I'm not a robot



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this document useful, undefined 75% (8)75% found this document useful (8 votes)6K views 2 pages The document provides guidance on interpreting scores from the Child Depression Inventory (CDI). It states that a clinically elevated score is a T-score above 65, and multiple elevated scores indicate more pervasive problems. It also defines the five
factors assessed by the CDI: negative mood, interpersonal problems, ineffectiveness, and not for clinical treatment of individual students.75%(8)75%
found this document useful (8 votes)6K views2 pagesThe document provides guidance on interpreting scores from the Child Depression Inventory (CDI). It states that a clinically elevated score is a T-score above 65, and multiple elevated score is a T-score above 65, and multiple elevated score This website uses cookies to improve your experience. We'll assume you're ok with this, but you can opt-out
if you wish. Accept Read More If your child has been diagnosed with depression or will be evaluated for depression in children and adolescents between the
ages of 7 and 17. The Children's Depression Inventory is used to scale theseverity of depressive disorder and persistent depressive disorder (formerly known as dysthymic disorder) in children. It can help practitioners distinguish between these disorders and other psychiatric
conditions. The Children's Depression Inventory is a child depression test that kids can take to screen for symptoms of childhood depression. It has become one of the most widely used depression test that kids can take to screen for symptoms of childhood depression. It has become one of the most widely used depression test that kids can take to screen for symptoms of childhood depression. It has become one of the most widely used depression test that kids can take to screen for symptoms of childhood depression. It has become one of the most widely used depression test that kids can take to screen for symptoms of childhood depression. It has become one of the most widely used depression test that kids can take to screen for symptoms of childhood depression.
professional for further evaluation. Early intervention is essential, so consider getting your child screened if they are showing signs of depression in children include the Beck Depression in children in children include the Beck Depression in c
the Weinberg Screening Affective Scale (WSAS). While depression is often considered an adult disorder, the Centers for Disease Control and Prevention (CDC) states that 4.4% of kids between the ages of 3 and 17 have been diagnosed with depression. The Children's Depression Inventory is a self-report assessment written at a first-grade reading
level. This means that your child will be given the paper and pencil assessment to complete by themselves. The CDI is designed to detect symptoms of depression and to
distinguish between depression and other psychiatric disorders. It can also be used as an instrument to monitor changes in depression symptoms over time. The short form of the test is generally used as a screening tool, while the long-form is used more often in the diagnosis of depression in children. Each item in the CDI has three statements, and
the child is asked to select the one answer that best describes their feelings over the past two weeks. There are five subscales within the assessment that measure different components of depression: Anhedonia (inability to experience joy) Ineffectiveness (lack of motivation or inability to complete tasks) Interpersonal problems
(difficulty making and keeping close relationships) Negative mood (irritability or anger) Negative self-esteem (the belief that you are not good at anything) The Children's Depression Inventory is popular in part because it is easy to administer and score. A child with age-appropriate reading abilities can complete the scale relatively quickly. The CDI has
excellent psychometric properties, which means that it measures depression in children accurately and reliably when used properly. Some research indicates, however, that the test is not appropriate for children who have reading difficulties. The CDI was tested on a large group representing the population of children in the United States. Research
has also shown that the Children's Depression Inventory (both the full version and short version) is a valid instrument for screening for depression in pediatric care are advised to follow up with diagnostic assessments to rule
out potential false positives. Only a professional trained on the properties of the CDI can accurately interpret the results. A raw score on the test is essentially meaning of the results with the professional who evaluated the child. While the CDI is good at
detecting the presence of depressive symptoms, it is not the best at determining their severity. You should discuss follow-up assessments with your child's doctor to determine the best course of treatment for your child. Milder symptoms may require other treatments
such as medications or psychotherapy. Like other self-report assessments used in children don't have the same sophistication as adults when it comes to understanding and reporting their emotions, their responses may not reflect their true
emotional state. In addition, children may be more likely than adults to attempt to give what they believe to be the desired answers rather than answers that represent their true feelings. Some researchers have also observed that children who do not have age-appropriate reading skills may receive an inaccuratediagnosis on the basis of their CDI
score. While the inventory has five subscales, some studies have failed to support the five-factor models are a better fit. The use of the CDI for children outside of the U.S. may be limited due to cultural-specific interpretations. One study found that demographic and socio-
cultural factors influenced the interpretation of depressive symptoms. This suggests that more research is needed to ensure the CDI is valid in cultures outside the U.S. The Children's Depression Inventory is a quick and painless depression in seeded to ensure the CDI is valid in cultures outside the U.S. The Children's Depression Inventory is a quick and painless depression in seeded to ensure the CDI is valid in cultures outside the U.S. The Children's Depression Inventory is a quick and painless depression in seeded to ensure the CDI is valid in cultures outside the U.S. The Children's Depression Inventory is a quick and painless depression in the control of the U.S. The Children's Depression Inventory is a quick and painless depression in the control of the U.S. The Children's Depression Inventory is a quick and painless depression in the control of the U.S. The Children's Depression Inventory is a quick and painless depression in the control of the U.S. The Children's Depression Inventory is a quick and painless depression in the control of the U.S. The Children's Depression Inventory is a quick and painless depression in the U.S. The Children's Depression Inventory is a quick and painless depression in the U.S. The Children's Depression Inventory is a quick and painless depression in the U.S. The Children's Depression Inventory is a quick and painless depression in the U.S. The Children's Depression Inventory is a quick and painless depression in the U.S. The Children's Depression Inventory is a quick and painless depression in the U.S. The Children's Depression Inventory is a quick and painless depression I
there are no right or wrong answers. Depressive symptoms tend to fluctuate in both children and adults. Therefore, the test's author recommends retesting any child who receives a positive score on the CDI two to four weeks after the initial test. A kid who receives a positive score on the CDI two to four weeks after the initial test.
comprehensive evaluation by a licensed mental health professional. If you are concerned about depression in your child, it is important to consult with your child, it is important to consult with your child, it is important to consult with your child, it is important that childhood depression in your child, it is important to consult with your child.
