12-5-2019

Latino and Non-Latino Parental Treatment Preferences for Child and Adolescent Anxiety Disorders

Laura D. Seligman
The University of Texas Rio Grande Valley, laura.seligman@utrgv.edu

Joseph D. Hovey
The University of Texas Rio Grande Valley, joseph.hovey@utrgv.edu

Marina Ibarra
The University of Texas Rio Grande Valley

Gabriela Hurtado
Prickly Pear Therapy and Training

Carla E. Marin
Yale University

See next page for additional authors

Latino and non-Latino Parental Treatment Preferences for Child and Adolescent Anxiety Disorders

Laura D. Seligman[a,*], Joseph D. Hovey[a], Marina Ibarra[a],

Gabriela Hurtado[b]

Carla E. Marin[c], Wendy K. Silverman[c]

[a] Department of Psychological Science, University of Texas Rio Grande Valley, Edinburg, TX.

[b] Prickly Pear Therapy and Training, Austin, TX

[c] Child Study Center, Yale University, School of Medicine, New Haven, CT

[*]Corresponding author: Laura D. Seligman, Department of Psychological Science, University of Texas Rio Grande Valley, Edinburg, TX 78539. Laura.seligman@utrgv.edu. 956.665.2866 (voice); 956.665.3333 (fax).

Abstract

There is frequently a presumption that Latino parents have a greater preference for involvement in their child's treatment for anxiety compared to non-Latino white parents. However, parent involvement may increase burdens associated with treatment and research suggests that Hispanic individuals already face significantly greater barriers to obtaining mental health treatment. In the current study, we compared Latino and non-Latino parents' preferences for parental involvement and perceptions of burdens in cognitive behavioral therapy (CBT) for youth anxiety. 117 parents (57 Latino) completed measures to assess child anxiety, perceptions of treatment involvement, and burdens associated with treatment. There were no significant differences between Latino and non-Latino parents except for a trend toward Latino parents reporting more concerns about the feasibility of obtaining CBT for their child's anxiety. Because Latino parents expressed concern about potential treatment barriers, cultural adaptations for treatment should focus on decreasing burden rather than increasing parental involvement.

Keywords: Latino, treatment preferences, CBT, parental involvement, child anxiety.

Latino and non-Latino Parental Treatment Preferences for Child and Adolescent Anxiety Disorders

Cognitive behavioral therapy (CBT) has been shown to be an efficacious treatment for anxiety disorders in children and adolescents [1-3]. Several studies show CBT outcomes are similar in Latino and non-Latino youth with anxiety disorders [4, 5] but, Latinos are less likely to seek psychological treatment [6, 7]. The public health impact of untreated anxiety disorders in Latino youth is high as Latino Americans are a rapidly growing segment of the population, comprising approximately 18% of the U.S. population [8] and there is evidence that Latino youth experience greater anxiety and worry compared with non-Latino youth [9, 10].

Improved understanding of how current evidence-based treatments match Latino individual's preferences and expectations may help to address this problem. In fact, the American Psychological Association (APA) has emphasized the exploration of treatment preferences and treatment perceptions as a key component of an evidence-based approach to the delivery of mental health services [11]. Despite this more than decade-old call, research is scarce even though data show that matching treatment with patients' treatment preferences and expectations can enhance engagement, therapeutic alliance, and improve perceptions of treatment [12, 13].

Because Latino culture places strong emphasis on *familismo,* which stresses the importance of both the nuclear and extended family unit, many have presumed that Latino parents have a stronger preference to be directly involved in their child's treatment than non-Latino white parents [e.g., 14]. If true, this preference would be important to consider when choosing an evidence-based approach for a child or adolescent with an anxiety disorder, as there are treatment options that involve the child only, the child and parent together, and the parent only [2, 15]. However, there are scant data examining whether this assumption is in fact correct.

This is particularly important because while many have assumed the emphasis on *familismo* would necessarily equate to Latino parents desiring to be involved in treatment, some research has suggested that the emphasis on family might function in other ways to simply decrease help-seeking altogether [16, 17]. There are two studies of which we are aware that examined Latino parents' views of parental involvement in child psychotherapy [18, 19]. Both interviewed parents about treatment preferences and found Latino parents view parental involvement in their children's treatment favorably; however, these studies did not address whether this expectation is different than that found in other cultural groups.

