Theses and Dissertations

2020-06-01

Psychometric Properties of the Spanish Version of the Treatment Support Measure (TSM-SP)

Corinne Elizabeth Ruth

Brigham Young University

Follow this and additional works at: https://scholarsarchive.byu.edu/etd

Part of the Social and Behavioral Sciences Commons

BYU ScholarsArchive Citation
https://scholarsarchive.byu.edu/etd/8462

This Dissertation is brought to you for free and open access by BYU ScholarsArchive. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of BYU ScholarsArchive. For more information, please contact ellen_amatangelo@byu.edu.
Psychometric Properties of the Spanish Version of the Treatment Support Measure (TSM-SP)

Corinne Elizabeth Ruth

A dissertation submitted to the faculty of Brigham Young University in partial fulfillment of the requirements for the degree of Doctor of Philosophy

Jared S. Warren, Chair
Gary S. Burlingame
Kat T. Green
Chad D. Jensen
Patrick R. Steffen

Department of Psychology
Brigham Young University

Copyright © 2020 Corinne Elizabeth Ruth
All Rights Reserved
ABSTRACT

Psychometric Properties of the Spanish Version of the Treatment Support Measure (TSM-SP)

Corinne Elizabeth Ruth
Department of Psychology, BYU
Doctor of Philosophy

Hispanic youth and families, although they comprise a sizeable portion of the population, are underrepresented in mental health settings within the United States and face significant barriers to receiving adequate treatment. Specifically, the lack of availability of Spanish assessment tools for application in treatment prohibits Hispanic clients from accessing the full extent of available therapeutic resources. The Treatment Support Measure (TSM) is a valid and reliable instrument that allows clinicians and researchers to collect information to better understand change processes and relevant client characteristics in therapy. The present study created a Spanish-translated version of the parent and youth TSM (TSM-SP) and assessed its psychometric properties in a Spanish-speaking community sample of 177 youth and 214 adult caregivers. The internal consistency reliability of all domains of the parent and youth versions of the TSM-SP was good, aside from the Youth Motivation domain. In contrast, the test-retest reliability of all domains of the parent and youth versions of the TSM-SP were generally poor. The construct validity of all domains of the parent and youth versions of the TSM-SP as examined by confirmatory factor analysis was excellent, aside from the Youth Motivation domain. Overall, these results laid the foundation for future research examining the utility and properties of the TSM-SP. The TSM-SP has potential to provide clinicians treating Spanish-speaking youth and families with a useful tool to help better serve these populations in therapy and broaden the scope of research into change processes in youth therapy to involve more diverse populations.

Keywords: Spanish translation, routine outcome monitoring, psychometrics, community setting
ACKNOWLEDGEMENTS

I would like to thank the youth and families who participated in this project for giving of their time and energy to support the goal of this research. Similarly, I extend my gratitude to Mountainlands Community Health Center staff for their role in facilitating data collection.

I appreciate the supportive faculty within the Department of Psychology at Brigham Young University whose guidance and mentorship served a critical role in my graduate education. I am particularly grateful to my dissertation chair and faculty mentor, Jared Warren, for his calming reassurance and insightful feedback. Similarly, the insights of my committee members Gary Burlingame, Kat Green, Chad Jensen, and Patrick Steffen were invaluable throughout the process. A special thanks to Nick Top for his continued advice across statistical challenges and to the Department of Spanish at Brigham Young University for their assistance with translation efforts.

I am grateful for the support of my partner, Freddy, along with his endless optimism and encouragement. I am indebted to my parents, Robert and Andria, for their unconditional support of my educational and professional dreams. I have deep appreciation for my mother’s example of how academic excellence can be achieved in balance with personal and family goals. Thank you, Mom, for being my inspiration.
# TABLE OF CONTENTS

Abstract ........................................................................................................................................... ii

Acknowledgements ......................................................................................................................... iii

List of Figures ................................................................................................................................... vi

List of Tables ...................................................................................................................................... vii

Analysis of the Psychometric Properties of the Spanish Version of the Treatment Support Measure (TSM-SP) ......................................................................................................................... 1

Introduction ........................................................................................................................................ 1

Mental Health Needs Among Hispanic Individuals ........................................................................... 2

Barriers to Mental Health Care for Hispanic Individuals ............................................................... 3

Change Processes in Youth Psychotherapy ...................................................................................... 4

Hispanic Populations in Routine Mental Health Care Settings ....................................................... 6

Measurement Instruments for Use in Youth Psychotherapy ........................................................... 8

Routine Outcome Monitoring with Spanish-Speaking Individuals ............................................... 10

Study Objectives ............................................................................................................................ 12

Study Questions ............................................................................................................................... 17

Methods .......................................................................................................................................... 17

Participants ....................................................................................................................................... 17

Measures .......................................................................................................................................... 21

Procedure .......................................................................................................................................... 24
Analysis.......................................................................................................................... 27

Results............................................................................................................................ 29

Reliability Analyses........................................................................................................ 29

Validity Analyses............................................................................................................ 32

Discussion......................................................................................................................... 38

Limitations....................................................................................................................... 45

Implications and Future Directions.................................................................................. 49

References.......................................................................................................................... 52

Appendix A........................................................................................................................ 67

Appendix B........................................................................................................................ 69

Appendix C........................................................................................................................ 71

Appendix D........................................................................................................................ 73

Appendix E........................................................................................................................ 75

Appendix F........................................................................................................................ 76

Appendix G........................................................................................................................ 78

Appendix H........................................................................................................................ 80

Appendix I........................................................................................................................ 82

Appendix J........................................................................................................................ 84
LIST OF FIGURES

Figure 1. Parent and youth participant totals at various stages of recruitment and sampling........................................................................................................... 20
LIST OF TABLES

Table 1 *TSM-P-SP Descriptive Statistics and Reliability Estimates by Domain* .................. 30

Table 2 *TSM-Y-SP Descriptive Statistics and Reliability Estimates by Domain* ............... 31

Table 3 *Goodness-of-Fit Indices for CFA of TSM-P-SP by Domain,*

*Initial and Following Modifications* .................................................................................. 33

Table 4 *TSM-P-SP Standardized Individual Item Loadings Before*

*and After Modification by Domain* .................................................................................. 34

Table 5 *Goodness-of-Fit Indices for CFA of TSM-Y-SP by Domain* ......................... 36

Table 6 *TSM-Y-SP Standardized Individual Item Loadings by Domain* ...................... 37
Analysis of the Psychometric Properties of the Spanish Version of the

Treatment Support Measure (TSM-SP)

Introduction

The existence of disparities in mental health care for minority individuals is a pressing public health concern that has garnered nationwide attention. As articulated by the Surgeon General’s report on the current state of psychosocial services, “the U.S. mental health system is not well equipped to meet the needs of racial and ethnic minority populations” (U.S. Department of Health and Human Services, 1999, p. 80). Across groups, minorities have more limited access to mental health services than Caucasians, are less likely to receive care for mental health concerns, and are more likely to receive lower quality care when they do so (U.S. Department of Health and Human Services, 1999).

As a minority group, individuals of Hispanic\(^1\) background are subject to marked discrepancies in access to and quality of mental health care (Kouyoumdjian et al., 2003). Thus, there is a substantial need within the field for culturally-appropriate psychological services for Hispanics. Individuals of Hispanic background comprise the largest minority group in the United States, forming 17.4% of the general population (Colby & Ortman, 2014). Ensuring that the clinical needs of Hispanics are met is becoming more important as this group rapidly expands. Experts project that by the year 2060 Hispanic individuals will make up 28% of the population of the United States (Colby & Ortman, 2014). As the Hispanic population increases, researchers, clinicians, and public officials recognize that special attention needs to be paid to ensure that this group is adequately served within the mental health care system (Kouyoumdjian et al., 2003).

\(^1\) For the purposes of this paper, the term “Hispanic” will be used (as opposed to Latino, Latin American, or Chicano) as this is the classification employed in most research on this population and in the United States Census and other government projects. The designation of Hispanic refers to persons of Central and South American or other Spanish culture or origin, regardless of race (Cresce et al., 2004).
The present study responds to demonstrated gaps in mental health care for Hispanic youth and families by assessing the psychometric properties of a Spanish clinical support tool, the Treatment Support Measure (TSM; Warren & Lambert, 2013). This investigation seeks to pave the way for the use of the Spanish-translated TSM to improve the quality of mental health care for Spanish-speaking youth and families as well as to support research into psychotherapy processes in these groups.

**Mental Health Needs Among Hispanic Individuals**

Epidemiological research has demonstrated that Hispanic individuals experience mental health disorders at significant rates. An estimated 28% of Hispanic males and 30% of Hispanic females living in the United States meet criteria for a mental health disorder across their lifespan (Alegría, Mulvaney-Davey et al., 2007). Studies have shown that Hispanics born in the United States are at a heightened risk for psychiatric disorders compared to Hispanics who have recently immigrated to the United States (Alegría et al., 2008). In addition, rates of mental illness in Hispanics who speak English are significantly higher than in Hispanics with low English proficiency (Alegría, Mulaveney-Davey et al., 2007). Prominent researchers in the field, including Marks et al. (2014), have suggested that this pattern of results indicates that the stress of acculturation acts as a unique risk factor for mental health concerns for Hispanics.

Although Hispanics experience mental health disorders at a significant rate, they are typically underrepresented in mental health settings. Many studies of rates of participation in psychological care conducted across the United States have documented that Hispanics with mental health needs utilize psychological services at a significantly lower rate than Caucasians (Alegría et al., 2008). For example, Alegría et al. (2002) found that, among individuals who met criteria for a psychiatric condition, a significantly higher proportion of Caucasians (11.8%)
reported accessing specialty mental health services in comparison to Hispanics (5.9%). More specifically, research has found that Hispanic children have particularly low rates of mental health services utilization compared to other ethnic groups (Wells et al., 2001). Kataoka et al. (2002) found that, in a nationally representative sample of children, adolescents, and their families, a significantly higher proportion of Hispanic children with mental health needs did not receive mental health care in the past year (88%) compared to Caucasian children with mental health needs (76%). In addition to accessing services at a lower rate, Hispanic individuals have been shown to return less frequently to therapy than Caucasians following a first appointment. Rios-Ellis (2005) documented that, in routine care settings, roughly 70% of Hispanics who attended one mental health appointment do not return.

**Barriers to Mental Health Care for Hispanic Individuals**

The finding that Hispanics with mental health disorders are receiving psychological services at notably lower rates than Caucasians indicates that the psychological needs of Hispanics are not being met by the current system of care (Burnam et al., 1987; Ortega et al., 2000). Accordingly, the federal government, as articulated by the report of The President’s New Freedom Commission on Mental Health, has declared that Hispanics, along with other racial and ethnic minorities, experience a disproportionate burden associated with untreated mental health conditions that must be eliminated (Hogan, 2003). In order to remedy this substantial disparity, systematic barriers to care need to be lifted in order to provide Hispanic youth and families with necessary mental health support. Barriers to accessing care are vast and include factors such as lack of economic resources within Hispanic families, lack of mental health facilities in predominately Hispanic areas, cultural stigma associated with seeking mental health care, lack of
knowledge about mental illness, and shortages of Spanish-speaking mental health clinicians (Kouyoumdjian et al., 2003; Nadeem et al., 2007; Woodward et al., 1992).

For many Hispanic individuals, a significant impediment to receiving appropriate care is the lack of Spanish-translated measures for use in psychotherapy (Beck et al., 2003). Objective measurement of outcomes has become a strongly-encouraged practice in routine clinical care over recent decades (Carlier et al., 2012; Slade, 2002). As explained by Carroll et al. (2001), many measures commonly used to measure mental health symptoms in routine clinical care and psychotherapy research are not translated into Spanish. Additionally, those that have been translated have not established translation equivalency (Okazaki & Sue, 1995). Given that 32% of Hispanics living in the United States speak little or no English, untranslated measures are inaccessible to a significant portion of the Hispanic population (Stepler & Brown, 2015). In response to this gap in accessibility of measures, the object of the present study is to translate and determine the psychometric properties of a Spanish-translated version the TSM to pave the way for wider use of this measure in clinical care and research with Hispanic individuals.

Change Processes in Youth Psychotherapy

In line with this developing prerogative to better meet the clinical needs of children with mental health difficulties and their families, it has become evident in recent decades that targeted research is needed in order to improve the effectiveness of therapy for youth. While therapy leads to improvement for many children and young adults, a sizeable portion of clients do not seem to improve as a result of mental health treatment. Studies of therapy outcomes in children and youth treated in community mental health settings have found that up to 24% of clients deteriorate during therapy (Warren et al., 2010). Poor response to therapy is a pressing public health concern for youth. Youth with psychiatric conditions who do not improve in therapy are
likely to have significant emotional and behavioral symptoms that persist or worsen throughout their life (de Haan et al., 2013). Further, youth with psychiatric problems who do not respond to psychotherapy are more likely than those who experience improvement in treatment to experience negative life outcomes such as dropping out of school, exhibiting illegal or delinquent behavior, abusing drugs and alcohol, and losing employment (Lochman & Salekin, 2003; Moffitt et al., 2002). The high rate of treatment failure indicates that there is considerable room for improvement in the administration of youth mental health care, especially within community-based mental health settings which is where a sizeable portion of minority youth are receiving psychological services (Bui & Takeuchi, 1992).

When examining and responding to instances of treatment failure, is it essential to understand the mechanisms involved in facilitating psychotherapy outcomes (Kazdin, 2007). Although there has been considerable research examining the effectiveness of various psychosocial treatments for youth, there has been limited research investigating the mechanisms through which these treatments exert effects, particularly in usual care settings (Schmidt & Schimmelmann, 2015). Understanding the mechanisms of youth psychotherapy has important implications for maximizing therapy outcomes, especially for populations that are currently under-engaged with the mental health care system (such as ethnic and racial minorities), and responding to instances of treatment failure (Chorpita et al., 2011). If researchers have a working knowledge of how psychological treatments exert effects, they can better understand what factors may be involved when treatments do not produce desired improvement in specific individuals or defined groups or when individuals or groups are unsatisfied with the care they receive.
The American Psychological Association (APA) Presidential Task Force for Evidence-Based Practice has articulated the importance of measuring client characteristics in both research on youth therapy outcomes and routine clinical practice (APA Presidential Task Force on Evidence-Based Practice, 2006). The body of research indicates that a variety of client and family factors (e.g., motivation, social support, therapeutic alliance) influence youth outcomes in mental health treatment, providing multiple potential explanations of therapy change processes and mechanisms (Hawley & Garland, 2008; Kazdin, 2007; Shirk & Karver, 2003). Accordingly, the APA has asserted that, “psychological services are most likely to be effective when they are responsive to the client’s specific problems, strengths, personality, sociocultural context, and preferences” (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 278). In line with this emphasis, researchers and clinicians have begun to prioritize addressing and measuring extratherapeutic factors that may play a role in treatment outcomes as part of the therapy process (Roehrle & Strouse, 2008).

**Hispanic Populations in Routine Mental Health Care Settings**

When the body of clinical research on youth psychotherapy outcomes in routine care settings is viewed as a whole, it becomes apparent that there is a lack of representation of individuals of Hispanic backgrounds within study samples. Many studies on youth in psychotherapy do not report the ethnic composition of their sample and, when they do so, many studies include relatively few participants of minority backgrounds (Weisz et al., 2005). For example, in their analysis of data from 322 randomized clinical trials of psychosocial treatments for youth, Chorpita and Daleiden (2009) reported that only 11% of youth participants across studies identified as Hispanic/Latino. In their meta-analysis of 236 studies examining youth therapy outcomes, Weisz et al. (2005) found that only 5% of youth sampled were of Hispanic or
Latino background. As explained by Huey and Polo (2008), the lack of inclusion of ethnic minority participants in efficacy studies has led some scholars to argue that data from existing trials showing the effectiveness of certain psychosocial treatments cannot be validly extended to these groups. Thus, there is a need for increased research on outcomes for minority youth, especially those of Hispanic background, in psychotherapy.

