Construction of the Structured Assessment of Functioning and Effectiveness-Revised (SAFE-R) : Validation Against the Million Adolescent Clinical Inventory (MACI) and Against Other Clinical Measures in an Adolescent Residential Setting

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CONSTRUCTION OF THE STRUCTURED ASSESSMENT OF FUNCTIONING AND EFFECTIVENESS-REVISED (SAFE-R): VALIDATION AGAINST THE MILLON ADOLESCENT CLINICAL INVENTORY (MACI) AND AGAINST OTHER CLINICAL MEASURES IN AN ADOLESCENT RESIDENTIAL SETTING

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Submitted in Partial Fulfillment of the Requirements of the Degree of Doctor of Psychology

May 2008
PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE
DEPARTMENT OF PSYCHOLOGY

Dissertation Approval

This is to certify that the thesis presented to us by John Girard Kuna on the 30th day of May, 2008, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

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Acknowledgments

First of all, I would like to acknowledge my Lord and Savior, Jesus Christ, who has been with me from my inception, unto this day, and until always.

Next I would like to acknowledge my family members who have encouraged me while tolerating me. I think of my wife, JoEllen, who helped in so many ways from providing meals to shuffling and sorting a seemingly endless amount of dissertation paperwork. There were so many times that she literally saved me from exhaustion either by her humor, by her faithful helpfulness, or by her cooking. Next I would like to thank my son Phillip for his helpfulness relative to being a resource person for my document challenges. Thank you, Phillip, for reminding me of the “eye of the tiger”. I was not feeling very “Rocky” at times and your encouragements really helped. My daughter Beth is also acknowledged for her constant encouragements. It was Beth, who at a critical point in the production of this dissertation reminded me, “Dad, God knew that you would be going through this now, the day that you walked into that first class.” Also, I would like to thank my son Jason, who provided a course reality check in some of his phone messages. In particular, I have kept and replayed a salient favorite, “Dad, hang up the phone and call me back!” Finally, I acknowledge all my grandchildren who kept me smiling with their constant reminders of all the fun a family can squeeze in during rather stressful times.

In terms of my faculty, I would equally acknowledge Dr. Chupella, Dr. McCloskey, and Dr. Badner. Without Dr. Chupella’s dedication to the safety of adolescents in KidsPeace, the motivation and insight into this project may not have been possible. Dr. Chupella provided innumerable hours dedicated to forming and reframing
items for the SAFE-R. His constant mentorship and professionalism are ubiquitously integrated among the lines of this dissertation. There is little more left to describe accurately how warm, dedicated and helpful a faculty member arrived in Dr. McCloskey. We will not soon forget the numerous times that Dr. McCloskey returned e-mails and made every effort to answer or rapidly return my cryptic and anxious messages. Finally, I have a deep and genuine appreciation for my dissertation Chairperson, Dr. Badner. From the earliest classes of Developmental Psychology to the intricacies of the Rorschach you have shown yourself to be a paradigm of endurance for me, for this project and for so many of my classmates. With a sincere and thankful heart, I thank you all.
ABSTRACT

Adolescents present with various emotional and mental health problems when admitted to residential settings. Such problems increase the probability that these clients represent a safety risk to themselves, to peers and to treatment staff. Psychometric devices can best meet the complex needs for assessment when such instruments are easily administered, well constructed, and diagnostically accurate.

However, the usage of psychological assessment instruments labors under growing restrictions by time limited health care delivery systems. With a concerted effort, the field of psychology must respond with a sense of advocacy and a realistic explanation for the value and utility of assessments devices. Such an initiative is required if the testing and assessment capacity of psychological services, as supplied by practitioners is to continue. Time-limited health care providers have claimed that psychological assessments are time consuming, costly and of limited usefulness in the general framework of health care. In the past, indiscriminate usage of expensive evaluation materials may have enhanced such a bias. Over utilization of assessment instruments has been highlighted by time-limited health care as a major factor that initiates rising provider costs to members. Time limited health care has constrained various applications of testing instruments by an increased resistance to reimbursement of assessment instruments and procedures. Unfortunately, psychology as a field has demonstrated a lack of advocacy regarding the ongoing need to promote and initiate innovative research that could underscore the efficacy and utility of assessment instruments. Because this has been the case, this constrained reimbursement process has
become extended in the direction of severely monitoring and truncating psychological assessments (Eisman et al., 2000).

This study responds to the continued need for applied research regarding safety and risk assessments as applied to adolescents in a residential setting by providing a description of the construction and validation of the Structured Assessment of Functioning and Effectiveness-Revised (SAFE-R). The SAFE-R, 110 item instrument, is scored on a Likert scale ranging from 1 = Strongly Disagree to 5 = Strongly Agree. The SAFE-R purports to measure 10 clinically relevant domains and scales including: Critical Risk and Safety Items, Anxiety/Attention Deficit Hyperactivity Disorder (ADHD), Borderline Personality Tendencies, Conduct Problems, Depressiveness, Mania, Posttraumatic Stress, Psychosis, Substance Abuse and Effectiveness. The validation of the SAFE-R is conducted by comparisons against scores on select scales of the MACI and against current clinical diagnoses. Research indicates that in spite of a restrictive atmosphere of time-limited healthcare reimbursements, the Millon Adolescent Clinical Inventory (MACI) continues to be a popular psychometric instrument among psychologists who are required to provide assessments of adolescents (Cashel, 2002).

Archival data was obtained for 126 clients from an adolescent residential population. Demographic statistics included Means and Standard Deviations regarding such factors as Ethnicity, Gender, Age and levels of intellectual functioning (Full Scale Intelligence Quotients). Pearson correlations were then conducted between elevations of the clinical scales of the SAFE-R when compared with elevations of select scales of the MACI. Such SAFE-R and such MACI scales are believed to assess similar, yet not necessarily identical traits. Then, Pearson point biserial correlations were generated
between elevated scores of the SAFE-R scales, elevated scores of select MACI scales and available diagnoses. Point Biserial correlations are utilized when one set of data is continuous, such as scale scores and when another set of data is dichotomous. Specifically, the pairing of having been diagnosed with a disorder and not having been diagnosed represented a dichotomous pairing. Pearson point biserial correlations were then generated between items of the SAFE-R scales and available psychiatric and psychological diagnoses. Specifically, the procedure of pairing SAFE-R item Specificity in terms of being diagnosed with a disorder versus SAFE-R item Sensitivity in terms of being diagnosed with a disorder represented a dichotomous pairing. Finally, Pearson point biserial correlations were generated between item endorsements of Safety and Risk Critical Items of the SAFE-R with endorsements of items of select Noteworthy Responses categories on the MACI. Specifically, the procedure of comparing item Specificity versus item Sensitivity represented a dichotomous pairing.
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Noverum me, Domine, noverum te,

et in eternam fruar Te.

Prayer of St. Augustine

For Kat
The Ongoing Need for Safety/Risk Assessments

At KidsPeace, visitors are greeted by a poster that reads, "We believe that safety is a primary need and fundamental right of all children." Safety and risk assessment of youth in the residential setting is one of the most crucial tasks of treatment and triage. The assessment regarding potential danger for violence to self or others is a critical feature of an accurate psychological evaluation. Client and staff safety may depend upon the production of accurate risk and safety assessments. Accurate assessments are needed to offset problems of over-utilization of benefits, enhancement of treatment protocols, and provision of appropriate triage.

The need for safety/risk assessments for adolescents is increasing (Tiffin & Kaplan, 2004). Residential Treatment Centers (RTC) differ from the needs of Residential Treatment Facilities (RTF). RTC's traditionally concentrate on the admission and treatment of youth that are deemed to have severe behavioral problems such as Conduct Disorder. RTF's include adolescents who have psychiatric diagnoses that are seen as being part of the client's impairments. Such severe psychiatric diagnoses include but are not limited to Conduct Disorder (CD), Bipolar Disorder (BD), Borderline Personality Disorder (BPD), Major Depressive Disorder (MDD), Posttraumatic Stress Disorder (PTSD), Psychosis (PY), and Substance Abuse (SA). Behavioral and mental health problems such as Anxiety (AN) and Attention Deficit/
Hyperactivity Disorder (ADHD) also appear related to the risk of unsafe and even aggressive problem behaviors.

**Complexity of Residential Safety and Risk Assessments**

Youth living away from families will tend to have more serious clinical profiles than youths living with families. Research indicates that youths living away from families are more likely than youths living with families to have 2 psychiatric diagnoses. Additionally, adolescents living away from families were at increased risk for such problems as substance use, suicidal behaviors, abuse or neglect, as well as other serious impairments in overall mental health, behavioral and social functioning (Pottick, Warner & Yoder, 2005).

Adolescents and children with BD are at increased risk for danger of suicide attempts and/or violence to others (Goldstein, Axelson, Birmaher, & Brent, 2007; Papulos, Hennen & Cockerham, 2005). Mixed depression has been associated with higher risk of suicidality than is non-mixed depression (Benazzi, 2007). Bipolar youths who are at increased risk for suicidality are also more likely to be admitted to residential settings (Rizzo et al., 2007). The early identification of BD and the early implementation of treatment strategies are critical factors in management of symptoms. Childhood onset BD is associated with higher rates of co-morbid conditions such as ADHD, Oppositional Defiant Disorder (ODD), CD, various anxiety disorders and substance abuse disorders (Correll et al., 2007). Additionally, BD clients in inpatient residential settings may continue to be at risk for harm to self and to others for extended periods of time post admission status (Rizzo et. al., 2007).

Assessments of risk for adolescents need to include features of Conduct Disorder behaviors. Research indicates serious long term problems for the pediatric population with early
diagnosis of conduct problem behaviors. Early on, aggressiveness and behaviors that violate the rights of others are persistent. Somewhat less than 50% of 8-10 year olds are identified as antisocial when 18 years of age. Children who are violent as adolescents can, with 50% reliability, be properly assessed as conduct problems as early as 7 years of age (Keen, 2007). According to research conducted among both adults and adolescents, past violent behaviors have long been recognized as perhaps the best single predictor of future violence (Thornberry, Huizinga, & Loeber, 1995; Tolan, Guerra & Kendall, 1995). Violent acts include battery and other actions severe enough to cause injury to another person, whether or not any injury actually occurred. Also included are acts of sexual assault and threats performed while the perpetrator is holding a weapon. In general, the acts were violent enough that criminal charges did or could have been levied. Adolescents with CD behaviors are at an increased risk for significant problems of violence and homicide (Loeber et al., 2005; Tarter et al., 2002). Inpatient adolescents with Conduct Disorder problems continue to be at high risk for violence and harm to others. Additionally, youth with conduct problems are at increased risk for violent crimes when presenting as co-morbid with psychiatric diagnoses of substance abuse, depression or anxiety. This increased risk may follow youth into early adulthood (Copeland, Miller-Johnson, Keeler, Angold & Costello, 2007).

Adolescents with MDD are at an increased risk for suicidality (Eskin, Ertekin, Dereboy, & Demirkiran, 2007; Esposito & Clum, 2002; Karen et al., 2008). The assessment and treatment of depression is, therefore, a critical factor in preventing adolescent suicide (Pelkonen, & Marttunen, 2003). Depression and hopelessness are highly correlated with suicidal behaviors among adolescents with co-morbid diagnostic problems such as BPD (Horesh, Orbach, Gothelf, Efrati & Apter, 2003). Additionally, there is a high correlation of poor self-disclosure among
depressed and suicidal adolescents. Research has shown that poor self-disclosure responses are associated with suicidal thinking, suicide attempts and suicidal attitudes. The inability to communicate internal processes to those close to oneself has been seen as an important risk factor in suicidal behaviors. (Horesh, Zalsman & Apter, 2004). Nonetheless, there is evidence that suicide screenings may be effective even when conducted within 24 hours of placement (Gallagher & Dobrin, 2005).

Adolescents who suffer from PTSD are also seen as being at an increased risk for harm to self or others (Cashel, Ovaert and Holliman, 2000). There has been a growing interest over the previous 15 years regarding the diagnosis of PTSD in children and adolescents; extensive research has identified the specific symptoms of this disorder and its associated risk factors in children and adolescents. Prevalence rates of PTSD in the general population are high, having been estimated at 6.3% to 27.1%. Reported rates of PTSD among juvenile offenders are higher than those estimated for other urban adolescent groups. Estimates in this population can range from 24% to 32%. Research has indicated that problems of trauma may lead to a continuance of crime and to a cycle of violence committed by delinquents. Such ongoing evidence clearly indicates the need for reliable and well-validated screening measures for the identification of problems of PTSD (Cashel, Ovaert and Holliman, 2000). The impulsivity of violence to self or to others is also a part of the PTSD diagnosis (Fehon, Grilo and Lipschitz, 2005). The elevated potential of violence and risk in adolescents is intertwined with the comorbidity of PTSD involving psychiatric disorders such as Major Depression, Bipolar Disorder and Substance Abuse (Dilsaver, Benazzi, Akiskal, & Akiskal, 2007; Kilpatrick et al, 2003; Najavits, Gotthardt, Weiss, & Epstein, 2004). Finally, the interactions between traumatized adolescents and pathology are complex. Such interactions may go beyond the scope of PTSD symptom
taxonomy. Various outcomes may include other internalizing disorders, disruptive disorders, juvenile delinquency, borderline personality, physical illnesses or no immediately apparent reaction (Onan, Myers, Collert & Brent, 2002).

The recognition of psychotic diagnoses, such as Schizophrenia, is an alarm for heightened safety precautions (Kelly, Conley & Carpenter, 2005). If these are not properly diagnosed and remain untreated, problems of psychosis in youth can lead to social alienation, homelessness, substance abuse and suicide (Jarbin & Von Knorring, 2004; Lehman, 2007; Reith, Whyte, Carter & McPherson, 2003; Vajda, & Steinbeck, 2000).

Adolescents can also have intensive psychiatric symptomology that warrants a diagnosis of Borderline Personality Disorder. Research has consistently determined that adolescents diagnosed with BPD show an increased risk for violence and self-harm (Horesh, Orbach, Gothelf, Efrati, & Apter, 2003: Kjellander, Bongar, & King, 1998; Santisteban, Muir, Mena, and Mitrani, 2003). Further, individuals with BPD are at increased risk because BPD often presents as comorbid with MDD or SA (Fountoulakis, Leucht & Kaprinis, 2008, Links, Gould & Ratnayake, 2003).

Adolescents involved with SA are at a higher risk for suicidality and fatalities (Esposito-Smythers & Spirito, 2004; Fournier & Levy, 2006). Higher rates of homicidal behaviors have been linked to an increased usage of drugs and alcohol (Roe-Sepowitz, 2007). An increased co-morbidity of SA and MDD is also related to suicidal behaviors (Pelkonen, & Marttunen, 2003). Additionally, adolescents and young adults with SA are significantly more likely to increase their risk of sexually risky behaviors and sexually transmitted diseases (STD). Such individuals have been identified as being at higher risk for having multiple sexual partners, for inconsistent use of prophylactics for protection, and for already having contracted an STD (Cook et al., 2006).
Anxiety as well as depressive problems are often co-morbid with ADHD (Gadow, Nolan, Sverd, Sprafkin & Schwartz, 2002). Comorbid behavioral and mental health problems such as Anxiety (AN) and Attention Deficit/ Hyperactivity Disorder (ADHD) appear related to an increased risk of unsafe and aggressive Conduct Disorder problems (Pelcovitz, Kaplan, DeRosa, Mandel & Salzinger, 2000). ADHD and anxiety problems are also associated with early onset of alcohol and risk of alcohol dependence (Sartor, Lynskey, Heath, Jacob & True, 2006). Additionally, adolescents who have anxiety problems may be at increased risk for sub-clinical self-harm (Croyle & Waltz, 2007).

A comprehensive risk and safety assessment also requires a review of factors associated with the potential for violence (Borum, Bartel & Forth, 2002) and with sexual offending recidivism (Worling, 2004). As noted above, past violence is often a significant predictor or continued problems of violent behaviors (Cunningham et al., 2006). Research has long indicated that past suicidality is a significant predictor of recurrent suicidal problems (Lewinsohn, Rohde, & Seeley, 1994). Adolescents are at risk for continued fire-setting problems when fire interest persists (MacKay, et al., 2006).

Further, among children who act out in a sexually inappropriate manner, there is a definite possibility of a history of sexual abuse. Such children may be tending to react to their environments and to their relationships in a sexualized fashion. In the literature, a history of child sexual abuse (CSA) has been associated with increased readmission to adolescent inpatient psychiatric care (Bobier & Warwick, 2005). Adolescents who have been victimized or traumatized show increased tendencies for high-risk behaviors including substance abuse, delinquent behaviors and self-injury (Danielson et al., 2006).
Finally, a complete and comprehensive safety/risk assessment device needs to include information related to protective factors, resiliency of personality and effectiveness factors. Research has indicated that protective factors yield positive treatment regarding adolescents with high aggression problems. Such protective factors include good problem solving abilities and higher interpersonal skills (Vance, Bowen, Fernandez, & Thompson, 2002). Resiliency of personality has been shown to offset problems of suicidality among depressed adolescents (Fergusson, Beutrais & Horwood, 2003). This factor has been described as the ability to succeed or to have positive outcomes despite problems and adverse conditions. Markers of a resilient personality may include above average intelligence, the ability to develop thoughtful solutions, positive responsiveness to others and adaptability after an environmental change, the capacity to self-soothe or to be soothed by others after a stressful event, overall calm mood states and realistic self-esteem. Resiliency has also been understood as the ability to reframe or eliminate negative interpretations of events (Cutuli, Chaplin, Gillham, Reivich, & Seligman, 2006). Effectiveness factors of treatment, such as viewing counselors’ skills positively, have been researched to indicate reduced length of retention for adolescents in substance abuse treatment (Battjes, Gordon, O’Grady & Kinlock, 2004).

Overall, such complex, diverse and intensive assessment needs require easily administered assessment devices that can be given either adjunct to intake interviews or in response to treatment team referral needs.
The Use of Clinical/Structured Interviewing

Clinical/Structured interviews are utilized as assessment procedures at KidsPeace. Healthcare providers, however, have reduced reimbursements for the core testing practices traditionally found in psychological practice by systematically limiting and eliminating psychological assessments. In the recent past, such providers have claimed that the Diagnostic and Statistical Manual of Mental Disorders- 4th Edition (DSM-IV) does not specifically make reference to usage of any psychological instruments for assessment purposes (American Psychological Association, 1994). These groups have proposed that it would be prudent to follow the guidelines that are included in the DSM-IV. Such guidelines include an emphasis on clinical interviews, direct observations, and information obtained from others who have known or who have also observed the client.

To the contrary, psychological assessments require substantial reinforcement from empirically based psychometric instruments to prevent errors from influencing evaluations; among these errors is interviewer confirmatory bias. Further, there is extensive evidence that disturbed children and adults might not be accurate reporters during a clinical interview. There are a multiplicity of factors that complicate interviews including the clients’ limited verbal skills, defensiveness, deceptiveness, and poor understandings of their own problems and symptoms (Eisman et al., 2000). These confounds have often produced an abundance of false positives and false negatives during clinical interviews, structured interviews and accumulations of data from client relatives.

Psychometric instruments can yield varied dimensions of information. A review by Meyer et al. (2001) makes an explicit statement that sole reliance upon a clinical interview can often lead to a faulty conceptualization of clients’ conditions. An integration of data is
accumulated from multi-method assessment practices. This review (Meyer et al., 2001) concludes that there is glaring empirical evidence that well trained psychologists add unique and enhanced value to evaluations when validated and empirical-based testing instruments are included as part of an assessment protocol.

Additionally, many of the more economical practices such as structured interviews that psychologists have utilized to offset sagging reimbursements, have increasingly come under the fire of efficacy studies. According to research, the structured interview can allow clinicians to make explicit yet inaccurate judgments (Tucker, 1998; Hammond, 1996). Errors in judgment occur when the clinician remains intent upon responses to specific interview questions, such as those that may conform to diagnostic criterion, without fully considering the salience and application of these responses in the clients’ broader life contexts. The clinician must adequately recognize how the individual responses join together into a symptomatically coherent pattern (Meyer et al., 2001; Klein, Ouimette, Kelly, Ferro, & Riso, 1994). Further confounds arise when clients are poor historians or are biased presenters of information. Response styles such as defensiveness or exaggeration will affect interviewer interpretations of client responses (Pogge, Stokes, Frank, Wong, & Harvey, 1997).

A two-year study cited that a major weakness of the SCID-II structured interviews (Chanen et al., 2004) is that the administrator would require an increased level of expertise and clinical intuition when compared with using an Axis I SCID-IV. The authors concluded that only clinically experienced interviewers should, therefore, be utilizing the SCID-II. The study concluded that this restriction alone proposed a practical and financial limitation for future research regarding structured interviewing efficacy.
The Use of Actuarial Assessment Instruments

Actuarial instruments are also commonly utilized for the assessment of adolescents at KidsPeace. Actuarial instruments involve reliance upon historical data to assess the client’s degree of problems related to safety and risk. Such instruments have been criticized as yielding a superficial impression of science and objectivity (Reid, 2003). When making assessments, there may be little allowance for the consideration of additional dynamic factors such as efficacy of therapy or increase of family income. Such factors may mitigate or modify static based conclusions. Research has not demonstrated that actuarial methods are superior to other clinical methods. Also, because of legal complications, some authors conclude that actuarial devices should not be allowed to replace clinical risk assessments (Litwalk, 2001). Actuarial devices often purport to offer life-changing classifications, triage and safety/risk assessments for individuals, based on group membership. Such a practice may ignore any of the individual’s modifying or mediating information. An ongoing problem with validation of actuarial devices for assessments is that “clear and convincing” substantiation is the burden of proof required by the state in most or almost all civil commitment proceedings.

Various Actuarial Instruments

Popular actuarial instruments such as the Structured Assessment of Violence and Risk in Youth (SAVRY) or the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR) are useful in indicating an estimated level of recidivism risk. These instruments have been grounded in a depth of research study and review. As an instrument designed to assess future risk of violence, the SAVRY (Borum, Bartel & Forth, 2002), depends less on structured
The SAVRY is broken down into four major headings that are further divided into various categories. The four major headings of the SAVRY are: 1). Historical Risk Factors, 2). Social/Contextual Risk Factors, 3). Individual/Clinical Risk Factors and 4). Protective Factors. Categories within each heading have been grounded with empirical research to illustrate the fact that the heading has an appropriate relevance to predict violence and risk behaviors. The first three headings of the SAVRY provide the administrator with a four point continuum (Lo-Mod-Hi-X) for risk and violence assessment. The X level would refer to a coding that signifies a factor which is evaluated as being at an extremely significant level as a predictor of violence or as a protective factor. The final heading of Protective Factors is coded by means of a Present-Absent-X format. All headings are allowed a section to define Critical Items that are especially salient to the administrator. For example, the first category under the heading of Historical Risk factors is History of Violence. A Lo coding would mean that the subject has committed no acts of violence, a Mod would refer to the subject’s having performed one or two acts of violence and a Hi coding would indicate that the subject has, in their past, a listing of three or more acts of violence.

The ERASOR (Worling, 2004), whose items are based on empirical research, is regarded as an actuarial/interview format based risk assessment instrument for juvenile sexual offenders (Beech, Fisher, & Thornton, 2003). The ERASOR is designed to assess risk in 12 to 18 year old sexual offenders. There are four categories of ratings for risk potential: 1). Present; 2). Partial/Possibly Present; 3). Not Present; 4). Unknown. The ERASOR is composed of 25 specific
risk factors (RF) that are organized into five categories: 1). Sexual Interests, Attitudes and Behaviors; 2). Historical Assaults; 3). Psychosocial Functioning; 4). Family/Environmental Functioning; and 5). Treatment.

The items of the ERASOR assess both static and dynamic variables related to past sexual offenses. Dynamic domains include sexual interests, pro-offending attitudes, socioaffetive problems and self-management. Further items are related to issues of family environment, problematic relationships with parents and lack of parental support. Questions related to family behaviors and histories are a critical part of the assessment.

Although the ERASOR relies primarily on actuarial information, individuals at risk for sexual offense recidivism can be seen as being in a state of change. Change factors might include developmental pathways, cognitive development, or family circumstances. The Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) is also an assessment tool for estimating sexual offense recidivism. The authors of the J-SOAP-II note that evaluators have substantial responsibility to protect others from high risk offenders yet should be aware of the danger inherent in imposing life altering consequences upon low risk adolescents (Prentky & Righthand, 2003).

Advantages of Empirically Normed Instruments

Empirically validated psychometric instruments such as the MACI are also utilized for the assessment of adolescents at KidsPeace. Formal psychological testing can aid in circumventing the problems associated with clinical/structured interviews or actuarial instruments. Meyer et al., (2001) lists several important areas. First, psychological assessments are able to glean evidence representing a broad base of clinical domains, some of which may be
inadvertently overlooked during clinical interviewing. Second, psychological tests provide empirically quantified information, allowing for accurate and impartial measurement of patient characteristics. Third, psychological testings have standardized administration and scoring procedures. Such protocols enhance the clinician’s ability to attend to subtle cues of other complicating psychological or neuropsychological conditions (Groth-Marnat, 2000). Standardized instruments also can reduce legal and ethical problems by minimizing any confirmatory bias that may inadvertently enter into the evaluation. When standardization is lacking in less formalized assessments, the interaction between the clinician and the patient may vary considerably, due to interactions of clinician personality factors. Fourth, psychological tests are normed, allowing each patient to be compared with a relevant group of peers. A concern and danger is that, over time, clinicians using informal evaluation processes may tend to develop their own internal standards. Such internal standards may become skewed or biased by the type of patients routinely treated in a particular setting. Normed results allow the clinician to formulate refined and unbiased inferences about client strengths and weaknesses. Normed information can accurately compare how typical or unique the client may be on a given characteristic. This factor allows the clinician to appreciate more clearly base rates regarding the frequency with which certain conditions occur in a population setting (Finn & Kamphuis, 1995). Fifth, ongoing research upon scales of empirical instruments can place the standards of reliability and validity well beyond those provided by information gained simply by clinical interviews. Without utilization of empirically driven psychometric instruments, clinicians may have poorer access to external standards. Such standards are needed to monitor the accuracy of the process of clinical decision-making.
The Millon Clinical Adolescent Inventory

The Millon Clinical Adolescent Inventory (MACI) has also shown continued application in the time-limited health care environment. The MACI (Millon, Millon & Davis, 1993) is an assessment tool for measuring mental health and behavioral problems in adolescents who range in age from 13 years, 0 months to 18 years, 11 months. This instrument has been studied relative to its advantages in providing economical and accurate assessments in the face of constrained managed health care resources (Cashel, 2002). In addition to 12 Personality Patterns Scales, 8 Expressed Concerns Scales and 7 Clinical Syndromes scales, the MACI has 8 categories of Noteworthy Responses; these latter are valuable for rapid evaluations in the areas of self-harm, harm to others, and factors related to childhood sexual abuse. Such Noteworthy Responses categories include Acute Distress, Dangerous Ideation, and Childhood Abuse.

