FATHER PERCEPTIONS OF PSYCHOLOGICAL SERVICES FOR CHILDREN: THE EFFECT OF PROMOTING THE USE OF SERVICES AMONG MEN

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ABSTRACT

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by Kevin Triemstra

Father involvement in parent training programs has been associated with greater maintenance of treatment gains, lower attrition rates, and less maternal stress. However, men caregivers are significantly less likely than women caregivers to participate in behavioral parent training programs and psychological treatment in general. Previous research has provided several possible reasons why men are involved in psychological treatment for their children at lower rates than women; however, few studies to date have attempted to evaluate specific strategies designed to improve father perceptions about seeking psychological help for their children. The purpose of this study was to determine the effect of promoting the use of behavioral parent training programs among men on their attitudes toward seeking psychological treatment for their children and their evaluation of a specific treatment. This study also evaluated whether fathers' adherence to masculine gender-role norms moderated their evaluation of treatments and their attitudes toward seeking psychological help for their children. Fathers of children between the ages of 2 and 12 were recruited through online advertising and social networking. Each participant completed the Bem Sex-Role Inventory (BSRI), read a case vignette of a child with significant behavioral problems, and read one of three randomly assigned treatment descriptions. The three treatment descriptions included a traditional description of Parent-Child Interaction Therapy (PCIT), a masculine description of PCIT that was altered to be more consistent with traditional American masculine gender-role norms, and a one-sentence treatment recommendation that did not provide descriptive details of the treatment being recommended. Participants were then asked to complete the Treatment Evaluation Inventory-Short Form (TEI-

SF) and Attitudes Toward Seeking Professional Psychological Help Scale-Parent (ATSPPHS-P) form. Results indicated that fathers who read the description of PCIT that was altered to be consistent with masculine gender-role norms evaluated the treatment more favorably than those who read the one-sentence recommendation for treatment. Fathers who read the traditional description of PCIT did not differ significantly from those in the control condition in their evaluation of the treatment. Fathers' attitudes toward seeking psychological help for their children did not differ significantly between study conditions. Contrary to our expectations, father conformity to masculine gender-role norms did not moderate the relationship between their evaluation of the treatment descriptions and the study condition. These findings suggest that fathers have a significantly more positive perception of psychological treatments for children if the program is described in a way that is consistent with traditional masculine gender-role norms. These results should inform how treatments for children are marketed to parents and underscore the importance of appealing to both men and women when providing services to children.

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CHAPTER I

INTRODUCTION

Men in the United States have traditionally been less likely than women to seek help for mental health concerns and for physical health problems (Courtenay, 2003; Good, Dell, & Mintz, 1989; Leaf & Bruce, 1987; Wills & DePaulo, 1991). Research over the past two decades has begun to evaluate methods and strategies for increasing men's participation in psychotherapy (Blazina & Marks, 2001; Rochlen, Blazina, & Raghunathan, 2002; Rochlen, McKelley, & Pituch, 2006; Robertson & Fitzgerald, 1992). Incongruity between traditional American masculinity ideals and seeking help for psychological problems is a factor in the lower rates of participation by men in psychological treatment (Addis & Mahalik, 2003; Berger, Levant, McMillan, Kelleher, & Sellers, 2005; Good, Dell, & Mintz, 1989; Johnson, 1988; Mahalik et al., 2003), as men within conventional U.S. culture are commonly socialized in a way that promotes the avoidance of emotional openness and encourages self-reliance (Mahalik et al., 2003). Characteristics of traditional American masculinity include maintaining control over external situations and being seen as a competent individual with little need for social support (Mansfield, Addis, & Mahalik, 2003; Mahalik et al., 2003). Men who exhibit these characteristics may have difficulty admitting vulnerabilities and may experience greater self-stigma associated with seeking psychological help (Pederson & Vogel, 2007).

A similar gender pattern exists regarding the tendency of parents to seek help for their children. Women are not only more likely to seek mental health services for themselves, they are also more likely to seek psychological services for their children (Budd & O'Brien, 1982; Coplin & Houts, 1991; Tiano & McNeil, 2005; Mansfield, Addis, & Courtenay, 2005; Mather, 2010). Mothers are seen as the gatekeepers to the physical and psychological health of their children.

Unlike mothers, fathers have significantly lower rates of participation in psychological services for their children (Budd & O'Brien, 1982; Coplin & Houts, 1991; Tiano & McNeil, 2005). However, evidence exists that children benefit from the participation of both their fathers and their mothers in treatment for psychological concerns (Webster-Stratton, 1985b; Bagner & Eyberg, 2003). Therefore, it is imperative for researchers to gain an understanding of the factors that influence fathers' participation in children's mental health treatment.

Underutilization of Mental Health Services

Although men have significantly lower rates of participation in psychological services, the underutilization of mental health treatment among both men and women has been an area of considerable concern across cultures and age. Estimates of individuals with diagnosable psychological disorders who do not seek help for their distress range from 70-80% (Alonso, Angermeyer, & Bernert, 2004; Baxter, Kokaua, Wells, McGee, & Browne, 2006; Howard, et al., 1996; Lin, Goering, Offord, Campbell, & Boyle, 1996; Norquist & Regier, 1996; Pavuluri, Luk, & McGee, 1996). For example, in a study of 21,425 European adults over 18 years old, only 25.7% of those with mental health concerns consulted formal health services or mental health services about their difficulties (Alonso et al., 2004). In a study of 8,116 Canadian adults over the age of 15, only 25% of those with diagnosable psychological disorders sought any assistance for their concerns (Lin et al., 1996).

Another troubling finding is that those seeking help for psychological difficulties tend to seek help from general medical practitioners and not psychologists, psychiatrists, or counselors. In a large Canadian sample only 10% of those seeking assistance for psychological concerns sought help from psychologists, whereas nearly half (49.9%) sought help from their general practitioner or family doctor (Lin et al., 1996). Many individuals with diagnosable disorders do

not have any contact at all with any health services for their problems (Baxter et al., 2006). Mental health service contact is often related to the severity of a person's psychological disorder. However, even those with more severe psychological concerns seek help at low rates (24%; Medina-Mora et al., 2005).

Along with adult treatment underutilization, child mental health concerns have also gone largely untreated (Farmer et al., 1999; Leaf et al., 1996; Pavuluri et al., 1996; Zahner, Pawelkiewicz, DeFrancesco, & Adnopoz, 1992). Children with assessed psychological disorders have been found to receive psychological services 11% to 40% of the time (Farmer et al., 1999; Zahner, Pawelkiewicz, DeFrancesco, & Adnopoz, 1992; Merikangas et al., 2011). Parents seek psychological help for their children at rates similar to rates of adult psychological treatment utilization. The underutilization of psychological services appears to be problematic across populations and age.

Factors Associated with Treatment Underutilization

Several factors have been posited as reasons why mental health help-seeking occurs at such low rates for children. Pavuluri and colleagues (1996) hypothesized that parents who are considering seeking help for their children go through a multi-step process before seeking help. The first step for parents in moving towards seeking help is being able to recognize that their children have a problem that needs attention. The second step is actively thinking about getting help after recognizing that a problem exists. The final step of the process is crossing the perceived barriers to getting help for their children. Several common barriers to help-seeking given by parents include thinking that they should be able to handle the problem themselves, thinking that the problem will get better over time, or not knowing where to go in order to get help for their children (Pavuluri et al., 1996). For parents, several child characteristics and

demographics moderate the movement through these decision-making stages, including children's symptom severity, socioeconomic status, gender, race, and age (Bussing, et al., 2003; Turner, Finkelhorn, & Ormrod, 2007; Wildman, Stancin, Golden, & Yerkey, 2004). Attitudinal variables (e.g., stigma perception, self-reliance, and perception of the utility of mental health service) are also important factors related to parent help-seeking behavior (Fischer & Turner, 1970; Hornblow et al., 1990; Wrigley, Jackson, Judd, & Komiti, 2005).

Although there are many factors that contribute to the underutilization of mental health care, a person's attitudes toward seeking psychological services may play a more critical role in determining help-seeking behavior than time constraints, financial concerns, or access to care (Hornblow et al., 1990; Sareen et al., 2007). Attitudinal characteristics have been found to predict a person's intent to seek professional psychological services, which in turn predicts actual help-seeking behavior (Fischer & Turner, 1970; Mackenzie, Gekoski, & Knox, 2006). In their Theory of Reasoned Action (TRA) Ajzen and Fishbein (1973) described behavior as being caused by intention. The authors suggest that a person's intention to perform any action can be traced to that individual's attitudes toward the behavior and the cultural or social context in which the behavior will be performed (Sutton, 1998). In relation to parent help-seeking, the importance of a parent's attitude toward seeking psychological help cannot be overstated. A parent's attitudes and intentions predict their subsequent behavior when they are considering the need to seek help for their children. In order to provide insight into the behaviors of parents, researchers have focused on the antecedent attitudes concerning help-seeking.

Attitudes about seeking mental health services are associated with the subsequent use of such services in adults, parents, and adolescents (Barker & Adelman, 1994; Leaf, Bruce, & Tischler, 1986). Studies of adults have found that some of the most commonly reported reasons

for treatment discontinuation are beliefs about treatment and perceptions about needs. Individuals who terminate treatment prematurely often indicate a desire to solve their own problems or deny that they have an emotional problem that necessitates treatment (Kessler, Brown, & Broman, 1981). The same attitudinal barriers are found in adolescents where the most critical factors influencing help-seeking behavior for mental health concerns are the attitudes and perceptions regarding treatment (Barker & Adelman, 1994). Additionally, the stigma that accompanies the use of mental health care is a common variable that prevents individuals from seeking help for psychological concerns (Cauce, Domenech-Rodriguez, & Paradise, 2002; Corrigan & Rusch, 2002; Corrigan, 2004). Parent attitudes including their beliefs about mental health disorders, beliefs concerning the effectiveness of treatments, and fear of stigmatization significantly influence their utilization of treatment for their children. Studies have found strong relationships between parents' attitudes toward psychological services and their willingness to seek help for their children's concerns (Stiffman, Pescosolido, & Cabassa, 2004; Yeh et al., 2005).