untreated. It can affect a child's personal development, well-being, health, and academic achievement. Such effects can also carry over into adulthood. Detecting childhood depression early and treating it effectively can help kids feel better and protect their well-being as they develop. As a library, NLM provides access to scientific literature. Inclusion
in an NLM database does not imply endorsement of, or agreement with, the contents by NLM or the National Institutes of Health. Learn more: PMC Disclaimer | PMC Copyright Notice . 2023 May 25;18(5):e0286197. doi: 10.1371/journal.pone.0286197Childhood-onset depression has adverse consequences that are sustained into adulthood, which
increases the significance of detection in early childhood. The Childrens Depression Inventory (CDI) is used globally in evaluating depressive symptom severity in adolescents, and its second version, the CDI-2, was developed by taking into account advances in childhood depression research. Prior research has reported inconsistencies in its factor
structure across populations. In addition, the CDI-2s psychometric properties and evaluate its factorial structure with a Singaporean community sample of non-clinical respondents. A total sample of 730 Singaporean children
aged between 8.5 and 10.5 years was used. Psychometric properties of the CDI-2, including internal consistency as well as convergent and discriminant validity, were assessed. Factor analyses were conducted to assess the developers original two-factor structure for a Southeast Asian population. This two-factor structure was not supported in our
sample. Instead, the data provided the best fit for a hierarchical two-factor structure with factors namely, socio-emotional problems and demographic elements influence interpretation of depressive symptoms and therefore the emerging factor structure of the construct
under scrutiny. This study highlights the need to further examine the CDI-2 and ensure that its interpretation is culture-specific. More qualitative work could also bring to light the idiosyncratic understanding of depressive symptomatology, which would then guide culture-specific validation of the CDI-2. Approximately 4.4% of the worlds adult
population is thought to suffer from depression [1]. The experience and effects of depression in adults have been studied in-depth and are well-documented across many different populations. For example, Ogbo and colleagues [2] found that depressive disorders in South Asian adults had a prevalence rate of 3.9%. However, a lesser-known
phenomenon is childhood depression. Although several studies have shown that the effects of childhood-onset of depression can be felt through adolescence, up to and including adulthood [3], it has not been rigorously studied across various populations. Kovacs and Lopez-Duran [4], among others, reported that the persistent adverse outcomes as a
result of childhood-onset of depression are more severe and acute compared to the negative consequences of late-onset depression at an early age is thus compounded, particularly when one takes into account the fact that childhood depression can re-occur and is associated with adverse later
life outcomes such as poor academic achievements, interpersonal problems, substance abuse, and suicide [5]. Discrepancies exist in the documented prevalence of depression. For example, the prevalence of childhood depression has been reported as
10.9% among 9 to 10-year-old American children [6], 8.2% in 13 to 17-year-old American youths [7], and 17.4% in boys and 20.6% in girls among Korean adolescents aged 1318 years [8]. These studies have not all used a standardized measure of childhood depression, which makes it harder to accurately gauge the incidence and severity of the
disorder in this population. In addition, treatment for childhood depression is often not sought, as children experience some form of mental distress, including depression, but less than one-third of these children
are likely to report their symptoms and seek any treatment. These findings have been supported by Reavley and coworkers [10], who estimate that less than 50% of youth who suffer from depression seek treatment for it. Therefore, understanding childhood depression becomes particularly important and the onus is on adults to identify signs of
depression in children. However, it is sometimes difficult for adults to recognise depression in children are varied and cover the full gamut of symptoms as manifested through both internalising behaviours. This is problematic in several ways. Firstly, parents and teachers are both more likely
to note externalising behaviour and misattribute them to conduct disorder or somatic issues [11], rather than depressive symptoms. Secondly, such externalising behaviour can, on some occasions, be misattributed as part of growing up and not taken seriously as a sign of childhood depression [12]. At the same time, children displaying internalising
behaviours such as anxiety and withdrawal may slip through the cracks, as these symptoms are not directly observable nor as troublesome for adults may be overlooked among children [13]. Symptoms of depression can also present themselves in different
ways depending on gender and developmental age [14, 15]. For example, the inability to feel pleasure in normally pleasure in however, a child showing signs of anhedonia reported as a common symptom of depression regardless of age. However, a child showing signs of anhedonia reported as a common symptom of depression regardless of age.
showing signs of anhedonia report decreased appetite [16]. Similarly, research has identified gender as a risk factor for depression because girls report more symptoms in children only emerge in early adolescence, between 13 to 15 years of age [18, 19]. Given the
rising concerns regarding childhood depressive symptoma in children and adolescents. Researchers suggest that one way of doing so effectively is via self-report questionnaires used to evaluate the
incidence and severity of depressive symptoms in children, because studies have found that children can record their emotional states with the same degree of consistency and precision that adults record their emotional states with the same degree of consistency and precision that adults record their emotional states with the same degree of consistency and precision that adults record their emotional states with the same degree of consistency and precision that adults record their emotional states with the same degree of consistency and precision that adults record their emotional states with the same degree of consistency and precision that adults record their emotional states with the same degree of consistency and precision that adults record their emotional states with the same degree of consistency and precision that adults record their emotional states with the same degree of consistency and precision that adults record their emotional states with the same degree of consistency and precision that adults record their emotional states with the same degree of consistency and precision that adults record their emotional states with the same degree of consistency and precision that adults record their emotion and precision that adults record their emotion and the same degree of consistency and precision that adults record the same degree of consistency and precision that adults record the same degree of consistency and precision that adults record the same degree of consistency and precision that adults record the same degree of consistency and precision that adults record the same degree of consistency and precision that adults record the same degree of consistency and precision that adults record the same degree of consistency and precision that adults record the same degree of consistency and precision that adults record the same degree of consistency and precision that adults record the same degree of consistency and the same degree of consistency and the same degree of consistency and the same degree of co
children and adolescents is the Childrens Depression Inventory (CDI), which was developed by Maria Kovacs [21] and quickly adopted by both practitioners and researchers upon publication [22]. The CDI comprised a total score of depressive symptoms as well as five subscales into which the items of the questionnaire were divided. Despite its
