
Examining the Social Validity of the FRIENDS Treatment Program for Anxious Children

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This study conducted the first evaluation of elements of social validity of the FRIENDS program, a cognitive-behavioural treatment package for childhood anxiety disorders. Parents, children, and adolescents were surveyed over time on their global satisfaction with the program, the acceptability of treatment components, and the completion of homework tasks. Results indicated a high level of satisfaction with the FRIENDS program and a high completion rate of homework tasks. Contrary to expectations, children rated the cognitive skills as more useful than adolescents did. Adolescents reported the behavioural strategy of graded exposure as more useful than other strategies. In addition, the relationship between treatment acceptability and clinical outcome was not significant. Limitations of the study and directions for further research are discussed.

The current Australian National Standards for Mental Health Services (National Mental Health Working Group, 1996) emphasised the use of treatment procedures that are not only cost and time effective but also involve the active participation of consumers and their carers. This focus on consumer participation is also found in the United States and Great Britain, following increased pressure from government agencies, the American Psychological Association, and managed-care organisations (Crawford & Kessel, 1999; Foster & Mash, 1999). While the outcomes of psychological treatments are routinely evaluated in terms of symptom change and adaptive functioning, the assessment of the social importance (or *social validity*) of treatments has not been as consistent. This study examines elements of social validity for a group program designed to treat anxious children and their parents.

The purpose of social validity assessments is to evaluate the acceptability or viability of a programmed intervention (Schwartz & Baer,

1991). In a seminal article, Wolf (1978) encouraged behavioural analysts to assess social validity, arguing that “‘social importance’ was a subjective value judgement that only society was qualified to make” (pp. 206–207). Most current approaches define three elements of an intervention that can be assessed for their social validity. These are (a) the social significance of the *goals* of treatment, (b) the social appropriateness and acceptability of the treatment *procedures*, and (c) the social importance of the *effects* or the *outcomes* produced by treatment procedures. Social validity is best thought of as a process, rather than a result or outcome, which can be assessed at several stages in the treatment process (Fawcett, 1991). Specifically, it can be evaluated at the beginning of the intervention, while treatment is ongoing, immediately after termination, and at follow-up.

Fawcett (1991) reported that the dominant form of social validity is the acceptability of (or consumer satisfaction with) treatment procedures. Assessments of treatment acceptability are

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part of the broader issue of viability of treatment and are particularly important as researchers transport their interventions to community settings (Foster & Mash, 1999). The American Psychological Association provided guidelines for the developers of interventions that explicitly include issues relating to social validity in their second "clinical utility" axis (Task Force on Psychological Intervention Guidelines, 1995, cited in Foster & Mash, 1999). Specifically, the clinical utility axis relates to evaluations of "the ability (and willingness) of practitioners to use, and of patient to accept, the treatment in question, and to the range of applicability of that treatment" (p. 312).

The assessment of treatment acceptability usually relies on the use of self-report questionnaires. However, the use of these subjective measures raises a number of methodological issues. As clinicians frequently use combined treatment packages, global satisfaction measures may obscure which elements of the treatment package contribute most to the variance in satisfaction ratings (Foster & Mash, 1999). For example, consumers may be satisfied with the homework tasks, but be disappointed in the intake procedures. Schwartz and Baer (1991) suggested that evaluating specific components increases the usefulness of information collected on social validity questionnaires. However, ratings of specific elements of combined treatments may not reflect their impact on overall satisfaction or acceptability when the treatments are presented as a package (Foster & Mash, 1999). Thus, the optimal questionnaire addresses both specific components of treatment packages and an overall measure of satisfaction and acceptability.

The optimal assessment of social validity incorporates several important methodological issues. First, to reduce the demand characteristics of collecting this information, consumers' anonymity should be ensured and the interviewer should be someone other than the treating health professional (Crawford & Kessel, 1999; Foster & Mash, 1999). Second, the use of multiple informants in collecting acceptability data is recommended (Fawcett, 1991; Foster & Mash, 1999; Schwartz & Baer, 1991). Because children and adolescents are often the recipients

of interventions, their views on the acceptability of the intervention are important to its long-term viability. However, assessing children and adolescents can present unique difficulties. Wong (1999) evaluated an inpatient treatment for adolescents with severe emotional or behavioural problems. He found that despite instructions to rate treatment components on how they "helped you with your problems", ratings reflected the adolescents' liking or disliking of an item rather than its utility. These results illustrate the difficulties in relating treatment acceptability to the effectiveness of the program: a high level of satisfaction with particular treatment components may or may not reflect their effectiveness in reducing symptoms (Foster & Mash, 1999).

Although treatment acceptability and intervention effectiveness are often equated, research examining their relationship has been mixed. Some studies report that consumer satisfaction is correlated with therapist's ratings of global improvement (e.g., LaSala, 1997), while other studies have found no significant correlation between consumer satisfaction and symptom improvement (e.g., Peckearik & Guidry, 1999; Ries, Jaffe, Comtois, & Kitchell, 1999). Other studies describe data for measures of both treatment acceptability and clinical effectiveness but fail to explore the potential relationship between the two variables (Granello, Granello, & Lee, 1999; Macpherson et al., 1998). There is a need for more research to understand the relationship between treatment acceptability and outcome.

