Strengths of Children and Adolescents in Residential Settings: Prevalence and Associations With Psychopathology and Discharge Placement

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ABSTRACT

Objective: During the past few years there has been growing interest in developing strength-based approaches to services, particularly for children and adolescents. **Method:** This study assesses the prevalence of 30 strengths for a random sample of children and adolescents in residential placements in Florida. In addition, the relationship between strengths and clinical and functional characteristics is studied. **Results:** Results suggest that there is substantial variation across individuals on the presence of strengths and the potential for development. Strengths were associated with symptoms, risk behaviors, and functioning. Level of strengths predicted success in the reduction of risk behaviors during the child/adolescent's stay. In addition, the level of strengths was independently associated with good dispositional outcomes. **Conclusions:** The findings provide further empirical support for the importance of strengths and the utility of an integrated model that considers both psychopathology and strengths in planning for children's services. *J. Am. Acad. Child Adolesc. Psychiatry,* 2000, 39(2):176–181. **Key Words:** children, adolescents, strengths, assessment.

A variety of factors have led to an increasing emphasis on the identification and use of strengths in mental health service delivery for children, adolescents, and their families during the past 15 years. Beginning with the landmark work of Jane Knitzer in *Unclaimed Children* (1982) and the National Institute of Mental Health's funding of the Child and Adolescent Service System Program in 1984, there has been consistent movement toward the inclusion of parents as partners in the treatment process as well as an increased focus on the strengths of both the child and family (Eber et al., 1996; Powell et al., 1997; Walsh, 1998). The emphasis on strength-based treatment plans and the full involvement of parents in the treatment process was furthered by the work of Stroul and Friedman in their seminal work (1986, 1994). The second edition was the first to include the change to "child first" language, which emphasizes the strengths of the child rather than the disability.

The Robert Wood Johnson Foundation's funding of their Mental Health Services Program for Youth (MHSPY) initiative from 1988 to 1994 introduced a strength-based, family-focused approach to an organized system of behavioral health care for children and adolescents (Cole and Poe, 1993). The Foundation subsequently funded the MHSPY replication sites through 1997 (Sokol, 1997). The innovation of wraparound services to address complex needs in community settings has been strength-based in both its conceptualization and implantation (Lourie, 1987; Rosenblatt, 1996; Stroul and Goldman, 1990).

Strength-based approaches generally conceptualize strengths in 2 ways. First, assets, resources, and abilities can be used to assist in helping a child or adolescent develop into a healthy and happy adult. Accordingly, strengths are used as building blocks for service planning. The research on the importance of protective factors in coping with psychosocial stressors is consistent with this conceptualization (Ickovics and Park, 1998; Luthar and Zigler, 1991; Rutter,

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1987; Scheier et al., 1986; Schwartzberg, 1994; Thompson, 1987). Second, some strengths can be developed. Thus, changes in the availability of various assets, resources, and abilities for a given child or adolescent can be viewed as a service delivery outcome.

Although there has been considerable research on the role of strengths, resilience, and coping (Borduin, 1994; Bruns et al., 1995; Luthar and Zigler, 1991; Rosenblatt, 1996; Rutter, 1987; Wolin and Wolin, 1993), most of this research has focused on intraindividual strengths (Walsh, 1998; Weise et al., 1996). Although this research is relevant to the development of strength-based approaches, the growth of the strength-based, family-focused approach to the treatment of children and adolescents can be further facilitated by the development of comprehensive strength-based assessment tools. In addition, there has been only limited research on the relationship between strength-based approaches and clinical outcomes (Weise et al., 1996). Despite this, preliminary data indicate that there are improved outcomes for children and adolescents who have completed strength-based programming; early research suggests that such alternative community-based approaches can be effective and economical (Bruns et al., 1995; Eber et al., 1996; Lourie, 1987; Rosenblatt, 1996). Further research on strength-based approaches could inform our understanding of who has what strengths, how the presence of strengths is related to psychopathology and functioning, and which strengths can be developed in the course of services delivery.

