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Examining the Effects of a Strength-Based Therapeutic Assessment Process on Students' Perceptions of Teacher-Student Relationship, Hope, and Academic Competence

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EXAMINING THE EFFECTS OF A STRENGTH-BASED THERAPEUTIC ASSESSMENT PROCESS ON STUDENTS' PERCEPTIONS OF TEACHER-STUDENT RELATIONSHIP, HOPE, AND ACADEMIC COMPETENCE

by

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ABSTRACT

Examining the Effects of a Strength-Based Therapeutic Assessment Process on Students' Perceptions of Teacher-Student Relationship, Hope, and Academic Competence

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One major purpose of school-based assessment approaches is to identify ways to intervene to promote positive school academic, social, and well-being outcomes for all students. Although schools traditionally use assessment tools to identify students' weaknesses and needs, they can also use strength-based assessment tools to guide intervention planning and to validate students' and teachers' positive views of student skills and characteristics. Sharing these strengths and how to use them may enhance a student's perception of the teacher-student relationship, hope, and academic competence. A second approach to assessment, called Therapeutic Assessment (TA), has yielded similar child outcomes for youth in clinical settings. The purpose of this study was to evaluate the effects of a strength-based therapeutic assessment process on teacher-student relationship, hope, and academic competency beliefs of students as compared to students

receiving assessment as usual in school settings.

Study participants included 16 students and 7 teachers. Student participants were randomly assigned to one of two groups: the treatment group, which received a strength-based therapeutic assessment approach, or the control group, which received assessment as usual in school settings. Student-teacher relationship quality, student hope levels, and students' academic competency beliefs were measured before and after enacting treatment conditions. Data were analyzed using *t* tests on change scores.

Although no statistically significant differences were found between students in the treatment and control groups on the dependent variables (teacher-student relationship quality, student hope levels, and academic competency beliefs), a medium strength effect size ($d = 0.55$) was found for the Children's Hope Scale (CHS). This indicates that the treatment condition may have moderate practical significance in increasing student hope levels. Additionally, a small effect size ($d = -0.38$) was found for the Competence Beliefs and Subjective Task Values Questionnaire (CBSTVQ) average math variable. This indicates that the treatment condition is moderately associated with students experiencing a decrease in perceived math competence. Future research on this topic should use a larger sample size in order to better determine whether or not the treatment condition has statistically significant effects on the dependent variables of teacher-student relationship quality, student hope levels, and academic competency beliefs.

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PUBLIC ABSTRACT

Examining the Effects of a Strength-Based Therapeutic Assessment Process on Students' Perceptions of Teacher-Student Relationship, Hope, and Academic Competence

Teresa A. Duszlak

One major purpose of school-based assessment approaches is to identify ways to intervene to promote positive school academic, social and well-being outcomes for all students. Although schools traditionally use assessment tools to identify students' weaknesses and needs, they can also use strength-based assessment tools to guide intervention planning and to validate students' and teachers' positive views of student skills and characteristics. Sharing these strengths and how to use them may enhance a student's perception of the teacher-student relationship, hope and academic competence. Likewise, a second approach to assessment, called Therapeutic Assessment (TA), has yielded similar child outcomes for youth in clinical settings. The purpose of this study was to evaluate the effects of a strength-based therapeutic assessment process on teacher-student relationship, hope, and academic competency beliefs of students as compared to students receiving assessment as usual in school settings.

Student participants were randomly assigned to one of two groups: the treatment group, which received a strength-based therapeutic assessment approach, or the control group, which received assessment as usual in school settings. Student-teacher relationship

quality, student hope levels, and students' academic competency beliefs were measured before and after experimental conditions were enacted.

Although no statistically significant differences were found between students in the treatment and control groups on any of the dependent variables (teacher-student relationship quality, student hope levels, and student-reported academic competency beliefs), a medium strength effect size (d = 0.55) was found for the Children's Hope Scale (CHS). This indicates that the treatment condition may have moderate practical significance in increasing student hope levels. Additionally, a small, but meaningful effect size (d = -0.38) was found for the Competence Beliefs and Subjective Task Values Questionnaire (CBSTVQ) average math variable. This indicates that the treatment condition is moderately associated with students experiencing a decrease in perceived math competence. Future research on this topic should use a larger sample size in order to better determine whether or not the treatment condition has statistically significant effects on the dependent variables of teacher-student relationship quality, student hope levels, and academic competency beliefs.

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Introduction

One major purpose of school-based assessment approaches is to identify ways to intervene to promote positive school academic, social and well-being outcomes for all students. In school settings, the treatment utility of assessment refers to the degree to which the assessment process and results lead directly to positive academic, social and well-being outcomes for students. Specific assessment modes are chosen via careful consideration of the likely treatment utility of that assessment mode for identifying or changing factors that influence school outcomes (Hayes, Nelson, & Jarrett, 1987). Preliminary research demonstrates that therapeutic assessment with children (TA-C) has treatment utility on child mental health and behavioral outcomes when used in clinical settings (Poston & Hanson, 2010). In clinic settings, TA-C is a collaborative assessment process involving the child, parent(s) and clinician (Tharinger, Gentry, & Finn, 2013). It functions as both an information-gathering tool and as a brief intervention as the clinician works to collaborate during the assessment process with parents and child. Collaboration includes selecting, administering and sharing assessment outcomes and insights with parents and child. In addition, the TA-C approach has demonstrated several positive outcomes for children and parent(s), including improved parent-child relationships, increased parental levels of hope, increased parental understanding of their child's issue, increased motivation for parental follow through with service recommendations and

stronger beliefs in parents' own abilities to parent the child (Finn & Tonsager, 1992; Tharinger et al., 2009). Parental reports indicate that TA-C yields positive outcomes for children including less frequent behavioral problems, improved mood and better social functioning (Tharinger et al., 2009).

Therapeutic Assessment (TA), the broader model upon which the more specialized TA-C model is based, differs from other assessment approaches because of its focus on the assessment process as a brief intervention opportunity. It is this unique focus of TA that enhances factors that may similarly influence important school outcomes. For instance, students with higher quality teacher-student relationships, hope levels and competency beliefs tend to demonstrate greater academic engagement and performance than students with lower levels (Chouinard, Karsenti, & Roy, 2007; Curry, Snyder, Cook, Ruby, & Rehm, 1997; Grolnick, Gurland, Jacob, & Decourcey, 2002; Singh, Granville, & Dika, 2002; Wigfield & Eccles, 2000; Wigfield et al., 1997). Thus, research findings on the treatment utility of TA have important implications for treatment practices in school settings involving the school psychologist, teacher and students.

Positive teacher-student relationships and feelings associated with them motivate students to persist in learning skills at school. Teacher-student relationships develop as students receive approval for class involvement from the teacher. Students then maintain or increase their involvement in order to receive additional approval (Davis, 2003). Teacher approval involves teacher attitudes, statements or behaviors that indicate to the student that the teacher believes he or she to be a capable and valuable contributor to the class.

Hope, a second factor contributing to academic engagement in students, can be defined as the belief in one's ability to find ways to meet a goal (Snyder, 2000). When one is motivated by this belief or confidence in one's own abilities, one is more likely to initiate actions and plans to achieve goals. Additionally, another component of the hope construct is that of holding a belief in one's abilities to accomplish each step to goal attainment using one's skills and abilities (Snyder, Ilardi, Michael, & Cheavens, 2000). Instructional support from teachers on goal setting and ways to overcome barriers is one factor that influences hope (Lopez, Rose, Robinson, Marques, & Pais-Ribeiro, 2009).

Academic competency, another contributing factor to academic engagement, can be defined as the attitude and belief that the person has the skills to be successful. Competency belief is based on the framework of expectancy theory. Theorists postulate that students' expectations and competence beliefs regarding successful task completion are contributing factors to students' choice of tasks to complete and students' use of skills to perform tasks. Student expectancy is also influenced by the development of positive teacher-student relationships (Wigfield & Eccles, 2000).

It is important to note that the development of these three factors (teacher-student relationship, hope, and academic competency beliefs) relies upon both the teacher's and student's awareness and understanding of the student's abilities and strengths. Unfortunately, in school settings, student assessments tend to focus only on the identification and understanding of academic and behavioral deficits. A collaborative approach, focusing on better understanding students' strengths, may provide more valuable insight for intervention planning purposes. Identified strengths could then be

incorporated into intervention planning. They could be used in a way that addresses any student weaknesses, whether cognitive, academic or social-emotional in nature.

Research supports the need to leverage student strengths for intervention planning (Rudolph & Epstein, 2000). Moreover, students may additionally benefit from the use of strength-based assessments when they are incorporated into a TA-C framework in school settings. This study examined the influence of strength-based assessments using brief TA framework between teacher, student and school psychologist on students' perceptions of teacher-student relationship quality, hope, and academic competency.

Research Question

The research question that was asked was: Is there a significant difference between students who experience a strength-based therapeutic assessment process and students who do not experience a strength-based therapeutic assessment process on the following variables: (1) teacher-student relationship quality, (2) student self-reported levels of hope, and (3) academic competence of student experiencing classroom problems?

It was hypothesized that students who participated in a strength-based therapeutic assessment process would report significantly increased levels of teacher-student relationship quality, hope, and academic competence as compared to students who did not participate in a strength-based therapeutic assessment process.

CHAPTER II

LITERATURE REVIEW

Academic, behavioral and learning difficulties put many students at high risk of negative academic and life outcomes. Thus, a critical outcome of the assessment process with struggling students is treatment utility, defined as the degree that assessment impacts positive change in an individual's well-being, psychosocial functioning or life functioning (Hayes, Nelson, & Jarrett, 1987). This literature review details the TA approach, including its empirically supported positive client outcomes, followed by important findings and implications on teacher student relationships, student hope, and student academic competency beliefs. Finally, advantages of using strength-based assessments will be discussed as well as the incorporation of strength-based assessment practices into the TA process.

Treatment Utility of Therapeutic Assessment

TA is the process of utilizing a psychological assessment as a short-term and collaborative intervention to influence desired outcomes (Tharinger, Krumholz, Austin, & Matson, 2011). Overall, TA is a semistructured mixture of assessment and intervention techniques. TA has been successfully used to treat different populations, including adults, couples, adolescents, and children (Tharinger et al., 2011).

TA is implemented in a specific sequence of steps. First, the therapist gathers assessment questions from the client as well as others involved in the client's life when appropriate. For example, a client's parent may ask the following assessment question:

"Why does my child have such difficulty concentrating at school?" Second, the client and any significant adults in the client's life complete formal assessments (e.g., scales and standardized tests) that are selected with the aim of answering the identified assessment questions posed in step one. Next, the therapist meets with the client and any other included adults to collaboratively discuss assessment feedback and plan for the future. In this collaborative discussion between the client, any involved adult(s) and therapist, participants focus upon the following two goals for the meeting: answering the identified assessment questions and exploring possible next steps for change. The fourth step is a 'written communication phase' that consists of the therapist providing individualized written feedback for client and other adult participants to summarize the discussion as well as any formal reports required for referral sources. Lastly, the client and any included adults will attend a follow-up meeting with the therapist to discuss client progress since the last meeting (Tharinger et al., 2011).

