

# Youth Risk and Resilience Inventory

## Administrator's Guide



Robert P. Brady, Ed.D.

## Introduction

Today's youth continue to find themselves in situations of stress, conflict, and abuse. Identified risk factors include exposure to schoolplace violence (Zinna, 1999), family violence (Adamson & Thompson, 1998), unsafe neighborhoods (Schwartz & Gorman, 2003), and the violence observed in the news and portrayed in the media (Bushman & Anderson, 2001; Cheng et al, 2004). Other factors recognized as risks are associated with peer rejection, bullying, intimidation, teasing, fearfulness, depressive feelings, and violent and abusive experiences (NIMH, 2000). In a study of 40,000 children over a five-year period, Lundy and Grossman (2005) found that 43% of the older children and beginning adolescents were often afraid, almost 60% experienced mood swings, and more than one half reported social problems. It has been estimated that 10 to 15% of individuals between 9 and 17 years of age have some symptoms of depression (Guida, 2001). The *Youth Risk and Resilience Inventory (YRRI)* was developed to screen for risk factors and to identify individual assets or resilience factors. Identifying, understanding, and promoting resilience factors and personal strengths are encouraging avenues for clinical application and further research (APA, 2004; Kersting, 2003; Beardslee, 1989; Seligman & Csikszentmihalyi, 2000).

### **Purpose**

The *YRRI* was designed for use with youth to screen for the presence of risk factors such as teasing, intimidation, bullying, physical abuse, violence, and victimization; to identify signs of emotional stress; and to assess their impact on the individual. The *YRRI* addresses *external* risk factors that may be present in school, home, and community situations. *Interpersonal* risk factors associated with the value and quality of relationships are also addressed. Lastly, the *YRRI* helps identify *intrapersonal* risk factors that can contribute to subjective distress and dysphoria. The *YRRI* also surveys resilience factors, sometimes

called protective factors or personal assets. Resilience factors are the strengths that contribute to healthy coping and endurance. They include self-directedness; proactiveness; goal setting; planfulness; persistence; affirming families; and supportive relationships with peers, adults, and significant others.

### **Readability and Human Interest Level**

By applying the Flesch (1949) formulae and scales, the *YRRI* readability, or "reading ease," was determined to be at the fourth grade level, and "human interest" exceeded the "very interesting" level.



## Development and Psychometric Properties

### Content Validity

Content validation results from the specification and the logical analysis of a given content domain (Lemke & Wiersma, 1976). Content validity involves both Item validity and Sampling validity (Gay & Airasian, 2000). "Item validity is concerned with whether the test items are relevant to the measurement of the intended content area. Sampling validity is concerned with how well the test samples the total content area being tested" (Gay & Airasian, 2000). The content of Risk Factor items was developed from findings in the social, behavioral, and medical science literature (Adamson & Thompson, 1998; Ballif-Spanvill, Clayton & Hendrix, 2003; Barnett & Fiorentino, 2000; Becker & McCloskey, 2002; Bennett & Fineran, 1998; Bushman & Anderson, 2001; Clingempel & Henggeler, 2003; Frost & Pakiz, 1990; Hasan & Power, 2004; Herrenkohl, Herrenkohl & Egolf, 2003; Johnson, 1995; Kelley, 1994; Kilpatrick & Williams, 1997; MacEwen, 1994; McCloskey, Figueredo & Koss, 1995; Newberger & DeVos, 1988; O'Keefe, 1994; Pakiz, Reinherz & Giaconia, 1997; Piotrkowski & Brannen, 2002; Porter, 1980; Rubenstein, Halton, Kasten, Rubin & Stechler, 1998; Silvern, Karyl, Waede, Hodges, Starek, Heidt & Min, 1995; Spaccarelli, Sandler & Rousa, 1994; Wallerstein, 1984; Werner, 1989). Thirty-six Risk Factor items were included in the YRRI. The development of Resilience Factor items was based on the research and discussions of resilience factors, protective factors, and personal strengths and assets reported in the behavioral and social science literature (APA, 2002; Aspy, Oman, Vesely, McLeroy, Rodine & Marshall, 2004; Beardslee, 1989; Bowen & Flora, 2002; Kersting, 2003; Knowlton, 2001; Levant, 2003; Liem, James, O'Toole & Boudewyn, 1997; Masten, 2001; Neher & Short, 1998; Seligman & Csikszentmihalyi, 2000). There are 18 Resilience Factor items in the YRRI. Sampling validity was accomplished by surveying school, home, and community situations. Symptoms of depression, anxiety spectrum disorders, and emotional states, as well as dimensions of both intra- and inter-personal relationships, were also addressed in meeting sampling criteria.