In the United States, there is a large gender discrepancy among those seeking mental health services for their own psychological concerns. Men consistently seek mental health services to a lesser extent than women (Courtenay, 2003; Good, Dell, & Mintz, 1989; Leaf & Bruce, 1987; Wills & DePaulo, 1991). In several studies American women were found to be at least twice as likely to seek psychological services as American men (Wills & DePaulo, 1991; Lin et al., 1996; Rhodes, Goering, To, & Williams, 2002). This same gender discrepancy is found when researchers have examined fathers and mothers in relation to seeking help for their children (Budd & O'Brien, 1982; Coplin & Houts, 1991). Researchers have suggested that one

possible reason for the help-seeking differences between men and women is men's adherence to masculine gender-role norms (Addis & Mahalik, 2003; Berger et al., 2005).

Masculine Gender-Role Norms

Gender-role norms are described as rules and standards that guide and constrain behavior (Mahalik et al., 2003). It is generally supported that gender-role norms are learned throughout development through a socialization process where social teachers, such as parents and the media, model conventional gender behaviors and reinforce children who behave according to the standards of their gender (Bem, 1981b; Lytton & Romney, 1991; O'Neil, 1981). At as early as age five-years-old, children are already able to differentiate behaviors that are typical for men and those that are typical for women (Lytton & Romney, 1991). When children and adults act according to the standards and rules of their gender, they are considered to be conforming to gender-role norms.

Mahalik and colleagues (2003) specified that the perceived characteristics of traditional masculine norms in the United States include wanting to win, having emotional control, being a playboy, being self-reliant, espousing the importance of work, having power over women, having disdain for homosexuals, being physically tough, and pursuing status. Masculine gender-role norms are contrasted with feminine gender-role norms that include wanting to be nice in relationships, wanting to be thin, being modest, being domestic, being nurturing toward children, being sexually faithful, wanting to have romantic relationships, and having investment in appearance (Mahalik et al., 2005). Mahalik and colleagues (2003) conceptualized conformity to gender-role norms as occurring on a continuum and suggested that men and women fall somewhere between total rejection and total acceptance of a gender-role norm. Close adherence to masculine gender-role norms has been found to increase a person's likelihood to have a

variety of psychological and physical health problems and to decrease a person's willingness to obtain help for such problems (Addis & Mahalik, 2003). Men report more negative attitudes toward seeking help and report higher levels of experiencing negative self-stigma associated with seeking mental health treatment when compared to women (Vogel, Wade, & Hackler, 2007). This strong relationship between negative help-seeking attitudes and high conformity to masculine gender-role norms is also prevalent when examining fathers' attitudes toward seeking help for their children (Triemstra & Niec, 2010).

Several studies have found that characteristics of the American masculine gender-role identity appear to constrain men in their help-seeking intentions (Addis & Mahalik, 2003; Berger et al., 2005; Good, Dell, & Mintz, 1989; Johnson, 1988; Mahalik et al., 2003). Many researchers associate the difference between men and women in mental health help-seeking with masculine gender-role socialization, which largely discourages talking about personal problems with others (Addis & Mahalik, 2003; Berger et al., 2005; Good, Dell, & Mintz, 1989; Johnson, 1988; Mahalik et al., 2003). Additionally, being self-reliant and having control over one's behaviors and emotions provides further barriers for men in seeking help (Mahalik et al., 2003). If an individual espouses to be masculine, seeking help for emotional difficulties or for problems with managing a child's behaviors would be in contrast with their gender identity. In the same way, seeking help of any kind may represent for men a loss of status, loss of autonomy, incompetence, and loss of control (Moller-Leimkuhler, 2002). As such, masculine gender-role socialization and general discomfort with mental health help-seeking seem to be linked theoretically and empirically.

There is some evidence that adhering to masculine gender-role norms does not result in characteristically masculine behaviors when individuals also adhere strongly to feminine gender-

role norms (Bem, Martyna, & Watson, 1976; Brannon, 1978; Lenney, 1991). These individuals have been described as behaving in ways consistent with either masculinity or femininity depending on what a given situation calls for (Bem, 1974). Individuals conforming highly to both masculine and feminine gender-role norms will theoretically have more positive attitudes about seeking help for themselves or for their children when compared to predominately masculine individuals.

The resistance that men have toward seeking help for themselves has negative effects on their own physical and psychological well-being (Good et al., 1995; Blazina & Watkins, 1996; Levant et al., 2009). Furthermore, it may be that parents who adhere to masculine gender-role norms not only restrict help-seeking for their own problems but also for their children's problems. Indirect evidence for this restriction in parent help-seeking can be found in the child treatment literature; fathers are significantly less likely to participate in treatment for their children than mothers (Budd & O'Brien, 1982; Coplin & Houts, 1991; Tiano & McNeil, 2005; Fabiano, 2007). Only recently have researchers started to investigate ways to increase men's participation rates in mental health services for themselves and for their children.

Father Involvement in Treatment

Behavioral parent training programs are unique in their treatment of childhood concerns because they involve the extensive participation of parents in the treatment sessions (Webster-Stratton, 1981; Eyberg, 1988). The modality of behavioral parent training programs makes the participation of parents a necessity for treatment progress and positive outcomes. Not only do behavioral parent training programs promote caregiver involvement, it is a requirement. The absence of fathers in parent training programs is, therefore, especially troublesome (Budd & O'Brien, 1982; Coplin & Houts, 1991).

Several extensive literature reviews have been completed that have examined fathers' participation rates in behavioral parent training programs. An examination of father participation rates in treatment for their children between 1970 and 1981 found that only 92 (13%) out of the 747 families participating in behavioral parent training research, across 56 separate studies, had fathers involved in treatment (Budd & O'Brien, 1982). In this review less than one half (44%) of the 64 available studies even reported statistics about father participation in treatment. Another examination of father participation rates during the period between 1981 and 1988 found that the reporting of father involvement in treatment stayed consistent with only 13 (37%) of the 35 published studies on behavioral parent training reporting father statistics (Coplin & Houts, 1991). In this review only 248 (20%) of the 1,253 families involved in behavioral parent training research from 1981 to 1988 were found to have fathers participating in the intervention or outcome assessment. It is important to note that many of the early studies on behavioral parent training either neglected to analyze fathers separately from mothers, neglected to analyze the effect that father involvement had on treatment, or neglected to invite fathers to participate in treatment altogether. However, even when father participation was assessed, fathers' rate of involvement in treatment for their children was significantly lower than mothers' (Budd & O'Brien, 1982; Coplin & Houts, 1991).

The effectiveness of parent training programs on decreasing disruptive behaviors in children has been examined extensively, yet the influence of fathers' participation has drawn minimal attention. Whether it is due to lack of sample size or lack of intent on the part of researchers, fathers have seldom been evaluated on how their presence in treatment affects the overall efficacy of a program (Tiano & McNeil, 2005). It is relevant to note that when effectiveness of treatment has been evaluated based on father involvement, father participation

does not seem to affect treatment gains assessed immediately following treatment completion (Adesso & Lipson, 1981; Bagner & Eyberg, 2003; Martin, 1977; Phares, Fields, & Binitie, 2006; Webster-Stratton, 1985b). However, several studies have found that increased father involvement in treatment is associated with increases in long-term maintenance of treatment gains (Bagner & Eyberg, 2003; Coplin & Houts, 1991; Webster-Stratton, 1985b).

Initial examinations of father involvement in family-based interventions had varied results and were inconclusive in their findings. For example, in several studies of father involvement in brief family therapy aimed at reducing parent-child conflict, father presence in treatment did not produce any significant positive differences in treatment outcomes. Mother-only treatment groups were found to be as effective in reducing parent-child conflict as dual parent treatment groups (Martin, 1977; Adesso & Lipson, 1981). Conversely, Firestone, Kelly and Fike (1980) found that father inclusion in behavioral management groups produced significant changes in reported child conduct post-treatment, whereas mother-only groups did not report such changes.

In the past three decades, the effects of father inclusion in behavioral parent training have been more consistent as father inclusion has been associated with better treatment outcomes (Webster-Stratton, 1985a; Bagner & Eyberg, 2003). The participation of a second caregiver appears to bolster the maintenance of acquired parenting skills and serves to maintain the decreases in disruptive behaviors in children. The maintenance of skills has been attributed to an increased consistency found in parenting practices of those dual parent participators. When both parents are involved in behavioral parent training, it is more likely that parent-child interaction skills and discipline strategies will be used consistently after treatment completion (Bagner & Eyberg, 2003; Webster-Stratton, 1985b). Better outcomes have also been achieved in general

family therapies when fathers are involved (Bischoff & Sprenkle, 1993; Gurman & Kniskern, 1978). Involving fathers in treatment has been associated with lower attrition rates, less marital stress, and fewer negative mother-child interactions (Clark & Baker, 1983; Strain, Young, & Horowitz, 1981; Webster-Stratton, 1985b). A father's participation in family therapy is related to less parental conflict and less likelihood that fathers will sabotage the therapy by going against the maternal caregiver's actions (Phares et al., 2005).

In addition to improvements in outcomes, father involvement appears to significantly influence treatment initiation and treatment continuation. When both mothers and fathers are involved in seeking family therapy services, the probability of treatment attendance is greater than when only the mother is involved in seeking help (Slipp, Ellis, & Kressel, 1974). Families that terminate treatment are more likely than those that continue to have fathers who are uninterested in treatment continuation. Father attitudes in particular are predictive of treatment continuation and termination (Shapiro & Budman, 1973).

Findings relating father involvement to treatment success or treatment continuation are only preliminary and correlational. However, these findings provide support for the need to include fathers in the treatment of childhood psychological disorders. The potential benefits of having fathers participate in parent training programs and family therapy makes the search for strategies to attract fathers warranted.