TA uses an eclectic mix of concepts and techniques from various psychological orientations such as behavioral, social learning, cognitive-behavioral, object relations, attachment, narrative, humanistic and family systems. It is presumed that people's desire to experience self-verification, self-enhancement, self-efficacy and self-discovery leads to the positive outcomes commonly experienced by means of TA (Aschieri & Fantini, 2012; Tharinger et al., 2011).

Poston and Hanson (2010) conducted a meta-analysis consisting of 17 studies from 1954 to 2006 on TA with adults (age range, 18 to 40) to ascertain whether or not assessment as an intervention models have therapeutic value. All studies examined the

degree to which treatment processes and client outcomes changed when traditional psychological assessment testing was combined with personalized, collaborative testing feedback. Following study selection, researchers looked at the mean of reported effect sizes within each study in order to calculate the aggregate effect size for the meta-analysis (d = 0.423; CI [0.321-0.525]). In sum, about 66% of people who received assessment as an intervention, in that they received both traditional psychological assessment testing and collaborative feedback, had better outcomes than people in the control groups who received only traditional psychological assessment testing. Next, researchers assigned all reported treatment outcome variables to one of three categories: process-oriented, outcome-oriented or process/outcome oriented. Researchers found an average effect size for the process-oriented category of d = 1.117 (CI [0.679-1.555]), for the outcome-oriented category of d = 0.367 (CI [0.256-0.478]), and for the process/ outcome-oriented category of d = 0.547 (CI [0.193-0.901]). Overall, researchers found that TA has positive therapeutic value in terms of improving the therapeutic process, bettering client outcomes and increasing combined process/outcome variables.

Finn and Tonsager (1992) showed that sharing Minnesota Multiphasic Personality Inventory (MMPI-2) results with college clients also leads to positive therapeutic outcomes. In this study, college students in the experimental group (n = 32) received feedback on their MMPI-2 results while students in the control group (n = 29) received only attention from the examiner. Participants in the experimental group had significantly lower symptom distress (p < .01) and significantly increased positive subjective impressions (p < .01), self-esteem (p <. 01), and more hope about solving problems (p <

.01) as compared to the control group two weeks after the feedback session. The authors hypothesized that the feedback procedure for the experimental group produced significant results because the feedback procedure provided self-verification for participants by actively confirming aspects of the client's self-concept that had not before been verified by others. Researchers also provided self-enhancement for participants during the feedback session by reframing client's experiences in a more positive light based upon client assessment results.

Although TA has been conducted primarily with adults, emerging research supports the efficacy of TA for children and adolescents in clinical settings. More specifically, TA-C has demonstrated success in helping parents to understand their children differently, increasing parental empathy for the child, and positively changing parent-child interaction patterns (Tharinger et al., 2011).

Tharinger et al. (2009), for example, studied the effects of TA-C on social-emotional behaviors in 14 youth, ages 8 to 11 years old, with parent-child dyads (n = 14) in a pre/post study without a control group. The TA-C process included the use of parental interviews and behavioral scale assessments to help develop a new perspective or way of viewing behavioral problems. Child behavioral problems as well as potentially supportive solutions to the behavioral problems were then transformed into a "Fable Story" format to help families understand how to deal with the behavioral problems at home. Statistically significant treatment outcomes from pre- to posttest included high treatment acceptability, decreased symptomatology in clients (d = 0.74) and improved familial functioning (d = 0.38). Children also reported a stronger family connection *(d* =

0.50). Last, clients' mothers demonstrated increased positive emotions (d = 0.58), including empathy, positive emotions, and hopefulness, as well as decreased negative emotions (d = 1.18) in regards to their children's futures.

In a similar research study, Hansson, Hansson, Danielsson, & Domellof (2016) studied the effects of a collaborative and therapeutic approach (CTA) on children's self-reported psychiatric symptoms. Researchers randomly assigned participants who were 7 to 17 years old to three groups: 11 children received CTA, 11 children received parent support, and 9 children were on a waiting list. Participant pre and posttest scores on the Beck Youth Inventories were analyzed using a two-way analysis of variance (ANOVA) in order to determine if children in the CTA group experienced reductions in their self-reported psychiatric symptoms. Results indicate that all groups showed improvement over time. In addition, no significant group by time interaction was found. Researchers did find, however, that the CTA group reported a fewer number of symptoms on BYI subscales immediately following the intervention as well as six months later for the BYI Anger and Anxiety subscales.

There are also a number of single case studies to date that report similar positive outcomes for the TA-C process (Dubose, 2002; Fulmer, Cohen, & Monaco, 1985; Handler, 2007; Michel, 2002; Mutchnick & Handler, 2002; Purves, 2002; Quirk, Strosahl, Kreilkamp, & Erdberg, 1995; Tharinger, Finn, Wilkinson, & Schaber, 2007). Positive outcomes noted in these single case studies include parental reports of a clearer understanding of children's behavioral problems as well as parental reports of increased feelings of parental competence. Additionally, children have reportedly demonstrated less

frequent behavioral problems, improved mood and social functioning, and better school adjustment as a result of TA-C.

Research on the effects of TA-C on client hope levels is limited. However, in a particular case study by Tharinger et al. (2007), researchers discuss a case study of an 11-year -old female and her grandparents who, together, took part in a TA-C process that increased the 11-year-old female's levels of hope. The girl reported that she felt more hopeful and better about herself. Case outcomes also included the following: a decrease of over a standard deviation on the girl's externalizing symptom score on the BASC-2 and caregiver reports of less crying, screaming, talking back, and wall kicking. Caregivers furthermore reported that appropriate behaviors increased 65% and that they were highly satisfied with the therapeutic assessment process. Overall, the client and family were satisfied with the treatment, the client's symptoms decreased and the client experienced an increase in hope and self-esteem. Thus, for this particular child, her hope levels increased as a result of participating in the TA-C process.

TA-C has demonstrated beneficial outcomes for children and adolescents from ages 7 to 17 years old in clinical settings (Hansson et al., 2016; Tharinger et al, 2009). If TA-C were used in school settings, students may similarly benefit from TA-C in the following ways: improvements in teacher-student relationship quality, increased hope and increased competency beliefs. Although such TA-C outcomes have been demonstrated in clinical settings, TA-C has not yet been studied in school settings. These three outcomes and their relationships with academic engagement will be discussed in the following section.

Academic Engagement and Related Variables

Researchers represent the academic engagement construct in four parts: (1) academic investment, (2) behavioral participation, (3) psychological feelings and reactions and (4) cognitive investment (Appleton, Christenson, & Furlong, 2008). A number of social, emotional and cognitive variables have been identified that can either foster or hinder a student's motivation to be engaged and, in turn, to learn academic material. Three such influential variables include the following: teacher-student relationship, academic competence beliefs and hopefulness. These three potential outcomes of the TA process will be discussed next in more detail.

Teacher-Student Relationship

The development of a positive teacher-student relationship plays an important role in supporting academic engagement and achievement. Quality of teacher student relationship (TSRQ) is defined within a school context as the degree to which a teacher student relationship provides appropriate nurturance and structure to a student. The teacher student relationship should provide enough nurturance and structure in order to best promote student motivation and development of social, emotional and academic skills. Extensive research has shown that teacher and student ratings of TSRQ are moderate predictors of academic engagement and are small to moderate predictors of academic performance at all grade levels (Hamre & Pianta, 2006; Hughes, Luo, Kwok, & Loyd, 2008; Liew, Chen & Hughes, 2010; Roorda, Koomen, Spilt, & Oort, 2011; Valiente, Lemery-Chalfant, Swanson, & Reiser, 2008). For example, Hughes (2011)

conducted a 4-year longitudinal study on 714 academically at-risk elementary students to examine how student perceptions of the TSRQ influenced student academic motivation and achievement. Taken together, teacher and student reports of TSRQ accounted for a statistically significant increments in explained variance in Year 4 of 4.4%, 3.2%, and 7.2% for student perceived reading competency, math competency and school belonging, respectively above baseline and child predictive factors (gender, free lunch, IQ, and retained). Moreover, student reports of TSRQ uniquely predicted all outcomes including school belonging, perceived academic competence and math achievement. Teacher and student rated TSRQ also accounted for a statistically significant increment of explained variance in Year 4 in behavioral engagement ($R^{sq}_{change} = .056$, $p < .001$), reading achievement ($R^{sq}_{change} = .011$, $p < .05$), and math achievement ($R^{sq}_{change} = .008$, $p < .05$). In sum, these findings suggest the importance of evaluating student perceptions of teacher support as well as the need for positive interventions to improve teacher student relationship quality.

In a meta-analysis, Roorda et al. (2011) examined the relationship between certain affective qualities of teacher-student relationships (TSRs) and students' levels of school engagement and achievement. Researchers analyzed 99 studies of preschool to high school age students. Positive affective qualities of teacher-student relationships included empathy and warmth. Researchers did four separate analyses to examine the associations of the following variables: positive aspects of TSR and engagement, negative aspects of TSR and engagement, positive aspects of TSR and achievement, and negative aspects of TSR and achievement. Roorda et al. found medium to large effect sizes for the

associations between positive relationships and engagement ($r = .39$, $p < .01$, for fixed effects model; $r = .34$, $p < .01$, for random effects model) and for the associations between negative relationships and engagement ($r = -.32$, $p < .01$, for fixed effects model; $r = -.31$, $p < .01$, for random effects model). Associations between positive relationships and achievement ($r = .16$, $p < .01$, for both fixed and random effects models) and associations between negative relationships and achievement ($r = -.15$, $p < .01$, for fixed effects model; $r = -.18$, $p < .01$, for random effects model) were small to medium. Results indicate that students' academic engagement is influenced by teacher-student relationship quality.

Hope

Hope is defined as the belief in one's ability to find ways to meet a goal (Snyder et al., 2000). When one is motivated by this belief or confidence in one's own abilities, one is more likely to initiate actions and plans to achieve goals. Additionally, another component of the hope construct is that of holding a belief in one's abilities to accomplish each step to goal attainment using one's skills and abilities (Snyder et al., 2000). Van Ryzin (2011) used a sample of 423 secondary school students to study the reciprocal effects of student perceptions of school environment, engagement in learning, hope and academic achievement. Researchers defined student perceptions of school environment as perceptions of autonomy, teacher/peer support and goal orientation. Ryzin predicted that the resultant data would fit a particular model: student perceptions of school environment leads to changes in engagement in learning which then leads to changes in academic achievement and hope. This predicted model demonstrated good fit

with the data, v (81) = 150.98, $p < .001$; v /*df* - 1.86; CFI = .98; TLI = .96; RMSEA = .045 (.034 | .056). Thus, results from the study demonstrated a link between student perception of school environment and student engagement in learning. Additionally, in a different study, another link was found between student engagement in learning and changes in academic achievement and hope over a 1-year time span which was perhaps due to more goal planning and persistence (Snyder et al., 1991). Snyder et al. (1997) showed that high levels of hope in school-age students also correlated with positive social interactions, self-esteem, optimism and academic achievement.

Providing students with guidance in goal setting and planning based on interests, strengths and values has been shown to increase hopefulness. Lopez et al. (2009), for example, developed a 5-week hope-based intervention and examined its effects on hope levels, life satisfaction, self-worth, academic achievement and mental health for middle school students ($n = 62$). The lessons focused upon four topics including: (1) clear goal conceptualization, (2) production of several pathways toward goal attainment, (3) application of energy to the goal pursuit, and (4) reframing obstacles as challenges to conquer. Immediately after the intervention, the experimental group had increased hope from pre to post-assessment ($p < .001$), higher life satisfaction scores ($p < .001$) and improved self-worth ($p < .001$) as compared to the control group who did not receive the intervention. The experimental group also differed significantly on these variables from the control group at a 6-month, and 18-month follow-up.