### Concurrent-Criterion Validity

*Concurrent validity* is the ability of a test to produce results in keeping with those of some criterion within the same time frame (Sellitz et al, 1976). In the case of the YRRI, an initial concurrent validity study was conducted in September and October of 2004. It was hypothesized that children and adolescents identified by their teachers, case workers, or counselors as at-risk would have significantly higher Risk Factor scores on the YRRI than the participating children and adolescents identified as non at-risk. Seventy-six individuals,

ranging in age from 10 to 19 years, participated in this initial study. The difference between the scores of the two groups was assessed using a *t* test. Results indicated that the individuals identified as at-risk had significantly higher Risk Factor scores than the non at-risk group ( $t = 2.08$ ,  $df = 74$ ,  $p = .04$ ). The hypothesis that the at-risk participants would obtain higher Risk Factor scores than the non at-risk group was accepted. The statistical results suggested that 96% of the variability in Risk Factor scores could be accounted for by the risk status of study participants, and 4% of the variability could be attributed to chance. These findings provided some early support for the YRRI's use as a practical screening device for risk factors.

*Resilience Factors* were also addressed in the September-October 2004 study. It was hypothesized that the non at-risk participants would obtain significantly higher Resilience Factor scores than those participants identified as at-risk by their teachers, caseworkers, or counselors. The *t* test results, ( $t = 3.21$ ,  $df = 74$ ,  $p = .002$ ) supported acceptance of the hypothesis. In other words, 99.8% of the variability in Resilience Factor scores could be attributed to level of resilience and only .2% accounted for by chance.

In general, these early results suggested higher Risk Factor scores and lower Resilience Factor scores for the at-risk group in the study. On the other hand, the non at-risk group had higher Resilience Factor scores and lower Risk Factor scores. A follow-up correlational study (Pearson  $r = -.45$ ,  $p < .001$ ) affirmed an inverse relationship between these constructs.

Replications of the Risk Factor study were conducted in November 2004 ( $t = 4.23$ ,  $df = 91$ ,  $p < .0001$ ), in January 2005 ( $t = 4.82$ ,  $df = 100$ ,  $p = .0001$ ), and in March 2005 ( $t = 4.77$ ,  $df = 111$ ,  $p = .0001$ ). These concurrent validity studies provided additional confirming results. In these three more-recent studies, when the differences in Risk Factor scores of a sample of children and adolescents from non at-risk situations were tested against those children and adolescents independently identified as at-risk, the at-risk sample obtained significantly higher Risk Factor scores.

At-risk children and adolescents from a variety of settings were included in the January 2005 study. *Table 1* presents a break down of the sample groups by setting and/or situation. The *t* test findings suggest significantly higher Risk Factor scores for the at-risk participants identified by their teachers, those being seen by the school counselors, and those beginning substance abuse treatment. Risk Factor scores were higher for the sample of children and adolescents in a domestic violence shelter completing the seventh week of an eight-week treatment program, although the difference did not reach the .05 level of significance. These findings suggest that the YRRI has strong potential for use in screening for at-risk children and adolescents.

**Table 1: Differences in Risk Factor scores of at-risk participants compared to non at-risk participants**

At-risk participants	<i>t</i>	degrees of freedom <i>df</i>	probability <i>p</i>
At-risk identified by classroom teacher	2.74	75	<i>p</i> = .008*
At-risk seen by school counselor	4.45	78	<i>p</i> < .0001*
At-risk completing domestic violence shelter program	1.74	77	<i>p</i> = .08
At-risk beginning substance abuse treatment	1.94	80	<i>p</i> = .05*

\*Statistically significant

**Table 2: Differences in Resilience Factor scores of at-risk participants compared to non at-risk participants**

At-risk participants	<i>t</i>	degrees of freedom <i>df</i>	probability <i>p</i>
At-risk identified by classroom teacher	3.24	74	<i>p</i> = .002*
At-risk seen by school counselor	0.43	78	<i>p</i> = .66
At-risk completing domestic violence shelter program	1.81	77	<i>p</i> = .07
At-risk beginning substance abuse treatment	2.10	80	<i>p</i> = .039*

\*Statistically significant

The scores for *Depression-related items* (numbers 25, 26, 31, 32, 34, 40) for the at-risk sample were tested against the scores of the Depression-related items of the non at-risk sample. The at-risk sample had significantly higher scores on the Depression-related items (*t* = 2.13, *df* = 100, *p* < .0001). In a similar way, the differences between scores on *Anxiety Spectrum items* (numbers 8, 23, 43, 46, 50) were tested for the at-risk and non at-risk samples. Results showed that the at-risk sample scored significantly higher on the Anxiety-related items (*t* = 4.02, *df* = 100, *p* < .0001).

