The Influence of Parent Gender and Child Age on the Acceptability of Treatments for Child Anxiety

by

Bradley D. Zacharias

A Thesis Submitted to the Faculty of Graduate Studies of

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Abstract

Treatment acceptability refers to judgments individuals make about the appropriateness, fairness, and suitability of a treatment. Studies focusing on perceptions of treatments for childhood internalizing problems (e.g., anxiety) are quite rare relative to studies of externalizing problems (e.g., aggression). Even rarer are treatment acceptability studies that have compared mothers' versus fathers' attitudes toward interventions for internalizing problems such as child anxiety. This study examined the influence of parent gender and child age on parents' ratings of acceptability of parent-focused psychosocial, child-focused psychosocial, and medication treatments for child anxiety. A community sample of 44 mothers and 28 fathers from 2-parent homes read vignettes describing either a 6- and a 13-year-old boy or a 6- and a 13-year-old girl exhibiting symptoms of anxiety and then rated the acceptability of each of the three interventions. Both child- and parent-focused psychosocial treatments were rated as significantly more acceptable than medication treatment across both child age and parent gender. Parent-focused psychosocial interventions were rated more positively than child-focused psychosocial interventions for younger children. Medication was rated as more acceptable for older children compared with younger children. These findings indicate that, although child age plays some role in parents' judgments of the above treatments, overall, both parent- and child-focused psychosocial treatments are perceived much more positively than medications. The implications of these findings in terms of understanding treatment adherence and efficacy are discussed.

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The Influence of Parent Gender and Child Age on the Acceptability of Treatments for Child Anxiety

A growing body of literature has examined the influences of parental cognitions on parenting behavior and children's socio-emotional outcomes. However, an imbalance favoring maternal over paternal representation has characterized this literature, especially when the research has focused on negative childhood outcomes. Despite evidence that fathers do indeed play a role in the optimal (Biller, 1993) and suboptimal development of children (Phares, 1996), the parenting literature focuses largely on mothers (Phares, 1996). The lack of focus on fathers when researching suboptimal child development has needlessly limited our understanding of a number of factors that may influence the environment in which childhood problems develop, are maintained, and are treated. It has also led to a faulty perception that mothers are primarily responsibility for childhood problems and child psychopathology.

There currently exists a small but growing literature evincing both similarities and differences between mothers and fathers in terms of their attitudes, behaviors, and ultimately, their influence on their children's well being (e.g., Phares, Ehrbar, & Lum, 1996; Russell et al., 1998; Miller & Kelley, 1992). In terms of differences between mothers and fathers, Russell and colleagues (1998), utilizing mother and father self- and spouse-reports, found sex-based differences in parenting style (authoritative, authoritarian, and permissive styles) in a sample of Australian families. Specifically, mothers were consistently rated as more authoritative than fathers, while fathers were judged as more authoritarian than mothers (Russell et al., 1998). Another avenue of research investigating influences on child well being has also uncovered some similarities

and differences across mothers and fathers. This area of research is known as treatment acceptability.

Treatment acceptability (TA) is defined as the "judgments of lay persons, clients, and others of whether the procedures proposed for treatment are appropriate, fair, and reasonable for the problem or client" (Kazdin, French, & Sherick, 1981). TA is one of the components of a broader research literature known as social validity that seeks to establish the acceptance of a specific treatment by a particular community. The remaining components of social validity are: (1) the goals of the treatment must be desirable to the community; and (2) consumers need to be satisfied with treatment outcomes (Wolf, 1978). Of the three components comprising social validity, research on the acceptability of treatments has traditionally been the primary focus (Gresham & Lopez, 1996).

A prominent model of TA (Wit & Elliott, 1985) posits an interrelationship between a number of factors affecting one's ratings of the acceptability of a particular intervention. Initially, judgments about the appropriateness of a given treatment are made. This leads to the selection of a treatment. The combined influence of the first two factors lead to the next factor: the actual implementation of the chosen treatment and the adherence to the guidelines laid out in the particular treatment. Ultimately, the model proposes that the implementation and adherence have an important influence on the final component of the model: treatment efficacy, which feeds back into the initial stage of the model and influences attitudes toward the acceptability of a treatment.

Some research has established the existence of positive associations between treatment acceptability and treatment efficacy (Reimers, Wacker, Cooper, & DeRaad, 1992; VonBrock & Elliott, 1987), as well as the positive relations between treatment

acceptability, treatment effectiveness, and treatment implementation (Clark & Elliott, 1988; Boothe & Borrego Jr., 2004). However, other research has not replicated these positive associations (Sterling-Turner & Watson, 2002; Noell et al., 2005). Perhaps there are other factors, in addition to initial perceptions of treatment acceptability, which play a role in the implementation and ultimately the effectiveness of treatment. For example, Foster and Mash (1999) point out the potential influence of clinician communication of a treatment plan following a thorough assessment on a client's perception of treatment acceptability. Indeed, analog studies have shown that factors such as type of rationale for treatment (Cross-Calvert & McMahon, 1987) and whether treatment determination is perceived (i.e., by the client or clinician) to be collaborative versus unilateral (Kusick, Gutkin, & Wit, 1991) can influence the acceptability of a given treatment. It appears, then, that attitudes toward the acceptability of a particular treatment are not fixed and can be influenced by several factors including exposure to new information. The source of the new information may also influence the flexibility of consumers' initial attitudes toward a treatment. For example, it is likely that some clients' initial perceptions of the acceptability of a treatment change following an assessment and consultation with a knowledgeable and caring therapist. Hence, research in this area could measure consumers' ratings of treatment acceptability at multiple time points over the course of the initial assessment and consultation with a clinician to observe any changes following the commencement of treatment. Findings of a clearer association between consumers' ratings of treatment acceptability and treatment adherence and efficacy may result.

The importance of examining treatment acceptability is highlighted by findings that there is often a gap between consumers' and service providers' perceptions of

acceptability for various treatments. For example, Ritalin is one of the most tested and proven medications used in the treatment of attention deficit-hyperactivity disorder (ADHD) in children and adults. Yet, consumers' perceptions of the acceptability of Ritalin have been observed to be low (Liu, Robin, Brenner, & Eastman. 1991). Understanding consumers' perceptions of treatment acceptability is important because their attitudes toward treatments can affect their treatment-seeking behaviors, and ultimately, in somewhat of a supply-and-demand health care marketplace, may eventually influence the kinds of treatments that are made available. Health professionals could also use knowledge about the attitudes consumers' have toward treatments to devise community education programs to either correct faulty perceptions of treatments and/or provide more information about effective treatments. Finally, treatment acceptability research is simply one important aspect of social validity.

Fathers and Treatment Acceptability

Within the treatment acceptability (TA) literature, there are examples of the distinct quality of paternal attitudes compared with maternal attitudes (e.g., Miller and Kelley, 1992; Phares et al., 1996). It appears that, in some conditions, the opinions of fathers differ from those of mothers regarding what treatments are deemed appropriate for the problems of their children. This may be an important avenue of research because paternal attitudes may have an influence on treatment outcome that is unique to the influence of maternal attitudes (Phares, 1996). For instance, fathers' but not mothers' emotional overinvolvment with an adolescent child hospitalized with an eating disorder predicted significantly higher rates of premature dropout from the treatment program (Szmukler, Eisler, Russell, & Dare, 1985).

Another important reason to examine fathers' perceptions of treatments is that the knowledge gained could illuminate reasons for discrepant rates of involvement in therapy for child problems across male and female parents. Overall, the data suggest that mothers significantly more than fathers become involved in child and family therapy (Churven, 1978; Bagner & Eyberg, 2003; Phares, 1996; Duhig, Phares, & Birkeland, 2002). This pattern is comparable to differential rates of involvement found in individual psychological services. Women predominate admission to outpatient therapy clinics (Russo, 1990), and even with similar symptomatology, men are significantly less likely to seek therapy than women (Padesky & Hammen, 1981). The common assumption is that gender differences in therapy involvement are likely linked to sex-role socialization whereby females are socialized to talk about their problems and males are socialized not to disclose psychological concerns (Basow, 1992). Besides this, other researchers cite the lack of availability of weekday evening or weekend sessions for treatment as another reason fathers fail to involve themselves in therapy (Bagner & Eyberg, 2003). Besides this, little is known about why fathers attend therapy with their children at significantly lower rates than mothers. Perhaps there are other explanatory factors for the relative lack of father involvement in child and family therapy. One such factor may be the degree to which fathers' attitudes toward treatment differ from mothers' attitudes.

Current knowledge of mothers' attitudes toward treatments by far exceeds what is known about fathers' attitudes toward treatments. Uncovering and understanding unique paternal attitudes toward treatment acceptability may give clinicians the information needed to foster greater father involvement in their children's intervention in the future as well as reduce attrition rates for fathers who do get involved in treatment. Perhaps lack of

paternal involvement in therapy for their children is associated with less positive attitudes toward the intervention offered; conversely, higher rates of father involvement may be associated with more positive perceptions of the treatment. For instance, results from one study indicated that fathers' ratings of increased external behavioral contingencies (i.e., discipline) were significantly higher than mothers' ratings of the same intervention for both externalizing and internalizing child problems (Phares, Ehrbar, & Lum, 1996). Results such as these could inform clinicians of unique paternal attitudes toward certain types of treatments or components of intervention packages. Hence, if choosing from among a number of comparably effective treatments (including increased behavioral control), a clinician may be more inclined to include increased behavioral control as this may lead to greater paternal involvement and potentially better treatment outcomes. Alternatively, clinicians could simply emphasize the component of increased behavioral control when describing the intervention package to the parents. Overall, knowledge of paternal attitudes toward treatment acceptability can help clinicians develop treatment packages that are more highly acceptable, not only to mothers, but also to fathers (especially when the intervention involves parental participation).

The importance of paternal involvement in child therapy lies in its association with positive child outcomes following therapy. Results from several studies of behavioral parent training suggest that the participation of either mothers or fathers results in comparable treatment gains (e.g., Adesso & Lipson, 1988; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989; Nicol et al., 1988). For example, in one study that randomly assigned families to either mother-only parent training, father-only parent training, both mother and father parent training, or a no-treatment control group, no

significant differences emerged between the three treatment groups (Adesso & Lipson, 1988). That is, training of either or both parents was approximately equally effective in reducing a variety of child behavior problems. Additionally, all three treatment groups showed significantly greater decreases in child misbehavior than the no treatment control group. In a more recent study of therapy outcomes for an intervention focusing on parent-training to reduce pre-school children's behavioral problems (Bagner & Eyberg, 2003), results indicated that involvement of both mothers and fathers in treatment (i.e., Parent-Child Interaction Therapy) had no effect on treatment outcome (i.e., reducing child misbehavior) at post-treatment compared with mother-only involvement. However, involvement of both mothers and fathers in treatment had a positive effect on the maintenance of treatment gains at 4-month follow-up as compared with mother-only involvement. Given that an important goal of treatment is to produce positive post-treatment changes that persist or even increase over time, augmenting our knowledge of what may increase participation of both parents in treatments for their children seems an important line of research.

These studies illustrate at least two important factors relating father inclusion in treatment with positive child outcomes: (1) the inclusion of *either parent* (fathers or mothers) can result in therapeutic benefits for the treatment of child problems immediately post-treatment, and (2) the inclusion of *both parents* (fathers as well as mothers) in parent-focused interventions may provide the added benefit of increased maintenance of treatment gains over time as opposed to mother inclusion alone. Therefore, it appears that, in the study of attitudes and behaviors associated with parental

involvement in child and family therapy, an exclusive focus on mothers' attitudes is unwarranted.

Treatment Acceptability: Influential Factors

A number of factors have been proposed to influence treatment acceptability. These factors include characteristics of the intervention, characteristics of the rater, and characteristics of the intervention target. The following will briefly examine each with a focus on unique paternal versus maternal aspects.

Characteristics of Treatment

Intervention characteristics such as how invasive and/or punitive a treatment is perceived to be can influence perceptions of treatment acceptability. A comprehensive review of research on treatment acceptability found that parents tended to rate noninvasive and nonpunitive strategies (e.g., positive reinforcement) as acceptable; but rate punitive techniques (e.g., corporal punishment) as unacceptable (Cross-Calvert & Johnston, 1990). Whether or not information about treatment efficacy is available, and whether or not the available information is positive or negative can also influence perceptions of treatment acceptability. For example, university students' treatment acceptability ratings of school-based interventions for disruptive problems were higher when information about treatment efficacy was provided versus when it was not. Ratings of treatment acceptability were found to be slightly lower when no information regarding treatment efficacy was provided (Tingstrom, McPhail, & Bolton, 1989).

With regard to maternal versus paternal differences in attitudes toward particular features of intervention characteristics, Bennum (1989) found that fathers' but not mothers' perceptions of a competent and directive therapist were positively associated

with treatment outcome. Another study found that fathers responded more positively to therapy than mothers when the therapist provided structuring behaviors (e.g., task-oriented and implicitly controlling behaviors) during therapy sessions (Newberry, Alexander, & Turner, 1991).

Characteristics of Raters

Treatment acceptability has also been seen to vary according to rater characteristics. Cultural background, gender, and parent status are some of the variables that have been found to be of influence. In terms of cultural background, one study utilized a sample of future teachers who had graduated from either urban or rural high schools. The participants were asked to judge the acceptability of two common treatments (special education placement and Ritalin) for children labeled as having ADHD. Interestingly, those who had graduated from a rural high school judged the interventions as more acceptable than participants from urban high schools (Stinnett, Crawford, Gillespie, Cruce, & Langford, 2001). An attempt by the authors to explain these results note that rural participants may likely have internalized a more restricted range of socially acceptable behaviors and may have had less exposure to students who deviate from that range. This may have made rural participants more accepting of the treatment. Urban participants, however, having been exposed to more individuals, more diversity, and a wider range of behavioral functioning, may be more tolerant of a wider range of behaviors and thus less interested in and accepting of treatments for the presented problems (Stinnett et al., 2001).

Parent status has also been found to influence perceptions of the acceptability of treatments. Specifically, research focusing on women's perceptions of the acceptability

and effectiveness of treatments for the self-injurious behavior of children found that mothers rated an intrusive intervention (i.e., shock) as less acceptable than women who did not have children (Pickering, Morgan, Houts, & Rodrigue, 1988). Hence, this study reveals that parents may be more sensitive to aversive procedures in treatments for child problems than nonparents. Pickering et al. (1988) note that this may be due to parents' increased personal investment in the presented treatments (as they have their own children) and therefore greater sensitivity to aversive components that may be perceived as inhumane and/or subject to abuse (Pickering et al., 1988).

Parent gender has also been found to impact treatment acceptability. Specifically, when asked to provide TA ratings for a vignette describing an 8-year-old boy exhibiting behavioral problems, fathers rated the use of external behavioral control (including corporal punishment) more favorably than mothers, whereas mothers' ratings of positive reinforcement, response cost, and room time-out were higher than fathers' ratings (Miller & Kelley, 1992). These findings reiterate the importance of including fathers in research on attitudes toward treatment. A greater understanding of the unique attitudes of fathers regarding treatment acceptability for their children may help service providers in structuring therapy for children (especially when fathers are directly involved with the intervention). Perhaps, this would increase initial and ongoing perceptions of treatment acceptability for the intervention and may result in lower attrition rates and increased treatment efficacy in the longer term.

Characteristics of the Target of the Intervention

The target of the intervention (i.e., the behavioral problem[s] of the child) has also been seen to affect treatment acceptability. Ratings vary, for example, based on the

severity of the target problem. If the problem behavior is perceived to be quite severe, TA ratings have generally been demonstrated to increase (e.g., Von Brock & Elliott, 1987, Kazdin, 1980a; Witt, Martens et al., 1984; Witt, Moe et al., 1984; Reimers et al., 1991). One study utilized an undergraduate sample and evaluated the influence of severity of the target problem (i.e., disruptive child behavior) on TA ratings of positive reinforcement, time-out, medication and shock treatment. Findings revealed that positive reinforcement was rated highest (followed by time-out, medications, and shock treatment) across all levels of severity. However, ratings of TA for all the treatments examined increased with problem severity (Kazdin, 1980b).

The acceptance of treatments has also been found to vary based on whether the problem behavior is externalizing or internalizing in nature. For instance, Kalfus and Razzano (1992) found that mothers rated behavioral interventions as more acceptable for treating child aggression than for child withdrawal. In another study, mothers and fathers rated increased behavioral contingencies as more acceptable for an externalizing behavior problem (i.e., oppositional defiant disorder) compared to an internalizing behavior problem (i.e., depression); however, parents' TA ratings were significantly higher for medication, individual therapy, and family therapy when considering depression versus oppositional defiant disorder (Phares, Ehrbar, & Lum, 1996).

The influence of child age. Research on the influence of child age has yielded mixed results. Some studies have demonstrated that child age does influence the levels of acceptability for treatment strategies (e.g., Phares et al., 1996); however, others have not (e.g., Tingstrom et al., 1989; Elliot & Fuqua, 2002). Given the inconsistency of findings,

it is apparent that the influence of child age on perceptions of treatment acceptability warrants further examination.

Norton and colleagues (1983) investigated the impact of both child gender and child age on parents' and teachers' TA ratings of five behavioral interventions (contingent observation, reinforcement, isolation, isolation with contractual agreement, and attention-withdrawal accompanied by isolation) targeting disruptive child behavior. Participants evaluated case vignettes only varying in child age (5 years vs. 10 years) and gender (female vs. male). Child age was seen to influence ratings of effectiveness; however, it was not seen to influence ratings of acceptability. Specifically, participants rated reinforcement as more effective for older children, while rating the remaining treatments as more effective for younger children. In terms of treatment acceptability ratings, there were no significant differences across either age or gender. However, the investigators used a single-item scale to rate treatment acceptability, which may not have been adequately sensitive. Additionally, the focus on behavioral interventions (to the exclusion of alternatives such as medications) may have resulted in a restricted range of TA ratings (Norton et al., 1983).

Another study examined the impact of child age on TA ratings of a number of school-based, behavioral treatments (time out, corporal punishment, differential reinforcement of incompatible responses, and parental classroom presence; Tingstrom et al., 1989). Three hundred and two university undergraduates were presented with a case description of either an 8 or 13 year old boy exhibiting disruptive behaviors followed by descriptions of several interventions, each of which were rated using the Treatment Evaluation Inventory (TEI; Kazdin, 1980a). No associations between the age of the child

and TA ratings were found. However, the failure to find age effects may have been a result of the ages examined (8 and 13 years old). These two ages may be too similar. Perhaps descriptions of children reflecting a larger age-range may have resulted in differences in participants' TA ratings. In fact, a study using vignettes of children across a wider age range did find mean differences in TA ratings based on child age (Phares, Ehrbar, & Lum, 1996).

Utilizing a sample of 200 parents, Phares and colleagues (1996) found evidence supporting the influence of child age on perceptions of treatment acceptability. In particular, parents' TA ratings of increased behavioral contingencies were higher for younger children (i.e., 6 year-olds) than older children (i.e., 15-yer-olds; Phares, Ehrbar, & Lum, 1996). When comparing results from Phares et al. (1996) to Tingstrom et al. (1989), a significant difference in child age range in the vignettes is readily observable (i.e., 6-15 years of age and 8-13 years of age, respectively). This may explain why the former and not the latter obtained results consistent with the child-age hypothesis. Drawing from the developmental literature and its findings that children develop the ability for abstract thought over time may help elucidate this phenomenon.

The ability of a person to engage in and fully benefit from certain kinds of therapy (e.g., cognitively or verbally mediated interventions such as cognitive-behavioral therapy [CBT] versus more behaviorally focused interventions, working directly with children versus those that focus on working with parents) hinge somewhat on how able the client is to perform abstract mental operations. A focus on concrete thinking may limit a client's ability to engage in cognitive restructuring and other aspects of CBT. Given that the ability to think abstractly develops over time, it stands to reason that certain

treatments will be more appropriate for some clients than others, based on their level of cognitive development. This phenomenon can be seen in the quality of a child's self-understanding/self-conception.