The MACI has been utilized as part of the admission protocol for residential treatment facilities (Romm, Bockian and Harvey, 1999). In this study, Personality Patterns of the MACI has shown few sex differences, with the exception that girls have higher levels on Self-Demeaning than do boys. However, sex differences in this study included variance in Clinical Syndromes. Girls were more likely to endorse Eating Dysfunction, Depressive Affect and Suicidal Tendency. Boys were more likely to endorse Delinquent Predisposition.

Various studies have relied on the MACI to evaluate problems of mood disorders (Hiatt & Cornell, 1999; Bickel & Campbell, 2001; Glaser, Calhoun, Petrocelli, Bates & Owens-Hennick, 2005) as well as the assessment of safety issues such as the risk for perpetration of sexual offending (Richardson, Kelly, Graham & Bhate, 2004). This latter study showed that “Dysthymic/Negativistic” types had elevations on the scales of Unruly, Forceful, Oppositional, Borderline Tendencies and Self-Demeaning Scales. Further, Antisocial types showed notable
elevations on Unruly and Forceful scales. Other research with severe adolescent offenders has shown correlations between MACI clinical Anxiety scales and suicidal behaviors (Taylor, Kemper, Loney, & Kistner, 2006).

The MACI has demonstrated its ability to correlate risk and conduct problems with problems of childhood abuse (Grilo, Sanislow, Fehon, Martino & McGlashan, 1999). One pilot study used the MACI to determine personality differences in adolescents who have presented with and without a history of suicide attempts (Velting, Rathus & Miller, 2000). Those who have attempted suicide showed higher scores on the Forceful and Borderline Tendency scales but lower scores on the Submissive and Conforming scales. Another pilot study has examined personality differences in adolescents presenting with comorbid, CD, ADHD and SA (Rayner, Kelly & Graham, 2005).

Also, because of its relatively shorter length and ease of scoring, the MACI has been utilized in adolescent residential facilities to validate other research driven, cost effective instruments such as the Massachusetts Youth Screening Instrument-2nd Edition (MAYSI-II) (Grisso, Barnum, Fletcher, Cauffman & Peuschold, 2001). The MAYSI-II is a brief 52 item screening measure that identifies the presence of mental, emotional or behavioral problems in youth whose age ranges from 12 to 17 years. There are seven scales utilized in the MAYSI-2: 1). Alcohol/Drug use; 2). Angry-Irritable; 3). Depressed-Anxious; 4). Somatic Complaints; 5). Suicidal Ideations; 6). Thought Disturbance; and 7). Traumatic Experiences. These scales have provided guidelines for juvenile justice staff in identifying the needs of adolescents in the juvenile justice system. Notably, the factor that identified the Traumatic Experience Scale did not include high loadings for symptoms of Posttraumatic Stress Disorder. The authors stated that such a result may have occurred because MAYSI-2 items may have loaded in the analysis on
factors that pertained to other problem areas. In this study, four scales of the MACI correlated highly with MAYSI-2 scales. These MACI scales included Substance Abuse Proneness, Impulsive Propensity, Depressive Affect and Suicidal Tendency.

The MACI (Blumentritt, Angle & Brown, 2004) has demonstrated ability for multicultural usage when providing correlations of personality patterns and diagnoses as defined by the DSM-IV. Notably, in this study of troubled Mexican-American youths, the personality patterns measured by the Unruly and Oppositional scales showed clinical elevations.


Overall, the MACI has shown a significant application in enhancing assessments relative to the intensive mental health and behavioral problems of adolescents in residential settings.

Purpose of this Study

The purpose of this study is to validate the SAFE-R empirically. Research indicates the need for psychologists to add psychological assessments to other psychological interventions (Yates & Taub, 2003). The overall goal of this study is the validation of the SAFE-R by comparisons against 1). A psychometrically valid, reliable, and standardized psychometric instrument such as the MACI. The MACI has shown the ability to provide reliable and accurate information related to the diagnoses of behavioral and mental health problems and 2). to determine a comparison with available and current psychological/psychiatric diagnoses.
It is proposed that the validation of the SAFE-R could offer several advantages. First, individuals have required more extensive clinical training for the correct administration of the structured interview format of the original SAFE. With the SAFE-R, there would be no need for the substantial amount of clinical expertise and background that otherwise is required of clinicians applying the structured interview format of the SAFE. The development of a normed self-report instrument could reduce the need for extensive manual study, the supervision of administration or the extensive training in structured interviewing skills and actuarial review. There would potentially be a saving in reduced hours required for expert supervision by a trained administrator of a new user. Second, if such an instrument were to produce reliable and valid results, there could be a substantial saving in time needed to interview clients and interpret the results as required by the protocol of the SAFE’s original format. Third, the SAFE closely follows the format of the SAVRY to determine risk and safety issues associated with various clinical problems. The SAFE depends upon the clinical skills and interviewing abilities of the administrator to extract evidence and information required for accurate diagnoses of psychiatric/psychological problems such as BD, PTSD and BPD. The potential to provide such diagnoses would be enhanced within the format of the SAFE-R. Additionally, the SAFE-R could rapidly provide risk and safety information related to issues of harm to self, harm to others and potential for sexual offense recidivism. Fourth, a normed instrument would potentially lessen liability or litigation problems that may arise after admission and triage. Fifth, many time-limited health care groups may deny reimbursement for the extensive time required by supervisors for the training of interns or unlicensed postdoctoral students to conduct assessments by means of structured interviews or actuarial reviews. Many clinical training programs are at risk for closure because of such economic pressures. The value of these particular assessment skills are in
danger of being reduced and possibly eliminated within the health care field (Eisman et al., 2000).

Rationale

**Limited Health Care Reimbursements**

In an attempt to meet complex diagnostic demands, child assessment practices have been growing at an enormous rate. Psychologists provide multi-dimensional services including tests of intelligence, of visual motor capabilities, of academic achievement and even of adaptive behaviors ratings. Millions of children receive psychological assessments and other related testing (Kamphaus, Petoskey & Rowe, 2000). Appropriate triage and treatment recommendations are critical to resource management for the expedient utilization of limited health care benefits. In particular, problems with over- and under-utilization are well researched in the residential and hospital settings. Clients continue to require rapid assessment because health care benefits are becoming more restricted along multiple levels of service (Ekerd, 1994). Improper or erroneous diagnoses can result in substantial over-utilization of benefits. An inordinate amount of resources can be consumed for very minimal outcomes. It remains an ongoing requirement upon intake at residential centers that assessment tools be able to provide not only accurate information for diagnosis, but also accurate assessment of risk and safety problems.

Health care services have provided limitations on child and adolescent health care in general. Adolescent residential services particularly have come under increased scrutiny. It has become critical to vouch for the clinical usage of time-intensive and potentially costly psychological instruments. Residential admission processes are coming under increased pressure
to reduce costs and provide triage with accurate placements and assessments (Lyons, Libman-
Mintzer, Kisiel & Shallcross, 1998). Research is driven to determine variables that are predictive
of positive outcomes for residential treatments, for risk factors and for accurate triage. From the
day of admission, critical factors seem to indicate lowered levels of positive outcomes. Such
factors include a history of physical or sexual abuse and internalized psychopathology (Connor,
Miller, Cunningham & Melloni, 2002). Assessment devices and protocols must be able to focus
rapidly on salient and critical client factors to provide cost efficient and accurate assessments of
mental health problems or risk and safety evaluations.

Research reviews have demonstrated that psychologists are buckling under the restraints
of limited health care reimbursements. The question of whether or not to maintain the practice of
including assessment instruments in evaluations has been researched, with results that are both
favorable and unfavorable (Palmiter, 2004). The unfavorable conclusion indicated that childcare
clinicians might not always employ cost effective, efficient and empirically based assessment
instruments. Further, a sizable group within the field of psychology has begun to reduce their
perceptions of the importance of ongoing research in developing assessment instruments.
Nonetheless, the information from this report indicates that most childcare clinicians would
indeed like to be able to increase their testing repertoire with additional cost effective and
efficient testing instruments.

Other threats to the practice of assessments in clinical practice include the fact that
limited health care benefits may pay less for assessments per hour than for individual therapy.
Another strategy to lower reimbursements is to allow an unreasonably lowered number of hours
for an assessment yet still anticipate proper and professional completion. Extensive studies have
shown for quite some time that the hours allowed for scoring, interpreting and writing a report is
less than the probable time taken even to complete administration of the particular test. For
example, one national based health care group was at one time reportedly allowing only one hour
for the administration, scoring and interpretation of the Wechsler Adult Intelligence Scale (Ball,
Archer & Imhoff, 1994). Since 1995, the American Psychological Association’s (APA) Board of
Professional Affairs (BPA) have formed a Psychological Assessment Work Group (PAWG) that
seeks to define two critical areas of health care trends: 1). To appraise the extent of the threat to
psychological assessments by the health care system and 2). To define research studies that can
document the utility and the necessity in the application of psychological assessments by
clinicians (Meyer et al., 2001). Several reviews have been produced (Eisman et al., 2000;
Kubiszyn et al., 2000; Meyer et al., 2001). Among these reviewers, Meyer et al. (2001) has
noted that psychological test validity may need to be considered as having an equivalent place
beside medical test validity.

In such a financially restrictive atmosphere, ethical demands require that psychological
service providers offer a standard of care to their clients. Practitioners who treat children and
adolescents, in particular, need to become equipped with the latest and most current, empirically
based assessment instruments. Psychologists require vigilance to operate as intelligent advocates
for adolescent clients who have much less choice or voice in battling limiting health care
reimbursements (Cashel, 2002). Overall, well educated, empirically research-driven
psychologists may need to join with the advocacy power of state and national psychological
associations. Such collaboration can aid the effort to reverse the ongoing decline of
reimbursements for psychological testing (Kubiszyn et al., 2000).

In spite of increased funding restrictions placed upon psychological evaluations,
the personality and intellectual functioning portions of assessment remain as integral parts of
psychological evaluations. Currently, measures being severely restricted include the tools considered to be traditionally important such as the Minnesota Multi-Phasic Inventory (MMPI), the Wechsler Intelligence Scales for Children (WISC), the Wechsler Adult Intelligence Scales (WAIS), the Rorschach, the Thematic Apperception Test (TAT) and the Millon inventories (Piotrowski, Belter & Keller, 1998). According to Cashel (2002), favored instruments frequently used by child and adolescent psychologists included the Minnesota Multi-Phasic Inventory – Adolescent Version (MMPI-A), the MACI, the Reynolds Adolescent Depression Scale, the TAT and the Youth Self Report. When psychologists were surveyed about which tools in particular were not being reimbursed and were therefore were being less utilized, the list included negative and marked losses of usage for the WISC (-22.8%), the Rorschach (16.7%) and the MMPI (-11.7%). The Millon Clinical Adolescent Inventory (MACI) was not as severely reduced in usage (-5.6%) in the previously mentioned study by Cashel (2002). Regarding an estimated ability to diagnose their clients accurately, 29% reported the anticipation of a negative impact because of payment restrictions that result in the loss of favored and time-honored instruments.

Despite the ongoing need for accurate and rapid assessment instruments, there are also caveats that must be carefully considered. Scales that can accurately measure problems of adolescent psychopathology ought not to be simply diluted versions of adult scales and measures. Adolescent instruments need to be tuned to the pace of development in cognitive and emotional capacities. As noted above, especially in trauma assessments, other reactions to trauma that are not specifically included in a diagnostic taxonomy may be critical to the evaluators’ intentions and purposes. Further, instruments attempting to measure adolescent mental health or behavioral problems can impose strain upon adolescent test responding and functioning. This strain may lead to clinical regression and invalid responding. Reactivity of
responding may become a problem regarding validly. In these terms, reactivity would mean that clients having taken a test or similar tests in the past may show various untoward effects regarding valid responding. Therefore, instruments intending to measure adolescent psychopathology must be carefully chosen to avoid the possibility of their being unusually stress inducing, of being not sensitive, too invasive or too long (Onan, Myers, Collert & Brent, 2002).

Formulation of the Original SAFE

History of the Original SAFE

Before providing a discussion regarding the construction of the SAFE-R, it is appropriate to provide a brief sketch of the background of the original SAFE, a copy of which is found in Appendix B. During 1999, Robert G. Chupella, Ph.D. began working in tandem with KidsPeace treatment team requests to provide a rapid, accurate and low cost safety and risk assessment device. The result was a structured clinical interview that was named the Structured Assessment of Function and Effectiveness (SAFE), Child and Adolescent Version. The main purpose of the instrument was to offer diagnostic impressions as a basis for recommendations for safety, risk, and triage issues. As a structured clinical interview/actuarial device, the original SAFE, Child and Adolescent Version has been in use at KidsPeace National Center for Kids in Crisis at Orefield, Pennsylvania for over nine years. The instrument is a combination structured interview and actuarial assessment device that provides a rapid accumulation of client information for diagnosis of clinical problems and for safety or risk assessments. The original SAFE has been utilized extensively within the locations of the KidsPeace National Center such as at the hospital, residential diagnostics, and both at intensive and at non-intensive residential homes. A manual had been prepared and provided for administrators of the original SAFE.
Structured interviewing generally has been a procedure that has an extensive history in psychological services. The utility of structured interviews has been well accepted in the field of psychological assessments. Primarily, such assessment devices have attempted to produce a diagnostic profile that would yield a diagnosis according to DSM-IV standards.

There are thirteen sections in the original version of the SAFE. These sections include:

1). Identifying Information
2). Referral Issues
3). History of Treatment: (Psychosocial, medication)-Outcomes
4). Family Issues
5). Personal and Social Issues
6). Developmental and Health History
7). Sexual History
8). Education (past-present)
9). Mental Status Evaluation
10). Functioning: Risk Issues History: 1. Risk to self. 2. Risk to others
11). Psychoactive Substance Use
12). Effectiveness Factors
13). Diagnostic Impressions and
14). Interviewer Rating- Need for Assistance.

These domains comprised an extensive amount of information that was drawn together in the structured interview format upon a client's admission to the residential setting.

The construction of the original SAFE began with Dr. Chupella distributing copies to Doctoral level readers at KidsPeace over a period of time during the late 1990's. Their suggestions were incorporated and the document was prepared with regard to their combined suggestions and clarifications. The document was designed as a guide to aid the trained clinical administrator in making a comprehensive structured interview. After the Diagnostic Impressions section was completed, the interviewer filled out the final Need for Assistance section. Typical safety risks included concerns regarding potential for elopement, for self-harm such as self-mutilation and for suicidality. Other safety risks included potential for sexualized grooming or sexual assaults, for physical assaults on staff or other residents, for fire-setting or for destruction of property.
As noted, the information gained in the original SAFE structured interview format concluded with recommendations about Need for Assistance. Need for Assistance was rated as No Need, Moderate Need, Average Need, Strong Need and Emergency Need. These qualifiers were utilized by admissions and residential staff to prepare and initiate initial treatment and triage. The concept of Need for Assistance was defined as a recommendation for more or less intensive staff preparedness in regard to the client’s risk potential. The overall structure of the original SAFE would provide evidence for diagnosis of clinical problems as well as for assessments of risk and safety issues. The original SAFE enhanced the diagnosis and treatment recommendations associated with major behavioral problems such as CD and/or SA as well as clinical problems such as MDD. The skill of the clinician during the interview process may or may not have produced information that related to risk factors inherent in psychiatric/psychological disorders such as BD, PTSD or BPD.

Comparison of the Original SAFE and the SAVRY

The constructs that are utilized in the original SAFE can be seen as being closely related to those applied in the SAVRY. Although the original SAFE predates the SAVRY, both instruments were at the time purporting to provide diagnostic information by means of an interview/actuarial format. The following is a brief review of several salient headings and categories from the original SAFE, including a comparison with those of the SAVRY.

Historical Risk Factors

Historical Risk Factors is the first major heading within the SAVRY. The original SAFE utilizes a heading of Risk Issues History. Categories for questioning under the original SAFE

Research has shown that there are various domains within a history of risk factors that can lead to an accurate predication regarding recidivism of violence (Tolan, Guerra & Kendall, 1995). Within this SAVRY heading, there are ten categories: 1). History of Violence; 2). History of Non-violent offending; 3). Early Initiation of Violence; 4). Past Supervision/Intervention Failures; 5). History of Self-harm or Suicide Attempts; 6). Exposure to Violence in the Home; 7). Childhood History of Maltreatment; 8). Parental/Caregiver Criminality; 9). Early Caregiver Disruption and 10). Poor School Achievement.

*History of Self-harm or Suicide Attempts*

The original SAFE gains such relevant information in the heading of Mental Status Evaluation. A typical category in this heading would be Suicidal Ideations. The original SAFE heading of Risk Issues History also includes relevant categories such as Suicidal Ideations, Planning, Intent, Furtherance and Lethality. Adolescents with a history of self-harm or suicidal attempts have been researched as being at greater risk for future violence (Apter et al., 1995).

*Social/Contextual Risk Factors*

Social/Contextual Risk Factors compose the second major heading in the SAVRY. The original SAFE has comparable headings and categories with which to accumulate data for diagnostic precision. There are six categories within this heading of the SAVRY: 1). Peer Delinquency; 2). Peer Rejection; 3). Stress and Poor Coping; 4). Poor Parental Management; 5).
Lack of Personal/Social Support and 6). Community Disorganization. Comparable headings in the original SAFE include: 1). Family Issues; 2). Referral Issues; and 3). Sexual History. There are also comparable categories within these headings.

*Peer Delinquency*

Association with delinquent peers is a risk factor for delinquency and violence in youth (Loeber & Hay, 1997). A further critical factor is the frequency of association with a delinquent or criminal peer grouping. The original SAFE provides the opportunity to acquire such information under the heading of Family Issues. Categories in this heading of the original SAFE include Legal Problems and Loss/Abandonment. Another important heading in the original SAFE is Referral Issues. The Referral Issues heading could obtain information from the interview or from a review of records of formal legal charges.

*Poor Parental Management*

This SAVRY category refers to a constellation of ineffective supervision and discipline. Problems in such areas can lead to delinquency and substance abuse. There is a predicated increased risk for violence among males (Capaldi & Patterson, 1996). The original SAFE inquires about this information by means of two headings. The first would be Family Issues with categories such as Abuse, Neglect, Loss/Abandonment and Domestic Violence. The second heading is that of Sexual History. The administrator can determine issues of parental neglect in certain situations. Such situations would include parental neglect that fails to protect the children from sexual abuse or a familial milieu that fosters inappropriate sexual play.
Individual Risk Factors

Individual Risk Factors is the third major heading in the SAVRY. The original SAFE has comparable headings and categories to guide interview questions. There are eight categories within this heading of the SAVRY: 1). Negative Attitudes; 2). Risk Taking/Impulsivity; 3). Substance Abuse Proneness; 4). Anger Management Problems; 5). Low Empathy/Remorse; 6). Attention Deficit/ Hyperactivity Difficulties; 7). Poor Compliance and 8). Low Interest/Commitment to School. Comparable headings in the original SAFE include: 1). Risk Issues History; 2). Mental Status Evaluation; and 3). Psychoactive Substance Use. There are also comparable categories within these headings.

Risk Taking/Impulsivity

This category examines factors of Risk Taking because these are linked to the occurrence of violence and delinquency in youth. Risk Taking may have a high association with violent behaviors (Fehon, Grilo, & Lipschitz, 2005). The original SAFE utilizes two headings to gain information relevant to these factors. The first heading is Risk Issues History. Information is gained in this heading from the categories of Thrill Seeking Activities, AWOL, and Health Compliance. The second heading in the original SAFE is Mental Status Evaluation. Categories in this heading include Insight and Overall Impulse Controls.

Substance Abuse Problems

Significant substance abuse is a risk factor for violent behavior in youth (Loeber & Hay, 1997). The original SAFE has a similar heading under the section of Psychoactive Substance
Use. Pertinent categories that are used to obtain information include Age of Onset, Frequency, Tolerance/Dependence, and Last Use.

**Anger Management Problems**

Difficulty managing anger, especially an explosive temper is associated with increased risk for violence (Cornell, Peterson, & Richards, 1999). A comparable original SAFE heading is Risk Issues History. This heading includes the categories of Verbal, Physical and Sexual Aggression.

**Protective Factors**

Protective Factors is the final major heading of the SAVRY. The presence or absence of such factors has been researched as a predictive variable for future violence (Vance, Bowen, Fernandez, & Thompson, 2002). There are six SAVRY categories within this heading: 1). Prosocial Involvement; 2). Strong Social Support; 3). Strong Attachments and Bonds; 4). Positive Attitude Toward Interventions and Authority; 5). Strong Commitment to School and 6). Resilient Personality Traits. Comparable headings in the original SAFE include: 1). Effectiveness Factors; and 2). Personal and Social History. There are also comparable categories within these headings. The three SAVRY categories that are compared here are Prosocial Involvement, Strong Social Support and Resilient Personality Traits.

**Prosocial Involvement**

As in the original SAFE, this SAVRY heading is an actuarial and/or interview process that obtains strength/weakness based information. Such activities included are those indicating
that the adolescent is involved in helping, cooperating, recognizing other’s feelings, participation in prosocial activities and affiliation with organizations. Poor social involvement is perhaps the strongest predictor of later violence in adolescents (Lipsey & Derzon, 1998). Prosocial behaviors can buffer the risk of delinquency and aggression. The original SAFE obtains information from the heading of Effectiveness Factors. Questions are obtained from categories such as Accessing Support, Future Perspective, Problem Solving and Interpersonal Skills. Additional categories in the heading of Effectiveness Factors include Empathy, Remorse, Regard for Safety of Others, and Self-appraisal. The original SAFE also utilizes another heading, Personal and Social History. In this heading there are the categories of Early On Peer Relationships and Current Family and Peer Relationships.

*Strong Social Support*

This category refers to a network of peers and of adults who provide emotional support and actual assistance in times of need. Such support promotes resilience in children and discourages violence and delinquent activities. The original SAFE obtains information from the heading of Effectiveness Factors. As noted, questions are obtained from categories such as Accessing Support, Future Perspective, Problem Solving and Interpersonal Skills. Additional categories in the heading of Effectiveness Factors include Empathy, Remorse, and Self-appraisal. The original SAFE also can utilize the heading Personal and Social History. In this heading there are the categories of Early On Peer Relationships and Current Family and Peer Relationships.
Resilient Personality Traits

The original SAFE accumulates salient information by means of three pertinent headings: 1). Effectiveness Factors; 2). Education, and 3). Referral Issues. Categories in Effectiveness Factors, as noted, include Accessing Support, Frustration Tolerance, Future Perspective, Problem Solving and Interpersonal Skills. Further categories in the heading of Effectiveness Factors include Empathy, Remorse, Regard for Safety of Others, Regard for Personal Safety, Self-appraisal and Motivation for Change. Categories in the heading of Education include Level of Achievement, Type of Progress and Social Relationships (peer-authority). Finally, categories in the heading of Referral Issues include Documentations and Findings and Testings.

Overall, in terms of construct and face validity, the constructs provided in the original SAFE run very closely parallel with those utilized in the SAVRY. In terms of construct and face validity, both instruments appear able to provide estimates of risk, safety and need for intervention. When used by an expertly trained clinician, the original SAFE would be expected to provide estimates of risk and safety concerning behavioral problems such as those seen in CD, SA and even possibly MDD diagnosis. However, as noted above, the original SAFE in its original format does not necessarily show the construct or face validity for assessment of certain psychological problems such as BD, PTSD or BPD. The ability to obtain required information and apply such diagnoses would in great part depend almost entirely upon the expertise, clinical skills and judgment of the administrator.
The Structured Assessment of Functioning and Effectiveness-Revised

The SAFE-R is a 110 item instrument that is scored on a Likert scale ranging from 1 = Strongly Disagree to 5 = Strongly Agree. This instrument is composed of a Risk and Safety Critical Items Domain, the 8 proposed clinical scales and the Effectiveness Domain.

The SAFE-R Risk and Safety Critical Items domain purports to assess factors associated with violence to self or others, criminality, and sexual offending recidivism. The 8 SAFE-R scales purport to measure clinical concerns such as: Anxiety/ADHD, Borderline Personality Traits, Conduct Problems, Depressiveness, Mania, Posttraumatic Stress (PTSD), Psychosis and Substance Abuse. Finally, the SAFE-R has an Effectiveness domain to provide qualitative information regarding the presence of prosocial mediating and protective factors.

The SAFE-R has four qualifiers to indicate problems of inattention or maladaptive test taking response styles:

26. There are health problems in my family. 1 2 3 4 5
35. I know that I am taking this test. 1 2 3 4 5
47. I know where I am at right now. 1 2 3 4 5
62. There are health problems in my family. 1 2 3 4 5

Erratic answering among the qualifiers may result in a cautious or an inapplicable interpretation.

The Risk and Safety Critical Items domain was designed to have the items individually reviewed and was not intended for aggregation into a scale.

Results of the 8 clinical scales were qualitatively determined by summing the raw number of the items that are endorsed in each domain. Raw scores are then evaluated according to a grouped frequency distribution format including: 1). No indication; 2). Low Indication; 3). Moderate indication; 4) High indication; and 5). Extreme indication. Instructions note that there may also be other items that have high scores in a positive direction; these can become of interest for continued therapeutic discussion and attention.
Items in the SAFE-R were specifically constructed to follow symptom descriptions and to enhance heterogeneity. This process was also intended to lessen the potential for overlap of constructs.

Research Hypotheses

Introduction of Research Hypotheses

Hypothesis 1): It is hypothesized that there will be significant and positive Pearson correlations between elevations of the clinical scales of the SAFE-R when compared with elevations of select scales of the MACI. Such SAFE-R and such MACI scales are believed to assess similar, yet not necessarily identical traits. The MACI scales include: 1). Borderline Tendency (9); 2). Oppositional (8A); 3). Substance Abuse Proneness (BB); 4). Suicidal Tendency (GG); 5) Delinquent Predisposition (CC); 6) Unruly (6A); 7) Depressive Affect (FF); 8). Forceful (6B); 9). Anxious Feelings (EE); and 10). Self-Demeaning (8B). The scales of the SAFE-R include: 1). Anxiety/ADHD; 2). Borderline Traits; 3). Conduct Problems; 4). Depression; 5). Mania; 6). Posttraumatic Stress; 7). Psychosis; and 8.). Substance Abuse.