The treatment of childhood anxiety disorders has seen the growing number of clinical trials investigating the efficacy of group-format cognitive-behavioural programs. The cognitive-behavioural protocol targeting individual children with anxiety disorders began to receive consistent empirical support in the early 1990s (e.g., Kendall, 1994). This theoretical perspective addresses anxiety as a multidimensional construct manifested at physiological, behavioural, and cognitive levels (Kendall et al., 1991). Cognitive-behavioural interventions are commonly presented as a treatment package, comprising modelling, exposure (systematic desensitisation and in vivo), operant condition-

ing, cognitive restructuring, and problem-solving procedures (Barrett, 2000).

Barrett (1998) conducted the first study into the efficacy of cognitive-behavioural treatment for children with anxiety disorders in a group format. Children (ages 7 to 14 years) were randomly assigned to three treatment groups: group cognitive-behavioural therapy (GCBT), GCBT plus family management (GCBT-FAM), and waiting list (WL). The percentage of children who no longer met *DSM-III-R* criteria for any anxiety disorder (*Diagnostic and Statistical Manual of Mental Disorders*; American Psychiatric Association (APA), 1987) was significantly more for children in the treatment conditions (85% and 65% respectively) than for children in the waiting-list control condition (25%). Subsequent randomised clinical trials (Silverman et al., 1999; Shortt, Barrett, & Fox, in press) comparing the therapeutic efficacy of group cognitive-behavioural therapy (GCBT) versus a waiting-list control condition have yielded similar results. These studies report that a greater percentage of children in GCBT no longer met their primary diagnosis compared to children assigned to the control condition.

Child anxiety treatments typically target children aged between 7 and 14 years. Kendall (1994) and Ronen (1997) noted the importance of tailoring treatments to meet children's developmental needs, as many cognitive assessment and intervention protocols appear to assume that children of all ages are capable of metacognitive processes and are able to self-regulate their own behaviour (Barrett, 2000). In response to this, the "FRIENDS" program (Barrett, Lowry-Webster, & Turner, 2000) was designed to be sensitive to these developmental differences. It has two parallel forms: *FRIENDS for Children*, for children aged 6 to 11 years, and *FRIENDS for Youth*, for adolescents aged 12 to 16 years.

The varying cognitive ability of children and adolescents is expected to have a direct impact on their capacity to benefit from cognitive therapy approaches (Barrett, 2000). Cognitive therapy may be more appropriate for adolescents as it best facilitates their eagerness to use new linguistic abilities for describing experiences and emotions, while younger children may require a

more experiential approach (Ronen, 1997). King and Ollendick (1989) tentatively suggested that respondent-based and cognitive procedures are more effective for older children, and operant-based and vicarious procedures are more effective for younger children. As the impact of cognitive ability on the effectiveness of cognitive intervention is uncertain, the degree to which children and adolescents find these techniques acceptable may also differ.

The treatment acceptability of group cognitive-behavioural therapy (GCBT) for childhood anxiety disorders has not been explicitly examined by previous studies (Barrett, 1998; Silverman et al., 1999). Given the developmental changes that take place in the target population of children and adolescents, explicit attention needs to be paid to the components of the GCBT program: specifically, differential ratings of the modelling, exposure, operant, cognitive restructuring, and problem-solving procedures. In addition, multiple informants (parents and their children) need to be assessed throughout the program to establish an accurate and comprehensive picture of consumer satisfaction with GCBT. This study aims to assess the social validity of the program. The combination of treatment acceptability data with the objective data of clinical outcomes in an overall evaluation of an intervention provides both the consumer and the researcher/practitioner with an empirical base for future treatment.

The purpose of this study is to evaluate the treatment acceptability of the FRIENDS program, a family-based group cognitive-behavioural treatment for clinically anxious children (Barrett et al., 2000). Specifically, three areas of treatment acceptability will be examined:

- the extent to which consumers are satisfied with the FRIENDS program, with a detailed assessment of treatment components, sessions, and homework tasks;
- the extent to which there are age differences in the ratings of techniques and skills learnt in the FRIENDS program, including cognitive and behavioural techniques;
- the possible relationship between level of treatment acceptability and clinical outcome, with the hypothesis that a high level

of satisfaction is correlated with a high level of clinical improvement.

Method

Participants

All participants in this study were taken from a larger research project designed to evaluate the efficacy of the FRIENDS program (Shortt et al., in press). In total, 55 children and 12 adolescents were included in the treatment groups. Five children withdrew from the program for reasons including illness or birth in the family ($n = 2$), child disinterest in the program ($n = 2$), and parental belief that the problem was not severe enough to warrant the time commitment ($n = 1$). In addition, posttreatment assessment data were unavailable for 2 participants, so the present analyses are based on the remaining 48 children (20 male, 28 female; mean age = 8.19 years) and 12 adolescents (3 male, 9 female; mean age = 12.33 years).