Academic Competency Beliefs

Research supports that self-competency beliefs also predict academic engagement

(Chouinard et al., 2007; Grolnick et al., 2002; Singh et al., 2002; Wigfield & Eccles, 2000; Wigfield et al., 1997). Researchers have studied the mechanisms that motivate students to engage in academic tasks via the perspective of Expectancy-Value Theory. Expectancy-Value theorists state that students who judge themselves as having the ability to successfully complete upcoming tasks are likely to be more motivated to engage in the activity (Wigfield, 1994; Wigfield & Eccles, 1992). Believing that effort will increase abilities also enhances feelings of competency and thereby the motivation to learn how to complete tasks (Trautwein, Ludtke, Roberts, Schnyder, & Niggli, 2009). Finally, theorists advance that engagement is also influenced by the students' interest, value and personal goals in carrying out a task (Wigfield, 1994). Students' beliefs about how well they will do in various academic tasks are influenced by prior successes as well as by adult support, feedback and expectations (Nicholls, 1984). Because confident students are likely to make persistent efforts to complete tasks, academic interventions may include strategies to increase academic competency beliefs.

In sum, research supports the importance of the following three outcomes in school settings: teacher-student relationship quality, students' belief in their own academic competence and students' hope levels. The TA-C process may increase these beneficial student outcomes. In school settings, the collaborative process between teacher, student and school psychologist will need to include assessments that increase both teacher and students' knowledge and understanding of students' abilities and strengths. In this manner, students' beliefs in their own competencies, their hope levels and their relationships with teachers may improve.

Strength-Based Approach

Strength-based approaches assume that children and youth have strengths that are important to their social, emotional, behavioral and academic development (Nickerson & Fishman, 2013). Acknowledgment of student strengths is important for several reasons. First, this information increases understanding and knowledge of children's successes in their lives as well as their capacities in various domains. Focusing on strengths may lead to increased child motivation to engage in services, to the more likely development of a positive school-parent relationship and parental feelings of involvement in the Individual Education Plan (IEP) process (Epstein et al., 2003). Second, identification of students' strengths enables team members to select treatment goals and plan interventions based on both children's strengths and needs (Rudolph & Epstein, 2000). Finally, numerous research studies demonstrate that strengths can serve as protective factors for positive youth development (Brownlee et al., 2013). In a 20-year-long longitudinal study by Raskind, Goldberg, Higgins, and Herman (1999), researchers worked to identify specific personal characteristics and experiences that lead youth to positive life outcomes, despite learning difficulties. Researchers found that the following six protective factors contribute significantly to positive life outcomes: goal setting, self-awareness, perseverance, emotional coping strategies, social support systems and proactivity. These six personal characteristics can serve as protective factors by counteracting risk factors, thereby leading to positive student social, emotional, behavioral and academic development (Raskind et al., 1999).

Researchers have also studied the effects of strength-based assessments on youth

with emotional or behavioral concerns. Cox (2006) examined the effect of adding a strength-based assessment, the Behavioral and Emotional Rating Scale (BERS), to the usual diagnostic assessment procedure for youth with emotional or behavioral concerns. Participants included 84 youth requesting or receiving psychotherapy from a publically funded mental health agency. The experimental group received the usual diagnostic assessment and the BERS. The control group received only the usual diagnostic assessment. Youth caregivers completed the BERS and therapists were asked to share BERS results indicating specific youth strengths and resources and recommendations with the youth and family for intervention planning. Differences between the two assessment groups were evaluated on the following short- and long-term outcome variables: child functioning, parent satisfaction, and service measures. Researchers administered the Child Behavior Checklist (CBCL), Youth Self-Report (YSR), and Child and Adolescent Functional Assessment Scale (CAFAS) to assess for changes in child functioning over the course of therapy. Parent satisfaction was measured using the Client Satisfaction Questionnaire 8 (CSQ-8). Service measures were assessed as the percentage of missed or cancelled therapy appointments and treatment drop-out. Last, a clinician survey was administered to measure the therapists' strength-based orientation (SBO). Results revealed that no significant differences in child functioning were found between the experimental and control groups on any of the child functioning measures. However, researchers did identify a significant interaction on the therapist SBO score between groups and time on the CBCL total problems score ($F = 3.99$, $df = 2$, $p = 0.023$) and on the CBCL internalizing scale ($F = 4.54$, $df = 2$, $p = 0.014$). Youth who were in the

experimental group and who were also receiving services from a highly strength-based therapist made better gains over time than youth in the control group who also had highly strength-based therapists. In other words, youth tend to get improved therapeutic outcomes when a strength-based assessment is administered only when their therapists see value in the use of the strengths information gained from the strength-based assessment. Lastly, clients who had received feedback on the BERS from the therapist missed significantly fewer appointments than those in which it was absent from the records (X^2 = 4.72, *df* = 1, *p* = .03). Clients receiving in-session BERS feedback missed or cancelled an average of 8% of sessions while clients who did not receive the BERS feedback missed or cancelled an average of 14% of sessions.

Using a multiple case study, Bozic (2013) investigated the use of strength-based assessments on intervention planning in schools. Six high school or near high school age participants in this study were demonstrating emotional or behavioral problems. A combination of results from the Child and Adolescent Strengths Assessment (CASA) and the Assets Interview (AI) with youth was used in order to identify actual and potential personal, interpersonal and systems level strengths. Identified strengths were then incorporated into intervention planning in one of the following four ways: (1) a selected strength was used to address a difficult area, (2) the intervention targeted specific strength(s) or protective factors, (3) a strength was acknowledged and developed in order to promote positive identity development, or (4) concerns were reframed as opportunities to develop new potential strengths. Results revealed that identified strengths contributed to intervention development when selecting intervention targets and supportive strategies.

After the intervention plan was enacted, about 80% of the participants in the study experienced positive outcomes on the Target, Monitoring and Evaluation (TME) Scale and the CASA.

In order to incorporate strengths into the educational planning process, student strengths must first be identified using strength-based assessments as one part of the school-based assessment process. Strength-based assessments, as defined by Epstein and Sharma (1998), measure emotional and behavioral competencies that aid in social relationship building and academic achievement. Strength-based assessments take several different forms including interviews, observations or standardized and norm-referenced tools (Jimerson, Sharkley, Nyborg, & Furlong, 2004).

Currently, problem-oriented approaches primarily focus on the identification of deficits that need remediation in school settings. Consequently, educators who rely upon these problem-oriented approaches often fail to provide adequate attention to the assessment of students' strengths and they also often fail to capitalize on students' strengths in ways that can help support remediation interventions (Rudolph & Epstein, 2000). Schools are mandated by the Individuals with Disabilities Education Act (IDEA, 2004) to consider strengths of students with disabilities during the development and revision of students' IEP. Yet, research conducted by Fish (2006) demonstrated that parents of students with disabilities reported that educators did not collaborate adequately during IEP meetings. Instead, parents reported that treatment planning during IEP meetings was dominated by discussions of the failures of the child. Moreover, parents also expressed a desire to include more significant strength-based discussions in IEP

meetings in order to encourage the attainment of more positive outcomes for their children (Fish, 2006).

Although strength-based assessment strategies, to date, have shown preliminary promise in playing a role in desired change for youth with social or emotional issues, few researchers have used randomization procedures or experimental designs to compare the efficacy of strength-based assessment strategies to more traditional assessment strategies (Brownlee et al., 2013). As evident in studies detailed above, research on strength-based assessment use has primarily targeted youth with emotional or behavioral issues. Clearly, more research needs to be done on other strength-based factors that may influence treatment outcomes. Moreover, given the positive outcomes of the TA-C approach, evaluating outcomes of a strength-based assessment within a TA format may yield additional positive results.

Statement of Purpose

Treatment utility is a primary goal of school-based assessment. Using strength-based assessments in schools allows for the identification of current student strengths to employ in the classroom. Students' strength use in school can increase students' ability and motivation to engage in classroom activities. Although schools traditionally use assessment tools to identify students' weaknesses and needs, they can also use strength-based assessment tools to guide intervention planning and to validate students' and teachers' positive views of student skills and characteristics. Sharing these strengths and how to use them may enhance a student's perception of the teacher-student relationship,

hope and academic competence. Importantly, these factors have been shown to be associated with academic engagement. Evidence of the positive effect of the TA-C process on similar child outcomes in clinical settings warrant conducting studies of TA on students in school settings. Collaboratively assessing and discussing student strengths between teacher, student and school psychologist may enhance a student's perception of the student-teacher relationship, hope and academic competence. Thus, the aim of this study is to evaluate the effect of a strength-based therapeutic assessment process on teacher-student relationship, hope, and academic competency beliefs of student experiencing classroom problems relative to students who do not experience a strength-based therapeutic assessment process.

CHAPTER III

METHOD

Participants and Settings

Participants ($N = 16$) were recruited from students attending two public schools in third to fifth grade in Idaho. All sixteen students who were selected to participate in the study were reported by their teachers as needing extra behavioral support in the classroom for specific behavioral issues. Examples of teacher-reported behavioral issues include peer conflicts (bullying peers, conflict with peers, and physical aggression towards peers), disruptive behaviors (talking out in class, interrupting peers during instruction, and leaving one's seat without permission), non-compliant behaviors (work refusal and failure to follow teacher directives), and other issues (off-task/easily distracted and disorganization). Students without a disability or students that are classified as a student with a disability without significant cognitive deficits (e.g., specific learning disability, attention deficit hyperactivity disorder, emotional disturbance) were included as participants in the study. See student participant characteristics in Table 1.

Teacher characteristics of participating teachers are detailed in Table 2. Teachers were involved in the nomination of student participants for the study, in the identification of students' strengths, and in collaborative meetings with students and researcher.

Researchers randomly assigned half of the student participants to the treatment group and half to the control group. All assessment procedures and collaborative meetings were conducted with students and teachers in private and quiet classrooms.

Table 1

Student Characteristics

Variables	Mean	*SD*	%	*N*
Age	9.31	0.87		
Grade				
3			50.0	8
4			37.5	6
5			12.5	2
Gender				
Male			81.3	13
Female			18.8	3
Race/ethnicity (White)			100.0	16
ELL services (No)			100.0	16
Special education services				
Yes			50.0	8
Emotional disturbance			18.8	3
Other health impairment			12.5	2
Specific learning disability			23.6	4
No			50.0	8
Behavior issue				
Peer conflict			37.5	
Disruptive			31.3	
Noncompliance			18.8	
Other			12.5	

Table 2

Teacher Characteristics

Variables	Mean	*SD*	%	*N*
Years teaching	14.28	8.73		
Degree				
BA/BS			57.14	4
MA/MS			42.86	3
Gender (Female)			100.00	7
Race/ethnicity (White)			100.00	7

Measures/Materials

Demographic Forms

A brief demographics questionnaire, entitled Student Demographics, was completed by parents in order to gather information about each participating student in regards to student disability status, English Language Learner (ELL) status, gender, age, ethnicity and grade (see Appendix B). Teachers completed a Teacher Demographic form that gathered information, including teacher gender, age, education level, and years of teaching experience (see Appendix C).