When the differences in *Resilience Factor scores* of a sample of children and adolescents from non at-risk situations were tested against the Resilience Factor scores of youth who were beginning court-ordered substance abuse treatment, the former obtained significantly higher Resilience Factor scores (*t* = 2.10, *df* = 80, *p* = .039). On the other hand, when the Resilience Factor scores of the at-risk children being seen by the school counselor were tested against the non at-risk sample, no significant differences in Resilience scores were found (*t* = .43, *df* = 78, *p* = .66). In addition, the Resilience Factor scores for those at-risk youth completing an intervention program at a domestic violence shelter were higher than the non at-risk participants in the study (*t* = 1.81, *df* = 77, *p* = .07). Results showed that for the samples of at-risk youth who were either seen by the school counselor, or were in treatment at a domestic violence shelter, Resilience Factor scores were not significantly different from the non at-risk sample. These preliminary findings may suggest that for these samples of at-risk youth, school counselor intervention and domestic violence shelter programs contributed to fostering resilience, personal assets, and strengths. These results particularly speak to the efficacy of both in-school and domestic violence shelter programs for at-risk students. These findings also speak to the YRRI's potential use for At-Risk Program evaluation. Resilience Factor data are summarized in *Table 2*.

### Reliability

*Reliability* is the degree to which a test can consistently measure what it is supposed to measure (Gay & Airasian, 2000). Reliability studies were conducted in September-October 2004 (*n* = 76) using the split-half method; see *Table 3*. Spearman-Brown correlations computed for each scale were as follows: Risk scale (*r* = .827, *p* < .001) and Resilience scale (*r* = .802, *p* < .001). Further internal item consistency was assessed using Cronbach's alpha (mean  $\alpha$  = .72), with a composite Spearman-Brown coefficient of .837 for the YRRI. These findings meet acceptable criteria for test reliability and internal consistency (Hood & Johnson, 2002).

**Table 3: Split-half reliability and internal consistency**

Measure	Spearman-Brown <i>r</i>	Probability <i>p</i>
Youth Risk and Resilience Inventory (YRRI)	.837*	<i>p</i> < .001**
Risk Factor scale	.827	<i>p</i> < .001**
Resilience Factor scale	.802	<i>p</i> < .001**

\*Based on Cronbach mean  $\alpha$  = .72 \*\*statistically significant

### Standard Error of Measurement

The Standard Error of Measurement (SEM) is a measure of the variability of any given score based on the reliability of each test scale. The SEM for both the Risk Factor scale and the Resilience Factor scale are presented in *Table 4*.

**Table 4: Standard Error of Measurement (SEM)**

scale	SEm raw score	mean raw score	sd raw score	SEm T score	mean T score	sd T score
Risk Factors	7.09	70.45	17.09	4.15	50	10
Resilience Factors	6.81	68.13	11.26	4.45	50	10

## Preliminary Norms

The scores of a sample ( $n = 76$ ) of youth ranging in age from 10 to 19 years ( $mn = 14.33$ ,  $sd = 2.71$ ) were used to develop preliminary norms for the Risk and Resilience scales of the *YRRI*. The sample was drawn from a population of youth from urban, rural, and suburban settings who had been given the *YRRI* by a teacher, caseworker, counselor, and/or mental health worker. Scores were then normalized and standard scores (in this case, T scores) were developed.

## Administration

### Directions

Youth (ages 10–17) are asked to read each statement and then indicate how often the statement would describe them or their situations by circling 1 for *Never*, 2 for *Seldom*, 3 for *Sometimes*, 4 for *Often*, and 5 for *Very Often*. They are asked to read and respond to each item.