Children and adolescents with one or more anxiety disorders were referred from university psychology clinics, child mental health centres, school guidance officers, and parents following media advertisements. Only children and adolescents with a principal diagnosis of generalised anxiety disorder, separation anxiety disorder, or social phobia were included in treatment. The majority of children (75%) had comorbid anxiety disorders and 2 children had comorbid dysthymia. All children and adolescents with intellectual or severe physical impairment, or who were currently involved in psychosocial or pharmacological interventions, were referred elsewhere and were not included in this study.

Participants were randomly assigned to one of seven treatment groups, controlling for age. Five groups used the *FRIENDS for Children* program and two groups used the *FRIENDS for Youth* program. Each group had an initial composition of 5 to 13 children. Due to attrition, the final composition of the groups was 5 to 12 children.

Treatment Materials

The FRIENDS program (Barrett et al., 2000) is a family and peer-group intervention using cognitive-behavioural strategies. The name of the program, FRIENDS, is an acronym for the strategies taught (*F* – Feeling worried?, *R* – Relax and feel good, *I* – Inner thoughts, *E* – Explore plans, *N* – Nice work so reward yourself, *D* – Don't forget to practice, and *S* – Stay calm). The program originated with the development of the *Coping Koala Group Workbook* (Barrett, 1995), which was an Australian adaptation of Kendall's cognitive-behavioural treatment program, *Coping Cat Workbook* (Kendall, 1990).

The FRIENDS program consists of 10 weekly sessions and 2 booster sessions, which are conducted 1 month and 3 months following completion of treatment. Specific strategies taught to participants included (a) recognising somatic symptoms of anxiety, (b) identifying and challenging anxious thoughts, and (c) using coping skills such as relaxation, problem-solving, and self-reward for approach behaviour (e.g., graduated exposure). The FRIENDS program also incorporates a concurrent parent training program, which is conducted in a group format for approximately 6 hours. Topics covered in these sessions include (a) coping with their own symptoms of anxiety, (b) reinforcement strategies, and (c) brief training in communication and problem-solving skills. Group processes include normalisation of anxiety experiences, group exposure through discussion and role-play of common threatening experiences, and peer learning through discussion of successes and difficulties.

Treatment Acceptability Measures

Three measures of treatment acceptability were administered during the study. In order to reduce demand characteristics, the anonymity of respondents was preserved through the omission of identifying information. Each week, parents completed a questionnaire focusing on the information and skills learnt in the previous session. Three items relating to the usefulness, ease of understanding, and confidence in using the information were measured on 5-point semantic differential scales. Two items related to the com-

pletion of the homework task and the utility of that task. A further two items were open-ended in format, relating to the child's feelings about the session and giving the parents an opportunity to make comments on the program.

The second measure was a questionnaire focusing on the parents' final evaluation of the FRIENDS program. The first set of 11 items related to how useful each skill was for their child, using a 5-point scale from 1 (*not useful*) to 5 (*very useful*). The second set of 16 items related to how useful the skills were to themselves as parents, using a 5-point scale from 1 (*not important*) to 5 (*very important*). A third set of six items focused on their impressions of the program facilitators, using a 5-point scale. The final two items related to an overall evaluation of the program (1 *poor* to 10 *excellent*) and how they would recommend the program to others (1 *not recommend* to 10 *highly recommend*).

The third measure was a questionnaire focusing on the children and adolescents' final evaluation of the FRIENDS program. The first set of 10 items related to the effectiveness of the skills in helping with their worries (bad, OK, good). Further questions related to how often the skills would be used (not at all, sometimes, often) and how enjoyable the program was (boring, OK, fun). A final open-ended question was an opportunity for comment on the program.

Clinical Outcome Measures

Clinical outcome was assessed using a diagnostic interview and self-report questionnaires administered prior to and following the FRIENDS program. Children's diagnostic status was determined using the Diagnostic Interview Schedule for Children, Adolescents and Parents (DISCAP; Holland & Dadds, 1995) with the children's parents. The diagnostic categories of the DISCAP correspond to those used in the *DSM-IV* (APA, 1994), and it has good reliability and validity (Johnson, Barrett, Dadds, Fox, & Shortt, 1999). The DISCAP uses a severity rating scale of 1 (*low*) to 6 (*high*) severity. At posttreatment, diagnostic interviews were conducted by psychologists naive to the child's diagnostic status.

The Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978; see James, Reynolds, & Dunbar, 1994, for a review) total anxiety score was used as the child-completed anxiety outcome. Mothers completed the Child Behaviour Checklist (CBCL; Achenbach, 1991; see Daughtery & Shapiro, 1994, for a review), of which the Internalising scale was used to evaluate treatment outcome. Mothers were also asked to complete a Depression, Anxiety and Stress Scale (DASS; Lovibond & Lovibond, 1993; see Brown, O'Leary, & Barlow, 1993, for a review). The total DASS score was used to assess parental distress measure.

Design and Procedure

Dependent variables related to the levels of treatment acceptability and clinical outcome. Between-subjects variables were age (child or adolescent) and treatment group (1–7), and the within-subjects variable was session number (1–8).