Promoting the Use of Mental Health Services Among Men

One promising practice in targeting treatment underutilization among underserved populations is through media messaging that is designed to decrease the stigma associated with psychological treatment by increasing people's knowledge and awareness of mental health treatments. Likewise, adapting psychological treatments to be more acceptable and culturally

sensitive to specific racial or ethnic groups has become increasing emphasized in psychological literature (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009). In several instances, protocols for evidence-based treatments have been adapted so that key concepts and treatment strategies can be better understood and accepted by those within a specific cultural group (Griner & Smith, 2006). The need to consider culture in the practice of psychology and in the development of specific treatments has been a point of emphasis in the field over the past decade (APA, 2006). It has recently been proposed that men also represent a distinctive culture with beliefs that prevent them from participating in psychological treatment at the same rate as women (Mansfield, Addis, & Mahalik, 2003). Although unlikely to be intentional, some psychological treatments have been designed for and promoted primarily to women (Rochlen, McKelley, and Pituch, 2006). Psychological treatments for children also appear to appeal more strongly to mothers than fathers (Phares, Ehrbar, & Lum, 1996).

There have been several attempts at improving the rate of utilization of mental health services among men (Blazina & Marks, 2001; Robertson & Fitzgerald, 1992; Rochlen et al., 2001; Rochlen, McKelley, & Pituch, 2006; Fabiano et al., 2009). Robertson and Fitzgerald (1992) studied the way men perceive counseling by developing two different brochures describing adult psychotherapy. The first brochure described psychotherapy in terms thought to be more consistent with masculine gender-role norms (i.e., classes, workshops, and seminars), whereas the second brochure described counseling in a traditional way (i.e., therapy and counseling). The study found that although the brochures described the same treatment, reasons for the treatment, and staff conducting the treatment, men who adhered to traditional masculine gender-role norms were more positive in their perceptions of the non-traditional brochure than of the traditional brochure. The researchers concluded that the reason for this difference was that

the non-traditional brochure used wording that was more congruent with masculine gender-role socialization.

Results of studies seeking to promote the use of psychotherapy among men have been mixed, however. Blazina and Marks (2001) asked men to rate their perceptions of traditional psychotherapy treatments, alternative treatments, and support groups for men. They found that the participants in their study who conformed closely to traditional masculine gender-role norms rated each of the treatments negatively. Contrary to their hypothesis that traditional psychotherapy would be most averse to men, the most negatively rated treatment approach was found to be the support groups. Rochlen et al. (2002) examined men's evaluations of two career counseling brochures, one targeting men and another written in a gender-neutral manner. They found that exposure to either brochure appeared to decrease the stigma associated with seeking career counseling. However, they did not find significant differences between men's acceptability of the brochure targeting men and the gender-neutral brochure.

In a more recent study, Rochlen, McKelley, and Pituch (2006) investigated the use of a gender-specific promotional campaign on men's perceptions and attitudes toward seeking help for depression. As part of a campaign to reach more men diagnosed with depression or mood disorders, the researchers developed three different brochures providing information about the treatment of depression. One brochure was aimed at appealing to men specifically, another was designed to be gender-neutral, and a third brochure was already in use and not designed with any gender in mind. The results of their study found that men rated the brochures similarly; however, those participants with negative attitudes toward seeking help rated the masculine-oriented brochure as more appealing than those not designed for men.

Although these studies do not provide consistent evidence that promoting psychological materials to men results in more treatment utilization, there is reason to believe that tailoring educational materials and program brochures to men results in less resistance to their content. In response to these studies, researchers have begun to identify ways in which they can adapt traditional psychotherapy to be more acceptable to men. McKelley and Rochlen (2007) theorized that men have strong negative reactions to words traditionally used to describe mental health services and to the format of therapy sessions. They examined recent research on executive coaching and found that men outnumber women in utilizing executive coaching services. Additionally, studies have consistently found that men react positively to the idea of working with a coach (Wasylyshyn, 2003). The reasons for men rating the acceptability of coaching positively can be attributed to both the terminology used and the collaborative approach employed by coaches that emphasizes skill-building and self-help (McKelley & Rochlen, 2007).

Fabiano and colleagues (2009) utilized the coaching terminology that appears to appeal more to men in designing and evaluating a father-specific behavior parent training program for children diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD). In the Coaching Our Acting-Out Children: Heightening Essential Skills (COACHES) program, the developers included traditional behavior parent training, sports skill training for the children, and parent-child interactions during patient participation in a soccer game. Outcomes of the COACHES treatment were compared with a traditional behavior parent training program. Results indicated no significant differences in treatment outcome on ADHD measures between groups; however, fathers in the COACHES treatment groups were significantly more likely to attend sessions, complete homework, and be satisfied with the treatment than those in the traditional behavioral parent training group. Adapting a treatment to include activities that are more consistent with

masculine gender-role norms had a significant and positive effect on treatment acceptance and adherence.

Fathers' attitudes toward psychological treatment for their children and their perceptions of behavioral parent training programs need further investigation. Although researchers have begun to adapt treatments to the needs of men and fathers, it is likely that fathers who have children with psychological or behavioral concerns are still faced with behavioral treatment options that are not wholly consistent with traditional masculine gender-role norms. Therefore, it is important to determine what information can be provided to fathers so that they are more willing to participate with their children in evidence-based psychological treatment. The purpose of the current study was to evaluate father perceptions of psychological treatment for children and to determine whether changing the description of an evidence-based treatment would result in more positive evaluations of the treatment and more positive attitudes toward seeking help for their children.

Summary and Hypotheses

The absence of fathers in psychological treatments for children is consistent with research that has found that men generally seek help at lower rates than women. It is been theorized that masculine gender-role socialization plays an important role in restricting men's help-seeking behavior (Addis & Mahalik, 2003; Berger, Levant, McMillan, Kelleher, & Sellers, 2005; Good, Dell, & Mintz, 1989; Johnson, 1988; Mahalik et al., 2003). Therefore, researchers have begun to adapt psychological treatment descriptions and programs to be more consistent with masculine gender-role norms with mixed results (Blazina & Marks, 2001; Robertson & Fitzgerald, 1992; Rochlen et al., 2001; Rochlen, McKelley, & Pituch, 2006; Fabiano et al., 2009). Strategies for improving the rate of father utilization of behavior parent training programs have not been

extensively examined. The purpose of the current study was to investigate the effects of promoting an evidence-based psychological treatment for children using varied terminology (i.e., traditional psychological terminology, masculine gender-role consistent terminology) on fathers' perceptions of the treatment and attitudes toward seeking psychological help for their children.

Three treatment descriptions were designed for the current study: a traditional PCIT description, a masculine-oriented PCIT description, and a one-sentence recommendation for psychotherapy describing the treatment as "therapy with a psychologist to address behavior problems." The one-sentence recommendation was designed to be brief, lacking specific information about the service being described. Participants were randomly assigned to read one of the treatment descriptions before evaluating the treatment and rating their attitudes toward seeking psychological help for their children.

It was hypothesized that:

1. Fathers who read the masculine-oriented PCIT description would have significantly more positive evaluations of the treatment and significantly more positive attitudes toward seeking psychological help for their children than those who read either the traditional PCIT description or the one-sentence recommendation for psychotherapy.
2. Fathers who read the traditional PCIT description would have significantly more positive evaluations of the treatment and significantly more positive attitudes toward seeking psychological help for their children than those who read the one-sentence recommendation for psychotherapy.
3. Fathers' level of conformity to traditional masculine gender-role norms would moderate the relationship between the study condition and evaluations of the treatment description and the relationship between the study condition and fathers'

attitudes toward seeking psychological help for their children. Participants with high conformity to masculine gender-role norms who read the masculine PCIT description would have significantly more positive evaluations of the treatment and significantly more positive attitudes toward seeking psychological help for their children than those who read the traditional PCIT description.

CHAPTER II

METHOD

Participants

Participants were fathers of children between the ages of 2 and 12 years old. One hundred and thirty-eight fathers recruited from online advertising and postings on social networking sites initially agreed to participate in the study. Fourteen participants were excluded from the analysis because they did not complete one of the measures or had missed more than 20% of the questions on any measure (Arbuckle, 1996; Peng, Harwell, Liou, & Ehman, 2007). One hundred and twenty-four participants were included in the analysis. Excluded participants who completed demographic variables did not differ significantly from included participants on any demographic characteristics. No significant differences were found between groups in age of participant, years of education, annual household income, target child's age, or other caregiver's years of education (Table 1). Chi-square tests were conducted on seven other demographic variables using a Bonferroni-adjusted alpha level of .007 for each comparison (.05/7). Bonferroni corrections to alpha levels account for the increase in the probability of Type I statistical errors when testing multiple hypotheses by calculating statistical significance based on the number of hypotheses being considered (Shaffer, 1995). Participants excluded from the analysis did not differ significantly with those included in the analysis with regard to target child gender, $\chi^2(1, 138) = 2.36$, $p = 0.13$, history of child diagnosis of learning or developmental disorders, $\chi^2(1, 138) = 0.39$, $p = 0.53$, history of child participation in psychological treatment, $\chi^2(1, 138) = 0.09$, $p = 0.77$, history of participant participation in psychological treatment, $\chi^2(1, 138) = 0.09$, $p = 0.77$, participant marital status, $\chi^2(4, 138) = 4.01$, $p = 0.41$, or participant racial background, $\chi^2(4, 138) = 2.72$, $p = 0.61$. The absence of significant differences found between participants included

in the study and those not fully completing the surveys suggest that the excluded cases were not missing data due to known participant characteristics.

Table 1. *Summary of Differences Between Included and Excluded Cases on Demographic Variables*

	Participants			
Variable	Included	Excluded	*t*	*df*
Father Age	37.45 (9.38)	36.64 (7.56)	0.31	136
Years of Education	15.59 (2.64)	15.36 (3.05)	0.31	136
Target Child's Age	6.90 (3.47)	6.07 (3.75)	0.84	136
Household Income	8.59 (2.92)	8.43 (3.59)	0.20	135
Years of Education (Other Caregiver)	14.49 (3.71)	15.79 (2.86)	-1.26	115

Note. Standard Deviations appear in parentheses below means.
* $p < .05$.
** $p < .01$.

