UNIVERSITY of DENVER

EVIDENCED-BASED PRACTICE WITH DIVERSE POPULATIONS:

An Assessment and Treatment Review

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EVIDENCED-BASED PRACTICE WITH DIVERSE POPULATIONS:

An Assessment and Treatment Review

Despite a growing emphasis on the use of evidence-based practices with diverse populations, it is often difficult to determine what evidence is available to support to the use of specific measures and treatments with a given population.

The reviews in this book were conducted by graduate students in the Department of Psychology at the University of Denver as part of a service-learning course titled, *Multicultural Issues & Mental Health*. This project was developed in collaboration with our partners at the Colorado Department of Human Services, Office of Behavioral Health. The ultimate goal of this project was to review available assessment instruments and treatments with an eye towards their use with diverse populations (broadly defined).

While the reviews are limited by the availability of information in the research literature, we believe that these reviews represent an important step in (a) applying evidence-based practices to diverse groups and (b) highlighting the need for additional research to inform the use of specific measures and treatments with diverse groups. We hope that these reviews will be useful for your clinical practice.

Sincerely,

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ASSESSMENT REVIEWS

TREATMENT REVIEWS

ADHD Rating Scale-IV (ADHD-RS)

Author:	GJ DuPaul
Citation:	DuPaul GJ, Anastopoulos AD, Reid, R. (1998). ADHD Rating Scale-IV; Checklists, Norms, and Clinical Interpretations. New York: Guilford.
How to obtain the measure:	Paperback manual w/ permission to photocopy
Copyrighted:	Yes
Cost:	~$130
Measure description:	The ADHD Rating Scale-IV (ADHD-RS) is a screening level behavior rating inventory completed by caregivers and teachers to asses symptoms of ADHD in children.
Measure Format:	- 18 items - Respondents rate presence of each symptom over a six-month period on a 4-point scale "0=Never/Rarely; 1=Sometimes; 2=Often; 3=Very Often" - Identical Parent (Home) and Teacher (School) rating forms - 5-7 minutes to administer
Domains assessed:	• ADHD Inattention Symptoms (ADHD-I) • ADHD Hyperactivity Symptoms (ADHD-H/Im)
Languages Available:	• English • Spanish
Ages	• 5-18 years
Normative Sample	- DuPaul et al., 1998; parents of 2000 children and adolescents ages 4 to 20 years in the United States; 73.5% Caucasian, 14.2% African-American; 4.7% Hispanic, 4.3% Asian-American, 0.7% Native American, 0.3% Other or Unspecified - Separate norms available for four age groups: ages 5 to 7, ages 8 to 10, ages 11 to 13, ages 14 to 18 - No normative data are available for children under 5 years old
Psychometric Properties	
Reliability:	Internal Consistency Reliability: - Home/Parent α = 0.86-0.92 - School/Teacher α = 0.88-0.96 Test-Retest Reliability (i.e., 4 weeks) - Home/Parent = 0.78-0.86 - School/Teacher = 0.88-0.90 Interrater Reliability (i.e. parent and teacher) = 0.40-.0.45
References for Reliability:	DuPaul, G. J., Anastopoulos, A. D., Power, T. J., Reid, R., Ikeda, M. J., & McGoey, K. E. (1998). Parent ratings of attention- deficit/hyperactivity disorder symptoms: Factor structure and normative data. *Journal of Psychopathology and Behavioral Assessment, 20,* 83-102. Collett, B. R., Ohan, J. L., & Myers, K. M. (2003). Ten-year review of rating scales. V: scales assessing attention-

	deficit/hyperactivity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, *42*(9), 1015-1037.
Validity:	**Construct Validity** - Directly derived from ADHD symptoms included in DSM-IV **Convergent Validity** = 0.35-0.85 - Demonstrates positive correlations with the Attention Problems subscale of the Child Behavior Checklist (CBCL) and direct observations of child's behavior **Discriminant Validity (ability to discriminate between children with ADHD and other groups):** - ADHD compared to nonclinical controls - ADHD compared to clinical control - ADHD-Inattentive compared to ADHD-Combined Sensitivity is better for parent ratings (e.g. detecting "true" cases) Specificity is better for teacher ratings (e.g. fewer false positives)
References for Validity	DuPaul, G. J., Anastopoulos, A. D., Power, T. J., Reid, R., Ikeda, M. J., & McGoey, K. E. (1998). Parent ratings of attention- deficit/hyperactivity disorder symptoms: Factor structure and normative data. *Journal of Psychopathology and Behavioral Assessment, 20,* 83-102. Collett, B. R., Ohan, J. L., & Myers, K. M. (2003). Ten-year review of rating scales. V: scales assessing attention-deficit/hyperactivity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, *42*(9), 1015-1037.
Other Notes	- Teachers & parents both endorse higher scores for African-American children than for white children on all symptoms across all age groups - Teachers & parents endorse the same or lower scores for Hispanic children than for non-Hispanic white children
Summary	
Strengths:	- Directly derived from the symptoms listed in the DSM-IV, which assures construct validity - Parent and teacher rating forms have been normed on a large sample that was stratified by age, gender, race, ethnicity - Easy to use and quick to administer
Limitations:	- The normative sample was not representative of racial/ethnic distribution of the U.S. - Suboptimal sensitivity and specificity, which may lead to misclassifying children's clinical problems - Lack of normed data for children under 5 years old - Not updated to reflect changes in the DSM-V
Reviewer:	Lauren Gulley, M.A., Doctoral Student University of Denver Email: Lauren.Gulley@du.edu

Child Behavior Checklist for Ages 6-18

Author:	Thomas M. Achenbach
Citation:	Achenbach, T.M., & Rescorla, L.A. (2001). Manual for the ASEBA School-Age Forms & Profiles. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.
How to obtain the measure:	http://store.aseba.org/
Copyrighted:	Yes
Cost:	Yes
Measure description:	The CBCL/6-18 is a checklist that includes 120 behaviors that are rated by a parent/caretaker. The CBCL produces 8 syndrome scales, 5 DSM-oriented scales, broad-band internalizing and externalizing scales, and a total problems scale. Using a 3-point rating scale, parents rate how true each item is now, or was within the past 6 months, for their child.
Ages:	Appropriate for children ages 6-18
Measure format:	Parent/caregiver report
Number of items:	120 items rated on a scale from 0 ("not true") to 2 ("very true or often true")
Domains assessed:	• Anxious/Depressed • Withdrawn/Depressed • Somatic Complaints • Rule-Breaking Behavior • Social Functioning • Thought Problems • Attention Problems • Aggressive Behavior
Specific Population(s):	"Diversity"
Languages Available:	English, Albanian, American Sign Language, Amharic, Arabic, Armenian, Auslan ,Bahasa, Bangla, Bengali, Bosnian, Bulgarian, Cambodian, Catalan, Chinese, Creole, Croatian, Czech, Danish, Dutch, Estonian, Filipino/Tagalog, Finnish, Flemish, French, Ga, German, Greek, Gujarati, Haitian, Hebrew, Hindi, Hungarian, Icelandic, Italian, Japanese, Kannada, Kiembu, Korean, Latvian, Lithuanian, Maltese, Marathi, Nepalese, Norwegian, Papiamento Pashto, Polish, Portuguese, Romanian, Russian, Sami, Samoan, Sepedi, Serbo-Croatian, Sinahala(ese), Slovene(ian), Sotho, Spanish, Swahili, Swedish, Thai, Tibetan, Turkish, Ukrainian, Urdu, Vietnamese, Zulu
Population Used For Measure Development:	Gender: 44% male; 56% female Age: 8-16 Race: 60% Caucasian, 20% Black, 9% Hispanic, 12% Other
Normative Sample:	• National sample used to create norms based on age (6-11 and 12-18) and gender • T-scores 70+ denote clinical significance
Training Required:	• *Administration:* None • *Scoring:* Manual/Video, prior experience with psychological testing/Interpretation, training by experienced clinician (4+ hours)

Psychometric Properties	
Reliability:	• Internal consistency reliability: α = 0.8 • Test-retest reliability: *r* = 0.88 • Inter-rater reliability: *r* = 0.73
References for Reliability:	Achenbach, T.M., & Rescorla, L.A. (2001). Manual for the ASEBA School-Age Forms & Profiles. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.
Validity:	• Content validity: Yes • Construct validity: Yes • Predictive validity: Yes
References for Validity:	Achenbach, T.M., & Rescorla, L.A. (2001). Manual for the ASEBA School-Age Forms & Profiles. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.
Summary	
Strengths:	• One of the most widely used parent-report measures of youth symptoms • Norms using a national, ethnically diverse sample • Parallel forms (for teacher and youth self-report) available
Limitations:	• Cost • Length of the measure
Reviewer:	Jamie M. Novak, Doctoral Student University of Denver Email: Jamie.Novak@du.edu
Review Date:	5/16/2014

Children's Depression Inventory (CDI)

Author:	Maria Kovacs, Ph.D.
Citation:	Kovacs, M. (1985). The Children's Depression Inventory (CDI). *Psychopharmacology Bulletin, 21*, 995-998.
How to obtain the measure:	www.mhs.com/product.aspx?gr=cli&prod=cdi&id=overview
Copyrighted:	Yes
Cost:	Yes; available from Multi-Health Systems, Inc.
Measure description:	The Children's Depression Inventory (CDI) is a measure of child and adolescent depression symptoms experienced within the past two weeks. It is an extension of the Beck Depression Inventory, which is a widely used measure for adult depression. The CDI was initially developed for English-speaking children in the U.S., eight years of age and up. The range of possible scores is 0-54, with cut-offs typically around 20; scores equal to or higher than 36 are generally indicative of severe depression.
Ages:	Appropriate for children ages 7-17 years old
Measure format:	Child self-report; typically administered verbally by an examiner who records the child's responses, but could alternatively be completed by the child on paper
Number of items:	27 items, each consisting of three statements which are coded on a scale from 0 to 2
Domains assessed:	• Negative mood • Interpersonal problems • Ineffectiveness • Anhedonia • Negative self-esteem
Specific Population(s):	Specifically investigated in European American, African American, Native American, and Hispanic/Latino/a samples, but may be valid for other groups (see section "Normative Sample")
Languages Available:	English, Spanish, French (Canadian), Italian, Japanese, Norwegian, Russian, Ukrainian, Afrikaans, Dutch, German, Hebrew, French (European), Hungarian, Lithuanian, Swedish, Spanish (European), Polish, Turkish, South African English
Normative Sample:	• Public school students in Florida • Grades 2-8 (ages 7-16) • From middle-class families • Data on race/ethnicity for this sample is unavailable
Training Required:	• Manual: Kovacs, M. (1992). Children's Depression Inventory Manual. North Tonawanda, NY: Multi-Health Systems, Inc. • Examiners should be at least masters or doctoral level professionals in psychology, education, or social work who have formal training in administration of clinical assessments.
Psychometric Properties in Hispanic/Latino/a Children and Adolescents	

Reliability:	• Internal consistency reliability
	  o Alphas: 0.82-0.85 (0.85 in boys; 0.86 in girls) in various samples
	• Split-half reliability
	  o Spearman correlation coefficient: 0.65
	• Note: in the normative sample, boys had higher scores

	than girls; however, in the Hispanic sample, girls had significantly higher scores than boys.
References for Reliability:	Davanzo, P., Kerwin, L., Nikore, Vipan, Esparza, C., Forness, S., & Murrelle, L. (2004). Spanish translation and reliability testing of the Child Depression Inventory. *Child Psychiatry and Human Development, 35*(1), 75-92. Rivera, C. L., Bernal, G., & Rossello, J. (2005). The Children Depression Inventory (CDI) and the Beck Depression Inventory (BDI): Their validity as screening measures for major depression in a group of Puerto Rican adolescents. *International Journal of Clinical and Health Psychology, 5*(3), 485-498.

Validity:	• Construct validity
	  ○ Principal components analysis revealed that factors are generally stable across clinical and non-clinical samples, but, to our knowledge, construct validity has not been tested in a sample of Hispanic children.
	• Predictive validity
	  ○ In one study, all participants scoring above the cutoff demonstrated clear symptoms of depression and received a diagnosis of depression.
	  ○ In another study of Puerto Rican adolescents, appropriate cut-off scores were shown to differ from those of the normative sample.

References for Validity:	Davanzo, P., Kerwin, L., Nikore, Vipan, Esparza, C., Forness, S., & Murrelle, L. (2004). Spanish translation and reliability testing of the Child Depression Inventory. *Child Psychiatry and Human Development, 35*(1), 75-92. Carey, M. P., Faulstich, M. E., Gresham, F. M., Ruggiero, L., & Enyart, P. (1987). Children's Depression Inventory: Construct and discriminany validity across clinical and nonreferred (control) populations. *Journal of Consulting and Clinical Psychology, 55*(5), 755-761.
Summary	
Strengths:	• Studies assessing reliability and validity in Hispanic samples report similar psychometric properties as larger samples with primarily Caucasian participants.
Limitations:	• Studies evaluating reliability in Hispanic youth generally have small sample size and are limited to one school. Results may not generalize to children outside of the U.S. or children who are recent immigrants to the U.S. • Race/ethnicity data was not collected for the normative sample, so use of those norms for ethnic minority youth may be problematic.
Additional Comments:	• There are separate forms for parent- (CDI:P) and teacher-report (CDI:T) and a 10-item short-form (CDI:S).
Reviewer:	Lane L. Nesbitt, B.A., Doctoral Student University of Denver Email: Lane.Nesbitt@du.edu
Review Date:	May 19, 2014

Conners' Parent Rating Scales-Revised (CPRS-R)

Author:	C. Keith Conners, Ph.D.
Citation:	Conners (1997). *Conners' Rating Scales-Revised Technical Manual.* North Tonawanda, NY: Multi-Health Systems
How to obtain the measure:	www.mhs.com/conners3
Copyrighted:	Yes
Cost:	Yes
Measure description:	Rating scales for ADHD and other behavioral symptoms
Ages:	Appropriate for children 6-18
Measure format:	Parent report (Teacher report and child self-report also available)
Number of items:	Long form: 80 items, Abbreviated form: 27 items
Domains assessed:	• Cognitive Problems/Inattention • Hyperactivity • Oppositional • Anxious-Shy • Perfectionism • Social Problems • Psychosomatic
Specific Population(s):	Ethnic minority children
Languages Available:	English, Spanish, French-Canadian
Population Used For Measure Development:	2,482 students Gender: 50% male; 50% female Age: 3-17 Race: 84% Caucasian, 5% Black, 4% Hispanic, 7% Other
Normative Sample:	• Sample selected from 200 schools in US and Canada • Factor means derived by age group (3-5, 6-8, 9-11, 12-14, 15-17) and gender • T-scores > 65 (93rd percentile) denote clinical significance
Training Required:	• None
Psychometric Properties in Ethnic Minority Children	
Reliability:	• Internal consistency: .74 - .94 • Interrater reliability (kappa): .868 • Test-retest reliability: .47-.85

Validity:	• Construct validity
	  o 7-factor structure in normative sample
	  o 3-factor structure with Spanish-speaking children
	• Criterion validity: *r* = .33 with Connors CPT
	• Discriminant validity
	  o Sensitivity: 92.3%
	  o Specificity: 94.5%
	  o False positive rate: 5.5%
	  o False negative rate: 7.7%
	• Predictive validity
	  o 94.4% positive predictive power
	  o 92.5% negative predictive power