Following referral, parents were contacted and a face-to-face interview was arranged. Parents completed a diagnostic interview and the child completed the RCMAS. Parents were given their self-report measures (CBCL and DASS). These measures were re-administered in another assessment session following the FRIENDS program.

Children and adolescents were required to attend all sessions of the FRIENDS program. If a session was not attended, an individual "make-up" session was held by one of the facilitators. Each session of the FRIENDS program began with a 10-minute conjoint meeting with children or adolescents and their parents. During this time, session content was outlined, homework activities were reviewed, and individual children's progress was monitored. Next, the children's session was conducted for 60 minutes. During this time, parents waited in a nearby room and completed the weekly questionnaire. Following this, a session for parents was conducted for 30 to 40 minutes and the questionnaires were collected. At least one parent from each family was required to attend the parent training sessions. In Session 10, the

parents, children, and adolescents completed the final evaluation questionnaires. Due to time constraints, the weekly questionnaire was not administered in this session, and consequently the data for Sessions 9 and 10 are not available. In the majority of cases (80%), mothers attended the parents' session. In 20% of families, both parents attended. All sessions were treated jointly by two clinical doctorate candidates.

All sessions of the FRIENDS program were videotaped, and a double treatment integrity check was conducted to ensure adherence to the treatment manual. Twenty-five per cent of the tapes were randomly selected and observed by two independent clinicians. The integrity checks showed 95.2% and 97% concordance between session and manual content. Inter-rater agreement on session content was high (kappa, 96% agreement).

Analyses

The data were analysed using SPSS/PC Version 10 for Windows. One-way ANOVAs were one method used to screen for differences in the clinical outcome data. In all other analyses, nonparametric statistics were used: (a) the Mann-Whitney *U* test analysed independent samples, (b) Wilcoxon tests analysed matched

pairs, (c) Kruskal-Wallis tests were used to examine differences between groups, and (d) Friedman tests compared groups of related samples. Correlations were calculated by Spearman's correlation coefficients. To reduce the probability of a Type I error and to control the familywise error rate, a conservative level of α was used for all statistical analyses ($\alpha = .01$). Open-ended questions were analysed using qualitative analysis, with responses grouped into common themes.

Results

Characteristics of the Sample

Table 1 displays the sociodemographic and clinical outcome data for families in each age group. One-way ANOVAs and nonparametric tests were performed to ensure that there were no significant differences between age groups and treatment groups. No significant differences were detected.

Weekly Questionnaire

Table 2 displays the results from the weekly questionnaire about the utility of the information and skills from the previous session. No significant differences were found between age

TABLE 1

Sociodemographic and Clinical Outcome Data for Each Age Group Prior to FRIENDS Program

	Children (<i>n</i> = 48)	Adolescents (<i>n</i> = 12)
Age (mean, <i>SD</i>)	8.19 (1.45)	12.33 (0.78)
Mother's occupation (mean, <i>SD</i>) ^a	6.11 (3.39)	6.43 (3.27)
Father's occupation (mean, <i>SD</i>) ^a	3.46 (1.98)	4.00 (2.12)
% Primary diagnosis GAD	26.0%	31.3%
% Primary diagnosis SAD	13.0%	1.3%
% Primary diagnosis soc. phobia	7.0%	31.3%
Severity rating for primary diagnosis (mean, <i>SD</i>) ^b	4.89 (0.92)	4.81 (0.83)
Number of diagnoses (mean, <i>SD</i>)	2.39 (1.04)	2.36 (1.08)
DASS (by mother; mean, <i>SD</i>)	14.52 (9.72)	11.77 (12.38)
CBCL - Internalising scale (by mother; mean, <i>SD</i>)	67.64 (7.06)	64.08 (9.31)
RCMAS (mean, <i>SD</i>)	12.17 (6.93)	14.71 (7.28)

Note. ^a Occupation = 1 (high income) to 10 (low income).

^b Severity rating = 1 (low) to 6 (high). Ratings 3 and above considered clinically significant.

group and utility ratings on individual sessions. Parents of children rated each individual session similarly to parents of adolescents. Across all sessions, parents of children rated Sessions 1 and 2 as significantly less useful than all other sessions (Mann–Whitney U ; $p < .01$). No significant differences were found across sessions or age groups in terms of parents' ratings of the "ease of understanding" and "confidence with which they could use" the information and skills from the previous session ($p > .01$).

Table 3 displays the results from the weekly questionnaire on the number of children and adolescents who completed the homework task for each session and how useful it was. The session with the highest proportion of children who completed the homework task "easily" was Session 2 (89%), whereas for adolescents it was Session 8 (100%) and Session 3 (100%). For children, the homework from Session 7 (the step plan) was rated as the most useful, while the task from Session 1 (identifying a positive family time) was rated as least useful. For adolescents, the homework from Session 8 (step plan and self-rewards) was rated as most useful, while the homework from Session 1 (identifying a positive family time) was rated as least useful. No significant differences were found across age groups or sessions in terms of the utility of the homework task ($p > .01$).