Hypothesis 2): It is hypothesized that there will be a positive relationship between elevated scores on select scales of the SAFE-R, elevated scores on select scales of the MACI, and clinical diagnoses. The MACI scales include: 1). Borderline Tendency (9); 2). Oppositional (8A); 3). Substance Abuse Proneness (BB); 4). Suicidal Tendency (GG); 5) Delinquent Predisposition
(CC); 6) Unruly (6A); 7) Depressive Affect (FF); 8) Forceful (6B); 9) Anxious Feelings (EE); and 10) Self-Demeaning (8B). The scales of the SAFE-R include: 1) Anxiety/ADHD; 2) Borderline Traits; 3) Conduct Problems; 4) Depression; 5) Mania; 6) Posttraumatic Stress; 7) Psychosis; and 8) Substance Abuse. The clinical diagnoses include: 1) ADHD; 2) Anxiety Disorders; 3) Borderline Personality Traits; 4) Bipolar Disorders; 5) Conduct Disorder; 6) Depressive Disorders; 7) Posttraumatic Stress Disorder; 8) Psychotic Disorders; and 9) Substance Abuse Disorders.

**Hypothesis 3):**

It is hypothesized that items in specific SAFE-R scales that are thought to address behaviors and cognitive states consistent with a specific clinical diagnosis will positively correlate with the respective clinical diagnoses (i.e., the items of the SAFE-R scales will be endorsed in the expected manner by program residents with that diagnosis). Further, it is hypothesized that there will be additional SAFE-R items that correlate highly with some diagnoses. Such clinical diagnoses include: 1) ADHD; 2) Anxiety Disorders; 3) Borderline Personality Traits; 4) Bipolar Disorders; 5) Conduct Disorder; 6) Depressive Disorders; 7) Posttraumatic Stress Disorder; 8) Psychotic Disorders; and 9) Substance Abuse Disorders.

**Hypothesis 4):**

It is hypothesized that the endorsements of Safety and Risk Critical Items of the SAFE-R will significantly correlate with endorsements of specific Noteworthy Responses items of the MACI. Noteworthy Responses categories include Acute Distress, Dangerous Ideation, and Childhood Abuse. The line items of these Noteworthy Responses are listed in Appendix E.
CHAPTER 2

METHODOLOGY

Participants

Subject records were selected from the 15 residential houses at KidsPeace at settings of KidsPeace National Center for Kids in Crisis. These locations are at Orefield, PA, Saylorsburg, PA, and at Bethlehem, PA. The 15 residential houses provide services to children and adolescents with various severe behavioral and mental health problems.

For this study, individuals that qualified for an Axis II diagnosis of Mental Retardation were excluded. This qualification was determined by review of records. Subjects between the ages of 13 years 0 months to 18 years 11 months were included in the review. Subjects chosen for this study were selected from the residential settings described above.

Research Design

This study was conducted by means of an archival review. According to the actuarial review, 126 subjects were determined as having met inclusion criterion. Dates of administration of the SAFE-R and MACI ranged from 06/2006 until 03/2008. Demographic characteristics of subjects were obtained for this study during the archival review. Demographics included age, sex, ethnicity, and intellectual functioning. Diagnoses were gained from available information from Psychological Evaluations, Psychiatric Evaluations or Initial assessments. KidsPeace
clients may have multiple Psychological and Psychiatric evaluations over the length of a residential stay. These evaluations are administered to clients at KidsPeace as part of their initial referral or comprehensive psychological evaluations. Evaluations that were closest in time relative to the administrations of the SAFE-R and MACI were accepted for this study.

SAFE-R results were excluded when qualifier results indicated caution in application or interpretations. Invalid results on the MACI were excluded from this analysis. Exclusion criteria regarding invalid responding for the MACI followed the recommendations from the manual. Specifically, the MACI has four Modifying Indices for validity. The MACI VV Reliability and BR Validity were reviewed for acceptability. Additionally, the MACI validity markers were studied for the degree of under-reporting psychopathology (MACI Disclosure raw score <201) or over-reporting psychopathology (MACI Disclosure raw score >589). All Modifying Indices of Disclosure, Desirability and Debasement were reviewed and were considered to be in an acceptable BR range.

Measures/Instruments

Formulation of the SAFE-R

During the winter of 2004-2005, the construction of the SAFE-R was initially proposed in consultation by this author with Robert G. Chupella, Ph.D., who is a Pennsylvania State licensed psychologist and is Supervisor of Residential Psychological services at KidsPeace. He is also a consultant of Revere House and Franklin House Diagnostics at the Orefield campus of KidsPeace National Center for Kids in Crisis. Dr. Chupella also serves as consultant for all residential houses at KidsPeace Pioneer Center for sexual offenders. He has, in addition, served on numerous committees dedicated for the implementation and formulation of the current
KidsPeace Clinical Model. Further, Dr. Chupella is Training Director at KidsPeace, which is an approved site by the Association of Psychology Postdoctoral and Internship Centers (APPIC).

In consultation with Dr. Chupella, the thirteen general headings of the original SAFE were reduced into five highly salient content areas. A listing of the thirteen original headings is noted on the following pages. These thirteen headings were consolidated into five major headings to facilitate the composition of the SAFE-R. These five headings were: 1). Personal and Social History; 2). Mental Status Evaluation; 3). Risk Issues History; 4). Psychoactive Substance Use and 5). Effectiveness Factors.

Line items that reflected these content areas were composed by rational means as described here. These line items were incorporated within a five point Likert scale, which ranged from 1 = Strongly Disagree to 5 = Strongly Agree. The use of a Likert scale was chosen with the hope of producing varied levels of responses as opposed to those that could be obtained from a true/false format. True/false formats may inadvertently limit shades of meaning for client disclosures. The introduction of the Likert scale was, therefore, an attempt to refine the sensitivity of questions to enhance the disclosure of information regarding various clinical problems. For example, this modification was done in an attempt to increase disclosure for clients when answering such questions as:

26. There has been neglect in my family of origin
15. There has been sexual abuse in my family.

The psychoactive Substance Abuse portion was modified from an originally demographic format to a Likert scale format according to the suggestions of the readers and the approval of Dr. Chupella. This portion included questions of withdrawal and tolerance regarding substance usage.
Some additional refinements regarding Effectiveness factors, such as personal resiliency, were incorporated above and beyond the format of the original SAFE. Effectiveness factors are those which may mitigate the assessment of risk/safety; these may also buffer the risk of future violence. Such factors may also become involved in treatment and intervention strategies. A general information section regarding gender, race and age was included solely for describing demographic characteristics.

Also beyond the format of the original SAFE, the following additions were included for clinical/ risk assessments: 1). 10 items regarding PTSD; 2). 9 items related to mania and expansive mood; and 3). 6 items related to potential for sexual offending.

As stated previously, the formulations of the items of the SAFE-R were composed by rational means. Specifically, copies of proposed 5 point Likert scale items were reviewed by three doctoral level students and three licensed psychologists besides Dr. Chupella. These readers scanned the items to determine, first, the feasibility of asking such item questions in terms of potential and accurate answering. Second, the readers scanned the line items to determine the apparent overall face and construct validity of the questions within the context of the five SAFE content areas. Finally, Dr. Chupella reviewed each set of refinements proposed by the readers. By this procedure, Dr. Chupella provided a final review of face and construct validity that was also part of the construction of the original SAFE. Dr. Chupella reviewed the sentence construction to determine whether or not the sentence format would make sense relative to the original meanings of concepts within the context of the original SAFE and to the proposed surveying of clinical problems. Any item sentences that were judged as deviating from the original intentions of the SAFE or from relevant clinical/safety risk problems were discarded. All line items were then consolidated into a final draft of 110 line items (Appendix A). These items
were then set into random order by means of a Microsoft Excel program. Reading level was
determined to be at a six grade level by means of Microsoft Word review.

SAFE-R proposed scales were formed by rational means. Inclusions or exclusions of
various items within the proposed domains and scales were periodically initiated and reviewed
by Dr. Chupella. This process included many discussions with doctoral level interns, with this
author and with Dr. Chupella. The result was the current composition of the Risk and Safety
Critical Items Domain, the 8 proposed clinical scales and the Effectiveness Domain.

The SAFE-R Risk and Safety Critical Items domain purports to assess factors associated
with violence to self or others, with criminality, and with sexual offending recidivism. The 8
SAFE-R scales purport to measure clinical concerns such as: Anxiety/ADHD, Borderline
Personality Traits, Conduct Problems, Depressiveness, Mania, Posttraumatic Stress (PTSD),
Psychosis and Substance Abuse. Finally, the SAFE-R has an Effectiveness domain to provide
qualitative information regarding the presence of prosocial mediating and protective factors.

Subsequently, the SAFE-R was instituted as Standard of Care at KidsPeace during the
summer of 2006. Any licensed clinician at KidsPeace was then able to utilize the SAFE-R for
assessment of risk and safety problems.

Scoring of the SAFE-R

The SAFE-R has four qualifiers to indicate problems of inattention or maladaptive test
taking response styles:

26. There are health problems in my family. 1 2 3 4 5
35. I know that I am taking this test. 1 2 3 4 5
47. I know where I am at right now. 1 2 3 4 5
62. There are health problems in my family. 1 2 3 4 5

Erratic answering among the qualifiers may result in a cautious or an inapplicable interpretation.
The Risk and Safety Critical Items domain was designed to have the items individually reviewed and was not intended for aggregation into a scale.

Results of the 8 clinical scales were qualitatively determined by summing the raw number of the items that are endorsed in each domain. Raw scores are then evaluated according to a grouped frequency distribution format that may include: 1) No indication; 2) Low Indication; 3) Moderate indication; 4) High indication; and 5) Extreme indication. Instructions noted that there may also be other items that have high scores in a positive direction; these can become of interest for continued therapeutic discussion and attention. A listing of the current items of the proposed Risk and Safety Critical Item Domain, the 8 proposed SAFE-R clinical domains, and the Effectiveness Domain is provided in Appendix D.

The Millon Adolescent Clinical Inventory

The MACI (Millon, 1993) was recognized for the purpose of validation of the SAFE-R. Both the MACI and the SAFE-R are listed as Standard of Care assessment instruments at KidsPeace. As noted previously, the MACI, which has shown great resilience, utility and continued application in the assessment of troubled adolescents has been extensively normed and researched for validity and reliability. The applications of this instrument have been prolific in the areas of clinical problems and mental health issues.

As noted above, the MACI has maintained clinical popularity as an assessment tool and as a standard for measuring adolescents. The MACI was formed through the participation by psychologists and other clinicians who used the MAPI-C (Millon Adolescent Personality Inventory-Clinical) for evaluating and providing services for adolescents. The MACI, composed of 160 True/False questions, was normed in two phases with a total of 1,017 adolescents. These
adolescents who ranged in age from 13 to 19 years had at least a 6th grade reading level. The adolescents were chosen from 28 states in the United States of America and from Canada. The data set was collected from May 1991 to February 1992; a second cross validation phase was also initiated between June and October 1992. When using Sample A data, Alpha coefficients for reliability range from a low of 0.73 for Scales D and Y to a high of 0.91 for Scale B. When using sample B and C data, reliability coefficients range from 0.69 for Scale D to 0.90 for Scale B. Alpha coefficients for the Personality Patterns scales range from 0.73 for Scale 3 to 0.89 for Scale 8B. Test-retest reliability was calculated using adolescents from sample A and B. These correlations ranged from 0.57 for Scale E to 0.92 for Scale 9. The median stability coefficient was 0.82. Cross validation of The MACI scale scores was obtained by means of comparisons with clinician judgments and scores from collateral test instruments. Regarding comparisons with clinical judgments, in Sample B, 14 of 25 coefficients were significant (p < .05). The largest coefficient observed for Personality Patterns was 0.27 on Scale 2A (Inhibited) and 6B (Forceful). The highest coefficient for the Expressed Concerns (0.43) was Scale H, Childhood Abuse. The two largest coefficients for the clinical Syndromes were 0.36 for Substance Abuse proneness and 0.37 for Depressive Affect (Scale FF). The overall median coefficient was 0.17 for Sample B. For Sample C, the coefficients were higher, with a median of 0.25 and with 20 of the 254 coefficient computed as significant (p < .05).

Regarding the comparison with collateral instruments that purport to measure similar constructs, correlations indicate positive results. For example, scores on the Drive for Thinness and Body Dissatisfaction measures on the Eating Disorder Inventory II compared with the Eating Dysfunction scale of the MACI as 0.75 and 0.88 respectively. The Depressive affect scale of the
MACI correlated well with the Beck Hopelessness Scale and that Beck Depression Inventory (0.59). Generally, when constructs were very similar, correlations were high.


For ease of rapid discussion and analysis, the MACI has 8 categories of Noteworthy Responses: 1). Acute Distress; 2). Dangerous Ideation; 3). Emotional Isolation; 4). Anorexic Tendency; 5). Bulimic Tendency; 6). Drug-Abuse Inclination; 7). Alcohol-Abuse Inclination; and 8). Childhood Abuse.

Comments Regarding Test Construction of the MACI

The MACI was formed by research that attempted to propose questions related to diagnostic problems. However, the Millon inventories have been criticized because the scales at times will reflect DSM criterion and at times reflect Millon’s theories. Practitioners must struggle to decide which of the interpretations of scale results have been empirically driven or which have been conceptually derived. Further, the MACI contains interpretive information from
a history of DSM editions (Groth-Marnat, 1999, pp.310-312). As a consequence, clinicians may need to divide clinical concepts into those which are obsolete and those which are current. Such disparities may result in an estimate of personality style and not of personality disorder. Practitioners who intend the test to provide actual diagnoses may be extending the usage beyond realistic expectations of the instrument. Additionally, there have been concerns that the scales of the Millon inventories may overlap in content. The homogeneity of constructs may be somewhat similar and therefore redundant. A related difficulty is that scales with related interpretations tend to emphasize a client’s deficiencies, yet neglect to balance the clients’ strengths against these deficiencies. Interpretations may tend to provide a rather severe negativistic interpretation of the client’s functioning. Nonetheless, the Millon inventories provide a crucial aspect of objective assessments because the instruments are specifically designed to understand more fully the networking of personality dysfunction and Axis I problems.

Procedures

Upon admission to KidsPeace, clients and their custodial parties are requested to sign consent forms acknowledging permission for and involvement of clients on appropriate levels of psychological and psychiatric evaluations. These evaluations typically include interviewing and psychometric testing. For this study, a historic/archival review was conducted; therefore, no additional consent forms were obtained from the subjects or their custodial parties. All personal information remains in the possession of KidsPeace and no identifying information was retained in the study. All administrations of instruments were completed by: 1). A doctoral level psychology practicum student or intern; 2). A non-licensed doctoral level Psychology Associate at KidsPeace; or 3). A licensed Psychologist at KidsPeace. All practicum students, psychology
interns and Psychology Associates were given training in the administration and scoring of the SAFE-R by this author or by Dr. Chupella. The report writing of the practicum students, psychology interns and Psychology Associates was supervised by various licensed psychologists at KidsPeace. All administrations of the MACI and SAFE-R were reviewed as having been completed within 44 days. This time period is the time allotted for Referral or Comprehensive Psychological evaluations at KidsPeace. The order of the instruments as presented to the subjects may have been randomized.

Statistical Analysis to Test Hypothesis

Strategies to test hypothesis 1:

Pearson correlations were determined between BR score elevations of specific scales of the MACI when compared with elevated scores of SAFE-R clinical scales. Such scales of the MACI include: 1). Borderline Tendency (9); 2). Oppositional (8A); 3). Substance Abuse Proneness (BB); 4). Suicidal Tendency (GG); 5). Delinquent Predisposition (CC); 6). Unruly (6A); 7). Depressive Affect (FF); 8). Forceful (6B); 9). Anxious Feelings (EE); and 10). Self-Demeaning (8B). The scales of the SAFE-R included: 1). Anxiety/ADHD; 2). Borderline Traits; 3). Conduct Problems; 4). Depression; 5). Mania; 6). Posttraumatic Stress; 7). Psychosis; and 8). Substance Abuse.

Strategies to test hypothesis 2:

Pearson point biserial correlations were generated between elevated scores of the SAFE-R scales, elevated scores of select MACI scales and available diagnoses. Point Biserial
correlations are utilized when one set of data is continuous, such as scale scores, and another set of data is dichotomous. Specifically, the pairing of being diagnosed with a disorder and not being diagnosed represented a dichotomous pairing.

**Strategies to test hypothesis 3:**

Pearson point biserial correlations were generated between items of the SAFE-R scales, and available psychiatric and psychological diagnoses. Point Biserial correlations are utilized when one set of data is continuous, such as scale items, and another set of data is dichotomous. Specifically, the procedure of pairing item Specificity in terms of not being diagnosed with a disorder versus item Sensitivity in terms of being diagnosed with a disorder represented a dichotomous pairing.

**Strategies to test hypothesis 4:**

Pearson point biserial correlations were generated between item endorsements of Safety and Risk Critical Items of the SAFE-R with endorsements of items of select Noteworthy Responses categories on the MACI. Point Biserial correlations are utilized when one set of data is continuous, such as scale items, and another set of data is dichotomous. Specifically, the procedure of pairing item Specificity in terms of not being diagnosed with a disorder versus item Sensitivity in terms of being diagnosed with a disorder represented a dichotomous pairing.
CHAPTER 3

RESULTS

Descriptive Statistics for the Subjects

Age

Subjects ranged in age from 13 years and 0 months to 18 years and 11 months. The Mean age was 15.1 years with a Standard Deviation (SD) of 1.6 years.

Sex

There were 81 males and 45 females involved in this archival study.

Ethnicity

There were 77 Caucasians subjects, 16 Hispanic subjects, 22 African-American subjects and 11 subjects listed as Other.

Intellectual Functioning

No subjects included in this study were diagnosed with Mental Retardation. In terms of Full Scale Intelligence Quotient (FSIQ), 18 subjects were in the Borderline range (70-79 FSIQ), 33 subjects were in the Below Average range (80-89 FSIQ), and 53 subjects were in the average range (90-109 FSIQ). In terms of a Verbal Intelligence Quotient (VIQ), 13 subjects were in the Borderline range, 25 subjects were in the Below Average range, and 60 subjects were in the Average range.

The Mean FSIQ of the 18 Borderline subjects was 74.7, with a SD of 2.9. The Mean VIQ for these subjects was 80.5, with a SD of 6.7.
Hypotheses and Specific Findings

Hypothesis 1

The strategy to test Hypothesis 1 required that Pearson correlations had to be determined between clinical level score elevations of specific scales of the MACI when compared with clinical level scores of SAFE-R scales. Such scales of the MACI included: 1). Borderline Tendency (9); 2). Oppositional (8A); 3). Substance Abuse Proneness (BB); 4). Suicidal Tendency (GG); 5) Delinquent Predisposition (CC); 6) Unruly (6A); 7) Depressive Affect (FF); 8). Forceful (6B); 9) Anxious Feelings (EE); and 10). Self-Demeaning (8B). The scales of the SAFE-R included: 1). Anxiety/ADHD; 2). Borderline Traits; 3). Conduct Problems; 4). Depression; 5). Mania; 6). Posttraumatic Stress; 7). Psychosis; and 8.). Substance Abuse.

As predicted, there were various notable correlations determined between clinical level elevations in the above noted MACI scales and SAFE-R scales.

There was a correlation between the MACI Borderline Tendency scale and the SAFE-R Conduct Problems scale ($r = .452$). The MACI Oppositional scale correlated with the SAFE-R Borderline Traits scale ($r = .316$) and the Conduct Problems scale ($r = .489$).

There were multiple correlations between the MACI Substance Abuse Proneness scale and several SAFE-R scales. Such correlations included: 1).MACI Substance Abuse Proneness and SAFE-R Anxiety/ADHD ($r = .438$); 2). MACI Substance Abuse Proneness and SAFE-R Borderline Traits ($r = .415$), 3). MACI Substance Abuse Proneness and SAFE-R Conduct Problems ($r = .400$); 4). MACI Substance Abuse Proneness and SAFE-R Depressiveness ($r = .416$); 5). MACI Substance Abuse Proneness and SAFE-R Mania ($r = .446$) and 6). MACI
Substance Abuse Proneness and SAFE-R Posttraumatic Stress ($r = .423$). Additionally, MACI Substance Abuse Proneness negatively correlated to SAFE-R Effectiveness ($r = -.307$).

Multiple correlations were determined between the MACI Suicidal Tendency scale and various SAFE-R scales. Such correlations included: 1). MACI Suicidal Tendency and SAFE-R Anxiety/ADHD ($r = .679$); 2). MACI Suicidal Tendency and SAFE-R Borderline Traits ($r = .607$), 3). MACI Suicidal Tendency and SAFE-R Conduct Problems ($r = .427$); 4). MACI Suicidal Tendency and SAFE-R Depressiveness ($r = .652$); 5). MACI Suicidal Tendency and SAFE-R Mania ($r = .628$); 6). MACI Suicidal Tendency and SAFE-R Posttraumatic Stress ($r = .670$) and 7). MACI Suicidal Tendency and Psychosis ($r = .484$).

Multiple correlations were determined between the MACI Delinquent Predisposition scale and various SAFE-R scales. Such correlations included: 1). MACI Delinquent Predisposition and SAFE-R Anxiety/ADHD ($r = .573$); 2). MACI Delinquent Predisposition and SAFE-R Borderline Traits ($r = .589$), 3). MACI Delinquent Predisposition and SAFE-R Conduct Problems ($r = .497$); 4). MACI Delinquent Predisposition and SAFE-R Depressiveness ($r = .549$); 5). MACI Delinquent Predisposition and SAFE-R Mania ($r = .533$); 6). MACI Delinquent Predisposition and SAFE-R Posttraumatic Stress ($r = .628$) and 7). MACI Delinquent Predisposition and Psychosis ($r = .518$).

Multiple correlations were determined between the MACI Unruly scale and various SAFE-R scales. Such correlations included: 1). MACI Unruly and SAFE-R Borderline Traits ($r = .466$); 2). MACI Unruly and SAFE-R Conduct Problems ($r = .508$); 3). MACI Unruly and SAFE-R Mania ($r = .365$); 4). MACI Unruly and SAFE-R Posttraumatic Stress ($r = .329$) and; 5). MACI Unruly and SAFE-R Substance Abuse ($r = .709$).
The MACI Depressive Affect scale correlated with the SAFE-R Conduct Problems scale as $r = .289$. The MACI Forceful scale correlated negatively with the SAFE-R Conduct Problems scale as $r = -.297$ and with the SAFE-R Substance Abuse scale as $r = -.361$.

Multiple correlations were determined between the MACI Anxious Feelings scale and various SAFE-R scales. Such correlations included: 1). MACI Anxious Feelings and SAFE-R Anxiety/ADHD ($r = .634$); 2). MACI Anxious Feelings and SAFE-R Borderline Traits ($r = .613$), 3). MACI Anxious Feelings and SAFE-R Conduct Problems ($r = .377$); 4). MACI Anxious Feelings and SAFE-R Depressiveness ($r = .704$); 5). MACI Anxious Feelings and SAFE-R Mania ($r = .604$); 6). MACI Anxious Feelings and SAFE-R Posttraumatic Stress ($r = .704$) and; 7). MACI Anxious Feelings and Psychosis ($r = .578$).

Finally, multiple correlations were determined between the MACI Self-Demeaning scale and various SAFE-R scales. Such correlations included: 1). MACI Self-Demeaning and SAFE-R Anxiety/ADHD ($r = .505$); 2). MACI Self-Demeaning and SAFE-R Borderline Traits ($r = .713$), 3). MACI Self-Demeaning and SAFE-R Conduct Problems ($r = .433$); 4). MACI Self-Demeaning and SAFE-R Depressiveness ($r = .703$); 5). MACI Self-Demeaning and SAFE-R Mania ($r = .592$); 6). MACI Self-Demeaning and SAFE-R Posttraumatic Stress ($r = .675$) and 7). MACI Self-Demeaning and Psychosis ($r = .543$). The MACI Self-Demeaning scale correlated with the SAFE-R Substance Abuse scale as $r = .337$. The above information is summarized in Table 1.
### Table 1

**Clinical range correlations of select MACI scale elevations and SAFE-R scale elevations**

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<th>SLAA</th>
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<th>SLCD</th>
<th>SLD</th>
<th>SLM</th>
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<td>.704</td>
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Hypothesis 2

In accordance with the previously outlined strategy to test Hypothesis 2, Pearson point biserial correlations were generated between elevated scores of select MACI scales, of the SAFE-R clinical scales, and current salient diagnoses. Such scales of the MACI included: 1) Borderline Tendency (9); 2) Oppositional (8A); 3) Substance Abuse Proneness (BB); 4) Suicidal Tendency (GG); 5) Delinquent Predisposition (CC); 6) Unruly (6A); 7) Depressive Affect (FF); 8) Forceful (6B); 9) Anxious Feelings (EE) and 10) Self-Demeaning (8B).

The scales of the SAFE-R included: 1) Anxiety/ADHD; 2) Borderline Traits; 3) Conduct Problems; 4) Depression; 5) Mania; 6) Posttraumatic Stress; 7) Psychosis and 8) Substance Abuse. SAFE-R scale ranges are unique to each particular scale. Results are indicated by Moderate (MOD), High or Extreme (EX) ranges.

The diagnostic categories included, yet were not limited by: 1) ADHD; 2) Anxiety Disorders; 3) Bipolar Disorder; 4) Borderline Personality Traits; 5) Conduct Disorder; 6) Depression; 7) Posttraumatic Stress Disorder; 8) Psychotic Disorders and 9) Substance Abuse Disorders.