Santrock (2000) defines self-understanding as, "a child's cognitive representation of the self, the substance and content of the child's self-conceptions" (Santrock, 2000). During early childhood (approximately 18 months of age through 5-6 years of age), children often conceive of themselves in external, physical terms (Santrock, 2000). During middle to late childhood (approximately 6-11 years of age), however, children develop a more internal, psychological as well as social orientation in their self-understanding. Adolescence (approximately 11-22 years of age) is usually characterized by further development of this ability to use internal, psychological, abstract, as well as social information when defining oneself (Santrock, 2000). It appears that the period of middle to late childhood and the period of adolescence shares a common characteristic: the ability to use internal, psychological, abstract and social information for self-understanding (albeit with adolescence representing more sophistication). Early childhood, however, is distinguished from the other developmental intervals in that the child lacks this ability. It is likely that these cognitive differences in children across developmental periods are apparent to most adult raters (parents and nonparents) and that these evaluations of a child's cognitive ability influence raters' perceptions of age-appropriate types of treatments. Given that, it is plausible that adult raters may be more likely to perceive treatments differently when considering children who are in the early childhood years versus adolescence (i.e., Phares et al., 1996) rather than when comparing children at middle-to-late childhood to adolescence (i.e., Tingstrom et al., 1989). Also,

child age may be more likely to influence TA ratings when raters evaluate specific forms of treatment such as treatments involving a therapist directly working with the child (child-focused) versus treatments that work to change child behavior by working directly with parents rather than the child (parent-focused).

In a recent study of perceptions of parent versus child focused treatment for child anxiety, Mak and Freeman (2006) found that child age did impact TA ratings. Four hundred and sixteen undergraduate students read case descriptions of either an anxious 6- and 13-year-old male or 6- and 13-year-old female and then provided TA ratings for a child-focused psychosocial intervention, a parent-focused psychosocial intervention, and medication treatment. Treatment acceptability was measured using the Treatment Evaluation Inventory (TEI; Kazdin, 1980a). Results showed that parent-focused treatments were rated as more acceptable for younger children than older children, and child-focused treatments received higher TA ratings for older children versus younger children (Mak & Freeman, 2006).

Results of a treatment outcome study may lend support for the influence of child age on treatment acceptability ratings. Barrett and colleagues (1996) conducted a randomized controlled trial comparing the efficacy of CBT versus CBT plus family anxiety management (CBT + FAM) for child anxiety interventions. In terms of younger children (i.e., 7-10 year-olds), results indicated that a greater percentage of participants in the CBT + FAM condition (100%) no longer met diagnostic criteria at posttreatment than participants in the child-focused CBT condition (55.6%). Results for older children (i.e., 11-14 year-olds), however, produced no significant differences across treatment conditions (Barrett, Dadds, & Rapee, 1996). The above results suggest a link between the

enhancement of parenting skills and treatment efficacy for interventions targeting anxiety in younger children. Additionally, the findings indicate that adding a family component to otherwise individually-focused psychosocial interventions for child anxiety may result in higher TA ratings for younger compared with older children.

Efforts to explain findings of greater treatment gains for family-based therapy for younger children commonly cite the tendency of adults to hold parents more responsible for the behaviors of younger children (Phares et al., 1996). The underlying logic for such attitudes hinges on the developmental nature of children's limited cognitive, emotional, and social capacities, behooving parents to provide close monitoring and supervision of their children's behaviors. In the context of therapy, these limitations reduce the child's ability to comprehend psychoeducational material, identify and understand emotional states, and to engage in abstract thought, thereby indicating parental involvement in treatment (Piacentini & Bergman, 2001). Throughout adolescence however, the cognitive, emotional, and social gains result in the allocation of greater responsibility to adolescent clients compared to younger children (Barrett, 2000; Piacentini & Bergman, 2001). Further evidence has been generated by studies examining parent attributions for younger versus older children. For example, numerous studies have found that mothers make greater internal attributions (disposition and intentionality) for the misbehaviors of older versus younger children (Dix, Ruble, Grusec, & Nixon, 1986; Gretarsson & Gelfand, 1988).

Treatment Acceptability for Internalizing Problems

Much of the treatment acceptability research has focused on externalizing behavioral problems that tend to focus on disruptive social behaviors (e.g., Kazdin,

1980a, 1984; Kazdin et al., 1981; Norton et al., 1983; Reimers et al., 1991), while internalizing problems have received significantly less research attention (Chavira, Stein, Bailey, & Stein, 2003; Phares, Ehrbar, & Lum, 1996). Yet, there are numerous deleterious effects of internalizing problems on children. For example, the occurrence of difficulties related to anxiety in childhood is associated with higher rates of anxiety disorders, affective disorders and substance abuse in late adolescence and early adulthood (e.g., Pine et al., 1998; Regier et al., 1998; Schatzberg et al., 1998). Additionally, Coplan, Barber, and Lagace-Seguin (1999) conducted a study of the associations between temperament (including negative emotionality) and later academic achievement in preschool children. Specifically, they found a relation between child temperament and the development of literacy and numeric skills. Further, the association held even after controlling for parent education and receptive vocabulary. A relation between social anxiety and a failure to complete high school has been found for females. For both males and females, the disorder is associated with the failure to enter and complete college (Kessler, Foster, Saunders, & Stang, 1995). In many instances, with less education, there come a number of life difficulties. Overall, reduced educational success can seriously limit life satisfaction, as education is now considered the most influential factor in the increase of one's socio-economic status and maintenance of health and well being (Kessler et al., 1995). Hence, a greater understanding of treatment acceptability for internalizing problems like child anxiety is certainly warranted.

Miller and colleagues (2002) examined school psychologists' perceptions of the acceptability and efficacy of three school-based psychosocial treatments for child depression (Miller, DuPaul, & Lutz, 2002). Participants read a case vignette depicting a

group of three students from the fifth grade (two females and one male) exhibiting depressive symptoms, and then rated one of three interventions (cognitive restructuring, social skills training, or self-control therapy) using the Behavior Intervention Rating Scale (BIRS; VonBrock & Elliott, 1987). Although TA ratings for self-control therapy and cognitive restructuring did not differ significantly, both were rated as more acceptable than social skills training (Miller et al., 2002). While childhood depression has been the focus of several treatment acceptability studies, little research has examined perceptions of treatments for child anxiety disorders. Yet, anxiety problems are the primary reason for referral of children and adolescents for mental health services (Beidel, 1991) and there have been significant advances in the treatment of child anxiety in both school-aged (e.g., Kendall et al., 1997) and younger children (e.g., Rapee, Kennedy, Ingram, Edwards, & Sweeney, 2005).

One study has examined the acceptability of home tutoring with psychotherapy, behavioral management, hospitalization, and drug therapy for anxiety-based school refusal in children (Gullone & King, 1991). Participants were 376 parents, teachers, secondary school students, and nurses, each of whom read a vignette describing a 6-year-old female experiencing substantial anxiety regarding attending school. Behavioral management was rated as most acceptable and effective, with home tutoring with psychotherapy, hospitalization, and drug therapy rated as second, third, and fourth, respectively, in terms of acceptability ratings and effectiveness. Rater influences on TA ratings were also found: home tutoring with psychotherapy, hospitalization, and drug therapy were all rated higher by students than by both professionals and parents. Moreover, rater gender was associated with TA ratings. Male respondents rated

medication and hospitalization more positively than females, whereas females rated behavioral management and home tutoring with psychotherapy more positively than males (Gullone & King, 1991). To date, only two published studies have investigated consumers' perceptions of treatment for child anxiety disorders. Barrett, Shortt, & Wescombe (2001) evaluated perceptions of treatment among parents and their children enrolled in the "FRIENDS" program. The FRIENDS program embodies both parent-focused and child-focused components in group based CBT for children and adolescents with anxiety disorders and their parents (Barrett, Lowry-Webseter, & Turner, 2000). Both parents and children provided high global satisfaction ratings for the program and the majority of participants reported they would recommend the program to others (Barrett et al., 2001). However, the parent-focused and child-focused components were not evaluated separately. Others have recently examined parental perceptions of treatment acceptability for child social anxiety (Chavira, Stein, Bailey, & Stein, 2003). One hundred and ninety parents, randomly selected from a pediatric primary care mailing list, provided data in terms of TA ratings for medications, counseling acceptability, and counseling feasibility. Parents provided higher endorsements for counseling acceptability and counseling feasibility than for medication. As this study does not describe the sample of parents in terms of gender, the existence of any differences across paternal and maternal attitudes toward treatment could not be examined. Based on past research, there is good reason to believe that some differences across parent gender may have been found (e.g., Miller & Kelley, 1992, etc.).

Mak and Freeman (2006), focusing on a sample of 416 university students enrolled in an introductory psychology class, studied treatment acceptability for three

types of interventions targeting child anxiety. Participants were randomly assigned to read two case vignettes depicting either an anxious 6- and 13-year-old boy or an anxious 6- and 13-year-old girl. Each vignette was followed by descriptions of child-focused psychosocial treatment, parent-focused psychosocial treatment, and medication treatment. Both parent-focused and child-focused psychosocial interventions were rated as more acceptable than medication. With regard to child age, parent-focused treatment was rated as more acceptable than child-focused treatment for younger children and child-focused treatment was rated as more acceptable than parent-focused treatment for older children. Contrary to findings of gender differences in parental attitudes toward treatments found in some other studies (e.g., Miller & Kelley, 1992; Phares, Ehbar, & Lum, 1996), the male and female undergraduate students in this sample did not differ in terms of TA ratings for three interventions. As has been seen in previous research (Pickering, Morgan, Houts, & Rodrigue, 1988), however, parent status may have been an influential factor in this study as well. In fact, only a small portion of Mak and Freeman's (2006) sample (7.7%) was parents. Perhaps rater gender differences in TA ratings would have emerged in a sample of adults who have experience raising their own children.

Fathers' Versus Mothers' Perceptions of Treatment Acceptability

Given that research has at times found gender-based differences in terms of parenting attitudes that in turn can influence a child's well-being, it stands to reason that continued efforts would be made to uncover and examine unique maternal versus paternal attitudes where they exist. However, few studies in the treatment acceptability literature have collected data from both mothers and fathers or when data from both parents is available, compared the responses of mothers versus fathers. In a review of 36 articles

focusing on parents and their attitudes toward the acceptability of treatments (studies listed in Appendix A), only 10 included fathers in their sample. Of these 10 studies, 4 included separate analyses of fathers and mothers (Miller & Kelley, 1992; Phares, Ehrbar, & Lum, 1996; Bennett, Power, & Rostain, 1996; and Rostain, Power, & Atkins, 1993). Of the four studies conducting separate analyses, three compared TA ratings across mothers and fathers. (Rostain et al., [1993] did not examine mean ratings, but examined the factor structure of an attitude toward treatment questionnaire in a sample of mothers versus fathers). Each of the other three studies found significant mother versus father differences in TA ratings for child interventions. This confirms general findings that fathers have at times been found to have attitudes that are unique to mothers in terms of parenting their children (Phares, 1996).

In one of the above studies (Miller & Kelley, 1992), 69 mother-father pairs (n = 138) provided TA ratings of six treatments in response to a vignette of an 8-year-old boy exhibiting noncompliant behavior toward parents and aggressive behavior toward a younger sister. Fathers and mothers rated positive interventions (e.g., positive reinforcement) as more acceptable than punitive and intrusive treatment procedures (e.g., spanking). However, fathers in this study rated external behavioral control (including spanking and medications) as significantly more acceptable than mothers. Also, mothers rated positive reinforcement, response cost, and room time-out, as more acceptable than fathers did (Miller & Kelley, 1992).

Phares and colleagues (1996) also examined parent gender-based differences in TA ratings (Phares, Ehrbar, & Lum, 1996). One-hundred-fifty mothers and 43 fathers provided TA ratings in response to vignettes of either a boy or a girl, either aged six- or

fifteen-years, and either exhibiting externalizing or internalizing problems. Findings once again uncovered parent gender-based discrepancies. In particular, mothers' TA ratings were higher than fathers' TA ratings for individual child therapy and family therapy across vignettes. In addition, fathers' TA ratings were significantly higher than mothers' for increased behavioral contingencies (e.g., more discipline). Finally, although both fathers' and mothers' ratings of the severity of the problems depicted in the vignettes were high (above 6 on a 7-point scale), the severity ratings of mothers were significantly higher than fathers.

Bennett, Power, and Rostain's (1996) naturalistic examination of the relation between parents' stated willingness to pursue treatment and their actual treatment adherence also yielded findings of differential TA ratings across mothers and fathers. Specifically, surveys of parents of children who were assessed for Attention Deficit-Hyperactivity Disorder (ADHD) showed that mothers' TA ratings for counseling acceptability were significantly higher than fathers' TA ratings for counseling acceptability (Bennett, Power, & Rostain, 1996).

Although significant differences have been found between mothers' and fathers' TA ratings across various treatments, rank ordering of treatments by fathers and mothers is very similar. For example, even though Phares et al. (1996) found that mothers' TA ratings were higher than fathers' TA ratings for individual child therapy and family therapy, and that fathers' TA ratings were significantly higher than mothers' for increased behavioral contingencies (e.g., more discipline), rank order of the means of TA ratings of treatments across mothers and fathers were identical. Miller and Kelley (1992), as well as Bennett et al. (1996), though finding gender-based differences in parental TA

ratings, produced the same rank order results across parent gender. What this implies is that there may be no qualitative difference between fathers and mothers in terms of attitudes toward treatments for children. Therefore, as parents are expected to exhibit similar rank ordering of treatments, predicted differences in this study pertain only to mean ratings across parent gender for certain treatments.

Overall, the above studies illustrate similarities and differences between mothers and fathers in terms of attitudes toward treatments for children. This indicates that increased inclusion and analysis of data on fathers in treatment acceptability research can add important new information about parental attitudes that form a part of the developmental context of a potentially anxious child. Additionally, fathers, like mothers, also make decisions about treatments for their children. With the focus of treatment acceptability research on mothers to the exclusion of fathers, current perception of parental attitudes toward interventions for children may be incomplete and nonrepresentative.

Treatment acceptability research has utilized several methodologies: naturalistic (e.g., Kazdin, 2000), analogue (e.g., Boothe, 2004), and a combination of naturalistic and analogue (e.g., Reimers & Wacker, 1992). However, the most common means of conducting research in this area is to utilize the analogue methodology. This has entailed using audio (e.g., Kazdin, 1980) or written (e.g. Phares, Ehrbar, & Lum, 1996) case vignettes of children exhibiting problem behaviors along with descriptions of various treatments. Though there are proposed advantages to naturalistic methods (e.g., allow for greater external validity of true treatment acceptability ratings), the analogue method presents some advantages of its own. Case vignettes present standardized stimuli for

parents to evaluate as opposed to considering their own individual child's problems. Given high rates of comorbidity in children with anxiety problems and the range of symptom severity across children, analogue methods afford the advantage of greater control of what otherwise might have remained confounding variables in any particular study. Furthermore, analogue methods in treatment acceptability studies provide a more feasible way to examine previously understudied areas of research (such as internalizing disorders in children). Knowledge gained may aid researchers in determining whether or not similar inquiries utilizing naturalistic methods are justified.

Child Anxiety

Description, Prevalence, Gender, and Age of Onset

Anxiety has been defined as a state of mood characterized by strong negative affectivity along with physical symptoms of tension associated with the apprehensive anticipation of misfortune or danger (Barlow, 1988). According to community sample epidemiological studies, the most common psychiatric disorders among children are anxiety disorders with prevalence rates between 5.7% and 17.7% (Costello & Angold, 1995; Ollendick, Grills, & Alexander, 2001). Though there are numerous anxiety disorders, the most commonly occurring among children and adolescents are separation anxiety, overanxious disorder/generalized anxiety disorder, specific phobia, and social phobia. Obsessive-compulsive disorder and post-traumatic stress disorder are least common among children with an anxiety disorder (Last, Perrin, Hersen, & Kazdin, 1992; Costello & Angold, 1995).

Some research has revealed a greater prevalence of anxiety disorders among girls during childhood and adolescence than boys (Lewinsohn, Gotlib, Lewinshon, Seeley, &

Allen, 1998; Mackinaw-Koons & Vasey, 2000). By age 6, girls have reported symptoms of anxiety at twice the rates of boys' reports. This gender discrepancy appears to persist through childhood and adolescence (Mash & Wolfe, 2002). However, these findings should be considered with caution due to the possibility that girls may be more likely than boys to report symptoms of anxiety (Mash & Wolfe, 2002).

The age of onset of childhood anxiety disorders has been found to vary. For example, where findings of later ages of onset (i.e., from 11 to 14 years of age) are characteristic for social phobia and panic disorder in children, findings of earlier ages of onset (i.e., from 6 to 8 years of age) have been characteristic of research into separation anxiety disorder, specific phobia, and overanxious (or generalized anxiety) disorder in children (Last et al., 1992; Ost & Treffers, 2001). Although the age of onset has been observed later in childhood for some anxiety disorders, difficulties associated with excessive shyness, social anxiety, and social withdrawal may also appear in a persistent fashion earlier in children's lives and may precede the onset of an actual anxiety disorder.

Etiology of Child Anxiety

Due to its ostensibly multi-faceted etiology, past attempts by any one theoretical orientation, though demonstrating some explanatory power, have failed to fully account for the numerous forms of child anxiety, differential expression of the disorder across individual children, or the fluctuation of outcomes over time (Mash & Wolfe, 2002). Hence, new etiological models of child anxiety have begun to emerge that draw from diverse theoretical literatures, integrating the role of physiology and genetic predisposition (i.e., child temperament), as well as social contextual influences (e.g.,

parent-infant attachment; Chorpita & Barlow, 1998; Manassis & Bradley, 1994; Rubin & Mills, 1991).

Behavioral inhibition (BI) is a temperamental trait that often figures prominently in more contemporary etiological models of child anxiety. BI has been demonstrated to be an important risk factor for child anxiety and is defined as a withdrawal tendency where a child ceases play and vocalization and often retreats from or avoids social interactions with unfamiliar events and/or people (Kagen, Reznick, Clarke, Snidman, & Garcia-Coll, 1984). In terms of a risk factor, infants exhibiting BI have been found to be more shy, cautious, and socially inhibited at school age (Kagen, Reznick, & Snidman, 1987; Reznick et al., 1986). Moreover, Biederman and colleagues (1993; 1995) conducted longitudinal studies demonstrating that children characterized as behaviorally inhibited were more likely than non-inhibited children to develop multiple anxiety disorders, separation disorders, and avoidant disorder (Biederman et al., 1993; Biederman et al., 1995).

Research on child anxiety has found that the social context (including family factors) is implicated in how child anxiety is developed and maintained (Barrett, 2000; Rappee, 1997). One example of family factors is the type of behaviors parents emit in their home. Some common examples are overprotection, overcontrol, rejection/criticism, conflict, and modeling or direct reinforcement of anxious/avoidant behavior which have all demonstrated an association with child anxiety (Ginsburg & Schlossberg, 2002). Some recent research has found an association between parental cognitions (i.e., expectations) and the development and maintenance of child anxiety (Kortlander, Kendall, & Mindel-Panichelli, 1997). These findings of parental influence on children's

experience of anxiety have led researchers to the conclusion that interventions that focus on working directly with parents may be a useful way to reduce anxiety in children.

Common Interventions for Child Anxiety

Two basic categories make up current treatments for child anxiety: (1) psychosocial (e.g., cognitive-behavioral therapy) and (2) pharmacological (i.e., medication).