The expectation-maximization (EM) algorithm was used to replace missing data for 36 participants included in the study. The EM procedure input maximum likelihood values for those participants who missed items yet completed more than 80% of the items on each measure. This statistical technique has been shown to yield estimates of values that closely approximate observed data in statistical simulations when missing data is missing at random (Dempster, Laird, & Rubin, 1977). To determine whether missing data was missing at random, each measure with missing values was analyzed using Little's missing completely at random test (MCAR; Little, 1988). Results indicated that the missing data on the Treatment Evaluation Inventory-Short Form (TEI-SF), $\chi^2(39) = 32.59$, $p = 0.76$, and the Attitudes Toward Seeking Professional

Psychological Help Scale-Parent form (ATSPPHS-P), $\chi^2(510) = 482.31$, $p = 0.81$, were missing completely at random. Therefore, imputed data is not likely to be biased.

The ages of participants included in the study ranged from 21 to 68 years old (M = 37.45, SD = 9.38) and educational achievement ranged from 9 to 20 years (M = 15.59, SD = 2.64). Study participants reported having as many as six children in their household (M = 1.88, SD = 0.94). Participants were required to have at least one child between the ages of 2 and 12 years old in order to complete the study; however, participants were also asked to provide age and gender information on their other children. Additional participant characteristics are provided in table 2.

Measures

Participants completed four scales:

Attitudes Toward Seeking Professional Psychological Help Scale-Parent Form (ATSPPHS-P; Triemstra & Niec, 2010; APPENDIX A). The ATSPPHS-P is a 29-item scale that assesses a parent's attitude toward seeking mental health services for his or her child. The ATSPPHS-P consists of items such as, "Although there are clinics for parents with difficult children, I would not have much faith in them (item 1)", and "Emotional difficulties, like many things, tend to work out by themselves (item 9)." Respondents indicated their level of agreement with each item on a four-point scale (1 = disagree strongly; 4 = agree strongly). A high total score represents a positive attitude toward seeking mental health services for a child.

The ATSPPHS-P was adapted from the Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970; Triemstra & Niec, 2010). The

Table 2. *Participant Characteristics*

Variable		Frequency	Percent
Marital status			
	Married	99	79.8
	Unmarried	25	20.2
Ethnicity			
	White/Caucasian	103	83.1
	African American/Black	6	4.8
	Asian/Pacific Islander	6	4.8
	Hispanic/Latino	2	1.6
	Mixed Race	6	4.8
	No Answer	1	0.8
Income			
	>$100,000	31	25.0
	$90,001 to $100,000	7	5.6
	$80,001 to $90,000	17	13.7
	$70,001 to $80,000	14	11.3
	$60,001 to $70,000	9	7.3
	$50,001 to $60,000	15	12.1
	$40,001 to $50,000	9	7.3
	$30,001 to $40,000	8	6.5
	$20,001 to $30,000	6	4.8
	$10,001 to $20,000	4	3.2
	$5,001 to $10,000	2	1.6
	< $5,000	1	0.8
Participation in Individual Psychological Treatment			
	Yes	30	24.2
	No	90	72.6
	No Answer	4	3.2
Target Child Gender			
	Girl	71	57.3
	Boy	53	42.7
Child Participation in Psychological Treatment			
	Yes	22	17.7
	No	99	79.8
	No Answer	3	2.4

Note. n = 124 for all categories.

original ATSPPHS scale is made up of four subscales. The first subscale measures the recognition of the need for psychological help. The second subscale measures a participant's tolerance of the stigma attached to seeking professional psychological help. The third subscale measures a participant's interpersonal openness or willingness to reveal personal problems to others, and the fourth subscale measures a participant's confidence in mental health practitioners. The ATSPPHS-P mirrors the ATSPPHS and measures similar constructs related to the process of seeking professional psychological help. The ATSPPHS-P total score was used in the current study as a measure of participants' overall help-seeking attitudes toward obtaining mental health service for their children.

Previous studies of the original ATSPPHS have reported a high internal consistency (α = 0.86; Fischer & Turner, 1970) and high test-retest reliability (r = 0.73 to 0.89; Fischer & Turner, 1970) indicating a moderately good consistency of response within the entire scale. The construct validity of the ATSPPHS-P was demonstrated in a previous study finding that the total ATSPPHS-P scores correlated significantly (r = 0.93) with the original ATSPPHS (Triemstra & Niec, 2010). The original ATSPPHS has been found to be highly correlated with another help-seeking scale, the Help-Seeking Attitude Scale (r = 0.49; Plotkin, 1983). The original ATSPPHS has demonstrated a significant relationship with actual psychological help-seeking behavior (r = 0.39, $p < .0001$ for both men and women; Komiya, Good, & Sherrod, 2000). The ATSPPHS-P was found to have a high internal consistency in the current study (α = 0.89) and good split-half reliability (r = 0.81).

Bem Sex Role Inventory (BSRI; Bem, 1981a; APPENDIX B). The BSRI was developed in 1977 to assess femininity and masculinity traits in order to evaluate an individual's psychological androgyny. The BSRI is a 60-item self-report inventory consisting of 20 feminine

characteristic items (e.g., Sympathetic, Warm, Yielding), 20 masculine characteristic items (e.g., Forceful, Self-reliant, Competitive), and 20 neutral characteristic items (e.g., Helpful, Conventional, Conceited). Individuals rate themselves as to the extent each characteristic is true of them on a 7-point likert scale (1 = Never or almost never true, 7 = Always or almost always true). The BSRI was originally conceived as a way to categorize individuals into four classes of sex-roles, Masculine, Feminine, Androgynous, and Undifferentiated based on responses on each scale. The developers used a median-split technique to determine a cutoff for both scales using the sample of the original study as the normative group (Bem, 1981a). Orlofsky, Aslin, and Ginsburg (1977) found much higher cutoffs for both the masculine and feminine scales when they conducted median-splits to determine the most accurate scoring format for the BSRI. For the purposes of the current study, total scores for both the masculine scale and feminine scale were used to determine the effect of participants' gender-role conformity on their evaluation of the treatment descriptions. Median-splits using local norms for each scale were done to explore the differences between gender-role groups in their responses to the treatment descriptions.

Reliability for the BSRI has been found to be good for internal consistency ($\alpha = 0.75$ to 0.87; Bem 1981a) and for test-retest reliability ($r = 0.76$ to 0.94). The low intercorrelation between the masculine and feminine scales has been used to indicate the independence of the two dimensions ($r = 0.11$ and -0.02 for men, $r = -0.14$ and -0.07 for women; Lenney, 1991). Construct validity has been demonstrated through studies that found the BSRI scales to be highly correlated with other sex-role scales including the Conformity to Feminine Norms Inventory ($r = 0.40$; Mahalik, et al., 2005) and the Personal Attributes Questionnaire ($r = 0.78$ for Masculine scale and $r = 0.71$ for Feminine scale; Lippa, 1991). There are mixed results between studies attempting to validate the BSRI as a measure of androgyny as it was originally designed

(Whetton & Swindells, 1977). The BSRI was used in this study to measure participant perceptions of their masculine and feminine traits. In the current study, the BSRI Masculine scale was found to have good internal consistency ($\alpha = 0.89$) and split-half reliability ($r = 0.71$) and the BSRI Feminine scale was also found to have good internal consistency ($\alpha = 0.84$) and moderate split-half reliability ($r = 0.63$).

Treatment Evaluation Inventory – Short Form (TEI-SF; Kelley, Heffer, Gresham, & Elliott, 1989; APPENDIX C). The TEI-SF is a 9-item scale that assesses an individual's acceptance of a psychological program designed to treat children. The TEI-SF consists of items such as "I find this treatment to be an acceptable way of dealing with the child's problem behavior" and "I believe this treatment is likely to be effective." Each statement is rated on a five-point likert-type scale (1 = Strongly Disagree; 5 = Strongly Agree). A higher total score on the TEI-SF indicates greater acceptance of the treatment being evaluated and a more positive view of its efficacy. The TEI-SF was adapted from the original TEI, which is one of the most recognized measures for evaluating psychological treatments (Kazdin, 1980). The TEI-SF was created using factor analysis and was found to be consistent with the TEI in its factor structure while also lowering its reading level. The TEI-SF has been found to be a reliable alternative to the TEI (Kelly, Heffer, Gresham, & Elliot, 1989).

Previous studies report a high internal consistency for the TEI-SF ($\alpha = 0.85$; Kelly, Heffer, Gresham, & Elliot, 1989). Construct validity was demonstrated by Adams and Kelley (1992) who found that the TEI-SF was able to discriminate successfully between two different treatment methods. For the current study, the TEI-SF was found to have good internal consistency ($\alpha = 0.81$) and moderate split-half reliability ($r = .66$). The TEI-SF was used in the

current study to measure fathers' perceptions of three different descriptions of child psychological treatments.

Demographic Form (APPENDIX D). The demographic form used in the present study included questions regarding a respondent's age, race, years of education completed, number of children, marital status, occupation, history of participation in psychological therapy, and annual household income. It also posed questions regarding respondents' children's ages, genders, and races as well as whether any of their children has been diagnosed with a developmental delay or learning disorder, or whether any of their children have a history of participation in psychological treatment. This form was used in the current study to determine and control for the effect of demographic characteristics on fathers' attitudes toward psychological help-seeking for their children and evaluations of treatment descriptions.

Apparatus

SurveyMonkey.com. All surveys were available and administered through the World Wide Web at the SurveyMonkey.com portal, an on-line survey website. SurveyMonkey.com was used to collect expert reviews of the masculine adaptations to the PCIT description and was also used to administer the father survey. The father survey was made available through the website for approximately 60 days, at which time 124 completed surveys had been collected. There was no need for a user ID or password to complete the survey. The only end-user requirement was that participants have access to a standard web browser and an internet connection. No special software or downloads were required. The investigators tested the site and study survey for functionality prior to submitting the link to participants.

The hosting company, SurveyMonkey.com, aggregated the data into a file compatible with IBM SPSS Statistical software and returned it to the investigator via a secure e-mail

download. The website was programmed not to collect any participant identification (i.e., email addresses or names). Identities of the participants were unknown to the researcher. A separate survey was created on SurveyMonkey.com to collect e-mail addresses for the gift card drawings.