Items are presented in five groupings to facilitate self-scoring. Youth who are self-scoring may be asked to sum each of the five groupings and then transfer their subtotals to the summation box in Step 2. After obtaining their total yellow and green raw scores, youth may then see where these scores fall on the color-coded Risk and Strength (Resilience) bar histograms. It should be noted that the histograms were designed for general comparison purposes only. An additional self-reporting opportunity is provided for individuals who may elect, or be asked, to complete the My Journal section in Step 3 of the *YRRI*.

### Scoring

The sum of the responses on the 36 Risk Factor items is the total Risk Factor raw score. The responses on 18 Resilience Factor items are summed in a similar manner to obtain the Resilience Factor total raw score. Total raw scores can be converted to T scores.

**Table 5: Interpretation of Risk Factor scores**

	raw score*	T score**	
extreme risk	120	80	+3 <i>std dev</i>
high risk	105	70	+2 <i>std dev</i>
at-risk	87	60	+1 <i>std dev</i>
average risk	70	50	<i>mean</i>
low risk	60	40	-1 <i>std dev</i>
no risk	36	30	-2 <i>std dev</i>

\* +/-7.09 \*\* +/-4.15

## Interpretation

Using a *normative* approach, individual total Risk Factor raw scores can be compared to the norm group raw score totals in *Table 5* in order to estimate an at-risk level. For example, a Risk Factor raw score of 79 would fall into the average to high-average range for risk factors, and a Risk Factor raw score of 97 would fall into the at-risk to high-risk range. In a similar way, by using *Table 6*, a total Resilience Factor raw score can be used to estimate the level of Resilience Factors present. Cut off points for both Risk Factor raw scores and Resilience Factor raw scores were determined using the one standard deviation method for clinical significances (Wise, 2004). Generally speaking, Resilience raw scores between 58 and 78 fall within the low-average to high-average range. Regardless of the at-risk level obtained, it is recommended that a *critical item analysis* be undertaken.

**Table 6: Interpretation of Resilience Factor scores**

resilience	raw score*	T score**	
very high	90	70	+2 <i>std dev</i>
high	79	60	+1 <i>std dev</i>
average	68	50	<i>mean</i>
low	57	40	-1 <i>std dev</i>
very low	46	30	-2 <i>std dev</i>

\* +/-6.81 \*\* +/-4.45

*Critical items.* Using an *ipsative* or individualized approach, the next step in interpretation is to look at the response patterns of the following critical items:

Item 20: I have been forced to do things against my will.

Item 22: I feel I have been violated.

Item 28: I'm abused by someone close to me.

Item 41: Awful things have happened to me.

Item 52: I have been sexually abused.

Did the youth endorse any of these *critical items*? If so, explore the response further with the youth. For example, item 28 is "I'm abused by someone close to me." You might ask about the nature of the abuse and the frequency and duration of the abuse. Another example is item 20: "I have been made to do things against my will." Was the youth a victim of abuse; compromised on a date; forced to participate in hazing or bullying; or involved in an aberrant act because of fear of reprisal or additional bodily harm? Or was the youth merely told to go to his or her room to do homework instead of watching TV, or do some extra push-ups by an athletic coach?

**Depression-related items.** Next, check the response pattern for the Depression-related items for symptoms of depression: item 25...problems with sleep, item 26...sad and blue, item 31...bored, item 32...stay to myself, item 34...trouble concentrating, and item 40...things are stacked against me. See *Table 7* for total Depression-related items raw-score and cut-off-point comparisons.

**Anxiety Spectrum items.** The response pattern for items that survey emotional states such as worry, fear, rejection, and distress can also be explored. They include items 8 and 23...afraid, item 46...suffering inside, item 43...nightmares, and item 50...worry. Compare total raw score and cut off for these items in *Table 7*.

**Table 7: Mean scores and cut-off scores for Depression-related and Anxiety Spectrum items.**

<i>n</i> = 102	at-risk		cut-off point*	non at-risk	
	<i>mean</i>	<i>std dev</i>	<i>score</i>	<i>mean</i>	<i>std dev</i>
Depression-related	17.9	3.86	16.95	15.81	4.75
Anxiety Spectrum	11.23	3.05	9.73	8.45	3.23

\* The Jacobson & Truax (1991) formula for determining the cut-off points of adjacent samples was used.

**Victimization items.** Review the response pattern to the following items to determine a severity level for individuals subjected to taunts, harassment, and bullying: item 1...teased, item 2...pushed around, item 4...made fun of, items 7 and 16...threatened, and item 10...picked on.