Pharmacological interventions. Studies have demonstrated the efficacy of some pharmacological interventions for treating child anxiety (e.g., Rynn, Siqueland, & Rickels, 2001; Birmaher, et al., 2003; Rupp Anxiety Group, 2001). Currently, the front line medications are the selective serotonin reuptake inhibitors (SSRIs; e.g., sertraline, fluvoxamine, paroxetine, and fluoxetine) due to the support generated in clinically controlled trials of treatments for child anxiety (Walkup, Labellarte, & Ginsburg, 2002). For example, one study examined the effects of fluvoxamine in the treatment of social phobia, separation anxiety disorder, or generalized anxiety disorder in children and adolescents. Results of the double blind, placebo-controlled study supported the drug's efficacy. Specifically, while only 29% of participants in the placebo condition showed clinical improvement, 76% of participants on fluvoxamine exhibited clinical improvement based on scores on the Clinical Global Impression scale (Rupp Anxiety Group, 2001). Similar positive results have been seen using fluoxetine and sertraline to treat separation anxiety disorder, generalized anxiety disorder, and social phobia in children (e.g., Birmaher et al., 1994; Rupp Anxiety Group, 2001). Even though research has generated some support for the use of medication treatments for child anxiety,

research evaluating psychosocial interventions have generally produced higher and more enduring rates of improvement (Barlow, Gorman, Shear, & Woods, 2000).

Psychosocial interventions. Historically, research on psychosocial treatments for child anxiety has primarily focused on individual, child-focused cognitive-behavioral therapy (CBT), as well as parent -child CBT (e.g., Mendlowitz, Manassis, Bradley, Scapillato, Meizitis, & Shaw, 1999). More recently, researchers in this area have begun to examine parent-only CBT prevention and early intervention programs for child anxiety (e.g., Rapee, Kennedy, Ingram, Edwards, & Sweeney, 2005).

Randomized controlled trials have demonstrated the efficacy of child-focused CBT to reduce anxiety in children. For example, Kendall et al. (1997) compared individual, child-focused CBT (ICBT; n = 60) compared with Waitlist (WL) control condition (n = 34). The sample consisted of children (ages 9-13) diagnosed with overanxious disorder, separation anxiety disorder, or avoidant disorder. Results indicated a time by condition interaction for most measures (i.e., parent-report, child-report, and behavioral observation measures of child anxiety), with greater improvement over time exhibited by children receiving ICBT. Also, at the time of the post-treatment assessment, 53% of children in the ICBT condition no longer met criteria for the primary anxiety disorder diagnosis for which they were referred for treatment, compared with only 6% of children in the control group. Improvements were still evident at 1-year follow-up. (Kendall et al., 1997). Other studies have found similar results for the utilization of child-focused CBT (e.g., Cobham, Dadds, & Spence, 1998; Kendall et al., 1994).

Over the past few years, parent-focused components of psychosocial treatments have received growing research and clinical attention (e.g., Barrett, 1998; Barrett, Dadds,

& Rapee, 1996; Cobham, Dadds, & Spence, 1998; Dadds, Spence, Holland, Barrett, & Laurens, 1997). For example, Barrett and colleagues (1996) randomly assigned families of anxious children to a child-focused CBT condition, child focused CBT plus family (FAM = Family Anxiety Management, which entails parent training in the management of their child's anxiety as well as their own anxiety), or a Waitlist (WL) control group. The sample consisted of 45 boys and 34 girls between the ages of 6 and 15 years who met DSM-III-R diagnostic criteria for overanxious disorder, social phobia, or separation anxiety disorder. While significantly more children in both treatment conditions were free of anxiety diagnosis at posttreatment compared with WL controls (70% versus 26%, respectively), a larger proportion of children in the CBT + FAM condition were diagnosis-free compared with children in the child-focused CBT condition (84% versus 57%, respectively). This pattern was maintained at 12-month follow-up, with 70% of children in the child-focused CBT- group diagnosis-free, compared with 96% of those in the child-focused CBT + FAM condition. Interestingly, younger children and girls responded more positively to CBT + FAM, whereas no such differences were observed in boys and older children (Barrett, Dadds, & Rapee, 1996), suggesting that a parent-focused intervention may be of greater benefit to younger children.

As noted above, research has moved from solely focusing on child-focused interventions to examining child-focused CBT combined with some form of parent-focused or parent-child intervention. However, it may improve services for child anxiety if interventions that target only parents of anxious children were effective, available, and perceived as acceptable by parents. As parents spend significantly more time with their children than therapists do, it is quite likely that parents also exert considerably more

influence on their children. Researchers have noted that parenting variables such as parenting style can be a factor in either increasing recurrent anxious symptoms in children posttreatment (Kane & Kendall, 1989), or helping to maintain treatment gains (Kearney & Silverman, 1990). Hence, service providers can potentially multiply their efforts by training parents to be co-therapists in the home. With the high costs of treatment by health professionals, any way of multiplying efforts could have economic benefits, as well as increasing efficacy and efficiency of treatment.

Targeting parents in treatments for child anxiety may result in improved services especially for younger children, given their cognitive limitations and greater parental dependence. Rapee, Kennedy, Ingram, Edwards, and Sweeney (2005) recently evaluated a parent-focused early intervention program for 3 to 5 year old children exhibiting withdrawn/inhibited behavior. The researchers found that children of parents randomly assigned to a parent-focused-education program exhibited a significantly greater reduction in anxiety diagnoses at 12 months posttreatment compared with children of parents in a monitoring only condition (Rapee et al., 2005). Another study compared three treatment groups (i.e., parent-focused, child-focused, or parent- and child-focused) with a Waitlist (WL) control condition (Mendlowitz et al., 999). Sixty-two parents and children were randomly assigned to one of the three treatment conditions, while controls were made up of those participants who waited for treatment for 2-6 months. Results indicated comparable posttest treatment gains as measured by mean scores on the Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978) for all active treatment groups (Mendlowitz et al., 1999). Hence, psychosocial treatment packages targeting parents alone may produce similar results in terms of reduced anxiety

in children compared with child-focused psychosocial interventions. In terms of treatment acceptability and child age, recall that Mak and Freeman (2006) found TA ratings to vary as a function of child age. In particular, TA ratings were higher for parent-focused interventions when participants considered a younger versus an older child. TA ratings for child-focused interventions were higher for an older versus a younger child.

Aside from whether a treatment is parent-focused or child-focused, previous research has consistently revealed that psychosocial interventions are perceived as more acceptable than medication for a variety of psychological problems (Walker, Vincent, Furer, Cox, & Kjernisted, 2000; Dwight-Johnson, Sherbourne, Liao, & Wells, 2001). For example, in a survey of 1187 adult primary care patients exhibiting depressive symptoms, 67% of those who indicated a desire for active treatment reported a preference for counseling over medication treatment (Dwight-Johnson, Sherbourne, Liao, & Wells, 2001). Similar results were obtained in a sample of 23 community-based participants with a diagnosis of hypochondriasis, where 74% of respondents indicated psychological treatment as their first choice compared with 4% who reported medications as first choice, and 22% who reported equal preference. Forty-eight percent of respondents reported that they would only accept psychological treatment (Walker, Vincent, Furer, Cox, & Kjernisted, 2000). Studies utilizing samples of parents in particular have also found similar results (e.g., Phares, Ehrbar, & Lum, 1996; Miller & Kelley, 1992). Hence, the current study predicts that both mothers and fathers will provide higher TA ratings for psychosocial (parent-focused and child-focused) interventions compared with medications.

Summary and Overview of Proposed Study

Treatment acceptability is an important component of the study of social validity. Although its relation with treatment adherence and integrity may be complicated and at times elusive to researchers, treatment acceptability may influence treatment utilization and ultimately treatment outcomes and the information gleaned from such studies should be considered in the development of community-based treatment programs. A number of influential factors acting on the acceptability of treatments have been delineated within its literature including intervention characteristics, rater characteristics, and target characteristics. However, few studies have specifically compared mothers' versus fathers' attitudes toward the acceptability of treatments for their children or examined the influence of child age on parents' perceptions of different treatments. Furthermore, much of the treatment acceptability research has focused on child externalizing problems that can be characterized as socially disruptive/aggressive. Studies examining attitudes toward treatments for internalizing problems, however, are quite rare. No studies to date have compared parents' perceptions of parent-focused CBT, child-focused CBT, and medication treatments for child anxiety.

The primary objective of this study is to investigate the influence of parent gender and child age on parents' perceptions of three types of interventions targeting child anxiety. First, it is predicted that, across child age and parent gender, both types of psychosocial interventions will be perceived more positively than medication treatment. Second, it is predicted that both child-focused and parent-focused psychosocial treatments will be regarded more positively by mothers compared with fathers. Third, fathers will perceive medications more positively than mothers. Fourth, it is predicted

that parent-focused interventions will be perceived more positively than child-focused interventions for younger children given parents' perceptions of greater parental responsibility for the behaviors of younger children. Fifth, it is predicted that child-focused interventions will be perceived more positively than parent-focused interventions for older children. Finally, it is predicted that medication treatment will be perceived more positively for older children compared with younger children.

Primary Research Question

Do parent gender and child age affect parents' perceptions of the acceptability of child-focused psychosocial treatment, parent-focused psychosocial treatment, and medication treatment for child anxiety?

Hypothesis 1:

Both types of psychosocial interventions will receive higher treatment acceptability ratings than medication treatment across child age and parent gender.

Hypothesis 2:

Both child-focused and parent-focused psychosocial treatments will receive higher treatment acceptability ratings from mothers compared with fathers.

Hypothesis 3:

Medications will receive higher treatment acceptability ratings from fathers than from mothers.

Hypothesis 4:

Parent-focused psychosocial interventions will be rated as more acceptable for younger children versus older children.

Hypothesis 5:

Child-focused psychosocial interventions will be rated as more acceptable for older versus younger children.

Hypothesis 6:

Medication treatment will be rated as more acceptable for older children compared with younger children.

Exploratory Research Question

What kind of treatment-related information do parents want if making treatment decisions for an anxious child?

Method

Participants

Participants were a community sample of 72 cohabiting parents recruited from Winnipeg and surrounding area. The sample was made up of 44 mothers and 28 fathers ranging from 24 to 53 years of age (mothers: $M = 37.66$, $SD = 5.98$; fathers: $M = 39.44$, $SD = 5.96$). The majority of participants reported their ethnic background as Caucasian. Five respondents did not report their ethnicity. Education levels, incomes, and prevalence of problems in the children of participants are presented along with further information on ethnicity in Table 1. The modal number of children reported within each family was 2 ($M = 2.29$, $SD = .94$). The demographic questionnaire is provided in Appendix B.

Table 1

Demographic Information on Ethnicity, Education, Family Income, and Prevalence of Children's Mental Health Problems in (n = 72 Parents)

Variable	*n*	(%)
Ethnic background		
Caucasian	53	(73.6)
East or West Indian	4	(5.6)
Other (e.g., Asian, Latin American)	10	(13.9)
Not reported	5	(6.9)
Education		
Less than Grade 12	4	(5.6)
Completed College/Some University	36	(50.0)
Completed University		
Undergraduate Degree (e.g., BA, B.Ed)	16	(22.2)
Completed University		
Graduate Degree (e.g., MA, PhD)	9	(12.5)
Other	6	(8.3)
Not reported	1	(1.4)
Total Annual Household Income		
Less than $10,000.00	1	(1.4)
$10,000.00—19,999.00	2	(2.8)
$20,000.00—29,999.00	5	(6.9)
$30,000.00—39,999.00	3	(4.2)

Variable	*n*	(%)
Total Annual Household Income (continued)		
$40,000.00—49,999.00	6	(8.3)
$50,000.00—59,999.00	11	(15.3)
$60,000.00—69,999.00	8	(11.1)
$70,000.00—79,999.00	9	(12.5)
$80,000.00—89,999.00	7	(9.7)
$90,000.00—99,000.00	6	(8.3)
More than $100,000.00	13	(18.1)
Children with Mental Health Problems		
Anxiety	7	(9.7)
Anxiety and ADHD	3	(4.2)
Anxiety and Learning Disorder (LD)	1	(1.4)
ADHD	1	(1.4)
Anxiety, Depression, LD, and ADHD	1	(1.4)
LD and ADHD	1	(1.4)

Participants were also asked about their own medication use, counseling and the presence of mental health problems. These data are presented in Table2.

Table 2

Demographic Information on Medication use, Counseling and Mental Health Problems (Mothers [n=44] and Fathers [n = 28])

	Mothers		Fathers	
Variable	*n*	(%)	*n*	(%)
Seen by Psychologist/Counselor for:				
Anxiety and depression	7	(15.9)	2	(7.1)
Anxiety	4	(9.1)	1	(3.6)
Depression	2	(4.5)	0	(0)
Other mental health problem	3	(6.8)	4	(14.3)
Medication use for:				
Depression	6	(13.6)	0	(0)
Anxiety and depression	5	(11.4)	1	(3.6)
Anxiety	2	(4.5)	0	(0)
Other mental health problem	0	(0)	2	(7.1)

Participants also provided information regarding parents' time spent with children and at work outside the home as well as whom the respondent saw as the primary caregiver in the home. Response summaries are presented in Table 3.

Table 3

Demographic Information on Time Spent with Children, Time Spent at Work Outside the Home, and Sharing of Caregiving Responsibilities

	Mothers		Fathers	
Variable	*n*	(%)	*n*	(%)
Time per weekday with child(ren)				
Less than 1 hour	0	(0)	4	(14.3)
1-3 hours	9	(20.5)	12	(42.9)
4 hours or more	35	(79.5)	12	(42.9)
Time per weekend day with child(ren)				
1-2 hours	2	(4.5)	3	(10.7)
3-4 hours	2	(4.5)	4	(14.3)
5-6 hours	4	(9.1)	4	(14.3)
7 hours or more	36	(81.8)	17	(60.7)
Hours per week working outside home				
20 hours or less	22	(50.0)	2	(7.1)
21-39 hours	13	(29.5)	6	(21.4)
40 hours or more	9	(20.5)	20	(71.4)
Indications of primary caregiver				
Mother	27	(61.4)	14	(50.0)
Father	1	(2.3)	1	(3.6)
Shared Equally	16	(36.4)	13	(46.4)

Parents also reported on the Spence Child Anxiety Scale-Parent report (SCAS-P) their perceptions of anxiety in one of their own children between 5 and 14 years of age. Scores on the SCAS-P indicated that this is a sample of children who, on average, fall within the normal range of anxiety symptoms (M = 18.47, SD = 12.08 versus normative data for 7-12 year olds: M = 20.51, SD = 14.20; and 13-19 year olds: M = 16.56, SD = 11.68; Muris, Schmidt, & Merckelback, H, 2000). The Spence Child Anxiety Scale-Parent report is provided in Appendix C.

Case Vignettes

Parents read case descriptions of either a 6- and 13-year-old anxious boy or a 6- and 13-year-old anxious girl. These case descriptions are identical to those previously used in Mak and Freeman's (2006) study with undergraduates. Child gender in the vignettes was matched to (one of) the parents' child(ren) whose age falls between 5- and 14-years-old. If multiple children were identified within this age range, one child was randomly chosen for the study by researchers. Both mothers and fathers from the same family completed measures based on the same child gender. In previous research (i.e., Mariani & Freeman, 2003; Mak & Freeman, 2006), child gender has not been found to influence perceptions of treatment acceptability. Symptoms of anxiety included in case descriptions included extreme shyness, excessive worry, social inhibition/withdrawal, and reflected symptoms of generalized anxiety disorder and social anxiety disorder. For instance, cases described the child as being extremely quiet and shy, having relatively few friends, experiencing excessive fear regarding speaking in class, and experiencing general worry over things and others. The gender and age of the child varied across case descriptions; however, all other details remained constant. These case descriptions were

previously pilot-tested with a sample of 8 graduate students, clinicians, and other mental health workers. The symptoms of anxiety depicted in the case vignettes were rated as clinically significant and warranting intervention. Male and female case vignettes were reported to be realistic and age-appropriate (Mak & Freeman, 2006). The case vignettes are presented in Appendix D. Four questions assessing parents' perceptions of the severity of symptoms in the case vignettes and parents' perceptions of the importance of seeking treatment followed each case description in the current study. Parents' responses to these items indicated perceptions of clinically significant problems demanding treatment. These questions are presented in Appendix E. Table 4 presents the means and standard deviations for these items for mothers and fathers.

Table 4

Means (and Standard Deviations) for Items Measuring Parental Perceptions of Symptom Severity and Importance of Seeking Treatment for Younger and Older Case Vignettes

	Mothers		Fathers	
Items	*Mean*	*(SD)*	*Mean*	*(SD)*
Younger Child				
1. How much distress do you think this child is feeling?	6.39	(1.33)	6.14	(1.51)
2. To what extent is this child's anxiety likely to have a negative impact on school?	6.32	(1.46)	6.18	(1.34)
3. To what extent is this child's anxiety likely to have a negative impact on his/her social life?	6.64	(1.28)	6.46	(1.73)
4. How important do you think it would be for this child to receive treatment for her/his anxiety?	6.52	(1.60)	6.25	(1.90)

Items	Mothers		Fathers	
	Mean	*(SD)*	*Mean*	*(SD)*
Older Child				
1. How much distress do you think this child is feeling?	6.70	(1.11)	6.43	(1.07)
2. To what extent is this child's anxiety likely to have a negative impact on school?	6.59	(1.25)	6.21	(1.29)
3. To what extent is this child's anxiety likely to have a negative impact on his/her social life?	7.20	(1.07)	7.04	(.84)
4. How important do you think it would be for this child to receive treatment for her/his anxiety?	7.05	(1.26)	6.11	(1.60)

Note. All items based on an 8 point Likert-type scale. Higher scores reflect perceptions of greater distress, negative impact, and the importance of receiving treatment.

Treatment Descriptions

All parents read descriptions of three interventions targeting child anxiety: Child-focused psychosocial, parent-focused psychosocial, and medication treatment. The child-focused psychosocial intervention was described as working directly with the anxious child, teaching the child strategies to manage anxiety (e.g., cognitive restructuring, exposure exercises). The parent-focused psychosocial treatment was described as working directly with the parents, teaching them strategies to help their anxious child (e.g., reinforcing the child's approach tendency toward anxiety-provoking situations; helping the child to adjust thinking patterns to be more realistic) and to strengthen parents' self-efficacy in the challenges inherent in parenting (an) anxious child(ren). The description of the medication treatment included the prescription of selective serotonin

reuptake inhibitors such as sertraline (Zoloft) and fluvoxamine (Luvox) to reduce the child's experiences of anxiety in everyday life circumstances and to increase the child's approach of the feared situations. These three treatment descriptions are provided in Appendix F.

Mak and Freeman (2006) pilot-tested the above treatment descriptions with 6 graduate students in clinical psychology and 1 psychiatrist to ensure that descriptions provided adequate and accurate information for the different types of treatment for child anxiety. Child- and parent-focused psychosocial treatment descriptions were rated as representative of realistic treatments for child anxiety by all 7 respondents. Six of 7 respondents judged the description of medications as adequate and representative of pharmacological interventions for child anxiety. Further, the complexity of the two psychosocial interventions was rated as equal and all three treatments were rated as distinct approaches to the treatment of child anxiety.