It is especially important to develop tools and procedures for examining outcomes for Hispanic youth in community care settings, which is where a large portion of Hispanic children and adolescents with mental health needs receive care. Public community mental health centers are often supported by funding from government assistance programs, such as Medicaid, which allow them to serve individuals of low income backgrounds (Warren et al., 2010). Given that a significantly higher proportion of Hispanic families have income below the poverty line when compared to non-Hispanic Whites, individuals of Hispanic background present to community mental health facilities at disproportionately high rates (Kouyoumdjian et al., 2003). Specifically, national statistics show that 17.6% of Hispanic were living in poverty compared with 8.1% of non-Hispanic Whites in 2018 (U.S. Census Bureau, 2000). In addition, large-scale survey studies have demonstrated that Hispanic individuals are less likely than individuals of all other ethnic backgrounds to have health insurance (Angel & Angel, 1996). National reports indicate that as many as 35% of Hispanic individuals living in the United States do not have health insurance coverage (Campbell, 1999). As explained by Guendelman and Wagner (2000), individuals without health insurance with medical and psychosocial needs are more likely to access care from publicly-funded resources, including community mental health sites.
Measurement Instruments for Use in Youth Psychotherapy

Currently, there is a need for useful, practical, and reliable assessment instruments that are specifically crafted to inform the course of treatment for youth in real-world behavioral health settings (Beutler et al., 2004). In response, researchers have developed tools for use in routine clinical care that provide clinicians with patient-focused information that can be used to maximize the effectiveness of youth therapeutic interventions. These tools include both the regular measurement of outcomes along with the assessment of relevant client and family extratherapeutic variables that impact treatment processes and outcome (Lambert & Shimokawa, 2011). The use of standardized instruments to monitor client outcomes, referred to as routine outcome monitoring (ROM), is an evidence-based practice that allows therapists to maximize the effectiveness of treatment by providing them with useful feedback about their client’s progress so that they can alter treatment if the client is not on track to experience positive change in therapy (APA, 2006; Warren et al., 2009).

Research has shown that, in adults patients receiving mental health treatment, the routine monitoring of client progress in terms of symptom change throughout the course of therapy is related to positive effects in terms of treatment outcome, length of therapy, attrition rate, and rate of deterioration (Carlier et al., 2012; De Jong et al., 2014; Duncan & Reese, 2015; Gondek et al., 2016; Kendrick et al., 2016; Shimokawa et al., 2010). These improvements have been shown to be monumental, with some studies documenting three-fold increases in effect sizes for psychotherapy treatment as a result of implementing outcome measurement (Anker et al., 2009; Boswell et al., 2015; Kraus et al., 2011).

In conjunction, evidence-based practice includes attending to client characteristics that may influence the course and effectiveness of therapy and incorporating these factors into
treatment planning (APA, 2006). Assessing relevant client characteristics alerts clinicians to factors that may put their clients at risk of experiencing treatment failure or may be contributing to difficulties in treatment and provides them with the information needed to intervene on these factors (Beutler et al., 2004). The TSM, a clinical support tool (CST), was developed in order to provide clinicians with important information about these characteristics in their youth clients (Warren & Lambert, 2013). The TSM is intended to be employed as a treatment planning, clinical support, and research instrument to provide important information about what factors may be involved in whether or not a client shows positive change in therapy. The domains measured by the TSM have their roots in ecological systems theory along with the literature on child resilience (Bronfenbrenner, 1992; Luthar & Cicchetti, 2000; Masten & Douglas, 1998). As described in full by Warren and Lambert (2013), each of the factors assessed by the TSM has empirical and theoretical associations with youth therapy outcomes. By measuring these domains, the TSM provides therapists and researchers alike with integral information regarding the factors involved in the process of therapeutic change.

In routine clinical care, this measure is intended to be used in conjunction with the Youth Outcome Questionnaire (Y-OQ), a validated outcome measure for youth therapy clients (Burlingame et al., 2004; Warren & Lambert, 2013). Utilizing the information provided by administering the TSM can help a clinician better understand what factors may be involved when a client is not showing suitable progress as measured by the Y-OQ (Warren & Lambert, 2013). As the TSM has two versions, a parent-report and a youth-report form, it supplies therapists with information about both individual client characteristics and familial/parental factors that are relevant for treatment progress (Warren & Lambert, 2013). As a problem-solving tool, the TSM provides clinicians with helpful feedback at the onset and throughout therapy as to the strengths
and weaknesses of their client that can be incorporated into treatment. In addition, the TSM allows researchers to measure and investigate factors that are involved in change processes in youth therapy.

While the importance of routine measurement in facilitating positive psychotherapy outcomes has been articulated by many leaders in the field, community practitioners have yet to adopt regular assessment strategies, in part likely due to the lack of information on and availability of efficient measurement tools (Boswell et al., 2015). A recent survey of 396 mental health practitioners in England found that only 19.4% of those studied ‘routinely or occasionally’ used measures to assess treatment outcomes for their patient groups (Gilbody et al., 2002). Many groups and individuals who attempt to implement routine measurement in their clinical practice cite significant barriers and challenges, including the lack of available outcome measurement tools that are adapted to individuals of minority cultural backgrounds (Wampold, 2015).

**Routine Outcome Monitoring with Spanish-Speaking Individuals**

The body of research examining feedback measures with Hispanic samples is limited; however, existing studies show the reliability and validity of Spanish instruments. The Spanish version of the Outcome Questionnaire (OQ), the adult equivalent of the Youth Outcome Questionnaire (Y-OQ), has been shown to have adequate psychometric properties as measured by internal consistency and sensitivity. The Spanish OQ has been shown to have similar psychometrics properties and normative distributions to the original English version (Errázuriz, et al., 2017). Similarly, the Clinical Outcomes in Routine Evaluation (CORE), an outcome measure intended to quantify adult clients’ overall functioning and quality of life before and following psychotherapy, has been translated and validated in Spanish (Evans, 2000; Trujillo et al., 2016). In addition, a Spanish-translated version of the Outcome Rating Scale (OCS), is a
brief four-item assessment of general, individual, social, and relational well-being, has recently been shown to have adequate reliability and validity in Spanish (Moggia et al., 2018).

While multiple Spanish-translated measures for adult psychotherapy participants are available, there is a paucity of Spanish-translated global outcome measures intended for use with child and adolescent populations. Within specific clinical domains, Spanish-language outcome measures have been developed for youth audiences to assess symptom severity. For example, García-López et al. (2001) have demonstrated the validity and reliability of Spanish translations of the Social Phobia and Anxiety Inventory (SPAI) and the Social Anxiety Scale for Adolescents (SAS-A), two measures often used to assess changes in social anxiety in adolescents in response to treatment. However, a literature search did not yield any investigations utilizing measurement devices capable of assessing outcomes across clinical domains. The availability of such broad-based measures is essential in order to quantify outcomes in large samples of youth and assess the effectiveness of care within systems for Spanish-speaking youth.

There have been relatively few studies examining the utility and feasibility of routine outcome monitoring in Hispanic samples, especially with youth and families. Errázuriz and Zilcha-Mano (2018) found that, in a sample of 547 adult Spanish-speaking Chilean participants receiving outpatient psychotherapy, therapists receiving feedback on client progress only affected outcomes for clients with severe psychopathology and that the presence of feedback was related to more negative outcomes. In contrast, Priebe et al. (2007) conducted a randomized controlled trial examining the effect of feedback on therapy outcomes using participants from a variety of community mental health sites, including an outpatient clinic serving adult Spanish-speaking participants in Spain. They found that participants in the feedback condition reported significantly better quality of life and treatment satisfaction than control participants following
treatment. There were no site effects across the sample, demonstrating that this finding held for Spanish-speaking participants in Spain.

A small cluster of studies have used Spanish-translated outcome measures to examine therapy outcomes for children and adolescents receiving care in community settings according to a specified treatment model or approach. For example, Chorpita et al. (2017) administered Spanish-translated versions of the Brief Problem Checklist (BPC) and Top Problems Assessment (TPA) routinely throughout the course of psychotherapy to examine the effectiveness of a specific modularized cognitive behavioral treatment protocol in comparison to treatment-as-usual for youth in a community mental health setting. However, the investigators did not explicitly utilize client scores on these measures to provide therapists with information or examine the effect of administering these measures on participants’ outcomes, making it challenging to draw conclusions regarding the utility of routine outcome measurement from this data.

In light of these mixed findings and scarcity of research, additional studies are needed to clarify the influence of feedback instruments on therapy outcomes for Spanish-speaking clients. It is important that investigators examine both the feasibility of implementing feedback measurement in therapy with this subgroup as well as the impact of outcome assessment on treatment outcomes. The present study responds to these gaps by laying a foundation for the use of the TSM to collect feedback from Spanish-speaking youth and adults.

**Study Objectives**

The TSM is a useful clinical support tool that gives both clinicians and researchers valuable information about client characteristics that have implications for the effectiveness of treatment; therefore, it is imperative that the TSM be accessible by individuals of various ethnic
backgrounds. As part of the current study, researchers composed Spanish translations of the parent and youth versions of the TSM to broaden the pool of individuals who can be given this measure in routine clinical care and in research. The original English versions of the parent and youth-report forms of the TSM were found to have adequate test-retest reliability, internal consistency, and construct validity in a community sample of youth clients and their primary caregivers (Warren et al., in progress). While this finding that the English TSM is psychometrically sound suggests that a Spanish version of the measure may also operate in a valid and reliable fashion, these results cannot be generalized to establish the validity and reliability of a Spanish version of the instrument.

In order to allow for the TSM to be used in clinical practice and research with Spanish-speaking individuals, the psychometric properties of the translated version of the measure need to be established in a Spanish-speaking sample. Commonly, the process of translating a measure leads to unintentional alterations in the meaning of items along with changes to the internal structure of the instrument (Marin & Marin, 1991). Thus, as suggested by Kouyoumdjian et al. (2003), it is essential for researchers to examine the psychometric properties of a translated measure in order to ensure that the translated measure is both valid and reliable when administered to an appropriate sample.

In order to be useful in assessing Spanish-speaking individuals, the Spanish versions of the TSM must be reliable and valid. Reliability refers to the stability and consistency of a measure (Allen & Yen, 2001). In other words, reliability quantifies the extent to which differences in performance on a measure represent variations in true scores (actual differences in the construct of interest) rather than random error. To evaluate reliability, the present study assessed both the temporal and internal stability of the Spanish versions of the TSM. When
examining the utility of instruments, construct validity is also essential. Construct validity is defined as the degree to which an instrument actually measures the construct it purports to measure instead of other related characteristics (Cronbach & Meehl, 1955). For the purposes of this study, construct validity was assessed using Confirmatory Factor Analysis (CFA), a common method for evaluating the extent to which data collected using a measure holds to the hypothesized structure (DiStefano & Hess, 2005).

The current study sought to verify whether the Spanish parent and youth version of the TSM are reliable and valid in a community sample of Spanish-speaking youth and their caregivers. While the TSM is intended for use with clinical populations, the domains that it assesses are applicable to individuals outside of clinical settings. Although individuals who are seeking mental health care may endorse different levels of specific constructs, such as stress or self-efficacy, in comparison to community members, both sample groups are seen to lie on the same continuum. Thus, examining the psychometric properties of the Spanish versions of the measure in a nonclinical sample in order to facilitate recruitment and elevate statistical power is appropriate. The domains of the English versions of the parent and youth TSM have shown adequate reliability and validity in clinical samples. In addition, psychometric studies have yielded similar reliability and validity estimates between clinical and community samples for the partner measure, the Y-OQ (Ridge et al., 2009; Wells et al., 2003; Wells et al., 1999; Wells et al., 1996). Thus, we hypothesize that Spanish-translated versions of the parent and youth TSM will similarly show adequate internal consistency, test-retest reliability, and construct validity in a community sample of Spanish-speaking youth and their caregivers. The results of the present study will be used to support the further examination of the psychometric properties of the TSM in clinical populations.
Participants for the psychometric sample were solicited via online communication by the Qualtrics sampling team from a pool of registered individuals. This study used online participant recruiting methods in order to facilitate efficient data collection, bolster sample size, and expand the diversity of the sampling group. A growing body of literature has supported the utility of soliciting sample participants and collecting data using online channels of communication (Boas et al., 2018). Common arguments for the use of online sampling cite the efficiency of extending study invitations over digital communications, affordability, increased participant diversity, and ease of expanding samples into traditionally harder-to-reach groups (e.g., individuals with limited transportation). Studies originally conducted with convenience and nationally-representative samples have been successfully replicated using online sampling methods with equivalent effect sizes (Berinsky et al., 2012). Overall, while online sampling remains an emerging method of data collection, existing evidence supports the validity of using web platforms to recruit participants and collect data. The present study used an online sample in order to expand participant diversity and efficiency of data collection. Doing so was thought to augment the external validity and statistical confidence of feasible conclusions regarding the psychometric properties of the Spanish TSM while maintaining the internal validity of methodological design.

This psychometric information regarding the properties of the Spanish TSM serves as a foundation from which research and clinical care utilizing the Spanish TSM with Hispanic individuals can move forward. As elaborated, the needs of Hispanic youth and families are unmet by the current mental health care system and Hispanic individuals face substantial barriers to receiving sufficient care. A reliable and valid version of The Spanish TSM would provide a valuable clinical resource for therapists serving Hispanic populations, allowing more effective
assessment of extratherapeutic factors that may impact treatment outcome and process. Accordingly, using the Spanish TSM may be a viable means of improving the effectiveness of therapy for Hispanic youth and generally increasing the accessibility of evidence-based practices for minority populations.

In addition, creating a valid and reliable Spanish version of the TSM will allow researchers to administer the instrument to Spanish-speaking Hispanic participants in research settings. By utilizing the TSM with these individuals, researchers will not only be able to accrue more diverse, representative samples in large-scale clinical studies, but will also be able to examine culture-specific questions regarding how therapeutic change occurs and the influence of specific client characteristics in therapy within Hispanics as a whole and in specific ethnic subgroups. Specifically, research has shown that family and peer social support is a potent protective factor for preventing and lessening the impact of acculturative stress on the development of anxiety and depressive disorders in Hispanic youth and young adults (Crockett et al., 2007). Alegria, Sribney, and Mulvaney-Day (2007) explain that support from immediate and extended family and peers is a prominent component of Latino culture, accounting for its strong impact on mental health. Thus, social support may have a more prominent impact on psychotherapy outcomes for Hispanic youth than for youth of other ethnic background. Translating the TSM into Spanish and establishing its psychometric properties is an integral step in increasing the potential of clinical research to elucidate key information about therapeutic change processes in Hispanic populations.
Study Questions

The central questions of the study are as follows:

1. Does the TSM-SP demonstrate adequate reliability as measured by internal consistency and test-retest analyses?

2. Does the TSM-SP demonstrate adequate construct validity as measured by confirmatory factor analysis?

Methods

Participants

The present study utilized two separate samples. First, a clinical pilot sample of Spanish-speaking youth and parents presenting for psychosocial treatment in a community health center was utilized to assess the readability and comprehensibility of the translated versions of the TSM-P and TSM-Y. Participants in the pilot sample were drawn from youth and their primary caregivers who presented for psychosocial treatment for behavioral health concerns at a community health center in the Intermountain West region of the United States. The community health center from which the pilot sample was recruited specializes in providing bilingual services to Spanish-speaking individuals and families. Participation in the study was voluntary and did not impact families’ ability to obtain treatment. The pilot sample consisted of ten Spanish-speaking youth ages twelve through seventeen and ten Spanish-speaking parents/guardians of youth ages four through seventeen who presented for psychological treatment at a community mental health center. The youth pilot sample consisted of six female participants and four male participants with an average age of 14.8 years. The parent pilot sample consisted of nine female participants and one male participant. All parent participants had a child who was participating in outpatient psychotherapy, averaging 11.8 years of age.
Participants providing data for psychometric analyses were recruited and assessed through the Qualtrics online sampling system. To solicit a demographically diverse psychometric sample, participants were recruited from all regions of the United States. All participants were residents of the United States and self-reported proficiency in Spanish.