Behavioral and Emotional Rating Scale

The Behavioral and Emotional Rating Scale, Second Edition (BERS-2; Epstein, 2004) was used to evaluate the emotional and behavioral strengths of treatment-group participants. The BERS-2 is designed for ages 5 to 18 and takes about ten minutes to complete. Researchers administered two of the BERS-2 forms, the Teacher Report Survey (TRS) and the Youth Report Survey (YRS). For the BERS-2 TRS and YRS forms, individuals are rated on each item according to a 4 point Likert scale, ranging from 0 (not at all like) to 3 (very much like). The BERS-2 provides five strength subscale scores: interpersonal strength (14 items), involvement with family (10 items), intrapersonal strength (11 items), school functioning (9 items), and affective strength (7 items). In order to determine behavioral and emotional strengths for student participants, the five strength subscale scores from both the BERS-2 TRS and the BERS-2 YRS were utilized.

Internal consistency coefficients range from .81 to .89 for the BERS-2 TRS form and range from .79 to .88 for the BERS-2 YRS form for children without disabilities (N = 2,178) and for children with emotional disturbances (N = 861). According to the manual, the BERS–2 possesses adequate test–retest reliability for the TRS form (r = .85 to .99; N = 59) and the YRS form (r = .84 to .91; N = 42; Epstein, 2004; Epstein, Mooney, Ryser, & Pierce, 2004).

Academic and Behavioral Classroom Strengths Inventory

The Academic and Behavioral Classroom Strengths (ABCs) Inventory was constructed for this study in order to identify student strengths important to classroom settings (see Appendix D). The ABC's Inventory was developed following three steps. First, items were selected from several empirically based social skill and social-emotional learning programs developed to assess and teach preferred classroom academic and social behaviors (e.g., SKILL STREAMERS, SUPER HEROES, SSIS, PREPARE, ASSERT, and Strong Kids). Second, the internet was searched to identify informal strength-based assessments used for IEP planning. Last, a faculty and student researcher selected appropriate items from reviewed assessments for the ABC's Inventory. Items that were deemed as most appropriate for inclusion in the ABC's Inventory were those that seemed that they would be most helpful in devising intervention strategies to address teachers' referral concerns.

Overall, the ABC's Inventory contains a total of 55 items. Respondents rate individuals according to a six-point Likert scale from 1 (definitely not one of the

strongest relative strengths) to 6 (definitely one of the strongest relative strengths). Any items on which students received 4-, 5-, or 6-point ratings were considered as student strengths.

Inventory of Teacher-Student Relationships

The Inventory of Teacher-Student Relationships (IT-SR) is a 17-item measurement that has been modified from the more commonly used Inventory of Parent and Peer Attachments (IPPA; Armsden & Greenberg, 1987). The IT-SR, modified from IPPA by Murray and Zvoch (2011), is a student self-report measure that assesses teacher-student relationship quality for students in late childhood to early adolescence. The IT-SR consists of three subscales: communication (eight items), trust (five items), and alienation (four items). These three constructs are consistent with relationship security as defined by attachment theory (Ainsworth, Blehar, Waters, & Wall, 1978). All item responses use a Likert scale of 1 to 4: (1) almost never or never true, (2) sometimes true, (3) often true and (4) almost always or always true. The Communication Scale (α = 0.89; N = 86), the Trust Scale (α = 0.84; N = 86) and the Alienation Scale (α = 0.72; N = 86) have shown adequate internal consistencies with fifth-grade students (Murray & Zvoch, 2011). The overall sum of scores on the 17 item IT-SR measurement was used for analyses. Higher overall sums of scores on the measurement indicate higher quality teacher-student relationships.

Children's Hope Scale

The Children's Hope Scale (CHS) was administered to assess participants' self-

reported hope levels (see Appendix E). The CHS is a six-item scale that is completed by youth ages 8-16 using a 6-point Likert scale response format: (1) none of the time to (6) all of the time. The CHS assesses the degree to which children believe themselves capable of taking successful action to achieve their goals and of creating pathways through which they are able to achieve their goals. Snyder et al. (1997) showed that the internal consistency of the CHS (α = 0.72-0.86; N = 1466) is acceptable for use with children between 8 to 16 years old. Valle, Huebner, and Suldo (2004) also reported alpha coefficients of 0.83. The total CHS score was used for analyses in this study.

Competence Beliefs and Subjective Task Values Questionnaire

The Competence Beliefs and Subjective Task Values Questionnaire **(**CBSTVQ; Wigfield et al., 1997) was administered to assess students' perceptions of their own math, reading, and writing competencies. On each of the three CBSTVQ scales, the math, reading, and writing scales, students were asked to rate themselves on five items: (1) whether or not they think they are good at the subject, (2) how their performance in the subject compares to others, (3) how they view their performance as compared to other peers, (4) their future expectations of themselves in the subject and (5) how capable they think that they would be in learning something new in the subject. Students responded to each of these items with a number from 1 to 30 using the CBSTVQ student rating sheet (see Appendix F). Average item rating numbers (from 1 to 30) were calculated for the math, reading, and writing items.

Unlike the standardized response format for the CBSTVQ, a 7-point Likert scale,

numbers of 1 to 30 were presented to students as measurements on a thermometer for visual representation for participants. On the thermometer scale, the number 1 was labeled (verbally and written) with “not at all good” or “one of the worst,” the number 15 labeled with “ok,” and the number 30 labeled with “very good” or “one of the best.” In a study by Wigfield et al. (1997), researchers found that students’ reading and math CBSTVQ scores were similar, as was expected, to measures of students’ real achievement and to parent and teachers’ ratings of students’ achievement. Moreover, in prior studies when the CBSTVQ was administered to first, fifth and eighth grade students, the reading competence belief scale had an internal consistency ranging from 0.83 to 0.87, while the math competence belief scale had an internal consistency ranging from 0.82 to 0.87 (Hughes et al., 2011; Wigfield et al., 1997).

Procedures

Recruitment

After obtaining school district and University IRB approval for the study, teachers of third-, fourth-, and fifth-grade students at two Idaho elementary schools were sent a recruitment letter via email, asking for their participation and inviting them to nominate students for the study. Teachers were informed that they could nominate both students without a disability or students with a disability without significant cognitive deficits. Teachers were asked to identify a few students who regularly demonstrate some behavioral, academic, or learning difficulty in the classroom. The first eight teachers to volunteer at least two students for the study via email were contacted for the study. Seven

out of the eight teachers responded to further contacts regarding the study. After speaking with the eighth teacher about the research study, she decided she did not want to participate. Other teachers were contacted about participating, however, they too reported that they did not wish to participate due to end of the school year time-constraints.

Teachers who agreed to participate signed informed consent forms prior to the start of the study (Appendix A). Likewise, parents of the teacher nominated students were contacted for parental consent prior to the start of the study (Appendix A). All parents who were contacted gave consent for their children to participate in the study.

In total, 7 teachers and 16 students were recruited for study participation. Five of the seven teachers had two student participants each. Each of these five teachers had one student participant randomly assigned to the treatment group and one student participant randomly assigned to the control group. For the other two of seven teachers, each teacher had three participating students in their class. These teachers' students were also randomly assigned to the treatment or control group. One of the teachers with three participating students had two students randomly assigned to the treatment group and one student randomly assigned to the control group. The other teacher with three participating students had one student randomly assigned to the treatment group and two students randomly assigned to the control group. In total, sixteen students were randomly assigned from seven classes to participate in the control ($N = 8$) or treatment group ($N = 8$).

Pretest Assessments

First, all teachers completed the Teacher Demographics Form and students' parents completed the Student Demographics Form in regards to their child. Prior to the

implementation of the treatment, all students completed the pretest assessments: the IT-SR, CHS and CBSTVQ. The researcher read aloud directions to students and were available to answer student questions as needed during the pretest assessment administration session. The pretest assessments were administered in groups of two to three students at a time.

In addition to the rating scales that all students completed (IT-SR, CHS, and CBSTVQ), students from the treatment group also completed the BERS-2 YRS and the ABC's Inventory during the pretest assessment administration session. Likewise, only teachers of the students in the treatment group completed the BERS-2 TRS and the ABC's Inventory in order to help identify student strengths for students in the treatment group.

Treatment and Control Conditions

Treatment. After scoring and interpreting the strength-based assessments for students in the treatment group, the researcher met with these students' teachers to adequately prepare for the collaborative, small group meeting with each student. As part of this preparatory meeting with teachers, the researcher and teachers identified a list of several student strengths to share with students, discussed the need to maintain a positive, strengths focus during the collaborative meeting, and reviewed together the collaborative meeting outline to be followed during the meeting (see Appendix G). Additionally, teachers were specifically instructed to discuss the referral concern for which the student was referred for this study. Teachers were told to not discuss other concerns. Furthermore, teachers were told to not elaborate on the behavioral issue any more than

needed for the purpose of informing the student of the issue that the intervention plan will be aimed to address.

After proper preparation with teachers, the researcher met with each teacher and student pair together in one collaborative, small group meeting. During this half hour group meeting, students received personalized feedback from their teachers regarding what their teachers perceived as the students' personal strengths. Overall, the small group meeting format focused upon a collaborative review of the student and teacher strength-based assessment results, goal setting in the classroom to address student referral concerns, the development of a plan to use identified strengths in goal attainment and, lastly, the construction of a written, step-by-step plan to use strengths to achieve the chosen goal (see Appendix H for an example of meeting format). The student and teacher were both given a copy of the plan developed during the group meeting. In this manner, the teacher was appropriately informed of the plan, was able to reference the copy of the plan as needed, and was ready to prompt the student to apply his or her strengths during class time.

Control. After the completion of all pretest assessment measures for students from the control group, researchers met one-on-one with these students' teachers to problem-solve the reported referral concern. Students were not present in these one-on-one problem-solving meetings. Teachers were then given a copy of the plan developed during the researcher-teacher meeting. In this manner, the teacher was appropriately informed of the plan, was able to reference the copy of the plan as needed.

Posttest Assessments

The posttest assessments were administered 5 school days after the pretest assessment administration. All student problem-solving meetings for students in the treatment and control groups took place within the 5 school day period between the pre- and posttest. All student participants in both the treatment and control groups again completed the following posttest assessments: IT-SR, CHS, and CBSTVQ.

Research Design and Data Analysis

The study is a pre-post nonequivalent groups quasi-repeated measure design. Descriptive statistics (mean, standard deviation, and ranges) were reported for all measures. One-way, independent sample t-tests on change scores were used to explore differences between the treatment and control groups on the variables of IT-SR, CHS and CBSTVQ.

The t-test on change scores was chosen as a method of statistical analysis for several reasons. When assessing whether or not there are group differences in pretest to posttest change, potential statistical analysis methods include *t* tests on change scores, ANCOVA (using the time 1 score as a covariate), and ANOVA (using group and time as independent variables). The researcher chose *t* tests on change scores because the research question was looking at whether or not there is a treatment main effect on the dependent variables (ITSR, CHS, and CBSTVQ). This was because *t* tests on change scores do not assume that pretest scores are equivalent across groups. This means that when pretest differences do genuinely exist, *t* tests on change scores are not biased,

while, in contrast, an ANCOVA would be biased. A potential limitation of using *t* tests on change scores is that this statistical analysis method can be biased when regression towards the mean is significant. For instance, *t* tests on change scores may not be appropriate for use when participants are assigned to different groups depending upon their pretest scores (Mary, Berger, Sosa, & Pentoney, 2012). However, in this study, the assignment of participants to the treatment or control group was not based upon pretest scores, but instead was random. Therefore, this limitation is not a concern in regards to the use of the *t* test on change scores in this study.