Measures

Spence Children's Anxiety Scale-Parent Report (SCAS-P; Nauta et al., 2003, in press). This scale was included to provide sample descriptive information in terms of the level of anxiety children were perceived to be experiencing. The SCAS-P is a 38 item parent-report measure of child anxiety symptoms. Each item of the SCAS-P is rated on a 0 (never) to 3 (always) scale. The normative sample was made up of 484 parents of anxiety-disordered children as well as 261 parents of non-anxiety disordered children. A confirmatory factor analysis provided support for six intercorrelated factors: separation anxiety, generalized anxiety, social phobia, panic/agoraphobia, obsessive-compulsive disorder, and fear of physical injuries. Internal consistency for the subscales was

satisfactory to excellent: Corrected Spearman-Brown coefficients ranged from .83-.92 for the anxiety-disordered group, whereas the control group produced coefficients ranging from .80 to .90 (Nauta et al., 2003, in press; see Appendix C).

Treatment Evaluation Inventory-Short Form (TEI-SF; Kelley, Heffer, Gresham, & Elliott, 1989). The TEI-SF is a measure of treatment acceptability consisting of nine items rated on a 5-point Likert-type scale with all responses ranging from "Strongly Agree" to "Strongly Disagree." Derived from the 15-item Treatment Evaluation Inventory (TEI; Kazdin, 1980a), the TEI-SF was developed to reduce completion time and to use simplified wording for greater ease of understanding. An example of an item from the TEI-SF is, "I believe the child will experience discomfort during the treatment" (reverse scored). Higher scores on the TEI-SF indicate greater treatment acceptability. The TEI-SF has demonstrated good internal consistency (e.g., Kelley, Heffer, Gresham, & Elliott, 1989) as well as the ability to discriminate between various interventions (Kelley, Heffer, Gresham, & Elliott, 1989). The TEI-SF is provided in Appendix G.

Treatment Rank and Refusal Form. After completing the final TEI-SF, participants were asked to imagine that their child had an anxiety disorder and was experiencing problems similar to those in the case descriptions they previously read. They were asked, with that in mind, to rank their preference from 1 (most preferred) to 3 (least preferred) of parent-focused, child-focused and medication treatment. Parents were also asked which, if any, of the three treatments they would decline and to provide some rationale for their choices. Parents were also asked to rank their preferences out of a list of six locations from which they would like to receive treatment. Finally, participants

were asked to indicate which parent, if not both, would be most likely to attend treatment with an anxious child upon invitation by a health professional (see Appendix H).

Preferences for Information Regarding Treatments for Child Anxiety. This survey instrument consisted of a total of 18 items, with 14 assessing the importance to parents of receiving information on various types and aspects of treatments for children with anxiety, and four items measuring parents' acceptability of several modes of obtaining such information. An example of an item is, "How important would it be for you to receive information about what you and your child have to do as part of the treatment?" Responses ranged on an 8 point Likert-type scale from "Not important at all" to "Very important" (see Appendix I).

Procedure

Participants were recruited via notices placed in community recreational centers, public libraries, day-care centres, and a local magazine advertising a study of mothers' and fathers' perceptions of treatments for child anxiety. Questionnaires along with consent forms were mailed to participants, completed at home, and mailed back to the researcher. Participants received compensation in the form of one-five dollar Safeway gift card per person for completing and returning the questionnaire package. A total of 105 questionnaires were sent out and 76 were returned yielding a response rate of approximately 72%. Two questionnaires were withheld from the data due to the participants being single mothers, one was removed due to being an extreme outlier on several measures, and another questionnaire has been set aside awaiting a signed consent form. This resulted in a total 72 usable questionnaires.

Each questionnaire package included: (1) a cover letter (Appendix J); (2) 2 copies of a consent form (Appendix K); (3) an instruction sheet (Appendix L); (4) a demographics section; (5) two case vignettes (one each) of a 6-year-old and 13-year-old girl or a 6-year-old and 13-year-old boy exhibiting anxiety (each included four items regarding severity and importance of seeking treatment); (4) three treatment descriptions following each case vignette; (5) a copy of the TEI-SF following each treatment description; (6) one rank and refusal form (following the final TEI-SF); (7) one copy of the items assessing preferences for information regarding treatments for child anxiety (following the Rank & Refusal Form); (8) finally, one copy of the Spence Children's Anxiety Scale-Parent Report (SCAS-P). The treatment descriptions and child ages in the vignettes were counterbalanced to control for sequence effects. Child gender in the vignettes was matched to (one of) the parents' child(ren) whose age fell between 5- and 14-years-old. If more than one child was identified, the researcher randomly chose a child for this study. Both parents completed measures based on the same gender-matched vignettes.

Parents responded to notices by contacting the researcher by either a toll-free telephone number or by email. This contact resulted in a brief phone conversation between parents and the researcher. A script was used for the phone conversation (See Appendix M). The researcher strove to personally invite both parents to join in the study (this contact was emphasized for fathers) to increase participation and to ensure understanding of procedures, answer questions, and encourage completion and return of the questionnaire package in a timely manner. If possible, both parents were given a brief description of the research as a study of parental attitudes toward treatments for child

anxiety. During the initial call, confidentiality was addressed and a child within the age-range of interest was identified/selected for the study, whose name and gender was recorded on the participant's file. Parents were instructed to read all the instructions and complete questions in order of presentation (and to not read ahead), to check to ensure all items have been completed appropriately and to place all forms and questionnaires into the self-addressed postage-paid UM envelope and to place in the mail as soon as done. They were also encouraged to call researchers if they had any questions. Following receipt of completed questionnaires, the five dollar honorarium along with an initial study summary (see Appendix N) was mailed to participants. A final study summary will be sent out to participants following completion of the thesis.

Results

Effects of Rater Gender and Child Age on Treatment Acceptability Ratings

To address the primary research question and examine the effects of parent gender, child age, and treatment type on treatment acceptability ratings of parent-focused psychosocial, child-focused psychosocial, and medication treatments, a three-way mixed model analysis of variance (ANOVA) was conducted utilizing an alpha level of .05. Rater gender, child age, and treatment type were the independent variables; the scores on the TEI-SF served as the single dependent variable. Rater gender (mothers versus fathers) served as a between-subjects variable; treatment type (parent-focused psychosocial, child-focused psychosocial, medications) and child age (6 year-olds, 13 year-olds) served as within-subjects variables. Due to numerous instances where the assumption of sphericity was violated, ANOVAs were tested using the multivariate criterion of Wilk's Lambda (Λ) wherever appropriate (Green & Salkind, 2003).

The main effect for Treatment type was significant, $\Lambda = .30$, $F(2, 69) = 79.06$, $p < .001$; however, the main effect for Child age was nonsignificant, $\Lambda = .99$, $F(1, 70) = .66$, $p = .42$, and the main effect for Rater gender was also nonsignificant, $F(1, 70) = .47$, $p = .49$. The main effect for Treatment type was qualified by a significant Child age X Treatment Type interaction, $\Lambda = .78$, $F(2, 69) = 9.59$, $p < .001$. There were no other significant interactions (i.e., Rater gender X Treatment type, $\Lambda = .98$, $F(2, 69) = .55$, $p = .58$; Rater gender X Child age, $\Lambda = .10$, $F(1, 70) = .09$, $p = .77$; Rater gender X Child age X Treatment type; $\Lambda = .98$, $F(2, 69) = .78$, $p = .47$. Means and standard deviations for TEI-SF ratings by mothers and fathers are presented in Table 5.

Table 5

Means (and Standard Deviations) for TEI-SF Scores of Mothers and Fathers for Parent-focused, Child-focused, and Medication Treatment for Younger and Older Case Vignettes

	Mothers					
	Younger Child ($n = 44$)			Older Child ($n = 44$)		
Treatment	Parent	Child	Medication	Parent	Child	Medication
M	$36.98_{a,1}$	$34.32_{b,1}$	$21.11_{c,1}$	$35.00_{a,2}$	$33.98_{a,1}$	$23.00_{b,2}$
(SD)	(4.55)	(5.61)	(8.17)	(4.52)	(5.27)	(8.31)
	Fathers					
	Younger Child ($n = 28$)			Older Child ($n = 28$)		
Treatment	Parent	Child	Medication	Parent	Child	Medication
M	$35.43_{a,1}$	$34.14_{b,1}$	$21.39_{c,1}$	$34.21_{a,2}$	$34.42_{a,1}$	$22.04_{b,2}$
(SD)	(4.33)	(4.87)	(6.87)	(3.04)	(4.52)	(6.87)

Note. Higher scores reflect greater acceptability. Means with different letter subscripts indicate significant treatment differences ($p < .01$) within each age group. Means with different numeral subscripts indicate significant treatment differences ($p < .001$) between age groups for each treatment type.

The Child age X Treatment type interaction (Figure 1) was followed-up with simple main effects analyses examining differences in mean ratings of treatment acceptability across the three treatment types within each level of child age. Analyses indicated a significant effect for treatment type within the older child vignettes, $\Lambda = .33$, $F(2, 70) = 71.07$, $p < .001$, as well as within the younger child vignettes, $\Lambda = .27$, $F(2, 70) = 94.22$, $p < .001$.

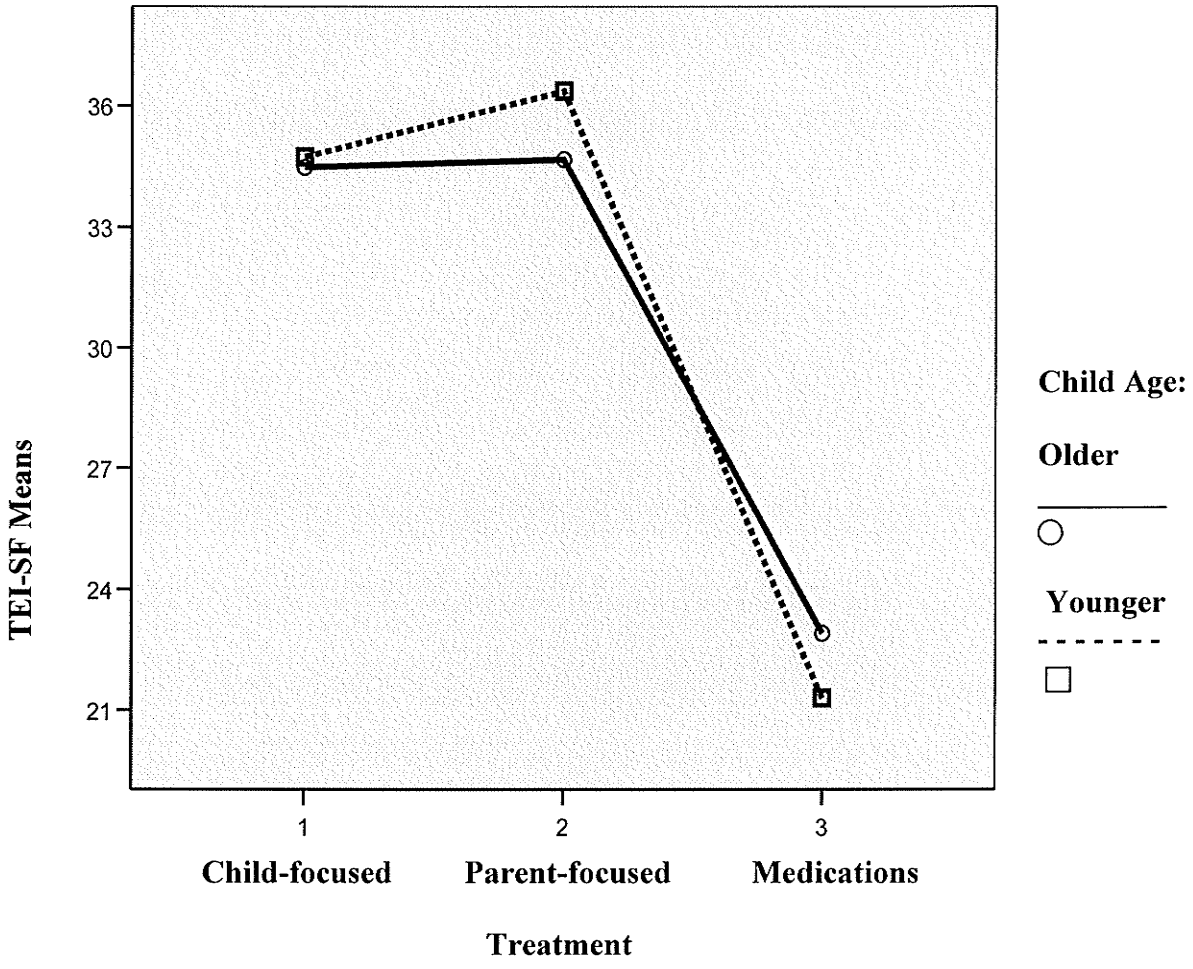

Figure 1. Mean TEI-SF Scores for Parent-focused, Child-focused, and Medication Treatment as a Function of Child Age and Treatment Type.

Post hoc paired-samples *t* tests were conducted to probe differences in mean TA ratings within younger and older child vignettes. A Holm's sequential Bonferroni procedure was used to control for familywise error. Pairwise comparisons indicated significant differences in treatment acceptability ratings across all three treatments for both younger and older children. For younger child vignettes, parent-focused treatment was rated as more acceptable than both child-focused treatment, $t(71) = 3.25$, $p < .01$ and medication, $t(71) = 13.82$, $p < .001$. Child-focused treatment was rated as more acceptable than medication, $t(71) = 11.27$, $p < .001$. Effect sizes (*d* values reflecting standardized mean differences for matched pairs; Cohen, 1988, p. 48) were calculated to determine the magnitude of the differences in treatment acceptability ratings between the treatment types. Effect sizes for mean differences between child-focused treatment and medication treatment, and between parent-focused treatment and medication treatment were 2.01 and 2.50, respectively. The effect size for the comparison between child-focused and parent-focused treatment was .43.

For older child vignettes, pairwise comparisons indicated no significant differences in treatment acceptability ratings between child- and parent-focused treatments, $t(71) = -1.12$, $p = .265$; however, both child-focused treatment and parent-focused treatment were rated significantly higher than medication, $t(71) = 11.86$, $p < .001$; $t(71) = 10.98$, $p < .001$, respectively. Effect sizes for mean differences between child-focused treatment and medications and between parent-focused treatment and medications were 1.78 and 2.03, respectively. The effect size for the mean difference between child- and parent-focused treatments was .15.

A second set of post hoc paired samples *t* tests were computed to assess differences between mean TA ratings for each treatment across younger and older child vignettes. Medication was rated significantly higher for older versus younger children, $t(71) = 2.72$, $p < .01$, and parent-focused treatment was rated significantly higher for younger versus older children, $t(71) = 4.43$, $p < .001$. No significant difference for child-focused treatment was found between older and younger child vignettes, $t(71) = -.64$, $p = .526$. Effect sizes for comparisons between younger and older children for the child-focused treatment, parent-focused treatment, and medications were .06, .41, and .19, respectively. Table 6 presents means and standard deviations for TEI-SF scores for the three treatments with rater gender collapsed.

Table 6

Means (and Standard Deviations) for TEI-SF Scores for Parent-focused, Child-focused, and Medication Treatment for Younger and Older Child Case Vignettes (Parents)

	Younger Child ($n = 72$)			Older Child ($n = 72$)		
Treatment	Parent	Child	Medication	Parent	Child	Medication
M	$36.37_{a,1}$	$34.74_{b,1}$	$21.31_{c,1}$	$34.67_{a,2}$	$34.48_{a,1}$	$22.92_{b,2}$
(SD)	(4.46)	(4.88)	(7.21)	(3.76)	(4.17)	(7.69)

Note. Higher scores reflect greater acceptability. Means with different letter subscripts indicate significant treatment differences ($p < .01$) within each age group. Means with different numeral subscripts indicate significant treatment differences ($p < .001$) between age groups for each treatment type.

Treatment Ranking

Following completion of the final TEI-SF, parents were asked to imagine their own child was exhibiting symptoms of anxiety similar to those in the vignettes and to rank-order the treatments based on their preferences. Only two of the 72 treatment ranking forms were incorrectly completed and these were subsequently corrected during a follow up telephone conversation between the participants and investigator. This resulted in 72 completed ranking forms. When asked to indicate their first choice of treatment, 61.4% of mothers selected parent-focused treatment, 38.6% selected child-focused treatment, and none selected medication. For fathers, 28.6% selected parent-focused treatment, 67.9% selected child-focused treatment, and 3.6% selected medication. Rank orders by mothers and fathers of the three treatments are provided in Table 7.

Treatment Refusal

Following treatment ranking, participants indicated which, if any, of the three treatments they would refuse, given their own child had problems with anxiety as described in the case vignettes. Responses from mothers indicated that 36.4% would refuse none of the treatments, 2.3% would refuse parent-focused treatment, 2.3% would refuse child-focused treatment, and 61.4% would refuse medication treatment. Fathers indicated that 39.3% would not refuse any of the treatments and that 60.7 % would only refuse medications. Responses from both mothers and fathers indicated none would refuse more than one treatment. Table 8 presents percentages of refusal for mothers and fathers.

Table 7

Treatment Ranking Frequencies for Mothers and Fathers

	Treatment Type					
	Parent-focused		Child-focused		Medication	
Ranking	%	(*n*)	%	(*n*)	%	(*n*)
			Mothers ($n = 44$)			
First	61.4	(27)	38.6	(17)	0	(0)
Second	31.8	(14)	61.4	(27)	6.8	(3)
Third	6.8	(3)	0	(0)	93.2	(41)
			Fathers ($n = 28$)			
First	28.6	(8)	67.9	(19)	3.6	(1)
Second	67.9	(19)	28.6	(8)	3.6	(1)
Third	3.6	(1)	3.6	(1)	92.9	(26)

Note. Values in parentheses represent actual frequencies

Table 8

Treatment Refusal Frequencies for Mothers and Fathers

	Treatment			
Respondents	None	Parent-focused Only	Child-focused Only	Medication Only
Mothers (n = 44)				
%	36.4	2.3	2.3	61.4
(n)	(16)	(1)	(1)	(27)
Fathers (n = 28)				
%	39.3	0	0	60.7
(n)	(11)	(0)	(0)	(17)

Note. Values in parentheses represent actual frequencies

Parents were asked to provide rationale for their most preferred and least preferred treatment. The majority of fathers (i.e., 78%) and many mothers (i.e., 46.2%) who indicated the parent-focused treatment as most preferred cited the importance to the treated child of parental support and guidance. The second most prevalent rationale (i.e., 22% of fathers and 42.3% of mothers) for those choosing parent-focused as most preferred emphasized harnessing parents' increased ability to teach their children for the benefit of providing treatment. The most prevalent rationale (i.e., 77% of fathers and 90% of mothers) provided by parents choosing child-focused treatments as most preferred emphasized the benefit of increased independent coping skills in the treated child. The dominant rationale for parents indicating medications as least preferred (i.e., 100% of

both mothers and fathers) focused on negative side effects and the opinion that medications should be used as a last resort. Appendix O presents parents' verbatim responses to these items.

Parents ranked six locations for receiving treatments from 1 (most preferred) to 6 (least preferred). The location ranked most often by mothers as most preferred was a family centre (43.2%) while a pediatrician's office was ranked as most preferred 22.7% and a school 20.5% of the time by mothers. Fathers most often ranked a pediatrician's office as most preferred (39.3%), while a school was most preferred by 25.0%, and a family centre was most preferred by 17.3%. Both mothers and fathers indicated that community health centres, mental health centres, and hospitals were ranked as least preferred most often. Table 9 presents frequencies of locations ranked as most preferred by mothers and fathers.

