Abstract

Background: Anxiety and depression are among the most common mental disorders during childhood and adolescence. Among the instruments for the brief screening assessment of symptoms of anxiety and depression, the Revised Child Anxiety and Depression Scale (RCADS) is one of the more widely used. Previous studies have demonstrated the reliability of the RCADS for different assessment settings and different versions. The aims of this study were to examine the mean reliability of the RCADS and the influence of the moderators on the RCADS reliability.

Methods: We searched in EBSCO, PsycINFO, Google Scholar, Web of Science, and NCBI databases and other articles manually from lists of references of extracted articles.

Results: A total of 146 studies were included in our meta-analysis. The RCADS showed robust internal consistency reliability in different assessment settings, countries, and languages. We only found that reliability of the RCADS was significantly moderated by the version of RCADS. However, these differences in reliability between different versions of the RCADS were slight and can be due to the number of items.

Limitations: We did not examine factor structure, factorial invariance across gender, age, or country, and test-retest reliability of the RCADS.

Conclusions: The RCADS is a reliable instrument for cross-cultural use, with the advantage of providing more information with a low number of items in the assessment of both anxiety and depression symptoms in children and adolescents.

Keywords: Meta-analysis; Reliability generalization meta-analysis; Revised Child Anxiety and Depression Scale; Children; Adolescents; Systematic Review

1. Introduction

Depressive and anxiety disorders, also termed “internalizing disorders,” are two of the most prevalent mental health problems as wells as the leading contributors to health burden among children and adolescents globally (Chisholm et al., 2016; Erskine et al., 2015). According to a recent meta-analytic review, global prevalence of these disorders are about 6.50% for anxiety and 2.60% for depressive disorders in youth (Polanczyk et al., 2015). Furthermore, anxiety and depression display a marked comorbidity between the two conditions, so it is estimated that between 15% and 70% of children and adolescents who have a diagnosis of depression will present with an anxiety disorder at the same time (Cummings et al., 2014; de Ross et al., 2012). Concerning children with anxiety disorder, the rate of comorbidity with depressive disorders is usually lower, between 10% and 15% (Cummings et al., 2014).

Given the negative impact that anxiety and depressive symptoms have on child development and its economic burden, efforts to prevent these disorders are now considered a public health priority (Chisholm et al., 2016; WHO, 2008). For this task, having reliable and valid screening measures of symptoms of anxiety and depression is essential (Chorpita et al., 2000). Self-report instruments have been the dominant method for assessing anxiety and depression, with several advantages over other assessment methods, such as interviews or observation (Southam-Gerow and Chorpita, 2007).

Several self-report measures have shown good psychometric properties for separately assessing symptoms of depressive or anxiety disorders. Thus, concerning the assessment of depressive symptoms, it is noteworthy to mention the Children´s Depression Inventory and its updated version (CDI, CDI-2; Kovacs, 1985, 2015); the Center for Epidemiologic Studies Depression Scale Revised (CES-D; Radloff, 1977), or the Beck Depression Inventories (BDI and BDI-II) (Becket al., 1961; Beck et al., 1996).

Concerning anxiety, there are some well-established self-report measures for assessing symptoms of anxiety disorders, such as the Spielberg State-Trait Anxiety Inventory for Children (STAI-C; Spielberger, 1973), the Multidimensional Anxiety Scale for Children (MASC; March et al., 1997), the Revised Children´s Manifest Anxiety Scale (RCMAS; Reynolds and Richmond, 1978), the Screen for Child Anxiety Related Emotional Disorders (SCARED; Muris et al., 1998), or the Spence Children's Anxiety Scale (SCAS; Spence, 1997, 1998). Most recently, Muris et al. (2016) developed the Youth Anxiety Measure for DSM-5 (YAM-5), a new scale for assessing child and adolescent anxiety disorders according to DSM-5 criteria (Garcia-Lopez et al., 2017; Muris et al., 2016). However, the YAM-5 also does not include an assessment of depressive symptomatology.

Given the marked comorbidity between anxiety and depression and the need for distinguishing both types of symptoms, as well as the need for a closer correspondence to new DSM-IV anxiety and depression disorders, the Revised Child Anxiety and Depression Scale (RCADS; Chorpita et al., 2000) was developed. The RCADS uses many of the items of the SCAS (Spence, 1997, 1998), along with items representing major depression symptoms and new items related to generalized anxiety and negative affect. This new measure consists of 47 items grouped into six subscales: Separation Anxiety Disorder (SAD; 7 items), Social Phobia (SP; 9 items), Generalized Anxiety Disorder (GAD; 6 items), Panic Disorder (PD; 9 items), Obsessive Compulsive Disorder (OCD; 6 items), and Major Depressive Disorder (MDD; 10 items) (Chorpita et al., 2000). The RCADS also provides an Anxiety total score, which is the sum of all Anxiety subscales except for MDD.

The RCADS is a self-report measure developed to screen and identify clinical symptomatology of anxiety and depression among children and adolescents (Chorpita et

al., 2005; de Ross et al., 2012). RCADS has proven to be a reliable and valid measure for the assessment of anxiety and depression in general and clinical populations of children and adolescents (Chorpita et al., 2000; Chorpita et al., 2005; de Ross et al., 2012; Sandin et al., 2010). Thus far, the measure has been translated into numerous languages, including Spanish (Sandin et al., 2010), Danish (Reinholdt-Dunne et al., 2011), German (Mathyssek et al., 2013), and French (Bouvard et al., 2015). Furthermore, a recent study asserted that the RCADS seems to be one of the most sensitive-to-change tools of the reported outcome measures they reviewed (Wolpert et al., 2015).