**Situation items.** Items specific to school, home, and community environments might also be reviewed. *School situation items* are items 1, 7, 11, 13, and 14. *Home situation items* include items 5, 35, and 47. Some *Community situation items* are items 16 and 17.

**Resilience items.** There are 18 Resilience items coded in green. Those items endorsed at the 4 for "Often" or 5 for "Very Often" level could be considered personal assets and strengths. Those items endorsed as 1 for "Never," 2 for "Seldom," or 3 for "Sometimes" are an indication that these protective factors may not yet be fully developed. Intervention strategies can then be initiated to address these needs.

**False negatives.** YRRI scores are based on honest and forthright item responses. Minimizing and denial can contribute to false negative scores. Individuals who want to make a good impression or who are responding in what they

perceive as a socially acceptable manner may produce false negative scores. Fears of discovery or exposure as well as fear of further intimidation or reprisal could also contribute to false negative scores.

**False positives.** Increased or exaggerated response patterns may be associated with or contribute to false positive scores. Such scores could reflect subjective distress or represent a cry for help.

Both false positives and false negatives could be clinically significant if other at-risk indicators and signs are present, such as a significant drop in school grades (Schwartz & Gorman, 2003), uncooperativeness, increased irritability, acting out, self-isolation (Zinna, 1999), reduced or lowered motivation and concentration, decrease in personal hygiene (Guida, 2001), and regressive behaviors (Lundy & Grossman, 2005) that are sometime manifested in younger children and may include increased clinging, enuresis, and baby talk. On a cautionary note, while over interpretation should be avoided, the tendency to under interpret or minimize seems always a concern (Fox & Hardling, 2005). Burns et al (2004) pointed out that of the 1.7 million children and adolescents investigated for maltreatment, just over 814,000 had a substantial need for mental health services but only 192,000 actually received them. Because the YRRI is meant to be a screening device, it should not be used as the sole measure to determine risk or resilience. If abuse is suspected, additional clinical procedures may be indicated including a clinical/counseling interview and additional collateral information such as developmental history, school history, family and social history, and treatment history, if any.

## Acknowledgments

For their assistance with the research and validation process, collecting data for reliability studies, and field testing the YRRI, warm appreciation is extended to Marney Alley, B.A.; Linda Brewster, Ph.D.; John Brooks, B.A.; James Calkin, B.S.; Karen Chaney, B.S.; Jennifer Ferry, M.A.; Christopher French, B.A.; Kristyn Hale, B.A.; Matthew Hammond, B.A.; Tim Husband, Ph.D.; Heather Holsopple, B.A.; Jacquelyn Marry, B.A.; Michelle Owen, M.A.; Barbara Render, B.A.; Melissa Sisson, M.L.S.; Matt Stanfield, M.A.; Frank Thelen, B.S.; Wendy Turpening, B.A.; Marj Tursek, M.A.; Lynn Venable, B.S.; and Sarah Weber, B.S. Special thanks go to Amy Good, B.S.; Keila Kilgore, M.A.; and Jane Myers, M.A. Very special thanks go to Sue Pines and Jill Mazurczyk from JIST Publishing for their superb editorial contributions.