Representation of Ethnic Minority Children:	• Normative sample underrepresentative of ethnic minority children, esp. Black/African American and Latino/Hispanic children • Lack of evidence of validity with ethnically diverse

	children for parent rating scale • Evidence of validity with ethnically diverse children for teacher rating scale (Fantuzzo et al., 2001) and adolescent self-report scale (Conners et al., 1997) • Limited evidence of validity with Spanish-speaking children (Farre-Riba & Narbona, 1997; Pineda et al., 2000)
Reliability and Validity References:	Conners, C. K., Wells, K. C., Parker, J. D., Sitarenios, G., Diamond, J. M., & Powell, J. W. (1997). A new self-report scale for assessment of adolescent psychopathology: factor structure, reliability, validity, and diagnostic sensitivity. *Journal of Abnormal Child Psychology*, *25*(6), 487-497. Fantuzzo, J., Grim, S., Mordell, M., McDermott, P., Miller, L., & Coolahan, K. (2001). A multivariate analysis of the revised Conners' Teacher Rating Scale with low-income, urban preschool children. *Journal of Abnormal Child Psychology, 29*(2), 141–52. Farré-Riba, A., & Narbona, J. (1997). [Conners' rating scales in the assessment of attention deficit disorder with hyperactivity (ADHD). A new validation and factor analysis in Spanish children]. *Revista de neurologia*, *25*(138), 200-204. Pineda, D. A., Rosselli, M., Henao, G. C., & Mejía, S. E. (2000). Neurobehavioral assessment of attention deficit hyperactivity disorder in a Colombian sample. *Applied Neuropsychology*, *7*(1), 40-46.
Summary	
Strengths:	• Parent, teacher, and adolescent versions available in short or long forms • Relatively well-validated • Translations to Spanish and French available • Available to complete and score by hand or computer
Limitations:	• Takes 10 (short form) to 20 (long form) minutes to complete • Minority children underrepresented in normative sample • Very limited evidence for validity in ethnic minority and non-English speaking children
Reviewer:	Kayla Knopp, B.S., Doctoral Student University of Denver Email: kayla.knopp@du.edu
Review Date:	May 20, 2014

Child PTSD Symptom Scale (CPSS)

Author:	Edna B. Foa, Kelly M. Johnson, Norah C. Feeny, and Kimberli R. H. Treadwell
Citation:	Foa, E. B., Johnson, K. M., Feeny, N. C., Treadwell, K. R. H. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology, 30,* 376-384.
How to obtain the measure:	Send an email to foa@mail.med.upenn.edu to request it. Or http://www.aacap.org/App_Themes/AACAP/docs/resource_centers/resources/misc/child_ptsd_symptom_scale.pdf
Copyrighted:	Yes
Cost:	No Cost
Measure description:	The CPSS is used to assess posttraumatic stress disorder diagnostic criteria and severity in children for the previous two weeks. It takes approximately 20 minutes to administer as an interview and 10 minutes to complete as a self-report. Symptom items are rated on a 4-point frequency scale (0= *not at all or only at one time*; 1= *Once a week or less/once in a while*; 2= *2 to 4 times a week/half the time*; 3= *5 or more times a week/almost always*). Functional impairment items are scored as *absent* or *present*.
Ages:	Children and adolescents from 8-18 years
Measure format:	Child self-report or interview by clinician or therapist.
Number of items:	26 items total: 2 open ended questions (about the most distressing traumatic event in life of child and length of time since the event), 17 symptom items, one for each symptom of PTSD in the DSM-IV, and 7 functional impairment items.
Domains assessed:	• PTSD diagnostic criteria and symptom severity.
Specific Population(s):	• Latino immigrant students living in the US • Latino children
Languages Available:	• English • Korean • Russian • Spanish
Population Used For Measure Development:	• 75 children participated in the standardization of the CPSS. • Gender: 41% male; 59% female • Age: 8-15 (mean= 11.8) • Race: 89% Caucasian, 11% were of other ethnicities
Other Samples:	• Kataoka, S.H. et al., (2003): 198 Latino/Hispanic immigrants. • Gudiño, O. G., & Rindlaub, L. A. (2014): 161 Latino students (56.5% girls), mean age =11.42 years, in a large urban public middle school in southern California.
Training Required:	• No special training required
Psychometric Properties in (Specific Population)	
Reliability:	**Foa, E. B., Johnson, K. M., Feeny, N. C., Treadwell, K. R. H. (2001):** • The psychometric properties of the *CPSS* show high internal consistency and test–retest reliability for both the total score and the three subscales.

	• Internal Consistency of PTSD symptoms: The total symptom score and three symptom clusters demonstrated high internal consistency. Coefficient alphas were .89 for total score, .80 for re-experiencing, .73 for avoidance, and .70 for arousal. • Test-retest reliability of PTSD symptom diagnosis: Test-retest reliability of PTSD diagnosis, after 1 to 2 weeks, was moderate with a kappa of .55 using a retest sample of 65 of the children. Diagnosis agreement between the two time points was 84%, which indicates a moderately high degree of reliability. • Test-retest reliability of PTSD symptom severity scores: Test-retest reliability coefficients for the total score and cluster scores were moderate to excellent: .84 for total score, .85 for re-experiencing, .63 for avoidance, and .76 for arousal. • Internal consistency of functional impairment items: The functional impairment scale demonstrated low internal consistency, coefficient α =.35. When the item "general happiness with life" was removed, internal consistency was excellent, coefficient α =.89. • Test-retest reliability of functional impairment: The test-retest reliability coefficient for the total impairment score was very good, r=.70, p<.001. **Gudiño, O. G., & Rindlaub, L. A. (2014):** • Total PTSD score demonstrated very high internal consistency in the overall sample and when English and Spanish measures were separated with all Cronbach's α coefficients above .75. **Kataoka, S. H., Stein, B. D., Jaycox, L. H., Wong, M., Escudero, P., Tu, W., ... & Fink, A. (2003):** • Internal consistency was high (Cronbach α = .89).
References for Reliability:	Foa, E. B., Johnson, K. M., Feeny, N. C., Treadwell, K. R. H. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology, 30,* 376-384. Gudiño, O. G., & Rindlaub, L. A. (2014). Psychometric Properties of the Child PTSD Symptom Scale in Latino Children. *Journal of traumatic stress*. Kataoka, S. H., Stein, B. D., Jaycox, L. H., Wong, M., Escudero, P., Tu, W., ... & Fink, A. (2003). A school-based mental health program for traumatized Latino immigrant children. *Journal of the American Academy of Child & Adolescent Psychiatry*, *42*(3), 311-318.
Validity:	**Foa, E. B., Johnson, K. M., Feeny, N. C., Treadwell, K. R. H. (2001):** • Convergent validity with the *Child Post-Traumatic Stress Disorder Reaction Index (CPTSD–RI)* was established. The correlations of the *CPSS* with depression and anxiety measures were lower than those with the *CPTSD–RI*, providing some support for discriminant validity of the *CPSS*. These results suggest that the *CPSS* is a useful tool for the

	assessment of posttraumatic stress disorder (PTSD) severity and for the screening of PTSD diagnosis among traumatized children. • Convergent validity of the CPSS symptom severity score: The CPSS total scale score was compared to the severity ratings obtained from the Child Post-Traumatic Stress Disorder-Reaction Index (CPTSD-RI). The Pearson product-moment correlation coefficient was .80 (p<.001). • Divergent validity of CPSS symptom severity scores: The CPSS total and subscale scores were correlated with depression (from the Depression Self-Rating Scale for Children, DSRSC) and anxiety (from the Multidimensional Anxiety Scale for Children, MASC) scores. These correlations were lower than the correlation with the CPTSD-RI providing preliminary support for the divergent validity of the CPSS. **Gudiño, O. G., & Rindlaub, L. A. (2014):** • With all Child PTSD Symptom Scale items loading on one factor, a single-factor model of PTSD provided adequate fit to the data. • A 3-factor *DSM-IV-TR* model of PTSD, with items loading onto three factors; re-experiencing, avoidance, and hyperarousal, presented a good fit to data. • Individual subscales and total PTSD score were significantly correlated with community violence exposure ($p < .001$). • The re-experiencing, avoidance, and hyperarousal subscales were significantly correlated with one another ($p < .001$). • The PTSD severity score was significantly and positively correlated with affective, anxiety, oppositional-defiant, and conduct problems scales of the Youth Self-Report. • PTSD severity was positively associated with both internalizing and externalizing symptoms, which is consistent with previous research. • All item loadings and correlations between latent factors were statistically significant (p<.001). • Individual subscales and total PTSD score were significantly correlated with community violence exposure (p<.001).
References for Validity:	Foa, E. B., Johnson, K. M., Feeny, N. C., Treadwell, K. R. H. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology, 30,* 376-384. Gudiño, O. G., & Rindlaub, L. A. (2014). Psychometric Properties of the Child PTSD Symptom Scale in Latino Children. *Journal of traumatic stress*.
Summary	
Strengths:	• The CPSS is easy and fast to administer. • The CPSS is worded and formatted to be developmentally appropriate for children and adolescents. • The CPSS is available at no cost. • The CPSS is aligned to the DSM-IV diagnostic criteria for PTSD.

Limitations:	• Currently, there is not a version of the CPSS aligned to the DSM-V. • The sample used to develop the CPSS and test its psychometric properties was small and mostly Caucasian. • Sensitivity and specificity of the CPSS have not been investigated. • Additional research is needed to establish appropriate clinical cutoffs to use for different populations and different screening aims.
Additional Comments:	More research is needed to test the reliability and validity of the CPSS with specific populations and with larger and more diverse samples.
Reviewer:	Skyler Leonard, M.Ed., Doctoral Student University of Denver Email: Skyler.leonard@du.edu
Review Date:	5/16/14

The Multidimensional Anxiety Scale for Children (MASC)

Author:	John March, M.D., M.P.H.
Citation:	March, J. (1997). Multidimensional Anxiety Scale for Children (MASC), Technical Manual. Tonawanda, NY: Multi-Health Systems.
How to obtain the measure:	http://www.mhs.com/product.aspx?gr=cli&id=overview&prod=masc2
Copyrighted:	Yes
Time:	15 minutes for administration, 15 minutes for scoring
Cost:	Yes, cost involved (see website for pricing)
Measure description:	The MASC assesses the presence of anxiety symptoms in youth. It distinguishes between anxiety symptoms and dimensions, and can be used in early identification, diagnosis, treatment planning, and monitoring of children.
Ages:	Appropriate for children ages 8-19
Measure format:	Child self-report
Number of items:	39 items rated on a 4 point Likert scale from 0 ("never true of me") to 3 ("often true about me")
Domains assessed:	• Physical symptoms • Harm avoidance • Social anxiety • Perfectionism • Anxious coping • Separation/ panic • Total anxiety
Specific Population(s):	Caucasian, African-American, Asian (Chinese, Taiwanese), Italian, Swedish, Icelandic
Where it can be used:	Can be used in multiple settings, such as clinics, schools, private practices and more.
Languages Available:	Available in Arfikaans, Dutch, English, English (South African), French (Canadian and European), German, Hebrew, Hungarian, Italian, Icelandic, Lithuanian, Norwegian, Polish, Spanish (European and United States), Swedish, Turkish
Population Used For Measure Development:	Gender: 46.7% male; 53.3% female Age: 8-19 (mean age for males = 14.58 (*SD*= 2.56); mean age for females =14.59 (SD= 2.65)) Race: 53.3% Caucasian, 39.2% Black, 0.7% Hispanic, 1.4% Asian, 3% Other
Normative Sample:	• Normed on a large sample of children and adolescents attending several different elementary, junior high, and high schools in the nation. All respondents were collected from regular classes. Children and adolescents living in the areas sampled had a higher than average chance of living in poverty and lower than average chance of graduating from high school. • T-scores > 70 denote very much above average scores; T scores of 66-70 denote much above average scores; T scores of 61-65 denote above average scores; T scores of 56-60 denote slightly above average scores
Training Required:	• Users should have an understanding of the basic principles and limitations of psychological assessments developed by the American Psychological Association (APA)
Scoring	• Can be hand-scored or scored on the computer. There is also an online format available.

Psychometric Properties in (Specific Population)	
Reliability:	• High internal reliability (Cronbach's alpha = .90; March et al., 1997). Moderate to strong internal reliability across all MASC subscales (Villabo et al., 2012). • Internal reliability was comparable for males (0.85) and females (0.87) (March et al., 1997). • Internal consistencies for the total and factor scores ranged from .50 to .88 and were satisfactory (March, 1997). • Intraclass correlation coefficient (ICC) exhibited satisfactory to excellent stability across all factors and subfactors. Stability was not affected by age or gender (March, Sullivan, & Parker, 1999). • Test-retest reliability over 3 week period is satisfactory; mean intraclass correlation coefficient (ICC) for the MASC total score was .785. • Test-retest reliability at 3 months is satisfactory; mean intraclass correlation coefficient (ICC) for the MASC total score was .933. • Satisfactory test-retest reliability was demonstrated for two empirically derived subscales as well, the MASC-10 and Anxiety Index (March, Sullivan, & Parker, 1999). • See table 1 for test-retest reliability for the full sample across race
References for Reliability:	March, J. (1997). Multidimensional Anxiety Scale for Children (MASC), Technical Manual. Tonawanda, NY: Multi-Health Systems. March, J.S., Parker, J.D., Sullivan, K., Stallings, P., & Conners, K. (1996). The Multidimensional Anxiety Scale for Children (MASC): Factor structure, reliability, and validity. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(3), 545-565. March, J.S., Sullivan, K., & Parker, J. (1999). Test-retest reliability of the Multidimensional Anxiety Scale for Children. *Journal of Anxiety Disorders, 13*(4), 349-358. Villabo, M., Gere, M., Torgersenm S., March, J.S., & Kendall, P.C. 2012. Diagnostic efficiency of the child and parent versions of the Multidimensional Anxiety Scale for Children. *Journal of Clinical Child & Adolescent Psychology, 41*(1), 75-85.
Validity:	• Confirmatory- Factor Analyses found that the MASC has a four-factor structure across two different groups of subjects. This was supported using confirmatory factor analyses with a large sample of children with ADHD (March et al., 1999). • Correlated with the RCMAS (r =.633) • Cross-validated in clinical and population samples (March, 1998). • Validity is stable across gender, race and age (March, 1998; March et al., 1997). • Construct validity was explored via correlations between MASC total score and other self-report measures of anxiety. Correlations were found between the MASC and the Spence Children's Anxiety Scales and demonstrated good convergent validity within reporter, excluding the harm avoidance scale (Baldwin & Dadds, 2007). • Divergent validity was obtained by correlations of MASC total

	score and symptoms of Attention-Deficit/ Hyperactivity Disorder (March et al., 1999). • Discriminative validity was also established in a large clinical sample of anxious and depressed children and adolescents, and the MASC subscales were able to discriminate between these groups (Rynn et al., 2006). • Predictive validity of the MASC total and scale scores for DSM-IV anxiety diagnoses in a referred sample (Van Gastel & Ferdinand, 2008): o MASC total score did not exceed threshold for being judged as fair in predicting any ADIS/ DSM-IV anxiety diagnosis o Separation Anxiety scale & Physical Symptoms scale predicted Panic Disorder and Agoraphobia fairly accurately o Social Anxiety Scale predicted Social Phobia o Harm Avoidance scale did not predict any ADIS/ DSM-IV diagnosis
References for Validity:	March, J.S., Conners, C., Arnold. G., Epstein, J., Parker, J., Hinshaw, S., Abikoff, H., Molina, B., Wells, K., Newcorn, J., Schuck, S., Pelham, W.E., & Hoza, P. (1999). The Multidimensional Anxiety Scale for Children (MASC): Confirmatory factor analysis in a pediatric ADHD sample. *Journal of Attention Disorders, 3*, 85-89. Rynn, M., Barber, J., & Khalid-Khan, S. 2006. The psychometric properties of the MASC in a pediatric psychiatric sample. *Journal of Anxiety Disorders,* 139-157. Van Gastel, W., & Ferdinand, R.F. 2008. Screening capacity of the Multidimensional Anxiety Scale for Children (MASC) for DSM-IV anxiety disorders. *Depression & Anxiety, 25*, 1046-1052.
Summary	
Strengths:	• "The MASC factor structure, which presumably reflects the in vivo structure of pediatric anxiety symptoms, is invariant across gender and age and shows excellent internal reliability. As expected, females show greater anxiety on all factors and subfactors than males. Three week and 3-month test-retest reliability was satisfactory to excellent." (March, Parker, Sullivan, Stallings, & Conners, 1999). • Has favorable psychometric properties and can be used as a screening instrument to assess and identify children with anxiety disorders (Villabo et al., 2012). • Norms contained a relatively large proportion of African American youth • A community sample of 142 youth (52% White, 34% African American, 10% Asian, Hispanic, or American Indian) also found robust psychometric properties. Test-retest reliabilities ranged from .76 to .92 across a three-week interval. There were no mean differences between White and African American youth on any of

	the factors.
Limitations:	• The stability of the MASC was lower for African- American than Caucasian subjects (see table 1; March, Sullivan, & Parker, 1999). • Mean internal consistency is lower for African American adolescents (Kingery, J.N., Ginsburg, G.S., & Burstein, M. 2009). Factor structure and psychometric properties of the Multidimensional Anxiety Scale for Children in an African American Adolescent Sample. *Child Psychiatry and Human Development, 040*, 287-300. • Factor analyses for African American adolescents revealed a three factor solution (social anxiety, physical symptoms, harm avoidance). Items reflecting separation anxiety did not emerge as a separate factor for this population. As such, more psychometric research with ethnic minority populations is needed for the MASC. • Has not been validated with racial/ethnic minority groups (other than African American youth; Kingery, Ginsburg, & Burstein, 2009). • Low parent-child agreement on the MASC. Scores over a 12 month period demonstrated greater stability for parental report than child report (Baldwin, J.S., & Dadds, M.R. 2007. Reliability and validity of parent and child versions of the Multidimensional Anxiety Scale for Children in community samples. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(2), 252-260).
Reviewer:	Ann Spilker, B.A., Doctoral Student University of Denver Email: ann.spilker@du.edu
Review Date:	05/20/2014

