Strengths-Based Assessment Instruments for Children and Adolescents

Sources:


Assessment is a critical component of mental health treatment, both for accurate diagnosis and appropriate treatment plan design. Historically, assessment instruments have emphasized symptoms and problem behaviors, but a shift in recent years has resulted in an increased focus on the strengths of youth and their social support systems in order to take advantage of these assets in treatment planning. This Data Trends covers three strengths-based assessment instruments that may be of use to clinicians and researchers.

Behavioral and Emotional Rating Scale (BERS):

The BERS is a 52-item scale, normed on a racially and ethnically representative national sample of 2,176 children without disabilities and 861 children with emotional and behavioral disorders, aged 5 to 18. It is completed by adults familiar with youth and measures emotional and behavioral strengths in five areas determined through factor analysis: Interpersonal Strengths (e.g. accepts “no” for an answer), Family Involvement (e.g. participates in family activities), Intrapersonal Strengths (e.g. demonstrates self-confidence), School Functioning (e.g. completes school tasks on time), and Affective Strengths (e.g. accepts a hug). Other research has documented that the BERS does not discriminate on the basis of race and ethnicity and has strong reliability and criterion validity. The article cited above (Epstein, 1999), describes the procedures used to establish content validity.

The ability of the BERS to discriminate between children with and without serious emotional disturbance (SED) was tested by comparing scores from students with SED at an alternative high school to students attending a general high school. As expected, SED youth scored significantly lower on each inventory item, demonstrating the ability of the BERS to differentiate between youth with more and less emotional and behavioral strengths. According to the author, the BERS “can be used for planning purposes in developing goals and objectives for a student’s IEP [and] can serve as an outcome measure to document progress in a strength area as a consequence of specialized services” (p. 262).

Child and Adolescent Strengths Assessment (CASA):

The CASA is a 30-item inventory on which an individual familiar with a child or adolescent rates strengths on six dimensions: Family (e.g. has strong positive relation with at least one parent), School/Vocational (e.g. excels in at least one subject), Psychological (e.g. has a sense of humor), Peer (e.g. has close friend(s)), Moral/Spiritual (e.g. has developed values/morals), and Extracurricular (e.g. has artistic/creative talent). Lyons and colleagues (2000) used the CASA to assess the prevalence of strengths among a sample of youth in residential treatment facilities and assessed the relationship of these strengths to psychopathology using the Childhood Severity of Psychiatric Illness (CSPI) scale.
The sample consisted of 450 youth (55% male) aged 5 to 19 years old, of whom 49% were Caucasian, 35% were African American, 11% were Hispanic, and 5% were Native American or Asian/Pacific Islanders.

The most commonly endorsed individual item was having a sense of humor, found in 36% of the sample, while the two least commonly reported items were participating in a community services youth group (3%) and participating in church youth groups (5%). There were significant negative correlations between strengths as rated on the CASA and risk factors and functional impairment on the CSPI. Additionally, regression analysis revealed that individuals with higher levels of strengths had a reduced level of risk and that children with a higher level of strengths were more likely to have positive placements after residential care. Based on these results, the authors recommend a greater focus on strengths in clinical assessment and the use of mental health services to build client strengths in addition to lessening symptoms, noting, “building strengths…may improve outcomes independent of any success in treating psychopathology” (p. 179).

**Reasons for Living Inventory for Adolescents (RFL-A):**

The RFL-A is a 32-item self-report inventory “that focuses on adaptive factors that are relevant in the assessment of adolescent suicidal behavior” (p. 1064) along five factors: Future Optimism, Suicide-Related Concerns, Family Alliance, Peer Acceptance and Support, and Self-Acceptance. Osman and colleagues (1998) describe the rigorous validation procedure for the RFL-A in which exploratory and confirmatory factor analysis were used to establish the five subscales and tests of alpha revealed high internal consistency. Additionally, RFL-A scores from a sample of 242 youth (115 boys) were compared to other measures to test construct, convergent, and discriminant validities. Results indicated that the each RFL-A scale was significantly and negatively correlated with the Beck Hopelessness Scale (BHS), the Suicidal Behavior Questionnaire (SBQ), the Suicide Probability Scale (SPS), and the depression scale of the Brief Symptoms Inventory (BSI), “suggesting that adolescents who endorsed more adaptive reasons for living reported less frequent suicide ideation, threats, and likelihood of attempts” (p. 1070) and demonstrating strong validity for the RFL-A. A final study compared psychiatric inpatient adolescents who had recently made a suicide attempt to non-attempting psychiatric inpatient adolescents and to a control sample of non-attempting high school students. Results showed that the high school non-suicidal group scored significantly higher on the RFL-A than the suicide attempter group, as did the non-attempting, inpatient group. Logistic regression analysis demonstrated that the RFL-A, combined with the SPS had an overall accuracy of 83.9% in assignment to the correct group.

Gutierrez and colleagues (2000) also tested the ability of the RFL-A to distinguish among adolescents with varying degrees of suicidal ideation and examined the relationship between scores on the RFL-A and scores on the Minnesota Multiphasic Personality Inventory for Adolescents (MMPI-A) and the Beck Hopelessness Scale (BHS). Consistent with the previous study, alpha reliability estimates ranged from .92 to .95 on the RFL-A subscales and confirmatory factor analysis supported the use of the five subscales. The authors also replicated previous discriminant validity results, showing, in this case, that the RFL-A total score distinguished between nonsuicidal, first attempter, and multiple suicide attempter groups. Among youth who were admitted to a psychiatric hospital for their first suicide attempt, the authors found differences between boys and girls on some RFL-A subscales. Comparing BHS scores to RFL-A subscales, the authors found “more hopeless adolescents have limited optimism about the future, low levels of peer acceptance and support, and a weak sense of alliance with their families” (p. 185). Results also showed that the RFL-A was a significantly better predictor of suicidality than the BHS. The authors conclude, “it may not always be possible to reduce risk factors, but increasing an adolescent’s reasons for living may be a reasonable treatment goal” (p. 186).