popularity, dozens of papers were published with factor structure of the CDI that deviated from the original five-factor structure [22]. For example, Hodges et al. [23] identified a two-factor structure of the CDI that deviated from the original five-factor structure of the CDI with no second-order factors among non-
clinical children. In addition, a meta-analysis of 24 studies with data from 35 samples of youth showed very little empirical justification to support the original model at times, the factors were noted to be different in terms of content. Some
researchers noted that the number and nature of factors extracted with the CDI vary depending on characteristics of the respondents, the language of the questionnaire and cultural interpretations of the
CDI presented conceptually different factors [25]. Several other researchers have also presented findings arguing that language and culture interact to heavily influence the CDIs factor structure. For instance, analysing CDI data from Nigerian
adolescents who completed the CDI in English showed a two-factor structure [28] and data from Australian adolescents who also completed the CDI in English corresponded with Kovacss originally suggested five-factor structure [28] and data from Australian adolescents who also completed the CDI in English showed a two-factor structure [28] and data from Australian adolescents who also completed the CDI in English showed a two-factor structure [28] and data from Australian adolescents who also completed the CDI in English showed a two-factor structure [28] and data from Australian adolescents who also completed the CDI in English showed a two-factor structure [28] and data from Australian adolescents who also completed the CDI in English showed a two-factor structure [28] and data from Australian adolescents who also completed the CDI in English showed a two-factor structure [28] and data from Australian adolescents who also completed the CDI in English showed a two-factor structure [28] and data from Australian adolescents who also completed the CDI in English showed a two-factor structure [28] and data from Australian adolescents who also completed the CDI in English showed a two-factor structure [28] and data from Australian adolescents who also completed the CDI in English showed a two-factor structure [28] and data from English showed a two-factor structure [28] and data from English showed a two-factor structure [28] and data from English showed a two-factor structure [28] and data from English showed a two-factor structure [28] and data from English showed a two-factor structure [28] and data from English showed a two-factor structure [28] and data from English showed a two-factor structure [28] and data from English showed a two-factor structure [28] and data from English showed a two-factor structure [28] and data from English showed a two-factor structure [28] and data from English showed a two-factor structure [28] and data from English showed a two-factor structure [28] and data from English showed a tw
conceptualised in very different ways across cultures despite the CDI being administered in a common language to all three cultures [22]. As researchers raised issues with the factor structure of the CDI, it has become evident that this measure requires further validation, especially with regard to its factor structure. In fact, upon reviewing over 300
data sets of the CDI as part of a meta-analysis, Twenge and Nolen-Hoeksema [30] suggested that a new normative sample be used, particularly in light of new findings and research in the field of childhood mental health. Maria Kovacs reviewed both the contents of the CDI and the standardization sample and published the CDI 2nd Edition CDI-2 [31].
The CDI-2 was validated with a sample consisting of 1100 American children aged 7 to 17 years across the four major geographic regions (Northeast, Midwest, West and South) of the U.S. Bureau of the Census in 2000, with Asians
making up just 4.2% of the standardization sample. The clinical sample consisted of 319 children, of which Asians again comprised 4.2%. Therefore, the original factor structure identified by the CDI-2 may not be fully representative of an Asian population. Interestingly, empirical studies continued to use the CDI to assess childhood depression, even
after the CDI-2 had been published. To the best of our knowledge, only one study has thus far examined the psychometric proposed by Kovacs and MHS staff [31] with a Korean non-clinical community sample. Surprisingly, while they reported a 2-
factor structure in line with the original study, they identified items loading on factors that were significantly different from the original factors. It thus remains to be seen whether the discrepancies noted in the factor structure of the CDI-2. Given the inconsistencies described
above and a lack of empirical studies validating the CDI-2 that confirm its factor structure of the CDI-2, and (b) evaluate psychometric properties of the CDI-2 with a Southeast Asian population within Singapore. Data from children who participated in the Growing Up in
Singapore Towards healthy Outcomes (GUSTO) birth cohort study was used for secondary analysis in this study. All the scales described below were administered to children as part of the GUSTO study when they were between 8.5 and 10.5 years old. For this study, a total of 732 children were given the Childrens Depression Inventory (2nd edition).
Data from two children was noted to be marked as unusable due to indiscriminate responses, while one childs data was incomplete, leaving a dataset from 729 participants for main analysis. Data for the Multidimensional Anxiety Scale for Children (2nd edition) (N = 450) and Social Emotional Assets and Resilience Scales (N = 340), which was
collected on a subset of this sample at 8.5 years of age, was also analysed. The CDI-2 comprises 28 items divided into two First-Order factors: Emotional Problems and Functional Problems and Functio
Negative Self-Esteem, and component items assess symptoms of distress, such as sadness, guilt, self-loathing, and anomalies in sleep patterns, eating habits, and energy levels. The Functional Problems subscale consists of Ineffectiveness and Interpersonal Problems, and component items assess symptoms of distress, such as peer and family
relationships and maladjustment in school. Children respond on a 3-point Likert scale of 0 (no symptoms) to 2 (definite symptoms). Therefore, higher scores on the CDI-2 subscales reflect a higher incidence of depressive symptoms. The MASC-2 was developed to measure symptoms of anxiety in children and adolescents aged 8 to 19 years. Its 50 items
assess emotional, physical, cognitive and behavioural symptoms of anxiety and can be presented in terms of 6 scales and 4 subscales; Separation Anxiety, Phobias, Generalised Anxiety Disorder (GAD), Social Anxiety and can be presented in terms of 6 scales and 4 subscales; Separation Anxiety Disorder (GAD), Social Anxiety Disorder (GAD), Disorder (GAD
(comprising Panic and Tense/Restless subscales) and Harm Avoidance. Children respond on a 4-point Likert scale of 0 (never) to 3 (Often). Therefore, higher scores on the MASC-2 scales reflect a higher likelihood of children experiencing symptoms of anxiety. The SEARS is a strength-based questionnaire for measuring positive socio-emotional
competencies and assets, including peer relationships, empathy, and resilience in children and adolescents aged between 5 and 18 years. The SEARS asks youths to rate themselves on 35 statements about how they feel, think or act using a 4-point Likert scale ranging from "Never" to "Almost Always". Higher scores on the SEARS suggest better
adjusted children. All statistical analyses were performed with R and SPSS Amos 26. We first tested the original factor structure of the CDI-2 with our data. Following a rather poor fit, an exploratory factor analysis was then conducted with the remaining data. In addition,
data available for the MASC-2, CDI-2 and SEARS for 444 participants at 8.5 years of age was used to establish convergent and divergent validity of them assessed at 9 years of age and 37.84% of them assessed at 10 years old.