Final Evaluation of the FRIENDS Program by Parents

Overall, parents evaluated the FRIENDS program highly, and the majority reported that they would recommend the program to others. On a 10-point scale, the mean overall evaluation for parents of children was 9.14 (SD 1.24) and for parents of adolescents it was 8.67 (SD 1.51). On a 10-point scale, the mean recommendation for parents of children was 9.65 (SD 0.98) and for parents of adolescents it was 9.67 (SD 0.82). Table 4 displays the mean ratings by parents of how useful the skills of the FRIENDS program were for the child or adolescent.

A Friedman test revealed that parents of children distinguish different skills in terms of utility ($\chi^2 = 27.12$, $p = .002$). A series of pair-wise comparisons between skills (Wilcoxon signed ranks tests) revealed that the relaxation games were rated by parents of children as less useful than identifying inner thoughts ($z = -2.78$, $p = .005$), thinking in more helpful ways ($z = -2.65$, $p = .009$), and rewarding brave behaviour ($z = -2.94$, $p = .003$). The six-block problem-solving plan was also rated by parents of children as less useful than identifying inner thoughts ($z = -2.65$, $p = .008$), thinking in more helpful ways ($z = -2.70$, $p = .007$), and rewarding brave behaviour ($z = -2.93$, $p = .003$). However, due to the potential problem of Type I error, caution is required in interpreting this result. At a descriptive level, rewarding brave behaviour was identified as the

TABLE 2

Mean Ratings by Parents of the Utility of the Information and Skills from the Previous Session
(1 Not At All Useful, 5 Extremely Useful)

Session number	Session content	Children Mean (SD)	Adolescents Mean (SD)
1	Introduction; normalisation of anxiety	3.63 (0.79)	3.17 (0.94)
2	Identifying and communicating emotions	3.77 (0.71)	3.60 (0.70)
3	Relationship between thoughts and feelings	4.16 (0.86)	4.00 (0.77)
4	Recognising body cues; relaxation techniques	4.30 (0.73)	3.91 (0.94)
5	Inner thoughts — identifying and challenging self-talk	4.30 (0.60)	3.78 (1.20)
6	Problem-solving plan for coping	4.21 (0.78)	3.78 (0.67)
7	Step plan (graduated exposure) for coping	4.33 (0.89)	3.90 (0.74)
8	Self-rewarding approach behaviour	3.63 (0.79) 4.25 (0.82)	4.25 (0.71)

TABLE 3

Results from the Weekly Questionnaire of the Number of Children and Adolescents Who Completed the Homework Task for Each Session and How Useful It Was

Session	Age	Yes (easily) %	Yes (with difficulty) %	No %	Useful? <i>M (SD)</i> (1 <i>not</i> , 5 <i>very</i>)
1	Children	77.3%	15.9%	4.5%	3.54 (1.07)
	Adolescents	54.5%	27.3%	18.2%	2.75 (0.89)
2	Children	89.1%	10.9%	0.0%	3.73 (0.78)
	Adolescents	90.9%	9.1%	0.0%	3.50 (0.93)
3	Children	68.3%	24.4%	7.3%	3.76 (1.05)
	Adolescents	100.0%	0.0%	0.0%	3.56 (0.53)
4	Children	48.9%	37.82%	13.3%	3.70 (0.77)
	Adolescents	70.0%	20.0%	10.0%	3.44 (1.01)
5	Children	61.9%	33.3%	4.8%	4.00 (0.88)
	Adolescents	77.8%	22.2%	0.0%	3.44 (1.01)
6	Children	52.6%	31.6%	15.8%	3.94 (0.95)
	Adolescents	88.9%	11.1%	0.0%	3.88 (0.64)
7	Children	47.2%	44.4%	8.3%	4.24 (0.92)
	Adolescents	90.0%	10.0%	0%	3.70 (0.95)
8	Children	63.6%	30.3%	6.1%	3.90 (1.03)
	Adolescents	100.0%	0%	0%	4.00 (1.00)

TABLE 4

Mean Rating by Parents Regarding How Useful These Skills Were for Their Child (1 *Not Useful* to 5 *Very Useful*)

Skill	Children (<i>n</i> = 43) Mean (<i>SD</i>)	Adolescents (<i>n</i> = 8) Mean (<i>SD</i>)
Rewarding brave behaviour	4.50 (0.59)	4.50 (0.76)
Identify inner thoughts	4.47 (0.67)	3.63 (0.74)
Think in more helpful ways	4.44 (0.67)	4.00 (0.76)
Challenge inner thoughts	4.37 (0.72)	3.63 (1.06)
Feel-good activities	4.26 (0.66)	4.25 (0.71)
Practicing	4.24 (0.76)	4.25 (0.71)
Step plan	4.19 (0.98)	3.50 (1.41)
Deep breathing	4.17 (0.88)	4.13 (1.46)
Identify body cues	4.14 (0.81)	3.88 (0.83)
Six-block problem-solving plan	4.00 (1.02)	3.13 (1.36)
Relaxation games	3.98 (0.96)	3.88 (1.25)

most useful skill for children and adolescents ($M = 4.50$). The skill identified by parents as least useful for children was relaxation games ($M = 3.98$), while for adolescents it was the six-block problem-solving plan ($M = 3.13$). Furthermore, identifying inner thoughts was rated as a signifi-

cantly more useful skill by parents of children than parents of adolescents (Mann-Whitney U ; $p < .01$). Differences between parents' of children and parents' of adolescents ratings for challenging inner thoughts and six-block problem solving approached significance ($p < .05$), where parents

of children rated these skills as more useful than parents of adolescents.