The psychometric sample consisted of 406 total individuals; 252 Spanish-speaking adult parents/guardians of youth ages four through seventeen and 186 Spanish-speaking youth ages twelve through seventeen. Responses from 38 adult participants who terminated participation in the questionnaire prior to completing all questions were excluded, leaving 214 adult participants for analysis. In response to recontact for the second wave of sampling, 85 participants completed the questionnaire a second time out of the 95 who initiated a response, yielding a Time 2 response rate of 44% and completion rate of 89%.

Of the full adult sample of 214 individuals, 1.9% \( (n = 4) \) were between the ages of 18 and 24, 38.3% \( (n = 82) \) were between 25 and 34, 40.2% \( (n = 86) \) were between 35 and 44, 15.4% \( (n = 33) \) were between 45 and 54, 3.3% \( (n = 7) \) were between 55 and 64, and 0.5% \( (n = 1) \) were over 65, and 0.5% \( (n = 1) \) declined to provide data on age. The median number of children between the ages of 4-17 of the adult participants was two. The average age of children of adult participants was 10 years old. 42.1% \( (n = 90) \) of adult participants identified as male and 58.0% \( (n = 124) \) identified as female. Almost all of the adult participants \( (n = 211, 98.6\%) \) identified being of Hispanic/Latino ethnic origin. Racial identity of the adult sample was 61.2% \( (n = 131) \) Caucasian/White, 3.3% \( (n = 7) \) Native American, 8.4% \( (n = 18) \) African American, 1.9% \( (n = 4) \) Asian, and 25.2% \( (n = 54) \) Other. 47.2% \( (n = 101) \) described their nationality as Mexican, 13.6% \( (n = 29) \) as Puerto Rican, 7.9% \( (n = 17) \) as Cuban, 29.0% \( (n = 62) \) as another Hispanic nationality, and 3.7% \( (n = 8) \) preferred not to disclose. Regarding education, the majority of the
sample had attained at least a high school diploma (92.1%, \( n = 197 \)), with 48.6% \( (n = 104) \) of these individuals having a college or post-graduate degree.

Responses from 10 youth participants who terminated filling out the questionnaire prior to completing all questions were excluded, leaving 177 youth participants for analysis. In response to recontact for the second wave of sampling, 58 participants initiated the survey and 51 completed the questionnaire a second time, yielding a Time 2 response rate of 33% and completion rate of 88%. Of the full sample of 177 youth, 59.9% identified as male \( (n = 106) \) and 40.1% \( (n = 71) \) identified as female. The average age of youth participants was 14.5 years. All youth participants identified as being of Hispanic ethnic origin. Racial composition of the youth sample was 66.7% \( (n = 118) \) Caucasian, 11.9% \( (n = 21) \) African American, 1.7% \( (n = 3) \) Native American, 1.1% \( (n = 2) \) Asian, and 18.6% \( (n = 33) \) Other. In terms of nationality, 54.2% \( (n = 96) \) of youth participants identified as Mexican, 14.1% \( (n = 25) \) as Puerto Rican, 8.5% \( (n = 15) \) as Cuban, and 23.1% \( (n = 41) \) as another Hispanic nationality. Figure 1 illustrates the recruitment and sampling process for the youth and adult psychometric samples.
The age range for both samples was selected to mirror the intended age ranges for the youth and parent versions of the TSM (Warren et al., in progress). For both sampling stages, participants were excluded if they did not indicate an ability to understand and respond to questions in Spanish. Parental participants were excluded if they did not have a child between the ages of four and seventeen. Youth participants were excluded if they were younger than twelve or older than seventeen. To screen out inattentive responding, participants were excluded if they completed the questionnaire in under half the median response time.

The sample size was based on the requirements of CFA as specified by Guilford (1954). There are a variety of published recommendations regarding the sample size needed to detect
model fit in CFA, ranging from 100 subjects (Kline, 1979) to 500 (Comrey & Lee, 1992). However, multiple recent simulation studies using Monte Carlo estimation techniques to determine minimum sample size required for CFA with ordinal data have concluded that, although having larger samples increases the likelihood that analyses will uncover the true structure of the data, in many situations utilizing data from 150-200 subjects produces sufficient power to detect model fit (Myers et al., 2011). Prior investigations have demonstrated that sample sizes of 200 individuals are most appropriate in situations when the specified model has few parameters and when there are minimal amounts of missing data, as is true in the present study (Kyriazos, 2018).

Measures

Demographic Questionnaire

Youth and adult participants completed a brief self-report demographic questionnaire assessing age, nationality, gender, and Spanish language ability. This information was used to assess the demographic composition of the sample.

Treatment Support Measure

The Treatment Support Measure (TSM) is a clinical support tool that assesses client characteristics that have been shown to be relevant to therapy outcomes in youth (Warren & Lambert, 2013). The TSM has two versions, a form for youth therapy clients age 12-17 (TSM-Y) and a form for the youths’ adult caregivers (TSM-P), each containing 40 items. Each item consists of a sentence that the respondent rates their degree of agreement with on a 5-point Likert scale (strongly disagree, disagree, neutral, agree, strongly agree). The youth version of the TSM assesses 4 domains: (a) feelings of self-efficacy (self-efficacy), (b) supportive relationships with family members and friends (social support), (c) motivation to participate in treatment
(motivation), and (d) the therapeutic alliance between the youth and the clinician (therapeutic alliance). The parent version of the TSM assesses 5 domains: (a) the parent’s supportive network of relationships (social support), (b) specific parenting skills and behaviors (parenting skills), (c) overall parental distress including personal stress and problems with parenting (parent distress), (d) parents’ feelings of self-confidence in their role as a parent (parenting self-efficacy), and (e) the alliance between the parent and the child’s clinician (therapeutic alliance).

Empirical support for the relationship of each these domains to youth therapy outcomes is found in Warren and Lambert (2013). In a recent psychometric study using youth participants seeking treatment at multiple community mental health clinics and their primary caregivers, Warren et al. (in progress) found that the domains of both the parent and youth versions of the TSM showed good internal consistency and test-retest reliability. Additionally, CFA showed that the hypothesized model of the domains of the parent and youth versions of the TSM fit adequately onto the collected data, demonstrating adequate construct validity (Warren et al., in progress). Sonsbeek et al. (2017) recently demonstrated that a Dutch-translated version of the TSM showed good convergent validity of the specific domains included in the TSM with corresponding measures including the Parenting Stress Index (PSI; Abidin, 1997), the Family Questionnaire (FQ; Scholte & Van der Ploeg, 2015), the Working Alliance Inventory (WAI; Tracey & Kokotovic, 1989), and others.

**Treatment Support Measure – Spanish Version**

Spanish translations of both versions of the TSM were created from the original Parent and Youth-Report versions of the English TSM (see Appendix A and B respectively), forming the Spanish Parent TSM (TSM-P-SP, see Appendix C) and the Spanish Youth TSM (TSM-Y-SP, see Appendix D). The procedures used to translate the items of the parent and youth versions of
the TSM were in line with the recommended translation standards set forth by Brislin (1970) as “best practices” to ensure equivalency between a source measure and the translated version. Accordingly, firstly, a bilingual graduate student who is familiar with the measure and its administration research translated the TSM-P and TSM-Y from English to Spanish. Translating measures into Spanish can be challenging due to the heterogeneous backgrounds of Spanish-speakers (Beck et al., 2003).

To maximize readability for the population of interest, conjugations and pronoun usage associated with Central and South American Spanish were used, rather than European forms. Simple sentence structure and language were used in order for the instruments to be understood by all Spanish-speaking individuals regardless of their education level or culture of origin. Idiomatic phrasing and culture-specific expressions were avoided. Weidmer et al. (1999) emphasized that the reading level of instruments is not often maintained during the process of translation. Therefore, Spanish word lists organized by grade level were consulted to compose the TSM-Y-SP at a fourth-grade reading level and the TSM-P-SP at a sixth-grade reading level.

Subsequently, the Spanish versions of the TSM-P and the TSM-Y were back-translated from Spanish to English by a group of bilingual individuals with experience and training in translation who were unfamiliar with the original measure. At this point, the original English versions of the TSM-P and TSM-Y were compared to the back-translated English version in order to ensure that the instruments were equivalent in meaning and not simply word-for-word translations. Any item that did not retain its original meaning and intent was re-translated and submitted again for back translation. The translated versions of the TSM-P and TSM-Y were edited as needed until the measures achieved equivalency.
The measures were then administered to the pilot sample of Spanish-speaking youth and parents of youth recruited from the clinical agency. All individuals within the pilot sample were youth seeking psychological treatment at a community mental health facility or parents of youth seeking treatment at a mental health facility to mirror the intended audience for the TSM-Y-SP and TSM-P-SP. This step is not employed in all translation studies due to the demands on time and effort, but is noted as a useful mechanism for ensuring that translated measures are comprehensible to individuals of different Spanish-speaking nationalities, background, and ages (Novy et al., 1998). Individuals in the pilot sample provided feedback as to the readability of the items and feasibility of completing the measure in the time span of a few minutes. All participants in the pilot sample reported being able to understand all items and completed the measure within ten minutes. Subsequently, the text of the translated youth and parent versions of the TSM were finalized, forming the TSM-Y-SP and TSM-P-SP.

**Procedure**

All procedures were approved by applicable Institutional Review Boards prior to initiation of data collection. All written and verbal procedures were conducted in Spanish and facilitated by Spanish-speaking research staff.

**Pilot Sample**

All Spanish-speaking youth ages twelve through seventeen and Spanish-speaking parents of youth ages four through seventeen presenting at the community health center were invited to participate in the pilot sample. Recruitment for the pilot sample occurred over a three-month period. Of individuals approached to participate in this portion of the study, 90% agreed to be involved.
Participants were approached by a trained research staff who, first, verified that participants spoke Spanish. This practice of including participants in studies of Spanish measures based on self-report of language proficiency is common-place in the measurement literature (e.g., Bedregal, et al., 2006). The research staff then explained the purposes and procedures of the study in Spanish according to a standardized script (Appendix E) and obtained youth participants’ informed assent (Appendix F) and adult participants’ informed consent (Appendix G). All parents of youth participants provided parental consent. Subsequently, youth and parent participants completed the appropriate versions of the TSM-SP on electronic tablets. All questionnaires were administered through the Qualtrics interface. During and following completion of the measure, the research staff solicited feedback from participants regarding the readability and comprehensibility of the measure. On average, the measure took about eight to ten minutes to complete. Youth and parent participants in the pilot sample were compensated five dollars for their time.

**Psychometric Sample**

Youth and parent participants for the psychometric sample were invited to participate in the study through standardized email communications. Participants were provided with information regarding the purpose and nature of the study. All youth participants gave informed assent (Appendix H) and all adult participants gave informed consent (Appendix I) prior to participating. All youth participants were recruited through contact made with their parents. All parents of youth participants completed a parental consent document (Appendix J). All participants indicated their Spanish-speaking ability, completed the brief demographic questionnaire, and completed the appropriate version of the TSM-SP through the Qualtrics online interface. According to embedded measures, adult participants took an average of seven
minutes and youth participants took an average of six minutes to complete the questionnaire battery. Participants were offered an incentive for completion of study materials based on their prior established compensation agreement with the recruitment agency. Recruitment for the psychometric sample occurred over the course of two weeks.

One week after the termination of data collection, youth and parent participants were recontacted through email to complete another administration of the TSM-SP. Similar to the first administration, participants were offered a monetary incentive based on their established compensation agreement.

The TSM was developed with a specified audience of youth and parents/guardians seeking mental health treatment and is intended to be used with this population (Warren & Lambert, 2013). Given the nature of the community sample utilized in the present study, some domains of the TSM-Y-SP and TSM-P-SP were not applicable to the participants and were thus excluded or modified. Specifically, adult participants did not complete questions on the Therapeutic Alliance domain of the TSM-P-SP because, in order to support recruitment, the sample was not confined to parents of children seeking mental health treatment.

Similarly, youth participants did not complete the Therapeutic Alliance domain of the TSM-Y-SP as the psychometric sample was not recruited from the subgroup of youth participating in psychotherapy. In line with this rationale, brief instructions were added to the Motivation domain of the TSM-Y-SP, which assesses youths’ motivation to participate actively in mental health treatment, prompting participants to respond to questions in relation to their current motivation to engage in therapy if they were to be referred, although they may not be engaging in mental health intervention at present.
Analysis

Stata 14.0 was utilized for descriptive statistics and reliability analyses. RStudio was used for confirmatory factor analysis. Outliers were assessed using box plots, histograms, and Mahalanobis distance. No univariate or multivariate outliers were observed. The assumptions of normality were evaluated using histograms, box plots, and Shapiro-Wilk tests. As expected, given the Likert-style of questions and previous investigations utilizing the measures of interest, participants’ domain scores on all facets of the TSM-P-SP and TSM-Y-SP were not normally distributed. The questionnaires were administered in a forced-response style. Thus, no missing data was present. Descriptive statistics were examined at the item and subscale level.

Reliability Analyses

To determine internal consistency of the TSM-Y-SP and the TSM-P-SP, we calculated Cronbach’s alpha and the average inter-item correlations for the items on each of the domains of the TSM-P-SP and the TSM-Y-SP. Cronbach’s alpha and inter-item correlation are two methods of determining to what extent responses to the items within a measure assess the same construct or run together (Allen & Yen, 2001). Data from the first administration of the instruments was used for these calculations. For determinations about whether the internal consistency of the measure is sufficient for reliability, the standard of ≥ 0.7 for Cronbach’s alpha (Cortina, 1993) and between 0.2 and 0.4 for inter-item correlation (Cohen & Swerdlik, 2005) was used to determine whether the internal consistencies of the measures were sufficient for reliability.

Test-retest reliability was calculated to determine the temporal stability of the TSM-P-SP and TSM-Y-SP. Test-retest reliability refers to the correlation between participants’ scores from first and second administrations of the instruments on each domain. Given that the TSM is intended to track client status on various extratherapeutic domains over the course of treatment,
it was expected that clients will experience fluctuations in the constructs that it measures over time. However, determining the extent to which youth and parent scores on the TSM-SP remain consistent is still valuable in establishing reliability. In addition, it was anticipated that the brevity of the one-week test-retest interval will reduce the influence of gradual fluctuations over time in the constructs of interest on participant scores. For test-retest reliability, a threshold of $\geq 0.7$ to indicate acceptable temporal stability as recommended by Guttman (1945) was utilized.