There were 377 (51%) male and 355 (49%) female participants. Data collected on households with a combined monthly income between $1999 to $5999 Singapore dollars, and only 1.9% of the participants came from households with combined monthly income below $1000
Singapore dollars. Approximately 7.7% of participants did not have available data on household income. Table 1 describes the breakdown of the demographic data comparisons were conducted between participants who completed the MASC-2 and SEARS from
data7.7%Computed descriptive statistics for results from all three scales used in this study are presented in Table 2, along with correlations between them. The CDI-2 scores (n = 444) have a minimum recorded value of 0 and a maximum recorded value
of 127 across all its subscales. The mean total score on the MASC-2 in our sample was M = 65.74, SD = 22.53. The SEARS scale (n = 340) has values that range from 0 to 104. The average total score obtained by participants was M = 55.57, SD = 20.70. Across all three scales, the large standard deviations point to a substantial degree of variance in
to .91 for the overall scale and all subscales [35]. The CDI-2 in our sample showed good overall reliability, Cronbachs = .854 [CI: .839, .869] (Table 3). However, a closer look at the reliability of the original CDI-2 subscales in our sample showed that subscales in our sample showed good overall reliability.
This points to some items as being read and interpreted differently by our participants in Singapore, consistent with previous research illustrating cultural differences in interpretation of the CDI [27, 29]. Scale Reliability Statistics Cronbachs CDI-2 (overall).854 [CI: .829, .872] CDI-2 Subscale A: Emotional Problems.737 [CI: .708, .764] CDI-2 Subscale B: CDI-2 (overall).854 [CI: .829, .872] CDI-2 Subscale A: Emotional Problems.737 [CI: .708, .764] CDI-2 Subscale B: CDI-2 (overall).854 [CI: .829, .872] CDI-2 Subscale A: Emotional Problems.737 [CI: .708, .764] CDI-2 Subscale B: CDI-2 (overall).854 [CI: .829, .872] CDI-2 (ov
Functional Problems. 763 [CI: .737, .788] The CDI-2 dataset was first screened for missing values. There were less than 0.1% missing values asingle participants responses were omitted from the dataset used for analysis consisted of 729 responses. We began by testing the
fit of the original two-factor structure of the CDI with our dataset by performing a confirmatory factor analysis with Maximum Likelihood estimation. A significant Bartletts test of sphericity (p < .001) and a good Kaiser-Meyer-Olkin measure of sampling of .810 verified that our sample was adequate for factor analysis [36]. We examined the model fit
using four commonly used practical fit indices: the goodness-of-fit index (CFI), the Tucker-Lewis index (CFI), the Tucker-Lewis index (TFI) and the root mean square error of approximation (RMSEA). Statisticians have recommended that the following range of values are used as a guide in interpreting fit index values [37] (Table 4). Practical Fit
Indices Good fit Acceptable fit Poor fit Root mean square error of approximation (RMSEA) .06.06 to .94 < .90 Considering previous inconsistencies of the CDI factor structure in mind, a total of three models were specified
in an initial confirmatory factor analysis: a single-factor model (Model 1), the original two-factor structure (Model 2) and a hierarchical two-factor structure (Model 3) which accounted for second-order factors that made up each of the two subscales in the CDI-2. The model fit indices used to examine the suitability of the model for our data are
guidelines by Hu and Bentler [37], the single-factor structure (2 (350) = 840.76, 2 / df = 2.40, GFI = .840, RMSEA = .044 [90% CI: .040, .048]), the original two-factor structure (2 (350) = 840.76, 2 / df = 2.40, GFI = .840, RMSEA = .044 [90% CI: .040, .047]), and hierarchical two-factor structure (2 (349) = 829.218, 2 / df = 2.38, GFI = .920, CFI = .843, RMSEA = .043 [90% CI: .040, .047]), and hierarchical two-factor structure (2 (349) = 829.218, 2 / df = 2.38, GFI = .920, CFI = .843, RMSEA = .043 [90% CI: .040, .047]), and hierarchical two-factor structure (2 (349) = 829.218, 2 / df = 2.38, GFI = .920, CFI = .843, RMSEA = .043 [90% CI: .040, .047]), and hierarchical two-factor structure (2 (349) = 829.218, 2 / df = 2.38, GFI = .920, CFI = .843, RMSEA = .043 [90% CI: .040, .047]), and hierarchical two-factor structure (2 (349) = 829.218, 2 / df = 2.38, GFI = .920, CFI = .920, CFI
(345) = 755.78, 2 / df = 1.63, GFI = .928, CFI = .876, TLI = .864, RMSEA = .040 [90% CI: .037, .044]) had fit indices that ranged from poor to average. None of the three models showed that while the single-factor model and two-factor model did not differ considerably
was not found to have a very good fit with our Singapore sample, we decided to conduct an exploratory factor analysis (EFA) to examine whether a better factor structure for our data might exist. A random sample of 100 participants was
retained for the confirmatory factor analysis (Group B). A significant Bartletts test of sphericity, p < .001, and a good Kaiser-Meyer-Olkin measure of sampling of .781 again verified that our sample of 100 participants was adequate for factor analysis [36]. The EFA, using Maximum Likelihood estimation with oblique rotation was conducted as factors