CHAPTER IV

RESULTS

The research question asked in this study was: Is there a significant difference between students who experience a strength-based therapeutic assessment process and students who do not experience a strength-based therapeutic assessment process on student self-reported levels of teacher-student relationship quality, hope, and academic competency beliefs for students experiencing classroom problems?

The hypothesis was that students who participated in a strength-based therapeutic assessment process would report significantly increased teacher-student relationship quality, levels of hope, and academic competence as compared to students not participating in a strength-based therapeutic assessment process.

Descriptive Statistics

Results from the BERS-2 YRS for students in the treatment group are reported in Table 3. Next, results from the BERS-2 TRS for students in the treatment group are reported in Table 4. Although the BERS-2 YRS and TRS results are not part of the research question related analyses, these descriptive statistics are included in order to give a complete overview of the treatment group students' strengths as described by youth and teacher-reports. High numbers indicate greater perceived student strengths.

Results for the ABC's Inventory – Youth Report for students in the treatment group are reported in Table 5. Results for the ABC's Inventory – Teacher Report for students in the treatment group are detailed in Table 6. Similar to the BERS-2 YRS and

Table 3

Behavioral and Emotional Rating Scale-2 YRS Results for Students in Treatment Group

	Student 9		Student 10		Student 11		Student 12[a]		Student 13[b]		Student 14		Student 15		Student 16	
Strength subscales	Scaled scores	%ile rank	Scaled scores	%ile rank	Scaled scores	%ile rank	Scaled scores	%ile rank	Scaled scores	%ile rank	Scaled scores	%ile rank	Scaled scores	%ile rank	Scaled scores	%ile rank
Interpersonal strength (IS)	7	16	7	16	6	9	17	99	15	95	14	91	12	75	6	9
Family involvement (FI)	8	25	6	9	7	16	12	75	16	98	11	63	15	95	7	16
Intrapersonal strength (IaS)	5	5	12	75	8	25	13	84	14	91	12	75	11	63	8	25
School functioning (SF)	10	50	8	25	6	9	16	98	15	95	14	91	9	37	8	25
Affective strength (AS)	6	9	12	75	8	25	12	75	15	95	8	25	12	75	9	37

[a] Student 12 completed the first page of the BERS-2 YRS properly, but then rushed through the second page, selecting all "3's" for the ratings on page two (the highest possible rating).

[b] Student 13 rated herself as all "3s" for every single item on the BERS-2.

Table 4

Behavioral and Emotional Rating Scale-2 TRS Results for Students in Treatment Group

	Student 9		Student 10		Student 11		Student 12		Student 13		Student 14		Student 15		Student 16	
Strength subscales	Scaled scores	%ile rank	Scaled scores	%ile rank	Scaled scores	%ile rank	Scaled scores	%ile rank	Scaled scores	%ile rank	Scaled scores	%ile rank	Scaled scores	%ile rank	Scaled scores	%ile rank
Interpersonal strength (IS)	5	5	9	37	11	63	7	16	7	16	9	37	6	9	6	9
Family involvement (FI)	7	16	13	84	12	75	11	63	6	9	10	50	9	37	7	16
Intrapersonal strength (IaS)	1	< 1	14	91	10	50	9	37	8	25	12	75	9	37	5	5
School functioning (SF)	4	2	12	75	7	16	7	16	7	16	9	37	7	16	4	1
Affective strength (AS)	4	2	14	91	11	63	13	84	8	25	14	91	6	9	10	50

Table 5

Academic and Behavioral Classroom Strengths Inventory: Youth Report

		Student no.							
Strength category	Specific strengths	9	10	11	12	13[a]	14	15	16
Rules	Following rules		5			6	5		4
	Accepting consequences or "no"			4	4	6	4		
	Working to earn points and rewards		6			6	5		6
	Handles transitions or change					6		5	
	Respecting others	5	4		4	6	4	4	
Work setting	Working with groups or teams					6		6	5
	Working with a partner			4	6	6	6		
	Working independently	5	6	4		6	5		6
	Working one-on-one					6			
	Spending time on homework	6	6		6	6	6		
Teaching time	Taking good notes			4		6	6		6
	Paying attention		4			6	4		
	Preparing or planning		4			6	6		
	Ignoring distractions					6	4		
	Organized					6	4		4
	Speaking to share ideas and answers		6		6	6	6		
	Listening to others ideas and answers					6	6		6
Getting directions	Listening to directions					6	4		
	Watching examples				6	6	5		6
	Reading written directions					6	4		4
	Writing out directions					6	4		
	Repeating or mapping out directions		6			6			5
	Following pictures, routines, or steps					6			6
	Role play		6	6		6	5		6
	Figuring out by self		6			6	4		4
	Mapping out or retracing steps					6			5
Own working	Trying first		6			6			
	Keeps trying		6			6			6
	Asking for help		6	5	6	6	6		
	Giving help		6			6			
	Handling hard tasks					6			5
	Completing small tasks in good time				5	6	5		
	Working with time limits					6	5		
	Works fast and its correct					6	4		
	Trying to do his or her best work		6		6	6		4	6
	Completing any work done correctly				4	6	5	4	
	Working carefully					6	5		
	Completing work on time	4			5	6	5		
	Turning work in				4	6	5		
	Memorizing		6			6	4		

(*table continues*)

		Student no.							
Strength category	Specific strengths	9	10	11	12	13[a]	14	15	16
	Spending time to study	5			4	6	5		
	Responding to brief work checks					6		5	
	Role playing		6	6		6	6	4	
	Giving presentations		6			6	5		
	Moving activities		5			6			
	Participating in classwide activities				6	6			
	Working in groups			4	6	6	4		
Emotions	Caring about work		6			6	5	6	6
	Being proud about work		4			6		5	5
	Staing calm and cool	4				6	5	5	
	Staying positive and cheerful	6	4	5	6	6	5	4	6
	Solving and talking out problems			4		6			5
	Making good choices				6	6		4	4
	Planning and meeting goals		6			6		4	5
	Being confident		6			6	6		6
	Accepting corrections and moves on		6		5	6	6	4	
	Feeling a sense of belonging, accepted, and included		4	6	4	4	6	6	
Work with others	Encouraging, complimenting others					6	6	5	6
	Being nice to others		6	5	5	6	6	4	
	Helping others		6			6	5		4
	Allowing others to join in					6	5	4	6
	Cooperating, sharing					6	4	6	
	Conversing with others	4				6	6	4	5
	Listening			4	6	6	6	5	
	Admitting mistakes		6	5	5	6	5		
	Sticking up for others	4	6			6	5	4	6

[a] Student 13 rated herself as "6" on every single item on the ABC's Inventory – Youth Report.

TRS results, the ABC's Inventory Youth Report and Teacher Report were included in the descriptive statistics in order to give a more complete understanding of the treatment group students' strengths as reported by youth and teachers. Ratings of 4, 5, and 6, indicate that students or teachers reported these areas as specific strengths for students.

Data analysis was conducted on each of the following measures for participating students in the treatment and control group: ITSR, CHS, and CBSTVQ. Descriptive statistics were calculated for all measures and are reported in Table 7.

Table 6

Academic and Behavioral Classroom Strengths Inventory: Teacher Report

		Student no.							
Strength category	Specific strengths	9	10	11	12	13[a]	14	15	16
Rules	Following rules		4			4	4	4	
	Accepting consequences or "no"		4			4	5	4	
	Working to earn points and rewards		6	4		5	4		
	Handles transitions or change	4		6		5	4		
	Respecting others	4		5			4	4	
Work setting	Working with groups or teams			6		5	6		
	Working with a partner			6	5	5	6	4	
	Working independently		6	5			4		
	Working one-on-one	6	5	5	6		5		
	Spending time on homework		5				4		
Teaching time	Taking good notes		4						
	Paying attention		5	6			5		
	Preparing or planning						4		
	Ignoring distractions						4		
	Organized					6	5		
	Speaking to share ideas and answers		4	6	4	4	6		4
	Listening to others ideas and answers			4	4	4	4		
Getting directions	Listening to directions		4				6		
	Watching examples		6	4		5	4		
	Reading written directions		4				4	4	
	Writing out directions							4	
	Repeating or mapping out directions	5	4			4	5	4	
	Following pictures, routines, or steps	5	5	4		5	4		
	Role play		4			5	6		5
	Figuring out by self		4				6		
	Mapping out or retracing steps		4				6		
Own working	Trying first		6			4	6		4
	Keeps trying		4		5		4		
	Asking for help		6	4	6	4	6		
	Giving help		6	6		4	5		
	Handling hard tasks		5	4			5	4	
	Completing small tasks in good time		5			5	5		4
	Working with time limits		6			4			
	Works fast and its correct		6			4	4	4	
	Trying to do his or her best work	4	5		5	5	4	4	
	Completing any work done correctly		5		4	4	5		
	Working carefully		5		5		5	4	
	Completing work on time		4		4	5	4	4	
	Turning work in		4		4	5	6		
	Memorizing		6	5		4	5	4	

(*table continues*)

		Student no.							
Strength category	Specific strengths	9	10	11	12	13[a]	14	15	16
	Spending time to study		4					4	
	Responding to brief work checks		6		4	4	5		
	Role playing				4	5	6		4
	Giving presentations		5	4		6	6		
	Moving activities			4		6	6		
	Participating in classwide activities		5	5		6	6		4
	Working in groups		5	5		6	5		
Emotions	Caring about work		5		5	4	5	4	
	Being proud about work		6		5	4	6	4	
	Staing calm and cool		6			4	6		
	Staying positive and cheerful		6			6	6	4	4
	Solving and talking out problems		5				5		
	Making good choices	4	5				5	4	
	Planning and meeting goals		5			6			
	Being confident		6			5	6	6	
	Accepting corrections and moves on		6				6	4	4
	Feeling a sense of belonging, accepted, and included		6		4	6	6	4	4
Work with others	Encouraging, complimenting others		5	4					
	Being nice to others		4	4		4	4		
	Helping others		5	5		6	4		4
	Allowing others to join in		5	5	4	4	4		4
	Cooperating, sharing		5	5		4	4		
	Conversing with others		6	5		5	6		
	Listening						5		
	Admitting mistakes						4		
	Sticking up for others		6	5		4	4		4

Inferential Statistics

T tests comparing students' scores from treatment and control groups at baseline were conducted to determine whether or not the students from the treatment and control groups differed from each other at baseline on the variables of ITSR, CHS, or CBSTVQ on math, reading, or writing. *T*-Test results are reported in Table 8. Based on the results of these t-tests on students' baseline scores, no statistically significant differences between students in the treatment and control groups were found at baseline on any of the variables.