Regarding the structure of the RCADS, most of the studies have shown support for the original six-factor model, both for clinical (Chorpita et al., 2000; Chorpita et al., 2005) and school-based samples (Van Oort et al., 2009). However, there are studies that have found support for a 25-item shortened version of the RCADS, which fit better to a five-factor structure but removed the OCD scale (Muris et al., 2002). In addition, this shortened version had psychometric properties that were equivalent with the original 47-item scale (i.e., satisfactory internal consistency with alpha coefficients ranging from .68 to .83) (Esbjorn et al., 2012). Another version of RCADS is the 30-item shortened version (RCADS-30; Sandin et al., 2010), which has the main advantage of respecting the original six-factor structure. Moreover, it has demonstrated reliability and validity coefficients equivalent to the original longer version (Sandin et al., 2010).

Although there has been a large number of translated, validated, and shortened versions of the RCADS for multiple languages and cultural settings since 2000, there has not been a study that has evaluated cross-cultural support for the mean reliability of the RCADS. It should be noted that reliability is not a property inherent to a test, because it is a property of scores obtained in a given application of a test (Marin-

Martínez et al., 2009). Consequently, we considered that the systematic review and meta-analysis of reliability coefficients of the RCADS would allow for the achievement of two fundamental objectives: (1) to estimate mean reliability of the RCADS total scale and its subscales; and (b) to determine the effect of different moderator variables in the variation of mean reliability. As a result, the aim of this systematic review was to evaluate cross-cultural support for the internal consistency of the RCADS.

2. Method

2.1. Search and selection of studies

We searched some of the main online databases: EBSCO, PsycINFO, Google Scholar, Web of Science, and NCBI Databases were searched using a combination of text words including any of the following keywords: "Revised Child* Anxiety Depression Scale" OR "RCADS." We did not use limiters to refine the search, or time constraints. An additional search was conducted with a downward review from the studies of validation of different versions of the RCADS. Moreover, we completed our search contacting major research teams who had published works with this scale.

The search included empirical studies published between 2000, the year the RCADS was first published, and June 2016. We obtained 2825 studies from databases and 8 through other sources, of which 2245 were duplicated.

2.2. Inclusion and exclusion criteria

The empirical studies were included if (1) the original or any version of the RCADS was applied, regardless of whether or not these were psychometric or using the instrument to capture symptoms; (2) the participants were aged between 6 and 18 years; (3) they reported any coefficient of internal consistency from the sample; (4) they

provided mean and standard deviations of the measure; and (5) they were published in English or Spanish.

2.3. Data extraction

As a first step, we developed a coding manual with the description of relevant variables (see Supplementary Table A1 as a summary of characteristics extracted from the studies)., instructions for the coding, coding forms, and five studies encoded as examples for the training of coders. From the examples, the discrepancies between coders were resolved by means of a meeting in which an agreement was reached. A total of 20 articles were coded by four independent trained coders.

We calculated correlations for quantitative and Fleiss' kappa (Fleiss, 1971) for qualitative variables in order to analyze the quality of the encoding process. The screening of 588 selected records was distributed between four of the authors as coders. Later, one of the authors conducted the coding process, with the subsequent review by another researcher.

2.4. Data analysis

A generalization study of the RCADS' reliability was conducted using a meta-analytic technique in order to quantitatively synthesize the research findings and infer whether a test is reliable across different samples. Therefore, for the calculation of effect size and the variance of alpha coefficients, these values were transformed following the Hakstian-Whalen transformation that allows normalizing the distribution of reliability coefficients (Hakstian and Whalen, 1976). For the calculation of effect size of mean and variances of the samples, we applied the procedures described by Botella et al. (2010). All effect sizes were weighted by the inverse of the variance (Botella and Meca, 2015). We used the Cochran's heterogeneity Q test (Hedges y Olkin, 1985); the percentage of heterogeneity (I^2, Higgins y Thompson, 2002), the heterogeneity index

(H^2; Higgins y Thompson, 2002), and the between-studies variance, (τ^2, Higgins y Thompson, 2002) as the statistics to assess heterogeneity in meta-analysis.

Publication bias was evaluated with the failsafe number (FSN) and the lower bound population reliability estimate (Howell and Shields, 2008).

Analysis of moderators was subsequently conducted. We calculated the analysis of moderators only with the version of 47 items, since it provides a sufficient number of studies, while the other versions have only a limited number of studies. As categorical moderators, we included country (U.S. vs. other countries), sample type (general vs. clinical samples), and language of the questionnaire. As continuous moderators, we examined the effect of mean age of the sample, gender (percentage of females), and variances for the test scores on the reliability coefficients. It was assumed that data followed a model of random effects due to the fact that two sources of variability were assumed (the variability attributed to sampling errors and inter-studies variability**)** and was calculated by the DerSimonian-Laird method for the adjusted estimation of heterogeneity. Statistical analyses were performed with the statistical package Metafor (Viechtbauer, 2010) implemented in R (R Core Team, 2016).

Finally, due to the fact that different versions of the RCADS use a different number of items, we analyzed whether the version of RCADS was a significant moderator for reliability.