Table 1. Test-Retest Reliability by race for the MASC (March, Sullivan, & Parker, 1999).
Mean ICC's by race

	African American	Caucasian
MASC total	.76	.91
Physical Symptoms	.85	.95
Tense	.86	.91
Somatic	.81	.94
Harm avoidance	.45	.84
Anxious coping	.51	.86
Perfectionism	.52	.73
Social anxiety	.80	.86
Humiliation fears	.75	.84
Performance fears	.74	.84
Separation anxiety	.84	.84
Anxiety Index subscale	.69	.84
MASC-10	.75	.89

Modified Checklist for Autism in Toddlers – Revised, with Follow-Up (M-CHAT-R/F)

Author:	Robins, Fein & Barton, 1999
Citation:	Robins, D.L., Fein, D., & Barton, M. (1999) *The Modified Checklist for Autism in Toddlers (M-CHAT)*. Self-published.
How to obtain the measure:	https://www.m-chat.org
Cost:	Available at No Cost
Measure description:	The M-CHAT-R/F is a 2-stage, parent report measure designed to screen for autism risk in toddlers ages 16-30 months. The measure identifies those children who would benefit from a more thorough developmental evaluation. The American Academy of Pediatrics recommends using the M-CHAT-R/F as a screening tool at 9, 18, and 24-month well-child visits as an adjunct to broad developmental screening.
Ages:	Appropriate for children ages 16-30 months
Measure format:	Parent/Caregiver Report
Number of items:	20 Yes/No Items (Initial Screening); 20 Items on Follow-Up Interview
Domains assessed:	• Verbal & Non-verbal Communication • Socialization • Play Skills • Restricted or Repetitive Behaviors • Motor Skills
Languages Available:	Translations are available in the following languages for the M-CHAT-R, although *validation of the translations is underway*: Albanian (with follow-up), Arabic (with follow-up), Chinese, French, Korean, Macedonian, Spanish (Spain), Spanish (Argentina/Uruguay). Languages in progress as of May, 2014: Bulgarian, Dutch, French (Canadian), German, Italian, Japanese, Persian, Polish, Portuguese (Brazil/Portugal), Spanish (Western Hemisphere), Turkish & Urdu.
Population Used For Measure Development:	• Gender: 51% male; 49% female • Mean Age: 20.4 Months (SD 3.1) • Race: 68% Caucasian, *specific breakdown of other ethnicities not reported*
Normative Sample:	• Multi-site sample used to generate initial psychometric data and determine appropriate cut-off scores (N = 18, 989)
Specific Cutoffs	• 0-2 = Low Risk (screen again after 24 months). • 3-7 = Medium Risk, administer Follow-Up. If Follow-Up Negative (0-1), no further action required. If Follow-Up Positive (2+), child should be referred for diagnostic evaluation or eligibility for early intervention. • 8-20 = High Risk, bypass follow-up and refer immediately to diagnostic evaluation or eligibility for intervention.
Training Required:	• No training required • Parents/Caregivers are encouraged to follow-up with Pediatricians if they have additional concerns.
Psychometric Properties	
Reliability:	• Internal consistency (α=.85)

	• Inter-rater Reliability (κ=.60-1.0
Validity:	• Sensitivity = .87 • Specificity = .99 • Positive Predicative Value (PPV) = .36 (Entire Sample); With Follow-Up Interview = .74
Select References for Reliability & Validity:	• Chlebowski et al. (2013). Large-scale use of the Modified Checklist for Autism in Low-Risk Toddlers. *Pediatrics*, 131(4), 1121-1127. DOI: 10.1542/peds.2012-1525 • Robins, D. (2008). Screening for autism spectrum disorders in primary care settings. *Autism*, 12(5), 537-556. DOI: 10.1177/1362361308094502
Summary	
Strengths:	• The M-CHAT-R/F is simply worded and easy to administer. • It provides a quick overview of developmental questions and easily indicates whether the child would benefit from additional evaluation. • It was developed with a large normative sample and ongoing studies of psychometric validation with more diverse populations are underway.
Limitations:	• Since the questions are Yes/No, they do not distinguish between the presence/absence vs. frequency of a behavior. For example, a parent may report, "Yes" to the question, "Does your child try to copy what you do?" if they've seen the child do this once. However, this may miss the fact that it would be developmentally normative for this behavior to be happening more often. • The M-CHAT-R/F is highly face valid, which may lead to parent under- or over-reporting.
Reviewer:	Lisa Ankeny, M.A., Doctoral Student University of Denver Email: lankeny@du.edu
Review Date:	05/20/2014

Parenting Stress Index Short Form (PSI-SF)

Author:	Richard R. Abidin, EdD
Citation:	Abidin, R. R. (1995). Parenting Stress Index, Third Edition: Professional Manual. Odessa, FL: Psychological Assessment Resources, Inc.
Measures:	http://www.parinc.com
Copyright:	Yes
Cost per copy:	$ 2.09
Measure Description:	This measure is a brief version of the Parenting Stress Index, fourth edition (Abidin, 1995), which is designed to evaluate the magnitude of stress in the parent-child system. The PSI/SF yields a Total stress score from three scales: Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child. It was developed at the request of clinicians and researchers who regularly used the full-length PSI and indicated the need for a valid measure that could be administered in less than 10 minutes
Ages:	18 to 60 years
Measure format:	Individual Self-report
Numbers of Items:	36 items rated from 1= *"strongly disagree"* to 5= *"strongly agree"*
Domains assessed:	Parental distress (PD) Parent-child dysfunctional interaction (P-CDI) Difficult child (DC)
Specific Population(s):	It can be used for populations of developmental disability, lower social-economic status, rural populations, and African American. For lower social-economic status and African American populations, reliability and good psychometrics of the index have been supported.
Languages Available:	English, Chinese, Dutch, Finnish, French, Greek, Icelandic, Italian, Japanese, Polish, Portuguese, Serbian, Spanish, Swedish, Hebrew; Spanish, Chinese, Portuguese, Finnish, Japanese, Italian, Hebrew, Dutch, and French were back translated;
Population Used For Measure Development:	840 Mothers selected from a well-care pediatric practice in Virginia. Age of Children: 10-84 months (M =43, SD=9.7) Gender: 47% female, 53% male Children's ethnicity: 87% White; 10% African American, and 3% Other Marital status: 88% married, 6% single, 4% divorced, and 2% separated Education: 8th grade or less (22.5%), 9th-12th (37.4%), vocational or some college (37.4%), and college graduates (37.4%)
Normative Sample:	Normal range=15th-80th percentile. Scores at or above the 85th percentile are considered high and defensive responding; scores at 10 or below are considered extremely low.

Training Required:	No
Psychometric Properties in (Specific Population)	
Reliability:	Test-retest reliability: minimal= 0.68, maximal=.85, average=.76 Cronbach's alpha: minimal= 0.80, maximal=.91, average=.85
Reference for Reliability	Mholiday (2012). Parenting Stress Index, Short Form. Retrieved from NCTSN Measure Review Database: www.NCTSN.org
Validity:	See table 1
Reference for Validity	Mholiday (2012). Parenting Stress Index, Short Form. Retrieved from NCTSN Measure Review Database: www.NCTSN.org
Summary	
Strengths	1) The measure offers a quick, easy way to screen for parenting stress. 2) The psychometric properties of the PSI/SF were supported by multiple studies. 3) The measure is widely used across languages and cultures. 4) Parenting stress is important when considering the well-being of children and families and this measure provides a brief way to assess this important construct.
Limitations	1) The short form version does not assess the parent-child dyad as in depth as the full-length version. 2) The measure is face valid, which may influence the responses that are given. 3) The ability of the measure to detect change due to treatment in clinical populations and in trauma samples has not received enough evidence. 4) Some items use double negatives, which can lead to populations whose native language is not English to have a hard time understanding it.
Reviewer:	Jiquan Lin, Doctoral Student University of Denver Email: Jiquan.Lin@du.edu
Review Date:	05/20/2014

Table 1. Construct Validity of PSI/SF

Validity Type	Nonclinical Samples	Clinical Samples	Diverse Samples
Convergent/Concurrent	Yes	Yes	Yes
Discriminant	Yes	Yes	Yes
Sensitive to change		Yes	
Intervention effects	Yes		Yes
Longitudinal/Maturation Effects			
Sensitive to theoretically distinct groups	Yes	Yes	Yes
Factorial validity	Yes		Yes

The Revised Multigroup Ethnic Identity Measure (MEIM)

Author:	Jean S. Phinney
Citation:	Phinney, J. (1992). The Multigroup Ethnic Identity Measure: A new scale for use with adolescents and young adults from diverse groups. *Journal of Adolescent Research, 7,* 156-176. Roberts, R. E., Phinney, J., Masse, L. C., Chen, Y. R., Roberts, C. R., Romero, A. (1999). The Structural of Ethnic Identity of Young Adolescents From Diverse Ethnocultural Groups. *Journal of Early Adolescence, 19 (3),* 301-322.
Measures:	See Appendix A
Copyright:	No
Cost:	No
Measure Description:	The Multigroup Ethnic Identity Measure (MEIM) is a self-report measure of ethnic identity of adolescents from diverse ethnic groups. The original MEIM contained 14 items that included three domains: affirmation and belonging; ethnic identity achievement; and ethnic behavior. However, based on the factor analysis on a large sample of adolescents, a two-factor model that contained two key structures (exploration and commitment) appeared to provide a better fit. As a result, the MEIM was revised to only contain 12 items included on two subscales.
Ages:	Adolescent and young adulthood
Measure format:	Adolescent Self-report
Numbers of Items:	14 items rated on a scale from 1= "*strongly disagree*" to 4= "*strongly agree*"
Domains assessed:	Affirmation, belonging, and commitment (seven items); Ethnic identity search (five items);
Specific Population(s):	Can be used in diverse populations and age ranges.
Languages Available:	English, Spanish, and French
Population Used For Measure Development:	Gender: 49% female, 51% male Age: mean age 12.9; 83% were between 12 and 14 years old Ethnicity: African American (1,237); Central American (253); Chinese American (177); European American (755); Indian American (188); Mexican American (755); Pakistani American (155); Vietnamese American (304); Pacific Islander (101); mixed ancestry (342)
Normative Sample:	No. Higher scores indicate stronger ethnic identity.
Training Required:	No
Psychometric Properties in (Specific Population)	
Reliability:	Internal Consistency Reliability Across Ethnicities (Cronbach's alpha): Overall sample: .85. Across ethnic groups, Cronbach's alpha ranged from .81 through .89.
Reference for Reliability	Roberts, R. E., Phinney, J., Masse, L. C., Chen, Y. R., Roberts, C. R., Romero, A. (1999). The Structural of Ethnic Identity of Young Adolescents From Diverse

	Ethnocultural Groups. *Journal of Early Adolescence, 19 (3),* 301-322.
Validity:	Structural and Construct Validity: 1) Factor loadings, Confirmatory Factor Analysis of the MEIM items for European American (Group 1), African American (Group2), and Mexican American (group 3), see table 1. 2) Correlations between MEIM and measures of Psychological well-being and salience of ethnicity, see table 2.
Reference for Validity	Roberts, R. E., Phinney, J., Masse, L. C., Chen, Y. R., Roberts, C. R., Romero, A. (1999). The Structural of Ethnic Identity of Young Adolescents From Diverse Ethnocultural Groups. *Journal of Early Adolescence, 19 (3),* 301-322. Phinney, J., & Ong, A. D. (2007). Conceptualization and Measurement of Ethnic Identity:Current Status and Future Directions. *Journal of Counseling Psychology, 54(3),* 271-281.
Summary	
Strengths	1) It is short and easy to administer, and the language is simple to understand. 2) Samples were drawn from diverse populations across ethnicities and ages, from young adolescence to young adulthood. Measures consistently showed a two-factors model that contained two key components: identity exploration and identity commitment, which indicate that it has good construct validity of measuring two concepts of ethnic identities across populations (Phinney & Ong, 2007) . 3) The subscales of the revised MEIM are highly intercorrelated, so they can be used either individually or in combination, depending on research questions (Phinney & Ong, 2007). 4) It is useful to assess the developmental status of global ethnic identity, as different scores of the two subscales can provide information about the stage of ethnic identity development an individual is in (Phinney & Ong, 2007).
Limitations	1) Even though samples consistently yield a two-factor structure of MEIM, item's loadings were not necessarily the same, and items that should be included in each factor were not the same across samples. Results from some samples suggested a 10-item revised version, and some suggested a 6-item revised MEIM. As a result, it is important to get more evidence of content and construct validity of MEIM (Phinney & Ong, 2007). 2) Even though Spanish and French versions exist, no evidence has been provided in terms of their validity and reliability. Little evidence has been provided to

	support the validity and reliability, as well as the translation quality of the scale in other languages either. 3) It does not contain questions related to other aspects of ethnic identity, such as ethnic identity behaviors, attitudes and values, etc. If researchers are interested in other aspects of ethnic identity development, they have to find other measures.
Reviewer:	Jiquan Lin, Doctoral Student University of Denver Email: Jiquan.Lin@du.edu
Review Date:	05/20/2014

Appendix A

In this country, people come from many different countries and cultures, and there are many different words to describe the different backgrounds or ethnic groups that people come from. Some examples of the names of ethnic groups are Hispanic or Latino, Black or African American, Asian American, Chinese, Filipino, American Indian, Mexican American, Caucasian or White, Italian American, and many others. These questions are about your ethnicity or your ethnic group and how you feel about it or react to it.

Please fill in: In terms of ethnic group, I consider myself to be _____

Use the numbers below to indicate how much you agree or disagree with each statement.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

1- I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.
2- I am active in organizations or social groups that include mostly members of my own ethnic group.
3- I have a clear sense of my ethnic background and what it means for me.
4- I think a lot about how my life will be affected by my ethnic group membership.
5- I am happy that I am a member of the group I belong to.
6- I have a strong sense of belonging to my own ethnic group.
7- I understand pretty well what my ethnic group membership means to me.
8- In order to learn more about my ethnic background, I have often talked to other people about my ethnic group.
9- I have a lot of pride in my ethnic group.
10- I participate in cultural practices of my own group, such as special food, music, or customs.
11- I feel a strong attachment towards my own ethnic group.
12- I feel good about my cultural or ethnic background.