**Construct Validity Analyses**

Confirmatory Factor Analysis (CFA) was used to examine the construct validity of each domain of the TSM-P-SP and TSM-Y-SP. Data from the first administration of the instrument for all domains was used in order to maximize the available sample. CFA determines whether collected data fits a hypothesized measurement model by dictating an estimated population covariance matrix that is compared to the observed covariance matrix, thus making it an appropriate analytic method for confirming the hypothesized domain structure of the TSM-P-SP and the TSM-Y-SP (Schreiber et al., 2006). The TSM was created to measure separate domains that clinicians can use to evaluate different areas of youth and family functioning and is not interpreted as a total summed score. Instead, domain scores are interpreted independently. Thus, the TSM-P-SP and TSM-Y-SP were analyzed as consisting of separate domains instead of a latent construct comprised by individual subscales. CFA analyses were used to determine whether the items within the four assessed domains of the TSM-P-SP and three domains of the TSM-Y-SP load onto four and three separate factors respectively. Given that there is an a priori model for the structure of the data based on the theoretical foundations of the TSM, CFA is the appropriate method of factor analysis rather than exploratory methods.
Typically, a maximum likelihood estimator is used within CFA. However, this method assumes (among other things) a continuous distribution of data along with multivariate normality (Bollen, 1989; Flora & Curran, 2004). Data from the present study was not normally distributed and was collected on an ordinal scale, violating these assumptions. Thus, the diagonally weighted least squares (DWLS) estimation method was used as this method is appropriate with discrete and non-normal data (Bandalos, 2014; Rhemtulla et al., 2012). Additionally, statistical research has demonstrated that DWLS is robust to smaller sample sizes (Rhemtulla et al., 2012).

Fit of the hypothesized measurement model was evaluated using both absolute and relative fit indices, namely: (1) the $\chi^2$ goodness-of-fit statistic; (2) comparative fit index (CFI); (3) Tucker-Lewis index (TLI); and root mean square error of approximation (RMSEA). The cutoff criteria established by Browne et al. (1993), McDonald and Ho (2002), and Hu and Bentler (1999) were used to define the fit indices obtained from the CFA. The criteria included: (1) $p$-value for $\chi^2$ goodness-of-fit statistic greater than 0.05; (2) CFI at or above 0.90; (3) TLI at or above 0.95; and (4) RMSEA less than 0.08. The use of these fit indices is recommended by many others such as Schreiber et al. (2006).

**Results**

**Reliability Analyses**

*TSM-P-SP*

Overall, all domains of the TSM-P-SP showed acceptable to excellent reliability. Cronbach’s $\alpha$s ranged from 0.78 to 0.93. Chronbach’s $\alpha$ for the Parenting Self-Efficacy subscale of the TSM-P-SP was 0.93, demonstrating excellent reliability. The average inter-item correlation was 0.73, suggesting that there were there was some overlap between items on this
subscale. Test-retest analysis indicated a pairwise correlation of 0.40 between participants’ first and second wave responses to items on this domain, showing poor test-retest reliability.

Chronbach’s $\alpha$ for the Parent Social Support subscale was 0.92, which indicates excellent reliability. The average inter-item correlation was 0.82, suggesting that there were there was repetitiveness between items on this subscale. Test-retest analysis yielded a pairwise correlation of 0.27, indicating poor test-retest reliability for this domain.

Chronbach’s $\alpha$ for the Parenting Skills subscale was 0.79, showing acceptable reliability within this scale. The average inter-item correlation was 0.33, suggesting that there was little overlap between items on this scale. Test-retest analysis produced a pairwise correlation of 0.44 between first and second wave responses, suggesting poor test-retest reliability for this domain.

Chronbach’s $\alpha$ for the Parent Distress subscale was 0.75, demonstrating acceptable reliability. The average inter-item correlation was 0.37, suggesting that there was little overlap between items on this scale. Test-retest reliability for this subscale was .60, showing marginal correlation between participants’ Time 1 and Time 2 responses on this domain. Table 1 shows overall means, standard deviations, internal consistency reliabilities, average inter-item correlations, and test-retest reliabilities for each subscale of the TSM-P-SP.

<table>
<thead>
<tr>
<th>TSM-P-SP domains</th>
<th>$M$</th>
<th>SD</th>
<th>$\alpha$</th>
<th>Average Inter-Item Correlation</th>
<th>$r$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting Self-Efficacy</td>
<td>30.36</td>
<td>6.21</td>
<td>0.93</td>
<td>0.73</td>
<td>0.40</td>
</tr>
<tr>
<td>Parent Social Support</td>
<td>28.50</td>
<td>6.60</td>
<td>0.92</td>
<td>0.82</td>
<td>0.27</td>
</tr>
<tr>
<td>Parenting Skills</td>
<td>45.76</td>
<td>7.79</td>
<td>0.79</td>
<td>0.33</td>
<td>0.44</td>
</tr>
<tr>
<td>Parent Distress</td>
<td>24.40</td>
<td>7.00</td>
<td>0.75</td>
<td>0.37</td>
<td>0.60</td>
</tr>
</tbody>
</table>

Note. $M$ = mean; SD = standard deviation; $\alpha$ = Cronbach’s alpha; $r$ = test-retest reliability
**TSM-Y-SP**

Overall, all but one of the domains of the TSM-Y-SP showed excellent internal consistency reliability. Chronbach’s $\alpha$ for the Youth Self-Efficacy subscale of the TSM-Y-SP was 0.97, demonstrating excellent reliability. The average inter-item correlation was 0.96, suggesting overlap between items on this subscale. Test-retest analysis indicated a pairwise correlation of 0.44 between participants’ first and second wave responses to items on this domain, showing poor test-retest reliability.

Chronbach’s $\alpha$ for the Youth Social Support subscale of the TSM-Y-SP was 0.96, demonstrating excellent reliability. The average inter-item correlation was 0.94, showing that there was likely overlap between items on this subscale. Test-retest analysis yielded a pairwise correlation of 0.52, indicating poor test-retest reliability for this domain.

Chronbach’s $\alpha$ for the Youth Motivation subscale of the TSM-Y-SP was 0.50, demonstrating poor reliability. The average inter-item correlation was 0.26, demonstrating that there is little overlap between items on this subscale. Table 2 shows overall means, standard deviations, internal consistency reliabilities, and average inter-item correlations for each subscale of the TSM-Y-SP. Test-retest analysis produced a pairwise correlation of 0.18 between first and second wave responses, suggesting poor test-retest reliability for this domain.

<table>
<thead>
<tr>
<th>TSM-Y-SP domains</th>
<th>$M$</th>
<th>SD</th>
<th>$\alpha$</th>
<th>Average Inter-Item Correlation</th>
<th>$r$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Self-Efficacy</td>
<td>59.69</td>
<td>14.93</td>
<td>0.97</td>
<td>0.96</td>
<td>0.44</td>
</tr>
<tr>
<td>Youth Social Support</td>
<td>59.34</td>
<td>14.81</td>
<td>0.96</td>
<td>0.94</td>
<td>0.52</td>
</tr>
<tr>
<td>Youth Motivation</td>
<td>17.51</td>
<td>3.29</td>
<td>0.50</td>
<td>0.26</td>
<td>0.18</td>
</tr>
</tbody>
</table>

Note. $M$ = mean; SD = standard deviation; $\alpha$ = Cronbach’s alpha; $r$ = test-retest reliability
Validity Analyses

TSM-P-SP

Normality testing was performed on the data from adult participants which indicated that responses on all subscales were not distributed normally. In addition, none of the subscales showed indications of multi-collinearity. Thus, participant responses on this measure met the assumptions of DWLS estimation. The CFAs performed on all subscales of the TSM-P-SP indicated excellent fit for the hypothesized measurement model with some modifications.

The fit indices for the Parenting Self Efficacy subscale, $\chi^2(14) = 1.29, p > .05$ were CFI = 1.00, TLI = 1.03 and RMSEA = 0.001, showed excellent fit for the proposed measurement model. The CFA for Parent Social Support also indicated excellent fit, $\chi^2(14) = 5.66, p > .05$, CFI = 1.00, TLI = 1.02, RMSEA = 0.001.

The CFA for Parenting Skills demonstrated excellent fit, $\chi^2(27) = 5.84, p > .05$, CFI = 1.00, TLI = 1.03, RMSEA = 0.001, following minor modifications. Specifically, items 15 ("I often get into long arguments with my child"/"A menudo tengo discusiones largas con mi hijo"), 20 ("If my child talks back or complains when I handle a problem, I ignore the complaining and stick to what I said"/"Si mi hijo habla mal o se queja cuando manejo un problema, ignoro las quejas y me adhiero a lo que dije"), and 23 ("When there is a problem with my child, things build up and I do things I don’t mean to do"/"Cuando hay un problema con mi hijo, las cosas se acumulan y hago cosas que no quiero hacer") were removed from the scale. These items were removed due to their weak factor loadings ($\lambda = -0.2, 0.3, \text{and} -0.08$ respectively), indicating that they did not effectively contribute to the Parenting Skills domain.

The CFA for Parent Distress also indicated excellent fit following modifications, $\chi^2(9) = 23.58, p > .05$, CFI = 1.00, TLI = 1.01, RMSEA = 0.001. Items 27 ("I feel I am able to handle
all my responsibilities very well” (“Siento que puedo manejar bien todas mis responsabilidades”), 28 (“I am able to handle the challenges of parenting without many problems”/“Siento que puedo manejar los desafíos de la crianza de los hijos sin muchos problemas”), 33 (“I find my work satisfying”/“Encuentro mi trabajo satisfactorio”), and 35 (“I like myself”/“Me gusto a mí mismo/a”) were removed from the scale. These items were removed due to their low factor loadings onto the latent variable ($\lambda = -0.001, 0.03, -0.07, \text{and} -0.06$ respectively). The fit indices for the CFAs for all TSM-P-SP domains before and after modification are presented in Table 3. Table 4 shows the loadings of individual items onto domains of the TSM-P-SP both prior to and following model modifications.

Table 3

<table>
<thead>
<tr>
<th>TSM-P-SP Domains</th>
<th>$\chi^2$</th>
<th>Df</th>
<th>CFI</th>
<th>TLI</th>
<th>RMSEA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting Self-Efficacy</td>
<td>1.29</td>
<td>14</td>
<td>1.00</td>
<td>1.03</td>
<td>0.001</td>
</tr>
<tr>
<td>Parent Social Support</td>
<td>5.66</td>
<td>14</td>
<td>1.00</td>
<td>1.02</td>
<td>0.001</td>
</tr>
<tr>
<td>Parenting Skills</td>
<td>128.88*</td>
<td>54</td>
<td>0.94</td>
<td>0.92</td>
<td>0.08</td>
</tr>
<tr>
<td>Parenting Skills (15, 20, 23 excluded)</td>
<td>5.84</td>
<td>27</td>
<td>1.00</td>
<td>1.03</td>
<td>0.001</td>
</tr>
<tr>
<td>Parent Distress</td>
<td>214.85*</td>
<td>35</td>
<td>0.81</td>
<td>0.76</td>
<td>0.16</td>
</tr>
<tr>
<td>Parent Distress (27, 28, 33, 35 excluded)</td>
<td>23.58</td>
<td>9</td>
<td>1.00</td>
<td>1.01</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Note. Df = degrees of freedom; CFI = Comparative Fit Index; TLI = Tucker Lewis Index; RMSEA = Root Mean Square Error of Approximation; * = $p < .05$
<table>
<thead>
<tr>
<th>Item</th>
<th>PSE</th>
<th>PSS</th>
<th>PS</th>
<th>PD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.85</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>0.88</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>0.86</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>0.80</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>0.81</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>0.67</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>0.83</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>0.84</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>0.86</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>0.86</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>0.83</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>0.78</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>0.77</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>0.69</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td>-0.21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>0.76</td>
<td>0.76</td>
<td>0.78</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>0.64</td>
<td>0.64</td>
<td>0.63</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>0.84</td>
<td>0.84</td>
<td>0.84</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>0.72</td>
<td>0.72</td>
<td>0.73</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>0.31</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>0.78</td>
<td>0.78</td>
<td>0.82</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>0.74</td>
<td>0.74</td>
<td>0.73</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td></td>
<td>-0.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>0.52</td>
<td>0.52</td>
<td>0.50</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>0.73</td>
<td>0.73</td>
<td>0.73</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>0.75</td>
<td>0.75</td>
<td>0.78</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td></td>
<td></td>
<td></td>
<td>-0.001</td>
</tr>
<tr>
<td>28</td>
<td>0.03</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>0.78</td>
<td>0.78</td>
<td>0.78</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>0.67</td>
<td>0.67</td>
<td>0.67</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>0.78</td>
<td>0.78</td>
<td>0.78</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>0.74</td>
<td>0.74</td>
<td>0.75</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td></td>
<td></td>
<td></td>
<td>-0.07</td>
</tr>
<tr>
<td>34</td>
<td>0.62</td>
<td>0.62</td>
<td>0.62</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td></td>
<td></td>
<td>-0.06</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>0.93</td>
<td>0.93</td>
<td>0.63</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* PSE = Parenting Self-Efficacy; PSS = Parent Social Support; PS = Parenting Skills; PD = Parent Distress
Normality testing was performed on the data from youth participants which indicated that responses on all subscales were not normally distributed. In addition, none of the subscales showed indications of multi-collinearity. Thus, responses on this measure satisfied the assumptions of DWLS estimation, indicating that DWLS could successfully be utilized in modeling analyses.

The CFAs performed on the Youth Self-Efficacy and Youth Social Support subscales of the TSM-Y-SP indicated excellent fit for the hypothesized measurement model with some modifications. The fit indices for the Youth Self-Efficacy subscale, $\chi^2(90) = 10.68, p > .05$ were CFI = 1.00, TLI = 1.02 and RMSEA = 0.001, demonstrated excellent fit. The CFA for Youth Social Support also indicated excellent fit, $\chi^2(90) = 54.65, p > .05$, CFI = 1.00, TLI = 1.01, RMSEA = 0.001.

Additionally, the CFA for Youth Motivation yielded adequate fit after modification, $\chi^2(4) = 6.12, p > .05$, CFI = 0.98, TLI = 0.94, and RMSEA = 0.06. To improve fit, the residuals of items 33 (“Being in therapy is a waste of time for me”/“Participar en terapia es una pérdida de tiempo para mí”) and 34 (“I’m only in therapy because my parent (or someone else) thinks I need help”/“Solo participo en terapia porque mi padre/madre (o alguien más) piensa que necesito ayuda”) were covaried because their residuals reflect a unique element of negative and critical opinions of attending therapy that is not shared with the rest of the items in the Youth Motivation subscale. Of note, the TLI for this model was below the standardized cutoff of 0.95 for good fit recommended by McDonald and Ho (2002), but above the more lenient cutoff of 0.90 for adequate fit recommended by others including Bentler and Bonett (1980). Nonetheless, analyses indicated that multiple items, including items 32, 33, and 34 demonstrated unacceptably weak
factor loadings ($\lambda = 0.20, -0.11, \text{ and } -0.12$ respectively). Removing these items based on their poor loadings left only two remaining items in the domain, making further factor analysis unsuitable. Thus, the CFA for Youth Motivation indicated that, while the hypothesized measurement model was adequately represented by the data from the present study, a notable proportion of the items on this subscale did not sufficiently contribute to the domain. The results for the final CFAs for all TSM-Y-SP domains are presented in Table 5. Table 6 provides the factor loadings of individual items onto the domains of the TSM-Y-SP. Of note, loadings for items on the Youth Motivation domain before modification are provided given that, following modification, there were not enough items remaining to perform factor analysis.