Determining whether parental involvement in treatment represents a potential clinically relevant cultural adaptation for child anxiety treatment is a critical question because the addition of parents in a child's treatment could increase the burdens associated with treatment and research shows Latinos already report experiencing significant barriers to obtaining mental health care [20-22]. Although many of these barriers relate to lack of culturally appropriate services (e.g., lack of availability of Spanish speaking providers) there are also many practical obstacles for Latino families wishing to obtain treatment – including affordability of care and transportation problems relating to lack of providers in Latino communities [17]. Tailoring treatments for Latino families with the additional component of parental involvement would first require data supporting the adaption and evidence that this preference would outweigh parental concerns about the burdens associated with obtaining mental health treatment.

With regard to parent perceptions of psychological treatment for children in general and for child anxiety in particular, much of what is known is limited to mothers' perceptions [23-25]. Fathers' preferences regarding child psychotherapy are largely unknown, as is the extent to which Latino fathers' preferences are similar to those of non-Latino fathers' preferences.

In the current study, we therefore compared Latino-American and non-Latino-American[1] parents' preferences for parental involvement in CBT for child anxiety, hypothesizing that Latino parents would express a greater preference for involvement in their child's treatment. We also examined parents' perceptions of the burdens associated with seeking treatment for a child with an anxiety disorder. Based on previous research we hypothesized that Latino parents would report more burdens associated with treatment. Additionally, we extend previous work by examining both mothers' and fathers' perceptions of treatment; given the ongoing lack of data on fathers, we had no specific hypotheses regarding parental sex.

Method

Participants and Procedures

Prior to data collection, all study procedures were reviewed and approved by the IRB. Participants provided consent before commencing with any study procedures.

One-hundred-twenty-five participants provided data through Amazon Mechanical Turk, Amazon's online crowdsourcing recruitment platform; each participant was reimbursed $3.25 for her or his participation. Individuals were eligible to participate in the study if they were U.S. citizens, aged 18 years or older, and had a child or adolescent between the ages of 8 and 18 years old in the home. The study was completed in Qualtrics with quotas set to obtain a sample that was 50% Latino. Eligible participants completed the measures described below as part of a larger research project examining parental factors in child anxiety. One-hundred-seventeen participants were mothers or fathers; the remaining 8 participants reported some other type of relationship with the child about whom they completed the survey (e.g., grandparent or legal guardian). For

[1] All parents were residing in the United States so although we use the terms "Latino" and "non-Latino" in the remainder of the manuscript, these terms refer to the participants' family origins and not their current home country.

the present study, we analyzed data from these 58 (49.6%) mothers and 59 fathers. Each participant was asked to report on a single child meeting the age requirement in their household; if a parent had more than one child, they were asked to report on the child whose birthday was closest to the date of the survey. Overall, parents reported on 70 boys (59.8%) and 40 girls (40.2%) with a mean age of 10.04 years (*SD* = 2.39). There were no significant differences on age or sex of child between Latino and non-Latino parents.

Demographic information on parents is provided in Table 1. Analyses revealed no significant differences between Latino and Non-Latino parents in age, marital status, education, and income. Twenty-five percent of participants reported they were diagnosed with a psychological disorder at some point in the past and/or that they had received psychological treatment. Eleven percent reported that their children had been previously evaluated and/or treated for a mental health disorder. There were no significant differences between Latino and non-Latino families in parent or child mental health history.

Measures

In addition to providing information on family demographics, participants completed the following measures as part of a larger survey.

Multidimensional Anxiety Scale for Children, 2nd edition [MASC 2; 26]. Youth anxiety was measured using the parent version of the MASC 2. The MASC 2 is a 50-item parent report of child anxiety designed to assess anxiety in youth from 8 to 19 years old. Each item presents the parent with a symptom of anxiety and asks the parent to indicate how often his/her child experiences the symptom using a response scale from 0 (“Never”) to 3 (“Often”). Ten subscales scores and a total score can be derived from the measure but only the total score was used in this study. This score is obtained by summing responses across the 50 items on the

measure. The MASC 2 was developed using statistical weighting of ethnicity and race to match Census data in the United States and Canada. Research also suggests that this measure functions well in cultures outside these two counties [27]. Reliability of the total score in the current sample was $\alpha = .97$.