Procedure

Adaptation of the Therapy Description. The primary objective of the current study was to evaluate the effects of masculine adaptations to an evidence-based treatment for child disruptive behavior disorders, PCIT, on fathers' evaluations of the treatment and attitudes toward seeking help for their children. Parent-Child Interaction Therapy (PCIT) was chosen as a representative treatment for the current study because it is an efficacious psychological treatment for children that emphasizes parent involvement (Eyberg, Nelson, & Boggs, 2008). Prior to the recruitment of participants, a brief description of PCIT was obtained through the PCIT website (www.pcit.org; APPENDIX E) which is owned by the official PCIT training organization, PCIT International. This particular description was chosen because of its use by the developers of PCIT on a highly visible, searchable, and official webpage and because of its brevity and potential for use in aiding clinical referrals. This unaltered PCIT description was presented to participants in the current study as a traditional evidence-based psychotherapy option for the treatment of disruptive behavior problems in children.

The unaltered description of PCIT was then adapted to be consistent with masculine gender-role norms. Changes to the wording of the traditional PCIT description were initially determined by the primary investigator so that each phrase in the description conformed to traditional American masculine gender-role norms. Mahalik and colleagues (2003) found eleven components to traditional masculinity that were used as a guide in initially adapting the PCIT description: wanting to win, having emotional control, being a playboy, being self-reliant,

espousing the importance of work, having power over women, having disdain for homosexuals, being physically tough, and pursuing status. References to parents were changed to include specific mentions of "fathers and mothers." Terminology including "treatment," "therapy," and "psychological" was removed and replaced with alternative words due to the stigma associated with psychology. The acronym "PCIT" was used as the name of the treatment as to avoid using the word "therapy" in the masculine description. The adapted description was then reviewed and revised by a licensed clinical psychologist and master trainer in PCIT.

To evaluate whether the changes that were made to the original description were done in a way that retained the description's accuracy in describing the key components of PCIT, three PCIT experts and trainers were asked to rate each statement of the masculine description based on whether they agreed that the statement accurately reflected PCIT (1 = Strongly Disagree, 3 = Neutral, 5 = Strongly Agree; APPENDIX F). Additionally, experts in the field of masculinity and fatherhood were asked to review the altered description of PCIT to determine the quality of adaptations made. Each masculinity expert had recently published research pertaining to masculinity in peer-reviewed journals or was referred to the primary investigator by editors of prominent masculinity journals. Experts were asked to rate each statement of the description based on whether they agreed that the statement was consistent with traditional masculine gender-role norms (APPENDIX G). SurveyMonkey.com was used to compile ratings through an internet-based survey.

Results of the PCIT expert review found that one reviewer rated an individual statement in the description as inaccurately describing PCIT. Every other statement of the description was rated strongly agree, agree or neutral as to whether the reviewers thought that the description was accurately depicting the treatment. Experts were asked to give feedback on those statements

rated as inaccurate and their feedback was then used to revise the description. Results of the masculinity expert review similarly found that each statement of the description was rated strongly agree, agree, or neutral by all three reviewers. Feedback from each reviewer was considered in creating the final adapted PCIT description (APPENDIX G).

Father Study. Participants were directed to SurveyMonkey.com to complete an internet-based survey. Upon beginning the survey, each participant was presented with an informed consent webpage stating the purpose of the study and requirements of completion. After consenting to the study, participants then completed the Demographic Form and BSRI before being presented with a case vignette describing a child with significant disruptive behavior problems (APPENDIX H). The case vignette developed for the current study described a child with significant disruptive behavior problems. The vignette provided behavioral examples corresponding to diagnostic criteria for Oppositional Defiant Disorder (ODD; APA, 2000). Participants were asked to read the vignette before being presented with a treatment recommendation for the child described.

After reading the vignette, participants were randomly assigned to read one of three treatment recommendations. All participants read that the description was "a common treatment recommendation for the types of behaviors that the child is showing." Fathers were provided with either the masculine adapted PCIT description (n = 38), the unaltered traditional PCIT description (n = 41), or the one-sentence statement, "It is recommended that the child and his parents participate in therapy with a psychologist to address his behavior problems" (n = 45). After reading their assigned treatment recommendation, participants completed the TEI-SF and the ATSPPHS-P. Following the completion of the surveys, participants were given an

opportunity to enter an email address into drawings for three $50 Amazon.com gift cards that were distributed upon the conclusion of the study.

CHAPTER III

RESULTS

Preliminary Analysis

Table 3 shows the intercorrelations and coefficient alphas of all four scales used in this study. An alpha level of .05 was used to determine significance for correlational analyses. Unless otherwise noted, Bonferroni-adjusted significance levels were used for all group contrasts. In addition, for comparisons involving three or more groups, the corresponding partial η^2 is reported as the effect size measure. For comparisons involving two groups, Cohen's *d* is reported.

Table 3. *Correlations and Coefficient Alphas for Scores on the TEI-SF, ATSPPHS-P, BSRI Masculine, and BSRI Feminine Scales*

Measure	1	2	3	4
1. TEI-SF	(.81)			
2. ATSPPHS-P	.35**	(.89)		
3. BSRI Masculine	.13	-.21*	(.89)	
4. BSRI Feminine	.14	-.18*	.44**	(.84)

Note. N = 124. Coefficient alphas are presented in parentheses along the diagonal. TEI-SF = Treatment Evaluation Inventory – Short Form, ATSPPHS-P = Attitudes Toward Seeking Professional Psychological Help Scale – Parent, BSRI Masculine = Bem Sex-Role Inventory Masculine scale, BSRI Feminine = Bem Sex-Role Inventory Feminine scale.
** $p < .05$. ** $p < .01$.*

Correlation results between the four study measures indicated that participants' evaluations of the treatment descriptions across all three study conditions were significantly and positively correlated to their attitudes toward seeking psychological help for their children. Additionally, participants' adherence to masculine gender-role norms and their adherence to

feminine gender-role norms were significantly and negatively correlated to their attitudes toward seeking psychological help for their children.

Group Differences on Demographic Variables

A series of one-way analyses of variance (ANOVA) were conducted in order to determine whether participants in the three study conditions differed with respect to demographic variables (i.e., respondent age, years of education, and ethnicity). Results indicated that the three groups were not significantly different in participant age, target child age, years of education completed, years of education completed by other caregiver, annual household income, or number of children (Table 4). Chi-square tests were conducted to determine whether participants in the three study conditions differed with respect to five additional a priori variables. A Bonferroni-adjusted alpha level of .01 was used to determine statistical significance (.05/5). Results indicated that participants in the three study conditions did not differ significantly in their history of participation in psychological treatment, $\chi^2(2, 120) = 0.23$, $p = 0.89$, child history of participation in psychological treatment, $\chi^2(2, 121) = 1.15$, $p = 0.56$, marital status, $\chi^2(8, 124) = 9.47$, $p = 0.30$, gender of the target child, $\chi^2(2, 124) = 0.36$, $p = 0.84$, or racial background, $\chi^2(10, 124) = 15.95$, $p = 0.10$.

A comparison of the gender-role identity characteristics of participants between study conditions was also conducted to determine whether participants differed in their adherence to masculine and feminine gender-role norms. A one-way multivariate analysis of variance (MANOVA) was performed to determine whether participants in the three study conditions differed on the BSRI Masculine and BSRI Feminine scales. Results of the overall test of equal group means was not significant, Wilks's $\lambda = 0.98$, $F(4, 240) = 0.78$, $p = 0.54$, partial $\eta^2 = 0.01$,

indicating participants in each study condition had similar adherence to masculine gender-role norms and adherence to feminine gender-role norms.

Table 4. *Summary of a Series of One-Way Analyses of Variance Comparing Study Groups on Demographic Variables*

Variable and Source	*SS*	*MS*	*F*(2, 123)	*p*	η^2
Participant Age					
Between	189.71	94.86	1.08	.34	.02
Within	10641.00	87.94			
Target Child Age					
Between	28.63	14.32	1.19	.31	.02
Within	1455.01	12.03			
Number of Children					
Between	3.41	1.70	1.95	.15	.03
Within	105.78	.87			
Years of Education Completed					
Between	1.85	.93	.13	.88	.00
Within	858.78	7.09			
Years of Education – Other Caregiver					
Between	9.59	4.79	.34	.71	.01
Within	1392.14	13.92			

Note. N = 124.

Primary Analysis

A one-way analysis of variance (ANOVA) was conducted to determine whether participants differed significantly between conditions in their evaluations of the program

description on the TEI-SF. Results indicated significant differences between groups on fathers' evaluations of the treatment (Table 5). Analysis of group differences using Bonferroni-adjusted significance levels indicated that participants who read the masculine PCIT description had significantly more positive evaluations of the treatment (M = 33.42, SD = 4.25) than those participants who read the one-sentence treatment recommendation, (M = 30.59, SD = 5.06), p = 0.02, d = 0.60. Participants who read the traditional PCIT description did not differ significantly in their evaluations of the treatment description (M = 32.87, SD = 4.33) with those participants in the control condition who read the one-sentence treatment recommendation, (M = 30.59, SD = 5.06), p = 0.07, d = 0.48. These findings indicated that fathers assigned to read the masculine PCIT description evaluated the treatment significantly more positively than those fathers who read the one-sentence treatment recommendation. However, fathers assigned to read the traditional PCIT description did not evaluate the program significantly different than those who read the one-sentence recommendation for psychological therapy. Further analysis indicated that participants who read the masculine PCIT description did not differ significantly in their evaluations of the treatment (M = 33.42, SD = 4.25) with those participants who read the traditional PCIT description (M = 32.87, SD = 4.33), p = 0.99, d = 0.13.

Results of a separate one-way ANOVA indicated that participants did not differ significantly between groups in their attitudes towards seeking professional psychological help for their children (Table 5). Participants who read the masculine PCIT description had similar attitudes toward seeking psychological help for their children (M = 81.59, SD = 2.09) compared with participants who read the traditional PCIT description (M = 85.09, SD = 2.01), p = 0.69, d = 0.27, and participants who read the one-sentence recommendation for psychotherapy (M = 81.66, SD = 1.92), p = 0.99, d = 0.01.