## References

- Adamson, J.L., & Thompson, R.A. (1998). Coping with interparental verbal conflict by children exposed to spouse abuse and children from nonviolent homes. *Journal of Family Violence, 13*, 213–232.
- American Psychological Association. (2004). *The Road to Resilience*. [brochure]. Comas-Diaz, L., Luthar, S.S., Maddi, S.R., O'Neill, K.H., Saakvine, K.W., & Tedeschi, R.G.: Contributors.
- Aspy, B., Oman, R.F., Vesely, S.K., McLeroy, K., Rodine, S., & Marshall, L. (2004). Adolescent violence: The protective effects of youth assets. *Journal of Counseling & Development, 82*, 268–275.
- Ballif-Spanvill, B., Clayton, C.J., & Hendrix, S.B. (2003). Gender, types of conflict, and individual differences in the use of violent and peaceful strategies among children who have and have not witnessed interparental violence. *American Journal of Orthopsychiatry, 73*, 141–153.
- Barnett, J.E., & Fiorentino, N. (2000). The mandatory reporting of abuse and neglect of minors: Ethical and legal issues and dilemmas. *Psychotherapy Bulletin, 35*, 27–31.
- Beardslee, W.R. (1989). The role of self-understanding in resilient individuals: The development of a perspective. *American Journal of Orthopsychiatry, 59*, 266–278.
- Becker, K.B., & McCloskey, L.A. (2002). Attention and conduct problems in children exposed to family violence. *American Journal of Orthopsychiatry, 72*, 83–91.
- Bennett, L., & Fineran, S. (1998). Sexual and severe physical violence among high school students: Power beliefs, gender, and relationships. *American Journal of Orthopsychiatry, 68*, 645–652.
- Bowen, N.K., & Flora, D.B. (2002). When is it appropriate to focus on protection in interventions for adolescents? *American Journal of Orthopsychiatry, 72*, 526–538.
- Burns, B.J., Phillips, S.D., Wagner, H.R., Barth, R.P., Kolko, D.J., Campbell, Y., & Landsverk, J. (2004). Mental health needs and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*, 960–970.
- Bushman, B.J., & Anderson, C.A. (2001). Media violence and the American public: Scientific facts versus media misinformation. *American Psychologist, 56*, 477–489.
- Cheng, T.L., Brenner, R.A., Wright, J.L., Sachs, H.C., Moyer, P., Rao, M.R., & Engg, M. (2004). Children's violent television viewing: Are parents monitoring? *Pediatrics, 114*, 94–99.
- Clingempel, W.G., & Henggeler, S.W. (2003). Aggressive juvenile offenders transitioning into emerging adulthood: Factors discriminating persistors and desistors. *American Journal of Orthopsychiatry, 73*, 310–323.
- Flesch, R. (1949). *The art of readable writing*. New York: MacMillan.
- Fox, C., & Harding, D.J. (2005). School shootings as organizational deviance. *Sociology of Education, 78*, 69–97.
- Frost, A.K., & Pakiz, B. (1990). The effects of disruption on adolescents: Time as a dynamic. *American Journal of Orthopsychiatry, 60*, 544–555.
- Gay, L.R., & Airasian, P. (2000). *Educational research*. Columbus, Ohio: Merrill.
- Guida, A. (2001). Depression...or just the blues? *The School Counselor, 39*, 11–13.
- Hasan, N., & Power, T.G. (2004). Children's appraisal of major life events. *American Journal of Orthopsychiatry, 74*, 26–32.
- Herrenkohl, E.C., Herrenkohl, R.C., & Egolf, B.P. (2003). The psychosocial consequences of living environment instability on maltreated children. *American Journal of Orthopsychiatry, 73*, 367–380.
- Hood, A.B., & Johnson, R.W. (2002). *Assessment in counseling: A guide to the use of psychological assessment procedures*. Alexandria, VA: American Counseling Association.
- Jacobson, N.S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*, 12–19.