3. Results

3.1. Meta-analysis of internal consistency of the RCADS (mean reliability)

We identified 588 manuscripts of which 442 were excluded after applying the inclusion and exclusion criteria (see Prisma flow diagram of the literature review

process in Figure 1). Hence, the search identified 146 articles comprising 192 studies that reported some coefficient of internal consistency. Most studies followed a cross-sectional design (k = 155), while the remaining ones were longitudinal or cross-sectional/longitudinal studies. Concerning the distribution of countries, studies were conducted predominantly in the United States (k = 96), followed by the Netherlands (k = 41) and Spain (k = 18). Other samples came from Germany, Australia, Belgium, Brazil, Bulgaria, Chile, China, Croatia, Cuba, Denmark, Philippines, Indonesia, Iran, Ireland, Italy, Montenegro, Nigeria, Palestine, Portugal, Romania, Serbia, and the United Kingdom. The sample sizes ranged from 16 to 6,767 participants; the final sample size consisting of 88,648 children and adolescents (51.40% of female) with a mean age of 11.66 years (SD = 1.41; range: 6–18). There was an ethnic majority of Caucasian participants (k = 88), with a varied and representative socioeconomic status (k = 74). Mainly, studies were conducted with general samples (k = 125; n = 79,747; 89.96%). A more detailed description of the versions of the RCADS used can be found in Table 1. A summary of the main data of the studies included in the systematic review and meta-analysis can be seen in Supplementary Table A1.

The coding process obtained good inter-rater concordance among judges (r > .91 y *kappa* > .88), indicating an excellent degree of agreement on the coding (Landis and Koch, 1977).

The heterogeneity test for reliability was significant for all subscales of the RCADS (see Table 2 and Fig. 2-9. Forest Plots). The variability of means and variances also showed a statistically significant heterogeneity for all subscales (see Tables 3 and 4). Furthermore, the variances of RCADS scores present a positive association to reliability. This variability of sample means and variances alerts one to the presence of biases in the selection of participants with regard to the range and population, and

implies a systematic heterogeneity in sample variances. Therefore, to control the effect of sampling in the variability of coefficients, we included the sample variance as a moderator, and later other moderator variables were added to the model.

The mean alpha coefficient for each subscale and for the RCADS full scale was calculated (see Table 2). The RCADS total score was found to have excellent mean reliability, with a mean alpha value of .93. Cronbach's alpha coefficients for the Anxiety scale was also excellent, with a mean alpha of .93, while the other subscales ranged from .74 to .85, indicating acceptable to good reliability. It can be also observed the heterogeneity exhibited by individual reliability coefficients in the studies (see Fig. 2-9).

Based on the calculations of the lower bound population reliability estimate ($\alpha_{UW\ means}$ = .71-.90 for all versions; $\alpha_{UW\ means}$ = .72-.92 for RCADS-47) and the Fail-Safe N at .60 (from 109 to 549 file drawer studies for all versions; from 80 to 454 file drawer studies for RCADS-47), we can conclude that the RCADS likely produces "reliable" scores even under very extreme circumstances (see table 5), both for all versions of RCADS and RCADS-47.

3.2. Analyses of moderators for RCADS-47

Concerning the categorical moderators, the reliability did not present any difference among countries, languages, or sample types for total score of RCADS, SAD, or OCD (see Table 6).

In contrast, our results showed that the mean reliability was higher for U.S. samples for SP, PD, GAD, and MDD. We also found that the language of the application had effects on the reliability of SP, being higher for English version of RCADS-47. Finally, the sample type showed an effect on the reliability for Anxiety total score, showing slightly higher reliability for general samples.

As regards continuous moderators, the mean age of the sample had an effect on the reliability for SP, PD, GAD, and MMD, showing that higher mean age was associated with greater reliability coefficients. It should be noted that the effect of the sample variances as moderator variables of the reliability coefficients of the RCADS subscales were not significant for any scale (see Table 7).

Regarding the role of the version of the RCADS on the mean reliability, our results indicated that the number of items of versions had a positive and significant effect on the reliability for all scales, except for SAD and GAD (see Table 8).

4. Discussion

This is the first study that analyzed the cross-cultural reliability of the RCADS through a systematic review and meta-analysis. Two specific aims were addressed. The first was to estimate the mean reliability of the RCADS full scale, its six subscales (Separation Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, Generalized Anxiety Disorder, Obsessive Compulsive Disorder, and Major Depressive Disorder), and the Anxiety scale. The second was to carry out an analysis of moderators of the reliability of the RCADS.

The results of the meta-analysis of alpha coefficients showed excellent reliability with a mean alpha of .93 for the RCADS full scale. As mentioned earlier, the RCADS is an adaptation of the SCAS (Spence, 1997, 1998). Our finding is consistent with the mean alpha value reported by Orgiles et al. (2016) for the SCAS full scale.

Concerning the RCADS subscales, the mean alpha value for the Anxiety scale was .93, while the mean alpha values for the six subscales ranged from acceptable for the Obsessive Compulsive Disorder and Separation Anxiety Disorder subscales (α = .74) to good for the Social Anxiety Disorder, Panic Disorder, Generalized Anxiety

Disorder, and Major Depressive Disorder subscales (α = .82–.85). These results are consistent with previous studies that reported that the internal consistency of the RCADS is good (e.g., Chorpita et al., 2000; Chorpita et al., 2005; Muris et al., 2002; Sandin et al., 2009, 2010). Moreover, these findings are slightly higher than the mean reliability values reported for the SCAS in a recent meta-analytic review (Orgiles et al., 2016). Given this study used a sample of 88,648 children and adolescents from 25 countries (representing six continents), we can conclude that the RCADS is a reliable instrument for evaluating the symptoms of anxiety and depression in children and adolescents in different cultural settings.

Regarding the second objective of this study, analysis of moderators, it should be noted that the results indicated that the reliability of the RCADS total score, Anxiety total score, SAD and TOC was not mediated by the variable of age. This is a relevant advantage in comparison with other similar measures, such as the SCAS total score, in which there was a significant mediator by age in all scales (Orgiles et al., 2016). Additionally, we did not find a general significant effect of mediation by the sample type, gender, country, or the language of the RCADS. Nevertheless, we found some significant effects of mediation by country (U.S. vs. other countries), language (English versus other languages), sample type (community vs. clinical samples) in some few scales.