Table 5. *Summary of the Effects of Study Condition on the Evaluation of the Treatment Description and Attitudes Toward Seeking Psychological Help for Children*

Source	*df*	*SS*	*MS*	*F*	*p*	η^2
TEI-SF						
Between	2	191.11	95.56	4.54	.01	.07
Within	121	2547.02	21.05			
Total	124	131405.88				
ATSPPHS-P						
Between	2	329.49	164.75	.99	.37	.02
Within	121	20051.94	165.72			
Total	124	869907.22				

Note. N = 124. TEI-SF = Treatment Evaluation Inventory – Short Form, ATSPPHS-P = Attitude Toward Seeking Professional Psychological Help Scale – Parent.

Moderation Analysis

Participants' adherence to masculine gender-role norms was hypothesized as a moderator of the relationship between study condition and fathers' evaluation of the treatment description. Additionally, participants' adherence to masculine gender-role norms was hypothesized as a moderator of the relationship between study condition and fathers' attitudes toward seeking psychological help for their children. That is, fathers with high conformity to masculine gender-role norms who read the masculine PCIT description would have significantly more positive evaluations of the treatment and significantly more positive attitudes toward seeking psychological help for their children than those who read the traditional PCIT description. In order to assess these hypotheses, participants were categorized into low and high masculinity groups based on their level of adherence to masculine gender-role norms. A median split of the BSRI Masculine scale was used to identify high and low masculinity groups. For exploratory

purposes, participants were also categorized into low and high femininity groups based on their level of adherence to feminine gender-role norms. A median split of the BSRI Feminine scale was used to identify high and low femininity groups.

Two 3-way ANOVAs were conducted with the evaluation of the treatment description (TEI-SF) and attitudes toward seeking psychological help for children (ATSPPHS-P) entered separately as dependent variables and study condition, adherence to masculine gender-role norms (BSRI Masculine), and adherence to feminine gender-role norms (BSRI Feminine) entered as independent variables. Participants' level of adherence to masculine gender-role norms and level of adherence to feminine gender-role norms were entered as separate independent variables to evaluate the main and interaction effects of each variable, to test the hypothesized interaction between adherence to masculine gender-role norms and study condition, and to conduct exploratory analysis on the effects of adherence to feminine gender-role norms. Results indicated that level of adherence to masculine gender-role norms did not significantly moderate the effect of study condition on fathers' evaluation of the treatment description (Table 6). Similarly level of adherence to masculine gender-role norms did not significantly moderate the effect of study condition on fathers' attitudes toward seeking psychological help for their children (Table 7).

Table 6. *Summary of the Three-Way Analysis of Variance of the Effects of Study Condition, Adherence to Masculine Gender-Role Norms, and Adherence to Feminine Gender-Role Norms on Evaluations of Treatment Descriptions*

Source	*df*	*MS*	*F*	*p*	η^2
Study Condition (C)	2	77.01	3.80	.03	.06
Masculinity (BSRI-M)	1	5.75	.28	.60	.00
Femininity (BSRI-F)	1	79.50	3.923	.05	.03
C x BSRI-M	2	45.90	2.27	.11	.04
C x BSRI-F	2	59.40	2.93	.06	.05
BSRI-M x BSRI-F	1	5.29	.26	.61	.00
C x BSRI-M x BSRI-F	2	3.71	.18	.83	.00
Within-cells Error	112	20.27			

Note. N = 124.

Exploratory Analysis

Exploratory analysis of the effect of fathers' adherence to feminine gender-role norms was also conducted. Participants were categorized into the four gender-role identity categories based on their level of adherence to masculine and feminine gender-role norms: predominantly masculine (n = 19), predominantly feminine (n = 20), androgynous (n = 43), and undifferentiated (n = 42; Bem, 1981a). Results indicated that the three-way interaction of study condition, adherence to masculine gender-role norms, and adherence to feminine gender-role norms was not a significant predictor of participants' evaluations of the treatment (Table 6) or of participants' attitudes toward seeking psychological help for their children (Table 7). Participants' level of adherence to masculine and feminine gender-role norms did not significantly moderate the effect of the study condition on participants' evaluations of treatment descriptions or attitudes toward seeking help for their children. The relatively low sample size of

predominately masculine participants and predominantly feminine participants in each study condition makes the comparison between groups exploratory and not necessarily predictive of larger samples.

Table 7. *Summary of the Three-Way Analysis of Variance of the Effects of Study Condition, Adherence to Masculine Gender-Role Norms, and Adherence to Feminine Gender-Role Norms on Attitudes Toward Seeking Psychological Help for Children*

Source	*df*	*MS*	*F*	*p*	η^2
Study Condition (C)	2	418.46	2.89	.06	.05
Masculinity (BSRI-M)	1	483.10	3.34	.07	.03
Femininity (BSRI-F)	1	.91	.01	.94	.00
C x BSRI-M	2	50.87	.35	.70	.01
C x BSRI-F	2	478.58	3.31	.04	.06*
BSRI-M x BSRI-F	1	1191.12	8.23	.01	.07
C x BSRI-M x BSRI-F	2	311.40	2.15	.12	.04
Within-cells Error	112	144.71			

Note. N = 124.

CHAPTER IV

DISCUSSION

Men have traditionally been less likely to participate in psychological treatment for their children than women (Budd & O'Brien, 1982; Coplin & Houts, 1991; Tiano & McNeil, 2005; Mansfield, Addis, & Courtenay, 2005; Mather, 2010). The purpose of the current study was to evaluate men's perceptions of an evidence-based psychological treatment for children and to determine the effect of changing how the treatment was promoted to fathers. Specifically, this study assessed whether adapting a description of PCIT to be more consistent with masculine gender-role norms would result in significantly more positive evaluations of the treatment and more positive attitudes toward seeking psychological help for children in a sample of fathers.

Father Evaluations of Masculine Treatment Adaptations

Mansfield, Addis, and Mahalik (2003) theorized that men represent a distinctive culture with beliefs that prevent them from participating in psychological treatment at the same rates as women. Participating in traditional psychological therapy is incongruent with masculine gender-role norms and may result in men experiencing a perceived loss of status, loss of autonomy, and loss of control (Moller-Leimkuhler, 2002). To reduce the incongruity between men's participation in psychological treatment and their gender-role identity, the current study adapted a description of PCIT to be consistent with masculine gender-role norms and assessed its effectiveness in appealing to fathers.

The results of the current study found that adapting a PCIT description to conform more closely to masculine gender-role norms significantly improved fathers' evaluations of the treatment. Fathers who read the masculine PCIT description evaluated the treatment significantly more positively than those who read the one-sentence psychotherapy recommendation. In

comparison, no significant difference in treatment evaluations was found between fathers who read the traditional PCIT description and fathers who read the one-sentence psychotherapy recommendation. Previous research on the promotion of psychological services among men have varied in their results; however, several studies have found that adapting psychological treatment materials to appeal directly to men had significant and positive effects on men's perceptions about the treatment (Robertson & Fitzgerald, 1992; Rochlen, McKelley, & Pituch, 2006; Fabiano et al., 2009). The results of the current study provide further evidence that adapting psychological treatment materials to be consistent with masculine gender-role norms has a significant effect on how men evaluate the treatment.

Fabiano and colleagues (2009) found that adding masculine-oriented treatment components to a behavioral parent training program resulted in significant improvement in father attendance and engagement in the treatment. However, other research studies on making psychological treatments more appealing to men have not typically assessed whether differences in the evaluation of the treatment materials resulted in increased help-seeking behaviors or participation in treatment among fathers. Further research is needed to fully understand the effects of adapting treatment descriptions and promotional materials to be more consistent with masculine gender-role norms on fathers' participation in treatment for their children.

Adherence to Masculine Gender-Role Norms

Participation rates in behavioral parent training programs are significantly lower for fathers when compared with mothers (Budd & O'Brien, 1982; Coplin & Houts, 1991; Tiano & McNeil, 2005). One reason for this discrepancy is that psychological treatments for children involve activities that are inconsistent with masculine gender-role norms (e.g., talking about emotions, not having control). Therefore, it was hypothesized that fathers in the current study

who adhered strongly to masculine gender-role norms would rate the traditional PCIT description significantly less positively than the masculine PCIT description due to its use of terminology and phrases incongruent with masculine gender-role norms. The results of the current study did not support this hypothesis. Fathers with high adherence to masculine gender-role norms had similar perceptions about the treatment whether they read the traditional PCIT description or the masculine PCIT description.

The absence of a moderating effect of gender-role adherence on the relationship between study condition and fathers' evaluations of the treatment description indicates that the masculine adaptations alone did not fully account for the significant differences in fathers' evaluations of the treatments. As a consequence of making the masculine adaptations to the PCIT description, psychological terminology was also removed or replaced. This reduction in the use of traditional psychological terminology may have made the treatment description more appealing to fathers regardless of their adherence to masculine gender-role norms. Additional studies will be necessary to determine the individual effects of each change made to the treatment description and to fully understand the role of adherence to masculine gender-role norms in reducing fathers' participation in psychological treatment for their children.

Attitudes Toward Seeking Psychological Help

It was hypothesized that masculine adaptations to the treatment description would produce significant changes in fathers' attitudes toward seeking psychological help for their children; however, this was not supported by the results of the current study. Rochlen, McKelley, and Pituch (2006) found similar results when evaluating the effectiveness of masculine adaptations to a brochure on the treatment of depression; men's attitudes toward seeking psychological help did not differ based on the brochure that they read. Previous research has

found that attitudes toward seeking psychological help are significantly correlated with conformity to masculine gender-role norms (Mahalik et al., 2003; Triemstra & Niec, 2010). This close link to gender-role identity may indicate that attitudes toward seeking help are developed throughout one's life in a process similar to gender-role socialization and may be harder to change than moment-by-moment perceptions of specific treatments (Bem, 1981b; O'Neil, 1981). Modifying fathers' attitudes toward seeking psychological help might require more intensive efforts and strategies not evaluated in the current study. Future research is needed to investigate the effects of other strategies on fathers' attitudes toward seeking psychological help for their children and to fully understand men's attitudes and beliefs that serve as barriers to participation in psychological services.