Table 5

<table>
<thead>
<tr>
<th>TSM-Y-SP Domains</th>
<th>$\chi^2$</th>
<th>Df</th>
<th>CFI</th>
<th>TLI</th>
<th>RMSEA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Self-Efficacy</td>
<td>10.68</td>
<td>90</td>
<td>1.00</td>
<td>1.02</td>
<td>0.001</td>
</tr>
<tr>
<td>Youth Social Support</td>
<td>54.65</td>
<td>90</td>
<td>1.00</td>
<td>1.01</td>
<td>0.001</td>
</tr>
<tr>
<td>Youth Motivation</td>
<td>6.12</td>
<td>4</td>
<td>0.98</td>
<td>0.94</td>
<td>0.06</td>
</tr>
</tbody>
</table>

*Note.* Df = degrees of freedom; CFI = Comparative Fit Index; TLI = Tucker Lewis Index; RMSEA = Root Mean Square Error of Approximation
Table 6
*TSM-Y-SP Standardized Individual Item Loadings by Domain*

<table>
<thead>
<tr>
<th>Item</th>
<th>YSE</th>
<th>YSS</th>
<th>YM Before Modification Attempts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.87</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>0.85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>0.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>0.84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>0.81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>0.85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>0.86</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>0.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>0.83</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>0.84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>0.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>0.89</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>0.84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>0.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>0.84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>0.80</td>
<td>0.82</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>0.82</td>
<td>0.80</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>0.83</td>
<td>0.83</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>0.81</td>
<td>0.82</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>0.82</td>
<td>0.82</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>0.82</td>
<td>0.82</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>0.80</td>
<td>0.80</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>0.73</td>
<td>0.76</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>0.82</td>
<td>0.82</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>0.82</td>
<td>0.80</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>0.86</td>
<td>0.86</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td></td>
<td>0.83</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td></td>
<td>0.83</td>
<td>0.71</td>
</tr>
<tr>
<td>29</td>
<td></td>
<td>0.20</td>
<td>0.20</td>
</tr>
<tr>
<td>30</td>
<td></td>
<td>-0.11</td>
<td>-0.11</td>
</tr>
<tr>
<td>31</td>
<td></td>
<td>-0.12</td>
<td>-0.12</td>
</tr>
<tr>
<td>32</td>
<td></td>
<td>0.43</td>
<td>0.43</td>
</tr>
</tbody>
</table>

*Note.* YSE = Parenting Self-Efficacy; PSS = Youth Social Support; YM = Youth Motivation
Discussion

This investigation built on existing research documenting the utility of instruments for routine outcome monitoring, including the TSM, in facilitating positive treatment outcomes for youth in community settings. Previous research with adults has shown that providing clinicians with feedback regarding symptoms as well as other predictive variables including motivation, self-efficacy, and social support leads to improved therapeutic outcomes (Shimokawa et al., 2010; Boswell et al., 2015). Research into developing and implementing feedback tools with youth populations is an emerging field, with few studies to date quantifying the impact of routine measurement with youth psychotherapy clients (Bickman et al., 2011).

As researchers have moved forward with the utilization of feedback measurement with children and young adults, it has become evident that it is essential for tools to adequately incorporate the diversity of the youth and families who are seeking mental health care (Beutler et al., 2004). One key demographic group that often faces barriers to inclusion in both research on and the actuarial use of feedback measurement is Spanish-speaking youth and families. A review of the current research highlighted the lack of available Spanish-language feedback tools designed for use with youth and families in psychotherapy. The primary aim of the present study was to examine the reliability and validity of Spanish-translated versions of the TSM, a common feedback tool, to lay the foundation for its use in clinical care and research with Spanish-speaking youth and families. This goal was adopted in response to the paucity of Spanish-language measurement tools for use with youth in routine community mental health settings, which underlies the lack of research on treatment outcomes for this demographic group as well as ethnic disparities in therapy participation.
To meet this demand, Spanish versions of the TSM-P and TSM-Y were created using multi-step procedures in line with recommended translation standards in order to ensure equivalency between English and Spanish editions (Brislin, 1970). Subsequently, the measures were piloted with a group of Spanish-speaking youth and parents seeking mental health treatment in a community health center. Anecdotal feedback from individuals in the pilot sample supported the feasibility of completing the measure within brief time periods and the comprehensibility of items. Building on positive reception from the pilot group, the measures were administered to a large community sample of Spanish-speaking youth and parents. Data was analyzed using multiple measures of internal consistency and test-retest reliability as well as confirmatory factor analysis. Given positive psychometric evidence for English versions of this measure, it was hypothesized that Spanish-translated versions would be similarly reliable and valid (Warren et al., in progress).

Overall, analyses demonstrated that many of the domains of the Spanish versions of the TSM-P and TSM-Y have adequate reliability and validity in the present community sample. Specifically, results showed good internal consistency reliability for all domains of the TSM-P-SP and all domains of the TSM-Y-SP aside from the Youth Motivation scale, which yielded poor internal consistency reliability. These results regarding reliability demonstrate that, when individuals respond to questions on the TSM-P-SP and TSM-Y-SP, their answers within individual domains run together.

Analyses demonstrated low test-retest reliability for all domains of the TSM-P-SP and TSM-Y-SP, indicating low stability of domain scores across time. This finding is likely accounted for by both methodological and conceptual factors. The online sampling interface was constrained to only permit resampling of the Time 1 group after the initial wave of data.
collection was terminated. Thus, parents and youth were re-contacted one week after the full initial sample was collected, rather than one week after each subjects’ individual Time 1 administration. Consequently, some participants who were sampled early during Time 1 data collection received their Time 2 invitation almost two weeks after their initial completion of the questionnaire. This increased lag between first and second administrations may have increased the variability between participants’ responses on their first and second completions of the measure. In addition, the fact that subjects differed in the length of their delay period between first and second administration may have introduced an additional source of response variability.

Secondly, the design of the instrument itself may have contributed to low test-retest reliability estimates. The TSM is intended to measure constructs that are anticipated to vary over time (Warren & Lambert, 2013). For example, Parental Distress, a subdomain on the TSM-P, is thought to fluctuate in line with daily stressors such as child misbehavior and occupational demands. It is possible that participants’ values of the measured constructs changed within the time interval, leading to low correlations between scores at initial and second administrations. As explained by Carmines and Zeller (1979), low test-retest correlations may be a valuable signifier that the underlying construct of interest has shifted in the sample of interest, warranting further investigation.

Thirdly, the community nature of the sample likely contributed to attenuation of the range of scores collected on individual TSM domains. As the psychometric sample was collected from community members, it is expected that their levels of constructs such as youth and parent social support, youth and parenting self-efficacy, and parenting skills would be higher and less variable than levels for families in a clinical setting, who, by the nature of them being referred for behavioral health care, would be likely to have more severe concerns in these domains.
Clustering of scores around the mean would diminish correlations between time 1 and time 2 scores, impacting reliability estimates (Fan, 2003).

In addition, CFA analyses demonstrated excellent fit of the hypothesized measurement model for all subscales of the TSM-P-SP and TSM-Y-SP. Minor modifications were made to the Parenting Skills and Parent Distress domains of the TSM-P-SP and the Youth Motivation domain of the TSM-Y-SP to improve model fit. Of note, multiple items on the Youth Motivation subscale had poor factor loadings. Since this domain originally contained only five items originally, deleting all items with low loadings would have collapsed the scale. In all, the results of CFA analyses suggested exceptional construct validity for all TSM domains aside from the Youth Motivation subscale. Overall, the present study provided evidence for the reliability and validity of the TSM-P-SP and TSM-Y-SP, excluding the Youth Motivation subscale, in a large sample of community youth and parents.

Poor internal consistency reliability and CFA model fit for the Youth Motivation subscale was expected given that this subscale is intended for use with youth who have been referred for psychotherapy. The domain is intended to measure youth’s motivation to participate in mental health treatment. In order to support obtaining an adequate sample size for factor analysis, the present study did not restrict recruitment to individuals who were seeking psychosocial care. Instead, the sample was collected from the community population of youth. It appears that youth participants struggled to respond the items in this domain in a consistent and cohesive fashion, likely because they were asked to extrapolate their state of mind to a potential scenario, creating more room for error and inconsistency in their responses. In contrast, the other domains were more applicable to participants’ current status and present lived experiences, yielding more unified results. Thus, within the boundaries of the present sample, all domains that were able to
be appropriately applied to a community group were shown to be valid and reliable. The Youth Motivation domain of the English TSM-Y has been shown to have acceptable reliability and validity in clinically-referred samples, suggesting that it more aptly applies to youth who are seeking or participating in psychotherapy (Warren et al., in progress).

Some modifications were required to multiple domains to yield acceptable CFA model fit. On the TSM-P-SP, items 15 (“I often get into long arguments with my child”/“A menudo tengo discusiones largas con mi hijo”), 20 (“If my child talks back or complains when I handle a problem, I ignore the complaining and stick to what I said”/“Si mi hijo habla mal o se queja cuando manejo un problema, ignoro las quejas y me adhiero a lo que dije”), and 23 (“When there is a problem with my child, things build up and I do things I don’t mean to do”/“Cuando hay un problema con mi hijo, las cosas se acumulan y hago cosas que no quiero hacer”) on the Parenting Skills domain and items 27 (“I feel I am able to handle all my responsibilities very well”/“Siento que puedo manejar bien todas mis responsabilidades”), 28 (“I am able to handle the challenges of parenting without many problems”/“Siento que puedo manejar los desafíos de la crianza de los hijos sin muchos problemas”), 33 (“I find my work satisfying”/“Encuentro mi trabajo satisfactorio”), and 35 (“I like myself”/“Me gusto a mí mismo/a”) on the Parent Distress domain were excluded due to low loadings. Of note, excluded items 15, 23, 27, 28, 33, and 35 were reverse-coded, meaning that high scores on the items indicated low quantity of the construct of interest.

This pattern of poor predictive value of reverse-coded items may indicate that participants were not closely paying attention to questions, a common issue in human subjects research (Maniaci & Rogge, 2014). Estimates of inattention in survey responding range from 5% to 50% depending on criteria for evaluating inattentive or careless responding (Hauser &
Schwarz, 2016; Johnson, 2005; Meade & Craig, 2012). It is possible that the nature of the online sampling procedures used in the present study inflated inattentive responding, although past studies have documented improved or equivalent performance on attention checks by online responders in comparison to traditional actuarial samples (Hauser & Schwarz, 2016; Landers & Behrend, 2015).

It is possible that differences in demand characteristics between this study’s community sample and the TSM’s target audience of clinically-referred families. It is expected that, when the TSM is administered to families in clinical settings, its use to support positive outcomes for their mental health care provides an incentive for deliberate responding. In the case of this study’s community sample, this same benefit was not present, reducing participants’ level of investment in responding in a careful and deliberate responding. To attempt to filter out inattentive responding, the present study employed an attention-check in excluding individuals who completed the questionnaire in under one half of the median pilot response time, a commonly recommended screen to identify inattentive responders (Meade & Craig, 2012). However, this pattern of poor loadings of reverse-coded items highlights the possible role of careless responding in increasing discontinuity and error within the data despite the inclusion of measures to exclude inattentive responders.

One excluded item, question 20 on the TSM-P-SP, was not reverse-coded and highlights a potential distinction between responses on the English and Spanish versions of the measure based on culture. This item (“If my child talks back or complains when I handle a problem, I ignore the complaining and stick to what I said”) probes a parents’ ability to implement a well-researched parenting strategy, planned ignoring of disruptive mild behaviors, that has been shown to facilitate positive child behavior change (Golding, 2000; Kazdin, 2008). A recent
dialogue within the field of parenting research has been initiated regarding how the practice of planned ignoring of disruptive behaviors should be appropriately applied to Hispanic families.

As explained by Borrego et al. (2006), the value of “respeto” (respect) is prominent within Hispanic cultures and dictates that individuals show high deference and respect to those in authority. In the context of childrearing, children are expected to “ser bien educado” (be well behaved) towards adult figures, including parents, across settings, especially in public spheres. Children acting disobedient or “talking back” reflects very poorly on their parents, thus often eliciting stern responses from parents aimed at immediately extinguishing the behavior. It has been documented that Hispanic parents are more likely than those of others cultures to respond immediately and firmly when children act out, especially in public (Fontes, 2002; Parke et al., 2004). For example, Calzada and Eyberg (2002) found that over 80% of Puerto Rican mothers endorsed “scolding or criticizing” their children when they misbehave.

For Hispanic families, ignoring this type of disruptive behavior, especially around others, reflects poorly on parents, implying permissiveness towards culturally-inappropriate conduct that violates expectations of respect. Thus, item 20 on the TSM-P-SP probing planned ignoring may be less likely to be related to other positive parenting behaviors, such as positive praising, appropriate supervision, and consistent consequences for Hispanic parents. In subsequent editions of the TSM-P-SP, this item may need revision to more culturally salient for Hispanic families. Potentially, the phrasing relating to “ignoring” could be eliminated from item because of its misalignment with cultural expectations and the question could instead focus on parents’ ability to remain consistent in holding to their original instructions.

In sum, the results of the current investigation provide foundational support for the feasibility of using a Spanish-translated version of the TSM-P-SP and TSM-Y-SP with youth and
their families. Analyses indicated good internal consistency reliability for both versions of the measure, suggesting that the measure assesses the constructs of interest in a consistent fashion. In addition, CFA analyses provided some evidence that the measure quantifies the hypothesized factors in a valid manner for most domains. However, results also indicated poor test-retest reliability along with poor loadings reverse-coded items, suggesting that inconsistent and inattentive responding along with attenuation of range likely impacted findings. These concerns may be related to the community nature of the sample along with the online sampling methods utilized, underscoring the necessity of additional research with clinical populations to clarify the psychometric properties of the TSM-SP. Further research is needed to determine whether the TSM-SP achieves adequate reliability and validity in clinical populations, mirroring the results of prior investigations of the English TSM (Warren et al., in progress).

Limitations

This investigation provides important evidence supporting the use of the Spanish-translated TSM-P and TSM-Y with Hispanic youth and families; however, these results should be viewed in the context of the study’s limitations. Namely, the present study employed a community sample in order to facilitate data collection. Although the TSM is intended to be used with clinical populations, the decision to pursue a community sample was made based on the challenges of recruiting a Spanish-speaking clinical sample in an efficient manner. Given that the present study aimed to employ modeling analyses, having a large sample to ensure sufficient statistical power was prioritized. Thus, the investigation’s conclusions regarding the Spanish TSM’s validity and reliability most aptly apply to community groups of Hispanic youth and families rather than the subset of clinically-referred individuals. Subsequent investigations should be conducted that expand this study’s conclusions by examining the psychometric
properties of the TSM-P-SP and TSM-Y-SP in clinical groups. Nonetheless, this investigation provides a preliminary foundation supporting the further investigation of the validity and reliability of the measure.

The nature of the community sample in the present study limited the scope of the TSM-P-SP and TSM-Y-SP domains that could feasibly be administered. Specifically, the Therapeutic Alliance domains of both the TSM-P-SP and TSM-Y-SP were omitted given that the sample collected was not constrained to parents and youth involved in psychotherapy. Although some individuals sampled may have been participating in psychotherapy, given that estimates of behavioral health service utilization range from about 5-20% it is unlikely that a significant portion of the sample was engaging in psychotherapy at the time that they completed the measures (Burns et al., 1995; Leaf et al., 1996). Since participants were not expected to be participating in behavioral health intervention, the questions on the Therapeutic Alliance domain were not administered. Therefore, the present study does not provide any indication as to whether the translated versions of these domains are valid and reliable when completed by Spanish-speaking youth and parents. Given this investigation’s positive support for the reliability and validity of the Spanish-translated versions of the other domains on the measure, it is expected that the Therapeutic Alliance domains would be similarly psychometrically sound. However, additional research is needed within clinical samples of Spanish-speaking youth and parents to support the use of the translated versions of these domains in routine clinical care and research.