Table 7

Descriptive Statistics for ITSR, CHS, and CBSTVQ

			Control			Treatment		
Variables		Time	*M*	*SD*	Range	*M*	*SD*	Range
ITSR Total		1	48.38	12.80	24 – 65	47.12	10.93	25 – 62
		2	49.75	13.02	27 – 68	49.50	10.56	26 – 59
CHS Total		1	22.62	5.66	13 – 31	23.00	8.40	11 – 36
		2	24.00	5.07	15 – 33	27.38	5.95	18 - 36
CBSTVQ	Average Math	1	17.28	6.03	6.60 – 21.40	17.20	5.56	12.40 – 30.00
		2	19.42	6.89	12.20 – 30.00	17.32	6.59	9.40 – 27.00
	Average Reading	1	25.08	5.35	13.00 – 30.00	20.2	8.42	10.00 – 30.00
		2	24.38	5.71	12.20 – 30.00	19.68	6.76	11.00 – 30.00
	Average Writing	1	20.75	5.15	13.80 – 28.00	16.35	9.86	3.00 – 30.00
		2	20.82	7.00	12.60 – 30.00	16.95	10.89	1.20 – 30.00

Table 8

T-Test Analysis of Baseline Scores for Treatment and Control Group

Variable		*t* Statistic	*p* value
ITSR Total		-0.48	0.64
CHS Total		0.10	0.92
CBSTVQ	Average Math	-0.03	0.98
	Average Reading	-1.38	0.19
	Average Writing	-1.12	0.28

After completing *t* tests to determine whether or not baseline scores for treatment and control groups were significantly different, *t* tests on change scores were conducted to answer the primary research question. *T* tests on change scores were used to determine if there were any statistically significant differences in changes over time between the

control and treatment groups. Descriptive statistics for the change scores are described in Table 9 and results from the *t* test are in Table 10.

Overall, data analysis results indicate that there are no statistically significant differences for students in the treatment group versus the control group on any of the dependent variables, including student-reported teacher-student relationship quality, student hope levels, and student-reported academic competency beliefs. Although results were not statistically significant, a medium strength effect size (d = 0.55) was found for the CHS. This indicates that the treatment condition may have moderate practical significance in increasing hope as measured by CHS scores. Additionally, a small, but meaningful effect size (*d* = -0.38) was found for the CBSTVQ Average Math variable. This indicates that the treatment condition is moderately associated with students experiencing a decrease in perceived math competence as measured by CBSTVQ Average Math scores. All other variables had effect sizes below or equal to 0.10. Results are further detailed in Table 9.

Table 9

Descriptive Statistics for Change Scores of ITSR, CHS, and CBSTVQ

		Control			Treatment		
Variables		*M*	*SD*	Range	*M*	*SD*	Range
ITSR Total		1.38	6.19	-10 – 10	2.38	13.35	-23 – 23
CHS Total		1.38	4.69	-4 – 9	4.38	6.14	-1 – 15
CBSTVQ	Average Math	2.15	6.40	-4.8 – 14.8	0.12	4.22	-5.8 – 5.6
	Average Reading	-0.70	1.17	-3.2 – 0	-0.52	3.93	-6 – 3
	Average Writing	0.08	5.33	-9 – 7	0.60	10.73	-16.8 – 20.6

Table 10

T-Test Analysis of ITSR, CHS, and CBSTVQ Total

Variable		*t* statistic	*p* value	Cohen's *d ES*
ITSR Total		0.19	0.85	0.10
CHS Total		1.10	0.29	0.55
CBSTVQ	Average Math	-0.75	0.47	-0.38
	Average Reading	0.12	0.91	0.06
	Average Writing	0.12	0.90	0.06

CHAPTER V

DISCUSSION

In order to determine whether or not a strength-based therapeutic assessment process was effective in increasing teacher-student relationship quality, teacher-student relationship quality, and student academic competency beliefs, student participants were randomly assigned to a treatment or control group. In the treatment group, students received strengths feedback from teachers, met in a collaborative small group setting, and personally contributed to a problem-solving session with teachers and a researcher. In contrast, teachers of students in the control group met with researchers to problem-solve the teacher's chosen student behavioral issue without any student involvement.

Statistical analysis on the results from the ITSR, CHS, and CBSTVQ measures for the treatment and control group did not confirm the hypothesis: Students who participated in a strength-based therapeutic assessment process did not report statistically significant increases in teacher-student relationship quality, levels of hope, or academic competence as compared to students who did not participate in a strength-based therapeutic assessment process. These results indicate that the strength-based therapeutic assessment process may not lead to better outcomes for students than the assessment process as usual in school settings, at least in the brief format in which it was delivered for the purposes of this study. Perhaps, a more intensive strength-based therapeutic assessment process would have had more beneficial results for students as compared to the assessment process as usual. For instance, what if students and teachers spent a longer time in the collaborative, small group meeting together with researchers discussing

student strengths together? Would it have been more helpful for students if there were a larger length of time for the strength-based therapeutic process? Perhaps, there simply was not enough time for improvement to happen in between the pretest and posttest measures, given that the entire process was only a week long.

Although there was a lack of statistically significant differences for students in the treatment group versus the control group on the dependent variables of ITSR, CHS, and CBSTVQ, a medium strength effect size (d = .55) was found for student scores on the CHS for students in the treatment group versus the control group. This medium strength effect size indicates that the treatment condition may be moderately effective in increasing students' hope levels. Hope, as conceptualized by the underlying theory upon which the CHS was designed, is defined as the belief in one's ability to find ways to meet a goal (Snyder et al., 2000). Hope is the holding of a belief in one's abilities to accomplish each step to goal attainment using one's skills and abilities (Snyder et al., 2000). Students in the treatment group, together with their teacher, identified useful school-related strengths, which may have, in turn, increased their own beliefs in their own abilities and skills. Since the CHS conceptualizes hope as the holding of a belief in one's abilities to accomplish each step to goal attainment using one's skills and abilities, it would make sense that students who experience an increase in their own beliefs about their abilities and skills would also experience a similar increase in hope levels as measured by the CHS.

Additionally, a small strength effect size (d = -.38), in the opposite direction of that expected, was found for students' academic competency beliefs in math. More

specifically, this finding suggests that the treatment condition may, for some reason, have decreased students' beliefs of competency in math. It is unclear why taking part in a strength-based therapeutic assessment process would have negatively impacted students' academic competency beliefs in math. Another explanation for these results is that there is an outlier in the control group. As listed on Table 9, the descriptive statistics for the changes scores indicate that the range of change scores for students in the control group was -4.8 to 14.8. In contrast, the range of change scores for students in the treatment group was -5.8 to 5.6. The outlier change score of 14.8 for a student in the control group is largely contributing to the small effect size that was found in the opposite direction of that expected for students' academic competency beliefs in math.

Practical Implications

During the student strength identification process for students in the treatment group, the BERS-2 rating scale results were useful in that they allowed for identification of broad domains of strengths. Based on each student's scores on each of the five strength subscales (interpersonal strength, family involvement, intrapersonal strength, school functioning, and affective strength), the researcher and teachers were able to quickly identify broad areas of strengths. The ABC's Inventory proved most helpful in the collaborative meetings for students in the treatment group when the researcher, teacher, and student worked together to develop intervention plans that utilize specific student strengths. In sum, for the purpose of the collaborative meeting, the ABC's Inventory provided more specific information to guide student treatment as compared to the BERS-

2 which provided more broad information. The ABC's Inventory would likely be helpful in schools for similar intervention planning for students. It may be a beneficial tool for school psychologists to use in such circumstances.

Using such a norm-based strengths scale could prove detrimental to students if they were to score poorly as compared to other same-age peers on many or possibly all of the strengths measured. Given the norm-based nature of the BERS-2, students could potentially receive below average scores on all areas of strengths measured. For example, in this study, two out of eight students received scores on all five BERS-2 TRS & YRS Strength Subscales that were below 50th percentile as compared to same-age peers. For these students, the BERS-2 may not be the most appropriate or beneficial measure to use in assessing student strengths.

In terms of the collaborative meetings for students in the treatment group, researchers and teachers were successful in maintaining a positive, strengths focus during most of these meetings. Interestingly, at the start of the study, most of the teachers were excited to take part in the strength-based therapeutic assessment process with students. These teachers seemed to be naturally more strength focused in their perspectives. In contrast, a few teachers had more difficulty identifying student strengths as evidenced by their low ratings of student strengths. For these teachers, the preparatory meeting was especially important. During the preparatory meeting, researchers coached teachers in how to maintain a positive tone for the collaborative meetings. After the teacher coaching, even the less naturally strength focused teachers were able to mostly maintain a positive strength focus in the collaborative meetings with students with minimal

redirection from the researcher. Based on these anecdotal results, teacher coaching may be an effective tool for encouraging positive interactions between teachers and students in school related meetings. It is also possible that the teacher coaching and teacher participation in the collaborative meetings may have caused teacher to change in their perspectives of students.

Limitations

Methodological Limitations

Several methodological limitations likely influenced the results of the study. These limitations may have contributed to the lack of statistically significant results. Firstly, it is possible that the current study does not yield statistically significant results due to the small sample size of eight students in each group. However, for this study, it was not feasible to get a larger sample size. Participants were recruited on a voluntary basis and a limited number of teachers volunteered to participate. This limited the student participant sample size.

Moreover, there are possible crossover effects because of the way by which students were assigned to different groups. More specifically, each teacher had two or three participating students who were assigned to different groups. For instance, five of the seven teachers had two participating students, each of whom were randomly assigned to different groups. This method of assignment of students to treatment and control groups likely caused shared variance on measurement scores across treatment and control groups. This is because two to three students were rating the same teacher on the ITSR.

Another possible crossover issue relates to the teachers themselves. Several of the teachers were especially interested in using the strength-based therapeutic assessment process for all of their participating students. It is possible that these enthusiastic teachers may have inadvertently or even intentionally transferred some parts of the strength-based therapeutic assessment process to their student(s) in the control group. This would have further reduced the likelihood of finding statistically significant results between the treatment and control group.

An additional limitation to the study was the time of the school year that the study was carried out. More specifically, because the study was completed during the last few weeks of the school year, participating students had to miss fun activities during the final week of school when completing the posttest measures. Even so, most students seemed to put forth adequate effort in completing the posttest measures for both the treatment and the control group per researcher observations. Yet, students' posttest measure responses may have more errors than their pretest measure responses due to students' desires to get back to fun class activities quickly. In sum, students' responses on the posttest measures may be less accurate than their pretest measure responses which were administered on a typical school day. If students did pay less attention to posttest assessment items, then there is likely some level of measurement error on students' posttest assessment scores due to random variance from such inattentive behavior during posttest assessment administrations.

Another indication that data quality was compromised was that of significantly different ranges for the dependent variable scores of the treatment group as compared to

the dependent variable scores of the control group on most of the measures. For example, the range for student ITSR scores was much larger for the treatment group than the control group. Such large ranges in the treatment group as compared to the control group indicates that data quality was likely compromised to some degree due various types of error. Data quality may have been compromised due to several reasons including timing issues or small sample size as previously discussed.

Another potential error source is that of measurement error due to the way in which students were asked to respond to the CBSTVQ items. The researcher noticed that during both the pretest and posttest administrations of the academic competency beliefs scale, the CBSTVQ, most student participants in both the treatment and the control groups rated themselves as one of the three following scores on each of the CBSTVQ Items: 1, 15, or 30. Students who rated themselves using other numbers on the 1-30 thermometer were primarily older participants (primarily in fifth grade). Younger participants did not seem to grasp the fact that they could use any number to rate themselves on the scale of 1-30, not just 1, 15, or 30. Overall, since most students gave 1, 15, or 30 ratings on each item, there may not be as much accuracy in the scores reported by students as the information that could have been gleaned from use of the entire 1-30 span of numbers. If, instead of delivering the CBSTVQ instructions in a different way, instructions for completing the CBSTVQ scale had been provided in the standardized way, students may have more fully utilized the range of scores that had been developed through research for use in responding to the CBSTVQ items.