Behavior Therapy Preference Scale [28]. The Behavior Therapy Preference Scale is a 14-item rating scale that assesses parent perceptions of potential barriers associated with treatment and contains three subscales: treatment acceptability (6 items), feasibility (3 items), and expectation of adverse effects (5 items). Developed by Fiks and colleagues (2012) to assess parental perceptions of ADHD treatment in primary care settings, we adapted the scale (with author permission) to improve its applicability to CBT for youth anxiety disorders. More specifically, parents were given a brief description of CBT for child anxiety and were asked to report on how they would view CBT if their child required treatment for a problem with "anxiety or being nervous or upset a lot of the time". We also added an item to assess parents' desire to be involved in treatment (i.e., "I would want to be involved in the therapy"). The response scale ranges from 0 = "Not at all" to 4 = "Completely", with adverse effects and barriers items reversed scored; as such, higher scores reflect higher levels of acceptability, feasibility, and lower expectations of adverse effects. Put another way, higher scores are indicative of more positive feelings about treatment. Scale scores were calculated by computing the mean score for all items on the scale, thereby keeping the metric used for individual items. Internal consistency estimates obtained in the current study were consistent with those of past research using the original scale version [28], α=0.87, α=0.87, and α= 0.79, for acceptability, adverse effects, and feasibility subscales, respectively. Although we are not aware of any research examining the cross-cultural validity of this measure, the internal consistency estimates obtained for Latino and

non-Latino parents suggest that the measure functioning similarly for both samples. For Latino parents, internal consistency estimates were α=0.86, α=0.89, and α= 0.81, for acceptability, adverse effects, and feasibility subscales, respectively and α=0.88, α=0.84, and α= 0.74 for non-Latino parents.

Results

Statistical analyses were conducted in SPSS 24 and Mplus Version 7.4 [29]. Missing data were accommodated using full information maximum likelihood methodology (Enders, 2010). Parents' perceptions of treatment acceptability, feasibility, adverse effects, and parental desire for involvement in treatment did not differ with sex of the parent or sex of the child, nor were parental perceptions related to whether the parent reported that they or their child had ever been diagnosed with a psychological disorder. Parent ratings of child anxiety on the MASC 2 were significantly correlated with parents' perceptions of adverse effects (r (117) = -.54, p < .001), feasibility (r (117) = -.37, p < .001), and acceptability ratings (r (117) = .22, p = .021). Moreover, consistent with previous research, Latino parents reported their child experienced significantly more anxiety (M = 56.35, SD = 30.96) than non-Latino parents (M = 35.27, SD = 20.42) , t(115) = 3.92p < .001, Therefore, child anxiety was used as a covariate in further analyses of parent perceptions of adverse effects, feasibility, and acceptability. Parents' desire for involvement in their child's treatment was not correlated with child anxiety (r (117) = .11, p = .29).

Item means and standard deviations for each of the Modified Behavior Therapy Preference Scale are presented in Table 2. A parallel of an independent samples t-test available in Mplus showed that there was not a significant difference between Latino and non-Latino parents in their desire to be involved should their child require treatment for an anxiety disorder (mean difference = -.12, critical ratio = -.52, p = .60; g = .11); both Latino and non-Latino

parents reported being interested in being involved in their child's treatment (see Table 2 for descriptive statistics).

The equivalent of a multiple regression analysis was conducted in Mplus predicting parents' perceptions of treatment acceptability, adverse events, and feasibility from child ethnicity controlling for child anxiety. Based on these analyses, both Latino and non-Latino parents reported moderately high levels of acceptability for CBT for child anxiety but analyses of acceptability ratings controlling for child anxiety suggest no significant differences on this dimension, (mean difference = -0.03; critical ratio = -.15, p = .88, g = .18). Similarly, the two groups did not differ in their perceptions of the potential adverse effects when child anxiety was controlled (mean difference = 0.12; critical ratio = .65, p=.52. g = .48*)*; however, there was a trend toward Latino parents viewing treatment as less feasible and the size of the effect was between medium and large according to Cohen's classification (mean difference = .38, critical ratio = 1.90, p = .06, d = .60). As expected, Latino parents reported more concerns about the feasibility of obtaining CBT for their child's anxiety should the need arise.

Two-way ANOVAs (parent sex X parent ethnicity) were also conducted to explore whether ethnic differences varied across mothers and fathers. Sex of the parent did not function to moderate ethnic differences.

Discussion

Past research has found that Latino adults frequently encounter barriers when seeking mental health services [e.g., 30]. Our findings suggest these same concerns come into play when parents consider treatment for child anxiety. Latino parents reported greater concerns, at the level of a trend, about the feasibility (e.g., financial costs and time commitment) required for CBT for child anxiety compared with non-Latino parents. This finding is especially important considering

Latino and non-Latino parents did not differ in their desire for involvement in the treatment. The recognition of the cultural value of *familismo* within the Latino culture has often led to the assumption that Latino parents would place a greater emphasis on their involvement in their child's treatment compared with non-Latino parents. Consistent with past research [18, 19], Latino parents responded positively to the idea of parental involvement in their child's treatment for anxiety; however, their response was not significantly different than that of non-Latino parents. This finding, coupled with the ethnic differences found in feasibility concerns, suggests that is premature to add parent sessions or parents' regular attendance in child sessions to treatments for child anxiety that appear to be equally effective without this additional burden.