It is also important to note that there are some limitations associated with the study’s use of online sampling methods. Although recent investigations have found no differences between rates of inconsistent, random, or inattentive responding between online and in-person samples,
the use of online sampling remains a relatively new and under-examined method of data
collection, especially when employed with youth participants (Berinsky et al., 2012; Boas et al.,
2018; Hauser & Schwarz, 2016). It is possible that utilizing online study collection methods led
to responding biases that differ from patterns found when the measures are distributed in-person.
Embedded timing measures showed that participants completing the questionnaires online took a
shorter time than individuals in the pilot sample who filled out the study materials in-person.
This distinction suggests that rapid responding may have been more common in the present
sample than if participants had been distributed the measure in-person, as it was constructed to
be used, introducing a new confound. It is important that follow-up investigations clarify the
equivalency between online and in-person responses to the TSM in order to extend the present
study’s findings to individuals taking the measure in actuarial settings.

The present study did not include a standardized measure of fluency to verify Spanish-
speaking status. The current study asked participants to self-report their ability to read and
respond to questions in Spanish in order to determine which individuals contacted would be
given the full battery of questions. Although it is common for investigators to include and
exclude participants based on self-report of language fluency, it is unknown whether this method
of screening participants holds consistently when online sample methods are used. When
individuals are assessed in-person, researchers have the ability to observe participants’ language
abilities during the brief interactions surrounding introducing the study and establishing consent.
When measures are administered online, there are no such opportunities to obtain information on
language fluency. Thus, we were unable to obtain actuarial information to corroborate
participants’ Spanish-speaking ability. Given the lack of language checks, some participants
could have overestimated or exaggerated their language abilities in order to obtain the monetary
compensation provided for completing the questionnaire, biasing the results. Also, the measure was translated using words and phrases common between various dialects of Spanish, focusing on making it readable to individuals from Mexico and other Central American countries, which are the primary ethnic groups served by the clinics in the target region. As a result, it is possible that the measure may not be as easily understood by individuals from other Spanish-speaking regions.

Additionally, the present study was limited in the scope of validity metrics that it was able to consider. This investigation focused on assessing construct validating using CFA, the results of which supported the validity of the youth and parent versions of the Spanish-translated TSM. However, the Spanish-translated TSM’s correlation with other instruments intended to assess similar constructs was not examined. Thus, the present study does not provide information regarding the Spanish TSM’s concurrent validity. Concurrent validity was not included due to the lack of available Spanish-translated measures that assess the specialized constructs of interest included on the TSM. Similarly, this investigation did not examine correlations between various domains on the TSM-P-SP and TSM-Y-SP to evaluate divergent validity. The decision to exclude divergent validity analyses was based on previous research documenting the relationships between constructs included on the TSM, such as Youth Motivation and Youth Therapeutic Alliance (Roest et al., 2016).

Lastly, the sample size utilized was on the lower end of recommended ranges for CFA. It is well-documented that larger sample sizes for CFA yield more precise factor loadings and are more resistant to error. However, recommendations as to appropriate samples sizes in CFA are mixed, with professionals encouraging sampling minimums ranging from \( n = 100 \) to \( n = 500 \) (Comrey & Lee, 1992; Curran et al., 1996; Guilford, 1954; Marsh et al., 1988). While this study
meets standard recommendations for sample size, having responses from additional participants could increase the power of statistical findings.

**Implications and Future Directions**

As part of this study, the first edition of a Spanish-language version of the TSM, a commonly used clinical support tool in the context of psychosocial treatment for children and adolescents, was created. The current investigation provided preliminary information regarding the psychometric properties of the TSM-SP in an online community sample, laying the foundation for its investigation within broader populations. In doing so, this project responded to the paucity of available Spanish-language clinical support measures developed for use with community populations by translating an existing measure and assessing its validity and reliability in a community sample. Results indicated good internal consistency reliability and construct validity for all examined domains of the parent and youth versions of the measure in the present sample, aside from the Youth Motivation subscale, which was challenging to apply to participants. These findings underscore the utility of the Spanish-translated version of the TSM and emphasize the importance of future research to solidify its psychometric properties in additional samples.

Specifically, future research should examine the reliability and validity of the youth and parent versions of the TSM-SP in clinical samples. The original authors of the TSM have noted that the measure is intended to be utilized to support clinicians who are working with youth clients in the context of psychotherapy (Warren & Lambert, 2013). While using a community sample provided initial psychometric data for the TSM-SP, it would be expedient to examine the properties of the measure in a clinical sample to expand these findings to the measure’s specific subgroup of interest. In addition, investigating the TSM-SP in a clinical sample is necessary to
obtain data on parent and youth responses to items on the Therapeutic Alliance domain, which was excluded from the present analysis due to its inapplicability to participants in our community sample. Future research on the psychometric properties of the TSM-SP in various subsets of Spanish-speaking clinical populations is necessary to provide additional information on the appropriate use of the measure. For example, future research should investigate potential differences between the comprehensibility, reliability, and validity of the TSM-SP between individuals of various Hispanic subgroups to ensure its ability to be utilized with youth and parents of diverse cultural and ethnic backgrounds.

The present investigation opens the door for future studies examining how the TSM-SP can be used to support both evidence-based care for youth with behavioral health needs and innovative research into improving therapy outcomes for children and families. Experts have consistently recommended the use of clinical support tools to assess client symptoms throughout treatment as well as important characteristics that are associated with outcomes (APA Presidential Task Force on Evidence-Based Practice, 2006). Developing and validating a Spanish-language version of the TSM provides the foundation for the expansion of this practice to when researching and treating Spanish-speaking youth and their parents. With the support of future research, the Spanish-language youth and parent versions of the TSM can be employed by clinicians to obtain additional information about youth patients in psychotherapy that can be used to adapt treatment to clients’ individualized needs and strength. For example, a therapist who determines that her adolescent patient is endorsing a lack of social support at the outset of treatment can focus initial stages of care on identifying additional opportunities for interpersonal connection. In addition, future findings related to the measure’s validity and reliability can support additional research utilizing the Spanish version of the TSM to quantify and track
important client characteristics in Spanish-speaking youth and families receiving psychotherapeutic intervention. Research in this vein is needed to better understand how client variables may uniquely impact care for Hispanic children and adolescents.

Overall, the present study, in creating and establishing the psychometric properties of the TSM-SP, addresses the lack of clinical measurement tools published in Spanish. This paucity of available assessment devices contributes to disparities in the quality of mental health care delivered to minority children and families (Kouyoumdjian et al., 2003). By seeking to develop and validate a Spanish-language measure of youth and family client characteristics, this investigation lays the foundation for extending findings on the benefit of measuring client variables in supporting positive treatment outcomes. In doing so, it looks to expand the availability and quality of evidence-based practices to Spanish-speaking youth and families seeking mental health care. Future investigations should continue to focus on meeting this goal in order to provide much-needed resources to minority individuals with behavioral health needs.
References


Chorpita, B. F., Daleiden, E. L., Ebeshutani, C., Young, J., Becker, K. D., Nakamura, B. J.,
children and adolescents: An updated review of indicators of efficacy and effectiveness.
*Clinical Psychology: Science and Practice, 18*(2), 154–172.

cluster randomized effectiveness trial comparing modular treatment with community
implemented treatment for youth with anxiety, depression, conduct problems, or

Cohen, R. J., & Swerdlik, M. E. (2005). *Psychological testing and measurement: An

Colby, S. L., & Ortman, J. M. (2014). *Projections of the size and composition of the U.S.

Associates.


census 2000: Analysis of data quality for the question on Hispanic origin* (No. 75). US
Census Bureau.

Crockett, L. J., Iturbide, M. I., Torres Stone, R. A., McGinley, M., Raffaelli, M., & Carlo, G.
(2007). Acculturative stress, social support, and coping: Relations to psychological


planning and problem solving in child mental health services.


Appendix A

English Version of the Parent-Report Treatment Support Measure (TSM)

**INSTRUCTIONS: (#1-7):** For questions 1-7 please rate how confident you are that you can do each of the parenting tasks described. Select the answer that best describes how you have felt about these things over the past week.
1. I can help my child feel loved and cared for. .................................................................
2. I can help my child develop good self-esteem..............................................................
3. I can help my child feel needed and wanted...............................................................
4. I can appropriately discipline my child when he/she does something wrong................
5. I can help my child to develop a healthy sense of independence. ..............................
6. I can avoid criticizing my child or blaming him/her too much......................................
7. I can respect my child’s feelings and ideas................................................................

**INSTRUCTIONS (#8-14):** Questions 8-14 are about your relationships with your family, friends, and significant others. Select the answer that best describes how you felt about these things over the past week.
8. My family really tries to help me. .................................................................
9. I get emotional help and support I need from my family...........................................
10. I can talk about my problems with my family.........................................................
11. My family is willing to help me make decisions......................................................
12. There is a special person who is around when I need help........................................
13. There is a special person in my life who cares about my feelings..............................
14. I have friends with whom I can share my joys and problems.................................

**INSTRUCTIONS (#15-26):** Questions 15-26 ask about parenting situations that are challenging for some parents. Select the answer that best describes you over the past week.
15. I often get into long arguments with my child..............................................................
16. I often show affection for my child through words, hugs, or other warm gestures. ....
17. When my child misbehaves I keep the discussion short and to the point..................
18. I look for opportunities to compliment my child......................................................
19. When there is a problem with my child I can usually keep the situation from escalating...
20. If my child talks back or complains when I handle a problem, I ignore the complaining and stick to what I said.................................................................
21. I regularly spend quality time with my child..............................................................
22. When I give my child a warning I follow through with what I said............................
23. When there is a problem with my child, things build up and I do things I don’t mean to do...
24. When my child misbehaves I handle it without getting upset..................................
25. When my child is out of sight or away with friends, I have a good idea what my child is doing ...
26. I frequently praise my child for his/her good behavior.............................................

**INSTRUCTIONS (#27-36):** Questions 27-36 based on how you have felt during the past week.
Questions about work refer to employment, housework, school, or volunteer work.
27. I feel I am able to handle all my responsibilities very well...................................
28. I feel I am able to handle the challenges of parenting without many problems...........
29. My child creates a lot of stress for me.................................................................
30. Being a parent takes up almost all my energy......................................................
31. I often feel overwhelmed as a parent.................................................................
32. I feel irritated........................................................................................................
33. I find my work satisfying....................................................................................
34. I have frequent arguments.................................................................................
35. I like myself........................................................................................................
36. I feel that I am not doing well at work.................................................................
INSTRUCTIONS (#37-40): Questions 37-40 are about working with your child’s therapist. Select the answer that best describes how you have felt about these things over the past week. It’s ok to say how you really feel about these things – your honest answers will help ensure your child receives the services he/she needs.

37. I look forward to meeting with my child’s therapist…………………………………………………………
38. I don’t feel my child is making much progress with his/her therapist……………………………………
39. I fell like my child’s therapist knows how to help my child………………………………………………
40. My child’s therapist really listens to me……………………………………………………………………
Appendix B

English Version of the Youth-Report Treatment Support Measure (TSM)

INSTRUCTIONS: (#1-15): For questions 1-15 please rate how confident you are that you can do each of the things described below. Select the answer that best describes how you have felt about these things over the past week.

1. I can make and keep good friends…………………………………………………..………………
2. I can get along well with most people……………………………………………...………………
3. When I have problems with friends I can work things out……………………………………….
4. I can work well in a group………………………………………………………..………………..
5. I can achieve my goals in life……………………………………………………………...
6. I can live up to what my parents expect of me………………………………………………
7. I can live up to what I expect of myself…………………………………………………………
8. I can control my temper……………………………………………………………...
9. When I have a problem, I can find ways to solve it………………………………………..
10. If I make a mistake I can fix it……………………………………………………………
11. When there are problems in my family, I can do things to improve the situation………………
12. I can get good grades in school………………………………………………..………………
13. I can get teachers to help me when I am stuck on school work……………………………
14. I can get another student to help me when I get stuck on school work………………………
15. I can motivate myself to do school work…………………………………………………...……...

INSTRUCTIONS (#16-30): Questions 16-30 are about your relationships with your immediate family (e.g., father, mother, step-parent or guardian, brother, sister), your extended family (grandparents, aunts, uncles, cousins) and your friends. Select the answer that best describes how you have felt about these things over the past week.

16. I have an immediate family member (father, mother, brother, or sister) who I can turn to for good advice
17. I feel like I “fit in” and belong with the members of my immediate family………………………..
18. My immediate family appreciates my abilities and helps me to believe in myself…………………..
19. I feel like my immediate family needs me……………………………………………………..…..
20. I feel emotionally connected to the members of my immediate family (we care about each other)…………………………………………………………………………………………
21. I have an extended family member (grandparent, uncle, aunt, or cousin) who I can turn to for good advice…………………………………………………………………………………………
22. I can count on members of my extended family if I need help……………………………………
23. My extended family appreciates my abilities and helps me to believe in myself…………………..
24. I feel like my extended family needs me…………………………………………………………
25. I feel emotionally connected to the members of my extended family (we care about each other)…………………………………………………………………………………………
26. I have family members or friends who can help me in material ways like providing me with food, clothing, or money…………………………………………………………………………………………
27. I feel like I “fit in” and belong with friends my age………………………………………………
28. I have a friend who I can turn to for good advice………………………………………………
29. My friends appreciate my abilities and help me to believe in myself………………………………
30. I feel emotionally connected to at least one friend my age (we care about each other)…………

INSTRUCTIONS (#31-36): Questions 31-36 ask how you feel about being in therapy. Select the answer that best describes how you felt about these things over the past week.

31. I’m glad I’m participating in therapy………………………………………………………………
32. The things I work on in therapy will help me in the future………………………………………
33. Being in therapy is a waste of time for me…………………………………………………………
34. I’m only in therapy because my parent (or someone else) thinks I need help…………………………
35. I am willing to do my part in therapy to make things better………………………………………
36. I’m participating in therapy to get the help I need………………………………………………

Strongly Disagree  Slightly Disagree  Neutral  Slightly Agree  Strongly Agree
INSTRUCTIONS (#37-40): Questions 37-40 are about working with your therapist. Select the answer that best describes how you felt about these things over the past week. It’s ok to say how you really feel about these things – your honest answers will help ensure you receive the services you need.

37. I feel like my therapist is on my side and tries to help me…………………………………………
38. I look forward to meeting with my therapist…………………………………………………..
39. I fell like my therapist knows how to help me………………………………………………..
40. My therapist really listens to me .......................................................................................
Appendix C
Spanish Translated Version of the Parent-Report Treatment Support Measure (TSM)

INSTRUCCIONES (#1-7): Por favor califique el nivel de confianza que tiene de poder realizar cada una de las tareas de crianza para sus hijos que se describen a continuación. Elige la respuesta que mejor describa cómo se ha sentido acerca de estas cosas durante la semana pasada.

41. Puedo ayudar a mi hijo a sentirse amado y cuidado. ..................................................
42. Puedo ayudar a mi hijo a desarrollarse autoestima. ..................................................
43. Puedo ayudar a mi hijo a sentirse especial y deseado. ..............................................
44. Puedo disciplinar apropiadamente a mi hijo cuando él/ella hace algo mal. ..............
45. Puedo ayudar a mi hijo a desarrollar un sentido sano de independencia. ..............
46. Puedo evitar criticar o culpar demasiado a mi hijo ...............................................  
47. Puedo respetar los sentimientos y las ideas de mi hijo ...........................................

INSTRUCCIONES (#8-14): Estas preguntas son acerca de sus relaciones con su familia, amigos y otras personas importantes. Elige la respuesta que mejor describa cómo se ha sentido acerca de estas cosas durante la semana pasada.

48. Mi familia verdaderamente trata de ayudarme ......................................................
49. Recibo la ayuda emocional y el apoyo que necesito de mi familia. ....................... 
50. Puedo hablar de mis problemas con mi familia .....................................................
51. Mi familia está dispuesta a ayudarme a tomar decisiones .....................................
52. Hay alguien especial que está cerca cuando necesito ayuda .................................
53. Hay alguien especial en mi vida a quien le importan mis sentimientos .................
54. Tengo amigos con los que puedo contar mis alegrías y problemas .....................