Other Limitations

Researchers have not yet identified a specific age range for which TA-C is most effective. Yet, TA-C has demonstrated beneficial outcomes for children and adolescents from ages 7 to 17 years old in clinical settings (Hansson et al., 2016; Tharinger et al, 2009). It is possible that TA-C may not have the same level of effectiveness in younger aged children as it has in older children and adolescents. Since student participants had a mean age of 9.31 years (SD = 0.87), most of the students were rather young in age. It is possible that, due to maturity levels or cognitive development, participating students failed to grasp the purpose of collaboratively meeting with teachers. Additionally, hope is a more developmentally advanced concept for children (Snyder et al., 2000). Therefore, younger children need to reach a certain developmental level before they are able to cognitively grasp the idea of hope. It is possible that younger participants may have had some difficulty conceptualizing the construct of hope when completing the CHS.

In addition, participating teachers may not have implemented the designed intervention plans for their students prior to the posttest assessment administration. One reason for a potential lack of intervention implementation may include a lack of time due to the short time frame (1-2 days) in between the collaborative meetings and posttest assessment administration. No treatment integrity measures were used to assess for teacher follow through on intervention plans for students. It is likely that the results of the study represent primarily the effects of the strength-based therapeutic assessment process rather than the use of intervention plans itself.

Future Directions

Future research should replicate the current study with a large sample size in order to better determine whether or not the treatment condition contributes to statistically significant differences in the dependent variables of teacher-student relationship quality, student reported hope levels, and competency beliefs in math, reading, and writing. It is possible that, with larger sample sizes, statistically significant differences may be revealed. More specifically, it would be especially interesting to further investigate the effects of the treatment condition on student hope levels with a larger sample size. It is possible that, such a research study, may reveal that the treatment condition causes an increase in student hope levels to a statistically significant degree.

Additionally, if further research determines that the treatment condition does contribute to a statistically significant change in teacher-student relationship quality, student hope levels, or competency beliefs, then it would worthwhile to further investigate how such changes come about. Follow-up research would then need to focus upon change mechanisms underlying such findings.

In the current study, the treatment condition included elements from both strength-based assessment approaches as well as therapeutic assessment. It would be helpful to conduct research studies that more specifically focus upon treatment conditions with only elements of strength-based assessment approaches or with only elements of therapeutic assessment. This would be especially true if further research were to reveal statistically significant findings for the treatment condition as designed in the current study.

Also, although researchers allowed teachers to refer students with both behavioral and academic concerns, all referred students were students with behavioral concerns. It would be interesting to investigate whether or not the strength-based therapeutic assessment approach would be helpful in students with academic difficulties in addition to only students with behavioral concerns. Perhaps, if this approach were used for students with academic-related referral concerns, students in the treatment group would be more likely to experience positive changes in their academic competency beliefs.

It is possible that the teacher coaching and teacher participation in the collaborative meetings may have caused teacher to change in their perspectives of students. Future research should look at how the teacher coaching and teacher participation in collaborative meetings may influence teachers. Such research would help determine if the strength-based therapeutic assessment process, as used in this study, works as a teacher intervention. For instance, do teachers who complete such a process with students change in the ways that they view students, work with students, or interact with others in school-related meetings? On a similar note, researchers could alter the collaborative meeting to also include having students discuss teacher strengths with teachers. Students could also give teachers feedback on what they do well in supporting them in the classroom. Perhaps, by adding these additional components to the collaborative meeting, teachers could benefit in addition to students from meeting participation.

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APPENDICES

Appendix A

Parent and Teacher Consent Forms

Parent Consent

Dear Parents,

We are writing to request permission to include your child in a study with Utah State University Psychology Department that is finding ways to help teachers support students who are experiencing academic or behavioral difficulties at school. You have been asked to take part because you are a parent of a child who may benefit from a brief problem-solving and intervention planning process involved in addressing your child's area of academic or behavioral difficulty. Professor Donna Gilbertson and graduate student/School Psychology intern, Teresa Duszlak, both in the Department of Psychology at Utah State University, are conducting this research study with 18 to 20 students.

What will your child be doing?

If you agree to allow your child to participate, the following will happen to you and your child.

1) You will be asked to fill out a Parent-Child Information Form to be returned to school.
2) The school psychologist/intern, Teresa Duszlak, will meet with your child to explain the study and ask for their assent to participate.
3) At the beginning of the study, your child will complete three surveys to rate quality of relationships at school, hope for meeting academic goals, and beliefs about academic competency for about 15 minutes.
4) Your child's teacher and child may or may not be asked to complete two Strengths Surveys for about 10 minutes.
5) The school psychologist/intern, Teresa Duszlak, will meet with your child's teacher to define what and why classroom difficulties are occurring for your child and what can be put in place to lessen difficulties.
6) Your child may or may not then meet with his or her teacher and the consultant to review his or her identified strengths and how to use strengths at school.
7) You may receive a 10 minute phone call to ask about your child's strengths.
8) Your child's teacher will receive a copy of the intervention plan.
9) At the end of the study, your child will complete four surveys for about 20 min to assess change in school relationships, hope levels, academic competency beliefs, and acceptability of the assessment process.

What are the risks for my child?

Participation in this research study may involve some added risks or discomforts. First, we selected brief surveys that will not take more than 20 min at a time for the child to complete; however this may cause your child to miss some class time. We will work closely with teachers to find the best time to work with children so that no school work will be missed. Second, there is some risk of loss of confidentiality given that discussing and planning student progress with the teacher is needed to find ways to support students in schools. We will only be meeting with your child's teacher to solely focus on the classroom or recess setting and will take additional steps to reduce this risk as described below. Finally, some children may experience slight psychological discomfort when discussing his or her strengths and how these can be used to support learning in the classroom. We will take care to observe any discomfort and take steps to make your child feel more comfortable (e.g., add additional praise, check understanding, maintaining a positive discussion). If any unforeseen risks are identified, we will immediately notify you of these.

What are the benefits for my child?
Your child is likely to benefit from this opportunity by having his or her academic or behavioral difficulty better addressed in the classroom by his or her teacher. By working with teachers about why difficulties are occurring and planning a solution, it is likely that the child's difficulty will become less of a problem. Furthermore, information gained by this study could potentially help the researchers determine how attention to student strengths can lead to psychological benefits for children in school settings.

What is the Voluntary Nature of Participation and Right to Withdraw without Consequence?
Participation in this research is entirely voluntary. You and your child may refuse to participate or withdraw from the study at any time without consequence. Refusal to participate will not result in any loss of instruction or learning time at school, or access to counseling services through the school.

What will take place to maintain confidentiality?
Research records will be kept confidential, consistent with federal and state regulations. To protect the privacy of you and your child, personal, identifiable information will not be included on any study documents. A number code will be used to replace your name and the name of your child on all documents. The code will be kept separate from the data throughout the study and it will be destroyed one year after the study is completed. Only the principal investigator and student researcher will have access to the coded data. To protect your confidentiality, the data will be kept in a locked file cabinet or on a password protected computer in a locked room, to maintain confidentiality. A report will be prepared at the end of this study with no individual results reported in the summary.

How may I ask questions?
If you have other questions or research-related problems, you may reach Donna Gilbertson at (435) 797- 2034 or donna.gilbertson@usu.edu. You may also contact Teresa Duszlak (208) 745-6693 x 1109 or TDuszlak@sd251.org.

IRB Approval Statement: The Institutional Review Board for the protection of human participants at USU has approved this research study. If you have any pertinent questions or concerns about your rights or a research-related injury, you may contact the IRB Administrator at (435) 797-0567 or email irb@usu.edu. If you have a concern or complaint about the research and you would like to contact someone other than the research team, you may contact the IRB Administrator to obtain information or to offer input.

Copy of consent: You have been given two copies of this Informed Consent. Please sign both copies and keep one copy for your files to keep contact information.

Investigator Statement: "I certify that the research study has been explained to the individual, by me or my research staff, and that the individual understands the nature and purpose, the possible risks and benefits associated with taking part in this research study. Any questions that have been raised have been answered."

Signatures of Researchers

Donna M. Gilbertson, Ph.D.	Teresa Duszlak, MS, MAPP
Principal Investigator	Graduate Researcher
(435) 797-2034	(208) 745-6693 x 1109

Signature of Parent / Guardian: Please initial one below and sign if agreeing to allow your child to participate

_____ NO, I do NOT want to participate in this study and I do not want my child to participate

_____YES, I am willing to have my child participate in this study.

Signature of Parent/Guardian_____Date_____

Printed Name of Parent / Guardian_____

Printed Name of Child_____

Child/Youth Assent: I understand that my parent(s)/guardian know about this research study and that permission has been given for me to participate. I understand that it is up to me to participate even if my parents say yes. If I do not want to be in this study, I do not have to and no one will be upset if I don't want to participate or if I change my mind later and want to stop. I can ask any questions that I have about this study now or later. By signing below, I agree to participate.

_____	_____
Name	Date

Teacher Consent

We are writing to request your participation in a study with Utah State University Psychology Department that is exploring ways that the assessment process in school settings support students who are experiencing academic or behavioral difficulties at school. You have been asked to take part because you are the teacher of one or two students who may benefit from the problem-solving and intervention planning involved in addressing your child's area of academic or behavioral difficulty. Professor Donna Gilbertson and graduate student/School Psychology intern, Teresa Duszlak, both in the Department of Psychology at Utah State University, are conducting this research study with 18 to 20 students.

What will you be doing?

If you agree to participate, the following will happen to you and your two students:

1) Student's parent consent and student assent will be obtained before starting the study with a student. Each students' parents will receive a phone call from the School Psychology intern, Teresa Duszlak, to explain the study. An informed consent will be sent home with the student who will return the written consent to school.
2) You will be asked to set up the best time for Teresa to meet with the students for 20 minutes to explain the study, ask for assent to participate, and ask them to complete surveys.
3) You will be asked to complete a teacher demographic form and attend a problem-solving session with the consultant for each student with parent consent. Teresa will meet with you in order to identify/define each student's problem, to generate a hypothesis for the function of the problem, and to select an intervention for the problem. This will require 20 to 30 minutes to meet for each child. You can choose to meet in one 40 to 60 min session or two 20 to 30 min sessions.
4) You will be asked to complete two Strengths Surveys in regards to one of your students that will take 10 min to complete.
5) You will be asked to set up a time to meet about student strengths and plan, for about 5 minutes, how to review the above student's identified strengths and to plan for how to incorporate strengths usage into the chosen intervention.
6) You will participate in the 15 min strength summary/discussion meeting between you, the student and the school psychologist/ intern.
7) Your will receive a copy of the intervention design to use if you so desire.
8) You will be asked to set up the best time for Teresa to meet with the students for 20 minutes to ask them to complete end of study surveys.

What are the risks for you?

Participation in this research study may involve some added risks or discomforts. Because we are talking about academic or behavioral difficulties your student is experiencing, you may experience slight psychological discomfort. Planning a useful intervention to address the student's academic or behavioral difficulty will help to alleviate this psychological discomfort. We recognize that your time is valuable.