were assumed to be correlated [38]. The initial EFA revealed seven factors with Eigenvalues greater than 1. To establish the number of factors to extract, a parallel analysis [39] was also used based on the number of factors with Eigenvalues greater than 1. To establish the number of factors to extract, a parallel analysis [39] was also used based on the number of factors to extract, a parallel analysis and the number of factors with Eigenvalues greater than 1. To establish the number of factors to extract, a parallel analysis [39] was also used based on the number of factors with Eigenvalues greater than 1. To establish the number of factors to extract, a parallel analysis [39] was also used based on the number of factors with Eigenvalues greater than 1. To establish the number of factors to extract, a parallel analysis [39] was also used based on the number of factors with Eigenvalues greater than 1. To establish the number of factors with Eigenvalues greater than 1. To establish the number of factors with Eigenvalues greater than 1. To establish the number of factors with Eigenvalues greater than 2. To establish the number of factors with Eigenvalues greater than 2. To establish the number of factors with Eigenvalues greater than 2. To establish the number of factors with Eigenvalues greater than 2. To establish the number of factors with Eigenvalues greater than 2. To establish the number of factors with Eigenvalues greater than 2. To establish the number of factors with Eigenvalues greater than 2. To establish the number of factors with Eigenvalues greater than 2. To establish the number of factors with Eigenvalues greater than 2. To establish the number of factors with Eigenvalues greater than 2. To establish the number of factors with Eigenvalues greater than 2. To establish the number of factors with Eigenvalues greater than 2. To establish the number of factors with Eigenvalues greater than 2. To establish the number of factors with Eigenvalues greater than 2. To establish the number of factors with Ei
size (n = 100) and number of variables (28) as our dataset was subjected to multiple iterations and the Eigenvalues from the exploratory factor analysis on our data set were then compared (Table 6). EFA-generated eigenvalues from our
dataset greater than random eigenvalues generated from parallel analysis were subsequently retained for further analysis. In addition, Factor 2 (Eigenvalue 1.93). Therefore, we noted that there might be a one-factor solution in addition to the two-
factor solution suggested by the parallel analysis, as was also noted when the model fit indices of a one-factor solution (Table 6). FactorFactor solution (Table 6). Factor solution (Table 6). Factor solution (Table 6). Factor solution (Table 6). Factor solution (
factor analysis with Maximum Likelihood extraction and oblique rotation was performed to assess the factor solution, similar to the original CDI-2 factor structure. Both factors
cumulatively accounted for 32% of the variance. However, in our sample, items that loaded onto Factor 1 and Factor 2 were different from the items that loaded onto each factor in the original CDI-2 subscales (Table 7). ItemsFactors and LoadingsKMO Measure of Sampling Adequacy = .781129RI feel like crying every day. 83821I do not have any
friends.7441I am sad all the time.7394Nothing is fun at all.5995My family is better off without me.56811I do not want to be with people at all.54919I feel alone all the time.5027RAll bad things are my fault.48110RI feel cranky all the time.47822I do very badly in subjects I used to be good in.4606RI
hate myself.39113I look ugly.3913I do everything wrong.36415RI have to push myself all the time to do my schoolwork.49126RI fall asleep during the day all the time.4522RNothing will ever work out for me.45020RI never have fun at
school.44117RMost days I do not feel like eating.41323RI can never be as good as other kids.40412RI cannot make up my mind about things.35418I worry about aches and pains all the time.233Eigenvalues7.0761.930Percentage of
variance 25.27% 6.90% As the original CDI-2 had two first-order and two second-order factors, we examined the items that loaded onto each of our factors presented in Table 7. We then performed two further exploratory factor analyses with Maximum Likelihood extraction and oblique rotationone on each of the factors that emerged in the first EFA
(Table 7), again specifying a two-factor solution. This analysis resulted in four second-order factors and named these: Negative emotion, Social isolation, Negative cognition and Vegetative symptoms. We then examined the items that
comprised our two first-order factors and we named these Socio-Emotional Problems and Cognitive-Behavioural Problems to fully capture the gamut of items across four distribution of items across four distributio
manifest in children in several ways, covering both internalising and externalising behaviours. The items factor and their respective item loadings are presented in Table 8. Items Factors and Loadings Socio-Emotional Problems Cognitive-Behavioural Problems Cognitive-Behaviours.
Symptoms6I hate myself.60219I feel alone all the time.56713I look ugly.5351I am sad all the time.5339I feel like crying every day.5238I want to kill myself.48810I feel cranky all the time.5174Nothing is fun at all.50324Nobody really loves me.48421I do not
have any friends.46311I do not want to be with people at all.44720I never have fun at school.44517Most days I do not feel like eating.27422I do everything wrong.51523I can never be as good as other kids.51212I cannot make up my mind about
things.4842Nothing will ever work out for me.47114I have to push myself all the time.3577All bad things are my fault.46416I am tired all the time.38715I have trouble sleeping every night.37626I fall asleep during the day all the time.31427Most days I feel like I cant stop
eating.248Eigenvalues2.7672.3922.4631.234Percentage of variance34.40%28.40%Results of the two EFA conducted earlier presents us with two possible models for the CDI-2 factor structure in the Singapore sample: 1. Two-factor model following the EFA item loadings (Model 4, Table 7) and 3.
Hierarchical two-factor model with two first-order factors (Model 5, Table 8). These two models were evaluated using commonly used practical fit indices using the data from group B (n = 629) and compared to the single factor model (Model 1). Once again, all three models were evaluated using commonly used practical fit indices using the data from group B (n = 629) and compared to the single factor model (Model 1).
to assess model suitability for our data. The results showed that our two-factor model (Model 4) (2 (349) = 687.42, 2 / df = 1.97, GFI = .926, CFI = .