Results suggest that Latino parents did not view the acceptability of CBT differently than non-Latino parents. Items on this scale ask parents to rate their expectations that CBT could help their child with problems with anxiety and whether they view this as a reasonable treatment option for treating child anxiety. Mean scores for both Latino and non-Latino parents on the scale suggest *all* parents viewed CBT for child anxiety somewhat favorably. Consistent with parental views on acceptability of treatment, there were no group differences in concerns about potential adverse effects of treatment, although it should be noted that the effect size approached the moderate range. There are inconsistent data about attitudes toward psychotherapy among Latino groups. Some studies have found that Latinos have negative perceptions about mental health treatment [e.g., 31, 32] whereas other studies have found that Latinos hold attitudes about mental health services are not different from non-Latino Whites [33]. Our results add to the evidence suggesting that Latinos may be more similar to non-Latino white adults than previously thought.

Given that research on treatments for child anxiety have included primarily Caucasian youth, there has been much discussion about the need for cultural adaptations when using these treatments with Latino youth. Our findings, suggesting cultural differences as well as similarities, can aid in an evidence-based approach to designing these adaptions. Although it has been assumed that the Latino culture's emphasis on family would suggest treatments with a high level of parental participation, our results suggest that the most effective cultural adaptations of evidence-based treatments for many Latino families in the United States, could be ones that decrease, not increase, the time commitments and costs of treatment. Brief treatments, recently shown to be comparable to standard CBT for youth with anxiety disorders [34], may be a particularly appropriate treatment choice for Latino youth when concerns regarding the burdens of treatment are present. Öst and Ollendick [34] found brief, intensive, and concentrated CBTs for child anxiety, while superior to both waitlist and placebo control conditions, did not differ from standard CBT for youth with a range of anxiety disorders, both at posttreatment and 1-year follow-up. An interesting caveat was that the effect of these treatments was moderated by parental involvement, with *less* parental involvement associated with higher effect sizes, suggesting that these treatments may be able to address both the time and financial feasibility concerns of Latino families.

A notable strength of this investigation is the inclusion of fathers in the sample. Our results suggest that mothers and fathers viewed CBT for child anxiety similarly. The absence of fathers from research has long been recognized [24] but has been slow to change. As gender roles change and fathers take more of a role in treatment decision-making it will become increasingly important to gain a better understanding of fathers' perspectives on treatment

options; online crowdsourcing methods such as the use of Amazon's Mechanical Turk can be particularly effective ways to get fathers involved in research [25].

Limitations and Future Directions

The assumption in the literature that Latino parents would evidence a differential preference for parent involvement in child treatment has been based on the recognition of the emphasis on family (*familismo*) in Latino culture. Given that we did not assess *familismo* in our sample, we are able to say that we did not find differences in parental preferences but we cannot rule out that this is due to low levels of *familismo* in our sample, nor can we draw conclusions about whether parental preferences are related to *familismo* in the assumed direction, or at all. This is an important topic for future investigation, particularly as there is some evidence that our sample is a relatively highly acculturated one [35]. This could have resulted in a restricted range in terms of adherence to *familismo* and other related cultural values; however, research suggests that although there is a relationship between acculturation level and *familismo,* the magnitude of this relationship is small [35].

Related to acculturation and representativeness of our sample more generally, it is notable that our sample was relatively well educated; more than half of the Latino and non-Latino parents had at least a college degree. Inasmuch as ethnicity is associated with socioeconomic status (SES), if differences thought to be related to culture are better accounted for by SES, this would not be reflected in our data. Clearly, more research is needed to disentangle SES from ethnicity. Additionally, our sample completed measures in English, and 98% of Latino parents reported they were born in the United States. Thus, it is possible that our findings may not generalize to a less acculturated sample. Nonetheless, results may be relevant to much of the Latino population in the United Sates, given that the majority of Latino-Americans

and Latino-American adults were born in the United Sates and as of 2017, 70% of Latino-Americans over the age of 5 years were proficient in English [36, 37]. Moreover, it should not be assumed that the current pattern of results would not apply to a less acculturated Latinos, as our findings in regard to concerns about the feasibility of obtaining mental health treatment replicate those of several other investigations, including those from a nationally representative sample of Latino-Americans [30] and a study of Latino immigrants' perceptions of barriers to healthcare services [38]. Moreover, our caution about adding parental involvement to child anxiety treatments may be *particularly* relevant when parents evidence low levels of acculturation. When CBT involving parents was compared to a more peer-focused treatment in a sample of Latino youth with an anxiety disorder, acculturation was found to moderate treatment outcome [39]. Youth whose parents were less acculturated had *poorer* outcomes with the parent-involved treatment compared to the peer treatment. Although this study does not speak directly to parent preference for treatment involvement, our failure to find a significant difference in parental preference for involvement coupled with this finding and those related to treatment feasibility concerns in Latino populations, lends support for our conclusion that at the current time, cultural adaptations should focus on factors increasing treatment feasibility rather than increasing parental involvement in treatment.