INSTRUCCIONES (#15-26): Estas preguntas se refieren a situaciones de crianza que son un reto para algunos padres. Elige la respuesta que mejor lo/a describa durante la semana pasada.

55. A menudo tengo discusiones largas con mi hijo ...................................................
56. A menudo demuestro mi cariño para mi hijo por medio de palabras, abrazos, u otros gestos cariñosos .................................................................
57. Cuando mi hijo se comporta mal, mantengo la conversación breve y al grano. ........
58. Busco oportunidades para elogiar a mi hijo ............................................................
59. Cuando tengo un problema con mi hijo generalmente puedo evitar que la situación se agrave ...
60. Si mi hijo habla mal o se queja cuando manejo un problema, ignoro las quejas y me adhiero a lo que dije .................................................................
61. Regularmente paso tiempo de calidad con mi hijo .............................................
62. Cuando le doy una advertencia a mi hijo, sigo lo que dije ......................................
63. Cuando hay un problema con mi hijo, las cosas se acumulan y hago cosas que no quiero hacer ....
64. Cuando mi hijo se comporta mal, lo manejo sin enojarme ................................
65. Cuando mi hijo está fuera de la vista o con amigos, tengo una buena idea de lo que está haciendo ....
66. Frecuentemente, elogio a mi hijo por su buen comportamiento .........................

INSTRUCCIONES (#27-36): Conteste las siguientes preguntas en base a cómo se ha sentido durante la semana pasada. Las preguntas sobre el trabajo se refieren al empleo, las tareas del hogar, la escuela o el trabajo voluntario.

67. Siento que puedo manejar bien todas mis responsabilidades .............................
68. Siento que puedo manejar los desafíos de la crianza de los hijos sin muchos problemas .................................
69. Mi hijo crea mucho estrés para mi .................................................................
70. Ser padre consume casi toda mi energía ...........................................................
71. A menudo me siento agobiado como padre/madre .............................................
72. Me siento irritado/a ................................................................................................
73. Encuentro mi trabajo satisfactorio ........................................................................
74. Tengo discusiones frecuentes .................................................................
75. Me gusto a mí mismo/a........................................................................................
INSTRUCCIONES (#37-40): Estas preguntas son acerca de cómo trabajar con el terapeuta de su hijo/a. Elige la respuesta que mejor describa cómo se ha sentido sobre estos asuntos durante la semana pasada. Está bien decir cómo se siente acerca de estas cosas, sus respuestas honestas le ayudarán a asegurar que su hijo/a reciba los servicios que él/ella necesita.

76. Espero con interés encontrar con el terapeuta de mi hijo. ...........................................
77. No siento que mi hijo está progresando con su terapeuta ...........................................
78. Siento que el terapeuta de mi hijo sabe ayudar a mi hijo ...........................................
79. El terapeuta de mi hijo realmente me escucha ...........................................
Appendix D
Spanish Translated Version of the Youth-Report Treatment Support Measure (TSM)

INSTRUCCIONES (#1-15): Por favor califica el nivel de confianza que tienes de poder realizar cada una de las cosas que se describen a continuación. Elige la respuesta que mejor describa cómo te has sentido acerca de estas cosas durante la semana pasada.

1. Puedo hacer y mantener amistades buenas .................................................................
2. Puedo llevarme bien con la mayoría de la gente ..........................................................
3. Cuando tengo problemas con mis amigos, puedo resolverlos ....................................
4. Puedo trabajar bien en grupo ....................................................................................
5. Puedo lograr mis metas en la vida ..............................................................................
6. Puedo estar a la altura de las expectativas de mis padres ...........................................
7. Puedo estar a la altura de las expectativas que tengo para mí mismo ............................
8. Puedo mantener mi temperamento bajo control ..........................................................
9. Cuando tengo un problema, puedo encontrar maneras de resolverlo ..........................
10. Si me equivoco, puedo arreglarlo .............................................................................
11. Cuando hay problemas en mi familia, puedo hacer cosas para mejorar la situación ...
12. Puedo sacar buenas notas en la escuela .................................................................
13. Puedo conseguir ayuda de mis maestros cuando me encuentro confundido por la tarea...
14. Puedo conseguir ayuda de otro estudiante cuando me encuentro confundido por la tarea...
15. Me puedo motivar a hacer la tarea ...........................................................................

INSTRUCCIONES (#16-30): Estas preguntas son acerca de tus relaciones con tu familia inmediata (por ejemplo, padre, madre, padrastro o tutor, hermano, hermana), tu familia extendida (abuelos, tíos, primos) y tus amigos. Elige la respuesta que mejor describa cómo te has sentido acerca de estas cosas durante la semana pasada.

16. Tengo un familiar inmediato (padre, madre, hermano o hermana) a quien puedo acudir por buenos consejos ........................................................................................................
17. Siento que pertenezco a mi familia inmediata y me llevo bien con ellos .................
18. Mi familia inmediata aprecia mis habilidades y me ayuda a creer en mí mismo .......
19. Siento que mi familia inmediata me necesita ................................................................
20. Me siento conectado/a emocionalmente a los miembros de mi familia inmediata ... (nos preocupamos el uno por el otro) ........................................................................
21. Tengo un pariente (abuelo/a, tío/a o primo/a) a quien puedo acudir por consejos buenos........
22. Puedo contar con los miembros de mi familia extendida si necesito ayuda .............
23. Mi familia extendida aprecia mis habilidades y me ayuda a creer en mí mismo .......
24. Siento que mi familia extendida me necesita ................................................................
25. Me siento conectado emocionalmente a los miembros de mi familia extendida ...(nos preocupamos el uno por el otro) ........................................................................
26. Tengo parientes o amigos que pueden ayudarme con cosas materiales como proveerme comida, ropa o dinero ..................................................................................
27. Siento que pertenezco al grupo de mis amigos de mi misma edad y me llevo bien con ellos....
28. Tengo un amigo a quien puedo acudir por consejos buenos ........................................
29. Mis amigos aprecian mis habilidades y me ayudan a creer en mí mismo ..................
30. Me siento conectado/a emocionalmente a por lo menos un amigo de mi edad ...(nos preocupamos el uno por el otro) ........................................................................

INSTRUCCIONES (#31-36): Estas preguntas se refieren a cómo te sientes acerca de estar en terapia. Elige la respuesta que mejor describa cómo te has sentido sobre estos asuntos durante la semana pasada.

80. Me alegra participar en terapia ...................................................................................
81. Las cosas en las que trabajo en terapia van a ayudarme en el futuro ..........................
82. Participar en terapia es una pérdida de tiempo para mí ............................................
83. Solo participo en terapia porque mi padre/madre (o alguien más) piensa que necesito ayuda......
84. Estoy dispuesto/a a hacer mi parte en terapia para mejorar las cosas .....................
85. Estoy participando en terapia para recibir la ayuda que necesito .................................
INSTRUCCIONES (#37-40): Estas preguntas son acerca de cómo trabajas con tu terapeuta. Elije la respuesta que mejor describa cómo te has sentido sobre estos asuntos durante la semana pasada. Está bien decir cómo te sientes acerca de estas cosas, tus respuestas honestas aseguran que recibas los servicios que necesitas.

86. Siento que mi terapeuta está de mi parte y trata de ayudarme ……………………………
87. Espero con interés las reuniones con mi terapeuta…………………………………………………
88. Siento que mi terapeuta sabe ayudarme. ……………………………………………………………
89. Mi terapeuta realmente me escucha …………………………………………………………………
Appendix E
English and Spanish Versions of Pilot Sample Recruitment Script

Script for recruitment - English

My name is ______________________ and I am a member of a research group at Brigham Young University. We are studying things that help young people in therapy. We would like to invite you and your child to participate in our study. Participation is simple and does not take much time. If you participate, you will sign a consent form. Afterwards, you will complete a brief questionnaire. If your child is at least 12 years old, he or she will complete a questionnaire as well. These questionnaires contain questions on your feelings about your relationships, your family, and your work. The questionnaire usually takes five to ten minutes to complete.

If you choose to participate, after completing the questionnaire you will receive five dollars.

Your and your child's answers will be kept confidential. The only people who will have access to the data will be the members of the research group. Participation in the study is voluntary and you can discontinue your participation at any time. Thanks for your consideration. Do you have any questions about the study?

Texto para reclutamiento - Español

Me llamo ______________________ y soy un/una miembro/a de un grupo de investigación de Brigham Young University. Estamos estudiando las cosas que ayudan los jóvenes en la terapia. Les invitamos a usted y su hijo a participar en nuestro estudio. La participación es sencilla y no toma mucho tiempo. Si ustedes participan, van a firmar una forma de consentimiento. Después, van a completar un cuestionario breve. Si su hijo tiene al menos 12 años, él o ella va a completar un cuestionario también. Estos cuestionarios contienen preguntas de sus sentimientos sobre sus relaciones, su familia, y su trabajo. El cuestionario usualmente tarda cinco a diez minutos en completar.

Si usted elige a participar, después de completa el cuestionario va a recibir cinco dólares.

Las respuestas de usted y su hijo serán confidenciales. Las únicas personas que tendrán acceso a los datos serán los miembros del grupo de investigación. La participación en el estudio es voluntaria y puede detener su participación en cualquier momento. Gracias por su consideración. ¿Tiene algunas preguntas sobre el estudio?
Appendix F

English and Spanish Versions of Pilot Sample Child Assent

Assent to participate in a research study - English

What is the study about?
We are Mrs. Corinne Ruth and Dr. Jared Warren and we work with Brigham Young University. We are studying therapy for young people and families. We are asking you to participate in our study because we want to learn more about things that help young people in therapy.

What am I going to do?
If you agree to participate in this study:
You will answer some questions about your relationships with your friends and family members, your studies at school, and your relationship with your therapist.

What are the benefits for me? Are there any risks?
You will not receive any direct benefit from your participation in this study. However, the results of this study will improve the quality of therapy for Hispanics youth. There are not many risks from participating in this study. Some people may feel bored, uncomfortable, or nervous about the questions. You do not have to answer any of the questions that you do not want to answer. If the questions make you feel upset, you can talk with your therapist for support.

Who will know that I am participating in the study?
We are not going to inform anyone that you are in the study and all your answers to the questions are private. Your answers will be stored in a safe place and will be protected with a password. Your parents may know that you are participating, but we are not going to tell them your answers.

Will I receive money from participating?
You will receive $5 after answering the questions.

Do I have to participate?
You do not have to be in this study if you do not want to. No one will be angry if you do not participate. You can stop your participation in this study at any time. Remember, being in this study is your decision.

Who can I contact if I have questions?
You can ask all the questions you want about the study. If you have questions about the study, you can ask your parents or us. To contact us, you can call Corinne Ruth at (801) 422-7759 or send an email to corinne_ruth@byu.edu.

Yes, I agree to participate in this research study.

Name (printed): ____________________ Signature: ____________________
Date: ____________________
Acuerdo para participar en un estudio de investigación - Español

¿De qué trata el estudio?
Somos Sra. Corinne Ruth y Dr. Jared Warren y trabajamos en Brigham Young University. Estamos estudiando la terapia para jóvenes y familias. Te estamos pidiendo que participes en nuestro estudio porque queremos aprender más sobre cosas que ayudan los jóvenes en la terapia.

¿Qué voy a hacer?
Si aceptas participar en este estudio:
Vas a responder a algunas preguntas sobre tus relaciones con tus amigos y miembros de tu familia, tus estudios en la escuela, y tu relación con tu terapeuta.

¿Qué son los beneficios para mí? ¿Hay riesgos?
No vas a recibir ningún beneficio directo por su participación en este estudio. Sin embargo, los resultados de este estudio van a mejorar la calidad de la terapia para los jóvenes hispanos. No hay muchos riesgos de participar en este estudio. Algunas personas pueden sentirse aburridas, incómodas, o nerviosas por las preguntas. No tienes que responder a ninguna de las preguntas que no deseas responder. Si las preguntas te molestan, puedes hablar con tu terapeuta para que te apoye.

¿Quién va a saber que estoy participando en el estudio?
No vamos a informar a nadie que estás en el estudio y todas tus respuestas a las preguntas son privadas. Tus respuestas se almacenarán en un lugar seguro y se protegerán con una contraseña. Tu padre quizás va a saber que estás participando, pero no vamos a decir tus respuestas a él o ella.

¿Voy a recibir dinero para participar?
Vas a recibir $5 después de responder a las preguntas.

¿Tengo que participar?
No tienes que estar en este estudio si no deseas hacerlo. Nadie se enojará si no participas. Puedes detener tu participación en este estudio en cualquier momento. Recuerda, estar en este estudio es tu decisión.

¿Quién puedo contactar si tengo preguntas?
Puedes hacer todas las preguntas que quieras sobre el estudio. Si tienes preguntas sobre el estudio, puedes pedirlas a tus padres o a nosotros. Para contactarnos, puedes llamar a Corinne Ruth al (801) 422-7759 o enviar un correo electrónico al corinne_ruth@byu.edu.

Sí, acepto participar en este estudio de investigación.

Nombre (en letra de imprenta): ____________________  Firma: _________________________
Fecha: __________________
Appendix G
English and Spanish Versions of Pilot Sample Parent Consent

Consent to participate in a research study - English

Introduction
This study is led by Corinne Ruth, M.S. and Jared Warren, Ph.D. from Brigham Young University. The goal of the study is to create a new questionnaire in Spanish that clients and therapists can use as part of treatment. You are asked to participate in the study because your child is a client at a mental health center which has agreed to participate in our research.

Procedures
If you agree to participate in this study:
- You will fill out a brief questionnaire about your family and your relationships, your role as a parent, your work, and your participation in therapy before your appointment today. The questionnaire usually takes five to ten minutes to complete.
- If your child is at least 12 years old, he or she will complete a brief questionnaire about their relationships with friends and family members, their studies at school, and their relationship with their therapist. The questionnaire usually takes five to ten minutes to complete.

Risks
Some people may experience discomfort about answering the questions. If you do not wish to answer a question, you may leave it blank. If the questionnaire makes you feel upset, you can talk with a therapist at the clinic for support.

Benefits
You will not receive any direct benefit for your participation in this study. Nevertheless, the results of this study will improve the quality of therapy for Hispanic youth.

Confidentiality
Your answers to the questionnaire and identifying data will be stored in a secure place and will be protected with a password. We will not share your information with anyone. Identifying data will be removed from the answers to make it impossible to identify individual people.

Compensation
If you agree to participate, you will receive $5 after completing the questionnaire.

Participation
Your participation in this study is completely voluntary. You have the right to withdraw your consent at any time or refuse to participate without risking your access to treatment.

Questions about the study
Before, during, or after your participation, you can contact the researcher Corinne Ruth at (801) 422-7759 or send an email to corinne_ruth@byu.edu with any questions.

Questions about your rights as a participant
If you have any questions about your rights you can contact the administrator of the Institutional Review Board at (801) 422-1461; A-285 ASB, Brigham Young University, Provo, UT 84602; irb@byu.edu.

Declaration of consent
I have read, understood, and received a copy of this form and I agree to participate voluntarily.

Name (in print): ___________________ Signature: ___________________ Date: ___________________
Consentimiento para participar en un estudio de investigación - Español

Introducción
Este estudio es dirigido por Corinne Ruth, M.S. y Jared Warren, Ph.D. de Brigham Young Universidad. La meta del estudio es crear un cuestionario nuevo en español que los clientes y terapeutas pueden usar como parte del tratamiento. Se le pide que participe en el estudio porque su hijo está un cliente en un centro de salud mental que ha aceptado participar en nuestra investigación.