.040, .048]). Our two-factor model (Model 4) was also found to be a better fit for our data than the original CDI-2s two-factor structure (Model 5) (2 (345) = 636.27, 2 / df = 1.85, GFI = .931, CFI = .895, and TLI = .885, RMSEA = .037
noted to be above 10. This approach was justified as the items within each factor are closely related to each other (although each item captures a distinct element of the factor) and TLI = .936, CFI = .936, CFI
shows model fit indices for all four models, including the modified hierarchical two-factor model.No.ModelModel FitModel Comparison2df2/ dfRMSEA [90% CI]TLICFICFIGFI1One-factor model687.423491.97.039 [.035, .044].867.878.033.9265Hierarchical two-factor
model636.273451.85.037 [.032, .041].885.895.017.9315aModified hierarchical two-factor model590.963421.73.034 [.029, .039].900.910.015.946Finally, we assessed the reliability (CR), and average variance extracted (AVE). Reliability of the subscales
was examined using internal consistency measures of Cronbachs alpha values and composite reliability values. The first-order factors (Socio-emotional problems and Cognitive-behavioural problems) showed good internal reliability with our Singapore community sample, Cronbachs = .842 [CI: .801, .870] and Cronbachs = .802 [CI: .790, .872],
respectively (Table 10). Individual item reliabilities suggested that removing item 17 ("Most days I do not feel like eating") from the subscale Socio-emotional Problems would improve Cronbachs to .907; however the overall scale reliability values > .6 (Table 10). Individual item reliabilities suggested that removing this item. Both factors also demonstrated composite reliability values > .6 (Table 10). Individual item reliability
10), indicating good internal reliability. FactorNo. of itemsCronbachs Composite Reliability aAverage Variance Extracted bSocio-emotional problems 14.802 [CI: .790, .872]. 751.805 Criterion-> .7> .7> .5 As all the model fit indices met the required levels, the proposed subscales were
assumed to have construct validity [40]. Convergent validity is established when all values of AVE exceed .5, along with CR values exceeding .7 [40]. As such, with AVE values of our proposed subscales > .700, they were considered to have met the criteria for convergent validity. The aim of this study was to examine the factor structure and
psychometric properties of the CDI-2 with a Singapore community sample. Symptoms of depression in children are diverse and can manifest across multiple facets of affect, behaviour, and cognition. The CDI has emerged as the most popular measure of childhood depressive symptoms [21]. Thus, it is unsurprising that multiple researchers have
analysed the factor structure and psychometric properties of the CDI to better understand how childhood depression is expressed. However, a meta-analysis of psychometric studies [30] revealed that empirically derived factor structures across different studies did not correspond to the original factor structure proposed by Kovacs [21] and indicated
cross-cultural differences in the factor structure of the CDI. In addition, apart from reporting different numbers of factors, the studies in the meta-analysis also reported differences in the content and interpretation of each sub-factor. Despite changes made in the original CDI and the subsequent development of CDI-2, the factor structure of this
instrument remains to be confirmed. Moreover, with only one prior study examining its factor structure in the Asian context [32], it was imperative that CDI-2 structure from that found by Kim and co-workers. We used both
exploratory and confirmatory factor analysis and was indeed confirmed as having a good fit to data compared to other factor
structures. Based on the factor loading patterns, two first-order factors and two second-order factors emerged. This finding is roughly consistent with both the original two- factor structure proposed by Maria Kovacs [31] and the only other study (to the best of our knowledge) that has evaluated the psychometric properties of the CDI-2 [32]. Thus, all
three studies, including the present one, suggest that the CDI-2 measures two main dimensions. Despite the overarching similarities, it must be noted that the original factor structure by Maria Kovacs suggested two first-order and two second-order factors; however, the factor structure proposed by Kim et al. [32] only had two factors. Furthermore,
the item loadings presented by Kim and coworkers substantially differed from Kovacs original item loadings presented in our study also vary significantly compared to the item loadings presented by both Kim et al. [32] and Kovacs and MHS Staff [31] and are further discussed here. Considering the lack of empirical papers
assessing the CDI-2, it is hard to situate our findings of Kovacs and MHS Staff [31], but more directly in relation to the Kim et al. with an Asian sample [32]. With regards to our factor structure, only one of our second-order factors (negative
cognition) corresponded to negative self-concept or low self-esteem; the latter two were both reported in the Kovacs and MHS Staff and Kim et al. studies [31, 32]. When considering the contents of each factor, somatic symptoms (Item 18 I worry about achieve and pains all the time) and concerns about foodings in each factor and individual item loadings in each factor.
(Item 27 Most days I feel like I cant stop eating) and appetite (Item 17 Most days I do not feel like eating) had lower item sometic symptoms and changes in appetite and eating behaviours may not be characteristic of childhood depression in an Asian population [41]. This is also
supported by findings from Kim et al [32], the only other study that has assessed the psychometric properties of the CDI-2 in an Asian population. They also reported low item loadings for items 17, 18 and 27, which indicated that guilty feeling, concern about somatic symptom and an increase in appetite may not reflect typical features of emotional or
functional problem in Korean children and adolescent group. All items loading onto the Negative Emotion second-order factor included key words of hate, alone, ugly, sad, crying, kill myself, cranky, better off without me. These words are clearly reflective of the experience of negative emotions. The Social Isolation second-order factor included items
that either reflected negative interactions with others (Item 25 I get into arguments with friends all the time) or a sense of loneliness (Item 4 Nothing is fun at all). Similarly, the Negative Cognition second-order factor predominantly consisted of items which conveyed negative thoughts about
oneself. Four of the five items that loaded onto our Vegetative Symptoms second-order factor correspond to Kovacs and MHS Staffs [31] Negative Mood/Physical Symptoms sub-factor from the original CDI-2 factor structure. However, we interpreted these items as vegetative symptoms because they relate to eating and sleeping behaviours. Our first
and second-order factors thus show that depressive symptoms manifest across four aspects of child development: emotional, social, cognitive and behavioural aspects. The differences in the manifestation and expression of depressive symptoms identified in this study and the other two studies that have used the CDI-2 [31, 32] might be attributed to an
interaction between culture and language [22, 25, 26]. Future studies could consider the suggestion of Bonicatto et al. [42] on how to tease out culture and language by comparing the factor structure of the CDI-2 among individuals from different countries that speak the same language. We also suggest
that future research discriminate between sources of variations in language and culture, perhaps by using bilingual respondents. It is important to note that our results might have been affected by a few limitations. When interpreting the results presented here, it is necessary to bear in mind the age of our participants. We examined the CDI-2