13- My ethnicity is
(1) Asian or Asian American, including Chinese, Japanese, and others
(2) Black or African American
(3) Hispanic or Latino, including Mexican American, Central American, and others
(4) White, Caucasian, Anglo, European American; not Hispanic
(5) American Indian/Native American
(6) Mixed; Parents are from two different groups

(7) Other (write in): _____

14- My father's ethnicity is (use numbers above)
15- My mother's ethnicity is (use numbers above)

Table 1: Factor loadings, Confirmatory Factor Analysis of the MEIM items for European American (Group 1), African American (Group2), and Mexican American (group 3)

	Factor1			Factor2		
	Group			Group		
Item	1	2	3	1	2	3
Happy to be member	.65	.77	.81			
Feel good about culture	.76	.79	.86			
Pride in Ethnic group	.77	.85	.79			
Understand group membership	.73	.67	.68			
Clear sense of ethnic background	.37	.44	.37	.38	.25	.38
Strong attachment to group	.83	.77	.73			
Sense of belonging to group	.75	.65	.69			
Active in ethnic organizations				.54	.53	.45
Participate in cultural practices				.67	.49	.60
Talked to others about group				.65	.60	.63
Think about group membership				61	.44	.40
Spend time to learn				.57	.67	.57

NOTE: Interfactor correlations of the two factors for group 1, 2, 3 were 0.74, 0.70, and 0.75. Factor 1 reflected affirmation, belonging, and commitment. Factor 2 reflected ethnic identity search.

Table 2: Correlations between MEIM and measures of Psychological well being and salience of ethnicity

	European American	African American	Mexican American	Total
Coping	.27***	.21***	.20***	.23***
Mastery	.26***	.13***	.12***	.19***
Self-esteem	.24***	.14***	.14***	.20***
Optimism	.24***	.14***	.10***	.19***
Loneliness	-.08*	-.04*	-.08	-.09***
Depression	-.14***	-.07*	-.01	-.09***
Salience of ethnicity	.44***	0.37***	.40***	.48***

Screen for Child Anxiety Related Disorders

Authors:	Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D
Citation:	Birmaher, B., Khetarpal, S., Brent, D., Cully, M., Balach, L., Kaufman, J., & McKenzie Neer, S. (1997).The Screen for Child Anxiety Related Emotional Disorders (SCARED): Scale construction and psychometric characteristics. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*(4), 545 -553.
How to obtain the measure:	http://psychiatry.pitt.edu/research/tools-research/assessment-instruments
Copyrighted:	No
Cost:	Available at No Cost
Measure description:	The SCARED is a self-report instrument that can be used by child and parent to screen for childhood anxiety disorders. These disorders include generalized anxiety disorder, separation anxiety disorder, panic disorder, and social phobia. In addition, it assesses symptoms related to school phobias. Forty-one items and 5 factors are commensurate with classifications of anxiety disorders used by the DSM-IV. In testing, child and parent versions of the SCARED have moderate parent-child agreement. Items on the SCARED demonstrate good internal consistency, test-retest reliability, and discriminant validity. Finally, the SCARED has been shown to be sensitive to treatment response.
Ages:	Appropriate for children ages 8-18
Measure format:	Parent report, Child self-report
Number of items:	41 items rated on a 3-point Likert scale (0=Not True or Hardly Ever True, 1=Somewhat True or Sometimes True, 2=Very True or Often True). Reading to the child is sometimes done, but it is not part of the standardized administration.
Domains assessed:	• Anxiety • General Anxiety • Separation Anxiety • Social Phobia • School Phobia • Physical Symptoms of Anxiety
Specific Population(s):	Outpatient children
Languages Available:	Arabic, Chinese, English, French, German, Italian, Portuguese, Spanish
Population Used For Measure Development:	Gender: 41% male; 59% female Age: 9-18 Race: 82% Caucasian, 18% Black
Normative Sample:	• Outpatient Clinical sample used to create norms

	• A total score of ≥ 25 may indicate the presence of an Anxiety Disorder. Scores higher than 30 are more specific.
Training Required:	• Prior experience with psychological testing/interpretation
Psychometric Properties in (Specific Population)	
Reliability:	• Internal consistency (*α* =.74 to .93) • Test-retest reliability (intraclass correlation coefficients =.70 to .90) • Moderate parent-child agreement (r =.20 to .47, P < .001, all correlations).
References for Reliability:	Birmaher, B., Khetarpal, S., Brent, D., Cully, M., Balach, L., Kaufman, J., & McKenzie Neer, S. (1997).The Screen for Child Anxiety Related Emotional Disorders (SCARED): Scale construction and psychometric characteristics. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*(4), 545 -553.
Validity:	• Discriminant validity (both between anxiety and other disorders and within anxiety disorders.) • Variations in scores are best explained by factors of gender and age, rather than race or ethnicity.
References for Validity:	Birmaher, B., Khetarpal, S., Brent, D., Cully, M., Balach, L., Kaufman, J., & McKenzie Neer, S. (1997).The Screen for Child Anxiety Related Emotional Disorders (SCARED): Scale construction and psychometric characteristics. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*(4), 545 -553. Hale, W. W. III, C, E., Raaijmakers, A. W., & Meeus, W. H. J. (2011). A meta-analysis of the cross-cultural psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED). *Journal of Child Psychology and Psychiatry, 52,* 80-90
Summary	
Strengths:	• The SCARED is simply worded and easy to administer. It is particularly useful as a screener for anxiety disorders and to discriminate between specific anxiety disorders. • In a meta-analysis of 25 studies from Belgium, Germany, Italy, the Netherlands, South Africa, China and the USA, the psychometric properties for the SCARED scales proved robust (Hale, et al, 2011) in relationship to symptoms of DSM-IV-TR anxiety disorders.
Limitations:	• The SCARED has not been evaluated to date with large samples of non-white individuals in the United States. • Parent and child report only displays moderate agreement. Though this is a problem with other

	measures of anxiety as well, the SCARED has not ameliorated the parent-child discrepancy.
Reviewer:	Rachel Lynn Miller, M.A., Doctoral Student University of Denver Email: Rachel.l.miller@du.edu
Review Date:	5/19/14

Strengths and Difficulties Questionnaires

Author:	Robert Goodman, PhD
Citation:	Goodman R (1997) The Strengths and Difficulties Questionnaire: A Research Note. Journal of Child Psychology and Psychiatry, 38, 581-586.
How to obtain the measure:	http://www.sdqinfo.org/
Copyrighted:	Yes
Cost:	Available at No Cost
Measure description:	The SDQ is a behavioral assessment for children and adolescents
Ages:	Appropriate for children ages 4-17 (Early-years SDQ 2-4)
Measure format:	Teacher and Parent report or Adolescent self-report
Number of items:	25 items rated on a scale from 1 ("not true") to 3 ("certainly true")
Domains assessed:	• Emotional Symptoms • Conduct Problems • Hyperactivity/Inattention • Peer Relationship Problems • Pro Social Behaviors
Specific Population(s):	The SDQ has been tested with Swedish, German, Finnish, Bangladeshi, Australian, Dutch, Norwegian, Japanese, Greek, and British populations. Test validation in the Swedish population will be the focus of the current review.
Languages Available:	The SDQ is available in 75 different languages including Japanese, Norwegian, Spanish and Swahili.
Population Used For Measure Development (Adolescent Self Report Version):	Gender: 58% male; 42% female Age: 11-16 Race: Information not provided
Normative Sample:	• National sample (National Health Interview Survey) used to create norms • Scores can be summed for each subscale – the following represent clinical cutoffs for parents (teachers): • Emotional Symptoms: 5(6) • Conduct Problems: 4(4) • Hyperactivity/Inattention: 7(4) • Peer Relationship Problems: 4(5) • Pro Social Behaviors: 4(4) • Total Difficulties Score: 17(16)
Training Required:	• Minimal Prior Experience Psych Testing/Interpretation Required
Psychometric Properties in (Specific Population)	
Reliability:	• Swedish Population: o Total Score Chronbach's Alpha: .76 o Split Half Reliability: .78 o All subscales Alphas's: >.55 o Test-Retest: Spearman Rank Order Correlation: .96
References for	Smedje H, Broman J-E, Hetta J, von Knorring A-L (1999)

Reliability:	Psychometric properties of a Swedish version of the "Strengths and Difficulties Questionnaire". European Child and Adolescent Psychiatry, 8, 63-70.
Validity:	• Swedish Population: o Factor analyses confirmed 5 presumed subscales.
References for Validity:	Smedje H, Broman J-E, Hetta J, von Knorring A-L (1999) Psychometric properties of a Swedish version of the "Strengths and Difficulties Questionnaire". European Child and Adolescent Psychiatry, 8, 63-70.
Summary	
Strengths:	• The SDQ is easy to access, administer, and score. It is particularly nice that versions for all age groups are formatted the same and thus can be scored all at once and scores are comparable to one another. It is translated in many different languages and provides teacher, parent, and self-report versions, which can be differentially appropriate across diverse context. • By assessing 5 distinct behavioral domains, the SDQ is among the broadest screening assessments of behavioral concerns for children and adolescents.
Limitations:	• Although applied in various European and Asian countries worldwide, little work has been done on validated the SDQ among racial minority groups within the United States. • The SDQ does not directly map on to the DSM diagnostic criteria for any specific diagnosis. Therefore, clinicians or researchers looking for a diagnostic tool may be limited by this measure.
Reviewer:	Aleja Pasrsons, M.A., Doctoral Student University of Denver Email: aleja.parsons@du.edu
Review Date:	06/07/14

Traumatic Event Screening Inventory

Authors:	Julian Ford, David Ribbe, Karen Rogers, Chandra Ghosh Ippen
Citations:	Ford, J.D., & Rogers, K. (1997). *Empirically-based assessment of trauma and PTSD with children and adolescents*. Paper presented at the 13th annual meeting of the International Society for Traumatic Stress Studies, Montreal. Ford, J.D., Thomas, J., Rogers, K., Racusin, R., Ellis, C.G., Schiffman, J., Daviss, W.B., & Friedman, M.J. (1996). *Assessment of children's PTSD following abuse or accidental trauma*. Paper presented at the 12th annual meeting of the International Society for Traumatic Stress Studies, San Francisco. Ippen, C. G., Ford, J., Racusin, R., Acker, M., Bosquet, M., Rogers, K., Ellis, C., Schiffman, J., Ribbe, D.,Cone, P., Lukovitz, M., & Edwards, J. (2002).*Traumatic Events Screening Inventory - Parent Report Revised.* Ribbe, D. (1996). Psychometric review of Traumatic Event Screening Instrument for Children (TESI-C). In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 386-387). Lutherville, MD: Sidran Press.
How to obtain the measure:	Traumatic Event Screening Inventory for Children (TESI-C): http://www.ptsd.va.gov/professional/pages/assessments/assessment-pdf/TESI-C.pdf Traumatic Event Screening Inventory, Self-Report Revised (TESI-SRR) and Traumatic Event Screening Inventory, Parent-Report Revised (TESI-PRR): Email Chandra Ghosh Ippen at Chandra.ghosh@ucsf.edu.
Copyrighted:	No
Cost:	Available at No Cost
Measure description:	The TESI-C is a measure that assesses a child's lifetime experience of a variety of potential traumatic events, including the following: exposure to or witnessing of severe accidents, exposure to disaster, exposure to or witnessing illness, separation or neglect, physical assault (actual or threatened), mugging, kidnapping (of self or someone else), attack by animal, witnessing family conflict or violence, witnessing community conflict or violence, and sexual molestation. Initial response choices are "yes," "no," "not sure," "refused," and "questionable validity." Positive and "not sure" responses are followed-up with closed-ended questions to establish Criterion A from the DSM-IV (i.e., criterion A-1, which involves experiencing or witnessing actual injury or threat of death/injury; and criterion A-2, which involves experiencing fear, helplessness, or horror); and open-ended questions about what happened, age of onset, age of offset, frequency, relationship of others involved, and consequences. The TESI-SRR and TESI-PRR are revised versions of the original TESI-C. Revision was undertaken to make the measure even more developmentally sensitive to the traumatic experiences that young children may experience.
Ages:	TESI-C: Appropriate for children ages 4-18. TESI-SRR: Appropriate for children ages 6-18. TESI-PRR: Appropriate for parents who report on children under

	age 6.
Measure format:	Semi-structured interview format
Number of items:	TESI-C: 15 items TESI-SRR and TESI-PRR: 24 items
Domains assessed:	• Severe accidents • Disaster • Illness • Separation or neglect • Physical assault • Mugging • Kidnapping • Attack by animal • Family conflict/violence • Community conflict/violence • Sexual molestation
Specific Population(s):	Child psychiatry and pediatric trauma patients
Languages Available:	English English and Spanish for TESI-SRR and TESI-PRR
Population Used For Measure Development:	Child psychiatry and pediatric trauma patients Unknown gender, age, race
Normative Sample:	Unknown
Training Required:	All versions are designed to be administered only by qualified mental health professionals or advanced trainees supervised by a qualified mental health professional. The critical qualifications are licensure for independent practice in child assessment and psychotherapy and supervised experience in assessment of psychotherapy with child survivors of trauma and their families.
Psychometric Properties in (Specific Population)	
Reliability:	• Internal consistency: Reported to be between .81 to .85 (Ribbe, 1997). • Inter-rater reliability: Independent review of 24 taped interviews by a second clinician yielded Cohen's kappa of .73 to 1.00 for various types of traumatic events (Ford & Rogers, 1997; Davis et al., 2000). • Test-retest reliability: Using a combination of TESI-C and TESI-P (parent version) ratings in a subgroup of 24 patients at outpatient follow-up 1 or more months later yielded good to fair agreement for several types of events (sexual abuse, κ = 0.83; family arguments, κ = 0.69; domestic violence, κ = 0.56; physical abuse, κ = 0.51; witnessing other's death or serious illness, κ = 0.49) and marginal to poor agreement for others (prior accident/medical procedures, κ = 0.41; verbal abuse, κ = 0.40; witnessing an accident, κ = 0.25; and experiencing a storm or natural disaster, κ = −0.07) (Ford & Rogers, 1997; Davis et al., 2000).
References for Reliability:	Davis, W.B., Racusin, R., Fleischer, A., Mooney, D., Ford, J. D., & McHugo, G. (2000). Acute stress disorder symptomatology during hospitalization for pediatric injury. Journal of the American Academy of Child and Adolescent Psychiatry, 39, 569-575. Ford, J.D., & Rogers, K. (1997). *Empirically-based assessment of trauma and PTSD with children and adolescents*. Paper

	presented at the 13th annual meeting of the International Society for Traumatic Stress Studies, Montreal. Ribbe, D. (1996). Psychometric review of Traumatic Event Screening Instrument for Children (TESI-C). In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 386-387). Lutherville, MD: Sidran Press.
Validity:	Unknown (Gray & Slagle, 2006)
References for Validity:	Not applicable
Summary	
Strengths:	• "The TESI appears to show promise as a useful and efficient screening inventory to assess child exposure to potentially traumatic events. Identification of traumatic event exposure allows the clinician to comprehensively assess and understand a child's functioning and thereby assist in treatment. As noted previously, the scale seems to have a number of advantages over other inventories. In addition to its clinical utility, the TESI appears to be of potential benefit for clinical research purposes. Furthermore, this approach to assessing trauma can be integrated with other methods" (Kantor & Jasinksi, 1997, p. 117). • "This is a structured interview scale that holds good promise for a comprehensive analysis of children's exposure to traumatic events and is one of the few measures available to screen for such events with very young children" (Strand, Sarmiento, Pasquale, 2005). • The scale allows for obtaining two summary indices: nonvictimization trauma (accident, disaster, illness); and victimization trauma (assault, mugging, community violence, family violence, or sexual molestation) (Ford et al., 1999).
Limitations:	• "A current limitation is the level of psychometric maturity" (Kantor & Jasinksi, 1997, p. 117). • Psychometric testing of the TESI-SRR and TESI-PRR is still underway (Strand, Sarmiento, Pasquale, 2005). • Test-retest reliability is stronger for some but weaker for other traumatic events.
Additional Comments:	None
Reviewer:	Tejas Srinivas, M.A., Doctoral Student University of Denver Email: tejas.srinivas@du.edu
Review Date:	5/20/14

