Evaluation of the Children's Depression Inventory 2nd Edition
Kate Telkamp
CHRD 736: Appraisal of the Individual
South Dakota State University
December 1, 2013

**General Information**

The Children's Depression Inventory (CDI) was first published by Multi-Health Systems, Inc in 1977 by Maria Kovacs, Ph.D. A 2nd Edition of the inventory, the CDI 2, was published in 2011 by the same author (Murphy, Geisinger, Carlson, & Spies 2011). This assessment tool is used to evaluate depressive symptoms in children and adolescents ages seven to 17 and can be administered to groups in both school and clinical settings (Multi-Health Systems, Inc. [MHS], 2004).

Within the CDI 2 are four forms: Self-Report Full-Length, Self-Report Short, Parent Report, and Teacher Report. The Self-Report contains 28 items that yield a Total Score, two scale scores, and four subscale scores. The short version of this form contains 12 items and yields a Total Score. The items on the Parent and Teacher versions correspond to those on the self-report forms, but are rephrased and focus on those signs of depression that can be observed by others. The Teacher version contains 12 items while the Parent version consists of 17 items. These versions yield a Total Score and two scale scores. (MHS, 2004)
The time required to complete the Children's Depression Inventory 2nd Edition depends on the versions that are being administered, and takes from about five to 15 minutes. According to Tests in Print (Murphy, Geisinger, Carlson, & Spies, 2011), the Self-Report Full Length can take up to 15 minutes, while the Self-Report Short and Teacher Report both should be completed in about five minutes. The Parent Report is judged to take ten minutes to complete.

The cost of this assessment tool depends on the scoring preference of the administrator. When ordering the Handscored version of the CDI 2 from the Multi-Health Systems, Inc website, the price for the complete kit is $289. This includes the Manual, as well as 25 each of the Self-Report, Self-Report Short, Parent and Teacher QuikScore Forms. The complete online kit is $319 and includes online forms of the different reports. Counselors can also purchase the scoring software at $399 for the complete kit. This includes the Manual, scoring software and 25 each of the report response forms. To purchase just the Manual itself is $88. (MHS, 2004)

Technical Evaluation

According to Multi-Health Systems, Inc. (2004), the normative sample for the CDI 2 (which includes the CDI:SR[S]) includes 1,100 children who ranged in age from seven to 17 years old. The sample was taken from 26 states in the United States, and was evenly proportioned in terms of age and gender. The distribution of race and ethnicity used in the norm sample was made to match that of the United States census distribution and pulled individuals from all four regions of the country. In addition to the normative sample, a clinical sample was used as well. This included 319 youth of the same age range who were diagnosed with Major Depressive Disorder, Attention-Deficit/Hyperactivity Disorder, Conduct Disorder, Generalized Anxiety Disorder, or Oppositional Defiant Disorder (MHS, 2004). The Parent Report and Teacher Report forms were created with a standardized sample of 800 parents and 600 teachers. These adults worked with or were parents to a balanced number of girls and boys between the ages of seven and 17 (Bae, 2012).

Reliability was shown through internal consistency. The Cronbach’s alpha values for all forms of the CDI 2 ranged from .67 to .91. Test-retest reliability was also obtained through testing 79 children within a 2- to 4-week interval. There was nearly no change shown during this time interval. The Teacher and Parent reports were also tested for test-retest reliability (Bae, 2012).
According to Bae (2012), construct validity suggests that the CDI 2 Self-Report form works well as a screening tool for depression. The Regular and Short forms were compared using the Pearson correlation which showed them to have high construct similarity. The Parent and Teacher forms were also tested and showed good model fits as well. Tests were conducted to determine how well the CDI 2 is able to distinguish youth with major depressive symptoms from those who do not have these symptoms. Results from these univariate and multivariate analysis of covariance showed that the group of children with major depressive symptoms had statistically significantly higher scores than all other groups (Bae, 2012).

Practical Evaluation

The Children's Depressive Inventory 2nd Edition can be administered through paper copies, online, or through scoring software available from Multi-Health Solutions, Inc (MHS, 2004). The CDI 2 can be administered in a group, and must be given by a B-level administrator. This indicates that the administrator must have a master's degree in psychology or education, or an equivalent degree in addition to training in assessment. The person administering the test must also have verification of licensure or certification that is recognized by the publisher (Whiston, 2013).

Reviewer Comments

In a review of the Children's Depression Inventory 2, Yunhee Bae (2012) cites the Emotional and Functional Problems scales, the addition of more subscales, and age and sex norms as components that support the use of this assessment tool. Bae also states that the reliability testing of the instrument indicates that it is appropriate for practical and academic applications. As far as weaknesses, Bae points out that the test is mainly written-text format, so alternatives would need to be used for youth with cognitive or physical disabilities. Bae recommends the use of this assessment repeatedly over time in order to access changes in depressive symptoms, but does not recommend use with children if participation is not voluntary.

Summary Evaluation
The Children's Depression Inventory 2 seems to be a useful tool in determining level of depression for children ages seven to 17. The fact that the instrument has forms for children, parents and teachers to complete adds to the overall validity of the test, and allows the counselor to get a clearer picture of what problems the student may be facing. I feel that both the norm group and clinical sample are representative of the United States population, and were large enough to establish reliability and validity of the test. Although this test would not be suitable for children who are not able to read and comprehend at the necessary level, it could still be given to their parents and/or teachers in order to gain information on that child. Because this assessment requires Level B qualifications be met before administration, most counselors would be capable of administering this assessment to their clients.
References