Table 5 displays mean ratings by parents of how important the skills of the FRIENDS program were for themselves. A Friedman test revealed that parents of children distinguish different skills in terms of importance ($\chi^2 = 58.82, p < .001$). A series of pair-wise comparisons (Wilcoxon signed ranks tests) between skills revealed over 20 significant differences ($p < .01$). However, due to the potential problem of Type I error, caution is required in interpreting this result. At a descriptive level, challenging inner thoughts was identified as the most important skill for parents of children ($M = 4.62$), while for parents of adolescents it was other parents' participation, ideas, feelings for the group ($M = 4.63$). The skill identified as least important for parents of children was relaxation games ($M = 3.38$), while for parents of adolescents it was the six-block problem-solving plan ($M = 4.50$). Parents of children and parents of adolescents did not differ in terms of their ratings for individ-

ual skills (Mann–Whitney U ; $p > .01$). However, differences between children's parents' ratings and adolescents' parents' ratings of the importance of identifying inner thoughts, challenging inner thoughts, and the explanation of how the FRIENDS program reduces anxiety approached significance ($p < .05$), where children's parents rated these skills as more important to themselves than adolescents' parents.

Analysis of the six questions regarding the facilitators of the program revealed no significant age differences ($p < .01$). These questions related to issues including the facilitators' approachability, explanations, group discussion, and questions. Overall, mean ratings of the facilitators were very high on a 5-point scale. Mean responses for parents of children on the six questions ranged from 4.55 to 4.79, while mean responses for parents of adolescents ranged from 4.25 to 5.00.

Table 6 displays parents' categorised responses to the open-ended questions regarding

TABLE 5

Mean Rating by Parents of How Important These Techniques and Factors Were for Themselves As a Parent (1 Not Important to 5 Extremely Important)

Technique/factor	Children Mean (SD)	Adolescents Mean (SD)
Challenge inner thoughts	4.62 (0.58)	4.13 (0.64)
Identify inner thoughts	4.57 (0.70)	4.00 (0.76)
Think in more helpful ways	4.57 (0.74)	4.25 (0.46)
Explanation of FRIENDS program	4.53 (0.80)	3.88 (0.64)
Information about anxiety	4.47 (0.85)	3.88 (0.99)
Other parents' participation, ideas, feelings for the group	4.44 (0.98)	4.63 (0.52)
Rewarding brave behaviour	4.31 (0.84)	4.38 (0.74)
Group activities and exercises	4.28 (0.73)	4.25 (0.46)
Deep breathing	4.24 (0.92)	4.50 (0.53)
Feel-good activities	4.15 (0.88)	4.38 (0.74)
Identify body cues	4.12 (0.83)	4.25 (0.71)
Rewards to encourage homework tasks	4.12 (0.98)	4.38 (0.74)
Step plan	4.07 (1.06)	3.88 (0.99)
Practicing	4.07 (1.06)	3.88 (0.83)
Six-block problem solving plan	4.02 (0.87)	3.38 (1.19)
Relaxation games	3.98 (0.95)	4.00 (1.07)

the “best” and “worst” parts of the FRIENDS program.

Final Evaluation of the FRIENDS Program by Children and Adolescents

A Friedman test revealed that children distinguish between different skills in terms of utility ($\chi^2 = 25.65, p = .002$). A series of Wilcoxon signed ranks tests revealed that children rate rewarding self as more useful than identifying feeling worried ($z = -3.15, p = .002$), inner thoughts ($z = -2.71, p = .007$), problem-solving plan ($z = -3.12, p = .002$), or practicing ($z = -2.83, p = .005$). The skill with the highest percentage of “good” responses was rewarding self

for children (80%) and the step plan for adolescents (91%).

Table 7 displays the children and adolescents’ responses to questions regarding how often they would use the skills (often, sometimes, not at all) and how enjoyable they found the FRIENDS program (fun, OK, boring). A total of 100% of adolescents and 97.7% of children reported that they would use the skills from the FRIENDS program often or sometimes, and that the program was either fun or OK.