The University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index for DSM-IV (Child and Adolescent Version)
(UCLA-PTSD RI)

Authors:	Robert Pynoos, M.D., Ned Rodrigez, Ph.D., Alan M. Steinberg, PhD, Margaret Stuber, M.D., Calvin Frederick, M.D.
Citation:	Steinberg, A. M., Brymer, M. J., Decker, K. B., & Pynoos, R. S. (2004). The University of California at Los Angeles post-traumatic stress disorder reaction index. *Current Psychiatry Reports*, 6, 96-100.
How to obtain the measure:	http://www.irct.org/Files/Filer/global/Training/Istanbul%202009/UCLA_PTSD_Adolescent.pdf http://www.irct.org/Files/Filer/global/Training/Istanbul%202009/UCLA_Child_PTSD_Index.pdf
Copyrighted:	Yes
Cost:	Available at No Cost
Measure description:	The UCLA PTSD Index is a screening instrument that assesses exposure to 26 types of traumatic events and assesses for posttraumatic stress disorder (PTSD) symptoms during the past month for school-age children and adolescents (ages 7-18). The symptom items map directly onto DSM-IV intrusion, avoidance, and arousal criteria, while two additional items assess associated features (fear of recurrence and trauma-related guilt). Scores include UCLA PTSD-RI total score, re-experiencing, avoidance, and arousal subscale scores.
Ages:	Appropriate for children ages 7-18 • Child Version: 7-12 • Adolescent Version: 13-18
Measure format:	Child self-report
Number of items:	20-22 symptom items Response Format: • Yes/ No for trauma exposure items • 5-point Likert scale (0 = None, 1 = A little, 2 = Some, 3 = Much, 4 = Most) for PTSD symptoms
Domains assessed:	• Traumatic Stress
Specific Population(s):	Ethnic minority children and adolescents
Languages Available:	English Arabic Armenian Chinese Farsi/Persian Filipino/Tagalog French German Greek Hebrew Japanese

<table>
<tr><td></td><td>Norwegian
Russian
Spanish</td></tr>
<tr><td>Population Used For Measure Development:</td><td>Unknown</td></tr>
<tr><td>Normative Sample:</td><td>Unknown</td></tr>
<tr><td>Training Required:</td><td>• Manual/Video
• Prior experience with psychological testing and interpretation</td></tr>
<tr><td colspan="2">Psychometric Properties in (Specific Population)</td></tr>
<tr><td>Reliability:</td><td>
<table>
<tr><th>Type</th><th>Rating</th><th>Statistic</th><th>Min.</th><th>Max.</th><th>Avg.</th></tr>
<tr><td>Internal-Consistency</td><td></td><td>Alpha</td><td>.88</td><td>.90</td><td>.89</td></tr>
<tr><td>Hispanic/Latino</td><td>.90</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Black/African American</td><td>.89</td><td></td><td></td><td></td><td></td></tr>
<tr><td>American Indian/Alaskan Native</td><td>.88</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Test-retest</td><td>.84</td><td>Pearson's r</td><td></td><td></td><td></td></tr>
</table>
Notes:
1.) Internal consistency was reported for a sample of 6,291 children and adolescents ages 7-18. For the total sample, internal consistency reliability (Cronbach's alpha) was reported as follows:
Full Scale = .90, re-experiencing = .82, avoidance= .79, arousal = .67

2.) Test-retest reliability data, with an interval range of 6 to 28 days, were reported for a sample of 73 adolescents.
</td></tr>
<tr><td>References for Reliability:</td><td>Elhai JD, Layne CM, Steinberg AS, Brymer, MJ, Briggs EC, Ostrowski SA, Pynoos, RS (2013). Psychometric properties of the UCLA PTSD reaction index. Part 2: Investigating factor structure findings in a national clinic-referred youth sample. Journal of Traumatic Stress, 26, 10-18.

Steinberg A.M., Brymer M.J., Kim S., Ghosh C., Ostrowski S.A., Gulley K., Briggs, E.C., Pynoos, R.S. (2013). Psychometric properties of the UCLA PTSD Reaction Index: Part 1. Journal of Traumatic Stress, 26, 1-9.

Roussos, A., Goenjian, A. K., Steinberg, A. M., Sotiropoulou, C., Kakaki, A., Kabakos, C., Karagianna, S., & Manouras, V. (2005). Posttraumatic stress and depressive reactions among children and adolescents after the 1999 earthquake in Ano Liosia, Greece. The American Journal of Psychiatry, 162, 530-537.

Steinberg, A. M., Brymer, M. J., Decker, K. B., & Pynoos, R. S. (2004). The University of California at Los Angeles post-traumatic stress disorder reaction index. Current Psychiatry Reports, 6, 96-100.</td></tr>
<tr><td>Validity:</td><td>Construct Validity Evaluated: Yes</td></tr>
</table>

Construct Validity:

Validity Type	Not known	Not found	Nonclinical Samples	Clinical Samples	Diverse Samples
Convergent / Concurrent				yes	yes
Discriminant					
Sensitive to Change				yes	yes
Intervention Effects			yes	yes	yes
Longitudinal / Maturation Effects				yes	yes
Sensitivity to Theoretically Distinct Groups			yes	yes	yes
Factorial Validity				yes	

Criterion Validity Evaluated: Yes

Criterion Validity:

Validity Type	Not Known	Not Found	Nonclinical Samples	Clinical Samples	Diverse Samples
Predictive Validity				yes	
Postdictive Validity	yes				

Limitations of Psychometric Properties: Replications of findings should be conducted in larger, more diverse child and adolescent PTSD screening samples to further establish the instrument's reliability and validity across various populations.

References for Validity:

Elhai J.D., Layne C.M., Steinberg A.S., Brymer, M.J., Briggs E.C., Ostrowski S.A., Pynoos, R.S. (2013). Psychometric properties of the UCLA PTSD reaction index. Part 2: Investigating factor structure findings in a national clinic-referred youth sample. *Journal of Traumatic Stress,* 26, 10-18.

Steinberg A.M., Brymer M.J., Kim S., Ghosh C., Ostrowski S.A., Gulley K., Briggs, E.C., Pynoos, R.S. (2013). Psychometric properties of the UCLA PTSD Reaction Index: Part 1. *Journal of Traumatic Stress,* 26, 1-9.

Rodriguez, N., Steinberg, A. S., Saltzman, W. S., & Pynoos, R. S. (2001). PTSD index: Preliminary psychometric analysis of child and parent versions. Symposium conducted at the Annual Meeting of the International Society for Traumatic Stress Studies, New Orleans, LA.

Summary	
Strengths:	• The UCLA PTSD RI for DSM-IV is a user-friendly, brief screening measure that provides information for both trauma exposure and PSTD symptoms following the DSM-IV diagnostic criteria. • In addition to the child and adolescent self-report version, the UCLA PTSD RI has an alternate version for parents to fill out about their children/adolescents; allowing for multiple raters to assess for trauma exposure and PTSD symptomatology.
Limitations:	• The assessment of trauma exposure may not include all relevant traumatic events (e.g., immigration, migration), and therefore additional traumas may need to be added to be relevant for a particular population. • The procedures are based on Western diagnostic model that may or may not be applicable across cultures. The symptom section may not include culturally relevant signs and symptoms of posttraumatic distress (e.g., "I cry," "I think too much"), and therefore may need to be adapted (Murray et al., 2011). • Findings suggest that it is more appropriate to score and interpret PTSD symptoms at the level of individual subscale score versus the total score. This further suggests that the UCLA-PTSD should be used as a screener to examine symptom profile using the subscale scores, and further evaluation for full threshold diagnostic criteria of PTSD should be conducted using clinical interview and observation (Elhai, et al., 2013).
Additional Comments:	A new version adapted for DSM-V diagnostic criteria is available; however reliability and validity of the measure have not been assessed.
Reviewer:	Kerry Gagnon, B.A., Doctoral Student University of Denver Email: Kerry.Gagnon@du.edu
Review Date:	May 20, 2014

Acceptance and Commitment Therapy (ACT)

Developer:	Steven C. Hayes, Ph.D. Kirk Strosahl, Ph.D. Kelly G. Wilson, Ph.D.
Citation:	Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. Guilford Press.
Treatment Manual:	http://contextualscience.org/treatment_protocols
Treatment description:	Developed within a coherent theoretical and philosophical framework, Acceptance and Commitment Therapy (ACT) is a unique empirically based psychological intervention that uses acceptance and mindfulness strategies, together with commitment and behavior change strategies, to increase psychological flexibility. Psychological flexibility means contacting the present moment fully as a conscious human being, and based on what the situation affords, changing or persisting in behavior in the service of chosen values. Based on Relational Frame Theory, ACT illuminates the ways that language entangles clients into futile attempts to wage war against their own inner lives. Through metaphor, paradox, and experiential exercises clients learn how to make healthy contact with thoughts, feelings, memories, and physical sensations that have been feared and avoided. Clients gain the skills to re-contextualize and accept these private events, develop greater clarity about personal values, and commit to needed behavior change. ACT is an orientation to psychotherapy, not a specific set of techniques; however, ACT protocols address six core processes: acceptance, cognitive fusion, being present, self as context, values, and committed action.
Recommended Populations:	• Children, adolescents, and adults • Individuals with anxiety disorders, depression, chronic pain, eating disorders, or psychotic symptoms
Specific Population(s):	Ethnic minority children
Settings:	Outpatient, school, and group settings
Languages Available:	N/A
Required Training/Certification:	• No official certification process • Training provided by ACT peer-reviewed trainers • Workshops, conferences, and academic training are also encouraged
Effectiveness in Ethnic Minority Children	
Evidence Base in Ethnic Minority Children:	• No studies examining effectiveness in ethnic minority children • Some evidence of effectiveness in ethnic minority adults (Hinton et al., 2013; Woidnek et al., 2012) • Some evidence of effectiveness for children and adolescents in general (Coyne et al., 2011)
Adaptations:	• For children: use concrete metaphors, involve parents • For ethnic minorities: emphasize culturally congruent processes; make religious/spiritual connections when appropriate;

References for Adaptations:	Coyne, L. W., McHugh, L., & Martinez, E. R. (2011). Acceptance and commitment therapy (ACT): Advances and applications with children, adolescents, and families. *Child And Adolescent Psychiatric Clinics Of North America*, *20*(2), 379-399. Hinton, D. E., Pich, V., Hofmann, S. G., & Otto, M. W. (2013). Acceptance and mindfulness techniques as applied to refugee and ethnic minority populations with PTSD: Examples from 'Culturally Adapted CBT'. *Cognitive And Behavioral Practice*, *20*(1), 33-46. Woidneck, M. R., Pratt, K. M., Gundy, J. M., Nelson, C. R., & Twohig, M. P. (2012). Exploring cultural competence in acceptance and commitment therapy outcomes. *Professional Psychology: Research And Practice*, *43*(3), 227-233.
Effectiveness:	*Children* • A series of single-case studies and uncontrolled small-group studies establish preliminary evidence of effectiveness (Murrell & Scherbarth, 2011) *Ethnic Minority Adults* • Case studies, pilot studies, and small-group RCTs establish preliminary evidence for effectiveness (Canon Garzon, 2013; Hinton et al., 2013; Woidneck 2012)
References for Effectiveness:	Canon Garzon, L. (2013). Acceptance and Commitment Therapy (ACT) as an alternative for reducing psychological distress experienced by Latino parents of children with autism: A pilot study. *Dissertation Abstracts International*, *74*. Murrell, A. R., & Scherbarth, A. J. (2011). State of the research & literature address: ACT with children, adolescents and parents. *International Journal Of Behavioral Consultation And Therapy*, *7*(1), 15-22.
Summary	
Research Strengths:	Research is beginning to focus on many different ethnic identities, including Latino parents, refugees, and people of Asian heritage.
Research Limitations:	Evidence base for use of ACT with ethnic minority youth is nonexistent. Evidence for use of ACT with either ethnic minority adults or majority youth is preliminary at best: there is a lack of RCTs, and no way to estimate treatment effect size currently. While recommendations for culturally-sensitive or culturally-adapted ACT protocols abound, there is no conclusive evidence for either the need for or effectiveness of such adapted protocols.
Reviewer:	Kayla Knopp, B.S., Doctoral Student University of Denver Email: kayla.knopp@du.edu
Review Date:	May 20, 2014

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Developer:	CBITS was developed by a team of clinician-researchers from the RAND Corporation, the University of California at Los Angeles (UCLA), and the Los Angeles Unified School District (LAUSD).
Citation:	Jaycox, L. H. (2003). *CBITS: Cognitive-Behavioral Intervention for Trauma in Schools*. Sopris West. Kataoka, S. H., Santiago, C. D., Jaycox, L. H., Langley, A. K., Stein, B. D., & Vona, P. (2014). Cognitive Behavioral Intervention for Trauma in Schools. *Dissemination and Implementation of Evidence-Based Practices in Child and Adolescent Mental Health*, 294.
Treatment Manual:	http://cbitsprogram.org/
Treatment description:	The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is designed to reduce symptoms of posttraumatic stress disorder (PTSD), depression, and behavioral problems; improve peer and parent support; and enhance coping skills of students who have been exposed to traumatic events. These events can include community and school violence, physical abuse, domestic violence, accidents, and natural disasters. CBITS combines a school-based group intervention and an individual intervention. The program includes 10 group sessions and 1-3 individual sessions for students, 2 parent psychoeducational sessions, and a teacher educational session. It is designed for delivery in the school setting by mental health professionals working in close collaboration with school personnel. CBITS incorporates cognitive and behavioral theories of adjustment to traumatic events and uses cognitive-behavioral techniques such as psychoeducation, relaxation, social problem solving, cognitive restructuring, imaginal exposure, exposure to trauma reminders, and development of a trauma narrative.
Recommended Populations:	• CBITS has primarily been tested with children in grades 3-8 and is intended for children from 6-12 years old.
Specific Population(s):	• Youth exposed to traumatic events
Settings:	School settings
Languages Available:	English and Spanish
Required Training/Certification:	• There is a free online training course to prepare to implement CBITS. • Sample materials and forms to deliver the CBITS intervention are available on the website • Video clips of experts providing practical advice on CBITS implementation
Effectiveness in (Specific Population)	
Adaptations:	• CBITS has been adapted for use with traumatized Latino immigrant children. Worksheets and parent