Regarding different versions of RCADS, longer versions, such as the original of 47 items (Chorpita et al., 2000), showed better reliability compared with the other versions with fewer items for all subscales, except for SAD and GAD. As for the RCADS-25 (Muris et al., 2002), this version showed a slightly lower reliability and did not provide the assessment of obsessive-compulsive disorder symptoms. With respect to the short version of the RCADS (RCADS-SV; Ebesutani et al., 2012), this version

presents a main advantage, which is its length. However, according to our review, perhaps it is the version that presents major disadvantages, because it loses clinically relevant information due to the fact that it provides only two scores (Anxiety and Depression total scores), and presents lower coefficients of reliability in comparison with the other versions. In this sense, it should be noted that the RCADS-30, the version of 30 items by Sandin and colleagues (2010), which respects the original 6-factor structure, shortens the measure by 17 items and had slightly lower reliability in comparison with the original RCADS. Indeed, Cronbach's alpha is a function of the number of items in a test, the average covariance between item-pairs, and the variance of the total score. Therefore, the number of items in the test can artificially inflate the value of alpha (Green et al., 1977). Accordingly, the correlations between items can be used as a measure free of the bias that produces a higher number of items. Hence, when calculating this correlation, we can find that the 47-item original version, the 25-item version, and the 30-item version have identical correlations between their items, highlighting the relative advantage of the 30-item version. Consequently, when the lower number of items and the respect to the original factor structure are taken together, the more advantageous version remains the 30-item version.

Limitations

This study has some limitations. First, we conducted an exhaustive search in order to collect all the existing scientific literature to date. However, it is possible that some research was not included in the search due to the criteria of inclusion or databases used. Consequently, this could affect the results. Second, other validity and reliability properties were not examined in this study, which should be addressed in future investigations. Therefore, we did not assess responsiveness, and sensitivity and

specificity estimates with a gold standard instrument for construct validity, factor structure and factorial invariance, or test-retest reliability of the RCADS.

Despite these limitations, the systematic review demonstrated that the RCADS has strong internal consistency reliability. In addition, compared with other measures such as the SCAS, the RCADS includes the assessment of depression and anxiety symptoms based on the DSM-IV, providing more information with a low number of items. Consequently, it can be noted that the RCADS is as reliable as the SCAS, but with the advantage of assessing symptoms of both anxiety and depression in children and adolescents, and with only three more items than the SCAS. The findings of this study therefore provide support for the use of the RCADS as a reference tool in the assessment of emotional symptoms in different settings, countries, and languages.

References

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Fig. 1. PRISMA flow diagram of study selecting process