Our statistical plan tested for group differences; despite a lack of significant difference between Latino and non-Latino parents, we did not conduct equivalency analyses. We chose not to do so as there are no available meaningful or commonly accepted standards for defining equivalence in parent perceptions of treatment, calling into question the validity of such analyses [40]. However, the lack of significant differences between Latino and Latino parents do not definitively indicate equivalence and, as such, our findings should be considered preliminary.

Lastly, many have questioned the quality of data and generalizability of studies conducted through online platforms such as MTurk; however, empirical studies suggest that information gathered in these studies can provide data at least equal to that gathered through traditional means and that MTurk samples tend to be more diverse than traditional samples used in psychology studies [41, 42]. One important way in which MTurk samples have been found to differ from general community samples, however, is in that they report higher levels of psychopathology – particularly anxiety and depression [43]. Given that parent anxiety and depression has been related to child anxiety [44], utilizing MTurk in this study allowed us to access a sample for which treatment preferences for anxiety disorders may be particularly relevant without narrowing our sample to one that is help-seeking - a sample very likely to have more positive attitudes toward treatment than those who do not seek treatment. On the other hand, conducting the study online meant we could exercise less tight control when evaluating the eligibility of participants; this could have led to interdependence of our data if more than one parent from a family chose to participate. However, given our sample size in comparison with the number of MTurk users, we believe that if this did occur, it would have occurred with a very small number of participants. Moreover, as we asked parents to report on themselves, as opposed to their child, the level of interdependence of data would be somewhat mitigated, although not completely. Taken together though, we suspect that any violations of the assumptions inherent in our analytic plan likely did not significantly affect the study findings.

Despite these limitations, our data do suggest that it may be incorrect, or at least an oversimplification, to assume that Latino parents seeking treatment for their child's anxiety would prefer more involvement in treatment than non-Latino parents; rather, a growing body of

evidence suggests that the burdens associated with obtaining treatment is a key issue to attend to in cultural adaptions for Latino mental health services.

Summary

The current study compared Latino and non-Latino parents' perceptions of CBT for youth anxiety disorders, examining mothers' and fathers' desire for involvement in treatment and perceptions of the burdens associated with treatment. Results indicated that Latino and non-Latino parents did not differ in terms of the expectation that they would be involved in their child's treatment for anxiety, perceptions of the acceptability of CBT for child anxiety, or its potential for adverse effects. However, Latino parents did report more concerns regarding the feasibility of treatment (at the trend level). Sex of the parent did not moderate these effects. Finding suggest that evidence-based cultural adaptations of CBT for child anxiety should focus on increasing treatment feasibility, with possible options including a focus on brief treatments that decrease both the time and costs of treatment.

Compliance with Ethical Standards

The authors declare that we have no potential conflicts of interest related to this research.

Research procedures were reviewed and approved by the IRB at the University of Texas Rio Grande Valley before any research activities commenced.

Informed consent was sought and obtained from all participants prior to their involvement in any research procedures.

References

1. Seligman LD, Ollendick TH (2011) Cognitive-behavioral therapy for anxiety disorders in youth. Child Adolesc Psychiatr Clin N Am 20: 217-238
2. Silverman WK, Pina AA, Viswesvaran C (2008) Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. J Clin Child Adolesc Psychol 37: 105-130
3. Higa-McMillan CK, Francis SE, Rith-Najarian L, Chorpita BF (2016) Evidence base update: 50 years of research on treatment for child and adolescent anxiety. J Clin Child Adolesc Psychol 45: 91-113
4. Pina AA, Silverman WK, Fuentes RM, Kurtines WM, Weems CF (2003) Exposure-based cognitive-behavioral treatment for phobic and anxiety disorders: Treatment effects and maintenance for Hispanic/Latino relative to European-American youths. J Am Acad Child Adolesc Psychiatry 42: 1179-1187
5. Pina AA, Zerr AA, Villalta IK, Gonzales NA (2012) Indicated prevention and early intervention for childhood anxiety: A randomized trial with Caucasian and Hispanic/Latino youth. J Consult Clin Psychol 80: 940-946
6. Cabassa LJ, Zayas LH, Hansen MC (2006) Latino adults' access to mental health care: A review of epidemiological studies. Administration and Policy in Mental Health and Mental Health Services Research 33: 316-330
7. Kouyoumdjian H, Zamboanga BL, Hansen DJ (2003) Barriers to community mental health services for Latinos: Treatment considerations. Clinical Psychology: Science and Practice 10: 394-422
8. U. S. Census Bureau, *QuickFacts United States*. 2017.