	handouts have been translated into Spanish. • CBITS has been adapted for use in American Indian reservation schools to reflect the traditional culture and wellness practices for practicing tribes. • CBITS worksheets have been adapted for use among low-literacy populations and youth in foster care. • CBITS has also been modified for delivery by non-clinicians and in a variety of settings (urban, rural, suburban, and tribal).
References for Adaptations:	Goodkind, J. R., LaNoue, M. D., & Milford, J. (2010). Adaptation and implementation of cognitive behavioral intervention for trauma in schools with American Indian youth. *Journal of Clinical Child & Adolescent Psychology*, *39*(6), 858-872. Kataoka, S. H., Stein, B. D., Jaycox, L. H., Wong, M., Escudero, P., Tu, W., ... & Fink, A. (2003). A school-based mental health program for traumatized Latino immigrant children. *Journal of the American Academy of Child & Adolescent Psychiatry*, *42*(3), 311-318. Ngo, V., Langley, A., Kataoka, S. H., Nadeem, E., Escudero, P., & Stein, B. D. (2008). Providing evidence based practice to ethnically diverse youth: Examples from the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program. *Journal of the American Academy of Child and Adolescent Psychiatry*, *47*(8), 858.
Effectiveness:	**Effectiveness by symptoms:** **PTSD symptoms:** CBITS was found to yield significantly decreased PTSD symptoms across multiple studies of youth exposed to traumatic events. **Depression symptoms:** CBITS intervention groups showed significantly decreased depression scores after treatment. **Psychosocial dysfunction:** CBITS intervention groups showed decreased psychosocial dysfunction scores (with a medium effect size) compared to waitlist controls. **Effectiveness in different populations:** **Original trial**: CBITS significantly reduced the symptoms of PTSD and depression in students who had been exposed to violence compared to a waitlist control group. **With Latino immigrant children:** Students in the intervention group had significantly greater improvement in posttraumatic stress disorder and depressive symptoms compared with those on the waitlist. **With American Indian youth:** Participants experienced significant decreases in anxiety and posttraumatic stress

	disorder symptoms, and avoidant coping strategies, as well as a marginally significant decrease in depression symptoms. Improvements in anxiety and depression were maintained 6 months post-intervention; improvements in posttraumatic stress disorder and avoidant coping strategies were not maintained at 6 months.
References for Effectiveness:	Goodkind, J. R., LaNoue, M. D., & Milford, J. (2010). Adaptation and implementation of cognitive behavioral intervention for trauma in schools with American Indian youth. *Journal of Clinical Child & Adolescent Psychology*, *39*(6), 858-872. Jaycox, L. H., Cohen, J. A., Mannarino, A. P., Walker, D. W., Langley, A. K., Gegenheimer, K. L., ... & Schonlau, M. (2010). Children's mental health care following Hurricane Katrina: A field trial of trauma-focused psychotherapies. *Journal of Traumatic Stress*, *23*(2), 223-231. Kataoka, S. H., Stein, B. D., Jaycox, L. H., Wong, M., Escudero, P., Tu, W., ... & Fink, A. (2003). A school-based mental health program for traumatized Latino immigrant children. *Journal of the American Academy of Child & Adolescent Psychiatry*, *42*(3), 311-318. Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., & Fink, A. (2003). A mental health intervention for schoolchildren exposed to violence: a randomized controlled trial. *JAMA*, *290*(5), 603-611.
Summary	
Research Strengths:	Three of the four studies used in this review were evaluated by the *National Registry of Evidence-based Programs and Practices* to determine the Quality of Research. Overall ratings were 3.0 or higher in a 4.0 scale. Strengths included: • Use of psychometrically sound measurements that are widely used and have strong reliability and validity. • Handling missing data well. • Use of appropriate analyses.
Research Limitations:	• Weakness of the three independently rated studies included unsystematic methods to rate fidelity to the treatment manual and confounding variables that were not resolved, such as group differences at baseline, lack of blinding, and different levels of attrition between treatment groups. • Symptom changes with Latinos were modest and on average remained in the clinical range at short-term follow up. • Qualitative studies that investigate immigrant

	Latino student and family perceptions and attitudes toward school-based mental health services are needed to further improve programs like CBITS. • Differences were found across Latino subgroups suggesting tailoring to specific ethnic groups may be necessary.
Additional Comments:	
Reviewer:	Skyler Leonard, M.Ed., Doctoral Student University of Denver Email: Skyler.leonard@du.edu
Review Date:	5/16/14

Cognitive Behavioral Therapies for Latino children with Anxiety Disorders

Developer:	Armando Pina
Citation:	Pina, A.A., Villalta, I.K., Zerr, A.A. (2009). Exposure based cognitive behavioral treatment of anxiety in youth: An emerging culturally-prescriptive framework
Treatment Manual:	Pina, A. A. (2007). *Acercamiento: An exposure-based treatment for phobic and anxiety disorders in Latino youth (Manual)*. Tempe, AZ: Lulu Publishing
Treatment description:	Cognitive Behavioral Therapies for anxiety disorders have been established as evidence-based treatments for Caucasian youth. However, only a few studies have compared whether these treatments are effective treatments for Latino youth with anxiety disorders. One study has found that exposure-based CBT procedures produced similar results in Latino and Caucasian youth aged 6-16, but these youths were highly proficient in English (Pina, Silverman, Fuentes, Kurtines, & Weems, 2003). In this study, there were no statistically significant differences among rating scales and diagnostic recovery rates between Latino and Caucasian children (Pina et al., 2003). However, in a different study, treatment gains as reported on the Revised Children's Manifest Anxiety Scale found significantly greater gains for Caucasian than for Latino youths (Rogers, Howard, & Vessey, 1993). It is important to note that exposure based CBT seem to have a potential effect for alleviating anxiety disorders in Latino youth. There is a lack of understanding of which factors of the existing treatment are effective and for whom. With Latino youth having relatively high rates of phobic and anxiety disorders, and particularly higher rates of separation anxiety when compared to Caucasians, cultural adaptations are critical. As such, a cultural adaptation for ethnocultural minorities has been advised (Malgady & Constantino, 1999). Pina et al., have made suggestions for working with minority youth, particularly in adapting the exposure based CBT programs for anxious Mexican-American youth based on a culturally prescriptive framework. This framework is for creating more culturally engaging and efficacious interventions, and is based on the current data showing that when minorities receive culturally-adapted services, less acculturated clients tend to respond well. (Pina, A.A., Silverman, W., Fuentes, R.M., Kurtines, W.M., & Weems, C.F. (2003). Exposure based cognitive behavioral treatment for phobic and anxiety disorders: Treatment effects and maintenance for Hispanic/ Latino relative to European-American youths. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(10), 1179-1187.)
Recommended Populations:	• Children ages 7-10 and at least one caregiver Efficacy studies include Mexican-origin youth.
Specific Population(s):	• Latino children and families.
Settings:	Clinical
Languages Available:	English, Spanish, English and/or Spanish
Required Training/Certification:	No specific certification required

Effectiveness in (Specific Population)	
	• Pretest to posttest analyses show that the effect is statistically significant (t [9] = .428, p <.01, *d* =1.3). Mean total anxiety scores decreased from 12.6 before treatment to 3.6 after treatment
Adaptations	The cultural framework treats the child as a "cultural broker" who provides information to the therapist for creating a cultural map, which is a report about the child's values from the culture/ family of origin. If this cultural map reveals that the child has high levels of *Familismo*, then this would be considered an aspect of culture to be utilized in the intervention, whereas if this were not the case, then this aspect of the culture would not be included in the intervention. Eventually, therapists will be able to create interventions that include evidence based cultural modules for working with Latino youth. Cultural mapping offers a formulation for developing and testing treatments for Latino minorities across interventions and modalities. What seems important for treatment engagement and efficacy seem to be how the components of emotion, cognition, and behavior are presented. The framework by Bernal and colleagues identifies 8 parameters that should be considered when adapting an intervention to a culture, including language, persons, metaphors, content, concepts, goals, methods, and contexts (Bernal, Bonilla, & Bellido, 1995). As such, these were targets of cultural adaptations that were made to the exposure modules of CBT for anxiety disorders in Mexican-origin youth. 1. Language: most anxiety treatment programs use acronyms such as FEAR, which do not readily translate into Spanish. As such, cultural adaptation involved translating these materials into Spanish, offering treatment itself in Spanish or English 2. Persons: clinicians should pay particular attention to the characteristics of the cultural group, and the child and parent should be comfortable with the clinician. For example, the clinician may have to share personal stories to show cultural similarities between herself and the client (such as favorite dishes), throughout the intervention. The clinician should also be able to accept values that reflect the parent and child's culture. 3. Metaphors: symbols and concepts that are recognized by the cultural group should be used. For example, in traditional CBT, stick figures are used to show the ways anxiety manifests; this is understood by Mexican-origin families as well. Other symbols, such as the CBT ladder which is used to teach the plan of gradual exposure to feared objects, are not as recognized by Mexican origin families and were not adapted. 4. Content: treatments should not go against the values, customs, traditions, or history of the cultural group. Key values that seemed particularly relevant were included in the treatment, such as religion and family obligations. The

	manual recommends that the clinician ask about weekly family activities, relatives in the country of origin, etc. 5. Concepts: in general, the standard exposure based CBT was consonant with Mexican culture; however, aspects such as calling the treatment sessions "*las clases*" (the classes) are adapted 6. Goals: goals for treatment are framed within cultural values and the expectations of the culture. 7. Methods: treatment methods are to be framed within the cultural values of the group. Many Latinos have stated that they prefer services in a family format instead of the individual format of standard CBT. 8. Context: consideration should be given to the economic, social, and individual context of the anxiety. This treatment was offered free-of-charge and near bus stops.
References for Adaptations:	• Pina, A.A., Villalta, I.K., Zerr, A.A. (2009). Exposure based cognitive behavioral treatment of anxiety in youth: An emerging culturally- prescriptive framework
Effectiveness:	*Mean Total Anxiety Scale* Pre to post effect was statistically significant for Mean Total Anxiety scale scores: decreased from 12.6 before treatment to 3.6 after treatment. *Physiological Anxiety* Significant decreases found: t[0]= 2.71, p <.03, d=.70 *Social- Concerns Concentration Scale* Significant decreases found: t[9[= 2.80, p <.02, d= 1.0 *Worry / Oversensitivity scale* Significant decreases found: t[9]= .508, p<.01, d= 1.4
References for Effectiveness:	• Pina, A.A., Villalta, I.K., Zerr, A.A. (2009). Exposure based cognitive behavioral treatment of anxiety in youth: An emerging culturally- prescriptive framework
Summary	
Research Strengths:	Preliminary treatment effect size data from ten treated youth of Mexican-origin demonstrate that the emerging culturally prescriptive framework for working with minority youth and the cultural based adaptions reduce anxiety symptoms. More studies are needed to replicate the findings and determine the efficacy of these adaptions.
Research Limitations:	Replication with a larger sample size is needed. Efficacy of CBT with diverse Latino youth should be established with a randomized clinical trial that has a treatment as usual condition. As moderators, such as acculturation or enculturation, are evaluated, this cultural adaptation of CBT should be further refined. Other potential mediators of a child's treatment response should also be explored.

Reviewer:	Ann Spilker, B.A., Doctoral Student University of Denver Email: ann.spilker@du.edu
Review Date:	5/20/2014

Dialectical Behavior Therapy for Suicidal Adolescent Inpatients

Developer:	Marsha Linehan, PhD, (modified by Laurence Y. Katz, M.D., Brian J. Cox, PH .D., Shiny Gunasekara, M.D., and Alec L. Miller, Psy.D.)
Citation:	Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press. Linehan, M. (1993). Skills training manual for treating borderline personality disorder. New York: Guilford Press.
Treatment Manual:	Available by purchase (see above)
Treatment description:	Dialectical Behavior Therapy (DBT) is a cognitive behavioral therapy originally developed by Marsha Linehan to treat individuals diagnosed with Borderline Personality Disorder. Addressing the result of biological vulnerability paired with a pervasively invalidating environment, DBT blends skills training, behavioral modification strategies, and validation to help patients create a life worth living. DBT is also a successful treatment for reducing the rate of suicide attempts as well as for reducing non-suicidal self-injury. DBT was originally created for individuals 18 years of age and older. Recent work has been done to determine if DBT is appropriate for the treatment of adolescent or even childhood behavioral issues and self-injurious behavior.
Recommended Populations:	• Adolescent inpatients aged 14-17 years • Efficacy studies include adolescents who were Caucasian (72.6%), Black (0%), Latino (1.6%), Asian American/ Pacific Islander (4.8%), First Nations Populations (19.4%) and 1.6% other backgrounds.
Specific Population(s):	None
Settings:	Inpatient settings
Languages Available:	English
Required Training/Certification:	• Master's Degree or equivalent in a mental health profession, and state license or equivalent to practice therapy • DBT training must be obtained via University work, continuing education, or a curriculum-based learning program in DBT given by a certified clinician. • This training must be followed by two completed cases, one year of DBT team membership, and current practice of DBT including team membership. Further details available at http://depts.washington.edu/brtc/dbtca/wp-content/uploads/2012/01/Prerequisites-for-Certification.pdf
Effectiveness in (Specific Population)	
Adaptations:	• For the treatment of adolescents, a 2-week inpatient adolescent DBT program was modified from the 12-week adolescent outpatient program. Patients were also seen twice weekly by a therapist for individual DBT psychotherapy.

References for Adaptations:	Rathus JH, Miller AL (2002), Dialectical behavior therapy adapted for suicidal adolescents. *Suicide and Life Threatening Behavior 32:*146–157. Miller, A. L., Rathus, J. H., & Linehan, M. M. (2006). *Dialectical behavior therapy with suicidal adolescents*. Guilford Press.
Effectiveness:	***Behavioral Problems*** • DBT significantly reduced behavioral incidents over the treatment as usual group **(*t*(1,59) = 1.98, p = .052)** **Depression score** • Reductions in BDI score at discharge and one-year follow up (effect size =1.67) **Suicidal Ideation** • Reduction in suicidal ideation at discharge and one-year follow up (effect size= 2.12) **Lifetime Parasuicide Count** • Reduction in parasuicidal attempts at discharge and one-year follow up (effect size =.63) **Note:** • No demographic differences were detected between groups at baseline
References for Effectiveness:	Katz, L. Y., Cox, B. J., Gunasekara, S., & Miller, A. L. (2004). Feasibility of dialectical behavior therapy for suicidal adolescent inpatients. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43*(3), 276-282.
Summary	
Research Strengths:	DBT was compared to Treatment as usual. The adolescents who were treated were given either DBT or TAU based on which ward they were residing in. The Katz et al., (2004) study was the first to evaluate the effectiveness of DBT in adolescents. Interestingly, the authors also noted a reduction of behavioral problems on the ward where DBT was implemented. Thus, there may be more potential effects of DBT that were not specifically measured by this study. There is certainly more room for study of the effectiveness of DBT in adolescents, and particularly for adolescents of color.
Research Limitations:	The effectiveness study was with a relatively small sample and effect sizes should be viewed as preliminary and requiring replication. Further, the sample used in the study was predominantly female (84%) and Caucasian (72.6%). This study was not designed to compare the effectiveness of DBT across racial/ethnic groups and the small number of non-white participants prevents us from drawing firm conclusions about the effectiveness of DBT in different racial/ethnic groups. The duration and scheduling of

	treatment components was also different than what would occur in a typical course of DBT in an outpatient setting. It is unclear how outcomes would vary based on delivery setting, treatment duration, or scheduling of sessions.
Reviewer:	Rachel Lynn Miller, M.A., Doctoral Student University of Denver Email: Rachel.l.miller@du.edu
Review Date:	5/19/14

Early Denver Start Model (EDSM)