Procedimiento
Si accede a participar en este estudio:
- Usted completará un cuestionario breve sobre su familia y sus relaciones, su rol como padre, su trabajo, y su participación en la terapia antes de su cita hoy. El cuestionario usualmente tarda cinco a diez minutos en completar.
- Si su hijo tiene al menos 12 años, él/ella completará un cuestionario breve sobre sus relaciones con amigos y miembros de la familia, sus estudios en la escuela, y su relación con su terapeuta. El cuestionario usualmente tarda cinco a diez minutos en completar.

Riesgos
Algunas personas pueden sentirse incómodas para responder a las preguntas. Si usted no quiere responder a una pregunta, puede omitirla. Si el cuestionario le molesta, puede hablar con una terapeuta en la clínica para que le apoye.

Beneficios
Usted no recibirá ningún beneficio directo por su participación en este estudio. Sin embargo, los resultados de este estudio van a mejorar la calidad de la terapia para los jóvenes hispanos.

Confidencialidad
Sus respuestas al cuestionario y datos de identificación personales se almacenarán en un lugar seguro y se protegerán con una contraseña. No compartiremos su información con nadie. Datos de identificación personales se quitarán de las respuestas para que sea imposible identificar a personas individuales.

Compensación
Si acepta participar, usted recibirá $5 después de completar el cuestionario.

Participación
Su participación en este estudio es completamente voluntaria. Usted tiene la derecha de retirar en cualquier momento su consentimiento o rehusar participar sin arriesgando su acceso a tratamiento.

Preguntas sobre el estudio
Antes, durante, o después de su participación, usted puede contactar a la investigadora Corinne Ruth al (801) 422-7759 o enviar un correo electrónico al corinne_ruth@byu.edu con cualquier pregunta.

Preguntas sobre sus derechos como participante
Si usted tiene alguna pregunta acerca de sus derechos puede contactar el administrador de la Junta de Revisión Institucional al (801) 422-1461; A-285 ASB, Brigham Young University, Provo, UT 84602; irb@byu.edu

Declaración del consentimiento
He leído, comprendido, y recibido una copia de esta forma y acepto participar voluntariamente.

Nombre (en letra de imprenta): __________________ Firma: __________________ Fecha: ___________
Appendix H
English and Spanish Versions of Psychometric Sample Youth Assent

Assent to participate in a research study - English

What is the study about?
We are Ms. Corinne Ruth and Dr. Jared Warren and we work with Brigham Young University. We are studying young people and their families. We are asking you to participate in our study because we want to learn more about things that help young people in therapy.

What am I going to do?
If you agree to participate in this study:
• You will answer some questions about your relationships with your friends and family members, your emotions, and your studies at school.
• In a week, you may receive an email invitation to answer the questions again.

What are the benefits for me? Are there any risks?
You will not receive any direct benefit from your participation in this study. However, the results of this study will improve the quality of therapy for Hispanics youth. There are not many risks from participating in this study. Some people may feel bored, uncomfortable, or nervous about the questions. You do not have to answer any of the questions that you do not want to answer. If the questionnaire makes you feel upset, you can talk with a friend or family member for support. If you need additional support, you can call the national crisis hotline at 1-800-273-8255.

Who will know that I am participating in the study?
We are not going to inform anyone that you are in the study and all your answers to the questions are private. Your answers will be stored in a safe place and will be protected with a password. Your parents may know that you are participating, but we are not going to tell them your answers.

Will I receive money from participating?
You and your parents will receive compensation in line with your original compensation agreement.

Do I have to participate?
You do not have to be in this study if you do not want to. No one will be angry if you do not participate. You can stop your participation in this study at any time. Remember, being in this study is your decision.

Who can I contact if I have questions?
You can ask all the questions you want about the study. If you have questions about the study, you can ask your parents or us. To contact us, you can call Corinne Ruth at (801) 422-7759 or send an email to corinne_ruth@byu.edu.

Yes, I agree to participate in this research study.

Name (printed): _________________________ Signature: _________________________
Date: _____________________
Acuerdo para participar en un estudio de investigación - Español

¿De qué trata el estudio?
Somos Sra. Corinne Ruth y Dr. Jared Warren y trabajamos en Brigham Young University. Estamos estudiando los jóvenes y sus familias. Te estamos pidiendo que participes en nuestro estudio porque queremos aprender más sobre cosas que ayudan los jóvenes en la terapia.

¿Qué voy a hacer?
Si aceptas participar en este estudio:
• Vas a responder a algunas preguntas sobre tus relaciones con tus amigos y miembros de tu familia, tus emociones, y tus estudios en la escuela.
• En una semana, puedes recibir una invitación por correo electrónico para responder a las preguntas otra vez.

¿Qué son los beneficios para mi? ¿Hay riesgos?
No vas a recibir ningún beneficio directo por su participación en este estudio. Sin embargo, los resultados de este estudio van a mejorar la calidad de la terapia para los jóvenes hispanos. No hay muchos riesgos de participar en este estudio. Algunas personas pueden sentirse aburridas, incómodas, o nerviosas por las preguntas. No tienes que responder a ninguna de las preguntas que no desees responder. Si el cuestionario te molesta, puedes hablar con un familiar o amigo. Si necesitas más ayuda, puedes contactar el número de crisis nacional al 1-800-273-8255.

¿Quién va a saber que estoy participando en el estudio?
No vamos a informar a nadie que estás en el estudio y todas tus respuestas a las preguntas son privadas. Tus respuestas se almacenarán en un lugar seguro y se protegerán con una contraseña. Tu padre quizás va a saber que estás participando, pero no vamos a decir tus respuestas a él o ella.

¿Voy a recibir dinero para participar?
Si aceptas participar, usted recibirá una compensación en consonancia con tu acuerdo original.

¿Tengo que participar?
No tienes que estar en este estudio si no deseas hacerlo. Nadie se enojará si no participas. Puedes detener tu participación en este estudio en cualquier momento. Recuerda, estar en este estudio es tu decisión.

¿Quién puedo contactar si tengo preguntas?
Puedes hacer todas las preguntas que quieras sobre el estudio. Si tienes preguntas sobre el estudio, puedes pedirlas a tus padres o a nosotros. Para contactarnos, puedes llamar a Corinne Ruth al (801) 422-7759 o enviar un correo electrónico al corinne_ruth@byu.edu.

Sí, acepto participar en este estudio de investigación.

Nombre (en letra de imprenta): ____________________  Firma: _________________________
Fecha: __________________
Appendix I
English and Spanish Versions of Psychometric Sample Adult Consent

Consent to participate in a research study - English

Introduction
This study is led by Corinne Ruth, M.S. and Jared Warren, Ph.D. from Brigham Young University. The goal of the study is to create a new questionnaire in Spanish that helps us understand more about parents, children, and their relationships. The questionnaire will be used to help counselors and therapists better understand how to help Spanish-speaking youth and families. You are asked to participate in the study because you are a Spanish-speaking parent of a child who is between the ages of 4 and 17.

Procedures
If you agree to participate in this study, you will fill out a brief questionnaire about your family and your relationships, your role as a parent, and your work. The questionnaire usually takes five to ten minutes to complete. In one week, you may receive an invitation to complete the questionnaire again.

Risks
Some people may experience discomfort about answering the questions. If you do not wish to answer a question, you may leave it blank. If the questionnaire makes you feel upset, you can talk with a friend or family member for support. If you need additional support, you can contact the national crisis hotline at 1-800-273-8255.

Benefits
You will not receive any direct benefit for your participation in this study. Nevertheless, the results of this study will improve the quality of mental health care for Hispanic youth.

Confidentiality
Your answers to the questionnaire will be stored in a secure place and will be protected with a password. We will not share your information with anyone. Identifying data will be removed from the answers to make it impossible to identify individual people.

Compensation
If you complete the questionnaire you will receive compensation in line with your original compensation agreement.

Participation
Your participation in this study is completely voluntary. You have the right to withdraw your consent at any time or refuse to participate.

Questions about the study
Before, during, or after your participation, you can contact the researcher Corinne Ruth at (801) 422-7759 or send an email to corinne_ruth@byu.edu with any questions.

Questions about your rights as a participant
If you have any questions about your rights you can contact the administrator of the Institutional Review Board at (801) 422-1461; A-285 ASB, Brigham Young University, Provo, UT 84602; irb@byu.edu.

Declaration of consent
I have read, understood, and received a copy of this form and I agree to participate voluntarily.

Name (in print): __________________ Signature: __________________ Date: __________________
Introducción
Este estudio es dirigido por Corinne Ruth, M.S. y Jared Warren, Ph.D. de Brigham Young Universidad. La meta del estudio es crear un cuestionario nuevo en español sobre padres, hijos, y sus relaciones. El cuestionario se utilizará para ayudar los consejeros y terapeutas a comprender cómo ayudar a los jóvenes y familias hispanohablantes. Se le pide a usted que participe en el estudio porque es el padre o madre de un hijo que tiene entre 12 y 17 años.

Procedimiento
Si accede a participar en este estudio, usted completará un cuestionario breve sobre su familia y sus relaciones, su rol como padre, y su trabajo. El cuestionario usualmente tarda cinco a diez minutos en completar. En una semana, usted puede recibir una invitación por correo electrónico para completar el cuestionario otra vez.

Riesgos
Algunas personas pueden sentirse incómodas para responder a las preguntas. Si usted no quiere responder a una pregunta, puede omitirla. Si el cuestionario le molesta, usted puede hablar con un familiar o amigo. Si necesita más ayuda, puede contactar el número de crisis nacional al 1-800-273-8255.

Beneficios
Usted no recibirá ningún beneficio directo por su participación en este estudio. Sin embargo, los resultados de este estudio van a mejorar la calidad de la terapia para los jóvenes hispanos.

Confidencialidad
Sus respuestas al cuestionario y datos de identificación personales se almacenarán en un lugar seguro y se protegerán con una contraseña. No compartiremos su información con nadie. Datos de identificación personales se quitarán de las respuestas para que sea imposible identificar a personas individuales.

Compensación
Si acepta participar, usted recibirá una compensación en consonancia con su acuerdo original.

Participación
Su participación en este estudio es completamente voluntaria. Usted tiene la derecha de retirar en cualquier momento su consentimiento o rehusar participar sin arriesgando su acceso a tratamiento.

Preguntas sobre el estudio
Antes, durante, o después de su participación, usted puede contactar a la investigadora Corinne Ruth al (801) 422-7759 o enviar un correo electrónico al corinne_ruth@byu.edu con cualquier pregunta.

Preguntas sobre sus derechos como participante
Si usted tiene alguna pregunta acerca de sus derechos puede contactar el administrador de la Junta de Revisión Institucional al (801) 422-1461; A-285 ASB, Brigham Young University, Provo, UT 84602; irb@byu.edu

Declaración del consentimiento
He leído, comprendido, y recibido una copia de esta forma y acepto participar voluntariamente.

Nombre (en letra de imprenta): ____________________  Firma: _________________Fecha: ______________
Appendix J
English and Spanish Versions of Psychometric Sample Parent Consent

Parent consent for child to participate in a research study - English

Introduction
This study is led by Corinne Ruth, M.S. and Jared Warren, Ph.D. from Brigham Young University. The goal of the study is to create a new questionnaire in Spanish about parents, children, and their relationships. The questionnaire will be used to help counselors and therapists better understand how to help Spanish-speaking youth and families. You child is asked to participate in this study because they are between the ages of 12 and 17.

Procedures
If you agree to allow your child to participate in this study, he or she will fill out a brief questionnaire about their relationships with their friends and family members, emotions, and studies at school. The questionnaire usually takes five to ten minutes to complete. In one week, you may receive an invitation for your child to complete the questionnaire again.

Risks
Some people may experience discomfort about answering the questions. If your child does not wish to answer a question, they may leave it blank. If the questionnaire makes them feel upset, they can talk with a friend or family member for support. If they need additional support, they can contact the national crisis hotline at 1-800-273-8255.

Benefits
Neither you nor your child will not receive any direct benefit for your participation in this study. Nevertheless, the results of this study will improve the quality of mental health care for Hispanic youth.

Confidentiality
Your child’s answers to the questionnaire will be stored in a secure place and will be protected with a password. We will not share their information with anyone. Identifying data will be removed from the answers to make it impossible to identify individual people.

Compensation
If you agree to participate, you and your child will receive compensation in line with your original compensation agreement.

Participation
You and your child’s participation in this study is completely voluntary. You have the right to withdraw your consent for your child to participate at any time.

Questions about the study
Before, during, or after your participation, you can contact the researcher Corinne Ruth at (801) 422-7759 or send an email to corinne_ruth@byu.edu with any questions.

Questions about your rights as a participant
If you have any questions about your rights you can contact the administrator of the Institutional Review Board at (801) 422-1461; A-285 ASB, Brigham Young University, Provo, UT 84602; irb@byu.edu.

Declaration of consent
I have read, understood, and received a copy of this form and I agree for my child to participate voluntarily.

Name (in print): ___________________________ Signature: ___________________________
Date: ___________________________
Introducción
Este estudio es dirigido por Corinne Ruth, M.S. y Jared Warren, Ph.D. de Brigham Young Universidad. La meta del estudio es crear un cuestionario nuevo en español sobre padres, hijos, y sus relaciones. El cuestionario se utilizará para ayudar los consejeros y terapeutas a comprender cómo ayudar a los jóvenes y familias hispanohablantes. Se le pide que su hijo participe en el estudio porque tiene entre 12 y 17 años.

Procedimiento
Si usted decide permitir que su hijo participe en el estudio, él o ella va a completar un cuestionario breve sobre sus relaciones con familiares y amigos, sus emociones, y sus estudios en la escuela. El cuestionario usualmente tarda cinco a diez minutos en completar. En una semana, usted puede recibir una invitación por correo electrónico para que su hijo complete el cuestionario otra vez.

Riesgos
Algunas personas pueden sentirse incómodas para responder a las preguntas. Si su hijo no quiere responder a una pregunta, puede omitirla. Si el cuestionario le molesta, su hijo puede hablar con un familiar o amigo. Si él o ella necesita más ayuda, puede contactar el número de crisis nacional al 1-800-273-8255.

Beneficios
Ni usted ni su hijo no recibirán ningún beneficio directo por su participación en este estudio. Sin embargo, los resultados de este estudio van a mejorar la calidad de la terapia para los jóvenes hispanos.

Confidencialidad
Las respuestas de su hijo al cuestionario y datos de identificación personales se almacenarán en un lugar seguro y se protegerán con una contraseña. No compartiríamos su información con nadie. Datos de identificación personales se quitarán de las respuestas para que sea imposible identificar a personas individuales.

Compensación
Si acepta participar, usted y su hijo recibirán una compensación en consonancia con su acuerdo original.

Participación
Su participación y la participación de su hijo en este estudio es completamente voluntaria. Usted tiene la derecha de retirar en cualquier momento su consentimiento para que su hijo participe.

Preguntas sobre el estudio
Antes, durante, o después de su participación, usted puede contactar a la investigadora Corinne Ruth al (801) 422-7759 o enviar un correo electrónico al corinne_ruth@byu.edu con cualquier pregunta.

Preguntas sobre sus derechos como participante
Si usted tiene alguna pregunta acerca de sus derechos puede contactar al administrador de la Junta de Revisión Institucional al (801) 422-1461; A-285 ASB, Brigham Young University, Provo, UT 84602; irb@byu.edu

Declaración del consentimiento
He leído, comprendido, y recibido una copia de esta forma y acepto que mi hijo participe voluntariamente.

Nombre (en letra de imprenta): ______________________  Firma: __________________________
Fecha: _________________