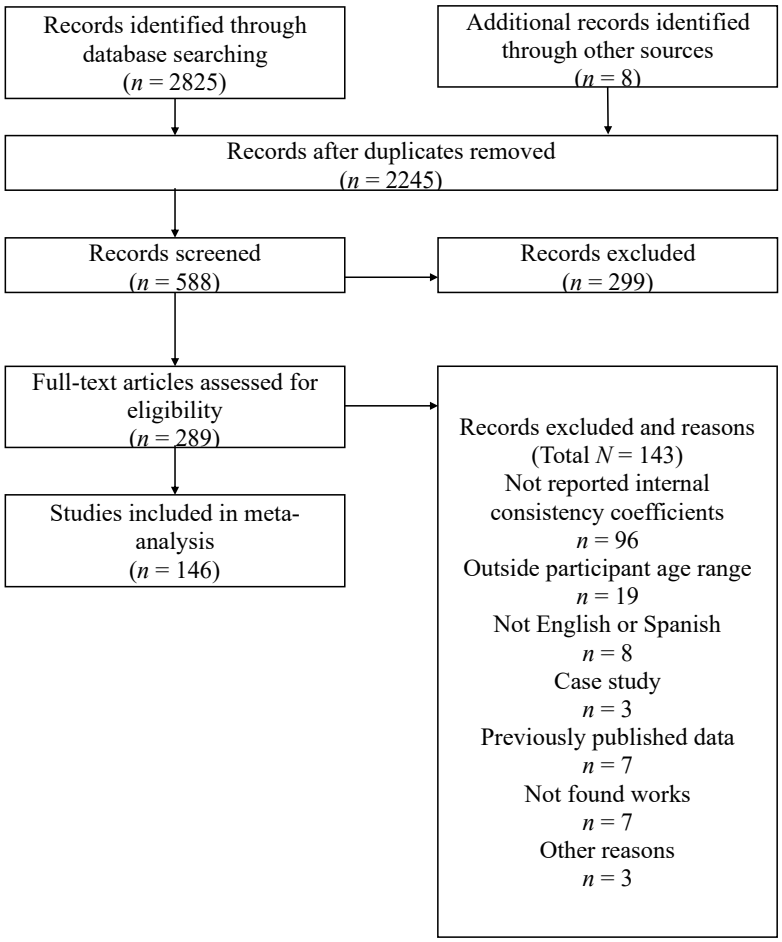

Table 1. Summary of the main descriptive data of the versions of the RCADS

	Versions								
	RCADS-47	RCADS-25	RCADS-25-P	RCADS-30	RCADS-47-P	RCADS-38	RCADS-19	RCADS-SV	RCADS-SV-P
First author (year)	Chorpita (2000)	Muris (2002)	Muris (2002)	Sandín (2010)	Ebesutani (2010)	Weems (2010)	Hogendoorn (2011)	Ebesutani (2012)	Ebesutani (2016)
Descriptives data									
k	142	18	1	13	7	2	2	4	3
n	66901	6462	372	8162	2634	1158	438	1580	941
% of females	54.03	56.55	46.80	51.25	43.57	49.00	54,5	51.00	53.67
Number of items									
Separation Anxiety Disorder (SAD)	7	5	5	5	7	n.r.	n.r.	n.a.	n.a.
Social Phobia (SP)	9	5	5	5	9	n.r.	n.r.	n.a.	n.a.
Obsessive-Compulsive Disorder (OCD)	6	n.a.	n.a.	5	6	n.r.	n.r.	n.a.	n.a.
Panic Disorder (PD)	9	5	5	5	9	n.r.	n.r.	n.a.	n.a.
Generalized Anxiety Disorder (GAD)	6	5	5	5	6	n.r.	n.r.	n.a.	n.a.
Major Depressive Disorder (MDD)	10	5	5	5	10	n.r.	n.a.	10	10
Anxiety total score (ANX)	37	20	20	25	37	n.r.	n.r.	15	15
RCADS total score	47	25	25	30	47	38	19	25	25

Note. RCADS = Revised Child Anxiety and Depression Scale; P = Parents version; SV = Short Version; *k* = number of studies ; *n* = sample size; n.a. = not available; n.r. = not reported.

Table 2. Heterogeneity test of reliability of RCADS scales[a]

	$Q_{(d.f.)}$	I^2	H^2	τ^2	T	SE	α	C.I. 95%	Range
SAD	510.15 $_{(28)}$ ***	94.51	18.22	.002	.637	.009	.74	[.71, .76]	[.66, .86]
SP	1522.17 $_{(39)}$ ***	97.44	39.03	.003	.527	.010	.85	[.83, .86]	[.75, .92]
OCD	540.67 $_{(29)}$ ***	94.64	18.64	.002	.630	.009	.74	[.72, .76]	[.57, .88]
PD	1388.98 $_{(38)}$ ***	97.26	32.56	.004	.546	.010	.83	[.81, .85]	[.68, .92]
GAD	890.53 $_{(42)}$ ***	95.28	21.20	.002	.557	.008	.82	[.81, .84]	[.70, .90]
MMD	3599.39 $_{(78)}$ ***	97.83	46.15	.006	.561	.009	.82	[.80, .83]	[.63, .94]
ANX	589.83 $_{(37)}$ ***	93.73	15.94	.001	.409	.006	.93	[.92, .93]	[.70, .96]
RCADS	712.45 $_{(39)}$ ***	94.53	18.27	.001	.399	.007	.93	[.92, .94]	[.78, .97]

Note. SAD = Separation Anxiety Disorder; SP = Social Phobia; OCD = Obsessive-compulsive Disorder; PD = Panic Disorder; GAD = Generalized Anxiety Disorder; MMD = Major Depressive Disorder; ANX = Anxiety total score; RCADS = RCADS total score.
Q = Cochran's heterogeneity Q test (Hedges y Olkin, 1985); *d.f.* = degrees of freedom; I^2 = percentage of heterogeneity (Higgins y Thompson, 2002); H^2 = heterogeneity index (Higgins y Thompson, 2002); τ^2 = between-studies variance; T = Transformed alpha coefficient; SE = Standard Error; α = Weighted mean alpha; 95% C.I.= 95% Confidence interval; Range = minimum and maximum alpha scores from studies.
[a] = Revised Child Anxiety and Depression Scale (Chorpita et al., 2000).
*** = $p < .001$.

Table 3. Contrast of heterogeneity of the means of the RCADSa scales[a]

	$Q_{(d.f.)}$	I^2	H^2	τ^2	*M*	*SE*	C.I. 95%	Range
SAD	3850.42 $_{(36)}$ ***	99.07	106.96	.032	0.59	.031	[0.53, 0.65]	[0.24, 2.26]
SP	19469.50 $_{(47)}$ ***	99.76	414.24	.059	1.04	.037	[0.97, 1.11]	[0.40, 1.88]
OCD	3876.01 $_{(37)}$ ***	99.05	104.76	.022	0.76	.025	[0.71, 0.81]	[0.34, 1.57]
PD	5124.91 $_{(47)}$ ***	99.08	109.04	.011	0.53	.016	[0.50, 0.56]	[0.22, 1.50]
GAD	20694.53 $_{(47)}$ ***	99.97	440.31	.097	1.08	.046	[0.99, 1.17]	[0.63, 1.90]
MMD	21358.81 $_{(64)}$ ***	99.70	333.73	.017	0.79	.025	[0.74, 0.84]	[0.12, 3.35]
ANX	4402.02 $_{(43)}$ ***	99.02	102.37	.041	0.74	.031	[0.68, 0.80]	[0.31, 1.53]
RCADS	821.18 $_{(15)}$ ***	98.17	54.75	.013	0.67	.029	[0.62, 0.73]	[0.34, 1.14]

Note. SAD = Separation Anxiety Disorder; SP = Social Phobia; OCD = Obsessive-compulsive Disorder; PD = Panic Disorder; GAD = Generalized Anxiety Disorder; MMD = Major Depressive Disorder; ANX = Anxiety total score; RCADS = RCADS total score.
Q = Cochran's heterogeneity Q test (Hedges y Olkin, 1985); *d.f.* = degrees of freedom; I^2 = percentage of heterogeneity (Higgins y Thompson, 2002); H^2 = heterogeneity index (Higgins y Thompson, 2002); τ^2 = between-studies variance; *M*= Estimation of the weighted mean; *SE* = Standard Error; α = Weighted mean alpha; 95% C.I.= 95% Confidence interval; Range = minimum and maximum mean scores from studies.
[a] = Revised Child Anxiety and Depression Scale (Chorpita et al., 2000).
*** = $p < .001$.