Developer:	Sally Rogers, Ph.D. & Geraldine Dawson, Ph.D.
Treatment Manual:	http://www.autismspeaks.org/what-autism/treatment/early-start-denver-model-esdm
Treatment description:	The Early Denver Start Model (EDSM) is a comprehensive behavioral early intervention for children with autism, ages 12-48 months. It is based in the principles of Applied Behavior Analysis (ABA) with an emphasis on relationship-focused development model. Its core features include: an emphasis on the normative developmental sequence, focus on interpersonal exchanges and positive affect, shared engagement and joint attention, language and communication taught inside a positive, affect-based relationship and intensive parent involvement. An RCT comparing EDSM to other community-based interventions showed EDSM to be superior in improving cognitive and language abilities and adaptive behavior.
Recommended Populations:	• Children ages 12-48 and at least one caregiver • Caucasian (73%), Latino (12.5%), Asian (12.5%), Multiracial (15%)
Settings:	Outpatient settings
Languages Available:	Manuals and Curriculum have been translated into Japanese, Spanish, French, Italian, Dutch & Arabic
Required Training/Certification:	• Requires a trained therapist
Effectiveness	
Effectiveness:	**IQ/Cognitive Abilities** • EDSM showed significant effects for cognitive abilities with an average increase of 15.4 points (> 1 SD) **Receptive & Expressive Language** • Significant improvements in receptive and expressive language after the intervention **Diagnostic Status** • Children who received EDSM were more likely to have improved diagnostic status after 2 years
References for Effectiveness:	Dawson et al., (2010). Randomized, Controlled-Trial of an Intervention for Toddlers with Autism: The Early Denver Start Model. Pediatrics, 125(1).
Summary	
Research Strengths:	• The research provides strong evidence for the efficacy of the approach with younger children, as well as the integration of parent involvement (vs. traditional ABA-approaches which rely exclusively on the therapist).
Research Limitations:	• The approach has not been well validated with an ethnically diverse sample. While the manuals have been translated, research is lacking regarding the efficacy of these translations.
Reviewer:	Lisa Ankeny, M.A., Doctoral Student University of Denver Email: lankeny@du.edu
Review Date:	05/20/2014

Interpersonal Psychotherapy—Adolescent Skills Training (IPT-AST)

Developer:	Jami Young, Ph.D. & Laura Mufson, Ph.D.
Citation:	Young, J. F. & Mufson, L. (2003). *Manual for interpersonal psychotherapy—adolescent skills training (IPT-AST)*. New York: Columbia University.
Treatment Manual:	Contact Dr. Young, JFYoung@rci.rutgers.edu
Treatment description:	Interpersonal Psychotherapy—Adolescent Skills Training (IPT-AST) is a group-based prevention and treatment program for adolescents with or without symptoms of depression. It places emphasis on developing interpersonal skills in order to improve the quality of interpersonal relationships. IPT-AST was initially developed for adolescents in grades 7-10 with subclinical depression symptoms. In IPT-AST, adolescents are taught specific communication skills in order to establish or strengthen interpersonal relationships. IPT-AST consists of one or two individual pre-group sessions with a leader, eight group sessions with other adolescents (sometimes with an individual mid-group session with a leader after the fourth group session and a post-group individual session after the eighth group session). IPT-AST has three phases: the initial phase highlights connections between interpersonal relationships and mood and teaches communication skills; the middle phase allows adolescents to practice applying the skills to hypothetical and real situations; the final phase builds adolescents' confidence in applying the skills outside the group in order to establish and maintain healthy relationships. IPT -AST is generally administered in eight weekly, 90-minute sessions in a school or university setting by one or two masters or doctoral level leaders. The treatment manual provides written outlines and scripted examples for each session. The program has been used primarily with Hispanic and Caucasian adolescents. In response to effectiveness studies, booster sessions have been added in hopes of increasing the long-term effectiveness of the program.
Recommended Populations:	• Adolescents in grades 7-10 (ages 12-16 years) and at least one parent if possible, though the program can be completed without parent involvement • Efficacy studies primarily include Caucasian and Hispanic adolescents, though African American children are also well-represented in most of these samples
Settings:	Outpatient, university, and school settings
Languages Available:	English
Required Training/Certification:	• Group leaders should be at least masters or doctoral level psychologists or child psychiatrists.
Effectiveness in Hispanic and Caucasian Adolescents	
Effectiveness:	***Reducing Depressive Symptoms*** • Significant reductions in depressive symptoms relative to a school counseling group immediately post-treatment (and 6-months post-treatment in some

	studies), but not relative to a CBT-based alternative treatment o Reductions were largest for those with many depression symptoms at baseline • No significant reductions in depressive symptoms relative to a school counseling group at 12-months post-treatment **Improving Overall Functioning** • Significant improvements in overall functioning relative to a school counseling group immediately post-treatment and 6-months post-treatment • No significant improvements in overall functioning relative to a school counseling group at 12-months post-treatment **Reducing Likelihood of Depression Diagnosis** • Significantly fewer depression diagnoses relative to a school counseling control group immediately post-treatment and 6-months post-treatment • No significant reductions in the likelihood of depression diagnosis relative to a school counseling group at 12-months post-treatment
References for Effectiveness:	Young, J. F., Mufson, L., Gallop, R. (2010). Preventing depression: A randomized trail of interpersonal psychotherapy—adolescent skills training. *Depression and Anxiety, 27*(5), *426-433.* *Young J. F., Mufson L, & Davies, M. (2006)*. Efficacy of interpersonal psychotherapy—adolescent skills training: An indicated preventive intervention for depression. *Journal of Child Psychology and Psychiatry, 47*(12),1254-1262. Horowitz J. L., Garber, J., Ciesla, J.A., Young, J.F., Mufson, L. (2007). Prevention of depressive symptoms in adolescents: A randomized trial of cognitive-behavioral and interpersonal prevention programs. *Journal of Consulting and Clinical Psychology, 75*(5), 693-706.
Summary	
Research Strengths:	• All studies used random assignment and good methodologies to assess intervention fidelity (e.g., direct supervisor observation, use of clinical guides). • Some of the studies reviewed consisted of mostly Hispanic adolescents, which is an underrepresented population in the psychology literature broadly and the treatment effectiveness literature specifically. African American participants were also well-represented in most of these samples, which is a strength because African Americans are often underrepresented in this type of research.
Research Limitations:	• No studies to date have randomly assigned parent involvement versus no parent involvement, so findings

	regarding parent involvement cannot be generalized.
Additional Comments:	• Some studies provide one pre-group session instead of two. • Parent level of involvement in the treatment may be an important moderator of outcomes. In one study, participants were mostly (70%) from single-parent homes, so it is important to consider the possibility that parental involvement may differ across various family structures (i.e., findings from children of single parents may not generalize to children of coupled parents). • The manual details alternate instructions for pre-, mid-, and post-group sessions without parent attendance.
Reviewer:	Lane L. Nesbitt, B.A., Doctoral Student University of Denver Email: Lane.Nesbitt@du.edu
Review Date:	May 19, 2014

Incredible Years Series

Developer:	Carolyn Webster-Stratton, Ph.D.
Citation:	Webster-Stratton, C. (2001). The Incredible Years: Parents and children videotape series: A parenting course (BASIC). Seattle, WA: Incredible Years. Webster-Stratton, C. (2002). The Incredible Years: Parents and children videotape series: A parenting course (ADVANCE). Seattle, WA: Incredible Years.
Treatment Manual:	http://incredibleyears.com/
Treatment description:	The Incredible Years (IY) Series is a treatment and prevention program for parents, teachers, and children that targets child socioemotional and behavior problems, especially externalizing problems (e.g. ODD, CD, ADHD) and internalizing problems. The goal of the IY Series is to improve parent-child and teacher-student interactions by increasing positive and nurturing caregiver behaviors and decreasing harsh and negative caregiver behaviors. The goals of the IY Series are also to foster child social competence, emotion awareness, and regulation and cognitive problem-solving skills. In the IY Series, group leaders utilize observational and experiential learning through video demonstrations and role-plays. Parents watch videotapes depicting parent models interacting with children in various situations and then group leaders facilitate discussion of these video vignettes. Parents practice new skills and techniques through role-plays and homework assignments. In addition, parents and teachers are encouraged to set and work towards their own personal goals. Depending on the developmental stage of the child and the identified level of risk, sessions can vary from 4 weekly sessions to 60 bi-weekly sessions. Key strategies of the IY Series include using praise, encouragement, and incentives to build positive relationships with children, using proactive discipline such as setting clear limits or employing time out, and ignoring, distracting, or redirecting child misbehavior. Other strategies are geared towards promoting children's socioemotional competence.
Populations:	• Children ages 2-12 • Children with clinical levels of ODD and/or ADHD • Children from socioeconomically disadvantaged populations (e.g. Head Start) or other high-risk populations (e.g. child protective service referred families & foster care) • Demonstrated effectiveness in Caucasian, Hispanic, African-American, and Asian-American populations • Implemented in several countries, including the United

	States, Canada, England, Scotland, Ireland, Denmark, Finland, Norway, Sweden, Australia, New Zealand, Portugal, and the Netherlands
Settings:	- Home - School (e.g. Head Start, primary grade school) - Health Centers (e.g. community mental health center, primary care practice, hospital) - Other (e.g. foster parent agencies, church, homeless shelters, jails, YMCA's)
Training/Certification:	Incredible Years ® Certification (recommended)
Effectiveness	
Effectiveness:	Parenting & Teacher Behaviors - Increases in positive parenting behaviors (e.g. child-directed play, praise, proactive discipline, limit setting, & monitoring) - Decreases in negative parenting behaviors (e.g. spanking/hitting, criticism, harsh discipline) Child Behaviors - Increases in child positive affect & pro-social behavior towards caregivers and peers (*d* = .23) - Increases in emotional awareness and regulation - Increases in cognitive problem-solving skills - Decreases in child disruptive behavior (*d* = .27) - Decreases in hyperactivity & inattention Family Behaviors - Increases in positive communication & problem solving
References for Effectiveness:	Menting, A. T. A., Orobio de Castro, B., & Matthys, W. (2013). Effectiveness of the Incredible Years Parent Training to Modify Disruptive and Prosocial Child Behavior: A Meta-Analytic Review. Clinical Psychology Review, 33, 901-913.
Summary	
Intervention Strengths:	There are many versions of the IY Series that have been developed for a variety of child ages, levels of risk, and settings, making it a very flexible intervention. In light of the manualized group training approach, the IY Series can still be adapted to fit the specific characteristics and needs of caregivers. The IY Series can be administered by professionals from a range of training levels, from child care workers and teachers to social workers and psychologists.
Intervention Limitations:	Because many versions of the IY Series have been developed for a wide variety of child ages, levels of risk, and intervention settings, it is unclear for which particular population the IY Series is most effective. For instance, some studies have shown larger effect sizes for treatment compared to prevention, suggesting that parents who are experiencing clinical levels of child behavior problems may be more motivated to engage in treatment. On the other hand, other studies have suggested that high-risk populations may benefit less, indicating that outside

	factors may limit engagement and effectiveness.
Reviewer:	Lauren Gulley, M.A., Doctoral Student University of Denver Email: Lauren.Gulley@du.edu

Multisystemic Therapy

Developer:	Scott Henggeler, PhD
Citation:	Henggeler, S. W., Melton, G. B. & Smith, L. A. (1992). Family preservation using multisystemic therapy: An effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting and Clinical Psychology, 60(6),* 953-961. doi: 10.1037/0022-006X.60.6.953
Treatment Manual:	http://mstservices.com/index.php
Treatment description:	Multisystemic therapy is an integrative approach targeting multiple systems (e.g. child, family, school, peers, and neighborhood/community) to improve psychosocial functioning for youth and their families. The approach primarily aims to reduce deviant influences and increase prosocial development across contexts through an intensive treatment program.
Recommended Populations:	• Children ages 12-17 • Treatment effects have not been shown to vary by ethnicity or gender
Specific Population(s):	
Settings:	In-home and community settings
Languages Available:	N/A
Required Training/Certification:	• See treatment manual
Effectiveness in Female Adolescents	
Adaptations:	• No modifications made, though few studies have sufficient sample sizes to analyze results separately by gender
References for Adaptations:	Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). Multisystemic therapy for antisocial behavior in children and adolescents (2nd ed.). New York: Guilford Press. c.f. Hipwell, A. E. Loeber, R. (2006). Do we know which interventions are effective for disruptive and delinquent girls? *Clinical Child and Family Psychology Review, 9(3/4)*, 221-255. doi: 10.1007/s10567-006-0012-2
Effectiveness:	**Incarceration** • In one randomized control trial, youth who received MST had 20% incarceration rate compared to 68% incarceration rate in youth receiving usual services **Social Skills** • Significant reductions in peer aggression • Significant increases in family cohesion
References for Effectiveness:	Henggeler, S. W., Melton, G. B. & Smith, L. A. (1992). Family preservation using multisystemic therapy: An effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting and Clinical Psychology, 60(6),* 953-961. doi: 10.1037/0022-006X.60.6.953 Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). Multisystemic therapy for antisocial behavior in children and adolescents (2nd ed.). New York: Guilford Press.
Summary	

Research Strengths:	Multisystemic therapy shows considerable efficacy across several randomized trials for treating youth with severe behavioral problems and delinquency. The findings appear consistent across ethnicity and genders.
Research Limitations:	Samples in many of these studies disproportionately measure male adolescents, despite the substantial numbers of female adolescents involved in the juvenile justice system and exhibiting severe behavioral problems. Though gender differences have not emerged in the efficacy of MST, they have yet to be fully studied and the need for adaptation remains as of yet unknown.
Additional Comments:	N/A
Reviewer:	Jamie M. Novak, Doctoral Student University of Denver Email: Jamie.Novak@du.edu
Review Date:	5/16/2014

Parent Child Interaction Therapy (PCIT)

Developer:	Sheila Eyberg, PhD, ABPP
Citation:	Eyberg, S. M., & Boggs, S. R. (1998). Parent-child interaction therapy: A psychosocial intervention for the treatment of young conduct-disordered children. In J. M. Briesmeister, C. E. Schaefer (Eds.), Handbook of parent training: Parents as co-therapists for children's behavior problems (2nd ed.) (pp. 61-97). Hoboken, NJ, US: John Wiley & Sons Inc.
Treatment Manual:	http://www.pcit.org/
Treatment description:	Parent-Child Interaction Therapy (PCIT) is a behavioral, parent training treatment program developed for young children (ages 2-7) with emotional and behavioral disorders (primarily conduct disorder). Based on Diana Baumrind's development theory, PCIT draws on both attachment and social learning theories, PCIT aims to improve the quality of parent child interactions and model pro social behaviors. Through two phases, parents are taught how to establish/modify parent child interactions in a way that allows for secure attachment development. These skills are couched in Child-Directed Interaction (CDI), which structures interaction time between the parent and child. Further, parents learn skills to consistently implement consequences for maladaptive child behavior. The latter skill is called Parent-Directed Interaction (PDI). CDI incorporates guiding behavioral principles for parents to apply when interacting with their children. Many of the nondirective skills taught during the CDI phase, which are aimed at fostering a bond between the parent and child, are similar to play therapy techniques. During the PDI phase, parents are taught more effective measures for appropriate discipline practices for their child in an attempt to mold and model acceptable behaviors. PCIT incorporates both teaching sessions and a live coaching session so the parents are afforded direct coaching on their newly acquired skills. PCIT has been used with children and families with a history of abuse, child prenatal substance exposure, as well as children with developmental disabilities, and generalized anxiety disorder.
Recommended Populations:	• Children ages 2-7 and at least one caregiver • Efficacy studies include Caucasian, Black, Latino, and Aboriginal children.
Specific Population(s):	Mexican American and African American children and families
Settings:	Outpatient and school settings
Required Training/Certification:	• PCIT Master Trainers are certified by PCIT International. Training requirements vary by level. Four distinct certification levels are available: PCIT therapist, Level I Trainer, Level II Trainer, Master Trainer
Effectiveness in (Specific Population)	
Adaptations:	• Mexican Americans: o Renamed the treatment Guiando a Ninos

	Activos. o Included engagement protocol for parents and extended family in treatment.
References for Adaptations:	Butler, A., Eyberg, S. (2006). Parent-child interaction therapy and ethnic minority children. Vulernable Children and Youth Studies, 1(3), 246-255.
Effectiveness:	• Significant reductions in child externalizing behaviors and child internalizing symptoms as compared to wait list participants. • Reduction in parent stress attributed to the child. • Increase in praise, descriptions, and reflections as compared to wait list participants. • Decrease in commands, questions, and negative talk as compared to wait list participants.
References for Effectiveness:	Thomas, R., Zimmer-Gembeck, M. (2012). Parent-Child interaction therapy: An evidence-based treatment for child maltreatment. Child Maltreatment, 17(3), 253-266.
Summary	
Research Strengths:	PCIT offers well tested assessment tools to monitor progress across treatment. Across studies, medium to large effect sizes are observed for changes in child behavior (both increases in positive behaviors and decreases in negative behaviors). PCIT international is an established oversight foundation that monitors the training and fidelity of the administration of PCIT.
Research Limitations:	Some studies don't use the suggested assessment measurement, which limits comparability of results across studies and populations. Further, attrition rates were higher in studies of marginalized communities and racial minorities, reducing sample size and limiting the interpretability of some results. Further, adaptations of PCIT were tested on small samples in some studies limiting generalizability.
Reviewer:	Aleja Parsons, M.A., Doctoral Student University of Denver Email: aleja.parsons@du.edu
Review Date:	06/07/14