Limitations and Future Directions

The current study has several limitations that reduce its generalizability. Due to the recruitment of a non-clinical community sample, it is difficult to generalize these findings to fathers with children who have clinically diagnosed psychological concerns. Therefore, it is not known whether the differences in participants' evaluations of the treatments would lead to a significant improvement in fathers' help-seeking behavior or participation in psychological treatment within a clinical population. Further research is needed to assess whether the results of the current study are sustained when conducted with a clinical sample. Future studies should consider involving families already in treatment for psychological concerns to determine whether masculine-oriented promotional materials have a significant effect on fathers' involvement in treatment for their children.

Due to the homogeneity of this study's sample, generalization to non-Caucasian or low income populations should be done with caution. The sample obtained for this study was found

to be predominately Caucasian, with the majority of participants' households making over $70,000 annually. Although some general trends may persist across cultures and income groups, some attitudes and gender-role norms may be significantly different in fathers from culturally diverse backgrounds. Previous studies have found that men in several racial minority groups in America, including Hispanics and African-Americans, appear to adhere to traditional masculine gender-role norms to similar extents as Caucasians (Wong, Owen, & Shea, 2012; Lease et al., 2010; Mahalik, Pierre, & Wan, 2006). However, significant differences have been found in help-seeking for mental health concerns between ethnic groups (Diala, Muntaner, Walrath, Nickerson, LaVeist, & Leaf, 2001). Future studies that recruit broader populations with diverse racial backgrounds are needed to fully understand the effect of the masculine adaptations to the treatment description and to make recommendations for clinicians serving diverse populations.

In addition to the limitations due to the homogeneity of the sample, disadvantages of conducting the study exclusively on-line are also important to note. Internet-mediated research has significant advantages including increasing investigators' access to groups and individuals difficult to reach through traditional research means (Garton, Haythornthwaite, & Wellman, 1999; Wellman, 1997). Additionally, internet-mediated research has also been shown to produce results on surveys similar to those completed in-person (Query & Wright, 2003). However, there are also significant disadvantages to internet-mediated research as well. An increased risk for false responding and random responding have been identified in research conducted solely on-line. Also, self-reported characteristics of respondents in research conducted on-line may not be reliably accurate (Dillman, 2007; Stanton, 1998). Although steps were taken in the current study to reduce the risk of false responding, confirming the authenticity of the information being provided on-line is difficult. In-person survey completion allows for verification of some

important core demographic variables that cannot be verified on-line including but not limited to the gender of the respondent.

Along with the possibility of false reporting, multiple responding is another disadvantage of conducting internet-mediated research. Procedures were in place in the current study to decrease the possibility of multiple responding; however, individuals with multiple computers or IP addresses may have still been able to respond more than once. The replication of these results in future studies is important for determining the authenticity of responding and accuracy of the current findings.

Lastly, several anomalies were found in the results of the BSRI Feminine scale measuring adherence to feminine gender-role norms. Based on previous evaluations of the effects of conformity to feminine gender-role norms, it was expected that the BSRI Feminine scale would be significantly and positively correlated to the ATSPPHS-P scale which measures parent attitudes toward seeking psychological help for children (Mahalik et al., 2005; Triemstra & Niec, 2010). Instead, the results found a significant negative relationship between the BSRI Feminine scale and the ATSPPHS-P, indicating that participants' adherence to feminine gender-role norms decreased their positive attitudes toward seeking psychological help for their children. This unexpected relationship between participants' adherence to feminine gender-role norms and their attitudes toward seeking psychological help for their children indicated that the BSRI may have failed to capture feminine gender-role conformity in a way similar to previous studies. Future studies should consider the use of a different gender-role identity scale in order to fully assess the role of gender-role socialization on treatment evaluation and attitudes toward seeking psychological help for children.

Conclusion

Fathers' rate of participation in psychological treatment for their children is significantly lower than mothers' (Budd & O'Brien, 1982; Coplin & Houts, 1991). One important barrier to father participation is their socialization to masculine gender-role norms which restrict help-seeking and dissuade fathers from becoming involved in psychological treatment for their children (Addis & Mahalik, 2003; Berger, Levant, McMillan, Kelleher, & Sellers, 2005; Good, Dell, & Mintz, 1989). The purpose of the current study was to determine the effect of promoting the use of behavioral parent training programs among men on their attitudes toward seeking psychological treatment for their children and their evaluations of an evidence-based treatment. The results provide initial confirmation that adapting evidence-based child psychological treatment descriptions to be more consistent with masculine gender-role norms produces significant improvements in fathers' evaluations of the treatment. Although further studies are needed to determine the clinical effect of promoting the use of child psychological services among fathers, the present study provides a clear indication that men find psychological treatments more acceptable when they are described in ways that do not conflict with masculine gender-role norms. These findings can be utilized to improve men's perceptions of psychological treatment for children and should provide useful examples of how clinicians can adapt their own materials to appeal to both men and women.

APPENDICES

APPENDIX A

ATTITUDE TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP – PARENT FORM
(Adapted from Fischer & Turner, 1974)

Below are a number of statements pertaining to child psychology and mental health issues. Read each statement carefully and indicate your agreement, probable agreement, probable disagreement, or disagreement. Please express your frank opinion in rating the statements. There are no "wrong" answers and the only right ones are whatever you honestly feel or believe. It is important that you answer every item.

0=Disagreement, 1=Probable Disagreement, 2=Probable Agreement, 3=Agreement

1.	Although there are clinics for children with mental troubles, I would not have much faith in them.	0	1	2	3
2.	If a good friend asked my advice about their child's mental health problem, I might recommend that they see a psychiatrist.	0	1	2	3
3.	I would feel uneasy bringing my child to a psychiatrist because of what some people would think.	0	1	2	3
4.	A parent with a strong character can get through their child's mental conflicts by himself or herself, and would have little need of help from a psychologist for their child.	0	1	2	3
5.	There are times when I have felt completely lost and would have welcomed professional advice for my child's behavioral or emotional problems.	0	1	2	3
6.	Considering the time and expense involved in psychotherapy, it would have doubtful value for a parent like me.	0	1	2	3
7.	I would willingly confide intimate matters to an appropriate person concerning my child if I thought it might help me or a member of my family.	0	1	2	3
8.	I would rather live through my child's mental health conflicts than go through the ordeal of getting psychological treatment.	0	1	2	3
9.	Children's emotional difficulties, like many other things, tend to work out by themselves.	0	1	2	3
10.	There are certain problems that should not be discussed outside one's immediate family.	0	1	2	3

11.	A child with a serious emotional disturbance would probably benefit most from being in a good mental facility.	0	1	2	3
12.	If I believed my child was having a mental breakdown, my first inclination would be to get professional attention.	0	1	2	3
13.	Keeping one's mind on a job is a good solution for avoiding worries and concerns about one's child.	0	1	2	3
14.	Having been a psychiatric patient is a blot on a child's life.	0	1	2	3
15.	I would rather be advised by a close friend than by a psychologist, even for my child's problems.	0	1	2	3
16.	A parent with a child who has an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help	0	1	2	3
17.	I resent a person – professionally trained or not – who wants to know about problems in my family.	0	1	2	3
18.	I would want to get psychiatric attention for my child if he or she was having difficulties for a long period of time.	0	1	2	3
19.	The idea of talking about my child's problems with a psychologist strikes me as a poor way to get rid of my child's emotional difficulties.	0	1	2	3
20.	Having a child who is mentally ill carries with it a burden of shame.	0	1	2	3
21.	There are experiences in my life I would not discuss with anyone.	0	1	2	3
22.	It is probably best not to know *everything* about oneself.	0	1	2	3
23.	If my child were experiencing a serious emotional crisis at this point in their life, I would be confident that I could find relief for them in psychotherapy.	0	1	2	3
24.	There is something admirable in the attitude of a person who is willing to cope with conflicts and fears concerning his/her child *without* resorting to professional help.	0	1	2	3
25.	At some future time I might want to have psychological counseling for my child.	0	1	2	3

26. A parent should work out his/her own problems with his/her child; getting psychological counseling would be a last resort.	0	1	2	3
27. Had my child received treatment in a mental hospital, I would not feel that it ought to be "covered up."	0	1	2	3
28. If I thought my child needed psychiatric help, I would get it no matter who knew it.	0	1	2	3
29. It is difficult to talk about personal and family matters with highly educated people such as doctors, teachers, and clergymen.	0	1	2	3

APPENDIX B

BEM SEX-ROLE INVENTORY
(Bem, 1981a)

On this page, you will find a number of personality characteristics listed. We would like you to use those characteristics to describe yourself, that is, we would like you to indicate, on a scale from 1 to 7, how true each of these characteristics is of you. Please do not leave any characteristic unmarked.

Never or Almost Never True (1)	2	3	Occasionally True (4)	5	6	Always or Almost Always True (7)

1. Defend my own beliefs
2. Affectionate
3. Conscientious
4. Independent
5. Sympathetic
6. Moody
7. Assertive
8. Sensitive to needs of others
9. Reliable
10. Strong personality
11. Understanding
12. Jealous
13. Forceful
14. Compassionate
15. Truthful
16. Have leadership abilities
17. Eager to soothe hurt feelings
18. Secretive
19. Willing to take risks
20. Warm
21. Adaptable
22. Dominant
23. Tender
24. Conceited
25. Willing to take a stand
26. Love children
27. Tactful
28. Aggressive
29. Gentle
30. Conventional
31. Self-reliant
32. Yielding
33. Helpful
34. Athletic
35. Cheerful
36. Unsystematic
37. Analytical
38. Shy
39. Inefficient
40. Make decisions easily
41. Flatterable
42. Theatrical
43. Self-sufficient
44. Loyal
45. Happy
46. Individualistic
47. Soft-spoken
48. Unpredictable
49. Masculine
50. Gullible
51. Solemn
52. Competitive
53. Childlike
54. Likable
55. Ambitious
56. Do not use harsh language
57. Sincere
58. Act as a leader
59. Feminine
60. Friendly

APPENDIX C

TREATMENT EVALUATION INVENTORY – SHORT FORM (TEI-SF)
(Kelley, Heffer, Gresham, & Elliott, 1989)

Please 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	2	3	4	5

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 D

DEMOGRAPHIC FORM

Please complete the information below as accurately as you can.