Table 9

Frequencies of Mothers' and Fathers' Locations for Receiving Treatment Ranked as Most Preferred

	Mothers			Fathers	
Locations	*n*	%	Locations	*n*	%
Family Centre	19	43.2	Pediatrician's Office	11	39.3
Pediatrician's Office	10	22.7	School	7	25.0
School	9	20.5	Family Centre	5	17.9
Community Health Centre	4	9.1	Community Health Centre	3	10.7
Mental Health Centre	3	6.8	Mental Health Centre	2	7.1
Hospital	2	4.5	Hospital	1	3.6

Participants were asked for their opinions regarding the kinds of information they would find important if their child were experiencing problems with anxiety. Responses indicated much similarity in terms of information that mothers and fathers are interested in, as well as mode of receiving that information. Item number three (i.e., "What you and your child have to do as part of the treatment"; $M = 7.75$) received the highest ratings from both mothers and fathers. Though the order differed, both mothers' and fathers' top three items included item 2 (i.e., "The various psychological treatment approaches available [such as counseling or therapy.]"). Items receiving the lowest endorsements by mothers were items 5, 9, and 1, whereas fathers' lowest three were items 5, 1, and 4. . In terms of modes of receiving treatment information, mothers and fathers responses indicated a preference for information given by discussion with a health care provider and in written form versus information provided by either video tape or on a web site. Table 10 presents the means and standard deviations for the treatment information items for mothers and fathers.

Table 10

Means (and Standard Deviations) for Items Assessing Parents' Preferences for Information Regarding Treatments for Child Anxiety

	Mothers		Fathers	
Items	*Mean*	*SD*	*Mean*	*SD*
1. The various medication treatment approaches available.	5.59	2.89	4.54	2.52
2. The various psychological treatment approaches available (such as counseling or therapy).	7.61	1.06	6.68	1.74

	Mothers		Fathers	
Items	*Mean*	*SD*	*Mean*	*SD*
3. What you and your child have to do as part of the treatment.	7.75	.651	7.11	1.55
4. The cost of the treatment to your family.	5.45	2.66	4.82	2.50
5. The cost of the treatment to the health care system.	2.50	2.31	3.14	2.65
6. Common side effects of the treatment.	7.59	1.04	7.07	1.27
7. Uncommon or rare side effects of the treatment.	6.89	1.74	6.18	2.02
8. The waiting period before starting the treatment.	7.32	1.07	6.61	1.17
9. How much of your time is required to take the treatment (for appointments and so on).	5.02	2.35	5.14	2.24
10. When appointments are scheduled for the treatment.	5.84	2.13	5.39	2.28
11. How long it takes before the treatment starts to reduce a child's anxiety.	6.39	1.96	6.11	1.62
12. How long the treatment continues.	5.98	2.28	5.64	2.08
13. What happens when the treatment is discontinued.	7.14	1.25	6.64	1.47
14. What treatment the health care professional who assesses the problem would recommend.	6.59	1.53	6.11	1.64
15. Information given in written form (in an information sheet or booklet which you could take with you)?	6.68	1.72	5.93	1.88
16. Information given by discussion with a health care provider?	7.09	1.41	6.57	1.45

	Mothers		Fathers	
Items	*Mean*	*SD*	*Mean*	*SD*
17. Information provided by discussion in a videotape (which you could take with you)?	5.52	2.38	5.57	2.10
18. Information provided on an Internet Website?	4.68	2.36	5.25	2.17

Note. All items based on an 8 point Likert-type scale. Higher scores reflect perceptions of greater importance and acceptability of type and mode of receiving treatment information.

Discussion

This study examined parents' perceptions of three treatments for child anxiety (child-focused psychosocial treatment, parent-focused psychosocial treatment, and medication) and whether perceptions varied across parent gender and child age. Overall, acceptability ratings were higher for both psychosocial treatments compared with medications. Contrary to predictions, mothers' and fathers' acceptability ratings did not differ. However, support was generated for some hypotheses pertaining to child age. Specifically, parents provided greater acceptability ratings for the parent-focused intervention as opposed to the child-focused intervention for the younger child, and rated medications as less acceptable for a younger versus an older child. Contrary to predictions, ratings of the child-focused versus the parent-focused treatment did not differ significantly for the older child. Also contrary to predictions, parents' treatment acceptability ratings for the child-focused intervention did not differ across child age.

Psychosocial Interventions versus Medications

Regardless of child age and rater gender, psychosocial treatments were perceived to be more acceptable than medication. This is consistent with extant research reporting greater endorsements for psychosocial interventions versus medications for adults with depression (Dwight-Johnson, Sherbourne, Liao, & Wells, 2001), hypochondriasis (Walker, Vincent, Furer, Cox, & Kjernisted, 2000), and insomnia (Morin, Gaulier, Barry, & Kowatch, 1992). Studies utilizing samples of parents in particular have observed similar phenomena (e.g., Phares, Ehrbar, & Lum, 1996; Miller & Kelley, 1992). A more recent study of parents' attitudes toward treatments found greater endorsements of psychosocial interventions versus medication for children with externalizing behavior

problems in a communication disorders population (Boothe et al., 2004). Like the current project, this study also utilized the TEI-SF (range of 9 – 45). The Mean scores for the TEI-SF for medications ranged from 21.55 (*SD* = 7.04) to 22.59 (*SD* = 7.95) which is comparable to the means in the current study (i.e., *M* = 21.11 [*SD* = 8.17] – *M* = 23.00 [*SD* = 8.31]). Additionally, effect sizes in the current project for mean differences between medications and psychosocial treatments ranged from 1.78 to 2.50, also similar to effect sizes found in Boothe et al. (2004; 1.90 – 2.17). Others using the original version of the measure as in the current study (i.e., TEI; Kazdin, 1980a), found effect sizes of the differences between psychosocial interventions and medications similar to ours (i.e., ES = 2.54 – 2.83; Miller & Kelley, 1992; ES = 1.13; Liu et al., 1991). A study of a university undergraduate sample using the TEI found effect sizes ranging from 1.28 – 1.34 for comparisons of means between psychosocial interventions and medication treatment (Mak & Freeman, 2006). Results such as these indicate even greater discrepancies in perceptions of psychosocial versus medication treatments among parents than among nonparents.

Cross Calvert and McMahon (1987) using the TEI (with a range from 15-105 = 90), categorized ratings into "positive" (i.e., from 60 to 105) and "negative" (i.e., from 15 to 60). Adapting that system of categorization for use with the TEI-SF (with a range from 9-45 = 36) yields a "positive" category (scores from 27 to 45) and a "negative" category (scores from 9 to 27). Employing this categorization system, TA ratings of medication treatment in this study (i.e., means ranging from 21-23) fell in the "negative" range, whereas TA ratings of parent-focused treatment (i.e., means ranging from 34-37) and child-focused treatment (i.e., means ranging from 34-35) fell in the "positive" range.

Treatment rankings of medications in the current study were concordant with low acceptability ratings as 93.5% of the parents indicated medications were the least preferred intervention and 61.1% of parents indicated they would refuse medication treatment altogether. Comments as to rationale for these rankings predominantly referred to adverse side effects and that medications should be a "last resort." When asked to indicate their first choice of treatment, 61.4% of mothers selected parent-focused treatment, 38.6% selected child-focused treatment, and none selected medication. For fathers, 28.6% selected parent-focused treatment, 67.9% selected child-focused treatment, and 3.6% selected medication. Treatment rankings for university undergraduates were similar to the parents in our sample (Mak & Freeman, 2006). That is, 77.5% ranked medications as least preferred for older children and 87.8% did so for younger children. Forty percent of students indicated they would refuse medications for an older child, whereas 58.6% said they would refuse medications for a younger child (Mak & Freeman, 2006). Hence, a greater percentage of parents indicated refusal of medications (above) versus the nonparent student sample.

Hypothesized results in terms of acceptability ratings of medication across child age were realized. Specifically, medication was found to be less acceptable for younger children compared to older children. Additionally, medication was ranked by most (i.e., 92.9% of fathers and 93.2% of mothers) parents as the least preferred treatment for their own child while many (i.e., 60.7% of fathers and 61.4% of mothers) parents said they would refuse it altogether. This mimics societal concerns about the safety and efficacy surrounding the use of antidepressant medication among children and adolescents (e.g., Health Canada and the United States Food and Drug Administration health advisory

warnings regarding the use and benefits of SSRIs; http://www.fda.gov/bbs/topics/ANSWERS/2003/ANS01256.html; http://www.hc-sc.gc.ca/english/protection/warnings/2004/2004_02.htm). A More recent Health Canada advisory includes warnings of potential risks to pre- and neo-natal infants (e.g., Health Canada health advisory regarding potential adverse effects of SSRIs and other anti-depressants on newborns; http://www.hc-sc.gc.ca/ahc-asc/media/advisories-avis/2004/2004_44_e.html). Even though public concern regarding the use of medication encompasses both children and adolescents, the significantly lower acceptability ratings of medication for younger children implies even greater concern about the potential harmful impact of medication on the physical and cognitive development of younger children.

Compared to the dramatic differences between ratings of medications and either psychosocial treatment, only small differences across the two psychosocial interventions were observed. These insignificant differences may be due to similar procedures as described in child-focused and parent-focused treatments. In fact, both were descriptions of the same treatment but structured to work directly with a child, or with the parent of the target child. More fathers ranked child-focused treatment as their most preferred intervention (i.e., 67.9%), whereas more mothers indicated that the parent-focused treatment was their most preferred (i.e., 61.4%). Only one mother indicated refusal of the parent-focused treatment and another mother indicated refusal of the child-focused intervention. Hence, overall, CBT was seen as highly acceptable for child anxiety whether working directly with a child in individual treatment or by working with parents.

Mothers' versus Fathers' Treatment Acceptability Ratings

The current study did not provide evidence that mothers and fathers differ significantly in terms of their attitudes toward treatments for child anxiety. This is inconsistent with some past studies that found fathers to differ from mothers in terms of attitudes toward treatments for children (Phares et al., 1996; Miller & Kelley, 1992; Bennett, Power, & Rostain, 1996). Explanatory sources include differences in sample characteristics, treatments presented, and the nature of the child's problems (addressed either naturalistically or depicted analogically) across the relevant studies.

One of the most common points of comparison between samples is socioeconomic status (SES). Although a formal SES questionnaire was not employed in the current study, some income and education information was collected that indicated some similarity across these study samples. Previous studies in which parent gender differences were found described samples in the lower minor technical professionals category (Phares et al., 1996; Bennet et a., 1996) and in the middle to upper SES (Miller & Kelley, 1992). The current sample reported levels of income and education indicative of higher SES as well; however, levels of educational attainment in our sample may have exceeded those of the above studies. Specifically, 50% of our sample of parents reported having completed college/some university, while nearly 22% reported that they had completed a bachelor degree and approximately 12% reported they had completed a graduate degree (e.g., MA, PhD). Therefore, the current sample reported a much higher rate of university education than the national rate (i.e., 85% versus 25% [in 2001], respectively; http://www.statscan.ca). Seventy-eight percent of fathers alone reported having been a university student while 39% reported having either an undergraduate or

graduate degree. As higher rates of education are associated with more egalitarian styles of parenting and gender roles (Thornton, Alwin, & Camburn, 1983), it is possible that our sample of fathers holds a less traditional view of fathering (e.g., as primarily emotionally aloof bread-winners) and may represent the views of a subset of fathers more involved in child-rearing than mainstream North American fathers. In terms of income, a full 36% of respondents reported annual earnings of 80,000 dollars or more with 18% reporting annual incomes of 100,000 dollars or more. Given that the national average annual income for two-parent families with children was 65,900 dollars in 2004, this appears to be a fairly affluent sample.

Parent-reports of time spent with children and parents' personal investment in child caregiving may further distinguish this sample. Regarding time with children, fathers reported spending between 30% and 50% of the time mothers did, proportions that are within established norms (Cabrera, Tamis-LeMonda, Bradley, Hofferth, & Lamb, 2000). However, given research finding that fathers are much less involved in day-to-day caregiving activities whether the mother works outside the home or not (e.g., Lamb, 1997), it was surprising that when asked whom participants' saw as their children's primary caregiver (mother, father, or share equally), approximately 36% of mothers and 46% of fathers reported it was shared equally. Additionally, when asked who would attend therapy with their child if invited by a health professional, 82% of fathers and 79% of mothers reported that both parents would. This is substantially higher than father-participation rates of approximately 30% in child and family therapy as reported by a sample of clinicians (Duhig, Phares, & Birkeland, 2002). Though intention does not guarantee action, both fathers and mothers in this sample believe fathers would be much

more inclined to attend therapy with their child than what is usually realized in clinical work. It is important to note that, though our fathers were seen as sharing child caregiving responsibilities at a higher rate than expected, it did not appear to be due to decreased work hours. Seventy-one percent of fathers reported weekly work outside the home of forty hours or more, while only 7% reported weekly work of 20 hours or less. Conversely, 20% of mothers in this study reported weekly work outside the home of 40 hours or more and 50% reported weekly work outside the home of 20 hours or less.

The above provides some evidence that the fathers in this study are more involved in day-to-day child caregiving than is the average father. Fathers' greater involvement in child caregiving may be associated with reduced discrepancies between mothers' and father's opinions about the needs of their children in general and specifically may lead to greater concordance about what treatment strategies are deemed appropriate.

Another potential reason the current study failed to find parent gender differences when others did pertains to the types of treatments offered in the various studies. Unlike Phares et al (1996) and Miller and Kelley (1992), the current study did not include a treatment focused exclusively on behavioral contingencies. If it had been offered, fathers in the current sample may have provided their highest endorsements for the behavioral interventions versus the other presented treatments. In fact, their treatment acceptability ratings for the behavioral method may have been significantly greater than mothers' ratings, leading to the mother/father distinctions found previously. Additionally, the current study did not ask fathers to rate individual or family therapy (Phares et al., 1996), or counseling (Bennet et al., 1996) which likely connote the demand for emotional

openness and disclosure, some of the very demands that may lead to fewer men than women seeking psychological services and counseling in the first place (Russo, 1990; Deane & Todd, 1996). Hence, mother versus father differences may have been reduced due the types of treatments presented. This indicates that dimensions other than a parent- versus child-focus distinction may elicit different views from mothers and fathers.

Another difference between the current study and the others is the type of child problem presented in the case vignettes. Whereas Miller and Kelley's (1992) analogue study and Bennet and colleague's (1996) naturalistic study addressed externalizing behavior problems, the current study provided descriptions of children with an internalizing disorder. It is possible that fathers are more likely to provide greater endorsements of behavioral strategies compared with family and/or individual counseling when they are presented with a child exhibiting an externalizing behavior problem (especially oppositional behaviors such as presented in Miller & Kelley, 1992). In fact, Phares and colleagues (1996) found that parents attributed greater personal responsibility to the child versus parents or teachers for the child's externalizing behavior problems versus internalizing problems and were therefore more likely to have the child alone engage in behavior therapy versus joining the child in family therapy. However, if the child instead exhibited internalizing problems, parents were more inclined to join the child in family therapy. This phenomenon fits well with Weiner's (1980) findings that individuals are more inclined to help if behavior is attributed to internal, uncontrollable causes; however, if behavior is attributed to internal, controllable causes, individuals often have a negative reaction and are less likely to help. Even though both mothers and fathers offered higher endorsements of the behavioral intervention versus family therapy

for an externalizing versus an internalizing problem, fathers' acceptability ratings of the behavioral intervention were significantly higher than mothers'. Hence, future studies seeking to uncover unique attitudes of mothers and fathers in perceptions of treatments for childhood problems should present both externalizing and internalizing problems.

It is possible that the current study accurately reflects attitude changes that have occurred in some fathers during the past decade or so since the above studies were conducted. Some researchers have noted significant increases for fathers over the past three decades in the relative amount of time fathers versus mothers spend with their children (Cabrera, Tamis-Lamonda, Bradley, Hofferth, & Lamb, 2000). Whereas fathers from two-parent families previously spent approximately 30% to 45% as much time with their children as mothers did, they now spend 67% on weekdays and 87% as much time as mothers on weekend days (Yeung, Sandberg, Davis-Kean, & Hofferth, 1998). If paternal attitudes were beginning to shift toward greater concordance with maternal attitudes in these matters, one would expect other treatment acceptability studies to fail to produce rater gender effects. In fact, this occurred in Mak and Freeman (2006). In their sample of 416 university undergraduates, males did not differ significantly from females in their ratings of the acceptability of treatments that were identical to those utilized in the present study. Additionally, Phares et al. (1996) failed to find parent gender differences in ratings of overall responsibility (either mother or father) for childhood problems; whereas previous studies had (Penfold, 1985; Watson, 1986). Again, a decade had passed between those studies. It is possible that society is sending a more positive message to fathers about their value as parents and that fathers' receipt of that message

may be one component leading to greater involvement in their children's lives (Biller, 1993) and greater mother/father concordance in opinions about treatments.

Parent-focused Treatment versus Child-focused Treatment

As predicted, parents' ratings of the parent-focused treatment were significantly higher than for the child-focused treatment when considering the younger child vignettes. These results suit common perceptions among adults of the developmental nature of children's cognitive, emotional, and social abilities that can either maximize or minimize benefits of treatments like CBT. How able a client is to engage in mental abstractions (e.g., self conceptualization, metacognitions), comprehend psychoeducational material, and demonstrate emotional awareness can determine his or her ability to engage in and ultimately benefit from the psychosocial treatments presented in this study. The limitations younger children generally exhibit in the above abilities, combined with their greater reliance on adult direction may explain why adults tend to hold parents more responsible for the behavior problems of younger children versus older children (Phares et al., 1996). The converse is also true. For example, numerous studies have found that mothers make greater internal attributions (disposition and intentionality) for the misbehaviors of older versus younger children (Dix, Ruble, Grusec, & Nixon, 1986; Gretarsson & Gelfand, 1988). It stands to reason, then, that parents who see an older child versus a younger child as more responsible for the development and treatment of problems are less likely to involve themselves in the intervention (Phares, Ehrbar, & Lum, 1996).

However, parents' greater acceptance of the parent-focused intervention may be due to factors other than conscious comparisons between the cognitive, emotional, and

social demands of presented treatments and the child's development in those realms. Perhaps parents are not fully aware of, for example, the significant cognitive demands (e.g., cognitive restructuring) inherent in the treatments presented in the current study. They may then see a child of age 6 or 13 years as equally capable of undergoing the child-focused version of this treatment, especially under the supervision of a trained professional. Parents may be more conscious of their supportive role in the child's life and therefore their potential role in the proposed treatments for their child. Indeed, the most common response in the current study as to parents' rationale for treatment rankings centered on their desire to be supportive and protective of their child. This sentiment may be especially potent when considering placement of a child into a situation that is potentially as anxiety provoking as psychological treatment. Given a parents' role as a child's primary emotional support is most prominent during a child's younger years (Santrock, 2000), it stands to reason that parents' acceptability of a parent-focused intervention would be higher for a younger child versus an older child.

Parents may also recognize the similarity between treatment and everyday parenting. In the present study, both the presented psychosocial treatments and day-to-day parenting involve adults supervising and training a child to think and behave in certain ways. Given the fact that the parent-child relationship offers certain advantages over the therapist-child relationship (e.g., significantly more time to deliver and monitor treatment, enhanced rapport with the child, and increased influence with the child) that can impact treatment outcome, parents may see parent-focused treatments as a more effective option. This may be more common when parents are dealing with a younger child because, as a rule, parents spend significantly more time with younger versus older

children (Bryant & Zick, 1996). Additionally, parents likely perceive a better chance to maintain treatment benefits when they, as their child's primary support, are aware of, and involved in treatment processes. Hence, even in the absence of treatment options that clearly demand cognitive and other capabilities seen to vary across younger and older children, parents may still rate parent-focused interventions more highly for a younger versus an older child.