Clinical Outcome

The relationship between treatment acceptability and clinical outcome was evaluated with a

TABLE 6

Parents’ Categorised Responses to the Questions Regarding the “Best” and “Worst” Parts of the FRIENDS Program

	Topic	Children % (n)	Adolescents % (n)
Best	Learn new skills or information	51.2% (22)	75.0% (6)
	Normalisation of anxiety/ contact with other families	30.2% (13)	25.0% (2)
	Parent involvement	7.0% (3)	0.0%
	Enjoyable experience	4.7% (2)	0.0%
	Child or family improvement	2.3% (1)	0.0%
	No response	4.7% (2)	0.0%
Worst	Difficult to attend sessions due to busy lifestyle	44.2% (19)	25.0% (2)
	Program too long	7.0% (3)	0.0%
	Homework tasks	4.7% (2)	0.0%
	Other	18.6% (8)	37.5% (3)
	No response	25.6% (11)	37.5% (3)

TABLE 7

Children’s and Adolescents’ Responses to Questions Regarding How Often They Would Use the Skills and How Enjoyable They Found the FRIENDS Program

Question	Age	% (n)		
		Often	Sometimes	Not at all
How much would you use these skills?	Children	40.9% (18)	56.8% (25)	2.3% (1)
	Adolescents	36.4% (4)	63.6% (7)	0.0%
How much fun was the program?		Fun	OK	Boring
	Children	77.3% (34)	20.5% (9)	2.3% (1)
	Adolescents	81.8% (9)	8.2% (2)	0.0%

series of Spearman's rho correlations. As the treatment acceptability data was collected anonymously, these correlations were calculated with the means for each treatment group. No significant correlations were found between the overall evaluation variable from the final evaluation questionnaire and any of the self-report measures (RCMAS, CBCL Internalising scale, and DASS) or posttreatment diagnostic status measure (percentage of diagnoses).

Discussion

This study examined the treatment acceptability of the FRIENDS program through three distinct research questions: (a) the extent to which consumers were satisfied with the FRIENDS program and its components (including sessions, homework tasks, and skills), (b) age differences in the ratings of the program, and (c) the relationship between treatment acceptability and clinical outcome.

Satisfaction with the FRIENDS Program

Overall, parents were highly satisfied with the FRIENDS program, and would highly recommend the program to others. In addition, most children and adolescents also rated the program as "fun". As suggested by Fawcett (1991) and Foster and Mash (1999), specific components of the program were examined over time. Sessions 1 and 2 of the program were rated as significantly less useful than other sessions by parents of children, with parents of adolescents showing a similar trend. This may be explained by the fact that the first two sessions were devoted to introducing participants and identifying feelings, rather than teaching anxiety-management strategies. Alternatively, ratings of later sessions may have been influenced by a contrast bias resulting from the fact that participants were able to compare current sessions with those that preceded them. However, while this comparison bias is implicit in the design of weekly evaluations, the effect is assumed to be small as the difference in perception of sessions differs only for the early weeks and does not occur systematically as the weeks progress.

Specific examination of the rate of completion of homework tasks indicates that they were

generally done at a high rate, with over 80% of parents stating that the homework task was completed either easily or with difficulty in all sessions. Parents of both children and adolescents rated the step plan (graduated exposure) as the most useful, although parents of adolescents rated that it was more useful when combined with self-rewards (positive reinforcement). A small proportion (4.7%) of parents of children nominated homework tasks as the worst part of the program. Homework tasks are a vital component in cognitive-behavioural approaches, as the practice of strategies learnt in therapy sessions promotes the consolidation and generalisation of skills (Ginsburg, Silverman, & Kurtines, 1995). The results of this study suggest that homework tasks were generally well accepted, although therapists may need to strengthen the rationale for homework tasks with some parents.

Parents nominated self-rewards as the most useful specific skill of the FRIENDS program. Children also rated this as the most useful skill, while for adolescents, the most useful was the step plan. According to parents, the least useful skills in the FRIENDS program were the relaxation games and the six-block problem-solving plan. While these findings may reflect the high utility of self-rewards in overcoming anxiety, they may also reflect the parents' and children's liking for the technique. This is similar to the findings of Wong (1999), who suggested that ratings of program components depended on the patients' liking for the technique rather than its utility. Self-rewarding is a system of positive reinforcement for brave behaviour, which may have been simple for parents to employ and may also have resulted in swift changes in observable behaviour. In addition, it is very likely that self-reward was a simple skill for children to use and that they enjoyed their rewards. Other skills, such as cognitive restructuring, problem-solving, and relaxation, were likely to have been more difficult for parents and children to use as they require repeated practice.

The majority of parents nominated the best part of FRIENDS as learning new skills or information, while the worst part of the program was their difficulty in attending sessions due to a busy lifestyle. This finding reflects the ongoing emphasis on brief effective interven-

tions that meet the needs of consumers (Crawford & Kessel, 1999). Although the FRIENDS program consists of only 10 sessions, attendance is still difficult for many families. In the future, brief interventions and self-directed treatments may be developed and these may be more acceptable to busy families.

Age Differences in Ratings of the FRIENDS Program

There was no difference between parents of children and parents of adolescents in their global satisfaction ratings of the FRIENDS program. In contrast, there were significant differences between the age groups on some components of the program. However, interpretation of these results needs to be cautious due to the small number of adolescents participating in this study.