Table 4. Contrast of heterogeneity of the variances of the RCADSa scales[a]

	Q (d.f.)	I^2	H^2	τ^2	*VAR*	*SE*	C.I. 95%	Range
SAD	1554.04 (38) ***	97.55	40.90	.003	0.20	.010	[0.18, 0.22]	[0.05, 3.94]
SP	8301.76 (49) ***	99.41	169.42	.011	0.25	.016	[0.22, 0.28]	[0.01, 2.25]
OCD	5832.65 (38) ***	99.35	153.49	.012	0.26	.019	[0.23, 0.30]	[0.01, 2.03]
PD	6776.25 (48) ***	99.29	141.17	.006	0.18	.012	[0.15, 0.20]	[0.01, 1.31]
GAD	7598.34 (49) ***	99.36	155.07	.010	0.28	.016	[0.25, 0.31]	[0.01, 3.61]
MMD	7840.62 (73) ***	99.07	107.41	.006	0.19	.010	[0.17, 0.21]	[0.01, 2.72]
ANX	1780.63 (47) ***	97.36	37.89	.003	0.14	.009	[0.12, 0.16]	[0.03, 0.59]
RCADS	747.15 (16) ***	97.86	46.70	.003	0.14	.013	[0.12, 0.17]	[0.04, 0.32]

Note. SAD = Separation Anxiety Disorder; SP = Social Phobia; OCD = Obsessive-compulsive Disorder; PD = Panic Disorder; GAD = Generalized Anxiety Disorder; MMD = Major Depressive Disorder; ANX = Anxiety total score; RCADS = RCADS total score.
Q = Cochran's heterogeneity Q test (Hedges y Olkin, 1985); *d.f.* = degrees of freedom; I^2 = percentage of heterogeneity (Higgins y Thompson, 2002); H^2 = heterogeneity index (Higgins y Thompson, 2002); τ2 = between-studies variance; *VAR* = Estimation of the weighted variance; *SE* = Standard Error; α = Weighted mean alpha; 95% C.I.= 95% Confidence interval; Range = minimum and maximum variance scores from studies.
[a] = Revised Child Anxiety and Depression Scale (Chorpita et al., 2000).
*** = $p < .001$.

Table 5. Lower Bound Estimates[a] and Fail-Safe Number[a] for RCADS subescales[b]

All versions of RCADS:	SAD	SP	OCD	PD	GAD	MDD	ANX	RCADS
Reporting samples	52	62	47	59	66	114	60	64
Mean	.74	.83	.73	.81	.81	.79	.90	.91
SD	.05	.06	.07	.06	.05	.08	.05	.05
Non reporting samples	40	41	39	37	44	58	33	29
File drawer reliability estimate	.70	.78	.68	.76	.77	.72	.86	.88
Lower bound estimate from alpha	.72	.81	.71	.79	.80	.77	.89	.90
Fail-Safe Number*	176.55	315.62	108.52	250.11	329.79	320.08	427.02	548.75
RCADS-47								
Reporting samples	30	40	30	39	43	79	39	41
Mean	.74	.85	.74	.83	.82	.81	.92	.93
SD	.05	.05	.07	.05	.05	.06	.05	.04
Non reporting samples	36	37	36	33	39	53	31	22
File drawer reliability estimate	.70	.81	.69	.79	.78	.77	.89	.90
Lower bound estimate from alpha	.72	.83	.72	.81	.80	.79	.91	.92
Fail-Safe Number*	97.68	271.73	80.34	216.19	223.28	346.25	348.12	453.57

Note. [a] = Howell & Shields (2008); [b] = Revised Child Anxiety and Depression Scale (Chorpita et al., 2000).
SAD = Separation Anxiety Disorder; SP = Social Phobia; OCD = Obsessive-Compulsive Disorder; PD = Panic Disorder; GAD = Generalized Anxiety Disorder; MDD = Major Depressive Disorder; ANX = Anxiety total score; RCADS = RCADS total score.
* = number of file drawer necessaries to downsize reliability under .60

Table 6. Categorical moderators analysis of RCADS scales[a]

Scale	Moderator	*QE (d.f.)*	*QM (d.f.)*	*I*2	*R*2	α	C.I. 95%	Range	α	C.I. 95%	Range
SAD							English			Others	
	Language	296.27 (17)***	0.76 (2)	94.26	0.00	.73	[.69, .77]	[.66, .86]	.73	[.66, .78]	[.68, .78]
							USA			Others	
	Country	298.59 (17)***	1.07 (2)	94.31	4.46	.75	[.68, .80]	[.67, .86]	.73	[.69, .76]	[.66, .84]
							General			Clínical	
	Sample	295.16 (17)***	0.79 (2)	94.24	5.38	.73	[.70, .76]	[.66, .84]	.73	[.67, .79]	[.67, .86]
SP							English			Others	
	Language	642.61 (28)***	9.22 (2)**	95.64	28.34	.87	[.85, .89]	[.78, .92]	.81	[.76, .86]	[.75, .84]
							USA			Others	
	Country	430.20 (28)***	13.61 (2)***	93.49	53.04	.88	[.86, .90]	[.78, .92]	.85	[.82, .87]	[.75, .92]
							General			Clínical	
	Sample	711.01 (28)***	2.98 (2)	96.06	23.87	.86	[.84, .88]	[.75, .92]	.88	[.84, .91]	[.78, .92]
OCD							English			Others	
	Language	250.86 (17)***	2.08 (2)	93.22	0.00	.77	[.74, .80]	[.57, .88]	.73	[.67, .78]	[.68, .77]
							USA			Others	
	Country	158.68 (17)***	3.85 (2)	89.29	33.49	.79	[.75, .82]	[.57, .82]	.75	[.72, .78]	[.68, .88]
							General			Clínical	
	Sample	258.63 (17)***	1.12 (2)	93.43	0.00	.76	[.73, .79]	[.68, .83]	.73	[.65, .80]	[.57, .88]
PD							English			Others	
	Language	585.18 (27)***	1.20 (2)	95.39	3.49	.85	[.82, .87]	[.68, .92]	.84	[.80, .88]	[.80, .87]
							USA			Others	
	Country	952.79 (37)***	6.70 (2)**	96.12	27.60	.85	[.83, .88]	[.75, .90]	.81	[.79, .83]	[.68, .92]
							General			Clínical	
	Sample	559.91 (27)***	1.35 (2)	95.18	11.41	.84	[.82, .86]	[.68, .90]	.85	[.81, .88]	[.75, .92]