responses of a cohort of 8.5 to 10.5 year olds while previous studies reported results from participants with a wider age range, e.g. Kim et al. [32] sampled participants aged 7 to 17 years old. Since the nature of the turbulent changes in emotional and psychological experience in general varies across different stages of adolescence, our results may
not apply to all developmental stages in their entirety, but rather, are only applicable for this age group spanning late childhood to early adolescence and late adolescence might be very different. Woo and colleagues
developed an Asian Adolescent Depression Scale, which demonstrated sound psychometric properties in a clinical and community sample of adolescents, and found four factors, namely negative socially oriented self-evaluation, negative inefficiency
were important in Singaporean adolescents conceptualization of depression and are likely to be Asian culture-specific dimensions. In addition, it would not have been useful to examine gender differences within our sample given that such differences within our sample given that such differences become apparent around 1315 years of age [18, 19]. It would be an important next step to examine
gender differences in factor structure of CDI-2 among older samples. Finally, this study only sampled Southeast Asian within Singapore, and therefore may not be generalisable to the broader Southeast Asian within Singapore, and therefore may not be generalisable to the broader Southeast Asian within Singapore, and therefore may not be generalisable to the broader Southeast Asian community. Despite the limitations mentioned above, we believe that this study constitutes a valuable contribution to the understanding of the
internal structure of the CDI-2, especially in terms of its cross-cultural uniqueness. The factor structure identified in the present study also suggests that depressive symptoms can manifest across all domains of a childs development and provides us with insight into aspects of depression that eight to ten-year olds in Singapore struggle with. This
allows educators and other specialists to tailor interventions to address specific facets of childhood depression, be they socio-emotional or cognitive-behavioural in nature. We also note the importance of more precise clinical phenotyping for the sake of investigations of underlying mechanisms, such as studies of neuroimaging or genotyping. S1 Table
Demographic variables comparing MASC and SEARS completers at year 8.5.(DOCX)The data are publicly-accessible using access procedures modeled after those of the National Institutes
of Health through requests to the GUSTO Executive Committee, and directed to Amber Guan, GUSTO cohort secretariat (amber.g@nus.edu.sg). The data access procedure is in accord with multi-party data management agreement established by the GUSTO participating sites. This research was supported by the Singapore National Research
Foundation under its Translational and Clinical Research (TCR) Flagship Programme and administered by the Singapore Ministry of Healths National funding was provided by the Singapore Institute of Clinical Sciences, Agency for
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citations, data availability statements, or supplementary materials included in this article.S1 Table. Demographic variables comparing MASC and SEARS completers at year 8.5.(DOCX)The data sets for this paper are derived from the Growing Up in Singapore towards Health Outcomes (GUSTO) longitudinal birth cohort study. The
data are publicly-accessible using access procedures modeled after those of the National Institutes of Health through requests to the GUSTO Executive Committee, and directed to Amber Guan, GUSTO cohort secretariat (amber.g@nus.edu.sg). The data access procedure is in accord with multi-party data management agreement established by the
GUSTO participating sites. Articles from PLOS ONE are provided here courtesy of PLOS Child psychology testMedical diagnostic methodChildren's Depression Inventory Subfields Basic psychology Abnormal Affective neuroscience Affective science Behavioral
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and CDI2) is a psychological assessment that rates the severity of symptoms related to depression or dysthymic disorder in children and adolescents.[1] The assessment is now in its second edition.[2][3] The 27 items on the assessment are grouped into five major factor areas.[1]
Clients rate themselves based on how they feel and think, with each statement being identified with a rating from 0 to 2.[1] The CDI was developed by American clinical psychologist Maria Kovacs, PhD, and was published in 1979.[1] It was developed by American clinical psychologist Maria Kovacs, PhD, and was published in 1979.[1] It was developed by American clinical psychologist Maria Kovacs, PhD, and was published in 1979.[1] It was developed by American clinical psychologist Maria Kovacs, PhD, and was published in 1979.[1] It was developed by American clinical psychologist Maria Kovacs, PhD, and was published in 1979.[1] It was developed by American clinical psychologist Maria Kovacs, PhD, and was published in 1979.[1] It was developed by American clinical psychologist Maria Kovacs, PhD, and was published in 1979.[1] It was developed by American clinical psychologist Maria Kovacs, PhD, and was published in 1979.[1] It was developed by American clinical psychologist Maria Kovacs, PhD, and was published in 1979.[1] It was developed by American clinical psychologist Maria Kovacs, PhD, and was published in 1979.[1] It was developed by American clinical psychologist Maria Kovacs, PhD, and was published in 1979.[1] It was developed by American clinical psychologist Maria Kovacs, PhD, and was published in 1979.[1] It was developed by American clinical psychologist Maria Kovacs, PhD, and an advantage of the psychologist Maria Kovacs, PhD, and adv
and accepted assessment for the severity of depressive symptoms in children and youth, with high reliability.[1] It also has a well-established validity using a variety of different techniques, and good psychometric properties. The CDI is a "Level B test," which means that the test is somewhat complex to administer and score, with the administrator
requiring training.[1]The BDI was used as a model for developing the CDI. The BDI is a clinically based, 21-item, self-rated symptom scale for adults in determining whether or not they are experiencing depression and/or depressi
development of a similar test for children and youth. With those considerations in mind, Kovacs development of the CDI. [1] It was derived using children as subjects. [1] In total, there were four phases of development of the CDI, including three revisions to the original 1975 assessment. [1]
The final version was developed and published in August 1979.[1] Kovacs reported that she and Aaron T. Beck worked together in using his adult scale of the BDI as a model for developing the CDI.[1][4]The test was originally designed for English-speaking American children, aged eight years old or older.[1] Skills needed for taking the test are the
lowest levels of reading and vocabulary comprehension, so it is suitable for children aged six years old or older.[1] The CDI has been translated into many languages, and has been administered to children worldwide.[1] The CDI manual includes comprehensive
information about psychometrics, norms, and item development. Many relevant charts are also included in the manual relating to reliability, constructs, and other areas. [1] Descriptions of CDI's scales are also provided, including examples of sample tests, along with associated tables of data and information. The directions for administration of the