Elevated scores of the select MACI scales were compared with subjects having an ADHD diagnosis. Results indicated that none of the MACI scales were very effective in differentiating between adolescent residents diagnosed with ADHD and adolescent residents not diagnosed with ADHD. For each MACI scale, the percentage of residents diagnosed with ADHD whose responses earned MACI scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with ADHD whose responses earned them elevated MACI scaled scores. This information is summarized in Table 2.0.
Table 2.0

Subjects Completing the MACI Not Diagnosed with ADHD Compared with Subjects Diagnosed with ADHD

<table>
<thead>
<tr>
<th>MACI scale ranges</th>
<th>Not Diagnosed ADHD</th>
<th>Diagnosed ADHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-74</td>
<td>75-84</td>
<td>≥85 Total</td>
</tr>
<tr>
<td>60-74</td>
<td>75-84</td>
<td>≥85 Total</td>
</tr>
<tr>
<td>6A (Unruly)</td>
<td>37% 12% 17% 66%</td>
<td>33% 18% 18% 69%</td>
</tr>
<tr>
<td>6B (Forceful)</td>
<td>11% 6% 10% 27%</td>
<td>11% 11% 4% 26%</td>
</tr>
<tr>
<td>8A (Oppositional)</td>
<td>41% 10% 7% 58%</td>
<td>51% 13% 0% 64%</td>
</tr>
<tr>
<td>8B (Self-Demeaning)</td>
<td>26% 4% 3% 33%</td>
<td>37% 2% 0% 39%</td>
</tr>
<tr>
<td>9 (Borderline Tendency)</td>
<td>17% 6% 4% 27%</td>
<td>15% 4% 2% 21%</td>
</tr>
<tr>
<td>BB(Substance Abuse Proneness)</td>
<td>7% 10% 22% 39%</td>
<td>13% 4% 15% 32%</td>
</tr>
<tr>
<td>CC (Delinquent Predisposition)</td>
<td>31% 17% 17% 65%</td>
<td>33% 18% 16% 67%</td>
</tr>
<tr>
<td>EE (Anxious Feelings)</td>
<td>30% 6% 7% 43%</td>
<td>42% 8% 4% 54%</td>
</tr>
<tr>
<td>FF (Depressive Affect)</td>
<td>12% 15% 27% 54%</td>
<td>24% 16% 20% 60%</td>
</tr>
<tr>
<td>GG (Suicidal Tendency)</td>
<td>12% 5% 6% 23%</td>
<td>7% 2% 0% 9%</td>
</tr>
</tbody>
</table>
Elevated scores of the clinical SAFE-R scales were compared subjects having an ADHD diagnosis. Results indicated that none of the SAFE-R scales were very effective in differentiating between adolescent residents diagnosed with ADHD and adolescent residents not diagnosed with ADHD. For each SAFE-R scale, the percentage of residents diagnosed with ADHD whose responses earned SAFE-R scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with ADHD whose responses earned them elevated SAFE-R scaled scores. This information is summarized in Table 2.1.

Table 2.1

Subjects Completing the SAFE-R Not Diagnosed ADHD Compared with Subjects Diagnosed ADHD

<table>
<thead>
<tr>
<th>SAFE-R scale ranges</th>
<th>Not diagnosed ADHD</th>
<th>Diagnosed ADHD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MOD</td>
<td>HIGH</td>
</tr>
<tr>
<td>Anxiety/ADHD</td>
<td>27%</td>
<td>5%</td>
</tr>
<tr>
<td>Borderline Traits</td>
<td>17%</td>
<td>3%</td>
</tr>
<tr>
<td>Conduct Problems</td>
<td>6%</td>
<td>0%</td>
</tr>
<tr>
<td>Depressiveness</td>
<td>20%</td>
<td>3%</td>
</tr>
<tr>
<td>Mania</td>
<td>32%</td>
<td>1%</td>
</tr>
<tr>
<td>Posttraumatic Stress</td>
<td>25%</td>
<td>11%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>11%</td>
<td>1%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>22%</td>
<td>13%</td>
</tr>
</tbody>
</table>
Elevated scores of the select MACI scales were compared subjects having an Anxiety Disorder. Results indicated that none of the MACI scales was very effective in differentiating between adolescent residents diagnosed with an Anxiety Disorder and adolescent residents not diagnosed with an Anxiety Disorder. For each MACI scale, the percentage of residents diagnosed with an Anxiety Disorder whose responses earned MACI scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with an Anxiety Disorder whose responses earned them elevated MACI scaled scores. This information is summarized in Table 3.0.
Table 3.0

*Subjects Completing the MACI Not Diagnosed with an Anxiety Disorder Compared with Subjects Diagnosed with an Anxiety Disorder*

<table>
<thead>
<tr>
<th>MACI scale ranges</th>
<th>Not diagnosed Anxiety</th>
<th>Diagnosed Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>60-74</td>
<td>75-84</td>
</tr>
<tr>
<td>6A (Unruly)</td>
<td>36%</td>
<td>15%</td>
</tr>
<tr>
<td>6B (Forceful)</td>
<td>12%</td>
<td>8%</td>
</tr>
<tr>
<td>8A (Oppositional)</td>
<td>45%</td>
<td>12%</td>
</tr>
<tr>
<td>8B (Self-Demeaning)</td>
<td>29%</td>
<td>4%</td>
</tr>
<tr>
<td>9 (Borderline Tendency)</td>
<td>17%</td>
<td>6%</td>
</tr>
<tr>
<td>BB (Substance Abuse Proneness)</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>CC (Delinquent Predisposition)</td>
<td>32%</td>
<td>18%</td>
</tr>
<tr>
<td>EE (Anxious Feelings)</td>
<td>34%</td>
<td>5%</td>
</tr>
<tr>
<td>FF (Depressive Affect)</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>GG (Suicidal Tendency)</td>
<td>11%</td>
<td>4%</td>
</tr>
</tbody>
</table>
Elevated scores of the clinical SAFE-R scales were compared subjects having an Anxiety Disorder. Results indicated that none of the SAFE-R scales was very effective in differentiating between adolescent residents diagnosed with an Anxiety Disorder and adolescent residents not diagnosed with an Anxiety Disorder. For each SAFE-R scale, the percentage of residents diagnosed with an Anxiety Disorder whose responses earned SAFE-R scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with an Anxiety Disorder whose responses earned them elevated SAFE-R scaled scores. This information is summarized in Table 3.1.
Table 3.1

Subjects Not Diagnosed with an Anxiety Disorder Compared with Subjects Diagnosed with an Anxiety Disorder

<table>
<thead>
<tr>
<th>SAFE-R scale ranges</th>
<th>Not diagnosed Anxiety</th>
<th>Diagnosed Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MOD</td>
<td>HIGH</td>
</tr>
<tr>
<td>Anxiety/ADHD</td>
<td>29%</td>
<td>6%</td>
</tr>
<tr>
<td>Borderline Traits</td>
<td>17%</td>
<td>2%</td>
</tr>
<tr>
<td>Conduct Problems</td>
<td>7%</td>
<td>0%</td>
</tr>
<tr>
<td>Depressiveness</td>
<td>19%</td>
<td>2%</td>
</tr>
<tr>
<td>Mania</td>
<td>32%</td>
<td>3%</td>
</tr>
<tr>
<td>Posttraumatic Stress</td>
<td>21%</td>
<td>8%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>11%</td>
<td>1%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>16%</td>
<td>8%</td>
</tr>
</tbody>
</table>
Elevated scores of the select MACI scales were compared with subjects having a Bipolar Disorder. Results indicated that none of the MACI scales was very effective in differentiating between adolescent residents diagnosed with a Bipolar Disorder and adolescent residents not diagnosed with a Bipolar Disorder. For each MACI scale, the percentage of residents diagnosed with a Bipolar Disorder whose responses earned MACI scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with a Bipolar Disorder whose responses earned them elevated MACI scaled scores. This information is summarized in Table 4.0.
Table 4.0

**Subjects Completing the MACI Not Diagnosed with a Bipolar Disorder Compared with Subjects Diagnosed with a Bipolar Disorder**

<table>
<thead>
<tr>
<th>MACI Scale ranges</th>
<th>Not diagnosed Bipolar</th>
<th>Diagnosed Bipolar</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-74</td>
<td>37% 14% 16% 67%</td>
<td>33% 16% 22% 71%</td>
</tr>
<tr>
<td>75-84</td>
<td>10% 7% 8% 25%</td>
<td>14% 11% 8% 33%</td>
</tr>
<tr>
<td>≥85</td>
<td>8% 1% 2% 25%</td>
<td>62% 8% 2% 72%</td>
</tr>
<tr>
<td>Total</td>
<td>22% 1% 2% 25%</td>
<td>48% 10% 2% 60%</td>
</tr>
<tr>
<td>6A (Unruly)</td>
<td>37% 12% 6% 55%</td>
<td>62% 8% 2% 72%</td>
</tr>
<tr>
<td>8A (Oppositional)</td>
<td>14% 3% 3% 20%</td>
<td>24% 11% 5% 40%</td>
</tr>
<tr>
<td>8B (Self-Demeaning)</td>
<td>8% 10% 17% 35%</td>
<td>14% 3% 27% 44%</td>
</tr>
<tr>
<td>CC (Delinquent Predisposition)</td>
<td>40% 18% 15% 73%</td>
<td>24% 16% 22% 62%</td>
</tr>
<tr>
<td>EE (Anxious Feelings)</td>
<td>36% 5% 5% 46%</td>
<td>30% 11% 11% 52%</td>
</tr>
<tr>
<td>FF (Depressive Affect)</td>
<td>18% 14% 19% 51%</td>
<td>14% 19% 38% 71%</td>
</tr>
<tr>
<td>GG (Suicidal Tendency)</td>
<td>6% 5% 3% 14%</td>
<td>22% 3% 5% 30%</td>
</tr>
</tbody>
</table>
Elevated scores of the clinical SAFE-R scales were compared subjects having a Bipolar Disorder. Results indicated that none of the SAFE-R scales was very effective in differentiating between adolescent residents diagnosed with a Bipolar Disorder and adolescent residents not diagnosed with a Bipolar Disorder. For each SAFE-R scale, the percentage of residents diagnosed with a Bipolar Disorder whose responses earned SAFE-R scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with a Bipolar Disorder whose responses earned them elevated SAFE-R scaled scores. This information is summarized in Table 4.1.
Table 4.1

**Subjects Completing the SAFE-R Not Diagnosed with a Bipolar Compared with Subjects Diagnosed with a Bipolar Disorder**

<table>
<thead>
<tr>
<th>SAFE-R Scale Ranges</th>
<th>Not diagnosed Bipolar</th>
<th>Diagnosed Bipolar</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MOD</td>
<td>HIGH</td>
</tr>
<tr>
<td>Anxiety/ADHD</td>
<td>23%</td>
<td>3%</td>
</tr>
<tr>
<td>Borderline Traits</td>
<td>15%</td>
<td>1%</td>
</tr>
<tr>
<td>Conduct Problems</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>Depressiveness</td>
<td>14%</td>
<td>1%</td>
</tr>
<tr>
<td>Mania</td>
<td>23%</td>
<td>1%</td>
</tr>
<tr>
<td>Posttraumatic Stress</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>6%</td>
<td>0%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>17%</td>
<td>9%</td>
</tr>
</tbody>
</table>
Elevated scores of the select MACI scales were compared subjects having Borderline Personality Traits. Results indicated that none of the MACI scales was very effective in differentiating between adolescent residents diagnosed with Borderline Personality Traits and adolescent residents not diagnosed with Borderline Personality Traits. For each MACI scale, the percentage of residents diagnosed with Borderline Personality Traits whose responses earned MACI scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with Borderline Personality Traits whose responses earned them elevated MACI scaled scores. This information is summarized in Table 5.0.
### Table 5.0

**Subjects Completing the MACI Not Diagnosed with Borderline Personality Traits Compared with Subjects Diagnosed with Borderline Personality Traits**

<table>
<thead>
<tr>
<th>MACI scale ranges</th>
<th>Not diagnosed Borderline</th>
<th>Diagnosed Borderline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>60-74</td>
<td>75-84</td>
</tr>
<tr>
<td>6A (Unruly)</td>
<td>38%</td>
<td>16%</td>
</tr>
<tr>
<td>6B (Forceful)</td>
<td>8%</td>
<td>9%</td>
</tr>
<tr>
<td>8A (Oppositional)</td>
<td>46%</td>
<td>11%</td>
</tr>
<tr>
<td>8B (Self-Demeaning)</td>
<td>28%</td>
<td>4%</td>
</tr>
<tr>
<td>9 (Borderline Tendency)</td>
<td>17%</td>
<td>6%</td>
</tr>
<tr>
<td>BB (Substance Abuse Proneness)</td>
<td>11%</td>
<td>7%</td>
</tr>
<tr>
<td>CC (Delinquent Predisposition)</td>
<td>32%</td>
<td>20%</td>
</tr>
<tr>
<td>EE (Anxious Feelings)</td>
<td>35%</td>
<td>6%</td>
</tr>
<tr>
<td>FF (Depressive Affect)</td>
<td>16%</td>
<td>15%</td>
</tr>
<tr>
<td>GG (Suicidal Tendency)</td>
<td>8%</td>
<td>3%</td>
</tr>
</tbody>
</table>
Elevated scores of the clinical SAFE-R scales were compared subjects having Borderline Personality Traits. Results indicated that none of the SAFE-R scales was very effective in differentiating between adolescent residents diagnosed with Borderline Personality Traits and adolescent residents not diagnosed with Borderline Personality Traits. For each SAFE-R scale, the percentage of residents diagnosed with Borderline Personality Traits whose responses earned SAFE-R scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with Borderline Personality Traits whose responses earned them elevated SAFE-R scaled scores. This information is summarized in Table 5.1.
Table 5.1

Subjects Completing the SAFE-R Not Diagnosed with Borderline Personality Traits Compared with Subjects Diagnosed with Borderline Personality Traits

<table>
<thead>
<tr>
<th>SAFE-R scale ranges</th>
<th>Not diagnosed Borderline</th>
<th>Diagnosed Borderline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MOD</td>
<td>HIGH</td>
</tr>
<tr>
<td>Anxiety/ADHD</td>
<td>27%</td>
<td>4%</td>
</tr>
<tr>
<td>Borderline Traits</td>
<td>12%</td>
<td>1%</td>
</tr>
<tr>
<td>Conduct Problems</td>
<td>7%</td>
<td>0%</td>
</tr>
<tr>
<td>Depressiveness</td>
<td>16%</td>
<td>1%</td>
</tr>
<tr>
<td>Mania</td>
<td>27%</td>
<td>1%</td>
</tr>
<tr>
<td>Posttraumatic Stress</td>
<td>17%</td>
<td>8%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>10%</td>
<td>0%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>18%</td>
<td>8%</td>
</tr>
</tbody>
</table>
Elevated scores of the select MACI scales were compared subjects having Conduct Disorder. Results indicated that none of the MACI scales was very effective in differentiating between adolescent residents diagnosed with Conduct Disorder and adolescent residents not diagnosed with Conduct Disorder. For each MACI scale, the percentage of residents diagnosed with Conduct Disorder whose responses earned MACI scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with Conduct Disorder whose responses earned them elevated MACI scaled scores. This information is summarized in Table 6.0.
Table 6.0

Subjects Completing the MACI Not Diagnosed with Conduct Disorder Compared with Subjects Diagnosed with Conduct Disorder

<table>
<thead>
<tr>
<th></th>
<th>Not Diagnosed Conduct</th>
<th>Diagnosed Conduct</th>
</tr>
</thead>
<tbody>
<tr>
<td>MACI scale ranges</td>
<td>60-74 75-84 ≥85 Total</td>
<td>60-74 75-84 ≥85 Total</td>
</tr>
<tr>
<td>6A (Unruly)</td>
<td>37% 11% 13% 61%</td>
<td>33% 20% 27% 80.0%</td>
</tr>
<tr>
<td>6B (Forceful)</td>
<td>10% 9% 9% 28%</td>
<td>13% 7% 7% 27%</td>
</tr>
<tr>
<td>8A (Oppositional)</td>
<td>43% 15% 5% 63%</td>
<td>47% 4% 4% 55%</td>
</tr>
<tr>
<td>8B (Self-Demeaning)</td>
<td>35% 1% 4% 40%</td>
<td>22% 9% 0% 31%</td>
</tr>
<tr>
<td>9 (Borderline Tendency)</td>
<td>20% 6% 3% 29%</td>
<td>11% 5% 4% 20%</td>
</tr>
<tr>
<td>BB(Substance Abuse Proneness)</td>
<td>4% 9% 22% 35%</td>
<td>20% 7% 16% 43%</td>
</tr>
<tr>
<td>CC (Delinquent Predisposition)</td>
<td>32% 15% 9% 56 %</td>
<td>31% 22% 31% 84%</td>
</tr>
<tr>
<td>EE (Anxious Feelings)</td>
<td>33% 9% 9% 51%</td>
<td>36% 2% 2% 40%</td>
</tr>
<tr>
<td>FF (Depressive Affect)</td>
<td>20% 12% 32% 64%</td>
<td>11% 20% 11% 42%</td>
</tr>
<tr>
<td>GG (Suicidal Tendency)</td>
<td>14% 5% 5% 24%</td>
<td>4% 2% 2% 8%</td>
</tr>
</tbody>
</table>
Elevated scores of the clinical SAFE-R scales were compared subjects having Conduct Disorder. Results indicated that none of the SAFE-R scales was very effective in differentiating between adolescent residents diagnosed with Conduct Disorder and adolescent residents not diagnosed with Conduct Disorder. For each SAFE-R scale, the percentage of residents diagnosed with Conduct Disorder whose responses earned SAFE-R scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with Conduct Disorder whose responses earned them elevated SAFE-R scaled scores. This information is summarized in Table 6.1.
Table 6.1

*Subjects Completing the SAFE-R Not Diagnosed with Conduct Disorder Compared with Subjects Diagnosed with Conduct Disorder*

<table>
<thead>
<tr>
<th>SAFE-R scale ranges</th>
<th>Not Diagnosed Conduct</th>
<th>Diagnosed Conduct</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MOD</td>
<td>HIGH</td>
</tr>
<tr>
<td>Anxiety/ADHD</td>
<td>34%</td>
<td>8%</td>
</tr>
<tr>
<td>Borderline Traits</td>
<td>19%</td>
<td>1%</td>
</tr>
<tr>
<td>Conduct Problems</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>Depressiveness</td>
<td>21%</td>
<td>3%</td>
</tr>
<tr>
<td>Mania</td>
<td>30%</td>
<td>4%</td>
</tr>
<tr>
<td>Posttraumatic Stress</td>
<td>16%</td>
<td>14%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>10%</td>
<td>0%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>16%</td>
<td>9%</td>
</tr>
</tbody>
</table>
Elevated scores of the select MACI scales were compared with subjects having a Depression Disorder. Results indicated that none of the MACI scales was very effective in differentiating between adolescent residents diagnosed with a Depression Disorder and adolescent residents not diagnosed with a Depression Disorder. For each MACI scale, the percentage of residents diagnosed with a Depression Disorder whose responses earned MACI scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with a Depression Disorder whose responses earned them elevated MACI scaled scores. This information is summarized in Table 7.0.
### Table 7.0

**Subjects Completing the MACI Not Diagnosed with Depression Compared with Subjects Diagnosed with Depression**

<table>
<thead>
<tr>
<th>MACI scale ranges</th>
<th>Not diagnosed depression</th>
<th>Diagnosed depression</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>60-74</td>
<td>75-84</td>
</tr>
<tr>
<td>6A (Unruly)</td>
<td>10%</td>
<td>9%</td>
</tr>
<tr>
<td>6B (Forceful)</td>
<td>43%</td>
<td>11%</td>
</tr>
<tr>
<td>8A (Oppositional)</td>
<td>43%</td>
<td>11%</td>
</tr>
<tr>
<td>8B (Self-Demeaning)</td>
<td>26%</td>
<td>4%</td>
</tr>
<tr>
<td>9 (Borderline Tendency)</td>
<td>15%</td>
<td>6%</td>
</tr>
<tr>
<td>BB(Substance Abuse Proneness)</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>CC (Delinquent Predisposition)</td>
<td>29%</td>
<td>19%</td>
</tr>
<tr>
<td>EE (Anxious Feelings)</td>
<td>34%</td>
<td>6%</td>
</tr>
<tr>
<td>FF (Depressive Affect)</td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>GG (Suicidal Tendency)</td>
<td>10%</td>
<td>2%</td>
</tr>
</tbody>
</table>
Elevated scores of the clinical SAFE-R scales were compared with subjects having a Depression Disorder. Results indicated that none of the SAFE-R scales was very effective in differentiating between adolescent residents diagnosed with a Depression Disorder and adolescent residents not diagnosed with a Depression Disorder. For each SAFE-R scale, the percentage of residents diagnosed with a Depression Disorder whose responses earned SAFE-R scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with a Depression Disorder whose responses earned them elevated SAFE-R scaled scores. This information is summarized in Table 7.1.
Table 7.1

Subjects Completing the SAFE-R Not Diagnosed with Depression Compared with Subjects Diagnosed with Depression

<table>
<thead>
<tr>
<th>SAFE-R scale ranges</th>
<th>Not Diagnosed Depression</th>
<th>Diagnosed Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MOD</td>
<td>HIGH</td>
</tr>
<tr>
<td>Anxiety/ADHD</td>
<td>27%</td>
<td>6%</td>
</tr>
<tr>
<td>Borderline Traits</td>
<td>14%</td>
<td>2%</td>
</tr>
<tr>
<td>Conduct Problems</td>
<td>6%</td>
<td>0%</td>
</tr>
<tr>
<td>Depressiveness</td>
<td>13%</td>
<td>2%</td>
</tr>
<tr>
<td>Mania</td>
<td>31%</td>
<td>2%</td>
</tr>
<tr>
<td>Posttraumatic Stress</td>
<td>17%</td>
<td>8%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>11%</td>
<td>1%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>15%</td>
<td>6%</td>
</tr>
</tbody>
</table>
Elevated scores of the select MACI scales were compared with subjects having Posttraumatic Stress. Results indicated that none of the MACI scales was very effective in differentiating between adolescent residents diagnosed with Posttraumatic Stress and adolescent residents not diagnosed with Posttraumatic Stress. For each MACI scale, the percentage of residents diagnosed with Posttraumatic Stress whose responses earned MACI scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with Posttraumatic Stress whose responses earned them elevated MACI scaled scores. This information is summarized in Table 8.0.
Table 8.0

Subjects Completing the MACI Not Diagnosed with Posttraumatic Stress Compared with Subjects Diagnosed with Posttraumatic Stress

<table>
<thead>
<tr>
<th>MACI scale ranges</th>
<th>60-74</th>
<th>75-84</th>
<th>≥85</th>
<th>Total</th>
<th>60-74</th>
<th>75-84</th>
<th>≥85</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>6A (Unruly)</td>
<td>36%</td>
<td>15%</td>
<td>18%</td>
<td>69%</td>
<td>33%</td>
<td>14%</td>
<td>17%</td>
<td>64%</td>
</tr>
<tr>
<td>6B (Forceful)</td>
<td>10%</td>
<td>9%</td>
<td>7%</td>
<td>26%</td>
<td>17%</td>
<td>4%</td>
<td>13%</td>
<td>34%</td>
</tr>
<tr>
<td>8A (Oppositional)</td>
<td>48%</td>
<td>7%</td>
<td>3%</td>
<td>58%</td>
<td>29%</td>
<td>29%</td>
<td>13%</td>
<td>71%</td>
</tr>
<tr>
<td>8B (Self-Demeaning)</td>
<td>27%</td>
<td>5%</td>
<td>1%</td>
<td>33%</td>
<td>46%</td>
<td>0%</td>
<td>8%</td>
<td>54%</td>
</tr>
<tr>
<td>9 (Borderline Tendency)</td>
<td>15%</td>
<td>6%</td>
<td>2%</td>
<td>23%</td>
<td>25%</td>
<td>4%</td>
<td>8%</td>
<td>37%</td>
</tr>
<tr>
<td>BB(Substance Abuse Proneness)</td>
<td>10%</td>
<td>7%</td>
<td>21%</td>
<td>38%</td>
<td>8%</td>
<td>13%</td>
<td>17%</td>
<td>38%</td>
</tr>
<tr>
<td>CC (Delinquent Predisposition)</td>
<td>33%</td>
<td>20%</td>
<td>17%</td>
<td>70%</td>
<td>25%</td>
<td>8%</td>
<td>17%</td>
<td>50%</td>
</tr>
<tr>
<td>EE (Anxious Feelings)</td>
<td>34%</td>
<td>7%</td>
<td>6%</td>
<td>47%</td>
<td>35%</td>
<td>4%</td>
<td>8%</td>
<td>47%</td>
</tr>
<tr>
<td>FF (Depressive Affect)</td>
<td>17%</td>
<td>14%</td>
<td>21%</td>
<td>52%</td>
<td>17%</td>
<td>17%</td>
<td>46%</td>
<td>80%</td>
</tr>
<tr>
<td>GG (Suicidal Tendency)</td>
<td>7%</td>
<td>4%</td>
<td>2%</td>
<td>13%</td>
<td>25%</td>
<td>4%</td>
<td>13%</td>
<td>42%</td>
</tr>
</tbody>
</table>
Elevated scores of the clinical SAFE-R scales were compared with subjects having Posttraumatic Stress. Results indicated that none of the SAFE-R scales was very effective in differentiating between adolescent residents diagnosed with Posttraumatic Stress and adolescent residents not diagnosed with Posttraumatic Stress. For each SAFE-R scale, the percentage of residents diagnosed with Posttraumatic Stress whose responses earned SAFE-R scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with Posttraumatic Stress whose responses earned them elevated SAFE-R scaled scores. This information is summarized in Table 8.1.
Table 8.1

*Subjects Completing the SAFE-R Not Diagnosed with Posttraumatic Stress Compared with Subjects Diagnosed with Posttraumatic Stress*

<table>
<thead>
<tr>
<th>SAFE-R scale ranges</th>
<th>Not Diagnosed Posttraumatic</th>
<th>Diagnosed Posttraumatic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MOD</td>
<td>HIGH</td>
</tr>
<tr>
<td>Anxiety/ADHD</td>
<td>28%</td>
<td>4%</td>
</tr>
<tr>
<td>Borderline Traits</td>
<td>12%</td>
<td>1%</td>
</tr>
<tr>
<td>Conduct Problems</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>Depressiveness</td>
<td>15%</td>
<td>0%</td>
</tr>
<tr>
<td>Mania</td>
<td>30%</td>
<td>2%</td>
</tr>
<tr>
<td>Posttraumatic Stress</td>
<td>16%</td>
<td>8%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>10%</td>
<td>0%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>14%</td>
<td>8%</td>
</tr>
</tbody>
</table>
Elevated scores of the select MACI scales were compared with subjects having a Psychotic Disorder. Results indicated that none of the MACI scales was very effective in differentiating between adolescent residents diagnosed with a Psychotic Disorder and adolescent residents not diagnosed with a Psychotic Disorder. For each MACI scale, the percentage of residents diagnosed with a Psychotic Disorder whose responses earned MACI scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with a Psychotic Disorder whose responses earned them elevated MACI scaled scores. This information is summarized in Table 9.0.
Table 9.0