GAD							English			Others	
	Language	400.36 (28)***	3.60 (2)	93.01	0.75	.84	[.82, .86]	[.70, .89]	.83	[.78, .86]	[.72, .90]
							USA			Others	
	Country	767.18 (28)***	6.67 (2)*	90.25	29.22	.85	[.83, .87]	[.70, .89]	.83	[.81, .85]	[.72, .90]
							General			Clínical	
	Sample	400.53 (28)***	3.73 (2)	94.66	8.92	.84	[.82, .86]	[.72, .90]	.83	[.80, .86]	[.70, .89]
MMD							English			Others	
	Language	2434.48 (51)***	1.28 (2)	97.91	1.38	.83	[.80, .86]	[.63, .94]	.84	[.75, .90]	[.79, .87]
							USA			Others	
	Country	1152.97 (51)***	8.39 (2)**	95.58	51.55	.86	[.83, .88]	[.63, .93]	.82	[.79, .84]	[.71, .94]
							General			Clínical	
	Sample	2413.95 (51)***	1.35 (2)	97.89	3.02	.83	[.80, .86]	[.71, .94]	.83	[.78, .87]	[.63, .91]
ANX							English			Others	
	Language	191.60 (24)***	2.89 (2)	87.47	11.37	.90	[.88, .92]	[.70, .96]	.90	[.86, .93]	[.92, .95]
							USA			Others	
	Country	190.87 (24)***	3.34 (2)	87.43	7.21	.90	[.87, .92]	[.70, .95]	.90	[.88, .93]	[.85, .96]
							General			Clínical	
	Sample	178.83 (24)***	7.12 (2)*	86.58	16.12	.91	[.88, .93]	[.85, .95]	.89	[.85, .91]	[.70, .96]
RCADS							English			Others	
	Language	82.58 (11)***	2.25 (2)	86.68	0.00	.93	[.91, .95]	[.78, .97]	.93	[.90, .95]	[.88, .96]
							USA			Others	
	Country	83.64 (11)***	2.39 (2)	86.85	0.00	.93	[.91, .95]	[.78, .96]	.93	[.91, .95]	[.87, .97]
							General			Clínical	
	Sample	83.36 (11)***	2.44 (2)	86.81	0.00	.93	[.91, .95]	[.78, .97]	.93	[.91, .95]	[.92, .97]

Note. SAD = Separation Anxiety Disorder; SP = Social Phobia; OCD = Obsessive-compulsive Disorder; PD = Panic Disorder; GAD = Generalized Anxiety Disorder; MMD = Major Depressive Disorder; ANX = Anxiety total score; RCADS = RCADS total score.
Q = Cochran's heterogeneity Q test (Hedges y Olkin, 1985); *QM* = heterogeneity explained by the model; *QE* = residual error heterogeneity; *d.f.* = degrees of freedom; I^2 = percentage of heterogeneity (Higgins y Thompson, 2002); R^2 = coefficient of determination; α = Weighted mean alpha; 95% C.I. = 95% Confidence interval; Range = minimum and maximum alpha scores from studies.
a = Revised Child Anxiety and Depression Scale (Chorpita et al., 2000).
* = $p < .05$; ** = $p < .01$; *** = $p < .001$.

Table 7. Continuous moderators analysis of RCADS scales[a]

Scale	Moderator	*QE* (*d.f.*)	*QM* (*d.f.*)	I^2	R^2
SAD	Age mean	283.76 (15)***	0.57 (2)	94.71	0.00
	% women	298.99 (16)***	2.35 (2)	94.65	3.53
	VAR	300.26 (18)***	0.79 (1)	94.01	5.68
SP	Age	550.02 (27)***	12.98 (2)***	95.09	37.24
	% women	746.66 (28)***	1.99 (2)	96.25	20.01
	VAR	746.81 (29)***	2.05 (1)	96.12	21.93
OCD	Age	202.54 (16)***	5.41 (2)	92.10	11.00
	% women	255.60 (16)***	0.55 (2)	93.74	0.00
	VAR	260.25 (18)***	0.33 (1)	93.08	0.75
PD	Age	5438.44 (26)***	9.89 (2)**	94.07	27.51
	% women	587.50 (26)***	1.51 (2)	95.58	2.32
	VAR	587.98 (28)***	1.25 (1)	95.24	10.88
GAD	Age	302.95 (25)***	7.77 (2)*	91.75	22.04
	% women	390.32 (27)***	3.99 (2)	93.08	9.03
	VAR	400.56 (29)***	3.34 (1)	92.76	9.31
MMD	Age	1549.11 (49)***	17.47 (2)***	96.84	35.06
	% women	2431.88 (50)***	1.33 (2)	97.94	2.56
	VAR	2438.97 (52)***	1.35 (1)	97.87	4.15
ANX	Age	96.95 (22)***	5.43 (2)	77.31	37.65
	% women	188.84 (22)***	3.76 (2)	88.35	9.32
	VAR	191.86 (25)***	2.94 (1)	86.97	14.45
RCADS	Age	80.64 (10)***	5.28 (2)	87.60	0.00
	% women	74.89 (10)***	5.69 (2)	86.65	0.00