The findings of age differences for specific components did not support the initial hypotheses, which predicted that children would find behavioural strategies more useful while adolescents would rate cognitive strategies as more useful (Barrett, 2000; Cole & Cole, 1993; Ronen, 1997). Parents of children rated identifying inner thoughts (cognitive strategy) as more useful for their child than parents of adolescents, and ratings of other cognitive skills approached significance in a similar pattern. In addition, cognitive and psychoeducational strategies were rated by parents of children as more important to themselves than parents of adolescents. It is possible that children may have needed more help to understand the abstract cognitive concepts, and that their parents became more involved with teaching these skills at home than parents of adolescents. These highly involved parents may have been in a better position to perceive a positive effect from the use of cognitive strategies. For this reason, parents of children may have rated the cognitive skills as more important and more useful than the parents of adolescents. Further research into the utility of skills and the reasons behind their preferences would clarify this issue.

Contrary to expectations, adolescents and children did not differ significantly from each other in their ratings of skills. Nevertheless,

there appear to be some trends in the differences between the age groups in their preferences for specific skills. Children rated the behavioural technique of self-reward as the most useful skill. This is consistent with previous research that found operant procedures most effective with this age group (King & Ollendick, 1989). However, adolescents rated another behavioural technique (step plan) as the most useful, which is inconsistent with the suggestion that cognitive techniques would appeal more to this age group (Ronen, 1997). It is suggested that adolescents may have felt a sense of control with this skill, as it required them to establish a graduated exposure hierarchy. When they achieved their final goal, they may have felt a sense of accomplishment over their fear.

Children distinguished different skills in terms of utility. Specifically, self-rewards was rated as more useful than identifying feeling worried, inner thoughts, problem-solving plan, or practicing. However, for adolescents, there were no significant differences between ratings of skills. This result is possibly due to the low number of participants in the adolescent group, which is likely to have reduced the power of the statistical analyses used to explore these differences in ratings. It is possible that with a larger group of adolescents, statistical analyses would have revealed significant differences in their ratings of skills.

Relationship Between Treatment Acceptability and Clinical Outcome

Contrary to expectations, no significant correlations were found between levels of treatment acceptability and measures of clinical outcome. This lack of relationship has been found in other studies of consumer satisfaction (e.g., Ries et al., 1999). This nonsignificant result may indicate that these two dimensions are indeed independent, suggesting that the perceived acceptability of the treatment is not a significant factor in the clinical outcome. Alternatively, this result may reflect that there was insufficient statistical power to explore this relationship. The present analysis was limited by the fact that treatment acceptability data were anonymous, and therefore, correlations were

based on the mean scores of each treatment group. Clearly, while the lack of relationship between treatment acceptability and clinical outcome is an interesting finding, future research is needed to replicate this finding using data for individual subjects.

Limitations and Directions for Future Research

A key limitation of this study is that it assesses a treatment package. Foster and Mash (1999) stated that, in evaluating the acceptability of a treatment package, it can be difficult for clients to discriminate the utility of the different skills. The skills were introduced in a certain order, building on previous knowledge and skill level. Therefore, ratings of the utility of skills introduced later in the program are mediated by the effect of previously learned skills. For example, it is difficult to determine if the high ratings of the step plan and self-rewards skills were influenced by previously learnt cognitive restructuring or relaxation strategies. Counterbalancing the order of presentation of skills, or comparing different strategies (e.g., cognitive vs. behavioural components) may provide the basis for further research in this area.

Another limitation of the study was the anonymity of the data. This limitation precluded not only effective analysis of the relationship between treatment acceptability and clinical outcome but also the examination of consumer satisfaction over time. For example, with individual data, parents who found the homework tasks useless could be identified and appropriate interventions made. Future research would benefit from tracking consumers' level of satisfaction throughout the course of the intervention, and relating this information with measures of their clinical outcome.

An important issue, when evaluating any treatment program, is the absence of data from participants who failed to complete the program. Often the true reasons for attrition are unknown and it is usually assumed that participants who are unhappy with the program are the ones most likely to withdraw from treatment. In this study, the attrition rate was 7.5% across both groups. Despite this being a relatively small fraction of the total sample, the

present results should be interpreted in light of the possible bias toward favourable comments from those who completed the program.

There are several important implications of using consumer satisfaction measures to evaluate the acceptability of treatment programs. First, consumer feedback is a valuable source of information that needs to be considered when designing or changing treatment programs. For example, the current findings suggest that sessions involving only group formation and exploration of feelings are found to be less useful than sessions that teach specific skills. Thus, incorporating skills that provide early successes into the initial sessions may enhance the acceptability of future treatments.

The treatment acceptability data also highlights the need for multiple informants because parents, children, and adolescents each had different views on the FRIENDS program. Further studies may consider including other sources of information, such as teachers and siblings. In addition, the finding of age-specific responses to the program reinforces the need for programs to accommodate the developmental needs of participants.

In summary, consumer reactions regarding the ease of understanding and utility of program components are important aspects of treatment development that clearly warrant increased research attention. The ongoing assessment of treatment acceptability, along with measures of clinical outcomes, will ensure the long-term development of highly efficacious and viable interventions for the community.

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