Over the past several years, we have been involved in a series of projects seeking to facilitate reforms in child mental health service systems (Lyons et al., 1998b). Our initial measurement approach was to focus on existing clinical models for the assessment of children with mental health needs (Lyons et al., 1997b, 1998a). During these projects, it became evident that we needed to expand these assessments to include strengths. To address this gap, we reviewed the existing literature and held a number of focus groups with family members and service delivery professionals. From these efforts, we developed an initial draft of the instrument, the Child and Adolescent Strengths Assessment (CASA). We then shared the instrument with experts in children's mental health, child welfare, child development, and social services (Lyons et al., 1997c). After incorporating feedback from these stakeholders, the final version of the CASA contained 30 strengths on 6 dimensions—family, school/vocational, psychological, peer, moral/spiritual, and extracurricular.

This study seeks to assess the prevalence of these carefully defined strengths in a population of children and adolescents in residential placements. In addition, the relationship of these strengths to psychopathology is investigated by correlating strengths measures to independently assessed clinical status using a reliable measure of symptoms, risk behaviors, and functioning. Finally, the development of our understanding of the role of strengths in services planning is investigated by studying the relationship of strengths to positive postdischarge placements.

METHOD

This study was conducted as an aspect of a feasibility study of bundled rate methodology for Medicaid in Florida. Fifteen residential placement sites that bill Medicaid for mental health services were selected for review. A 16th site that expressed interest in billing Medicaid in the future also agreed to participate. At each site, a random sample of 30 children and adolescents were selected from among cases who had received any Medicaid billing for services rendered in the previous year. At the non-Medicaid site, a random sample of children served during the previous year was taken. Each review team was composed of representatives from Child Welfare, Mental Health, and the Agency for Healthcare Administration. To ensure continuity, the first author was present at all site visits.

At the time of the review, each site was requested to complete the CASA. The CASA is a 30-item inventory that asks raters to consider each identified strength in 6 different domains—Family, School/Vocational, Peer, Psychological, Moral/Spiritual, and Extracurricular. For each strength, the rater chooses from among 3 anchored responses that indicate the presence of the strength and the potential for development. An example of anchors for several of the strengths can be found in Table 1. The internal consistency reliability for this sample was 0.92. The CASA was completed either by one of the child or adolescent's house parents or their primary therapist or caseworker.

The review measure was the Childhood Severity of Psychiatric Illness (CSPI) (Lyons, 1998; Lyons et al., 1997a,b). The CSPI is a 25-item rating scale with 4 anchored levels for each item. It can be used either prospectively or retrospectively with high reliability (Leon et al., 1999). When used retrospectively, the CSPI provides an assessment of the type and level of children's and adolescent's mental health needs as they are documented by service providers. The CSPI includes assessments of symptoms, risk behaviors, functioning, comorbid mental health conditions, and caregiver capacity. Each of the 4 levels of every item are anchored to allow greater reliability and interpretability. For example, for the item Suicide Potential, the 4 levels are essentially defined to be (1) no history, (2) history but no ideation or gesture in the past week, (3) ideation or gesture in the past week but not both in the past 48 hours, or (4) ideation and gesture in the past 48 hours with current ideation. After training, the reliability of the CSPI is generally greater than 0.85. In this study, the reliability was estimated to be 0.87 (weighted κ). In addition to the CASA and CSPI, basic demographic, child welfare, and service use information was obtained for each case.