These results are congruent with treatment outcome studies such as Barrett and colleagues (1996) who indicated advantages in terms of treatment gains that were greater for younger children undergoing CBT when a family anxiety management component was included versus child-focused CBT alone. Specifically, a greater percentage (i.e., 100%) of younger participants (i.e., 7-10 year-olds) in a CBT plus family anxiety management (CBT + FAM) no longer met criteria for an anxiety disorder at posttreatment versus participants in a child-focused CBT condition (55.6%). For older children (i.e., 11-14 year-olds), however, no such results were found (Barrett, Dadds, & Rapee, 1996). These results imply that treatment efficacy for interventions targeting anxiety in younger children may be associated with the enhancement of parenting skills. If so, adding a family component to otherwise individually-focused psychosocial interventions for child anxiety may result in higher acceptability ratings for younger compared with older children.

For older children, contrary to predictions, child-focused CBT and parent-focused CBT were rated as equally positive. Contrary to a similar study (i.e., Mak & Freeman, 2006), these participants found an intervention focusing on either the child or the parent equally acceptable when reading a vignette of an older child. Overall ranking of

treatments indicated equal preference for parent-focused and child-focused treatments when imagining that their own child had problems with anxiety. Perhaps parents, unlike nonparents in other studies like Mak and Freeman (2006), see treatments focusing on either parents or children as equally advantageous, when considering an older child. In general, this may parallel a phenomenon found by Pickering and colleagues (1988) where results differentiated between parent and nonparent women's perceptions of the acceptability and effectiveness of treatments for children's self-injury. They found that mothers rated an intrusive intervention (i.e., shock) as less acceptable than women who did not have children (Pickering, Morgan, Houts, & Rodrigue, 1988). In this case, an apparent interaction between some rater characteristic(s) more common in parents and a treatment characteristic (i.e., aversiveness) may have contributed to parents' greater sensitivity to the use of aversive procedures for child problems compared with nonparents' sensitivity. This heightened sensitivity is likely associated with parents' versus nonparents' increased exposure to and direct contact with children. Their personal investment into the caregiving they engage in with their children may increase their sensitivity to needs of children in general (and also to threats to the safety and comfort of children in general). Hence, they may view treatments perceived as aversive more negatively than nonparents, even if offered to a hypothetical child.

In the current study, parent- and child-focused treatments were endorsed equally for older children. For a younger child, parents' treatment acceptability ratings were higher for the parent-focused versus the child-focused intervention, indicating parents do place a higher premium on their involvement in the treatments for younger children. Among other things, this is likely due to parent's perceptions of younger children in

terms of relative cognitive and emotional limitations. However, parental perceptions of older children's advancements in relevant abilities compared with younger children was insufficient to reduce acceptability ratings for parent-focused treatment and/or to increase acceptability ratings for the child-focused treatment to produce predicted results in this study. It may be that parents' value of their active role in supporting, guiding, and teaching their children is proportional to their appreciation of the perceived advances in the applicable characteristics of older children. Again, parents who indicated parent-focused treatment as their first choice if they had an anxious child most often cited the importance to the treated child of parental support and guidance throughout treatment.

Influence of Child Age on Treatment Acceptability

In terms of differences in ratings of treatment acceptability across child age, parent-focused treatment was more positively endorsed for younger children than older children. This is consistent with current predictions as well as Mak and Freeman's (2006) study of university undergraduates. These findings were paralleled by research indicating parents' treatment acceptability ratings were higher for behavioral contingencies for internalizing and externalizing problems in younger children versus older children (Phares et al., 1996). Comparison of the current parent-focused intervention with Phares' and colleagues' (1996) behavioral contingencies, (e.g. verbal praise, time-out, positive reinforcement, etc.) reveal an important similarity. Essentially, both treatments target parents with the goal of training them to deliver, monitor, and adjust (if necessary) the components of treatment (behavioral and/or cognitive) with their children, under the guidance of a trained professional. Taking into account the developmental considerations in treatment, parental involvement and the use of behavioral approaches has been

suggested for the treatment of anxiety in younger children (Barrett, 2000; Piacentini & Bergman, 2001). Therefore, the fact that parents rated the parent-focused treatment more positively for younger children than older children was expected, given the limitations in cognitive ability and the increased dependence on parents of younger children relative to older children.

Contrary to predictions, the acceptability of the child-focused treatment did not differ significantly across child age. This finding is inconsistent with Mak and Freeman's (2006) finding that university undergraduates rated the child-focused treatment as significantly lower for younger versus older children. Given that the current case vignettes and treatment descriptions were identical to Mak and Freeman's (2006), it is surprising that results differed. However, similar nonsignificant results were reported by Phares and colleagues (1996) who found that parents' ratings of individual child therapy did not differ across child age (6 and 15 year-olds). As both individual child therapy as described in Phares et al. (1996) and child-focused treatment presumably involve the child attending therapy with a trained professional in the absence of parents, it can be argued that they both would likely foster comparable expectations in parents. Given similar results across these two studies, combined with Pickering et al. (1988) that also found treatment acceptability ratings to differ between parents and nonparents, it is possible that parents bring a somewhat unique perspective to evaluations of treatment acceptability.

Alternatively, the child-focused treatment description and the individual child therapy depicted in Phares (1996) may have incorporated insufficient detail to represent their respective demands on children. Without this type of information, parents would

have missed evaluative cues as to the lack of a match between a child's abilities and the treatments' demands. Treatment acceptability ratings have been shown to vary depending on the presence and type of information provided (e.g., Tingstrom, McPhail, & Bolton, 1989). Perhaps parents' endorsements of the child-focused treatment in the present study would have varied across child age had the treatment description provided more detail in terms of the cognitive demands of the intervention.

If the lack of findings for child-focused interventions in the present study was partly due to insufficient details in the treatment description, it is possible that the child age effect found in Mak and Freeman (2006) was associated with the background knowledge of the participants. They may have been better equipped to "fill in the blanks." Specifically, the university students in this sample may have required less information than parents to gain a more accurate impression of the demands of CBT due to their enrollment in an introductory psychology course. Given the prevalence of cognitive-behavioral interventions in the subject indexes of numerous introductory psychology texts (e.g., Bernstein, Clark-Stewart, Penner, Roy, & Wickens, 2000; Meyers, 1998; Passer & Smith, 2001), it is quite likely the university students had been exposed to instructional materials allowing greater familiarity than our parents with the demands (cognitive restructuring etc.) associated with CBT. For the students, the current portrayal of these cognitive demands may have been sufficient to prompt evaluation of the lack of fit between the child's development and the treatment's demands, leading to the expected results. Future studies should provide more detailed descriptions of CBT to those without the benefit of recent class instruction. This could more fully inform evaluators on the

aspects of a treatment that should inform their opinion as to the treatment's acceptability for a particular population.

Limitations

This study presented written case vignettes and treatment descriptions and thus did not recreate the ecological context of seeking, consultation, and receiving treatment. Some have noted that this is a common weakness of analog methodology as utilized in many treatment acceptability studies (Foster & Mash, 1999). For example, a consumer's acceptability ratings would likely increase following a lengthy consultation and assessment with a conscientious health professional. Analog studies have shown that factors such as the perceived level of client/clinician collaboration employed in the choice of a treatment also affect treatment acceptability (Kusick, Gutkin, & Wit, 1991). Written descriptions of anxious children also do not recreate the impact of exposure to a real-life anxious child. Perhaps parents ratings of treatments similar to those offered in the present study would change given they were engaged in seeking treatment for an actual child struggling with anxiety. For example, parents consulting with a child psychiatrist may show higher ratings of medications than those obtained in this study. Nonetheless, utilization of analog methodology to measure parents' opinions about treatments provided several advantages over a naturalistic design. First, analog methodology allowed for manipulation of child age while matching child gender to one of the parents' own children in this study. It also allowed for control of confounding variables (e.g., severity of anxious symptomatology and comorbidity in children). It also afforded an opportunity to scrutinize understudied variables such as treatment acceptability ratings of interventions targeting child anxiety (i.e., child-focused, parent-

focused). Finally, employing an analog methodology allowed for a replication of a previous study conducted with a university sample utilizing standardized research stimuli.

Another limitation is the fact that we presented participants with only one treatment at a time for evaluation on the TEI-SF, whereas it is possible that consumers in the real world would likely have combinations of various treatments to choose from. Choices might include combinations of psychosocial treatments and medications, or individual child-focused treatment and a parent-training group. While the acceptability of one treatment or the other in isolation may sometimes be lower, some research has found that opinions can change if two are offered in combination (Power, Hess, & Bennett, 1995). For instance, medications are often viewed less positively than psychosocial interventions; however, some research has shown more positive endorsements of medication when used in combination with behavioral treatments, compared to medication treatment alone (Power et al., 1995). Though the current study did not solicit ratings of combinations of treatments, parents were asked on the Rank and Refusal form to indicate which two of the three presented treatments (i.e., child- and parent-focused psychosocial and medications) they would be interested in if their child were anxious, given a combination of two treatments were made available. The overwhelming majority of parents (i.e., 94.4%) indicated they would take advantage of a combination of child-focused and parent-focused interventions, whereas only 6.9% said they would include medications in a combination of two of the three presented interventions.

Another limitation of this study is the demographics and resultant generalizability. Parents responded to notices placed in public libraries and community centers and a

community announcement in a Winnipeg newsmagazine targeting parents. Perhaps results would have been different had parents been recruited from clinical populations. Additionally, the demographics describe a fairly affluent sample of Caucasian parents. Results might have been very different had more parents from lower SES backgrounds and/or from more diverse ethnicities participated. Future studies examining treatment acceptability among more ethnically and financially diverse populations are warranted. In terms of the fathers, it is possible that this is a less representative group of "keener" dads who, unlike many other fathers, are willing to invest the time and energy to participate in a parent survey. This may have been due to SES indicators like income and education. Future studies should examine parent gender differences in treatment acceptability ratings within a less advantaged sample of parents.

Implications

The current study presents several important practical implications. The first pertains to external validity. In gathering data from parents from the community as opposed to other adults from more exclusive settings (e.g., university), results reflect more accurately the opinions of potential consumers of treatments for child anxiety. Interestingly, there were numerous similarities in results between the university students in Mak and Freeman's (2006) sample and the present parent sample. One discordant finding was that parents did not show a preference for a child-focused treatment over a parent-focused treatment for an older child. Besides illustrating that parents sometimes hold unique views to nonparents, in general, this finding educates clinicians as to parents' openness to both modes of treatment for early adolescent children. Future studies examining treatment acceptability should include a child in later adolescence to see if this

result holds. Similarly, parents, unlike Mak and Freeman's (2006) student sample, did not show greater acceptance of a child-focused treatment for an older versus a younger child. This may have something to do with unmeasured variables related to parenting (e.g., view of parents' supportive role of a child; desire to shelter their child from the stress of therapy). Alternatively, it may be due at least in part to a lack of information in the current description of the child-focused intervention regarding the level of demands that the treatment would place on a child. Given that some studies have shown that younger children experience difficulty with aspects of CBT such as cognitive restructuring (e.g., Spence et al., 2000; Beidel et al., 2000), this finding alerts clinicians as to the importance of educating parents about cognitive, emotional, and other demands inherent in certain treatments. If parents are made aware of these demands, they can make a more informed treatment choice, thereby increasing the odds of greater adherence and possibly more positive outcomes (Foster & Mash, 1999). Future studies on treatment acceptability (especially with samples of individuals not currently enrolled in university) should include a more detailed description of the treatments to ensure a fuller understanding of the demands of each intervention.

Overall, parents showed much stronger endorsements of both psychosocial interventions compared with medications. Interestingly, most of the effect sizes were pronounced in the current study compared with a previous study of nonparent adults (i.e., in some cases, a full standard deviation above effect sizes in Mak & Freeman, 2006). This may alert health professionals as to the importance of providing treatment options other than medications, such as psychosocially-based interventions. Otherwise consumers may be less inclined to receive and adhere to treatment. Parents also indicated their

preferences for locations for receiving treatments. Responses indicated preferences for family centres, pediatrician's offices, and schools over community health centres, hospitals or mental health centres. Fathers' most often ranked a pediatrician's office as their most preferred location for treatment (i.e., 39.3%). As fathers also indicated a strong preference for psychosocial interventions versus medications, this finding highlights the need for pediatricians and other medical health professionals to educate themselves as to types and availability of psychosocial interventions to enable referrals to appropriate agencies. Unlike fathers, mothers most often ranked a family centre as their most preferred location for treatment (i.e., 43.2%). In general, location preferences can help those who plan and implement treatment programs to select locations where parents are more likely to attend.

Additionally, knowledge of parent' preferences for psychosocial treatments over medications in general, and of child-focused and parent-focused CBT over medications in particular, justifies increased research and clinical attention on the understanding and development of those particular types of treatment. Parents also indicated preferences for information on various psychological treatments versus medications. For parents of an anxious younger child, implementation of a parent-focused CBT protocol may lead to greater treatment adherence and potentially longer-term maintenance of positive treatment outcomes (e.g., Rapee et al., 2005; Mendlowitz et al., 1999). For older children (or early adolescents), parents are equally accepting of a child-focused or parent-focused intervention. Clinicians then have the option of offering either treatment if deemed appropriate based on their assessment of the unique intra- and inter-individual characteristics and dynamics of a family. Given the high cost of health care, a focus on

the further development and implementation of psychosocial interventions for child anxiety may offer payoffs based on greater parent and child adherence to the treatment and possibly more significant and longer lasting rates of reduction in anxiety.

The present study indicates that, while child age at times is a consideration of parents in rating treatments for child anxiety, overall, both child-focused and parent-focused treatments are highly acceptable. Parents' acceptability ratings implied the belief that younger children versus older children may require, and realize increased benefits from, greater parental involvement in their treatment. At some level, this may reflect parents' recognition of developmental considerations inherent in decisions about treatments for their child. However, this finding needs to be taken in the context of a fairly small effect size (i.e., .43).

Including data from fathers and analyzing it separately from mothers' data allowed for important comparisons to be made. Fathers have sometimes exhibited differences in terms of parenting attitudes in general that can influence a child's well-being (e.g., Russell et al., 1998). They have also been observed to differ from mothers in terms of treatment acceptability ratings for the problems of children (e.g., Phares et al., 1996; Miller & Kelley, 1992; Bennet et al., 1996). In the present study, fathers resembled mothers to a surprising degree. Slight differences occurred in items such as treatment location preferences; however, on the central foci of the study, fathers held very similar opinions to mothers. Regarding treatment locations, fathers indicated their most preferred location was the pediatrician's office, whereas mothers indicated their most preferred location was a family centre.

In terms of core foci of this study, no significant differences between mothers and fathers were found for levels of treatment acceptability for any of the presented treatments, or for levels of perceived distress and importance of treatment-seeking for the children in the vignettes. Knowledge of these similarities should encourage clinicians to make greater efforts to offer treatments to both parents and schedule sessions at times when both mothers and fathers are able to attend. If today's fathers are getting more involved in child-rearing and are more willing to avail themselves for child treatment than fathers of the past, perhaps it is time to break with the traditional acceptance of only working with mothers in child interventions. Including fathers in their child's treatment may even lead to greater maintenance of treatment gains.

Given the paucity of data on fathers, future studies examining treatment acceptability should attempt to recruit fathers and to analyze father and mother data separately. As other studies have also failed to find differences between men and women regarding perceptions of treatments (e.g., Mak & Freeman, 2006), evidence may support that the gender gap is narrowing among well educated, affluent Caucasian families within this city. If this notion is verified in future research, there may come a time when studies examining treatment acceptability for childhood problems may focus on "parents" (*both* mothers and fathers; Phares, 1996, p. 314) instead of mothers and father separately.

The body of research examining treatment acceptability for externalizing childhood problems (e.g., Kazdin et al., 1981; Norton et al., 1983; Reimers et al., 1991) is disproportionately large compared to studies focused on childhood internalizing problems (e.g., Chavira, Stein, Bailey, & Stein, 2003; Phares, Ehrbar, & Lum, 1996) and few have explored the influence of parent (i.e., parent gender) and child characteristics (i.e., child

age; Phares et al., 1996). Additionally, the few treatment acceptability studies for internalizing childhood problems have dealt primarily with counseling therapy, medications, and/or medications (e.g., Chavira eta al., 2003; Phares et al., 1996). Researchers have only recently begun to examine treatment acceptability in child-focused versus parent-focused interventions for child anxiety (e.g., Mak & Freeman, 2006). Hence, this study is the first to compare and contrast mothers' and fathers' perceptions of parent-focused CBT, child-focused CBT, and medication treatments for child anxiety.

Conclusion

Gathering and analyzing data from *both* fathers and mothers when examining influences on suboptimal childhood outcomes can help elucidate previously unmeasured variables that constitute the setting in which a child's anxiety problems may develop, be maintained, and be treated. This knowledge can boost our understanding of contextual factors that contribute to the occurrence of these disorders via the identification of associations not only between mothers and childhood problems, but between fathers and childhood problems as well. This type of research may eventually result in dismantling the phenomenon of "mother-blaming."

In summary, it appears that, in some cases, child age impacts parents' ratings of acceptability, and in other cases it does not. Though effect sizes were relatively small, parents' ratings were greater for the parent-focused treatment (ES = .43) and lesser for medications for younger versus older children (ES = .19); however, their approval of the child-focused treatment was not influenced by child age. This suggests that perceptions of treatment acceptability are guided to some extent by child age. The finding also suggests that some raters may require more information about the developmentally-based

demands of certain treatments. In general, mean treatment acceptability ratings of both parent- and child-focused interventions reflected positive regard for these treatments for both younger and older children. Conversely, mean ratings indicated that medications were perceived negatively. Treatment acceptability studies such as this can offer clinicians important information to use in various settings. Whether speaking directly with individual clients or presenting materials for community-based education programs, clinicians and other educators can target misconceptions about treatments with relevant information in terms of the treatments' rationale and efficacy. This could reduce the gap that sometimes exists between public perception and empirical evidence.

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Appendix A

Bibliography of Treatment Acceptability Studies with Parent Samples

A: Studies analyzing mother and father data separately:

Bennett, D. S., Power, T. J., Rostain, A. L., & Carr, D. E. (1996). Parent acceptability and feasibility of ADHD interventions: Assessment, correlates, and predictive validity. *Journal of Pediatric Psychology, 21*(5), 643-657.

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Rostain, A. L., Power, T. J., & Atkins, M. S. (1993). Assessing parents' willingness to pursue treatment for children with attention-deficit hyperactivity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry. 32*(1), 175-181.

B: Studies including fathers but no separate mother and father analysis:

Boothe, J. L., & Borrego, J. Jr. (2004). Parents' acceptance of behavioral interventions for children with behavior and communication problems. *Child & Family Behavior Therapy, 26*(2), 1-15.

Finn, C. A. (2003). Remediating behavior problems of young children: The impact of parent treatment acceptability and the efficacy of conjoint behavioral consultation and videotape therapy. *Dissertation Abstracts International: Section A: Humanities and Social Sciences. 63*(7-A), 2456.

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Norton, G. R., Austen, S., Allen, G. E., & Hilton, J. (1983). Acceptability of time out from reinforcement procedures for disruptive child behavior: A further analysis. *Child & Family Behavior Therapy, 5*(2), 31-41.

C: Studies including mothers only (or omitting identification of parent gender):

Adams, C. D., & Kelley, M. L. (1992). Managing sibling aggression: Overcorrection as an alternative to time-out. *Behavior Therapy, 23*(4), 707-717.

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Appendix B

DEMOGRAPHIC QUESTIONNAIRE

Instructions: Please provide some of your background information below.