CDI are clear and easy to follow.[1] Information and directions about scoring the CDI, as well as the length of time it generally takes for an individual to complete the CDI is 15 minutes or less, while scoring time is 510 minutes.[1] The 27 items of the CDI
are grouped into five factor areas, including 'Negative Mood', 'Interpersonal Problems', 'Ineffectiveness', 'Anhedonia', and 'Negative Self Esteem'.[1] The 27 items include statements related to the following areas: sadness, pessimism, self-deprecation, anhedonia, misbehavior, pessimistic worrying, self-hate, self-blame, suicidal ideation, crying spells,
irritability, reduced social interest, indecisiveness, negative body image, school-work difficulty, sleep disturbance, fatique, reduced appetite, somatic concerns, loneliness, school dislike, lack of friends, school performance decrement, self-depreciation (via peer comparison), feeling unloved, disobedience, and fighting.[1]The CDI is an objective and
empirical test. Individuals can score between 0 and 54 on the CDI, with those results being converted to T-scores, [1] A cut-off score of 1920 is generally accepted on the CDI, but is not an absolute. [1] Studies of the CDI was
designed for individual rather than group administration. [1] A score of 36 or higher on the CDI is generally accepted to reflect a person who has relatively severe depression. [7] As a norm-referenced test, the CDI was normed with public school students in
grades 2 through 8", including 674 girls aged 715.[1] Individual data on the test-takers' ethnicity or race are unavailable.[1] Based on the total demographics of the school districts that were sampled, however, approximately "77% of the children were Caucasian and 23% were African American or Black, American Indian, or
Hispanic."[1] "The population was largely middle class, although a wide range of socioeconomic backgrounds were included."[1] Further, about 20% of the respondents came from single-parent families.[1] The Cronbach's alpha was used to obtain reliability measures. Across one group of nine studies, alpha measures were 0.71-0.89, reflecting good
internal consistency. The test adequately measures for depressive symptoms.[1] In another group of 16 studies of test-retest reliability, alpha measures for internal consistency reliability were 0.590.68. Further, studies in addition to those completed by
Kovacs[1] have shown moderate[8] to high reliability.[9][13][14] One study used the Kuder-Richardson test of internal consistency and obtained results reflecting high reliability.[15]In correlating the CDI and factors of the CDI 
correlations,[5][17][18] while other studies have shown no correlations (in certain areas). The validity has also been established. [1][5][12][13][14][17] Construct validity has also been established. [1][5][12][13][14][17] Construct validity has also been established.
and those that were considered clinical.[1] Some studies have reflected discriminant validity, while others have not. Kovacs reported in 1992 that further research on the CDI has been conducted with Caucasian participants of middle to lower class socioeconomic status throughout the world.[1]
The CDI can be given to children and youth across cultures, though its "internal consistency and factorial structure vary somewhat in different juvenile cohorts."[1] Kovacs and other researchers have reported obtaining higher CDI scores for African-Americans (particularly boys),[21] Japanese (substantially higher),[1][22] Hispanic (significantly
higher),[1][23] and Egyptian[10] individuals when compared to Caucasians. Additionally, test scores for older children (aged 13 years old), though the difference is small and not significant.[1] This is explained with the consideration of the development and maturation of
children at this age level,[1] with changes occurring in brain structure occurring at these ages. One study, however, reported that the CDI scores of younger (aged 611) children who are diabetic, CDI score results may mimic those of having depressive
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symptoms.[1] However, important to keep in mind is that diabetes "elicits noticeable emotional upheaval (mostly in the depressive symptoms domain) that nonetheless resolves in about six months."[1] Test data also reflects that the test is sensitive to changes over time in depressive symptoms.[1] There are main effects in the constructs of 'Interpersonal Problems', 'Ineffectiveness', and 'Anhedonia' between boys and girls.[1] Girls scored higher than boys on these constructs, based on Kovacs' studies performed on the CDI as of 1992, reflecting that girls had a tendency for having greater distress in these areas.[1] While some studies have reported significant differences between CDI scores for boys, [23][24][28][29][30] other studies have reflected higher CDI scores for boys, [36] than

girls, including those in single-parent families.[37] Children of divorced parents were found to score significantly higher on the CDI than children who have experienced sexual abuse; [39] and those who have attention deficit disorder; [40][41] on the CDI than children of higher on the CDI than learning disabilities, in comparison with controls.[42] Children who were rejected by their peers, when compared with children who were considered "average".[44]Children of individuals who are substance abusers also scored significantly higher on the CDI than children of non-substance abusers.[45] Another study researched levels of depression and self-esteem in gifted children, and found that boys were significantly more depressed on the CDI than their non-obese counterparts in one study.[47] Children who have posttraumatic stress disorder (PTSD)[48][49] and anxiety[50] were more depressed, based on their CDI score results, than children who did not have PTSD or anxiety. Females, aged 1217, who had attempted suicide scored significantly higher on the CDI than psychiatric controls;[51] and girls who were repeat attempters of suicide scored higher on the CDI than first-time suicide attempters.[51]A 2012 study researched the potential relationship between pediatric inflammatory bowel disease and ulcerative colitis, and depressive symptoms.[52] A significant positive correlation was found between IBD and somatic complaints that reflect depressive symptoms.[52] Researchers in this study stated that the CDI test item, "somatic complaints" could potentially be recognized as a sixth and separate factor on the test.[52]CDI factorial structure and internal consistency have variations in differing juvenile cohorts. The CDI tends to reflect a greater number of false negatives than false positives. As with any test, the CDI is not perfectly valid.[1] It is possible for test-takers of the CDI to "fake good." Individuals who take the CDI whose reading level is not age-appropriate may have difficulty with it, and therefore, their results may be incorrect.[1] It is important to account for and consider additional information about the individual rather than solelyusing CDI test scores on which to base decisions.[1] A variety of individuals may administer the CDI, however, as a caution and for ethical purposes, only those professionals who are trained to interpret assessments should do so.[1] Psychological testing a b c d e f g h i j k l m n o p q r s t u v w x y z aa ab ac ad ae af ag ah ai aj ak al am an ao ap ag ar as at au av aw ax ay az ba bb bc bd be Kovacs, M. (1992). Children's Depression Inventory. North Tonawanda, NY: Multi-Health Systems, Inc., 2014, Retrieved 20 February 2014. Children's Depression Inventory, 2nd edition Archived February 23, 2014, at the Wayback Machine, Multi-Health Systems, Inc., 2014, Retrieved 20 February 2014. 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