9. Varela RE, Sanchez-Sosa JJ, Biggs BK, Luis TM (2009) Parenting strategies and socio-cultural influences in childhood anxiety: Mexican, Latin American descent, and European American families. J Anxiety Disord 23: 609-616

10. Varela RE, Hensley-Maloney L (2009) The influence of culture on anxiety in Latino youth: A review. Clin Child Fam Psychol Rev 12: 217-233

11. American Psychological Association Presidential Task Force on Evidence-Based Practice (2006) Evidence-based practice in psychology. Am Psychol 61: 271-285

12. Iacoviello BM, McCarthy KS, Barrett MS, Rynn M, Gallop R, Barber JP (2007) Treatment preferences affect the therapeutic alliance: Implications for randomized controlled trials. J Consult Clin Psychol 75: 194-198

13. Seligman LD, Wuyek LA, Geers AL, Hovey JD, Motley RL (2009) The effects of inaccurate expectations on experiences with psychotherapy. Cognit Ther Res 33: 139-149

14. Wagner EF (2003) Conceptualizing alcohol treatment research for Hispanic/Latino adolescents. Alcoholism: Clinical and Experimental Research 27: 1349-1352

15. Lebowitz ER, Omer H, Hermes H, Scahill L (2014) Parent training for childhood anxiety disorders: The SPACE program. Cogn Behav Pract 21: 456-469

16. Lawton KE, Kapke TL, Gerdes AC (2016) Understanding parental locus of control in Latino parents: Examination of cultural influences and help-seeking intentions for childhood ADHD. Cultural Diversity and Ethnic Minority Psychology 22: 288-298

17. Turner EA, Cheng H-L, Llamas JD, Tran AGTT, Hill KX, Fretts JM, et al. (2016) Factors impacting the current trends in the use of outpatient psychiatric treatment among diverse ethnic groups. Current Psychiatry Reviews 12: 199-220

18. Pina AA, Villalta IK, Zerr AA (2009) Exposure-based cognitive behavioral treatment of anxiety in youth: An emerging culturally-prescriptive framework. Behavioral Psychology / Psicología Conductual: Revista Internacional Clínica y de la Salud 17: 111-135

19. Dumka LE, Gonzales NA, Wood JL, Formoso D (1998) Using qualitative methods to develop contextually relevant measures and preventive interventions: An illustration. Am J Community Psychol 26: 605-637

20. Law J, VanDerslice J (2011) Proximal and distal determinants of access to health care among Hispanics in El Paso County, Texas. Journal of Immigrant and Minority Health 13: 379-384

21. Corrigan PW, Torres A, Lara JL, Sheehan L, Larson JE (2017) Prioritizing the healthcare needs of Latinos with mental illness. International Journal of Culture and Mental Health 10: 19-32

22. Uebelacker LA, Marootian BA, Pirraglia PA, Primack J, Tigue PM, Haggarty R, et al. (2012) Barriers and facilitators of treatment for depression in a Latino community: A focus group study. Community Ment Health J 48: 114-126

23. Mak L, Walker JR, Hiebert-Murphy D, Altman G (2017) Information needs and preferences of parents considering treatment of child anxiety. J Dev Behav Pediatr 38: 173-180

24. Phares V, Fields S, Kamboukos D, Lopez E (2005) Still looking for Poppa. Am Psychol 60: 735-736

25. Parent J, Forehand R, Pomerantz H, Peisch V, Seehuus M (2017) Father participation in child psychopathology research. J Abnorm Child Psychol 45: 1259-1270

26. March JS, *Multidimensional Anxiety Scale for Children 2nd Edition (MASC 2) technical manual*. 2013, North Tonawanda, NY: Multi-Health Systems.