1. Gender: Male ____ Female ____

2. Age: _____

3. Ethnic background: _____

4. Education (please check highest level completed):

Less than Grade 12 ___

Completed College/Some University ____

Completed University Undergraduate Degree (e.g., B.A., B.Ed) _____

Completed a University Graduate Degree (e.g., M.A., M.Ed, Ph.D) ____

Other ____ (please describe): _____

Please check the category best describing your total annual family income:

Less than $10,000.00 _____

$10,000.00--$19,999.00 _____

$20,000.00--$29,999.00 _____

$30,000.00--$39,999.00 _____

$40,000.00--$49,999.00 _____

$50,000.00--$59,999.00 _____

$60,000.00--$69,999.00 _____

$70,000.00--$79,999.00 _____

$80,000.00—89,999.00 _____

$90,000.00—99,999.00 _____

More than $100,000.00 _____

6. Please indicate the number children in your family: _____

7. Have you ever participated in counseling or received psychological treatment for a mental health problem?

Yes ___ No ___
If yes, was it for problems related to:
Anxiety _____ Depression _____ Other (Please specify):_____

8. Have you ever taken medication for a mental health problem?

Yes ___ No ___
If yes, for what type of mental health problem?
Anxiety ____ Depression ____ Other (Please specify): _____

9. Please indicate whether any of your children have experienced problems with any of the following:

Anxiety _____ Depression ____ Learning Disorder ____
Attention –Deficit/Hyperactivity Disorder ____
Other (Please specify): _____

10. How much time per <u>weekday</u> do you spend with your child(ren)?

Less than 1 hour ___ 1-3 hours ___ 4 hours or more ___

11. How much time per <u>weekend day</u> do you spend with your child(ren)?

Less than 1 hour ___ 1-2 hours ___ 3-4 hours ___ 5-6 hours ___ 7 hours or more ___

12. How many hours per week do you work outside the home (paid or unpaid)?

20 hours or less _____ 21-39 hours _____ 40 hours or more _____

13. Whom do you see as your children's primary caregiver in your household?

Mother ___ Father ___ Shared Equally ___

Appendix C

Spence Child Anxiety Scale-Parent Report

Your Child's Date of Birth (*dd/mm/yyyy*): _____/_____/_____

Your Child's Gender (Boy or Girl): Boy Girl

BELOW IS A LIST OF ITEMS THAT DESCRIBE CHILDREN. FOR EACH ITEM PLEASE CIRCLE THE RESPONSE THAT BEST DESCRIBES YOUR CHILD. PLEASE ANSWER ALL THE ITEMS.

1. My child worries about things ..... Never Sometimes Often Always
2. My child is scared of the dark ..... Never Sometimes Often Always
3. When my child has a problem, s(he) complains of having a funny feeling in his/her stomach ..... Never Sometimes Often Always
4. My child complains of feeling afraid ..... Never Sometimes Often Always
5. My child would feel afraid of being on his/her own at home..... Never Sometimes Often Always
6. My child is scared when s(he) has to take a test ..... Never Sometimes Often Always
7. My child is afraid when s(he) has to use public toilets or bathrooms ..... Never Sometimes Often Always
8. My child worries about being away from us/me ..... Never Sometimes Often Always
9. My child feels afraid that s(he) will make a fool of him/herself in front of people ..... Never Sometimes Often Always
10. My child worries that s(he) will do badly at school ..... Never Sometimes Often Always
11. My child worries that something awful will happen to someone in our family ..... Never Sometimes Often Always
12. My child complains of suddenly feeling as if s(he) can't breathe when there is no reason for this ..... Never Sometimes Often Always
13. My child has to keep checking that (s)he has done things right (like the switch is off, or the door is locked)... Never Sometimes Often Always
14. My child is scared if (s)he has to sleep on his/her own ..... Never Sometimes Often Always
15. My child has trouble going to school in the mornings because s(he) feels nervous or afraid ..... Never Sometimes Often Always
16. My child is scared of dogs ..... Never Sometimes Often Always
17. My child can't seem to get bad or silly thoughts out of his/her head ..... Never Sometimes Often Always

18. When my child has a problem, s(he) complains of his/her heart beating really fast ..... Never Sometimes Often Always

19. My child suddenly starts to tremble or shake when there is no reason for this ..... Never Sometimes Often Always

20. My child worries that something bad will happen to him/her ..... Never Sometimes Often Always

21. My child is scared of going to the doctor or dentist ..... Never Sometimes Often Always

22. When my child has a problem, s(he) feels shaky ..... Never Sometimes Often Always

23. My child is scared of heights (e.g., being at the top of a cliff) ..... Never Sometimes Often Always

24. My child has to think special thoughts (like numbers or words) to stop bad things from happening ..... Never Sometimes Often Always

25. My child feels scared if (s)he has to travel in the car, or on a bus or train ..... Never Sometimes Often Always

26. My child worries what other people think of him/her ..... Never Sometimes Often Always

27. My child is afraid of being in crowded places (like shopping centres, the movies, buses, busy playgrounds)... Never Sometimes Often Always

28. All of a sudden my child feels really scared for no reason at all ..... Never Sometimes Often Always

29. My child is scared of insects or spiders ..... Never Sometimes Often Always

30. My child complains of suddenly becoming dizzy or faint when there is no reason for this ..... Never Sometimes Often Always

31. My child feels afraid when (s)he has to talk in front of the class ..... Never Sometimes Often Always

32. My child complains of his/her heart suddenly starting to beat too quickly for no reason ..... Never Sometimes Often Always

33. My child worries that (s)he will suddenly get a scared feeling when there is nothing to be afraid of ..... Never Sometimes Often Always

34. My child is afraid of being in small closed places, like tunnels or small rooms ..... Never Sometimes Often Always

35. My child has to do some things over and over again (like washing his/her hands, cleaning or putting things in a certain order) ..... Never Sometimes Often Always

36. My child gets bothered by bad or silly thoughts or pictures in his/her head ..... Never Sometimes Often Always

37. My child has to do certain things in just the right way to stop bad things from happening ..... Never Sometimes Often Always

38. My child would feel scared if (s)he had to stay away from home overnight ..... Never Sometimes Often Always

39. Is there anything else that your child is really afraid of? ..... YES NO

Please write down what it is, and fill out how often (s)he is afraid of this thing: _____ Never Sometimes Often Always

_____ Never Sometimes Often Always

_____ Never Sometimes Often Always

Appendix D

Case Vignettes

Case description of 6-year-old boy (followed by an example of sensitivity items)

Johnny is an anxious, 6-year old boy in the first grade. He is described by both his parents and elementary classroom teacher as a very shy and quiet child who rarely talks or plays with other children. He rarely, if ever speaks out in class and becomes visibly anxious when called upon in class. When called upon, he appears extremely uncomfortable and sometimes does not respond to the teacher's question or will respond very timidly, avoiding eye contact. His teacher notes that he tends to avoid interactions with other children during recess, has few friends, and is very apprehensive about joining group activities (e.g. soccer). Johnny's parents say that he is scared of trying new things and constantly worries about bad things that could happen to him. His parents report that he has had problems with anxiety both in and outside of home for more than a year. Both Johnny's parents and teacher are concerned about the negative impact that Johnny's anxiety is having on his social development and academic success.

Case description of 6-year-old girl

Jenny is an anxious, 6-year old girl in the first grade. She is described by both her parents and elementary classroom teacher as a very shy and quiet child who rarely talks or plays with other children. She rarely, if ever speaks out in class and becomes visibly anxious when called upon in class. When called upon, she appears extremely uncomfortable and sometimes does not respond to the teacher's question or will respond very timidly, avoiding eye contact. Her teacher notes that she tends to avoid interactions with other children during recess, has few friends, and is very apprehensive about joining group activities (e.g. playing games). Jenny's parents say that she is scared of trying new things and constantly worries about bad things that could happen to her. Her parents report that she has had problems with anxiety both in and outside of home for more than a year. Both Jenny's parents and teacher are concerned about the negative impact that Jenny's anxiety is having on her social development and academic success.

Case description of 13-year-old boy

Paul is an anxious, 13-year old boy in the eighth grade. He is described by both his parents and junior high school teachers as a very shy and quiet adolescent who rarely talks to his peers. He rarely, if ever speaks out in class and becomes visibly anxious when called upon in class. When called upon, he appears extremely uncomfortable and sometimes does not respond to the teachers' question or will respond very timidly, avoiding eye contact. His teachers note that he avoids interacting with his classmates, is anxious when he has to participate in class discussions, has few friends, and does not join any extracurricular activities (e.g. intramurals). Paul's parents say that he worries a great deal about what others think of him, will not go to parties, and is fearful of meeting new people. His parents report that he has had problems with anxiety both in and outside of home for more than a year. Both Paul's parents and teachers are concerned about the

negative impact that Paul's anxiety is having on his academic success and social development.

Case description of 13-year-old girl

Paula is an anxious, 13-year old girl in the eighth grade. She is described by both her parents and junior high school teachers as a very shy and quiet adolescent who rarely talks to her peers. She rarely, if ever speaks out in class and becomes visibly anxious when called upon in class. When called upon, she appears extremely uncomfortable and sometimes does not respond to the teachers' question or will respond very timidly, avoiding eye contact. Her teachers note that she avoids interacting with her classmates, is anxious when she has to participate in class discussions, has few friends, and does not join any extracurricular activities (e.g. choir). Paula's parents say that she worries a great deal about what others think of her, will not go to parties and school dances, and is fearful of meeting new people. Her parents report that she has had problems with anxiety both in and outside of home for more than a year. Both Paula's parents and teachers are concerned about the negative impact that Paula's anxiety is having on her academic success and social development.

Appendix E

Questions Regarding Severity and Likelihood of Seeking Treatment

Thinking of **6-year-old Johnny**, please circle the number that best reflects your opinion.

1. How much distress do you think the child in the vignette is feeling?

0----------1----------2----------3----------4----------5----------6----------7----------8

No Distress | Moderate Distress | High Distress

2. To what extent is this child's anxiety likely to have a negative impact on his/her performance in school?

0----------1----------2----------3----------4----------5----------6----------7----------8

No Impact | Moderate Impact | Large Impact

3. To what extent is this child's anxiety likely to have a negative impact on her/his social life?

0----------1----------2----------3----------4----------5----------6----------7----------8

No Impact | Moderate Impact | Large Impact

4. How important do you think it would be for the child to receive treatment for his/her anxiety?

0----------1----------2----------3----------4----------5----------6----------7----------8

Not at all Important | Moderately Important | Very Important

Appendix F

Treatment Descriptions

Child-focused psychosocial treatment

This treatment is directed toward the anxious children themselves. The approach focuses on teaching the child strategies to manage anxiety. A major goal of treatment is to help the child reverse his or her tendency to avoid situations that make him or her feel anxious. A key component of treatment is exposure exercises which encourage the child to approach situations and learn that the anxiety gradually subsides. The aim is for the child to learn that he or she can cope in the feared situation and gain a sense of control. The child is also taught exercises aimed at helping him or her think more realistically about anxiety-arousing situations and change unrealistic thoughts that promote anxiety. Finally, the child may learn about ways to relax.

Parent-focused psychosocial treatment

This treatment is directed toward the parents of anxious children. The approach focuses on teaching parents ways of helping their child to manage anxiety. A major goal of treatment is to help the child reverse his or her tendency to avoid situations that make him or her feel anxious. A key component is teaching the parent to assist the child to approach anxiety-producing situations. The aim is for the child to learn that he or she can cope in the feared situation and gain a sense of control. Parents are taught to develop confidence in handling situations in which their children are anxious. Parents are also taught ways to help their child think more realistically about anxiety-arousing situations and change unrealistic thoughts that promote anxiety. Finally, parents may be taught how to help their children relax.

Medication treatment

This treatment uses medication to treat anxiety in children. The antianxiety medications which are used most commonly are called selective serotonin reuptake inhibiters (SSRIs) such as sertraline (Zoloft) and fluvoxamine (Luvox). The medication is started at a low dose, taken daily, and gradually increased until the desired reduction in anxiety is achieved. Medication treatment is focused on reducing the anxiety that the child experiences in everyday life. With the anxiety level being reduced, children are more able to approach difficult situations that they may have been avoiding. Children thereby learn that they can cope with these feared situations and gain a sense of control. Another goal of medication is to help the child feel more relaxed.

Appendix G

Treatment Evaluation Inventory-Short Form (TEI-SF)

Instructions: Thinking of (e.g., **6-year-old Johnny**), please read the following treatment and then complete the items listed below by placing a checkmark on the line next to each question that best indicates how you feel about the treatment. Please read the items very carefully because a checkmark accidentally placed on one space rather than another may not represent the meaning you intended.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I find this treatment to be an acceptable way of dealing with the child's problem behavior	_____	_____	_____	_____	_____
2. I would be willing to use this procedure if I had to change the child's problem behavior	_____	_____	_____	_____	_____
3. I believe that it would be acceptable to use this treatment without children's consent	_____	_____	_____	_____	_____
4. I like the procedures used in this treatment	_____	_____	_____	_____	_____
5. I believe this treatment is likely to be effective	_____	_____	_____	_____	_____
6. I believe the child will experience discomfort during the treatment	_____	_____	_____	_____	_____
7. I believe this treatment is likely to result in permanent improvement	_____	_____	_____	_____	_____
8. I believe it would be acceptable to use this treatment with individuals who cannot choose treatments for themselves	_____	_____	_____	_____	_____
9. Overall, I have a positive reaction to this treatment	_____	_____	_____	_____	_____

Appendix H

Treatment Ranking Form

Instructions: Now try to imagine that your child has an anxiety disorder and is experiencing problems similar to those in the case descriptions you just read.

With that in mind:

1. Please rank your preference of the following treatments from 1 (most preferred) to 3 (least preferred):

_____ **Parent-focused treatment**

_____ **Medication treatment**

_____ **Child-focused treatment**

2. Are there any treatments you would decline? Yes ___ No ___

If Yes, check the treatment(s) you would decline:
___ Treatment directed toward the parent
___ Medication treatment
___ Treatment directed toward the child

3. In a sentence or two, please tell us why you ranked your most acceptable treatment **the way you did:**

_____
_____
_____

4. In a sentence or two, please tell us why you ranked your least acceptable treatment **the way you did:**

_____
_____
_____

5. If a **combination of two treatments** were made available for your child's anxiety, **which two** would you be most likely to take advantage of?

_____ Treatment directed toward the parent
_____ Medication treatment
_____ Treatment directed toward the child

6. Please rank your preferences for a location where you might receive treatment from 1 (most preferred) to 6 (least preferred):

_____ Pediatrician's office
_____ School
_____ Hospital
_____ Community Health Centre
_____ Family Resource Centre
_____ Mental Health Centre

Sometimes, treatments for child anxiety include an invitation for parents to join the child in the treatment in order to increase the treatment's effectiveness.

7. If you as parents were asked to attend treatment with your child, please indicate who would be most likely to accompany him/her:

Father ____ Mother ____ Both parents ____

8. If the type of treatment offered was a "parent group" designed to provide information about managing a child's anxiety, who would be most likely to attend?

Mother ____ Father ____ Both parents ____

Appendix I

Preferences for Information Regarding Treatments for Child Anxiety

Instructions: Continue to imagine you had an anxious child and were making decisions about treatments for that child, how important would it be for you to receive information about the following aspects of treatment?

Please circle the number that best fits your response rating from 0 to 8.

1. The various medication treatment approaches available:

0----------1----------2----------3----------4----------5----------6----------7----------8

Not important at all — Moderately important — Very important

2. The various psychological treatment approaches available (such as counseling or therapy):

0----------1----------2----------3----------4----------5----------6----------7----------8

Not important at all — Moderately important — Very important

3. What you and your child have to do as part of the treatment:

0----------1----------2----------3----------4----------5----------6----------7----------8

Not important at all — Moderately important — Very important

4. The cost of the treatment to your family:

0----------1----------2----------3----------4----------5----------6----------7----------8

Not important at all — Moderately important — Very important

5. The cost of the treatment to the health care system:

0----------1----------2----------3----------4----------5----------6----------7----------8

Not important at all — Moderately important — Very important

6. Common side effects of the treatment:

0----------1----------2----------3----------4----------5----------6----------7----------8
Not important at all — Moderately important — Very important

7. Uncommon or rare side effects of the treatment:

0----------1----------2----------3----------4----------5----------6----------7----------8
Not important at all — Moderately important — Very important

8. The waiting period before starting the treatment:

0----------1----------2----------3----------4----------5----------6----------7----------8
Not important at all — Moderately important — Very important

9. How much of your time is required to take the treatment (for appointments and so on):

0----------1----------2----------3----------4----------5----------6----------7----------8
Not important at all — Moderately important — Very important

10. When appointments are scheduled for the treatment:

0----------1----------2----------3----------4----------5----------6----------7----------8
Not important at all — Moderately important — Very important

11. How long it takes before the treatment starts to reduce a child's anxiety:

0----------1----------2----------3----------4----------5----------6----------7----------8
Not important at all — Moderately important — Very important

12. How long the treatment continues:

0----------1----------2----------3----------4----------5----------6----------7----------8

Not important at all	Moderately important	Very important

13. What happens when the treatment is discontinued:

0----------1----------2----------3----------4----------5----------6----------7----------8

Not important at all	Moderately important	Very important

14. What treatment the health care professional who assesses the problem would recommend:

0----------1----------2----------3----------4----------5----------6----------7----------8

Not important at all	Moderately important	Very important

<u>Instructions</u>: Information about treatment can be provided in a number of ways. How acceptable would the following ways of providing information be for you?

15. Information given in written form (in an information sheet or booklet which you could take with you)?

0----------1----------2----------3----------4----------5----------6----------7----------8

Not at all acceptable	Moderately acceptable	Very acceptable

16. Information given by discussion with a health care provider?

0----------1----------2----------3----------4----------5----------6----------7----------8

Not at all acceptable	Moderately acceptable	Very acceptable

17. Information provided by discussion in a videotape (which you could take with you)?

0----------1----------2----------3----------4----------5----------6----------7----------8

Not at all acceptable	Moderately acceptable	Very acceptable

18. Information provided on an Internet Website?

0----------1----------2----------3----------4----------5----------6----------7----------8

Not at all acceptable	Moderately acceptable	Very acceptable

Appendix J

Cover Letter

Dear Parent,

Thank you for taking the time to consider participating in this project. This survey was designed to gain insights into parent's opinions about treatments for child anxiety.

The attached consent form describes exactly what participation in the study would entail. If you would like to participate, please sign both copies of the consent form, and retain a copy for your own records. Participation in this study is completely voluntary and you are free to withdraw from this study at any time. All of your responses will be kept strictly confidential and will be stored in a locked research lab at the University of Manitoba's Department of Psychology. A Gift Card/Feedback Mailing List Form accompanies the Participation/Consent form to obtain your mailing address so that we can send you (a) an honorarium of a $5.00 Safeway gift card to thank you for your time, along with a debriefing information sheet when your questionnaire is completed and returned; and (b) A Summary of study findings that we expect to send you in September of 2006. If both you and your partner are participating, please complete the surveys independently.

To complete the study and provide participants with the final Study Summary including the results in a timely manner, we ask that you complete and return the survey package some time over the next week or so. If we have enough packets returned by the end of summer, we anticipate being able to provide the final Study Summary in September. Thank you very much for your time in considering this project.

Sincerely,

Brad Zacharias, BA (Hon)
Master's Student
Department of Psychology
University of Manitoba

Wendy Freeman, Ph.D
Assistant Professor
Department of Psychology
University of Manitoba

Appendix K

Participation/Consent Form

Research Project Title: Parental Attitudes Study

Researchers: Brad Zacharias, BA (Hon), Master's Student
Wendy S. Freeman, Ph.D., Assistant Professor
Department of Psychology, University of Manitoba

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information. Our contact information is provided on the following page.

The purpose of this study is to examine mothers' and fathers' opinions regarding how acceptable three different treatments for child anxiety are. Participation in this project entails filling out the following questionnaires, which will take approximately 60 minutes of your time, and then returning them to researchers using the enclosed self-addressed, postage-paid envelope.

This study is a part of a program of research on treatments for childhood emotional and behavioral disorders conducted by Dr. Wendy Freeman. This survey is a master's thesis project conducted by Brad Zacharias under her supervision.