Subjects Completing the MACI Not Diagnosed with a Psychotic Disorder Compared with Subjects Diagnosed with a Psychotic Disorder

<table>
<thead>
<tr>
<th>MACI scale ranges</th>
<th>Not diagnosed psychotic</th>
<th>Diagnosed psychotic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>60-74</td>
<td>75-84</td>
</tr>
<tr>
<td>6A (Unruly)</td>
<td>35%</td>
<td>15%</td>
</tr>
<tr>
<td>6B (Forceful)</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>8A (Oppositional)</td>
<td>44%</td>
<td>11%</td>
</tr>
<tr>
<td>8B (Self-Demeaning)</td>
<td>30%</td>
<td>4%</td>
</tr>
<tr>
<td>9 (Borderline Tendency)</td>
<td>15%</td>
<td>6%</td>
</tr>
<tr>
<td>BB(Substance Abuse Proneness)</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>CC (Delinquent Predisposition)</td>
<td>32%</td>
<td>18%</td>
</tr>
<tr>
<td>EE (Anxious Feelings)</td>
<td>34%</td>
<td>7%</td>
</tr>
<tr>
<td>FF (Depressive Affect)</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>GG (Suicidal Tendency)</td>
<td>10%</td>
<td>4%</td>
</tr>
</tbody>
</table>
Elevated scores of the clinical SAFE-R scales were compared with subjects having a Psychotic Disorder. Results indicated that none of the SAFE-R scales was very effective in differentiating between adolescent residents diagnosed with a Psychotic Disorder and adolescent residents not diagnosed with a Psychotic Disorder. For each SAFE-R scale, the percentage of residents diagnosed with a Psychotic Disorder whose responses earned SAFE-R scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with a Psychotic Disorder whose responses earned them elevated SAFE-R scaled scores. This information is summarized in Table 9.1.
Table 9.1

Subjects Completing the SAFE-R Not Diagnosed with a Psychotic Disorder Compared with Subjects Diagnosed with a Psychotic Disorder

<table>
<thead>
<tr>
<th>SAFE-R scale ranges</th>
<th>Not diagnosed psychotic</th>
<th>Diagnosed psychotic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MOD</td>
<td>HIGH</td>
</tr>
<tr>
<td>Anxiety/ADHD</td>
<td>29%</td>
<td>5%</td>
</tr>
<tr>
<td>Borderline Traits</td>
<td>16%</td>
<td>2%</td>
</tr>
<tr>
<td>Conduct Problems</td>
<td>7%</td>
<td>0%</td>
</tr>
<tr>
<td>Depressiveness</td>
<td>18%</td>
<td>2%</td>
</tr>
<tr>
<td>Mania</td>
<td>31%</td>
<td>3%</td>
</tr>
<tr>
<td>Posttraumatic Stress</td>
<td>20%</td>
<td>9%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>10%</td>
<td>1%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>16%</td>
<td>8%</td>
</tr>
</tbody>
</table>
Elevated scores of the select MACI scales were compared with subjects having Substance Disorders. Results indicated that none of the MACI scales was very effective in differentiating between adolescent residents diagnosed with Substance Disorders and adolescent residents not diagnosed with Substance Disorders. For each MACI scale, the percentage of residents diagnosed with Substance Disorders whose responses earned MACI scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with Substance Disorders whose responses earned them elevated MACI scaled scores. This information is summarized in Table 10.0.
### Table 10.0

**Subjects Completing the MACI Not Diagnosed with Substance Disorders Compared with Subjects Diagnosed with Substance Disorders**

<table>
<thead>
<tr>
<th>MACI scale ranges</th>
<th>Not diagnosed substance</th>
<th>Diagnosed substance</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-74</td>
<td>75-84</td>
<td>≥85 Total</td>
</tr>
<tr>
<td>6A (Unruly)</td>
<td>34% 14% 9% 57%</td>
<td>38% 15% 29% 82%</td>
</tr>
<tr>
<td>6B (Forceful)</td>
<td>10% 7% 8% 25%</td>
<td>13% 9% 7% 29%</td>
</tr>
<tr>
<td>8A (Oppositional)</td>
<td>42% 16% 4% 62%</td>
<td>47% 4% 7% 58%</td>
</tr>
<tr>
<td>8B (Self-Demeaning)</td>
<td>34% 4% 4% 42%</td>
<td>26% 4% 0% 30%</td>
</tr>
<tr>
<td>9 (Borderline Tendency)</td>
<td>20% 4% 3% 27%</td>
<td>13% 7% 4% 24%</td>
</tr>
<tr>
<td>BB(SUBSTANCE ABUSE PRONENESS)</td>
<td>7% 3% 6% 16%</td>
<td>13% 15% 38% 66%</td>
</tr>
<tr>
<td>CC (Delinquent Predisposition)</td>
<td>32% 3% 14% 49%</td>
<td>31% 36% 20% 87%</td>
</tr>
<tr>
<td>EE (Anxious Feelings)</td>
<td>41% 11% 9% 61%</td>
<td>25% 0% 4% 29%</td>
</tr>
<tr>
<td>FF (Depressive Affect)</td>
<td>16% 17% 30% 63%</td>
<td>18% 13% 18% 49%</td>
</tr>
<tr>
<td>GG (Suicidal Tendency)</td>
<td>14% 3% 4% 21%</td>
<td>5% 5% 3% 13%</td>
</tr>
</tbody>
</table>
Elevated scores of the clinical SAFE-R scales were compared with subjects having Substance Disorders. Results indicated that none of the SAFE-R scales was very effective in differentiating between adolescent residents diagnosed with Substance Disorders and adolescent residents not diagnosed with Substance Disorders. For each SAFE-R scale, the percentage of residents diagnosed with Substance Disorders whose responses earned SAFE-R scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with a Substance Disorders whose responses earned them elevated SAFE-R scaled scores. This information is summarized in Table 10.1.
Table 10.1

*Subjects Completing the SAFE-R Not Diagnosed with Substance Disorders Compared to Subjects Diagnosed with Substance Disorders*

<table>
<thead>
<tr>
<th>SAFE-R scale ranges</th>
<th>Not diagnosed substance</th>
<th>Diagnosed substance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MOD</td>
<td>HIGH</td>
</tr>
<tr>
<td>Anxiety/ADHD</td>
<td>34%</td>
<td>0%</td>
</tr>
<tr>
<td>Borderline Traits</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>Conduct Problems</td>
<td>6%</td>
<td>0%</td>
</tr>
<tr>
<td>Depressiveness</td>
<td>21%</td>
<td>3%</td>
</tr>
<tr>
<td>Mania</td>
<td>31%</td>
<td>4%</td>
</tr>
<tr>
<td>Posttraumatic Stress</td>
<td>19%</td>
<td>12%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>10%</td>
<td>1%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>4%</td>
<td>1%</td>
</tr>
</tbody>
</table>
Hypothesis 3

Hypothesis 3 stated that items in specific SAFE-R scales thought to address behaviors and cognitive states consistent with a specific clinical diagnosis positively correlated with the respective clinical diagnoses (i.e., the items of the SAFE-R scales will be endorsed in the expected manner by program residents with that diagnosis). Further, it is hypothesized that there will be additional SAFE-R items that correlated highly with some diagnoses.

Pearson point biserial correlations were generated between items of the SAFE-R scales, and available psychiatric and psychological diagnoses. Specifically, the procedure of pairing item Specificity in terms of not being diagnosed with a disorder versus item Sensitivity in terms of being diagnosed with a disorder represented a dichotomous pairing.

Sensitivity refers to the ability of a scale item to correlate highly with clinical level endorsements corresponding to the diagnosis of a subject. Most individuals diagnosed with a disorder might tend to endorse such a scale item. Specificity refers to the ability of a scale item to be limited to non-clinical level endorsements regarding the same diagnosis. Individuals not diagnosed with a disorder might tend not to endorse such a scale item. For the purpose of this study, cut-offs for item Specificity and Sensitivity were set at 70%.

Various SAFE-R ADHD Scale Items showed good scale item Sensitivity when compared with subjects diagnosed with ADHD. Such items included: item 5 = 73% and item 32 = 81%. However, these items did not show good item Specificity: item 5 = 38% and item 31 = 56%. There were no other items in the SAFE-R that showed both good Specificity and good Sensitivity in relation to subjects having an ADHD diagnosis. The results are tabulated in Table 11.
Table 11

SAFE-R ADHD Scale Item Specificity and Item Sensitivity

<table>
<thead>
<tr>
<th>SAFE-R ADHD scale items</th>
<th>No ADHD</th>
<th>ADHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. It is hard for me to pay attention.</td>
<td>38%</td>
<td>73%</td>
</tr>
<tr>
<td>20. People say that I am the nervous type.</td>
<td>61%</td>
<td>40%</td>
</tr>
<tr>
<td>25. I worry a lot about things.</td>
<td>21%</td>
<td>67%</td>
</tr>
<tr>
<td>28. Sometimes I simply go away in my mind.</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>31. I am diagnosed with ADHD.</td>
<td>56%</td>
<td>81%</td>
</tr>
<tr>
<td>41. People say that I do not sit still.</td>
<td>51%</td>
<td>69%</td>
</tr>
<tr>
<td>60. I sometimes get full of panicky feelings.</td>
<td>59%</td>
<td>29%</td>
</tr>
<tr>
<td>69. I have to check things again and again.</td>
<td>59%</td>
<td>23%</td>
</tr>
<tr>
<td>73. I am afraid something bad will happen.</td>
<td>56%</td>
<td>44%</td>
</tr>
</tbody>
</table>

The SAFE-R Anxiety Scale Items did not show good Item Sensitivity or Specificity when compared with subjects diagnosed with Anxiety. There were no other items in the SAFE-R that showed both good Specificity and Sensitivity in relation to subjects having an Anxiety diagnosis. The results are tabulated in Table 12.
### Table 12

**SAFE-R Anxiety Scale Item Specificity and Item Sensitivity**

<table>
<thead>
<tr>
<th>SAFE-R Anxiety Scale items</th>
<th>Item Specificity</th>
<th>Item Sensitivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. It is hard for me to pay attention.</td>
<td>34%</td>
<td>60%</td>
</tr>
<tr>
<td>20. People say that I am the nervous type.</td>
<td>60%</td>
<td>20%</td>
</tr>
<tr>
<td>25. I worry a lot about things.</td>
<td>24%</td>
<td>40%</td>
</tr>
<tr>
<td>28. Sometimes I simply go away in my mind.</td>
<td>48%</td>
<td>60%</td>
</tr>
<tr>
<td>31. I am diagnosed with ADHD.</td>
<td>42%</td>
<td>40%</td>
</tr>
<tr>
<td>41. People say that I do not sit still.</td>
<td>44%</td>
<td>40%</td>
</tr>
<tr>
<td>60. I sometimes get full of panicky feelings.</td>
<td>64%</td>
<td>20%</td>
</tr>
<tr>
<td>69. I have to check things again and again.</td>
<td>55%</td>
<td>44%</td>
</tr>
<tr>
<td>73. I am afraid something bad will happen.</td>
<td>55%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Various SAFE-R Mania Scale Items showed good scale item Sensitivity when compared with subjects diagnosed with a Bipolar Disorder. Such items included: item 1 = 86%; item 21 = 81%; item 29 = 78%; item 90 = 78%; and item 109 = 81%. However, these items did not show good item Specificity: item 1 = 24%; item 21 = 49%; item 29 = 41%; item 90 = 55%; and item 109 = 55%. There were no other items in the SAFE-R that showed both good Specificity and good Sensitivity in relation to subjects having a Bipolar diagnosis. The results are tabulated in Table 13.
Table 13

SAFE-R Mania Scale Item Specificity and Item Sensitivity

<table>
<thead>
<tr>
<th>SAFE-R Mania Scale items</th>
<th>No Bipolar</th>
<th>Bipolar</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I'll take more chances when happy or excited.</td>
<td>24%</td>
<td>86%</td>
</tr>
<tr>
<td>8. I have hurt others or myself by my spending.</td>
<td>71%</td>
<td>43%</td>
</tr>
<tr>
<td>13. I might take risks that put myself into danger.</td>
<td>45%</td>
<td>49%</td>
</tr>
<tr>
<td>21. I might go to bed angry or wake up angry.</td>
<td>49%</td>
<td>81%</td>
</tr>
<tr>
<td>29. At times, I can do with less sleep than usual.</td>
<td>41%</td>
<td>78%</td>
</tr>
<tr>
<td>45. At times, I will really seek thrills.</td>
<td>47%</td>
<td>62%</td>
</tr>
<tr>
<td>90. Others have asked me to slow down my talk.</td>
<td>55%</td>
<td>78%</td>
</tr>
<tr>
<td>106. At times, I can't get sex out of my mind.</td>
<td>66%</td>
<td>32%</td>
</tr>
<tr>
<td>109. My thoughts may come on fast and get mixed up.</td>
<td>55%</td>
<td>81%</td>
</tr>
</tbody>
</table>

One SAFE-R Borderline Traits Scale Item showed good scale item Sensitivity when compared with subjects diagnosed with Borderline Personality Traits. This was item 37 = 77%. However, this item did not show good item Specificity: item 37 = 65%. There were no other items in the SAFE-R that showed both good Specificity and good Sensitivity in relation to subjects having a Borderline Personality Traits diagnosis. The results are tabulated in Table 14.
### Table 14

**SAFE-R Borderline Traits Scale Item Specificity and Item Sensitivity**

<table>
<thead>
<tr>
<th>SAFE-R Borderline Traits scale items</th>
<th>No Borderline</th>
<th>Borderline</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. I might take risks that put myself into danger.</td>
<td>45%</td>
<td>44%</td>
</tr>
<tr>
<td>30. I have had thoughts about killing myself.</td>
<td>72%</td>
<td>68%</td>
</tr>
<tr>
<td>37. I have cut myself purposely.</td>
<td>65%</td>
<td>77%</td>
</tr>
<tr>
<td>58. I have run away from school or my home.</td>
<td>45%</td>
<td>67%</td>
</tr>
<tr>
<td>59. People say that I have eating problems.</td>
<td>76%</td>
<td>61%</td>
</tr>
<tr>
<td>73. I am afraid something bad will happen.</td>
<td>58%</td>
<td>61%</td>
</tr>
<tr>
<td>75. I have hurt others physically when angry.</td>
<td>37%</td>
<td>50%</td>
</tr>
<tr>
<td>86. I have plans to kill myself.</td>
<td>94%</td>
<td>22%</td>
</tr>
<tr>
<td>93. I do not enjoy large gatherings of people.</td>
<td>53%</td>
<td>44%</td>
</tr>
<tr>
<td>98. There were times I’ve injured myself on purpose.</td>
<td>63%</td>
<td>67%</td>
</tr>
<tr>
<td>101. People say my sexual fantasies are strange.</td>
<td>85%</td>
<td>22%</td>
</tr>
<tr>
<td>106. At times, I can’t get sex out of my mind.</td>
<td>68%</td>
<td>39%</td>
</tr>
<tr>
<td>107. I might hurt others or myself.</td>
<td>85%</td>
<td>47%</td>
</tr>
</tbody>
</table>

There were no SAFE-R Conduct Problems Scale items that showed good scale item Sensitivity when compared with subjects diagnosed with Conduct Disorder. Other items in the Conduct Problems Scale showed good Specificity. However, such items did not show good Sensitivity. The results are tabulated in Table 15.
Table 15.

SAFE-R Conduct Problems Scale Item Specificity and Item Sensitivity

<table>
<thead>
<tr>
<th>SAFE-R Conduct Problems scale items</th>
<th>No Conduct Item specificity</th>
<th>Conduct Item sensitivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. I can not get along with my teachers.</td>
<td>63%</td>
<td>49%</td>
</tr>
<tr>
<td>6. I am fascinated with fires.</td>
<td>72%</td>
<td>22%</td>
</tr>
<tr>
<td>12. I am involved in a gang.</td>
<td>79%</td>
<td>33%</td>
</tr>
<tr>
<td>22. I’ve had problems such as fighting before age 10.</td>
<td>58%</td>
<td>62%</td>
</tr>
<tr>
<td>23. I have had thoughts about killing someone.</td>
<td>68%</td>
<td>18%</td>
</tr>
<tr>
<td>32. I have been accused of raping someone.</td>
<td>94%</td>
<td>16%</td>
</tr>
<tr>
<td>48. I have destroyed property when angry.</td>
<td>14%</td>
<td>67%</td>
</tr>
<tr>
<td>58. I have run away from school or my home.</td>
<td>43%</td>
<td>56%</td>
</tr>
<tr>
<td>68. I’ve caused problems by not going to school.</td>
<td>43%</td>
<td>51%</td>
</tr>
<tr>
<td>72. I have forced sex upon another person.</td>
<td>94%</td>
<td>9%</td>
</tr>
<tr>
<td>75. I have hurt others physically when angry.</td>
<td>41%</td>
<td>60%</td>
</tr>
<tr>
<td>78. I enjoy looking at pornography.</td>
<td>65%</td>
<td>49%</td>
</tr>
<tr>
<td>83. I have picked out others for harm.</td>
<td>80%</td>
<td>24%</td>
</tr>
<tr>
<td>85. I might steal from others in my home.</td>
<td>68%</td>
<td>36%</td>
</tr>
<tr>
<td>88. I have had sex with a child in the past.</td>
<td>88%</td>
<td>18%</td>
</tr>
<tr>
<td>94. I will verbally abuse others, when I have to.</td>
<td>46%</td>
<td>55%</td>
</tr>
<tr>
<td>100. I have picked a fistfight.</td>
<td>46%</td>
<td>55%</td>
</tr>
<tr>
<td>102. I have plans to kill someone.</td>
<td>90%</td>
<td>2%</td>
</tr>
<tr>
<td>110. I have been accused of molesting someone.</td>
<td>93%</td>
<td>18%</td>
</tr>
</tbody>
</table>
Various SAFE-R Depressiveness Scale Items showed good scale item Sensitivity when compared with subjects diagnosed with a Depression Disorder. Such items included: item 24 = 92% and item 25 = 89%. These items did not show good item Specificity: item 24 = 16% and item 25 = 29%. Other items in the Depressiveness Scale showed good Specificity: item 23 = 75%; item 30 = 69%; item 46 = 79%; and item 86 = 94%. Such items did not show good Sensitivity: item 23 = 35%; item 30 = 48%; item 46 = 46%; and item 86 = 20%.

Additionally, item 97 (I’ll recall scary things when I do not want to.) approximated good Sensitivity and good Specificity (Sensitivity = 69%; Specificity = 74%). No other items in the SAFE-R showed both good Specificity and good Sensitivity in relation to subjects having Depression. The results are tabulated in Table 16.
Table 16

SAFE-R Depressiveness Scale Item Specificity and Item Sensitivity

<table>
<thead>
<tr>
<th>SAFE-R Depressiveness scale items</th>
<th>No Depression</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. I am often sad or gloomy.</td>
<td>56%</td>
<td>62%</td>
</tr>
<tr>
<td>23. I have had thoughts about killing someone.</td>
<td>75%</td>
<td>35%</td>
</tr>
<tr>
<td>24. I have anger problems.</td>
<td>16%</td>
<td>92%</td>
</tr>
<tr>
<td>25. I worry a lot about things.</td>
<td>29%</td>
<td>89%</td>
</tr>
<tr>
<td>30. I have had thoughts about killing myself.</td>
<td>69%</td>
<td>48%</td>
</tr>
<tr>
<td>46. I avoid my friends, family and my work.</td>
<td>79%</td>
<td>46%</td>
</tr>
<tr>
<td>51. I feel that I could cry easily.</td>
<td>48%</td>
<td>48%</td>
</tr>
<tr>
<td>86. I have plans to kill myself.</td>
<td>94%</td>
<td>20%</td>
</tr>
<tr>
<td>93. I do not enjoy large gatherings of people.</td>
<td>56%</td>
<td>58%</td>
</tr>
<tr>
<td>108. People tell me I look exhausted.</td>
<td>51%</td>
<td>65%</td>
</tr>
</tbody>
</table>

Various SAFE-R Posttraumatic Stress Scale Items showed good scale item Sensitivity when compared with subjects diagnosed with Posttraumatic Stress. Such items included: item 4 = 71%; item 28 = 84%; item 42 = 83; and item 52 = 71%. These items did not show good item Specificity: item 4 = 63%; item 28 = 34%; item 42 = 43; and item 52 = 38%. An item in the Posttraumatic Stress Scale showed good Specificity: item 97 = 71%. This item did not show good Sensitivity: item 97 = 58%. Additionally, item 17 (Bad things that happened keep coming to mind.) approximated good Sensitivity and good Specificity (Sensitivity = 67%; Specificity =
No other items in the SAFE-R showed both good Specificity and good Sensitivity in relation to subjects having Posttraumatic Stress. The results are tabulated in Table 17.

Table 17

SAFE-R Posttraumatic Stress Scale Item Specificity and Item Sensitivity

<table>
<thead>
<tr>
<th>SAFE-R Posttraumatic Stress scale items</th>
<th>No Posttraumatic</th>
<th>Posttraumatic</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. I have bad dreams or nightmares.</td>
<td>63%</td>
<td>71%</td>
</tr>
<tr>
<td>7. Bad memories of things just happen.</td>
<td>57%</td>
<td>65%</td>
</tr>
<tr>
<td>17. Bad things that happened keep coming to mind.</td>
<td>65%</td>
<td>67%</td>
</tr>
<tr>
<td>28. Sometimes, I simply go away in my mind.</td>
<td>34%</td>
<td>84%</td>
</tr>
<tr>
<td>42. I remember bad things about my childhood.</td>
<td>43%</td>
<td>83%</td>
</tr>
<tr>
<td>52. I will often daydream or “zone out”.</td>
<td>38%</td>
<td>71%</td>
</tr>
<tr>
<td>60. I sometimes get full of panicky feelings.</td>
<td>68%</td>
<td>50%</td>
</tr>
<tr>
<td>73. I am afraid something bad will happen.</td>
<td>58%</td>
<td>54%</td>
</tr>
<tr>
<td>80. My mind often just goes blank.</td>
<td>60%</td>
<td>67%</td>
</tr>
<tr>
<td>97. I’ll recall scary things when I do not want to.</td>
<td>71%</td>
<td>58%</td>
</tr>
<tr>
<td>99. I often think about bad things from the past.</td>
<td>55%</td>
<td>67%</td>
</tr>
</tbody>
</table>

Various SAFE-R Psychosis Scale Items showed good scale item Sensitivity when compared with subjects diagnosed with a Psychotic Disorder. Such items included: item 33 = 100%; item 55 = 100%; and item 63 = 100%. These items did not show good item Specificity: item 33 = 46%; item 55 = 30%; and item 63 = 41. Other items in the Psychosis Stress Scale
showed good Specificity: item 16 = 85%; item 57 = 81%; item 71 = 90%; and item 79 = 73%.

These items did not show good Sensitivity: item 16 = 50%; item 57 = 50%; item 71 = 50%; and item 79 = 50%. Item 95 (Voices in my head have told me to do bad things.) showed both good Sensitivity and good Specificity (Sensitivity = 100%; Specificity = 85%). Additionally, item 40 (I’ve had legal problems because of drugs/alcohol) showed both good Sensitivity and good Specificity (Sensitivity = 100%; Specificity = 70%). No other items in the SAFE-R showed both good Specificity and good Sensitivity in relation to subjects having a Psychotic Disorder Stress.

The results are tabulated in Table 18.

Table 18

SAFE-R Psychosis Scale Item Specificity and Item Sensitivity

<table>
<thead>
<tr>
<th>SAFE-R Psychosis scale items</th>
<th>No Psychosis</th>
<th>Psychosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item specificity</td>
<td>Item sensitivity</td>
<td></td>
</tr>
<tr>
<td>16. I believe I have special powers.</td>
<td>85%</td>
<td>50%</td>
</tr>
<tr>
<td>33. The things I say come out odd or strange.</td>
<td>46%</td>
<td>100%</td>
</tr>
<tr>
<td>55. I’m getting help for mental or emotional problems.</td>
<td>30%</td>
<td>100%</td>
</tr>
<tr>
<td>57. I have seen things that others say are not there.</td>
<td>81%</td>
<td>50%</td>
</tr>
<tr>
<td>63. People say I have mental or emotional problems.</td>
<td>41%</td>
<td>100%</td>
</tr>
<tr>
<td>71. I hear voices talking in my head.</td>
<td>90%</td>
<td>50%</td>
</tr>
<tr>
<td>79. I believe people are out to get me.</td>
<td>73%</td>
<td>50%</td>
</tr>
<tr>
<td>95. Voices in my head have told me to do bad things.</td>
<td>85%</td>
<td>100%</td>
</tr>
<tr>
<td>104. People tell me that I do not make sense</td>
<td>53%</td>
<td>50%</td>
</tr>
</tbody>
</table>
One SAFE-R Substance Abuse Scale item (item 77) showed good scale Sensitivity (80%) and good Specificity (85%) when compared with subjects diagnosed with Substance Disorders. Other items in the Substance Abuse Scale showed good Specificity: item 40 = 87%; item 56 = 87%; item 84 = 87%; item 87 = 72%; item 92 = 87%; and item 105 = 86%. These items did not show good Sensitivity: item 40 = 51%; item 56 = 27%; item 84 = 49%; item 87 = 51%; item 92 = 66%; and item 105 = 56%. No other items in the SAFE-R showed both good Specificity and good Sensitivity in relation to subjects having a Substance Abuse Disorder. The results are tabulated in Table 19.

Table 19

SAFE-R Substance Abuse Scale Item Specificity and Item Sensitivity

<table>
<thead>
<tr>
<th>SAFE-R Substance Abuse scale items</th>
<th>Item specificity</th>
<th>Item sensitivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>39. My family members might abuse drugs or alcohol.</td>
<td>50%</td>
<td>67%</td>
</tr>
<tr>
<td>40. I’ve had legal problems because of drugs/alcohol.</td>
<td>87%</td>
<td>51%</td>
</tr>
<tr>
<td>56. I get ill or upset if not using drugs or alcohol.</td>
<td>87%</td>
<td>27%</td>
</tr>
<tr>
<td>77. Others get upset about my drug and alcohol use.</td>
<td>85%</td>
<td>80%</td>
</tr>
<tr>
<td>84. I have increased using drugs or alcohol to get high.</td>
<td>87%</td>
<td>49%</td>
</tr>
<tr>
<td>87. My family has substance abuse problem</td>
<td>72%</td>
<td>51%</td>
</tr>
<tr>
<td>92. Others talk about how much I use drugs or alcohol.</td>
<td>87%</td>
<td>66%</td>
</tr>
<tr>
<td>105. I’ve lost school or job time due to drugs or alcohol.</td>
<td>86%</td>
<td>56%</td>
</tr>
</tbody>
</table>
Hypothesis 4

Hypothesis 4 stated that endorsements of Safety and Risk Critical Items of the SAFE-R correlated with endorsements of specific Noteworthy Responses items of the MACI. Noteworthy Responses categories included Acute Distress, Dangerous Ideation, and Childhood Abuse. A complete list of SAFE-R Risk and Safety Critical Items is provided in Appendix D. The list of select MACI Noteworthy Responses is provided in Appendix E.