27. Tan F-r, Wu W-f, Yao S-q (2010) A comparison between factor structure invariance of Multidimensional Anxiety Scale for Chinese and Italian children sample. Chinese Journal of Clinical Psychology 18: 704-706

28. Fiks AG, Mayne S, Hughes CC, Debartolo E, Behrens C, Guevara JP, et al. (2012) Development of an instrument to measure parents' preferences and goals for the treatment of attention deficit-hyperactivity disorder. Acad Pediatr 12: 445-455

29. Muthén LK, Muthén BO, *Mplus User's Guide Statistical Analysis with Latent Variables*. 7th ed. 1998-2012, Los Angeles, CA.

30. Parra-Cardona JR, DeAndrea DC (2016) Latinos' access to online and formal mental health support. The Journal of Behavioral Health Services & Research 43: 281-292

31. Interian A, Ang A, Gara MA, Link BG, Rodriguez MA, Vega WA (2010) Stigma and depression treatment utilization among Latinos: Utility of four stigma measures. Psychiatr Serv 61: 373-379

32. Interian A, Martinez IE, Guarnaccia PJ, Vega WA, Escobar JI (2007) A qualitative analysis of the perception of stigma among Latinos receiving antidepressants. Psychiatr Serv 58: 1591-1594

33. Gonzalez JM, Alegria M, Prihoda TJ (2005) How do attitudes toward mental health treatment vary by age, gender, and ethnicity/race in young adults? J Community Psychol 33: 611-629

34. Öst L-G, Ollendick TH (2017) Brief, intensive and concentrated cognitive behavioral treatments for anxiety disorders in children: A systematic review and meta-analysis. Behav Res Ther 97: 134-145

35. Bostean G, Gillespie BJ (2018) Acculturation, acculturative stressors, and family relationships among Latina/o immigrants. Cultural Diversity and Ethnic Minority Psychology 24: 126-138

36. Flores A. *2015, Hispanic Population in the United States Statistical Portrait*. 2017 [cited 2019 October 22, 2019].

37. Noe-Bustamante L. *Key facts about U.S. Hispanics and their diverse heritage*. Facttank: News in the numbers 2019 [cited 2019 October 22, 2019].

38. Cristancho S, Garces DM, Peters KE, Mueller BC (2008) Listening to rural Hispanic immigrants in the Midwest: A community-based participatory assessment of major barriers to health care access and use. Qual Health Res 18: 633-646

39. Vaclavik D, Buitron V, Rey Y, Marin CE, Silverman WK, Pettit JW (2017) Parental acculturation level moderates outcome in peer-involved and parent-involved CBT for anxiety disorders in Latino youth. Journal of Latina/o Psychology 5: 261-274

40. Rief W, Hofmann SG (2018) Some problems with non-inferiority tests in psychotherapy research: Psychodynamic therapies as an example. Psychol Med 48: 1392-1394

41. Gosling SD, Vazire S, Srivastava S, John OP (2004) Should We Trust Web-Based Studies? A Comparative Analysis of Six Preconceptions About Internet Questionnaires. Am Psychol 59: 93-104

42. Casler K, Bickel L, Hackett E (2013) Separate but equal? A comparison of participants and data gathered via Amazon's MTurk, social media, and face-to-face behavioral testing. Comput Human Behav 29: 2156-2160

43. Arditte KA, Çek D, Shaw AM, Timpano KR (2016) The importance of assessing clinical phenomena in Mechanical Turk research. Psychol Assess 28: 684-691

44. Beidel DC, Turner SM (1997) At risk for anxiety: I. Psychopathology in the offspring of anxious parents. J Am Acad Child Adolesc Psychiatry 36: 918-924