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Developer:	Esther Deblinger, Ph.D., Judith Cohen, M.D., and Anthony Mannarino, Ph.D.
Citation:	Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating Trauma and Traumatic Grief in Children and Adolescents*. Guilford Press.
Treatment Manual:	http://tfcbt.musc.edu/
Treatment description:	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a treatment program to help children, adolescents, and their parents overcome trauma-related difficulties. TF-CBT is based on learning and cognitive theories, specifically addresses distorted beliefs and attributions (e.g., guilt, powerlessness) related to the trauma exposure (e.g., child sexual abuse, domestic violence, traumatic loss), and provides a supportive environment for children and adolescents to talk about their traumatic experience. The treatment is aimed at reducing negative emotional and behavioral responses to the traumatic event. TF-CBT also helps non-offending parents cope effectively with their own emotional distress as a result of their children's trauma exposure and helps parents develop skills to support their children in their healing process. TF-CBT is typically a short-term treatment provided in 12 to 18 sessions of 50 to 90 minutes. The treatment involves individual sessions with child and parent/caregiver separately, and joint sessions with child and parent together. Individual sessions are designed to build the therapeutic relationship as well as provide education, skills, and a safe environment in which to address and process traumatic memories and trauma-related distress. Joint parent-child sessions are designed to help parents and children practice and use learned skills, and for children to share their trauma narrative while also fostering effective parent-child communication about the trauma. TF-CBT was developed for children ages 3 to 18 and their non-offending parents/caregivers. Appropriate candidates for the treatment include: children and adolescents with a history of sexual abuse and/or trauma exposure who experience PTSD; have elevated levels of depression, anxiety, shame, and other dysfunctional abuse-related feelings, thoughts, or behaviors; and demonstrate behavioral problems (e.g., age-inappropriate sexual behaviors). TF-CBT is also appropriate for children and adolescents who have a history of multiple traumas.
Recommended Populations:	• Children ages 3 to 18 and a non-offending caregiver • Efficacy studies include Caucasian (60%), Black (28%), Latino (4%), and Biracial (7%) children.
Specific Population(s):	Children exposed to trauma and their caregivers
Settings:	Outpatient mental health facilities; has been provided in hospital, group home, school, community, residential, and in-home settings

Languages Available:	English and Spanish
Required Training/Certification:	Training options: 10-hour web-based training, intensive 2-day skills-based training, advanced 1-2 day TF-CBT training, receive ongoing expert consultation from trainers for 6-8 months, and read treatment manual.
Effectiveness in (Specific Population)	
Adaptations:	• Culturally-Modified Trauma-Focused Cognitive Behavioral Therapy (CM-TF-CBT) for Latinos: adaptations consider: broader range of traumatic events, immigration/migration history, preferred language, acculturation, cultural constructs (e.g., gender roles, spirituality, familismo), and beliefs about mental health
References for Adaptations:	de Arellano, M. A. *Culturally-modified trauma-focused cognitive behavioral therapy and other applications of evidence-based practices: Trying to reach the rest of the iceberg* [PowerPoint slides]. Retrieved from: http://psyc.uark.edu/de_Arellano_talk.pdf
Effectiveness:	• Significant reduction in symptoms of PTSD, depression, and total behavior problems compared to Child-Centered Therapy (CCT). • Significantly greater improvements to parent's own levels of depression, abuse-related distress, parental support, and parenting practices compared to CCT. • Treatment gains maintained (e.g., reduction in PTSD symptoms, abuse-related feelings) 6- and 12-months post-treatment compared to CCT. • TF-CBT has been shown to be effective for children who have been victims of sexual abuse or exposed to domestic violence, in addition to other trauma exposure.
References for Effectiveness:	Cohen, J. A., Deblinger, E., Mannarino, A., & Steer, R. A. (2004). A multisite randomized controlled trial with children with sexual-abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry,* 43(4), 393-402. Deblinger, E., Mannarino, A. P., Cohen, J. A., & Steer, R. A. (2006). A follow-up study of a multisite, randomized, contolled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry,* 45(12), 14741484.
Summary	
Research Strengths:	The majority of the measures (e.g., K-SADS-PL, CDI, CAPS) used in the studies have excellent and well-tested psychometric properties. All of the studies reviewed used random assignment and good methodologies to assess intervention fidelity (e.g., audiotaping and review of a random sample of sessions, direct supervisor observation, use of clinical guides, treatments were manualized). Rates of adherence to the treatment protocol were high across all of the studies.
Research Limitations:	The studies were limited in diversity; there were relatively low Hispanic/Latino and no Asian families included in the studies, and therefore findings cannot be generalized to families of other ethnicities.

Additional Comments:	• TF-CBT is not recommended for: children and adolescents whose primary problems include conduct problems or other serious behavioral problems that existed prior to trauma exposure; children and adolescents who are acutely suicidal, engage in parasuicidal behaviors, or actively abuse substances. In such cases, other treatment approaches may be more useful prior to integrating TF-CBT treatment.
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Trauma Systems Therapy (TST)

Developer:	Glenn Saxe, PhD; Heidi Ellis, PhD
Citation:	Saxe, G. N., Ellis, B. H., & Kaplow, J. B. (2007). *Collaborative treatment of traumatized children and teens: The trauma systems therapy approach*. New York, NY US: Guilford Press.
Treatment Manual:	May be purchased through Amazon.com, Guilford Press, Barnes and Noble bookstores, and other major booksellers.
Treatment description:	Trauma Systems Therapy (TST) is a mental health treatment model for children and adolescents who have been exposed to trauma. The treatment was intentionally and explicitly developed to be developmentally informed, directly address the social ecology, be compatible with systems of care, and be amenable to dissemination. As such, the treatment addresses the (child or adolescent) client's individual emotional and behavioral symptoms and needs as well as the client's larger home, school, and community contexts. The ten treatment principles of TST are as follows: 1) fix a broken system; 2) put safety first; 3) create clear, focused plans that are based on facts; 4) don't "go" before you are "ready"; 5) put scarce resources where they'll work; 6) insist on accountability, particularly your own; 7) align with reality; 8) take care of yourself and your team; 9) build from strength; and 10) leave a better system. TST consists of five phases of treatment that correspond to different themes of traumatic stress care: 1) Surviving, 2) Stabilizing, 3) Enduring, 4) Understanding, and 5) Transcending. Treatment planning and initial phase of treatment will depend on the fit between the client's self-regulation capacities and stability of the social environment/system of care. Additionally, TST consists of seven modules that are used in various combinations depending on phase of treatment: 1) ready-set-go, 2) stabilization on site, 3) services advocacy, 4) psychopharmacology, 5) emotion regulation, 6) cognitive processing, and 7) meaning making. Treatment planning involves identifying all providers who will play a role in treatment, assessing the client on relevant instruments, evaluating overall level of emotion regulation and social-environmental stability to choose initial treatment phase, selecting relevant treatment modules, identifying priority problems, and specifying solutions for those problems. Length of treatment varies by client's level of severity and phases of treatment administered. The Surviving phase (indicated for most acutely symptomatic children), for example, averages 3 months in length. A child starting at this phase may be in the program for 12 months with the duration of services reduced based on placement at assessment in later phases. TST is not limited to one specific trauma type. Children and adolescents who have participated in the treatment have experienced a wide range of traumas, such as domestic violence, physical abuse, sexual abuse, exposure to war, medical trauma, or multiple traumas.
Recommended Populations:	• Targeted at children and adolescents ages 6–18 that are having difficulty regulating their emotions as a result of the interaction between the traumatic experience and the social environment.

	• TST has been adapted for use with several populations, including refugee and immigrant groups, substance abusing adolescents, medical trauma and pediatric settings, school based treatments, and residential settings. • In the largest study of TST to date, 124 total participants reported the following in terms of demographics: 56 (45.2%) girls, 68 (54.8%) boys, mean age of 10.74 years (SD=3.29), 73 (58.9%) Caucasian, 14 (11.3%) biracial or multiracial (11.3%), 13 (10.5%) White Hispanic, 8 (6.5%) African American, 6 (4.8%) Black Hispanic, 1 Native American, and 9 (7.3%) Other.
Specific Population(s):	Refugees
Settings:	An emphasis on innovation while maintaining minimum fidelity standards allows the model to be adapted to a variety of settings. TST was designed for individual and family treatment, but has been adapted by members of the intervention's innovation community for use in a group setting in residential treatment, with approximately 5-8 group members. TST can typically be conducted in the following settings: adoptive home, birth family home, community agency, foster home, hospital, outpatient clinic, residential care facility, and school.
Languages Available:	English, Spanish, Korean
Required Training/Certification:	• Training is currently available through individual agency contracts. • Once an agency contracts for TST consultation through the TST Development Group at the NYU Child Study Center, consultation with agency leadership begins to develop an Organizational Plan that outlines specifically how TST can help to meet the needs of the organizational mission and goals and how it can help to address barriers to achieving the agency's goals. This is accomplished through weekly phone consultation with agency leadership. Once the organizational planning process is well underway, a representative of the TST Development Group will come to the agency to provide a three day on site training. After the training, weekly consultation calls are provided to the teams implementing TST, as well as monthly calls with administration. During the contract year, the TST Development team will be helping the organization meet criteria to become a TST accredited organization. • A multi-disciplinary team is required including clinical, educational, and case management staff who are able to collaborate on assessment and treatment planning and implementation. The minimum educational requirement varies by discipline. Clinicians should have at least a Master's degree and case workers often have a Bachelor's degree.
Effectiveness in (Specific Population)	
Adaptations:	Trauma Systems Therapy for Refugees (TST-R) is designed to enhance refugee youth engagement in services by offering services along a continuum of care. • The first and broadest level of care involves community

	outreach to engage families and develop trust between communities and providers before a specific mental health need is identified; mental health information is made available and efforts are made to destigmatize seeking care. Concrete assistance with family needs may be provided at this stage as a means of preventing stress within families and building rapport between the program and the community. Partnerships with religious and community agencies are key at this level. • The second level of care focuses on decreasing acculturative stress and increasing social support, factors known to be associated with better mental health among refugee youth. This is accomplished through acculturation peer groups held in the school setting. Working in a group format further helps to build rapport with families by providing non-stigmatizing, supportive services for the youth in a highly valued setting (school). Coming to know children in a group setting also allows clinicians to more effectively identify those children in need of more intensive services. • The final level of care is full TST and focuses on those children who are demonstrating problems with emotion regulation and for whom the community-level and group-level care is not sufficient. TST services are provided for these youth in the school, with home-based care integrated for those in the Surviving and Stabilizing phases of treatment. Cultural provider (e.g. trained clinicians from a given community) and cultural broker (e.g. paraprofessionals partnering with clinicians who are not from the given community) models of care have both been used to help address cultural and linguistic barriers in the implementation of TST at this level of care.
References for Adaptations:	Adaptation is underway. Please visit this page for a description of TST-R, as provided above: http://www.aboutourkids.org/traumasystemstherapy/populations-service-types/refugees-and-immigrants Please visit this page for more information on Project SHIFA, which represents an implementation of TST-R for Somali youth in a school setting: http://www.aboutourkids.org/traumasystemstherapy/featured-programs/project-shifa
Effectiveness:	***Decrease in Hospitalization Rate and Length/Cost*** • The number of hospitalizations for children receiving TST was smaller than prior to TST implementation by 36%. Not taking into account changes in length of stay, the total dollars saved by preventing hospitalizations was approximately $210,000. In the TST program, the average length of stay per hospitalization was 23% shorter than the year prior to implementation, or from approximately 40 days per event to 31 days per event. Not taking into account the change in the overall number of hospitalizations, the savings related to shorter length of stay alone was approximately $89,000. Combining the effect of change in the number of

	hospitalizations and the length of stay in the hospital per event, Medicaid expenditures for hospitalizations were estimated to be reduced by $299,000 (51%) (Ellis et al., 2012). **Dropout** • At the 3-month reassessment, 9 of 10 (90%) patients receiving TST were still enrolled in treatment compared with only 1 of 10 (10%) patients in the care as usual (CAU) condition (Saxe, Ellis, Fogler, Navalta, 2012). **Symptoms** • Paired sample t-tests using data from the TST patients indicated substantial reductions on the PTSD-RI Criterion D subscale (i.e. arousal symptoms; t = 2.65, p = .04) and the Child Behavior Checklist aggressive behavior subscale (t = 2.85, p = .03; Achenbach, 2001). Improvement on the home safety subscale of the Child Assessment of Needs and Strengths-Trauma Exposure and Adaptation Version approached significance (t = 2.00, p = .08; Kisiel, Blaustein, Fogler, Ellis, & Saxe, 2009) (Saxe, Ellis, Fogler, Navalta, 2012). **Residential Treatment Outcomes** *Use of Physical Restraints* • Dramatic and sustained reduction in use of physical restraints at Boston Intensive Residential Treatment Program (Boston IRTP) in Boston, MA (Brown, McCauley, Navalta, & Saxe, 2013). *Functional Impairment* • Significant drop in levels of functional impairment as measured by the CAFAS in all eight domains with an average exit score of 56 by the end of the first year of TST (versus an average exit score of 120 for a pre-TST 2008 comparison group) at KVC Health Systems, Inc. in Lawrence, Kansas (Brown, McCauley, Navalta, & Saxe, 2013).
References for Effectiveness:	Brown, A., McCauley, K., Navalta, C., & Saxe, G. (2013). Trauma Systems Therapy in Residential Settings: Improving Emotion Regulation and the Social Environment of Traumatized Children and Youth in Congregate Care. *Journal Of Family Violence*, *28*(7), 693-703. doi:10.1007/s10896-013-9542-9. Ellis, B., Fogler, J., Hansen, S., Forbes, P., Navalta, C. P., & Saxe, G. (2012). Trauma systems therapy: 15-month outcomes and the importance of effecting environmental change. *Psychological Trauma: Theory, Research, Practice, And Policy*, *4*(6), 624-630. doi:10.1037/a0025192 Saxe, G. N., Heidi Ellis, B. B., Fogler, J., & Navalta, C. P. (2012). Innovations in Practice: Preliminary evidence for effective family engagement in treatment for child traumatic stress-trauma systems therapy approach to preventing dropout. *Child & Adolescent Mental Health*, *17*(1), 58-61. doi:10.1111/j.1475-3588.2011.00626.x
Summary	
Research Strengths:	The majority of the measures used in the studies have excellent and well-tested psychometric properties. Studies were unique in measuring relevant systemic/contextual factors important from a public health perspective, including decrease in hospitalization rate and length of stay, cost associated with these decreases,

	and decreases in treatment dropout, as well as more traditional outcomes including reduced symptomatology and functional impairment.
Research Limitations:	Very few studies have been conduced to assess the efficacy or effectiveness of TST. To date, the largest study of TST (124 children) did not involve random assignment or a comparison group. Additionally, the one study that used random assignment to TST or CAU had a small *N* of 20 children. Some of the measures used lack sufficient documentation of psychometric properties. Future studies examining TST within a controlled design (e.g., randomized control trials (RCTs)) utilizing multimodal assessments of child functioning and environmental stability will be necessary to help test the efficacy and effectiveness of TST as well as adaptations of TST.
Additional Comments:	None
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