RESULTS

The sample consisted of 450 cases, 123 of which had already been discharged from the residential facility at

TABLE 1
Examples of Anchors for Two of the Strengths Included in the Child and Adolescent Strengths Assessment

1. Has strong positive relation with at least one parent
   - *No evidence* would be used to rate an individual who has distant or conflictual relationships with all parents and/or caregivers. A child with no current contact with parents who has been in an out-of-home placement would be rated here.
   - *Interest/potential* would be used to rate an individual for whom it appears possible that such a relationship could develop within the next 3 months. For example, a child just reunited with a parent after a considerable separation would be rated here.
   - *Yes, definitely* would be used to rate an individual for whom there is a warm, loving relationship with a parent or caregiver. This relationship would be characterized by reciprocal attachment and strong communication. If the caregiver is not a parent, then the relationship must be at least 3 months in duration before using this level.

15. Has a sense of humor
   - *No evidence* would be used to rate an individual who has not displayed much of a sense of humor. Individual laughs only occasionally or not at the same time as others.
   - *Interest/potential* would be used to rate an individual who has displayed some sense of humor in laughing at the humor of others and occasionally attempting to use humor him/herself.
   - *Yes, definitely* would be used to rate an individual who has developed a sense of humor that is developmentally mature. The individual both laughs at humor of others and often generates humorous statements/reflections on him/herself.

the time of the review. Of the full sample, 55% were boys and 45% girls. The ages ranged from 5 to 19 years, with an average age of 13.7 years. Nearly half of the sample was white (49%), about one third (35%) was African-American, 11% was Hispanic, and the remaining 5% was made up of Native Americans and Asian/Pacific Islanders.

Table 2 presents the frequency of each level of the 30 strengths by presence/potential/absence. There is clear variation across the sample. The most common strength was having a sense of humor, which was found among more than one third of the children and adolescents. An additional half of the individuals demonstrated the potential for humor. The least common strengths involved participation in church and community groups. This is likely to be the result of residential placement, although residential placement did not eliminate these opportunities for all residents.

Table 3 presents the correlations between the CASA subscale and total scores and the CSPI measures of the current status of symptoms, risk behaviors, and functioning. The CASA total score and most subscale scores were negatively correlated with all CSPI scores. The exceptions were that family strengths and extracurricular strengths were not related to symptoms and risk. This pattern of correlations would argue for a generalized association of strengths with psychopathology and functioning. In each case, higher levels of strengths were associated with lower symptoms, risks, and functional impairment.

To predict improvement from admission to current status, we used a hierarchical regression model in which current risk behavior status was regressed on admission risk behavior status and then the total CASA score. The regression model was significant ($F_{2,346} = 314.3, p < .001$). Cases with higher levels of strengths had a reduced level of risk, controlling for admission levels.

For the 123 children and adolescents who had been discharged from the residential placement, discharge placements were categorized as either positive (i.e., home of parent of relative, adoptive or preadoptive home, or independent living) or negative (i.e., hospital, detention, residential treatment, group home, runaway, or shelter). Both level of risk, as measured by the CSPI ($t = -4.08$, $df = 123$, $p < .001$), and level of strengths, as measured by the CASA ($t = 2.95, p < .01$), were associated with whether the discharge placement was positive or negative. To test the independence of these effects, a logistic regression was undertaken. In this multivariate model, CASA total score remained significantly associated with the quality of the discharge placement (Wald = 3.79, $p < .05$). Overall, children and adolescents with a higher level of strengths were more likely to have a positive discharge placement.

DISCUSSION

The findings of this study demonstrate the potential importance of strengths of children and adolescents in the provision of mental health services. There was substantial variation across individuals and across types of strengths. In addition to the notable variation, correlational analyses suggest that strengths may serve an important role in level of functioning and dispositional planning. While the individual's level of strengths was associated with symptoms and risk behaviors, it was also independently associated

TABLE 2
Summary of Strengths as Assessed by the Child and Adolescent Strengths Assessment