Table 1

Demographic characteristics of the participants

	Latino	Non-Latino	Total *N* (%)
Gender *N* (%)			
Female	29 (49.2%)	30 (50.8%)	59 (50.4%)
Male	28 (48.3%)	30 (51.7%)	58 (49.6%)
Age Mean (SD)	32.0 (6.0)	34.00 (7.2)	33.0 (6.7)
Race *N* (%)			
American/Indian			
Asian	1 (1.8%)	4 (6.7%)	5 (4.3%)
Black or African American	1 (1.8%)	7(11.7%)	8 (6.8%)
White	21(36.8%)	49 (81.7%)	70 (59.8%)
Mixed	24 (42.1%)	0	24 (20.5%)
Other	10 (17.5%)	0	10 (8.5%)
Ethnicity *N* (%)			
Cuban	3 (5.3%)		
Mexican	38 (66.7%)		
Puerto Rican	9 (15.8%)		
South or Central American	6 (10.5%)		
Other	1 (1.8%)		
Marital Status			
Married	45 (78.9)	45 (75%)	90 (76.9%)
Separated	1 (1.8%)	2 (3.3%)	3 (2.6%)
Divorced	2 (3.5%)	1 (1.7%)	3 (2.6%)
Never Married	9 (15.8%)	11 (18.3%)	20 (17.1%)
Not Reported	0	1	1 (0.9%)
Education			
Some High School	1 (1.8%)	2 (3.3%)	3 (2.6%)
High School	6 (10.5%)	10 (16.7%)	16 (13.7%)
GED	2 (3.5%)	1 (1.7%)	3 (2.6%)
Some College	18 (31.6%)	13 (21.7%)	31 (26.5%)
College/Bachelor's	28 (49.1%)	30 (50%)	58 (49.5%)
Master's	2 (3.5%)	3 (5%)	5 (4.3%)
Technical Degree	0	1 (1.7%)	1 (0.9%)
Income			
Less than - $21,000	3 (5.3%)	3 (5%)	6 (5.1%)
$21,000 - $30,999	10 (17.5%)	5 (8.3)	15 (12.8%)
$31,000 - $40,999	14 (24.6%)	12 (20%)	26 (22.2%)
$41,000 - $50,999	10 (17.5%)	3 (5%)	13(11.1%)
$51,000 - $60,999	7 (12.3%)	10 (16.7%)	17 (14.5%)
$61,000 - $70,999	1 (1.8%)	8 (13.3%)	9 (7.7%)
$71,000 - $80,999	4 (7%)	8 (13.3%)	12 (10.3%)
over $81,000	8 (14.1%)	11 (18.3%)	19 (16.2%)

Table 2

Perceptions of cognitive behavior therapy for child anxiety by ethnicity and for the total sample

	Latino Mean (SD)	Non-Latino Mean (SD)	Total Mean (SD)	Effect Size[1] (95% CI)
Acceptability	2.47 (0.77)	2.31 (0.94)	2.39 (0.86)	0.18 (.18, -.55)
Cognitive-behavioral therapy would be a reasonable way to help my child.	2.33 (1.02)	2.02 (1.32)	2.17 (1.19)	
I would feel comfortable working with a counselor/psychologist to help my child.	2.39 (1.01)	2.25 (1.30)	2.32 (1.16)	
I would trust in a counselor/psychologist to help my child.	2.51 (.87)	2.43 (1.14)	2.47 (1.01)	
I would be able to receive cognitive-behavioral therapy for my child at a place where I feel comfortable.	2.25 (1.12)	2.45 (1.06)	2.35 (1.09)	
Cognitive-behavioral therapy would help improve my child's behavior.	2.47 (1.09)	2.20 (1.21)	2.33 (1.15)	
People who are important to me would support me in treating my child with cognitive-behavioral therapy.	2.89 (1.03)	2.55 (1.23)	2.72 (1.14)	
Feasibility	1.93 (1.07)	2.55 (1.00)	2.26 (1.07)	0.60 (.97,.22)
I would be concerned about the time it would take to meet with a counselor or psychologist to learn cognitive-behavioral therapy	2.04 (1.22)	2.82 (1.11)	2.44 (1.23)	
I would be concerned about the time it would take to work with my child using what we learned in cognitive-behavioral therapy.	2.11 (1.33)	2.57 (1.27)	2.34 (1.31)	
I would be concerned about the resources (insurance, income, or saving) I would need to cover the cost of treating my child with cognitive-behavioral therapy.	1.63 (1.21)	2.22 (1.33)	1.93 (1.30)	
Adverse Effects	2.04 (1.00)	2.52 (1.00)	2.30 (1.03)	0.48 (.84,.11)
I would be afraid that my child would be considered a problem child if he or she were to receive cognitive-behavioral therapy.	2.21 (1.28)	2.77 (1.32)	2.50 (1.32)	
I would feel my child would be treated differently by others if he or she were to receive cognitive-behavioral therapy.	2.07 (1.37)	2.52 (1.36)	2.30 (1.38)	
I would be worried about the reaction(s) my child might have to cognitive-behavioral therapy.	1.88 (1.14)	2.33 (1.22)	2.11 (1.20)	
I would be afraid that my child might react negatively to the things we would learn in cognitive-behavioral therapy.	2.09 (1.23)	2.48 (1.27)	2.29 (1.26)	
I would feel cognitive-behavior therapy may change some things I like about my child's personality.	2.00 (1.17)	2.47 (1.32)	2.24 (1.26)	

Desire for Parental Involvement (I would want to be involved in the therapy.)	2.85 (1.11)	2.73 (1.30)	2.79 (1.22)	0.11 (.25, -.48)

[1] Bias Corrected Hedges g.