Although all study procedures have purposely been developed to minimize teacher's time, you will be asked to spend about 90 minutes (30 minutes for one student and 60 minutes for a second student) participating in the study. This needed time includes the completion of the teacher demographic form and student Strengths Surveys, your participation in the problem-solving session, planning and partipation in the strength summary meeting. We will collaborate with you to find the best time for you to conduct all activities. Finally, there is some risk of loss of confidentiality given that discussing student progress with a teacher is needed to find ways to support students in schools. Parents will also be informed about identified school problems, strengths and proposed plans. To support student and teacher confidentiality, we will only focus on problem solving in the classroom or recess setting and take steps to reduce this risk as described below. If any unforeseen risks are identified, we will immediately notify you of these.

What are the benefits for you and your student?

By defining your student's problem behavior, choosing an intervention, and planning an intervention, it is likely that you will feel and be better equipped to manage the student's problem. Should you choose to use the intervention in your classroom, the student's difficulty may become less of a problem. Furthermore, information gained by this study could potentially help the researchers determine how using a Strength-Based Problem-Solving process can lead to psychological benefits for children in school settings.

What is the Voluntary Nature of Participation and Right to Withdraw without Consequence?

Participation in this research is entirely voluntary. You, your student or your student's parent may refuse to participate or withdraw from the study at any time without consequence.

What will take place to maintain confidentiality?

Research records will be kept confidential, consistent with federal and state regulations. To protect your privacy, any personal, identifiable information will not be included on any study documents. A number code will be used to replace your name and the name of your student on all documents. The code will be kept separately from the data throughout the study and it will be destroyed one year after the study is completed. Only the principal investigator and student researcher will have access to the coded data. To further protect your confidentiality, the data will be kept in a locked file cabinet or on a password protected computer in a locked room. The report prepared at the end of this study will not report any individual results in the summary.

How may I ask questions?

If you have other questions or research-related problems, you may reach Donna Gilbertson at (435) 797- 2034 or donna.gilbertson@usu.edu**.** You may also contact Teresa Duszlak (208) 745-6693 x 1109 or TDuszlak@sd251.org.

IRB Approval Statement: The Institutional Review Board for the protection of human

participants at USU has approved this research study. If you have any pertinent questions or concerns about your rights or a research-related injury, you may contact the IRB Administrator at (435) 797-0567 or email irb@usu.edu. If you have a concern or complaint about the research and you would like to contact someone other than the research team, you may contact the IRB Administrator to obtain information or to offer input.

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Signatures of Researchers

_____	_____
Donna M. Gilbertson, Ph.D.	Teresa Duszlak, MS, MAPP
Principal Investigator	Graduate Researcher
(435) 797-2034	(208) 745-6693 x 1109

Signature of Teacher:
By signing below, I indicate my willingness to participate. Please also confirm, or inform us, of non-English proficient nominees or parents.

Signature of Teacher_____Date_____

Printed Name of Teacher_____

Printed Name of Nominated Student_____

Is student English proficient?_____

Is/are the student's parent(s) English proficient? _____

If translations and/or an interpreter are needed, what language is preferred?
_____

Appendix B

Student Demographics Form

Student Demographics Form

1) Child's age: _____ Birth date (month/date/year): _____

2) Child's grade level: _____

3) Child's gender: [ ] male [ ] female

4) Child race/ethnicity: _____

5) Is your child receiving ELL services? [ ] yes [ ] no

6) Is your child receiving special education services? [ ] yes [ ] no

If so, what is your child's classification? _____

Appendix C

Teacher Demographics Form

Teacher Demographics Form

Teacher initials: _____

1) Your gender: [ ] male [ ] female

2) Your race/ethnicity: _____

3) Years teaching: _____

4) Education degree: BS/BA area: _____ MS/MA Area:_____

Appendix D

Academic and Behavioral Classroom Strengths Inventory (ABC's)

Academic and Behavioral Classroom Strengths Inventory (ABC's)

Rate student's relative strengths in this section. (1 – Definitely not one of the strongest relative strengths to 6 – Definitely one of the strongest relative strengths)

Definitely Not strongest					Definitely Very Strong		
1	2	3	4	5	6	Following rules	Rules
1	2	3	4	5	6	Accepting Consequences or No	
1	2	3	4	5	6	Working to earn points and rewards	
1	2	3	4	5	6	Handles transitions or change	
1	2	3	4	5	6	Working with group or teams	Work setting
1	2	3	4	5	6	Working with a partner	
1	2	3	4	5	6	Working independently	
1	2	3	4	5	6	Working one-on-one	
1	2	3	4	5	6	Spending time on homework	
1	2	3	4	5	6	Taking good notes	Lecture time
1	2	3	4	5	6	Paying attention	
1	2	3	4	5	6	Preparing or Planning	
1	2	3	4	5	6	Ignoring distractions	
1	2	3	4	5	6	Organized	
1	2	3	4	5	6	Speaking to share ideas and answers	
1	2	3	4	5	6	Listening to others ideas and answers	
1	2	3	4	5	6	Following teacher directions	Getting directions
1	2	3	4	5	6	Following examples	
1	2	3	4	5	6	Following written directions	
1	2	3	4	5	6	Repeating directions	
1	2	3	4	5	6	Following routines	
1	2	3	4	5	6	Following steps	
1	2	3	4	5	6	Trying first	Working
1	2	3	4	5	6	Keeps trying	
1	2	3	4	5	6	Asking for help	
1	2	3	4	5	6	Handling hard tasks	
1	2	3	4	5	6	Completing small tasks in good time	
1	2	3	4	5	6	Working with time limits	

1	2	3	4	5	6	Works fast
1	2	3	4	5	6	Tries to do his or her best work
1	2	3	4	5	6	Completes work correctly (even if not done)
1	2	3	4	5	6	Works carefully, takes time
1	2	3	4	5	6	Completing work on time
1	2	3	4	5	6	Turning work in
1	2	3	4	5	6	Memorizing
1	2	3	4	5	6	Spending time to study
1	2	3	4	5	6	Attention to details
1	2	3	4	5	6	Responding to brief work checks
1	2	3	4	5	6	Solves problems appropriately

1	2	3	4	5	6	Caring about work	Emotions
1	2	3	4	5	6	Being Proud about work	
1	2	3	4	5	6	Staying calm and cool	
1	2	3	4	5	6	Staying positive and cheerful	
1	2	3	4	5	6	Being Confident	
1	2	3	4	5	6	Accepting corrections and moves on	
1	2	3	4	5	6	High energy - likes to move around	

1	2	3	4	5	6	Encourages, compliments others	Work with others
1	2	3	4	5	6	Nice to other students	
1	2	3	4	5	6	Helping others	
1	2	3	4	5	6	Allows others to join in	
1	2	3	4	5	6	Cooperative, shares	
1	2	3	4	5	6	Good conversationalist	
1	2	3	4	5	6	Good listener	
1	2	3	4	5	6	Accepting Consequences or No	
1	2	3	4	5	6	Sticking up for others	

1 2 3 4 5 6 Other:

Appendix E

Children's Hope Scale

Children's Hope Scale (Snyder et al., 1997)

The directions will be read aloud to students. They will complete the questions independently unless extra assistance is required. Researchers will be available to answer any questions that students may have as they complete the questions.

Questions About Your School Goals

Directions: The six sentences below describe how children think about themselves and how they do things in general. Read each sentence carefully. For each sentence, please think about how you are in most situations. Place a check inside the circle that describes YOU the best. For example, color in the circle (O) above "None of the time," if this describes you. Or, if you are this way "All of the time," check this circle. Please answer every question by putting a check in one of the circles. There are no right or wrong answers.

1. / *think I am doing pretty well.*

o	**o**	**o**	**o**	**o**	**o**
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

2. / *can think of many ways to get the things at school that are most important to me.*

o	**o**	**o**	**o**	**o**	**o**
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

3. / *am doing just as well as other kids my age.*

o	**o**	**o**	**o**	**o**	**o**
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

4. *When 1 have a problem, I can come up with lots of ways to solve it.*

o	**o**	**o**	**o**	**o**	**o**
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

5. / *think the things I have done in the past will keep helping help me.*

o	**o**	**o**	**o**	**o**	**o**
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

6. *Even when others want to quit, I know that I can find ways to solve the problem.*

o	**o**	**o**	**o**	**o**	**o**
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

The total Children's Hope Scale score is achieved by adding the responses to the six items, with "None of the time" = 1; "A little of the time" = 2; "Some of the time" = 3; "Alot of the time" = 4; "Most of the time"

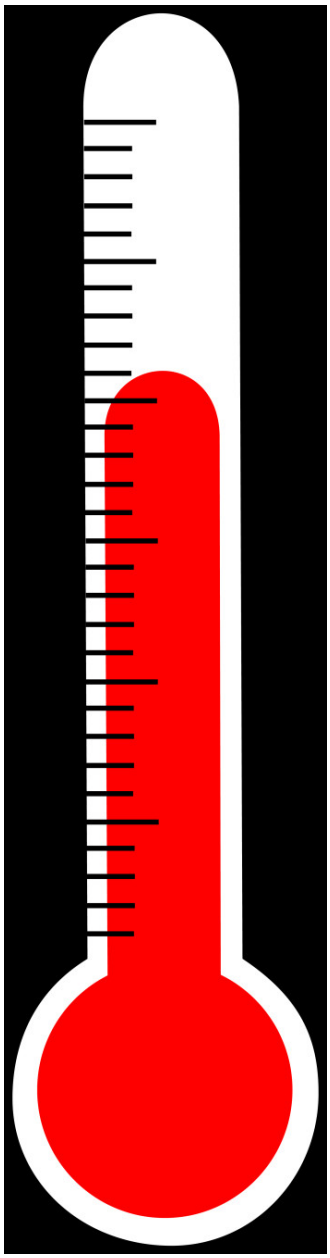
Appendix F

Children's Competence Beliefs and Subjective Task Values
Student Rating Sheet

Children's Competence Beliefs and Subjective Task Values
Student Rating Sheet

Student number _____ Pre or post _____Date _____

Question	*Rating Number*
Bike	
Math	
1	
2	
3	
4	
5	
Reading	
6	
7	
8	
9	
10	
Writing	
11	
12	
13	
14	
15	



Appendix G

Using My Strengths in My Classroom

Using My Strengths in My Classroom

Rationale:

Today we are learning how to set and work towards goals to improve work in your classroom A goal is a specific accomplishment that you and your teacher want to do to improve your work.

Your teacher identified a number of strengths that you can use to help you meet goals too. We are going to make a plan to meet a goal using your strengths. Doing this makes you recognize your accomplishments and feel proud about your successes.

Discuss Strengths

Strengths are things that you are good at and know how to do.

Here are your strengths that you and your teacher agreed on.

Here are additional strengths you picked.

Here are additional strengths your teacher picked.

One thing that you and your teacher would like you to work on is:

Ways to use your strengths in class to work on this goal

You should be proud of your strengths. You should use your strengths in class when trying to work on your goal. Here are some ways to use your strengths for this:

Give Strength Chart

You can keep this on your desk to use this week in class. We will share this with your teacher too.

Appendix H

Strength Chart

Strength Chart

My strengths:

One thing you and your teacher would like you to work on is:

Here are some ways I can use my strengths to work on my goal