VAR	85.09 (12)***	2.44 (1)	85.90	0.00

Note. SAD = Separation Anxiety Disorder; SP = Social Phobia; OCD = Obsessive-compulsive Disorder; PD = Panic Disorder; GAD = Generalized Anxiety Disorder; MMD = Major Depressive Disorder; ANX = Anxiety total score; RCADS = RCADS total score.
Q = Cochran's heterogeneity Q test (Hedges y Olkin, 1985); *QM* = heterogeneity explained by the model; *QE* = residual error heterogeneity; *d.f.* = degrees of freedom; I^2 = percentage of heterogeneity (Higgins y Thompson, 2002); R^2 = coefficient of determination.
a = Revised Child Anxiety and Depression Scale (Chorpita et al., 2000).
* = $p < .05$; ** = $p < .01$; *** = $p < .001$.

Table 8. Analysis of the RCADS[a] version as moderator

Scale	Version	*QE (d.f.)*	*QM (d.f.)*	I^2	R^2	α	C.I. 95%	Range
SAD		377.96 (34)***	3.05 (4)	91.00	4.06			
	RCADS-25					.74	[.71, .76]	[.71, .80]
	RCADS-30					.71	[.69, .73]	[.66, .80]
	RCADS-38					.75	[.68, .81]	[.76, .82]
	RCADS-47					.74	[.72, .75]	[.66, .86]
SP		828.68 (45)***	39.90 (4)***	94.57	48.01			
	RCADS-25					.76	[.72, .79]	[.74, .76]
	RCADS-30					.78	[.76, .80]	[.72, .84]
	RCADS-38					.85	[.80, .89]	[.74, .85]
	RCADS-47					.86	[.85, .87]	[.75, .92]
OCD		348.09 (32)***	14.55 (2)***	90.81	19.26			
	RCADS-30					.68	[.66, .71]	[.55, .77]
	RCADS-47					.76	[.75, .78]	[.57, .88]
PD		957.20 (43)***	14.97 (4)**	95.39	20.99			
	RCADS-25					.74	[.69, .78]	[.73, .75]
	RCADS-30					.77	[.75, .79]	[.65, .83]
	RCADS-38					.90	[.85, .93]	[.90, .90]
	RCADS-47					.83	[.82, .84]	[.68, .92]
GAD		505.19 (45)***	10.85 (4)	91.09	16.56			
	RCADS-25					.83	[.80, .85]	[.82, .83]
	RCADS-30					.80	[.79, .82]	[.72, .86]
	RCADS-38					.84	[.79, .88]	[.84, .84]
	RCADS-47					.84	[.83, .85]	[.70, .90]
MMD		2710.75 (79)***	35.89 (5)***	97.09	19.63			

	RCADS-25					.66	[.63, .70]	[.46, .82]
	RCADS-SV					.82	[.77, .86]	[.80, .85]
	RCADS-30					.74	[.70, .77]	[.59, .82]
	RCADS-38					.85	[.76, .91]	[.85, .85]
	RCADS-47					.83	[.82, .84]	[.63, .94]
ANX		229.46 (40)***	80.44 (4)***	82.57	66.99			
	RCADS-25					.82	[.81, .84]	[.76, .89]
	RCADS-SV					.80	[.78, .83]	[.80, .91]
	RCADS-30					.87	[.82, .90]	[.93, .93]
	RCADS-47					.90	[.89, .91]	[.70, .96]
RCADS		219.74 (26)***	122.04 (4)***	88.17	81.65			
	RCADS-19					.73	[.67, .77]	[.81, .88]
	RCADS-25					.86	[.85, .87]	[.84, .92]
	RCADS-SV					.84	[.82, .86]	[.79, .86]
	RCADS-30					.87	[.86, .88]	[.86, .93]
	RCADS-47					.93	[.92, .93]	[.78, .97]

Note. SAD = Separation Anxiety Disorder; SP = Social Phobia; OCD = Obsessive-compulsive Disorder; PD = Panic Disorder; GAD = Generalized Anxiety Disorder; MMD = Major Depressive Disorder; ANX = Anxiety total score; RCADS = RCADS total score.
Q = Cochran's heterogeneity Q test (Hedges y Olkin, 1985); *d.f.* = degrees of freedom; I^2 = percentage of heterogeneity (Higgins y Thompson, 2002); R^2 = coefficient of determination; α = Weighted mean alpha; 95% C.I.= 95% Confidence interval; Range = minimum and maximum alpha scores from studies.
[a] = Revised Child Anxiety and Depression Scale (Chorpita et al., 2000); RCADS-19 (Hogendoorn et al., 2011); RCADS-25 (Muris et al., 2002); RCADS-SV (Ebesutani et al., 2012); RCADS-30 (Sandin et al., 2010); RCADS-38 (Weems et al., 2010); RCADS-47 (Chorpita et al., 2000).
* = $p < .05$; ** = $p < .01$; *** = $p < .001$.