1. Your gender M F
2. Your age _____
3. Please list the gender of each of your children
   a. __
   b. __
   c. __
   d. __
   e. __
   f. __
4. Please list the age of your children
   a. __
   b. __
   c. __
   d. __
   e. __
   f. __
5. Number of years of education you have completed (Please select one. High school completion or GED equals 12 years)

   1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
6. Your occupation_____
7. Other primary caregiver's age (if there is no other primary caregiver, please leave blank) _____
8. Number of years of education other caregiver has completed (Please select one. High school completion or GED equals 12 years)

   1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Don't know
9. Has any of your children been diagnosed with a learning or developmental disorder?
10. Has any of your children ever participated in psychological treatment?
11. Have you ever participated in psychological treatment for your own concerns?

12. What is your current marital status?
    a. Divorced
    b. Married
    c. Never married, not living together
    d. Never married, living together

13. What is your racial background? (Select one or more as appropriate)
    a. American Indian/Native Alaskan
    b. Asian
    c. Black or African American
    d. Native Hawaiian/Other Pacific Islander
    e. White/Caucasian
    f. Latino/Hispanic
    g. Other
    h. I don't wish to answer

14. What is your child's racial background? (Please select an answer based on one of your children within the ages of 2 to 12 years. Select one or more as appropriate)
    a. American Indian/Native Alaskan
    b. Asian
    c. Black or African American
    d. Native Hawaiian/Other Pacific Islander
    e. White/Caucasian
    f. Latino/Hispanic
    g. Other
    h. I don't wish to answer

15. What is your approximate annual household income?
    a. Less than 5,000
    b. 5,001-10,000
    c. 10,001-20,000
    d. 20,001-30,000
    e. 30,001-40,000
    f. 40,001-50,000
    g. 50,001-60,000
    h. 60,001-70,000
    i. 70,001-80,000
    j. 80,001-90,000
    k. 90,001-100,000
    l. 100,000 or greater

APPENDIX E

PSYCHOLOGICAL TREATMENT DESCRIPTIONS

Traditional PCIT Description

Parent-Child Interaction Therapy (PCIT) is an empirically-supported treatment for conduct disordered young children that places emphasis on improving the quality of the parent child relationship and changing parent child interaction patterns. In PCIT, parents are taught specific behavioral skills to establish a nurturing and secure relationship with their child while increasing their child's prosocial behavior and decreasing negative behavior. This treatment focuses on two basic interactions. The Child Directed Interaction (CDI) is similar to play therapy in that parents engage their child in a play situation with the goal of strengthening the parent child relationship. The Parent Directed Interaction (PDI) resembles clinical behavior therapy in that parents learn to use specific behavior management techniques (i.e., reinforcement and punishment) as they play with their child.

Masculine PCIT Description

PCIT is an evidence-based intervention for children who have more behavior problems than other kids their age. In PCIT, fathers and mothers learn ways to gain better control over their child's behavior. Fathers and mothers are coached in subtle and direct behavioral strategies that are designed to decrease their child's misbehavior and increase their child's compliance. Coaches help parents build on the skills they already have so that they can better manage their child's behavior. PCIT has been shown to be effective in teaching parents ways to get their children to obey and behave at home and at school. PCIT is divided into 2 phases. The first phase includes coaching in behavioral strategies that will reduce annoying attention-seeking behaviors and strengthen the bond between parents and children. The second phase includes coaching in discipline, and parents are directed in how to use a set of proven discipline techniques that aim to increase their child's compliance with commands and rules.

Control Condition

It is recommended that Brandon and his parents participate in therapy with a psychologist to address his behavior problems.

APPENDIX F

PCIT EXPERT RATING SCALE

Please read the following paragraphs and use them as references as you answer the questions that follow.

Parent-Child Interaction Therapy (PCIT) has core components.

- Child Directed Interaction (CDI) Phase: parents engage their child in a play situation with the goal of strengthening the parent-child relationship.
- Parent Directed Interaction (PDI) Phase: parents learn to use specific behavior management techniques (i.e., reinforcement and punishment) as they play with their child.
- In PCIT, parents learn by receiving immediate feedback from therapists during interactions with their children.
- PCIT is assessment driven as treatment progression is based on parent mastery of skills.

TREATMENT DESCRIPTION FOR REVIEW

PCIT is an evidence-based intervention for children who have more behavior problems than other kids their age. In PCIT, fathers and mothers learn ways to gain better control over their child's behavior. Fathers and mothers are coached in subtle and direct behavioral strategies that are designed to decrease their child's misbehavior and increase their child's compliance with parents. Coaches help parents build on the skills they already have so that they can better manage their child's behavior. PCIT has been shown to be effective in teaching parents ways to get their children to obey and behave at home and at school. PCIT is divided into 2 phases. The first phase includes coaching in behavioral strategies that will reduce attention-seeking and build a bond between parents and children. The second phase includes coaching in discipline, and parents are directed in how to use a specific discipline strategy with their child that aims to increase their child's compliance with commands and rules.

Please rate how strongly you agree that each sentence below describes Parent-Child Interaction Therapy accurately.

1. "PCIT is an evidence-based intervention for children who have more behavior problems than other kids their age."

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
Comments/Suggestions

2. "In PCIT, fathers and mothers learn ways to gain better control over their child's behavior."

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
Comments/Suggestions

3. "Fathers and mothers are coached in subtle and direct behavioral strategies that are designed to decrease their child's misbehavior and increase their child's compliance with parents."

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
Comments/Suggestions

4. "Coaches help parents build on the skills they already have so that they can better manage their child's behavior."

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
Comments/Suggestions

5. "PCIT has been shown to be effective in teaching parents ways to get their children to obey and behave at home and at school."

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
Comments/Suggestions

6. "PCIT is divided into 2 phases. The first phase includes coaching in behavioral strategies that will reduce attention-seeking and build a bond between parents and children."

Strongly Agree
Agree
Neutral
Disagree

Strongly Disagree
Comments/Suggestions

7. "The second phase includes coaching in discipline, and parents are directed in how to use a specific discipline strategy with their child that aims to increase their child's compliance with commands and rules."

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
Comments/Suggestions

8. Overall, how well do you think this description describes the key components of PCIT? Would you change anything about the description provided?

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
Comments/Suggestions

9. Please use the space below to provide additional comments.

APPENDIX G

MASCULINITY EXPERT RATING SCALE

MASCULINE GENDER-ROLE NORMS

American masculine gender-role norms have been described in a variety of different ways by a variety of researchers. For the purposes of the current study, please consider the components of American masculine gender roles given below as you rate the components of the PCIT description.

Men who adhere to American masculine gender role norms are more likely to:
(1) restrict emotions
(2) avoid being feminine
(3) focus on toughness and aggression
(4) be self-reliant
(5) make achievement the top priority
(6) be non-relational
(7) be homophobic

TREATMENT DESCRIPTION FOR REVIEW

PCIT is an evidence-based intervention for children who have more behavior problems than other kids their age. In PCIT, fathers and mothers learn ways to gain better control over their child's behavior. Fathers and mothers are coached in subtle and direct behavioral strategies that are designed to decrease their child's misbehavior and increase their child's compliance with parents. Coaches help parents build on the skills they already have so that they can better manage their child's behavior. PCIT has been shown to be effective in teaching parents ways to get their children to obey and behave at home and at school. PCIT is divided into 2 phases. The first phase includes coaching in behavioral strategies that will reduce attention-seeking and build a bond between parents and children. The second phase includes coaching in discipline, and parents are directed in how to use a specific discipline strategy with their child that aims to increase their child's compliance with commands and rules.

Please rate each sentence below on how strongly you agree that it describes PCIT in a way that is acceptable in the context of American masculine gender-role norms.

1. "PCIT is an evidence-based intervention for children who have more behavior problems than other kids their age."

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
Comments/Suggestions

2. "In PCIT, fathers and mothers learn ways to gain better control over their child's behavior."

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
Comments/Suggestions

3. "Fathers and mothers are coached in subtle and direct behavioral strategies that are designed to decrease their child's misbehavior and increase their child's compliance with parents."

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
Comments/Suggestions

4. "Coaches help parents build on the skills they already have so that they can better manage their child's behavior."

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
Comments/Suggestions

5. "PCIT has been shown to be effective in teaching parents ways to get their children to obey and behave at home and at school."

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
Comments/Suggestions

6. "PCIT is divided into 2 phases. The first phase includes coaching in behavioral strategies that will reduce attention-seeking and build a bond between parents and children."

Strongly Agree
Agree
Neutral
Disagree

Strongly Disagree
Comments/Suggestions

7. "The second phase includes coaching in discipline, and parents are directed in how to use a specific discipline strategy with their child that aims to increase their child's compliance with commands and rules."

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
Comments/Suggestions

8. Overall, how well do you think this description describes the key components of PCIT? Would you change anything about the description provided?

Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
Comments/Suggestions

9. Please use the space below to provide additional comments.

APPENDIX H

CASE VIGNETTE

Brandon disobeys his parents often. He usually refuses to do things his parents ask him to do, such as cleaning up his room or doing his chores. In fact, when he is asked to clean up his room Brandon often yells, screams, and throws his toys. Brandon sometimes breaks toys and other things when throwing a tantrum and when he does he swears and blames his parents or sister for what happened. He argues with his parents a lot of the time and especially when he doesn't get his own way. Brandon also does things to his younger sister just to bother her. He pokes her and teases her enough to make her cry. Brandon also does things to to make his parents mad. For example, when his parents ask him to eat his vegetables, he throws them on the floor. When Brandon's parents try to talk to him about behaving and obeying, Brandon acts touchy and gets annoyed.

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