Pearson point biserial correlations were generated between items of the SAFE-R Safety and Risk Critical Items and salient diagnoses. Pearson point biserial correlations were also generated between salient Noteworthy Responses items of the MACI and salient diagnoses. Specifically, the procedure of pairing item Specificity in terms of not having been diagnosed with a disorder versus item Sensitivity in terms of having been diagnosed with a disorder represented a dichotomous pairing.

Sensitivity refers to the ability of a scale item to correlate highly with clinical level endorsements corresponding to the diagnosis of a subject. Most individuals diagnosed with a disorder might tend to endorse such a scale item. Specificity refers to the ability of a scale item to be limited to non-clinical level endorsements regarding the same diagnoses. Individuals not diagnosed with a disorder might tend not to endorse such a scale item. For the purpose of this study, cut-offs for item Specificity and Sensitivity were set at 70%.

Items from the MACI Noteworthy Responses were selected by rational means. Sensitivity and Specificity of the SAFE-R and MACI items were compared against various salient diagnoses. Many Risk and Safety Critical items are repeated in various SAFE-R clinical scales. Diagnoses were chosen, when possible, to reflect the area of content of the SAFE-R
scales. Other salient diagnoses, such as Sexual abuse of a Child, Perpetrator were chosen by rational means. All MACI items were compared with salient diagnoses by rational means. The diagnoses used to tabulate Specificity and Sensitivity of the SAFE-R Safety and Risk Critical Items included: Borderline Personality Traits, Conduct Disorder, Depression, Sexual Abuse of a Child, Focus on the Perpetrator, and Sexual Abuse of a Child, Focus on the Victim. The diagnoses used to tabulate Specificity and Sensitivity of the Noteworthy Responses of the MACI included: Borderline Personality Traits, Depression, Sexual Abuse of a Child, Focus on the Perpetrator, and Sexual Abuse of a Child, Focus on the Victim.

In reference to the diagnosis of Borderline Personality Traits, there were no SAFE-R Risk and Safety Critical Items that showed good scale item Sensitivity. Items among the Risk and Safety Critical Items that showed good Specificity included: item 30 = 72% and item 86 = 79%. The results are tabulated in Table 20.

Table 20

SAFE-R Risk and Safety Critical Items versus Borderline Personality Traits Diagnosis

<table>
<thead>
<tr>
<th>SAFE-R Risk and Safety Critical Items</th>
<th>No Borderline Item specificity</th>
<th>Borderline Item sensitivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. I have had thoughts about killing someone.</td>
<td>63%</td>
<td>49%</td>
</tr>
<tr>
<td>30. I have had thoughts about killing myself.</td>
<td>72%</td>
<td>22%</td>
</tr>
<tr>
<td>86. I have plans to kill myself.</td>
<td>79%</td>
<td>33%</td>
</tr>
<tr>
<td>102. I have plans to kill someone.</td>
<td>58%</td>
<td>62%</td>
</tr>
</tbody>
</table>
In reference to the diagnosis of Conduct Disorder, there were no SAFE-R Risk and Safety Critical Items that showed good scale item Sensitivity. Items among the Risk and Safety Critical Items that showed good Specificity included: item 6 = 72% and item 102 = 90%. The results are tabulated in Table 21.

Table 21

SAFE-R Risk and Safety Critical Items versus Conduct Disorder Diagnosis

<table>
<thead>
<tr>
<th>SAFE-R Risk and Safety Critical Items</th>
<th>No Conduct</th>
<th>Conduct</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. I am fascinated with fires.</td>
<td>72%</td>
<td>22%</td>
</tr>
<tr>
<td>23. I have had thoughts about killing someone.</td>
<td>68%</td>
<td>18%</td>
</tr>
<tr>
<td>102. I have plans to kill someone.</td>
<td>90%</td>
<td>2%</td>
</tr>
</tbody>
</table>

In reference to the diagnosis of Depression, there were no SAFE-R Risk and Safety Critical Items that showed good scale item Sensitivity. Items among the Risk and Safety Critical Items that showed good Specificity included: item 23 = 75%; item 30 = 70%; item 86 =94%; and item 102 = 95%. The results are tabulated in Table 22.
### Table 22

**SAFE-R Risk and Safety Critical Items versus Depression Diagnosis**

<table>
<thead>
<tr>
<th>SAFE-R Risk and Safety Critical Items</th>
<th>Item specificity</th>
<th>Item sensitivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. I have had thoughts about killing someone.</td>
<td>75%</td>
<td>35%</td>
</tr>
<tr>
<td>30. I have had thoughts about killing myself.</td>
<td>70%</td>
<td>48%</td>
</tr>
<tr>
<td>86. I have plans to kill myself.</td>
<td>94%</td>
<td>20%</td>
</tr>
<tr>
<td>102. I have plans to kill someone.</td>
<td>95%</td>
<td>15%</td>
</tr>
</tbody>
</table>

In reference to the diagnosis of Sexual Abuse of a Child, Focus on the Perpetrator, SAFE-R Risk and Safety Critical Item, item 15 showed good scale item Sensitivity and Specificity (Sensitivity, 79%; Specificity 76%). There were a total of 14 clients with that diagnosis in this population sample. There were 4 subjects that shared diagnoses of Sexual Abuse of a Child, Focus on the Victim and Sexual Abuse of a Child, Focus on the Perpetrator (29%). Other SAFE-R Risk and Safety Critical Item showing good Specificity included: item 2. = 73%; item 32. = 96%; item 72. = 96%; item 88. = 90%; and item 110. = 96%. The results are tabulated in Table 23.
Table 23

SAFE-R Risk and Safety Critical Items versus Sexual Perpetrator Diagnosis

<table>
<thead>
<tr>
<th>SAFE-R Risk and Safety Critical Items</th>
<th>No Perpetrator</th>
<th>Perpetrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. There has been sexual abuse in my family.</td>
<td>76%</td>
<td>79%</td>
</tr>
<tr>
<td>32. I have been accused of raping someone.</td>
<td>96%</td>
<td>50%</td>
</tr>
<tr>
<td>72. I have forced sex upon another person.</td>
<td>96%</td>
<td>29%</td>
</tr>
<tr>
<td>88. I have had sex with a child in the past.</td>
<td>90%</td>
<td>50%</td>
</tr>
<tr>
<td>110. I have been accused of molesting someone.</td>
<td>96%</td>
<td>64%</td>
</tr>
</tbody>
</table>

In reference to the diagnosis of Sexual Abuse of a Child, Focus on the Victim, SAFE-R Risk and Safety Critical Items, items 2. and 15. showed good scale item Sensitivity and Specificity (item 2., Sensitivity = 79%, Specificity 76%; item 15., Sensitivity = 79%, Specificity 76%). There were a total of 16 clients with that diagnosis in this population sample. There were 4 subjects that shared diagnoses of Sexual Abuse of a Child, Focus on the Victim and Sexual Abuse of a Child, Focus on the Perpetrator (25%). Other SAFE-R Risk and Safety Critical Item showing good Specificity included: item 32. = 91%; item 72. =95%; item 88. =87%; and item 110. = 90%. The results are tabulated in Table 24.
Table 24

SAFE-R Risk and Safety Critical Items versus Sexual Victim Diagnosis

<table>
<thead>
<tr>
<th>SAFE-R Risk and Safety Critical Items</th>
<th>No Sexual Victim</th>
<th>Sexual Victim</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Item specificity</td>
<td>Item sensitivity</td>
</tr>
<tr>
<td>2. I was sexually abused as a child.</td>
<td>79%</td>
<td>75%</td>
</tr>
<tr>
<td>15. There has been sexual abuse in my family.</td>
<td>71%</td>
<td>81%</td>
</tr>
<tr>
<td>32. I have been accused of raping someone.</td>
<td>91%</td>
<td>13%</td>
</tr>
<tr>
<td>72. I have forced sex upon another person.</td>
<td>95%</td>
<td>20%</td>
</tr>
<tr>
<td>88. I have had sex with a child in the past.</td>
<td>87%</td>
<td>25%</td>
</tr>
<tr>
<td>110. I have been accused of molesting someone.</td>
<td>90%</td>
<td>19%</td>
</tr>
</tbody>
</table>

In reference to the diagnosis of Borderline Personality Traits, there were no MACI Noteworthy Responses that showed good scale item Sensitivity. All items showed a Specificity of 100%. The results are tabulated in Table 25.
Table 25

**MACI Noteworthy Responses versus Borderline Personality Traits Diagnosis**

<table>
<thead>
<tr>
<th>MACI Noteworthy Responses</th>
<th>No Borderline</th>
<th>Borderline</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. I think everyone would be better off if I were dead.</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>54. I sometimes get so upset that I want to hurt myself seriously.</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>88. Killing myself may be the easiest way of solving my problems.</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>95. No one really cares if I live or die.</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>107. More and more often I have thought about ending my life.</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>123. I have tried to commit suicide in the past.</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>156. I've given thought to how and when I might commit suicide.</td>
<td>100%</td>
<td>0%</td>
</tr>
</tbody>
</table>

In reference to the diagnosis of Depression, there were no MACI Noteworthy Responses that showed good scale item Sensitivity. All items showed a Specificity of 100%. The results are tabulated in Table 26.
Table 26

**MACI Noteworthy Responses versus Depression Diagnosis**

<table>
<thead>
<tr>
<th>MACI Noteworthy Responses</th>
<th>No Depression</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. I think everyone would be better off if I were dead.</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>54. I sometimes get so upset that I want to hurt myself seriously.</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>88. Killing myself may be the easiest way of solving my problems.</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>95. No one really cares if I live or die.</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>107. More and more often I have thought about ending my life.</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>123. I have tried to commit suicide in the past.</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>156. I’ve given thought to how and when I might commit suicide.</td>
<td>100%</td>
<td>0%</td>
</tr>
</tbody>
</table>

In reference to the diagnosis of Sexual Perpetrator, there were no MACI Noteworthy Responses that showed good scale item Sensitivity. All items showed a Specificity of 100%. The results are tabulated in Table 27.
Table 27

**MACI Noteworthy Responses versus Sexual Perpetrator Diagnosis**

<table>
<thead>
<tr>
<th>MACI Noteworthy Responses</th>
<th>No Perpetrator</th>
<th>Perpetrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. I feel pretty shy telling people about how I was abused as a child.</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>72. I hate to think about some of the ways I was abused as a child.</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>129. I’m ashamed of some terrible things adults did to me when I was young.</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>137. People did things to me sexually when I was too young to understand.</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

In reference to the diagnosis of Sexual Victim, there were no MACI Noteworthy Responses that showed good scale item Sensitivity. All items showed a Specificity of 100%. The results are tabulated in Table 28.
Table 28

*MACI Noteworthy Responses versus Sexual Victim Diagnosis*

<table>
<thead>
<tr>
<th>MACI Noteworthy Responses</th>
<th>Item specificity</th>
<th>Item sensitivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. I feel pretty shy telling people about how I was abused as a child.</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>72. I hate to think about some of the ways I was abused as a child.</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>129. I’m ashamed of some terrible things adults did to me when I was young.</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>137. People did things to me sexually when I was too young to understand.</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Chapter 4

Discussion

Relevant Findings

Hypothesis 1

Hypothesis 1 stated that there would be significant and positive Pearson correlations between elevations of scales of the SAFE-R when compared with elevations of select scales of the MACI. Such SAFE-R and such MACI scales were believed to assess similar, yet not necessarily identical traits. As predicted, there were various notable correlations determined between elevations in the select MACI scales and the SAFE-R scales.

There was a significant correlation between the MACI Borderline Tendency scale and the SAFE-R Conduct Problems scale. According to the MACI Manual (Millon, Millon, & Davis, 1993), individuals with Borderline Tendencies will show poor judgments behaviorally, erratic exhibitions of person-to-person hostility, difficulties in relating to society, and self-destructive actions. The SAFE-R Conduct Problems Scale includes similar concepts, including poor relationships with others in authority, gang involvements, fighting, elopements, forcing sexual activity on others, difficulties in relating to society and verbally abusing others. Conduct problem youth are at high risk for violence and criminality (Tarter et al., 2002).

The MACI Oppositional scale correlated significantly with the SAFE-R Conduct Problems scale. MACI Oppositional scale items included such factors as moodiness, hostility, defiance aggression, and behavioral dyscontrol. The MACI manual notes that there will often be blends of the Borderline and Oppositional types. Both types are predicted to struggle with self-other conflicts. Such problems are also highlighted in the SAFE-R Conduct Problems Scale. As
noted above, such problems include poor relationships with others in authority, gang involvements, fighting, elopements, forcing sexual activity on others, difficulties in relating to society and verbally abusing others.

The MACI Substance Abuse Proneness Scale includes risk factors related to drug and alcohol consumption. These factors include problems of impairments in performances and behaviors, unacceptable social mannerisms, and a continued usage of such substances despite knowledge of the resulting ill and harmful effects. There were multiple, significant correlations between the MACI Substance Abuse Proneness Scale and several SAFE-R Scales. The highest correlations were: 1). MACI Substance Abuse Proneness Scale and SAFE-R Mania; and 2). MACI Substance Abuse Proneness and the SAFE-R Anxiety/ADHD.

The SAFE-R Mania Scale includes risk factors such as taking more risks when happy or excited, taking risks that might put the person into danger, seeking thrills, and hurting others by one’s spending. Adolescents with Bipolar Disorder are at increased risk for danger of suicide attempts and/or violence to others (Goldstein, Axelson, Birmaher, & Brent; Papolos, 2007). The SAFE-R Anxiety/ADHD Scale contains problems such as being the nervous type, being diagnosed with ADHD, becoming full of panic, and having excessive worries. Behavioral and mental health problems such as Anxiety and ADHD appear in the research as being related to an increased risk of aggressive Conduct Disorder problems (Pelcovitz, Kaplan, DeRosa, Mandel & Salzinger, 2000). Risk factors such as those that were contained in the SAFE-R Mania and the SAFE-R Anxiety/ADHD Scales were correlated by the subjects in terms of substance abuse problems. Additionally, MACI Substance Abuse Proneness negatively correlated to SAFE-R Effectiveness.
Multiple correlations were determined between the MACI Suicidal Tendency scale and various SAFE-R scales. The highest correlations included: 1). MACI Suicidal Tendency and SAFE-R Anxiety/ADHD; 2). MACI Suicidal Tendency and SAFE-R Posttraumatic Stress; 3). MACI Suicidal Tendency and SAFE-R Depressiveness; and 4). MACI Suicidal Tendency and SAFE-R Mania.

The MACI Suicidal Tendency Scale attempts to determine those individuals who are having suicidal thoughts and impulses. They might express feelings that they lack self-worth or purpose. Many of them might believe that others around them would be better off if they were not around. The SAFE-R Anxiety/ADHD Scale includes items related to their being overwhelmed by feelings of panic, to being nervous, to being afraid something bad will happen, and to having excessive worry. The SAFE-R Posttraumatic Stress Scale includes items related to problems of being afraid that something bad will happen, being panic-stricken, recalling former terrifying things and having nightmares. Adolescents who present with a diagnosis of PTSD are seen as at increased risk for harm to self or others (Cashel, Ovaert and Holliman, 2000). The SAFE-R Depressiveness Scale attempts to detect information related to past suicidality, current suicidal thoughts and urges, excessive worry, isolationism and sadness. Adolescents with MDD are at increased risk for suicidality (Eskin, Ertekin, Dereboy, & Demirkiran, 2007). Such risk factors were coordinated by the subjects in terms of suicidal problems.

Other correlations included 1). MACI Suicidal Tendency and SAFE-R Borderline Traits; and 2). MACI Suicidal Tendency and Psychosis. The SAFE-R Borderline Traits Scale contains requests for information related to past or present suicidality as well as to past or present problems of self-injurious behaviors. Adolescents diagnosed with BPD show an increased risk for violence and self-harm (Horesh, Orbach, Gothelf, Efrati, & Apter, 2003). Further, individuals
with BPD are at increased risk for comorbidity with MDD or SA (Fountoulakis, Leucht & Kaprinis, 2008). The SAFE-R Psychosis Scale seeks information related to command hallucinations and problems of paranoia. Psychotic diagnoses, such as Schizophrenia, call for heightened safety precautions because of concerns about harm and suicidality (Kelly, Conley & Carpenter, 2005). These SAFE-R risk factors were coordinated by the subjects in terms of suicidal problems.

Multiple significant correlations were determined between the MACI Delinquent Predisposition scale and various SAFE-R scales. Such correlations included: 1). MACI Delinquent Predisposition and SAFE-R Posttraumatic Stress; 2). MACI Delinquent Predisposition and SAFE-R Borderline Traits; 3). MACI Delinquent Predisposition and SAFE-R Anxiety/ADHD; 4). MACI Delinquent Predisposition and SAFE-R Depressiveness; 5). MACI Delinquent Predisposition and Psychosis; and 7). MACI Delinquent Predisposition and SAFE-R Conduct Problems.

The MACI Delinquent Predisposition Scale defines adolescents who have violated the rights of others, have broken societal rules, have threatened others, have used weapons on others, and have been involved with lying and with stealing.

The SAFE-R Posttraumatic Stress Scale involves questions related to past traumas. Such individuals are often involved with chaotic family lives and may have been part of street violence. These SAFE-R risk factors were coordinated by the subjects in terms of delinquency problems (MACI Delinquent Predisposition and SAFE-R Posttraumatic Stress).

As with the MACI Delinquent Predisposition Scale, the SAFE-R Borderline Traits scale is also related to various forms of antisocial activities and potential for harm to others. Such factors include truancy, hurting others when angry, and the potential to hurt others. Such SAFE-
R risk factor Borderline Personality problems were coordinated by the subjects in terms of
delinquency behaviors (MACI Delinquent Predisposition and SAFE-R Borderline Traits).

As noted previously, the SAFE-R Anxiety/ADHD Scale includes items related to being
overwhelmed by feelings of panic, being nervous, having excessive worry, and being diagnosed
with ADHD. These risk factors were correlated by the subjects in terms of delinquency problems
(MACI Delinquent Predisposition and SAFE-R Anxiety/ADHD).

The SAFE-R Depressiveness Scale attempts to detect information related to previous
suicidality, current suicidal thoughts and urges, excessive worry, isolationism and sadness. The
SAFE-R Mania Scale includes risk factors such as taking more risks when happy or excited,
taking risks that might put the person into danger, seeking thrills, and hurting others by one’s
spending. In terms of the subjects’ recognitions of mood problems, such risk factors were
correlated in terms of delinquency problems (MACI Delinquent Predisposition and SAFE-R
Depressiveness; MACI Delinquent Predisposition and SAFE-R Mania).

The SAFE-R Psychosis Scale notes problems of command hallucinations, of gaining help
for mental or emotional problems and of having paranoia. These particular risk factors were
correlated by the subjects with behaviors related to delinquency (MACI Delinquent
Predisposition and Psychosis).

The SAFE-R Conduct Problems Scale includes subject problems such as selectively
choosing others for harm, poor relationships with others in authority, gang involvements,
fighting, elopements, forcing sexual activity on others, difficulties in relating to society and
verbally abusing others. Such Conduct problem behaviors were correlated by the subjects to
delinquency activities (MACI Delinquent Predisposition and SAFE-R Conduct Problems).
Multiple significant correlations were determined between the MACI Unruly scale and various SAFE-R scales. Such correlations included: 1). MACI Unruly and SAFE-R Substance Abuse; 2). MACI Unruly and SAFE-R Conduct Problems; and 3). MACI Unruly and SAFE-R Borderline Traits.

The MACI Unruly Scale defined individuals who will tend to act out in a socially harmful manners, will resist attempts to form them to societal standards, will display an excessively defiant attitude and may be involved with conflicts involving parents, school or the law.

The SAFE-R Substance Abuse Scale reflects problems of upsetting others by their behaviors, having legal problems and truancy issues. Adolescents involved with SA are at a higher risk for suicidality and fatalities (Esposito-Smythers & Spirito, 2004). Additionally, higher rates of homicidal behaviors have been linked to an increased usage of drugs and alcohol (Roe-Sepowitz, 2007). Such risk factors were correlated by the subjects with behaviors related to unruliness (MACI Unruly and SAFE-R Substance Abuse).

The SAFE-R Conduct Problems Scale, as noted above, determines problems such as selectively choosing others for harm, poor relationships with others in authority, fighting, forcing sexual activity on others, difficulties in relating to society and verbally abusing others. Such Conduct problem behaviors were correlated by the subjects to the MACI Unruly Scale (MACI Unruly and SAFE-R Conduct Problems).

SAFE-R Borderline Traits Scale is also related to various forms of interpersonal conflicts, antisocial activities, a potential for harm to others, and hurting others when angry. Borderline Traits were correlated by the subjects to the MACI Unruly Scale (MACI Unruly and SAFE-R Borderline Traits).
Multiple significant correlations were determined between the MACI Anxious Feelings scale and various SAFE-R scales. Such correlations included: 1). MACI Anxious Feelings and SAFE-R Depressiveness; 2). MACI Anxious Feelings and SAFE-R Posttraumatic Stress; 3). MACI Anxious Feelings and SAFE-R Anxiety/ADHD; 4). MACI Anxious Feelings and SAFE-R Borderline Traits; 5). MACI Anxious Feelings and SAFE-R Mania; and 6). MACI Anxious Feelings and Psychosis.

According to the MACI manual, individuals with Anxious Feelings will have a sense of fear and foreboding, a generalized apprehensiveness, and an anxious apprehension toward future events.

The SAFE-R Anxiety/ADHD Scale includes items related to nervousness, panic, fear of the future and excessive worry. The SAFE-R Posttraumatic Stress Scale notes problems of fear of the future, dissociative states, panic and other ill effects of traumas. Such problem behaviors and states were correlated by the subjects to the MACI Anxious Feelings Scale (MACI Anxious Feelings and SAFE-R Anxiety/ADHD; MACI Anxious Feelings and SAFE-R Posttraumatic Stress).

In terms of information regarding mood problems, SAFE-R Depressiveness Scale items include information about worry, suicidality and isolating. SAFE-R Mania Scale Items provide information related to racing thoughts, lack of sleep and retiring or awakening in an angered state. These SAFE-R Scales were correlated by the subjects in terms of the content in the MACI Anxious Feelings Scale (MACI Anxious Feelings and SAFE-R Depressiveness; MACI Anxious Feelings and SAFE-R Mania).

The SAFE-R Borderline Traits Scale reflects information related to fear that something bad will happen, isolating behaviors, suicidality, self-harm and harm to others. Subjects
correlated such concepts with the items in the MACI Anxious Feelings Scale (MACI Anxious Feelings and SAFE-R Borderline Traits).

Among the items listed in the SAFE-R Psychosis Scale are those related to command hallucinations, having a diagnosis of mental or emotional problems, paranoia and incoherence. Such Psychotic problems were correlated by the subjects with the Anxious Feelings Scale (MACI Anxious Feelings and Psychosis).

Finally, multiple correlations were determined between the MACI Self-Demeaning scale and various SAFE-R scales. Such correlations included: 1). MACI Self-Demeaning and SAFE-R Borderline Traits; 2). MACI Self-Demeaning and SAFE-R Depressiveness; 3). MACI Self-Demeaning and SAFE-R Posttraumatic Stress; 4). MACI Self-Demeaning and SAFE-R Mania; 5). MACI Self-Demeaning and Psychosis. 6). MACI Self-Demeaning and SAFE-R Anxiety/ADHD; and 7). MACI Self-Demeaning and SAFE-R Conduct Problems.

The MACI manual describes Self-Demeaning individuals as being prone to act in ways that lead to their own defeat; they will also seem content to suffer and may sabotage the attempts of others to aid them. Such adolescents may defeat their own needs to gain pleasure or success; painfulness may have become preferable to pleasure. Such an imbalance may be passively accepted and even encouraged in relationships. They may promote others to exploit them.

As noted previously, individuals with Borderline problems will show poor behavioral judgments, erratic exhibitions of person-to-person hostility, difficulties in relating to society, and self-destructive actions. SAFE-R items involved with describing Borderline Traits include content related to past and present suicidality, isolating oneself, antisocial behaviors and self-injurious behaviors. Such risk factors were correlated by the subjects with behaviors related to Self-Demeaning qualities (MACI Self-Demeaning and SAFE-R Borderline Traits).
SAFE-R Scale items related to mood problems include such SAFE-R Depressiveness Scale items include information about worry, sadness, suicidality and isolation. Safe-R Mania Scale Items provide information related to putting oneself into danger, showing a lack of sleep and retiring or awakening in an angered state. Such SAFE-R Scales were correlated by the subjects in terms of the content in the MACI Self-Demeaning Scale (MACI Self-Demeaning and SAFE-R Depressiveness; MACI Self-Demeaning and SAFE-R Mania).

There were correlations of MACI Self-Demeaning scale elevations with anxiety problems as measured by the SAFE-R Anxiety/ADHD and Posttraumatic Stress Scales. The SAFE-R Anxiety/ADHD Scale includes items related to problems of attention, fear of the future and excessive worry. The SAFE-R Posttraumatic Stress Scale notes problems concerning fear of the future, negative memories about childhood, dissociative states, and other ill effects of traumas. (MACI Self-Demeaning and SAFE-R Anxiety/ADHD; MACI Self-Demeaning and SAFE-R Posttraumatic Stress).

SAFE-R Psychotic Scale problems include problems of command and other types of hallucinations, of incoherence, of gaining help for mental or emotional problems and of having paranoia. These particular risk factors were correlated by the subjects with items found in the MACI Self-Demeaning Scale (MACI Self-Demeaning Scale and Psychosis).

