide more effective care,

building deeper connections with those people and communities in our care. It also serves as a means for decolonizing our care, questioning and replacing the value systems that lead to the disproportionate deficit mapping of our marginalized communities. Strength-based care also opens the door to deeper healing for all involved. Using Mr. Berry's quote above, we see that from a strength-based lens, we are there to support people's journeys more than to correct, help, fix or treat.

In the simplest way of thinking about it, our deficit-based approach causes health professionals to dehumanize those we take care of, *dehumanizing* ourselves in the process, one clinical encounter at a time. A strength-based approach is a heartset and mindset toward *re-humanizing* the health professions.

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