Strength	Percent		
	No	Potential	Yes
Family Strengths			
Has strong positive relation with at least 1 parent	49.7	30.9	19.5
Has strong positive relation with 1 adult relative	47.1	28.5	24.4
Has strong positive relation with at least 1 sibling	36.2	35.3	28.6
Strong positive relations exist among relatives	54.2	28.5	16.3
Family has reliable communication	56.6	35.4	8.0
School/Vocational Strengths			
Excels in at least 1 subject	42.0	33.4	24.6
Likes to write (e.g., keeps a diary)	60.4	28.0	11.6
Reads for pleasure	56.8	32.3	10.9
Has done well for at least 1 year during school	43.6	31.5	24.8
Has a particular vocational skills	74.2	19.7	6.1
Is articulate in speech	31.0	40.3	28.7
Has identified career goals for adulthood	60.9	33.3	5.8
Psychological Strengths			
Has a sense of humor	16.7	46.4	36.8
Has the ability to adapt to stressful life circumstances	43.2	45.0	11.8
Has the ability to enjoy positive life experiences	16.9	51.2	31.8
Is able to express emotions accurately	36.2	51.8	12.1
Has the ability to trust others	32.1	52.3	15.6
Peer Strengths			
Has close friend(s)	36.7	45.7	17.6
Negotiates appropriately with peers	40.8	47.5	11.6
Is well liked by peers	34.9	44.1	21.0
Moral/Spiritual Strengths			
Has developed values/morals	32.1	52.1	15.8
Has expressed religious/spiritual beliefs	56.6	33.4	10.0
Attends religious services regularly	60.8	26.7	12.5
Participates in church youth groups	83.4	11.2	5.4
Extracurricular Strengths			
Has artistic/creative talent	42.2	39.5	18.3
Has a hobby or hobbies	41.7	39.3	19.0
Participates in a community services youth group	81.2	15.7	3.1
Participates in organized sports	61.9	23.4	14.7

with functioning levels. Consistent with other research (Eber et al., 1996; Luthar and Zigler, 1991; Rosenblatt, 1996), these findings suggest that building strengths could enhance functioning independent of any success in ameliorating psychiatric problems. Similarly, while the presence of risk behaviors was significantly related to successful discharge placements, level of strengths also was associated with positive dispositional outcomes. Thus, building strengths for children in residential settings may improve outcomes independent of any success in treating psychopathology. For example, Beardslee et al. (1997a,b) demonstrated that a fairly brief clinical intervention with at-risk parents can help build resiliency in children.

The 3 most common strengths in the present sample were a sense of humor, the ability to enjoy positive life experiences, and having a strong relationship with a sibling. Both humor and savoring appear to provide an opportunity to support creative interventions that build on these relatively common strengths. There also may be complex relationships among symptoms of certain psychiatric conditions and these strengths. For example, one would imagine the successful treatment of depression would influence the availability of humor and savoring skills. There is a growing body of literature on the use of humor in therapeutic interventions and its importance in overall well-being (Bernet, 1993; Gelkopf and Kreitler, 1996; Luthar and Zigler, 1991; Saper, 1990). The importance of social support has received considerable attention in the literature (Carver, 1998; Heatherton and Nichols, 1994; Luthar and Zigler, 1991); more specifically, the presence of strong sibling relationships is a potential building block for maintaining a sense of family among children and ado-

lescent wards of the state (Hamlin and Timberlake, 1994; Timberlake and Hamlin, 1982).

The 3 least common strengths were involvement in a religious group, involvement in a community services group, and identification of a career goal. The first 2 of these are easily reconcilable. One of the unfortunate aspects of placement in a residential facility can be the breaking of ties to the community (Bruns et al., 1995; Rosenblatt, 1996). Working to restore those ties through participation in groups outside of the facility could have important normalizing effects. The absence of career goals may reflect the variable age of children and adolescents in this sample. More likely it reflects the loss of future orientation that can occur among socioeconomically disadvantaged and disturbed children and adolescents (Nurmi, 1991; Stevens, 1997; Trommsdorff and Lamm, 1980).