As noted previously, the SAFE-R Conduct Problems Scale refers to misconduct behaviors such as selectively choosing others for harm, poor relationships with others in authority, fighting, forcing sexual activity on others, difficulties in relating to society and verbally abusing others. Such Conduct problem behaviors were correlated by the subjects with items found in the MACI Self-Demeaning Scale (MACI Self-Demeaning and SAFE-R Conduct Problems).
This information that has been presented would seem to indicate that the SAFE-R and the MACI would be useful for treatment and diagnoses for a risk, high acuity adolescent population. Indeed, as noted previously, various scales seemed to match in the expected directions. Such matching in particular included MACI Oppositional with SAFE-R Conduct Problems. Also matching in an expected direction was MACI Suicidal Tendencies with 1).SAFE-R Anxiety/ADHD; 2).with SAFE-R Borderline Traits; 3). with SAFE-R Depressiveness; 4). with SAFE-R Mania; 5). with SAFE-R Posttraumatic Stress; and 6). with SAFE-R Psychosis. Further, MACI Delinquent Predisposition matched with SAFE-R Conduct Problems. MACI Unruly also matched with SAFE-R Conduct Problems. MACI Anxiety matched in the expected direction with SAFE-R Anxiety/ADHD Scale. Finally, MACI Self-Demeaning Matched well with SAFE-R Depressiveness.

Hypothesis 2

In accordance with this previously outlined strategy to test Hypothesis 2, Pearson point biserial correlations were generated between elevated scores of the SAFE-R scales, elevated scores of select MACI scales and current diagnoses. The diagnostic categories within the sample populations included, yet were not limited by: 1).ADHD; 2).Anxiety Disorders; 3).Bipolar Disorder; 4).Borderline Personality Traits; 5). Conduct Disorder; 6).Depression; 7).Posttraumatic Stress Disorder; 8). Psychotic Disorders; and 9). Substance Abuse Disorders. The clinical scales of the SAFE-R include: 1). Anxiety/ADHD; 2). Borderline Traits; 3). Conduct Problems; 4). Depression; 5). Mania; 6). Posttraumatic Stress; 7). Psychosis; and 8.). Substance Abuse.
Overall, and without exception, the data indicated that none of the MACI scales and none of the SAFE-R scales were very effective in differentiating between adolescent residents diagnosed with any of the above specified diagnoses and adolescent residents not diagnosed with the above specified diagnosis. For each MACI or SAFE-R scale, the percentage of residents diagnosed with any of the above diagnoses whose responses earned scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with a disorder whose responses may have earned elevated MACI or SAFE-R scaled scores.

As will be seen in the discussion of hypotheses 3 and 4, such apparently confounding results between hypotheses 1 and 2 are best understood in the context of the inherent problems of item Specificity and Sensitivity that occur with a highly acute, multiple diagnosed adolescent population. For the purpose of this study, cut-offs for item Specificity and Sensitivity were set at 70%.

Sensitivity refers to the ability of a scale item to correlate highly with clinical level endorsements corresponding to the diagnosis of a subject. Most individuals diagnosed with a disorder might tend to endorse such a scale item. Specificity refers to the ability of a scale item to be limited to non-clinical level endorsements regarding the same diagnoses. Individuals not diagnosed with a disorder might tend not to endorse such a scale item.

*Hypothesis 3*

The results of hypothesis 3 also appear to confound the impressions of hypothesis 1. These results are again best understood in the context of the inherent problems of item Specificity and Sensitivity that occur with a highly acute, multiple diagnosed adolescent
population. A more detailed discussion regarding the problems of Specificity and Sensitivity in an acute referred population is provided.

According to the results of hypothesis 3, Various SAFE-R ADHD Scale Items showed good scale item Sensitivity including item 5. and item 32. However, these items did not show good item Specificity. The SAFE-R Anxiety Scale Items did not show good Item Sensitivity or good Specificity. Various SAFE-R Mania Scale Items showed good scale item Sensitivity including item 1., item 21., item 29., item 90., and item 109. However, these items did not show good item Specificity. One SAFE-R Borderline Traits Scale item 37. showed good scale item Sensitivity. However, this item did not show good item Specificity. There were no SAFE-R Conduct Problems Scale items that showed good scale item Sensitivity. Various SAFE-R Depressiveness Scale Items showed good scale item Sensitivity, including items 24. and item 25. These items, however, did not show good item Specificity. Various SAFE-R Posttraumatic Stress Scale Items showed good scale item Sensitivity including item 4, item 28, item 42, item 83, and item 52. These items did not show good item Specificity. Various SAFE-R Psychosis Scale Items showed good scale item Sensitivity including item 33., item 55., and item 63. These items did not show good item Specificity.

There were no other items in the SAFE-R that showed both good Specificity and good Sensitivity in relation to subjects having any respective clinical diagnoses.

Only SAFE-R Substance Abuse Scale item 77. (Others get upset about my drug and alcohol use.) indicated good scale Sensitivity and Specificity.
Hypothesis 4

Hypothesis 4 stated that endorsements of Safety and Risk Critical Items of the SAFE-R correlated with endorsements of specific Noteworthy Responses items of the MACI when compared with salient diagnoses. Noteworthy Responses categories included Acute Distress, Dangerous Ideation, and Childhood Abuse. The diagnoses used to tabulate Specificity and Sensitivity of the SAFE-R Safety and Risk Critical Items included: Borderline Personality Traits, Conduct Disorder, Depression, Sexual Abuse of a Child, Focus on the Perpetrator, and Sexual Abuse of a Child, Focus on the Victim. The diagnoses used to tabulate Specificity and Sensitivity of the Noteworthy Responses of the MACI included: Borderline Personality Traits, Depression, Sexual Abuse of a Child, Focus on the Perpetrator, and Sexual Abuse of a Child, Focus on the Victim.

There were only a few results that were notable. Such apparently confounding results of hypotheses are best understood in the context of the inherent problems of item Specificity and Sensitivity that occur with a highly acute, multiple diagnosed adolescent population.

In reference to the diagnoses of Borderline Personality Traits, Conduct Disorder, and Depression there were no SAFE-R Risk and Safety Critical Items that showed good scale item Sensitivity. SAFE-R Risk and Safety Critical Item, item 15. (There has been sexual abuse in my family.) showed good scale item Sensitivity and Specificity when compared with the diagnosis of Sexual Abuse of a Child, Focus on the Perpetrator. There were a total of 14 clients with that diagnosis in this population sample. In reference to the diagnosis of Sexual Abuse of a Child, Focus on the Victim, SAFE-R Risk and Safety Critical Items, items 2. (I was sexually abused as a child.) and 15. (There has been sexual abuse in my family.) showed good scale item Sensitivity and Specificity. There were a total of 16 clients with that diagnosis in this population sample.
Additionally, there were 4 clients that had dual diagnoses both of Sexual Abuse of a Child, Focus on the Perpetrator, and of Sexual Abuse of a Child, Focus on the Victim.

There were no MACI Noteworthy Responses that showed good scale item Sensitivity when correlated with the diagnoses of Borderline Personality Traits, Depression, Sexual Abuse of a Child, Focus on the Perpetrator, and Sexual Abuse of a Child, Focus on the Victim. When compared with this salient diagnoses, all MACI Noteworthy Responses showed Specificity of 100%.

Synthesis of Research Hypotheses

Overall, a referred adolescent population such as is found at KidsPeace is composed of individuals with multiple clinical problem areas and multiple diagnoses. In such a referred population, test instruments are often confounded regarding test item Specificity and Sensitivity. As noted in the discussion of hypothesis 1, elevations of select MACI scales matched well and in an expected direction with elevations of various SAFE-R clinical scales.

The data in hypothesis 2 indicated that none of the MACI scales and none of the SAFE-R scales were very effective in differentiating between adolescent residents diagnosed with any specified diagnoses and adolescent residents not diagnosed with specified diagnosis. For each MACI or SAFE-R scale, the percentage of residents diagnosed with any salient diagnoses whose responses earned scale scores in the elevated ranges was roughly equivalent to the percentage of residents not diagnosed with a disorder whose responses may have earned elevated MACI or SAFE-R scaled scores. There were apparent confounding results seen between hypothesis 1 versus those in hypothesis 2, hypothesis 3 and hypothesis 4.
As previously stated, Sensitivity refers to the ability of a scale item to correlate highly with clinical level endorsements corresponding to the diagnosis of a subject. Most individuals diagnosed with a disorder might tend to endorse such a scale item. Specificity refers to the ability of a scale item to be limited to non-clinical level endorsements regarding the same diagnoses. Individuals not diagnosed with a disorder might tend not to endorse such a scale item. Within a highly acute, multiple diagnosed adolescent populations, item endorsements generally did not show good Specificity and good Sensitivity. Such an understanding aids in the interpretation of how hypothesis 2, hypothesis 3 and hypothesis 4 were not successful, as had been predicted.

Such a conceptual framework also aids in explaining how various scale items of the SAFE-R scales showed good Sensitivity yet not good Specificity. As such, hypothesis 3 was not successful in predicting that SAFE-R items would show both good Specificity and good Sensitivity when compared with salient diagnoses. Further, there were no items found that had good Specificity and good Sensitivity when all SAFE-R items were compared with salient diagnoses. The one exception was SAFE-R Substance Abuse Scale item 77 (Others get upset about my drug and alcohol use.). This item showed good scale Sensitivity and Specificity when compared with a Substance abuse diagnosis. This item reflected an indirect questioning style.

Finally, hypothesis 4 was generally not successful in predicting that endorsements of Safety and Risk Critical Items of the SAFE-R correlated with endorsements of specific Noteworthy Responses items of the MACI when compared with salient diagnoses. There were two exceptions to the lack of coordination of Sensitivity/Specificity and salient diagnoses within the correlation of the specific items in hypothesis 4. These exceptions included: 1). SAFE-R Risk and Safety Critical item 15. (There has been sexual abuse in my family.) showed good scale item Sensitivity and Specificity when compared with the diagnosis of Sexual Abuse of a Child, Focus...
on the Perpetrator; and 2). SAFE-R Risk and Safety Critical Items, item 2 (I was sexually abused as a child.) and item 15 (There has been sexual abuse in my family.). Both items 2 and 15 showed good scale item Sensitivity and Specificity when compared with the diagnosis of Sexual Abuse of a Child, Focus on the Victim. Such SAFE-R items may become highly salient markers for clinicians’ scoring and interpreting the results of the SAFE-R.

Additionally, items 15 (There has been sexual abuse in my family.) and 77 (Others get upset about my drug and alcohol use.) involve a less direct answering approach. Such an approach appears to be consistent with the validity of the literature relative to concerns in answering styles of traumatized or disturbed adolescents. As noted above, instruments attempting to measure adolescent mental health or behavioral problems can impose strain upon adolescent test responding and functioning. This strain may lead to clinical regression and invalid responding. Reactivity of responding would mean that clients, having taken a test or similar tests in the past, may show various effects regarding valid responding (Onan, Myers, Collert & Brent, 2002). Nonetheless, the utility and veracity of indirect questioning is yet to be determined by ongoing research (Fulfer et al, 2007).

Implications

Overall, this study has indicated that a high acuity, multi-diagnostic referred adolescent population is not best served by attempts to limit assessments to the administration of any single pencil-and-paper test instrument. According to the research, there are not any particular scales for traumatized adolescents that can provide optimal suitability and utility. Various authors have recommended that users of psychometric instruments who are interested in assessing trauma in youth may need to test out the application of an instrument to realize more fully the limitations
with intended subjects and applications. Scales and instruments that appear to function well may need to be matched individually for the best psychometric properties for the intended purpose. Validity may need to be researched continually with diverse samples and applications. Trauma literature indicates that potential administrators of test instruments within such high risk populations must clearly define goals of measurement and usage of scales within realistic limits (Ohan, Myers, & Collett, 2002).

In terms of assessment of sexual offending recidivism, there are two familiar approaches. These two approaches are clinical predictions and actuarial assisted assessments. Unstructured clinical predictions are made by means of clinicians utilizing their background of anecdotal experiences. Such judgments have been somewhat better than chance. One embedded problem involves ways to ascertain the manner in which such clinical judgments are actually made. Without the description of judgment pathways, decisions may be difficult to uphold or rebuke. Another serious concern is a lowered level of accuracy. However, an advantage is the clinician’s ability to readily combine a variety of risk domains.

Advantages of empirically based actuarial instruments can include a higher agreement between different raters, ease of administration or scoring and retrospective empirical support for the risk factors considered. One notable disadvantage to actuarial based instruments is that there is not available an actuarial instrument that could possibly include all potential risk factors. The ERASOR has attempted to provide a direction of empirically guided clinical judgments. This approach combines both empirical research and clinical expertise. The strategy is based on empirically verified risk variables. Additionally, most research has been based on retrospective studies of adult male sexual offenders. Empirical evidence has been slow in forthcoming, relative
to the validity of actuarial assessments when applied to adolescent populations (Worling & Curwen, 2001).

This current research has added to the empirical research of safety and risk instruments by means of detecting SAFE-R Risk and Safety Critical item 2 (I was sexually abused as a child.) and 15 (There has been sexual abuse in my family.) as showing good scale item Sensitivity and Specificity when compared with the diagnosis of Sexual Abuse of a Child, Focus on the Victim. Good Specificity and Sensitivity of SAFE-R Risk and Safety Critical Items, item 15 (There has been sexual abuse in my family.) was also found when compared with the diagnosis of Sexual Abuse of a Child, Focus on the Perpetrator. According to the Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II), an indication of being a sexual victim is a risk factor for potential sexual offending recidivism (Prentky & Righthand, 2003). As noted, SAFE-R Risk and Safety Critical item 15 does not directly refer to the examinee; the utility of indirect questioning continues to be researched (Fulfer et al, 2007). Other research has indicated that being sexually victimized should be regarded as an Unlikely factor for sexual offending recidivism (Worling & Langstrom, 2003). Nonetheless, an implication of this current study is that clinicians may appropriately focus on such empirical results when evaluating clients for a determination of the diagnoses of Sexual Abuse of a Child, Focus on the Perpetrator and/or Sexual Abuse of a Child, Focus on the Victim.

The overall problems of poor correlations in item Sensitivity and Specificity may be expected among residential, high acuity populations. The various means and procedures that are in place at residential settings need to continue in place with the prospect of future, continual improvements. Such skills as accurate clinical interviewing need to be continuously refined and practiced. Actuarial devices that accumulate historic risk information will need to be faithfully
employed. Such instruments as the SAVRY, the ERASOR, and the original SAFE will need to remain as adjuncts in order to buttress the problems of an imbalance between Sensitivity and Specificity among test items.

Limitations of the Study

A referral adolescent population such as is found at KidsPeace is composed of individuals with multiple clinical problem areas and multiple diagnoses. In such a referral population, test instruments are often confounded regarding test item Specificity and Sensitivity due both to intrinsic and to clinical factors. Intrinsic factors include such problems such as anxiety during testing. Subjects may have other concerns that a forthright admission of symptoms may lead to legal charges, to further detainments, or to treatment of previously unheard of mental disorders. Additionally, because subjects may be at a higher level of clinical treatment than they previously had been, they may tend to be inaccurate, becoming poor reporters of their own internal processes and states. Finally, subjects may actually have had previous placements in various residential settings. Such subjects may have increased test experiences and are poorly motivated to perform according to the expectations of the test instrument.

Many items of the SAFE-R showed good Sensitivity to diagnosis. As defined earlier in this study, Sensitivity refers to the ability of a scale item to correlate highly with clinical level endorsements that correspond to the diagnosis of a subject. Most individuals diagnosed with a disorder might tend to endorse such a scale item. This study has indicated that subjects have multiple diagnoses; therefore, test items would tend to show Sensitivity for several SAFE-R items among the SAFE-R clinical scales. However, with rare exceptions, items that showed good
Sensitivity showed poor Specificity. Because of this, it was found in this study that a diagnostically complex referral population may invariably not show good Sensitivity and simultaneous good Specificity of psychometric test item endorsements. As noted previously, Specificity of test items refers to the ability of a scale item to be limited to non-clinical level endorsements regarding the same diagnoses. Individuals not diagnosed with a disorder might tend not to endorse such a scale item. For many of the reasons immediately noted, subjects within a high risk, multi-diagnosed population, may endorse items with poor correlation to actual diagnoses. For the purpose of this study, cut-offs for item Specificity and Sensitivity were set at 70%. In the future, further research and study may show that reliable cut-offs can be set at other levels.

The efficacy of the SAFE-R items in terms of Specificity and Sensitivity was limited by the acuity of the referral subjects. Future studies may involve normal or non-referred populations. Such a study may provide another vantage point to compare and contrasts item Specificity and Sensitivity in relation to diagnoses. There have been no previous studies to determine the efficacy of the SAFE-R with other age groupings. Future research may indicate whether or not the SAFE-R has enhanced application with an adult population or with other special needs populations.

Directions for Future Research

The SAFE-R has shown an ability to provide a level of detection regarding safety and risk problems. Certain scale items showed good Sensitivity and good Specificity. Good correlations of items' Sensitivity and Specificity were found especially among the Risk and Safety Critical items. The SAFE-R may require continued research with comparison against another high risk, multi-diagnostic instrument such as the MAYS1-II. The SAFE-R may
function well in a highly acute referral adolescent population when the administrator is prepared to regard the limits of correlations with conceptual constructs (MACI), yet not with clinical diagnoses.

Further, the SAFE-R may function well in a highly acute, referral, adolescent population when the administrator is prepared to regard the particular items that showed good Sensitivity and Specificity. Increased Sensitivity of test scales and items might be determined in the future by means of pre-and post-therapy testings. Caution is therefore advised in interpretations when test items show good Sensitivity and poor Specificity according to diagnoses. Nonetheless, items showing good Sensitivity can be utilized for awareness and for further questioning related to a diagnostic true positive. Further research may need to be followed on the Effectiveness Domain to determine the realistic limits of veracity and utility.

Risk instruments such as the J-SOAP-II do not offer predictions by means of weighed linear prediction. Instead, the procedure utilized is referred to as simple unit writing. In this procedure, all scores are added for all items and are divided by the total possible score to obtain a proportion. Such a practice has the benefit of avoiding clinically derived weights. Clinical notions might tend to regard the weight of an item without the direction of empirically supported data (Prentky & Righthand, 2003). The SAFE-R scoring may in time follow such a format. Results would need to be compared continually with ongoing available psychiatric or psychological diagnoses.
REFERENCES


APPENDIX A

SAFE-R – Scoring Form

I __________________________ agree that my answers are accurate and truthful
(print name)

Signature: ________________________ Date ____________

Age: ______ Gender: Male____ Female____
Ethnicity: Hispanic__ African-American__ Caucasian__ Asian______ Other_________

Please answer the following questions as to how you would disagree or agree to the
statements.

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<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
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<tr>
<td>1</td>
<td>I’ll take more chances when happy or excited.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>I was sexually abused as a child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>I can not get along with my teachers.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>I have had dreams or nightmares.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>It is hard for me to pay attention.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>I am fascinated with fires.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>Bad memories of things just happen.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>I have hurt others or myself by my spending.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>I bounce back from problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10</td>
<td>I am good at problem solving.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11</td>
<td>I have a health problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12</td>
<td>I am involved in a gang.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13</td>
<td>I may take risks that put myself into danger.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14</td>
<td>I have helped people in my community.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15</td>
<td>There has been sexual abuse in my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16</td>
<td>I believe I have special powers.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17</td>
<td>Bad things that happened keep coming to mind.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18</td>
<td>Children have been neglected in my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19</td>
<td>I am often sad or gloomy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20</td>
<td>People say that I am the nervous type.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21</td>
<td>I might go to bed angry or wake up angry.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22</td>
<td>I’ve had problems such as fighting before age 10.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23</td>
<td>I have had thought about killing someone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24</td>
<td>I have anger problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>25</td>
<td>I worry a lot about things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>26</td>
<td>There are health problems in my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>27</td>
<td>My family has had criminal problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>28</td>
<td>Sometimes, I simply go away in my mind.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>29</td>
<td>At times, I can do with less sleep than usual.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>30</td>
<td>I have had thoughts about killing myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>31</td>
<td>I am diagnosed with ADHD.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>32</td>
<td>I have been accused of raping someone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly Agree</td>
</tr>
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</tr>
<tr>
<td>33.</td>
<td>The things I say come out odd or strange.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>34.</td>
<td>I have learning problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>35.</td>
<td>I know why I am taking this test.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>36.</td>
<td>I am being treated for major medical problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>37.</td>
<td>I have cut myself purposely.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>38.</td>
<td>My family has had some mental problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>39.</td>
<td>My family members abuse drugs or alcohol.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>40.</td>
<td>I've had legal problems because of drugs or alcohol.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>41.</td>
<td>People say that I do not sit still.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>42.</td>
<td>I remember bad things about my childhood.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>43.</td>
<td>I have shown sorrow for past wrong doings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>44.</td>
<td>I have been held back in school.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>45.</td>
<td>At times, I will really seek thrills.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>46.</td>
<td>I avoid my friends, family and my work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>47.</td>
<td>I know where I am at right now.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>48.</td>
<td>I have destroyed property when angry.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>49.</td>
<td>Children have been abandoned in my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>50.</td>
<td>I cannot remember what I did yesterday.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>51.</td>
<td>I feel that I could cry easily.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>52.</td>
<td>I will often daydream or &quot;zone out&quot;.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>53.</td>
<td>I have been called an angry person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>54.</td>
<td>I have pretty good social skills.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>55.</td>
<td>I'm getting help for mental or emotional problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>56.</td>
<td>I get ill or upset if not using drugs or alcohol.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>57.</td>
<td>I have seen things that others say are not there.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>58.</td>
<td>I have run away from school or my home.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>59.</td>
<td>People say that I have eating problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>60.</td>
<td>I sometimes get full of panicky feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>61.</td>
<td>There has been physical abuse in my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>62.</td>
<td>There are health problems in my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>63.</td>
<td>People say I have mental or emotional problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>64.</td>
<td>I will often cooperate with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>65.</td>
<td>I walked or talked later than expected.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>66.</td>
<td>I believe the future will work out well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>67.</td>
<td>I am not often or easily angered.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>68.</td>
<td>I've caused problems by not going to school.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>69.</td>
<td>I have to check things again and again.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>70.</td>
<td>Most laws should be gotten rid of.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>71.</td>
<td>I hear voices talking in my head.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>72.</td>
<td>I have forced sex upon another person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>73.</td>
<td>I am afraid something bad will happen.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>74.</td>
<td>I have good impulse control.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>75.</td>
<td>I have hurt others physically when angry.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>76.</td>
<td>I am a good and worthy person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Question</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>77. Others get upset about my drug and alcohol use.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>78. I enjoy looking at pornography.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>79. I believe people are out to get me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>80. My mind often just goes blank.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>81. I usually do not listen to doctors.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>82. I remember things from last year.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>83. I have picked out others for harm.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>84. I have increased using drugs or alcohol to get high.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>85. I might steal from others in my home.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>86. I have plans to kill myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>87. My family has substance abuse problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>88. I have sex with a child in the past.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>89. I can feel what others are feeling.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>90. Others have asked me to slow down my talk.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>91. I believe in following directions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>92. Others talk about how much I use drugs or alcohol.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>93. I do not enjoy large gatherings of people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>94. I will verbally abuse others, when I have to.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>95. Voices in my head have told me to do bad things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>96. I have good self-confidence.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>97. I’ll recall scary things when I do not want to.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>98. There were times I’ve injured myself on purpose.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>99. I often think about bad things from the past.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>100. I have picked a fistfight.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>101. People say my sexual fantasies are strange.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>102. I have plans to kill someone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>103. Life’s problems do not keep me down.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>104. People tell me that I do not make sense.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>105. I’ve lost school or job time due to drugs or alcohol.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>106. At times, I can’t get sex out of mind.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>107. I might hurt others or myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>108. People tell me I look exhausted.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>109. My thoughts may come on fast and get mixed up.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>110. I have been accused of molesting someone.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
</tbody>
</table>
XII. Diagnostic Impressions:
I. 
II. 
III. 
IV. 
V. 

XIII. Interview Rating – Need for Assistance:
☐ No need for Assistance  ☐ Moderate Need  ☐ Average Need  ☐ Strong Need for Assistance
☐ Emergency Need for Assistance
Identify specific area of need: 

Identify appropriate level/setting of treatment: 

Treatment plan and objectives:

Signature: ____________________________
Credentials: ____________________________

SAFE
(Child And Adolescent Version)
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### X: Functioning continued: RISK ISSUES HISTORY -

2. Risk to Others

- Verbal Aggression: __________________________
- Physical Aggression: ________________________
- Sexual Aggression: _________________________
- Homicidal Behavior: _________________________
- Firesetting: ________________________________
- Gang Involvement: __________________________
- Destructiveness: ____________________________
- Targeted Individuals: ________________________
- Others: _________________________________

3. Psychoactive Substance Use

<table>
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<th>SUBSTANCE</th>
<th>AGE OF ONSET</th>
<th>FREQUENCY</th>
<th>TOLERANCE DEPENDENCE</th>
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- Behavior Effects: __________________________
- Other: _________________________________

### XI: Effectiveness Factors:

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IX: Mental Status Evaluation:

Appearance: ____________________________

Behavior: ____________________________

Cooperation: ____________________________

Visual, auditory, attentional, psychomotor: ____________________________

Speech: ____________________________

Affect: ____________________________

Mood: ____________________________

Thought Content: ____________________________

Reality Testing – hallucinations, delusions: ____________________________

Orientation – Level of consciousness: ____________________________

Memory: ____________________________

Cognitive Functioning: ____________________________

Anger Management Problems: ____________________________

Suicidal Ideations, Homicidal Ideations: ____________________________

Self-Injurious Behavior: ____________________________

Insight: ____________________________

Social Knowledge – moral judgment: ____________________________

X. Functioning: RISK ISSUES HISTORY -

1. Risk to Self

Suicidal Ideations, planning, intent, furtherances, lethality: ____________________________

Self-Injurious Behavior: ____________________________

Eating Disorder: ____________________________

Thrill Seeking Activities: ____________________________

Health Issues – Compliance: ____________________________

Other: ____________________________
IV: Family Issues:

Problem Areas: (Check all that apply)
☐ Abuse  ☐ Neglect  ☐ Mental Health  ☐ Marital  ☐ Legal  ☐ Loss-Abandonment
☐ Substance Abuse  ☐ Domestic Violence  ☐ Other (please explain) ________________

V: Personal and Social History:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

VI. Development and Health History:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

VII: Sexual History: (includes sexual victimization-perpetration, paraphilias, exposure to inappropriate sexual stimuli)

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

VIII. Education: (past-present)

Level of Achievement, School Difficulties ________________________________
Type of Progress: ______________________________________________________
Social Relationships (authority-peer): ________________________________
I. Identifying Information:

Name: ____________________________

Age: _______ Date of Birth: ____________________________ Sex: □ Male □ Female

Present Address: ____________________________

II. Referral Issues:

Interviewer: ____________________________ Date of Assessment: ____________________________

Referral Source: ____________________________

Reason for Referral: ____________________________

Chief Complaint: ____________________________

Pertinent Background (includes history of violence, non-violent offending, self-harm, exposure to negative role models, maltreatment):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Relevant Documentation – Findings (Includes psychological test results, medical, legal, history of adjudications):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

III. History of Treatment

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
APPENDIX C

The following is a list of selected MACI scales and corresponding items:

1. Personality Patterns Scale 9: Borderline Tendency:

These individuals may have severe problems in social competency and frequent yet treatable psychotic episodes. They are especially vulnerable to decompensation. They may present as isolating, hostile and even confused. Such adolescents are in conflict between extreme periods of dejection and apathy interspersed with spells of anger, anxiety or euphoria. They are prone to unstable lability in their moods. Such individuals may have severe problems with self-mutilation and suicidal ideations. These individuals may have difficult maintaining a consistent sense of identity. These adolescents may experience simultaneous feelings of rage, love and guilt toward others. There are 21 items in this scale:

True items:

4. I often resent doing things others expect of me.

18. I usually act quickly, without thinking.

34. I often feel as if I'm floating around, sort of lost in life.

44. As soon as I get the impulse to do something, I act on it.

54. I sometimes get so upset that I want to hurt myself seriously.

63. I worry a great deal about being left alone.

64. I often feel sad and unloved.

78. I will sometimes do something cruel to make someone unhappy.

84. I sometimes feel very unhappy with who I am.

88. Killing myself may be the easiest way of solving my problems.

104. If I want to do something, I just do it without thinking of what might happen.
107. More and more often, I have thought of ending my life.