- Johnson, M.P. (1995). Patriarchal terrorism and common couple violence: Two forms of violence against women. *Journal of Marriage and the Family, 57*, 283–294.
- Kelley, M.L. (1994). The effects of military-induced separation on family factors and child behavior. *American Journal of Orthopsychiatry, 64*, 103–111.
- Kersting, K. (2003). Lessons in resilience. *APA Monitor on Psychology, 34*, 30–31.
- Kersting, K. (2003). Teaching children about resilience. *APA Monitor on Psychology, 34*, 44.
- Kilpatrick, K.L., & Williams, L.M. (1997). Post-traumatic stress disorder in child witnesses to domestic violence. *American Journal of Orthopsychiatry, 67*, 639–644.
- Knowlton, L. (2001). The resilience of children in the face of trauma. *Psychiatric Times, 17*, 48–51.
- Lemke, E., & Wiersma, W. (1976). *Principles of psychological measurement*. Chicago: Rand McNally.
- Levant, R.E. (2003). Promoting resilience in response to war and terrorism. *The Michigan Psychologist, 2*, 12.
- Liem, J.H., James, J.B., O'Toole, J.G., & Boudewyn, A.C. (1997). Assessing resilience in adults with histories of childhood sexual abuse. *American Journal of Orthopsychiatry, 67*, 594–605.
- Lundy, M., & Grossman, S.F. (2005). The mental health and service needs of young children exposed to domestic violence: Supportive data. *Family in Society: The Journal of Contemporary Social Services, 86*, 17–29.
- MacEwen, K.E. (1994). Refining the intergenerational transmission hypothesis. *Journal of Interpersonal Violence, 9*, 350–365.
- Masten, A.S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist, 56*, 227–238.
- McCloskey, L.A., Figueredo, A.J., & Koss, M.P. (1995). The effects of systemic family violence on children's mental health. *Child Development, 66*, 1239–1261.
- National Institute of Mental Health. (2000). Child and adolescent violence research at the National Institute of Mental Health. *NIH Publications*, No. 00-4706.
- Neher, L.S., & Short, J.L. (1998). Risk and protective factors for children's substance use and antisocial behavior following parental divorce. *American Journal of Orthopsychiatry, 68*, 154–161.
- Newberger, C.M., & DeVos, E. (1988). Abuse and victimization: A life-span developmental perspective. *American Journal of Orthopsychiatry, 58*, 505–511.
- O'Keefe, M. (1994). Linking marital violence, mother-child/father-child aggression, and child behavior problems. *Journal of Family Violence, 9*, 63–78.
- Pakiz, B., Reinherz, H.Z., & Giaconia, R.M. (1997). Early risk factors for serious antisocial behavior at age 21: A longitudinal community study. *American Journal of Orthopsychiatry, 67*, 92–101.
- Piotrkowski, C.S., & Brannen, S.J. (2002). Exposure, threat appraisal, and lost confidence as predictors of PTSD symptoms following September 11, 2001. *American Journal of Orthopsychiatry, 72*, 476–485.
- Porter, B., & O'Leary, K.D. (1980). Marital discord and childhood behavior problems. *Journal of Abnormal Child Psychology, 8*, 287–295.
- Portes, P.R., Howell, S.O., Brown, J.H., Eichenberger, S., & Mas, C.A. (1992). Family functions and children's postdivorce adjustment. *American Journal of Orthopsychiatry, 62*, 613–617.
- Rubenstein, J.L., Halton, A., Kasten, L., Rubin, C., & Stechler, G. (1998). Suicidal behavior in adolescents: Stress and protection in different family contexts. *American Journal of Orthopsychiatry, 68*, 274–284.
- Schwartz, D., & Gorman, A.H. (2003). Community violence exposure and children's academic functioning. *Journal of Educational Psychology, 95*, 163–173.
- Seligman, M.E.P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55*, 5–14.
- Selltiz, C., Wrightsman, L.S., & Cook, S.W. (1976). *Research methods in social relations*. New York: Holt, Rinehart & Winston.

- Silvern, L., Karyl, J., Waede, L., Hodges, W.F., Starek, J., Heidt, E., & Min, K. (1995). Retrospective reports of parental partner abuse relationships to depression, trauma symptoms and self esteem among college students. *Journal of Family Violence, 10*, 177–202.
- Spaccarelli, S., Sandler, I.N., & Rousa, M. (1994). History of spouse violence against mother: Correlated risks and unique effects in child mental health. *Journal of Family Violence, 9*, 79.
- Wallerstein, J.S. (1984). Children of divorce: Preliminary report of a ten-year follow-up of young children. *American Journal of Orthopsychiatry, 54*, 444–458.
- Werner, E. (1989). High-risk children in young adulthood: A longitudinal study from birth to 32 years. *American Journal of Orthopsychiatry, 59*, 72–93.
- Wise, E.A. (2004). Methods for analyzing psychotherapy outcomes: A review of clinical significance, reliable change, and recommendations for future directions. *Journal of Personality Assessment, 82*, 50–59.
- Zinna, K.A. (1999). *After Columbine: A schoolplace violence prevention manual*. Silverthorne, CO: Spectra Publishing.

## About the Author

Dr. Robert P. Brady received his baccalaureate and master's degrees from Xavier University (Ohio). Early in his career he worked as a teacher and then as a school counselor. During his tenure in the public schools, he also coordinated summer Neighborhood Youth Corp programs for disadvantaged youth and a school-year Work Study program for special-needs youth. He earned his doctorate in Counseling and Educational Psychology at the University of Cincinnati in 1971. A licensed psychologist, Dr. Brady has maintained a private practice for more than 30 years. He is currently an Adjunct Professor of Counselor Education in the Graduate College of Siena Heights University where he has served as a teacher and mentor for more than three decades. Dr. Brady is the author of two other assessments published by JIST: the *Work Orientation and Values Survey (WOVS)* and the *Domestic Situation Inventory (DSI)*.