The present sample was composed of children and adolescents in residential placement, many of whom were in child welfare. One would expect that the prevalence and pattern of strengths in this study would not be comparable with those in the general population. In particular, the general low level of family strengths and the absence of an association between family strengths and risk behaviors may be specific to a child welfare population.

The present results do not shed any new light on which strengths are most amenable to change and what types of interventions are best suited for the purposes of strength-building. Such information represents an important next step in an evolving body of research on these phenomena. It is likely that some strengths may be more or less malleable/intransigent to intervention. Similarly, some strengths may be more or less within/outside the corridor of effects of mental health service interventions.

TABLE 3

Correlations Among the CASA Total and Domain Scores and the Symptoms, Risk Behaviors, and Functioning Scales of the CSPI

CASA	Symptoms	Risk Behaviors	Functional Impairment
Total score	−0.29**	−0.20**	−0.35**
Family	−0.13*	−0.08	−0.16**
School/Vocational	−0.24**	−0.13**	−0.30**
Peer	−0.32**	−0.17**	−0.29**
Psychological	−0.24**	−0.18**	−0.24**
Moral/Spiritual	−0.27**	−0.23**	−0.26**
Extracurricular	−0.08	−0.07	−0.24**

Note: CASA = Child and Adolescent Strengths Assessment; CSPI = Childhood Severity of Psychiatric Illness.

* $p < .5$; ** $p < .01$.

It appears that our results suggest an integration of clinical approaches aimed at treating and reducing symptoms and risk behaviors and strength-based approaches aimed at identifying and building resources, assets, and skills. An integrative approach may offer the best opportunity to help improve the functioning of at-risk children and adolescents and enhance the possibility of successful discharge placement. Either approach seems to offer the potential benefit; however, since strengths and psychopathology appear to be independent, an integrated approach that addresses both dimensions is indicated by our findings.

Community mental health for children and adolescents has witnessed an increased tension between traditional mental health providers and advocates of strength-based approaches. Often advocates of strength-based approaches pose the issue as a distinction between strengths and deficits. It is clear from the present results that psychopathology is not the opposite of strengths. Many children and adolescents with severe psychopathology also have significant strengths. Others have few. As such, the rhetoric describing psychopathology as a "deficit" may be somewhat misleading. It also has the potential untoward consequence of furthering the stigma of mental illness. An integrated approach in this area can both address the complex mental health needs and build upon positive aspects in the lives of children.

Limitations

There are several limitations to this study. First, the study was retrospective and predominantly cross-sectional in design. As such, dynamic relationships over time could not be assessed. Also, the completion of the CASA by workers depended on memory for those cases who had been discharged by the time of the study. Although the use of different informants for the CASA and the CSPI is a methodological strength of the present study, this design does introduce the potential for method variance that might underestimate the actual relationships. Finally, although the internal consistency reliability of the CASA was quite high, the interrater reliability of the CASA was not assessed in this study. Other research in the development of this scale supports its reliability across raters; however, this was not directly estimated in this study.

Clinical Implications

There are at least 2 clear implications of the present findings for clinical practice. First, this study supports greater attention to the assessment of strengths in clinical practice.

Most assessments focus on identifying psychopathology; clearly, understanding the strengths of children and adolescents has implications for both their functioning and the likelihood of high-risk behaviors. In reviewing case records, we have noted that often the generally required "strengths" sections of assessments are filled with statements such as "youth is a voluntary admission" or "youth likes to hang out with friends." The present findings suggest an evolving in the assessment of strengths in standard clinical care and documentation as an important priority.

Second, it also may be that a part of the role of mental health services is to build strengths. A person may struggle with depression for his or her entire life, and the purpose of treatment may be to provide tools (e.g., a sense of humor, coping skills, social support) that help in this struggle. Understanding the effects of mental health services would thus require the assessment of new strengths that result from treatment experiences. Monitoring the development of strengths and making strength development an active aspect of treatment would be indicated by the present findings.

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