115. Other people my age seem more sure than I am of who they are and what they want.

117. I do what I want without worrying about its effects on others.

121. I make my life worse than it has to be.

141. I seem to make a mess of the good things that come my way.

149. When I don't get my way, I quickly lose my temper.

153. I feel lonely and empty most of the time.

154. I feel pretty aimless and don't know where I'm going.

False items:

2. I'm pretty sure I know who I am and what I want in life.

145. I'm very mature for my age and know what I want to do in life.
2. Personality Patterns Scale 8A: Oppositional:

Oppositional is also a personality characteristic. As a personality pattern, the Oppositional type will be ambivalent between being obedient and being defiant. Unable to resolve the ambivalence, they will present as erratic between times of self-deprecation and guilt for failing to meet the expectations of others. At another time, this person will be seen as expressing stubborn negativism and resistance to having submitted to the wishes and demands of others. There are 43 items in this scale:

True Items:

4. I often resent doing things others expect of me.
16. I think everyone would be better off if I were dead.
18. I usually act quickly, without thinking.
19. I guess I'm a complainer who expects the worst to happen.
22. Drinking seems to have been a problem for several members of my family.
25. So little of what I have done has been appreciated by others.
28. I sometimes scare other kids to get them to do what I want.
34. I often feel as if I'm floating around, sort of lost in life.
37. Becoming involved in other people's problems is a waste of time.
39. I don't care what other kids think of me.
41. I don't mind telling people something they won't like hearing.
49. I find it hard to feel sorry for people who are always worried about things.
54. I sometimes get so upset that I want to hurt myself seriously.
57. I can hold my beer or liquor better than most of my friends.
66. I often deserve it when others put me down.
67. People put pressure on me to do more than is fair.

70. I make friends easily.

73. I'm no different from lots of kids who steal things now and then.

78. I will sometimes do something cruel to make someone unhappy.

88. Killing myself may be the easiest way of solving my problems.

90. Drinking really seems to help me when I'm feeling down.

91. I rarely look forward to anything with much pleasure.

95. No one really cares if I live or die.

97. I sometimes get pleasure by hurting someone physically.

105. I'm terribly afraid that no matter how thin I get, I will start to gain weight if I eat.

107. More and more often, I have thought of fending my life.

110. Good things just don't last.

117. I do what I want without worrying about its effects on others.

118. Lots of things that look good today will turn out bad later.

127. There are times I wish I were someone else.

128. I don't mind pushing people around to show my power.

134. I used to try hard drugs to see what effects they'd have.

136. Many other kids get breaks I don't get.

147. My future seems hopeless.

148. My parents have had a hard time keeping me in line.

149. When I don’t get my way, I quickly lose my temper.

157. I enjoy starting fights.

158. There are times when nobody at home seems to care about me.
False items:

5. I do my very best not to hurt people’s feelings.

23. I like to follow instructions and to do what others expect of me.

45. I’ve never been called a juvenile delinquent.

96. We should respect our elders and not think we know better.

130. I try to make everything I do as perfect as possible.
3. Clinical Syndrome Scale BB: Substance Abuse Proneness:

High scorers will show a maladaptive pattern of alcohol or drug usage that has led to a significant impairment of their function or behaviors. Many will spend an excessive amount of time obtaining substances, behaving in socially unacceptable ways, and have showed a tendency to continue using drugs or alcohol regardless of obvious harmful effects upon their lives. There are 35 items in this scale:

True items:

4. I often resent doing things others expect of me.
18. I usually act quickly, without thinking.
21. Punishment never stopped me from doing whatever I wanted.
22. Drinking seems to have been a problem for several members of my family.
30. When I have a few drinks I feel more sure of myself.
40. I used to get so stoned that I did not know what I was doing.
43. Things in my life just go from bad to worse.
44. As soon as I get the impulse to act upon something, I act on it.
52. I don’t see nothing wrong with using others to get what I want.
57. I can hold my beer or liquor better than most of my friends.
61. I don’t seem to have much feeling for others.
73. I’m no different from lots of kids who steal things now and then.
74. I prefer to act first and think about it later.
75. I’ve gone through periods when I smoked pot several times a week.
76. Too many rules get in the way of my doing what I want.
78. I will sometimes do something cruel to make someone unhappy.

90. Drinking really seems to help me when I’m feeling down.

92. I’m very good at making up excuses to get out of trouble.

97. I sometimes get pleasure by hurting someone physically.

104. If I want to do something, I just do it without thinking of what may happen.

111. I’ve had a few run-ins with the law.

117. I do what I want without worrying about its effect on others.

120. There have been times when I could not get through the day without some pot.

134. I used to try hard drugs to see what effect they’d have.

139. I will make fun of someone in a group just to put them down.

141. I seem to make a mess of the good things that come my way.

148. My parents have had a hard time keeping me in line.

150. I often have fun doing certain unlawful things.

152. When we’re having a good time, my friends and I can get pretty drunk.

False items:

5. I do my very best not to hurt people’s feelings.

8. I would never use drugs, no matter what.

9. I always try to do what is proper.

15. I’ve never done anything for which I could have been arrested.

23. I like to follow instructions and do what others expect of me.

45. I’ve never been called a juvenile delinquent.
4. Clinical Syndrome Scale GG: Suicidal Tendency:

High scorers admit to having suicidal thoughts and plans. There may endorse feelings of worthlessness and purposelessness. There may be a need for professional attention and alertness by family members. There are 25 items in this scale:

14. I feel pretty shy telling people about how I was abused as a child.
16. I think everyone would be better off if I were dead.
19. I guess I’m a complainer who expects the worst to happen.
25. So little of what I have done is appreciated by others.
26. I hate the fact that I don’t have the looks or brains I wish I had.
34. I often feel as if I’m floating around, sort of lost in life.
43. Things in my life go from bad to worse.
54. I sometimes get so upset that I want to hurt myself seriously.
64. I often feel sad and unloved.
84. I sometimes feel very unhappy with who I am.
85. I don’t seem to enjoy being with people.
88. Killing myself may be the easiest way of solving my problems.
89. I sometimes get confused or upset when people are nice to me.
95. No one really cares if I live or die.
107. More and more often I have thought of ending my life.
110. Good things just don’t last.
112. I’d like to trade bodies with somebody else.
123. I have tried to commit suicide in the past.
127. There are times I wish I were someone else.

129. I’m ashamed of some terrible things adults did to me when I was young.

136. Many others kids get breaks I don’t get.

140. I don’t like being the person I’ve become.

147. My future seems hopeless.

156. I’ve given thought to how and when I might commit suicide.

False item:

55. I don’t think I was sexually molested when I was a young child.
5. Clinical Syndromes Scale CC: Delinquent Predisposition:

These individuals endorse behaviors that have or will lead to situations in which the rights of others are violated. They may be inclined to threaten others, use weapons, be deceptive and lie persistently. They will steal or show other antisocial behaviors. Such adolescents may act out impulsively without concern for eventual consequences. These adolescents may chose to ignore or show passivity when consequences are imposed. They may be oriented to finding rewards for behaviors from a select and negative peer group. There are 34 items in this scale:

True items:
10. I like the way I look.
12. Nothing much that happens seems to make me either happy or sad.
21. Punishment never stopped me from doing whatever I wanted.
28. I sometimes scare other kids to get them to do what I want.
41. I don’t mind telling people something they won’t like hearing.
68. I think I have a good body.
73. I’m no different from lots of kids who steal things now and then.
76. Too many rules get in the way of my doing what I want.
78. I will sometimes do something cruel to make someone unhappy.
92. I’m very good at making up excuses to get out of trouble.
94. Sex is enjoyable.
111. I’ve had a few run-ins with the law.
117. I do what I want without worrying about its effect on others.
148. My parents have had a hard time keeping me in line.
150. I often have fun doing certain unlawful things.

152. When we’re having a good time, my friends and I can get pretty drunk.

155. Telling lies is a pretty normal thing to do.

False items:

5. I do my very best not to hurt people’s feelings.

8. I would never use drugs, no matter what.

15. I’ve never done anything for which I could have been arrested.

26. I hate the fact that I don’t have the looks or brains I wish I had.

32. I often fear I’m going to panic or faint when I’m in a crowd.

45. I’ve never been called a juvenile delinquent.

46. I’m often my own worst enemy.

65. I’m supposed to be thin, but I feel my thighs and backside are much too big.

69. I feel left out of things socially.

71. I’m a somewhat scared and anxious person.

81. I sort of feel sad when I see someone who’s lonely.

84. I sometimes feel very unhappy with who I am.

99. I don’t think people see me as an attractive person.

106. I won’t get close to people because I’m afraid they may make fun of me.

125. Lately, things seem to depress me.

127. There are times I wish I were someone else.

140. I don’t like being the person I’ve become.
6: Personality Patterns Scale 6A: Unruly:

Individuals with an Unruly Personality Pattern will show the outlook, temperament and socially unacceptable behaviors of the DSM antisocial personality disorder. These adolescents will act to counter anticipated deceit and derogation at the hands of others. To accomplish such goals, they will be hostile and duplicitous. Additionally, such adolescents will engage in illegal behaviors to seek retribution and/or exploitation of others. Such individuals show a strong desire for autonomy and will seek revenge for their perceptions of past injustices. They justify their impulsiveness and irresponsibility in order to avoid depreciation and to seek self-generated rewards. There are 39 items in this scale:

True items:

18. I usually act quickly, without thinking.
21. Punishment never stopped me from doing whatever I wanted.
28. I sometimes scare other kids to get them to do what I want.
39. I don’t care much what other kids think of me.
41. I don’t mind telling people something they won’t like hearing.
44. As soon as I get the impulse to do something, I act on it.
52. I don’t see anything wrong with using others to get what I want.
57. I can hold my beer or liquor better than most of my friends.
58. Parents and teachers are too hard on kids who don’t follow rules.
59. I like to flirt a lot.
68. I think I have a good body.
73. I’m no different from lots of kids who steal things now and then.
76. Too many rules get in the way of my doing what I want.

77. When things get boring, I like to stir up some excitement.

92. I’m very good at making up excuses to get out of trouble.

104. If I want to do something, I just do it without thinking of what might happen.

111. I’ve had a few run-ins with the law.

117. I do what I want without worrying about its effects on others.

120. There have been times when I could not get through the day without some pot.

135. I can charm people into giving me almost anything I want.

143. I am glad that feelings about sex have become a part of my life now.

148. My parents have had a hard time keeping me in line.

149. When I don’t get my way, I quickly lose my temper.

150. I often have fun doing certain unlawful things.

152. When we’re having a good time, my friends and I can get pretty drunk.

155. Telling lies is a pretty normal thing to do.

False items:

5. I do my very best not to hurt people’s feelings.

8. I would never use drugs, no matter what.

9. I always try to do what is proper.

15. I’ve never done anything for which I could have been arrested.

23. I like to follow instructions and do what others expect of me.

45. I’ve never been called a juvenile delinquent.

51. I don’t think I have as much interest in sex as others my age.

84. I sometimes feel very unhappy with who I am.
93. It is very important that children learn to obey their elders.

96. We should obey our elders and not think we know better.

99. I don’t think people see me as an attractive person.

116. Thinking about sex confuses me much of the time.

132. I often get frightened when I think of the things I have to do.
7: Clinical Syndrome FF: Depressive Affect:

Such adolescents may remain involved in everyday life but will show problems with discouragement, guilt, a lack of initiative, apathy, and low self-esteem. They show a sense of futility and self-depreciation. Times of dejection will be marked by tearfulness, feelings of worthlessness, suicidal ideations and a pessimistic outlook. Somatic process may include increased/decreased appetite, fatigue, weight loss or gain, insomnia or early rising. These individuals may show a loss of interest in pleasurable activities as well as a decreased effectiveness in performing ordinary and routine tasks. There could be problems of concentration. Such adolescents may have a dread of the future. They may show motor retardation or possibly agitation and pacing. Such adolescents may be excessively shy and introverted, sluggish and show a complaining and whining tone. There are 33 items in this scale:

True items:

1. I would much rather follow someone than be the leader.
15. I've never done anything for which I could have been arrested.
16. I think everyone would be better off if I were dead.
26. I hate the fact that I don't have the looks or brains I wish I had.
31. Most people are better looking than I am.
42. I see myself as falling far short of what I'd like to be.
43. Things in life just go from bad to worse.
45. I've never been called a juvenile delinquent.
63. I worry a great deal about being left alone.
64. I often feel sad and unloved.
69. I feel left out of things socially.
71. I’m a somewhat scared and anxious person.

80. I often feel I’m not worthy of the nice things in my life.

84. I sometimes feel very unhappy with who I am.

95. Nobody really cares if I live or die.

98. I often feel lousy after something good has happened to me.

99. I don’t think people see me as an attractive person.

106. I won’t get close to people because I’m afraid they may make fun of me.

107. More and more often I have thought of ending my life.

112. I’d like to trade bodies with someone else.

118. Lots of things that look good today will turn out bad later.

125. Lately, little things seem to depress me.

127. There are times I were someone else.

133. Lately, I feel jumpy and nervous almost all of the time.

141. I seem to make a mess of the good things that come my way.

142. Although I want to have friends, I have almost none.

147. My future seems hopeless.

153. I feel lonely and empty most of the time.

False items:

10. I like the way I look.

39. I don’t care much about what other kids think of me.

77. When things get boring, I like to stir up some excitement.

111. I’ve had a few run-ins with the law.

131. I am pleased with the way my body has developed.
8: Personality Patterns Scale 6B: Forceful:

These adolescents will operate in a system in which the normal tendencies toward pain and pleasure are reversed. Painful interactions can become the preferred mode on interpersonal relationships. Relationships may tend to exhibit stress, fear or cruelty. Such individuals will assume an active role in controlling, dominating and intimidating others. Actions that humiliate, demean, and abuse others may be experienced as pleasurable. There are 22 items in this scale:

True Items:

18. I usually act quickly, without thinking.
21. Punishment never stopped me from doing whatever I wanted.
28. I sometimes scare other kids to get them to do what I want.
41. I don’t mind telling people something they won’t like hearing.
52. I don’t see anything wrong with using others to get what I want.
60. To see someone suffering doesn’t bother me.
74. I prefer to act first and think about it later.
78. I will sometimes do something cruel to make someone unhappy.
97. I sometimes get pleasure by hurting someone physically.
104. If I want to do something, I just do it without thinking of what might happen.
117. I do what I want without worrying about its effects on others.
128. I don’t mind pushing people around to show my power.
139. I will make fun of someone in a group just to put them down.
148. My parents have had a hard time keeping me in line.
149. When I don’t get my way, I quickly lose my temper.
152. When we’re having a good time, my friends and I can get pretty drunk.
157. I enjoy starting fights.

False items:

5. I do my very best not to hurt people’s feelings.
9. I always do what is proper.
50. It is good to have a routine for doing most things.
71. I’m a somewhat scared and anxious person.
81. I sort of fell sad when I see someone who’s lonely.
9: Clinical Syndrome Scale EE: Anxious Feelings:

Such adolescents will tend to be tense, indecisive, restless and complain of a host of physical discomforts. They may have a general and socially anxious presentation. Such individuals are ready to react and can be easily startled. There may be persistent problems with fatigue or weakness. Somewhat hypochondriacal, any physical discomfort can become a described as a serious ailment. Somatic complaints are typically announced to gain attention.

There are 42 items in this scale:

True items:

8. I would never use drugs, no matter what.

15. I’ve never done anything for which I could have been arrested.

17. Sometimes, when I’m away from home, I begin to feel tense and panicky.

23. I like to follow instructions and do what others expect of me.

32. I often fear that I’m going to panic or faint when I’m in a crowd.

45. I’ve never been called a juvenile delinquent.

63. I worry a great deal about being left alone.

71. I’m a somewhat scared and anxious person.

79. I spend a lot of time worrying about my future.

99. I don’t think people see me as an attractive person.

109. I get very frightened when I think of being all alone in the world.

132. I often get frightened when I think of the things I have to do.

133. Lately, I feel jumpy and nervous almost all the time.

False items:

3. I don’t need to have close friendships like other kids do.
18. I usually act quickly, without thinking.

21. Punishment never stopped me from doing whatever I wanted.

39. I don’t care much what other kids think of me.

40. I used to get so stoned that I did not know what I was doing.

41. I don’t mind telling people something they won’t like hearing.

44. As soon as I get the impulse to act on something, I act on it.

49. I find it hard to feel sorry for people who are always worried about things.

57. I can hold my beer or liquor better than most of my friends.

58. Parents and teachers are too hard on kids who don’t follow rules.

68. I think I have a good body.

73. I’m no different from lots of kids who steal things now and then.

74. I prefer to act first and think about it later.

75. I’ve gone through periods when I smoked pot several times a week.

76. Too many rules get in the way of my doing what I want.

78. I will sometimes do something cruel to make someone unhappy.

90. Drinking really seems to help me when I’m feeling down.

92. I’m very good at making up excuses to get out of trouble.

94. Sex is enjoyable.

97. I sometimes get pleasure by hurting someone physically.

104. If I want to do something, I just do it without thinking of what might happen.

111. I’ve had a few run-ins with the law.

117. I do what I want without worrying about its effect on others.

120. There have been times when I could not get through the day without some pot.
143. I am glad that feelings about sex have become a part of my life now.

148. My parents have had a hard time keeping me in line.

150. I often have fun doing certain unlawful things.

152. When we’re having a good time, my friends and I can get pretty drunk.

157. I enjoy starting fights.
10. Personality Scale 8B: Self-Demeaning:

Individual scoring high on this scale show themselves as being their own worst enemies. They will often act in self-defeating fashions and will seem at times to be content with suffering. Such adolescents will appear to undermine the efforts of others to help them. They may refuse themselves pleasure and may sabotage even their own efforts to achieve success.

There are 44 items in this scale:

True items:

18. I usually act quickly, without thinking.
19. I guess I’m a complainer who expects the worst to happen.
20. It is not unusual to feel lonely and unwanted.
25. So little of what I have done has been appreciated by others.
26. I hate the fact that I don’t have the looks or brains I wish I had.
33. I sometimes force myself to vomit after eating a lot.
34. I often feel as if I’m floating around, sort of lost in life.
35. Most other teenagers don’t seem to like me.
46. I’m often my own worst enemy.
54. I sometimes get so upset that I want to hurt myself seriously.
64. I often feel sad and unloved.
66. I often deserve it when others put me down.
71. I’m a somewhat scared and anxious person.
74. I prefer to act first and think about it later.
80. I often feel I’m not worthy of the nice things in my life.
84. I sometimes feel very unhappy with who I am.
88. Killing myself may be the easiest way of solving my problems.
89. I sometimes get confused or upset when people are nice to me.
99. I don’t think people see me as an attractive person.
106. I won’t get close to people because I’m afraid they may make fun of me.
107. More and more often I have thought of ending my life.
108. I sometimes put myself down just to make someone else feel better.
110. Good things just don’t last.
112. I’d like to trade bodies with someone else.
118. Lots of things that look good today will turn out bad later.
121. I make my life worse than it has to be.
127. There are times I wish I were someone else.
132. I often get frightened when I think of the things I have to do.
133. Lately, I feel jumpy and nervous almost all the time.
136. Many other kids get breaks I don’t get.
137. People did things to me sexually when I was too young to understand.
140. I don’t like being the person I’ve become.
141. I seem to make a mess of the good things that come my way.
149. When I don’t get my way, I quickly lose my temper.
151. I guess I depend too much on others to be helpful to me.
153. I feel lonely and empty most of the time.
156. I’ve given thought to how and when I might commit suicide.
158. There are times when nobody at home seems to care about me.
160. I probably deserve many of the problems I have.
False items:

2. I’m pretty sure I know who I am and what I want in life.

6. I can depend on my parents to be understanding of me.

10. I like the way I look.

27. I like it at home.

68. I think I have a good body.
SAFE-R Domains and Scales

Risk and Safety Critical Items Domain:
2. I was sexually abused as a child.
6. I am fascinated with fires.
15. There has been sexual abuse in my family.
23. I have had thoughts about killing someone.
30. I have had thoughts about killing myself.
32. I have been accused of raping someone.
72. I have forced sex upon another person.
86. I have plans to kill myself.
88. I have had sex with a child in the past.
102. I have plans to kill someone.
110. I have been accused of molesting someone.

Clinical Scales:

Anxiety/ADHD:
5. It is hard for me to pay attention.
20. People say that I am the nervous type.
25. I worry a lot about things.
28. Sometimes I simply go away in my mind.
31. I am diagnosed with ADHD.
41. People say that I do not sit still.
60. I sometimes get full of panicky feelings.
69. I have to check things again and again.
73. I am afraid something bad will happen.

Borderline Personality traits:
13. I might take risks that put myself into danger.
37. I have cut myself purposely.
58. I have run away from school or my home.
59. People say that I have eating problems.
73. I am afraid something bad will happen.
75. I have hurt others physically when angry.
93. I do not enjoy large gatherings of people.
98. There were times I’ve injured myself on purpose.
101. People say my sexual fantasies are strange.
106. At times, I can’t get sex out of my mind.
107. I might hurt others or myself.
Conduct Problems:

3. I can not get along with my teachers.
6. I am fascinated with fires.
12. I am involved in a gang.
22. I've had problems such as fighting before age 10.
23. I have thoughts about killing someone.
32. I have been accused of raping someone.
48. I have destroyed property when angry.
58. I have run away from school or my home.
68. I've caused problems by not going to school.
72. I have forced sex upon another person.
75. I have hurt others physically when angry.
78. I enjoy looking at pornography.
83. I have picked out others for harm.
85. I might steal from others in my home.
88. I have had sex with a child in the past.
94. I will verbally abuse others, when I have to.
100. I have picked a fistfight.
102. I have plans to kill someone.
110. I have been accused of molesting someone.

Depression:

19. I am often sad or gloomy.
23. I have thoughts about killing someone.
24. I have anger problems.
25. I worry a lot about things.
30. I have had thoughts about killing myself.
46. I avoid my friends, family and my work.
51. I feel that I could cry easily.
86. I have plans to kill myself.
93. I do not enjoy large gatherings of people.
108. People tell me I look exhausted.

Mania:

1. I'll take more chances when happy or excited.
8. I have hurt others or myself by my spending.
13. I might take risks that put myself into danger.
21. I might go to bed angry or wake up angry.
29. At times, I can do with less sleep than usual.
45. At times, I will really seek thrills.
90. Others have asked me to slow down my talk.
106. At times, I can't get sex out of my mind.
109. My thoughts may come on fast and get mixed up.
Posttraumatic Stress:

4. I have bad dreams or nightmares.
7. Bad memories of things just happen.
17. Bad things that happened keep coming to mind.
28. Sometimes, I simply go away in my mind.
42. I remember bad things about my childhood.
52. I will often daydream or “zone out”.
60. I sometimes get full of panicky feelings.
73. I am afraid something bad will happen.
80. My mind often just goes blank.
97. I’ll recall scary things when I do not want to.
99. I often think about bad things from the past.

Psychosis:

16. I believe I have special powers.
33. The things I say come out odd or strange.
55. I’m getting help for mental or emotional problems.
57. I have seen things that others say are not there.
63. People say I have mental or emotional problems.
71. I hear voices talking in my head.
79. I believe people are out to get me.
95. Voices in my head have told me to do bad things.
104. People tell me that I do not make sense.

Substance Abuse:

39. My family members may abuse drugs or alcohol.
40. I’ve had legal problems because of drugs/alcohol.
56. I get ill or upset if not using drugs or alcohol.
77. Others get upset about my drug and alcohol use.
84. I have increased using drugs or alcohol to get high.
87. My family has substance abuse problems.
92. Others talk about how much I use drugs or alcohol.
105. I’ve lost school or job time due to drugs or alcohol.
Effectiveness Domain:

9. I bounce back from problems.
10. I am good at problems solving.
14. I have helped people in my community.
43. I have shown sorrow for past wrong doings.
54. I have pretty good social skills.
64. I will often cooperate with others.
66. I believe the future will work out well.
74. I have good impulse control.
76. I am a good and worthy person.
89. I can feel what others are feeling.
91. I believe in following directions.
96. I have good self-confidence.
Relevant MACI Noteworthy Responses

Acute Distress:
95. No one really cares if I live or die.

Dangerous Ideation:
16. I think everyone would be better off if I were dead.
54. I sometimes get so upset that I want to hurt myself seriously.
88. Killing myself may be the easiest way of solving my problems.
107. More and more often I have thought of ending my life.
123. I have tried to commit suicide in the past.
156. I’ve given thought to how and when I might commit suicide.

Childhood Abuse:
14. I feel pretty shy telling people about how I was abused as a child.
72. I hate to think about some of the ways I was abused as a child.
129. I’m ashamed of some terrible things adults did to me when I was young.
137. People did things to me sexually when I was too young to understand.