The following questionnaire packet has been designed to solicit parents' opinions about treatments for child anxiety. Completion of the questionnaire package will take approximately 60 minutes. The questions ask about basic demographic information (your child's age, gender, family income), information about your own child, and then your opinions about treatments for child anxiety.

Please read and sign the back of this page.

You are asked to not record your name on any of the questionnaires so that your responses remain anonymous. That is, only a number, not a name identifies each questionnaire package. Access to the surveys will only be available to the researchers listed above. Your responses will be kept strictly confidential and will be stored in a locked cabinet at the University of Manitoba's Department of Psychology that can only be accessed by the researchers. All questionnaires will be destroyed 5 years after publication (by approximately 2012).

You are asked to provide a mailing address on the enclosed Gift Card/Feedback Mailing List Form and return it along with a signed copy of this consent form and your completed questionnaire. The mailing list form will be stored separate from your completed questionnaire to maintain confidentiality and it will be destroyed once you have been sent the summary of study findings. Each parent who completes the questionnaire will receive a $5.00 gift card from Canada Safeway stores for participating in this study. The debriefing information sheet will be mailed to you upon receipt of your completed questionnaire. The summary of study findings will be sent to you in September of 2006.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

Should you have any questions, please feel free to contact Brad Zacharias by toll-free telephone at or by e-mail at .com, or, Dr. Wendy Freeman at (204) 474-7349.

This research has been approved by the Psychology/Sociology Human Subject Research Ethics Board (Protocol #P2006:022). If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122 or e-mail .ca. A copy of this consent form has been given to you to keep for your records and reference.

_____ _____

Participant's Signature Date (*mm/dd/yyyy*).

_____ _____

Researcher and/or Delegate's Signature Date (*mm/dd/yyyy*).

Appendix L

INSTRUCTIONS

This survey will take approximately one hour to complete and you will receive a five-dollar Safeway Gift Card for returning a completed questionnaire.

The survey package contains several questionnaire forms. Please read and complete the forms in the order they are presented to you. The first form asks you to provide some demographic information such as your age and educational background, and whether you've ever taken medication or gone to counseling for problems with anxiety or depression.

Following this general information form, you will find a description of a child with an anxiety problem. Please read this case description carefully, as you will be asked to rate the severity of the symptoms exhibited by the child in the description and to rate several treatments with reference to this child. After reading the case description, answer the questions on the same page. Then go to the next page and carefully read the short treatment description. Then fill out the ratings that follow thinking about the treatment and the child you just read about. There will be 2 more treatments that you will read about and rate for the same child.

Next, you will find a second case description of another child. Please read the description of this new child carefully and answer the questions on the same page. Then go to the next page and read the description of a treatment and rate it, thinking of this second child. This will be repeated for 2 more treatments.

After this, you will be asked to rank order your preferences for 3 treatments based on your own child having problems with anxiety. The following form asks you questions at to your interest in receiving information about different kinds of treatments for child anxiety. The final form asks for your opinions about receiving treatments for mental health problems.

Once you have completed all questions, please enclose the questionnaire package and one copy of the Participation/Consent form (signed) into the postage-paid Self-addressed envelope and return it to us within the next few days.

Thank you for your participation!

Appendix M

Telephone Script Used With Individuals Interested In Participation

"This is a study of mothers' and fathers' opinions regarding treatments for child anxiety. The way we will obtain your opinions is via a questionnaire. If both you and your partner are interested in participating, we will send you each a separate envelope containing all materials, including a self-addressed, postage-paid return envelope, within which you can return the completed forms. Once forms are returned, a Study Summary along with a $5.00 Safeway gift card will be mailed to you. Participation is completely voluntary and you may opt out at any time with no consequences to you. The questionnaire package contains a participation/consent form, instructions for completing the questionnaire, and the questionnaire itself. Please carefully read and sign the participation/consent form once you receive it, as it will further explain this to you. You will find an extra copy of this form to keep for your records. Please carefully read all instructions on the questionnaire and answer all questions in the order that they are presented. Also, please complete the questionnaire independently (do not consult with your partner about the questions while either is in the process of answering them). Please do not write any identifying information (e.g., your name or address) on the questionnaire. This will help protect your anonymity. All completed questionnaires will be kept in a locked cabinet at the University of Manitoba that can only be accessed by researchers. Without revealing any names, can you tell me the date of birth and gender of one of your children who is currently between 5 and 14 years of age? I will record this information on a number of forms that deal with your opinions about treatments for child anxiety. May I speak with your partner or get a phone number and e-mail address where

he/she can be reached? I need to communicate with him/her about these procedures as well."

Appendix N

Parent Survey

Study Summary No. 1

This study examines differences between mothers' and fathers' opinions regarding how acceptable three different treatments for child anxiety are. The treatments presented in this study are parent-focused psychosocial, child-focused psychosocial, and medication treatments. The study also examines how parents' opinions about these treatments might change based on the age of the child being evaluated.

One of the motivating concerns for this study is the lack of parenting research including the opinions of fathers. Despite evidence that fathers, as well as mothers, play an important role in the ways children develop, much of the research on parenting has focused on mothers. This is especially true when dealing with childhood problems (like anxiety). This has seriously limited our understanding of a number of factors that may influence the environment in which childhood problems develop, are maintained and are treated.

One area of research that seeks to understand parents' attitudes toward treatments for children is known as treatment acceptability. Treatment acceptability (TA) refers to opinions people have about how appropriate, fair, and suitable a treatment is. This is an important area of study because a person's opinions about how acceptable or unacceptable a treatment is can influence whether or not that person seeks out and adheres to a particular treatment. With parents often making treatment decisions on their child's behalf, their opinions about treatments may be one factor that indirectly influences the well being of their child. Sometimes health professionals invite parents to join in therapy with their child, as parental involvement has been shown to increase the effectiveness of certain treatments for child anxiety (especially with younger children). If parents' opinions are more positive about a treatment, the likelihood of their being willing to become involved in their child's treatment may increase, thereby increasing the likelihood of more positive results of the treatment.

Consistent with previous research, predictions were made that mothers would rate both child- and parent-focused psychosocial interventions more positively than fathers would. Additionally, fathers were predicted to rate medication as more acceptable than mothers would. It was also predicted that both mothers and fathers would rate child-focused psychosocial interventions as more acceptable for older children and parent-focused interventions as more acceptable for younger children. Finally, it was predicted that both mothers and fathers would rate both child- and parent-focused psychosocial treatments as more acceptable than medications.

At this time, we want to express our gratitude for your participation in this study. Enclosed in a small token of our appreciation in the form of a $5.00 Safeway gift card.

Thank-you very much!

Appendix O

Verbatim Responses to Requests for
Parents' Rationale for Most Preferred and Least Preferred Treatments

A: Most Preferred Treatment: Parent-focused:

Participant Number	Mother/Father	Rationale
001	M	Parent should always be involved in their children treatment as primary support
003	F	It always helps to have the parents aware of ways to help and on the "same page" (work together).
004	M	My child is young and I think that this treatment is least "invasive" and would be most effective.
007	M	The parent is step one. Armed with effective techniques, they can support and guide the child. This can all happen without the child even realizing it. Next step is to include the child in care plan. Now they know there is a problem and can participate in solving it (better understood by a 13 year old).
012	M	Young children are influence a lot by their parents and can benefit from knowledgeable support from them.
013	F	Parents that are supported and encouraged to help (child) seems to be first and best approach to attempt
015	F	I feel we would be best able to predict situations and provide advance guidance to deal effectively.
016	M	I feel a focus at home with family is likely the most comfortable environment would be the best start to treatment
018	F	This treatment should be a way of life; teaching your kids to deal with tough situations.
019	M	I feel a one-on-one discussion with the child and a Dr. is more beneficial than a parent reading from a book or notes.
024	M	8-10 years is early entry to adolescent stage and face physiological changes in body to parents especially mothers role in treatment in important.
025	F	Adolescents/teenagers are often not the best judge. Parents spend most time with children and they can influence much.
030	M	I feel my child would feel safe working with me to overcome their feelings.
032	M	Because of the age of my child. My child would still need parent guidance.

A: Most Preferred Treatment: Parent-focused (continued):

Participant Number	Mother/Father	Rationale
039	M	Parents can try to strongly encourage a child to do things that would help them. Such as managing play dates, getting their child involved in things like theater/public speaking etc.
041	M	I don't think my child could be successful without my active participation, and I believe that I could "coach" my child to achieve success.
046	M	Parent has the most influence control and time to change behavior.
047	F	I believe social problems/behavior can be prevented by involved parents who spend a good amount of quality time interacting with their children.
049	M	Treatment may prove to be anxiety provoking for the child and really put the focus on them as the source of the problem. If the parents are the focus in helping the child it may help the child/parent interactions.
057	M	I believe that the parents are responsible for the anxiety their child(ren) are experiencing.
059	M	I think it's important to start with the parents and eliminate any negative messages from them. Parents are then educated to help the child.
065	M	I feel a child would have an easier time with the parents trained to "help." He would feel less "un normal."
069	M	My child trusts and will listen to me. She would be willing to do things that I've suggested. I could explain the situation in a non-threatening manner. I could help her because I know her best.
074	F	When a child is young a parent can help the child.
076	M	Parents and children working together can help each other.
077	M	I believe anxiety can stem from parent-child interactions as big piece so I would look to parents to learn first then move to child focused if things did not improve.
079	M	Sometimes parents just don't know how to help their child with some issues. I wish specialists would realize that parents want to help, can help, and can be a big asset.
081	M	First, my sons are 10 and 2 and I believe that I can help them cope with stress/anxiety if I am taught how to do the right approach. Focusing on the child first wouldn't be effective if parents are clueless about what is going on.

Most Preferred Treatment: Parent-focused (continued):

Participant Number	Mother/Father	Rationale
083	M	Just something that I personally believe in.
091	M	Children learn from their parents. If the parents are educated on how to help the child will learn how to help themselves.
092	F	I believe that parents at this stage of the child's life are very "in tune" with their child.
097	M	Goes to the "root" of the anxiety—our caregivers are the ones we need the most to feel safe and secure.
098	M	At the age my child is, I believe it would be best to involve myself.
100	F	Due to the age of child, I feel the parents would have to take the lead role.
101	M	I think parent-focused treatment is the least intrusive treatment for the child.

B: Most Preferred Treatment: Child-focused:

Participant Number	Mother/Father	Rationale
002	F	We believe that there should be a combined treatment that focuses in child and parent. Parents should always be a support source to their children
008	F	I believe you should work with the child first
009	M	A natural drug free way is the best.
010	F	So the child can help themselves when the parent is not around
011	F	It teaches/facilitates the child to own her feelings and learn to live with discomfort. It empowers the child, primarily.
017	M	I believe my child needs to learn foremost, that as they approach different situations, his anxiety will subside.
026	M	I believe this treatment would empower the child as well as help them with anxiety. They need to feel they have some control of things.
028	F	Gives the child a chance to learn about the problem first hand and is able to help in getting better.
029	M	I believe that it would be the best thing for my child, if possible, to learn how to handle anxiety using learned techniques that they could apply for the rest of lives.

B: Most Preferred Treatment: Child-focused (continued):

Participant Number	Mother/Father	Rationale
034	M	Most acceptable to have child learn to face fears thereby decreasing unrealistic fears. If child continues to avoid fear—fear will grow bigger.
035	F	Child needs support and understanding. Child can learn to manage their anxieties with exposure to feared situations and confidence gained with success
038	F	By building the child's ability to cope with the situation it will benefit him/her indefinitely through life.
044	F	I think the child has to overcome this problem on their own and with encouragement and direction from parents.
045	M	If a child is old enough then this treatment would benefit him/her the most.
048	F	Expect longer-term benefits from teaching actual strategies "in situ(ation)."
050	M	Empowers the child more and gives the child alternatives on how to deal with anxiety and frightful situations.
053	M	I think you have to deal with the problem and I do not like the idea of medicine.
054	F	Child might understand better if it came from someone with experience in that field.
055	M	From experience I believe the child and parent both need treatment to get over the problem.
060	F	Teaching coping skills is fundamental for the child to move forward in life.
061	M	Teaching a child that is old enough to deal with his anxiety on his own would be more effective than parent-focused treatment because they have more independence from parents and more time spent at school
063	M	It's important for the child to understand his disorder and have coping techniques he can use, rather than rely on aids (other people/meds).
064	F	Skills that he/she can carry for life.
067	M	Permanent improvement depends on changing the child's thoughts about and reactions to situations that cause them anxiety.
073	M	Least invasive procedure. I feel child/parent treatment should be provided together.

B: Most Preferred Treatment: Child-focused (continued):

Participant Number	Mother/Father	Rationale
080	F	I think that if the child works on the treatment, the outcome will come sooner. It's a buy in for the child, will increase effectiveness.
084	M	In today's world, children are without their parents often and need to learn how to "treat" themselves.
088	F	I believe that the solution for the problem lies within the inner self of the one who has the disorder.
089	M	I feel the child needs to learn how to deal with anxious situations. The child needs to be taught coping mechanisms.
099	F	I feel you need to help the child achieve goals.
102	M	The child needs to "buy into" the treatment plan. I feel the child-focused treatment is the best option for success.

C: Most Preferred Treatment: Medications:

Participant Number	Mother/Father	Rationale
085	F	Medications are highly regulated and their efficiency is proven and measurable empirically.

D: Least Preferred Treatment: Parent-focused:

Participant Number	Mother/Father	Rationale
084	M	Not all parents will be able to implement what they have been taught.
085	F	May add tension to an already tense and vital relationship. Parental and child stress would likely increase.
089	M	I feel the parent needs to be involved and can help their child, but it should be the child who is directly taught by a professional.

E: Least Preferred Treatment: Child-focused:

Participant Number	Mother/Father	Rationale
092	F	The child is not equipped to make a rational decision on their own.

F: Least Preferred Treatment: Medications:

Participant Number	Mother/Father	Rationale
001	M	I believe medication should be the last resort
002	F	We believe medication should be a last resource
003	F	Too much dependency on drugs as a whole. Holistic first.
004	M	Medication is a temporary solution. I would only use it if the disorder was very seriously affecting the child's development.
007	M	The 2 situations didn't sound severe enough to resort to drugs.
008	F	Drugs have side effects which can be debilitating.
009	M	Drugs are only 30-50% effective according to drug companies themselves.
010	F	I believe in medication as a last resort.
011	F	Medication alters biochemistry and interferes with one's natural rhythms and physiology, therefore restricting freedom and forcing children (people) to rely on external solutions.
012	M	We do not fully know the effect of these drugs on a person. I would not want to medicate my child.
013	F	In this case I think medication is the most convenient, but greatly lacks relationship support love and family commitment which I believe is most NB. In fear and anxiety syndrome.
014	M	I don't believe in using drugs for every mental health related disorder-especially mot for kids. There could be lasting severe side effects, both physiological and psychological.
015	F	I do not feel medication with a five year old is appropriate as a long term solution and may lead to other problems due to prolonged drug use.
016	M	I would only agree to medicated treatment as an absolute last resort.
017	M	Medication, in my mind, would always be a last resort.
018	F	I believe drugs can solve one problem but probably create another.

F: Least Preferred Treatment: Medications (continued):

Participant Number	Mother/Father	Rationale
019	M	I do not want my child to be dependent on a drug to feel better! With knowledge comes wisdom.
024	M	I do not think modern medicine has those answers. Unless they use spiritual and traditional medicine.
025	F	Anxiety is a behavioral problem.
026	M	Medication can simply "mask" the root causes of the anxiety and if the child ever wants to stop medication the anxiety might remain.
034	M	I would be reluctant to start medication in a young child. If by teenage year, child and parent-focused treatment is not successful, I would use meds.
035	F	I would avoid medication in the very young if possible. If need be and both child-focused and parent-focused treatments were exhausted then meds could be a last resort for older child.
038	F	I would always try to build the child's natural ability first because I believe all have the power to do so. Drugs should be a last resort.
039	M	By both parent and child getting involved encouraging the child in activities, sports, music etc. That may make a difference in the child's behavior without the use of medications. If that doesn't work, consider medication.
040	F	I would want to at least try to find a effective method of treatment that didn't involve drugs. The drugs mentioned in the study can have unwanted side effects.
041	M	I don't like the potential side effects of medication.
044	F	Unless the child is in danger or a danger to others drugs are not the answer and should never be used.
045	M	Medication has too many bad side effects.
046	M	If medication determines the behavior and it will only be effective during a medicated period of time.
047	F	I don't believe in throwing medications at anything that may be otherwise preventable.
048	F	Expect longer-term benefits from teaching actual strategies "in situ(ation)."
049	M	I don't believe children should be medicated. Also, I feel that a child will perceive themselves to have more control over a situation if the attribute the overcoming of the anxiety to themselves rather than a drug.

F: Least Preferred Treatment: Medications (continued):

Participant Number	Mother/Father	Rationale
050	M	I do not feel it is always in the best interest that we medicate people especially children.
053	M	There is always side effects to medication.
054	F	I believe meds would be the last means of treatment. Child and parents should understand and learn different ways to handle these situations before using medication.
055	M	I believe medication is not a total fix—just a method to get through tough times.
057	M	I believe meds is only a temporary solution. Working with the parents and child will be more beneficial. A child should not be medicated because of what their parents are teaching them.
059	M	I believe medication can be addictive/doesn't help the child/parent use strategies re: anxiety coping
060	F	If symptoms are sever enough then perhaps meds should be used/considered. Otherwise meds sometimes mask underlying problems rather than teaching skills.
061	M	I feel medications should be a last resort and these case descriptions did not seem to warrant it in my opinion.
062	F	Medication as a last resort.
063	M	There is no "magic pill" Let's not mask the problem, let's deal with it. Personal experience: tried, tested and failed.
064	F	I don't believe in pumping a kid full of drugs.
065	M	To medicate a child before all other treatments are exhausted would be wrong. I feel medication would impede natural development.
067	M	Although I believe medication can be highly effective, I would want it used after or in conjunction with, a cognitive-based therapy.
069	M	I do not believe in giving drugs to children. I am more inclined to use holistic methods. I believe in treating problems not just symptoms.
073	M	I feel should be a last resort after all other treatments have been explored. Medication can have side effects.
074	F	Medication has a lot of adverse side effects.
076	M	Medication (I feel) is an easy way out.
077	M	I would prefer to deal with behaviors first and of no change deal with at a biochemical level in addition to behavior.
078	F	Chemical imbalance is a tricky thing. I think that although it has merits in selective situations generally, it is overused.

F: Least Preferred Treatment: Medications (continued):

Participant Number	Mother/Father	Rationale
079	F	While I do realize medication can be a huge factor in certain medical situations, in these situations I feel medication would be a last resort. Perhaps some anxiety is a result of certain stressors in a child's life, those need to be identified.
080	F	I am no big fan of giving meds to children, only as a last resort.
081	M	I am not comfortable about pill-induced treatment to anxiety. Maybe if the problem isn't helped by the first two treatments, then I'll go for next.
083	M	I believe that medication should be the last approach to a problem.
088	F	I believe that today's society is way too over-medicated and that parental support and professional counseling is more appropriate and effective than medication for this problem.
091	M	Don't believe medication is the answer.
097	M	I don't believe in medicating an anxiety issue especially with children who are still growing. I think that could really damage a child's sense of worth.
098	M	I believe there are way too many drugs given to children these days. That should be a last, very last resort to very extreme cases.
099	F	Medication is a last resort, you never know the long term effects.
100	F	Medication would be the last choice as I feel it isn't a long term solution.
101	M	I would try medication if parent and child focused treatments failed.
102	M	Medications currently used for anxiety have not been tested adequately for use in children. Side effects are numerous and long-term effects not known.