

## **How do Close Others to Those with Anxiety Feel About Treatment? Development and Validation of the Treatment Concerns Questionnaire–Close Others**

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### Author notes

Correspondence concerning this article should be addressed to Olivia A. Merritt at the above address or [oamerritt@uwaterloo.ca](mailto:oamerritt@uwaterloo.ca). The authors have no known conflicts of interest regarding this paper. This research has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (#40041 and #41835) and informed consent was obtained from all individual participants included in the study. The datasets generated during and/or analyzed during the current study are available from the corresponding author on reasonable request.

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## VALIDATION OF THE TCQ-C

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## Abstract

Background: The close others (e.g., family members, romantic partners) of people with anxiety and related disorders are typically involved in their treatment decisions. However, we know little about close others' attitudes towards and concerns about their loved one starting cognitive-behavioural therapy (CBT).

Methods: Study one surveyed close others of those with anxiety and related disorders (n=33) about their concerns about their loved one starting CBT. Thematic coding was completed, and items were developed to reflect these themes, comprising a measure of treatment concerns in close others. Study two involved the administration of the novel measure to a larger sample (n=287) to evaluate its structure, reliability, and validity.

Results: Close others endorsed having treatment concerns of moderate intensity. The final 17-item measure, the Treatment Concerns Questionnaire–Close Others (TCQ-C), has a robust four-factor structure, with internally consistent subscales including “Adverse Reactions”, “Personal/Family Consequences”, “Lack of Commitment”, and “Ineffectiveness”. The measure shows moderate correlations with treatment expectations (convergent validity) and small correlations with respondent distress (discriminant validity).

Conclusions: The value of this measure for clinicians and future directions for research are discussed.

*Key words:* treatment ambivalence; social context; anxiety and related disorders; therapy; family; psychometric evaluation

## **How do Close Others to Those with Anxiety Feel About Treatment? Development and Validation of the Treatment Concerns Questionnaire–Close Others**

It is estimated that up to one quarter of the North American population experiences an anxiety or related disorder in their lifetime (Somers et al., 2006). Anxiety can be effectively treated through psychological interventions, such as cognitive-behavioural therapy (Otte, 2011). However, only a small minority of people with anxiety seek treatment (Roness, Mykletun, & Dahl, 2005), and many delay treatment seeking for many years (e.g., one study found an average delay of 9-23 years; Wang, Berglund, & Olfson, 2005). Given the high economic burden of anxiety disorders in North America (Kessler & Greenberg, 2002; Koerner et al., 2004), it is essential to understand barriers to treatment seeking.

Those with anxiety and related disorders balance both approach and avoidance motivations in their decision to seek treatment (Kushner & Sher, 1989). For example, the distress and impairment from anxiety may be a motivation to seek treatment, while the stigma and cost of treatment may motivate treatment delay. In addition to a variety of personal factors that affect this decisional balance is the individual's social context, including the opinions and attitudes of family members and close others. Social context has been identified as an important factor in health outcomes (Repetti, Taylor, & Seeman, 2002) and in medical decision making (Pescosolido, 1992). Family members are often involved in health care decisions, including decisions about anxiety and related disorders (e.g. Geffken et al., 2006; Thompson-Hollands, Kerns, Pincus, & Comer, 2014). People with mental health difficulties commonly consult family members before health care professionals when considering treatment for mental health (Maria Bermúdez, Kirkpatrick, Hecker, & Torres-Robles, 2010; Henshaw, Sabourin, Warning, 2013) and one of the most frequent reasons for entering treatment is family influence/support or

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4 impairments in personal relationships as a result of mental health difficulties (Orford et al., 2006;  
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6 Polcin & Beattie, 2006; Tsogia, Copello, & Orford, 2001). People are sensitive to the anticipated  
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8 reactions and attitudes of close others (e.g., family, significant others) when considering therapy  
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10 (Leaf, Livingston Bruce, & Tischler, 1986; Earnshaw, Smith, Copenhaver, 2013).  
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14         Although there are multiple treatment options for individuals with anxiety and related  
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16 disorders, a first-line treatment is cognitive-behavioural therapy (CBT), an evidence-based  
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18 psychological treatment (for a recent meta-analysis, see Cuijpers, Cristea, Karyotaki, Reijnders,  
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20 & Huibers, 2016) that is considered the “gold standard” for anxiety treatment (David, Cristea, &  
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22 Hofmann, 2018). The impact of the family/interpersonal context on decisions about a  
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24 psychological treatment like CBT, specifically, is an important and interesting area of study. As  
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26 noted above, loved ones’ support could be an important reason to seek treatment, and positive  
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28 attitudes in loved ones may encourage someone to enter treatment earlier than they might  
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30 otherwise. In contrast, just as perceptions of social stigma are related to reduced help-seeking  
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32 efforts ( $d = -0.27$ ; Clement et al., 2014), the anticipation that close others may respond poorly to a  
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34 decision to seek treatment could foster apprehension about therapy (Corrigan, Druss, & Perlick,  
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36 2014). As Corrigan and colleagues noted, cultural factors or family members’ own negative  
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38 experiences with therapy may cause them to discourage their loved one from seeking therapy.  
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40 Additionally, even if treatment is initiated, the attitudes of close others have the power to  
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42 influence treatment engagement and success. For example, youth with behavioural challenges  
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44 with parents who perceive mental illness as unchangeable or see treatment as inconvenient are  
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46 less likely to report therapeutic change and are more likely to drop-out (Morrissey-Kane & Prinz,  
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4           Although research in youth samples suggests that close others' therapy attitudes can  
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6 influence treatment engagement, response, and drop out, there has been little research on this  
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8 topic, particularly for people with anxiety and related disorders. Treatment acceptability research  
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10 has surveyed parents of youth with ADHD (Berger, Dor, Nevo, Goldzweig, 2008) and family  
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12 members of those with schizophrenia (Irani, Dankert, & Siegel, 2004), finding that family  
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14 members are supportive of pharmacological interventions for mental health treatment. Tarnowski  
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16 and colleagues (1992) found that parents prefer therapy over medication for the treatment of  
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18 childhood depression, and similar findings have been reported for childhood anxiety (Brown,  
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20 Deacon, Abramowitz, Dammann, & Whiteside, 2007; Chavira, Stein, Bailey, & Stein, 2003).  
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22 However, these studies focus on childhood disorders and many are hypothetical (e.g., "*if* I had a  
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24 child with social anxiety..."). As such, we know little about the attitudes towards therapy held by  
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26 people who are close to an adult with an anxiety or related disorder.  
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33           Despite research showing that family members perceive therapy positively, there is  
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35 preliminary evidence that close others may also hold fears about therapy (e.g., that they may be  
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37 blamed for the development of the disorder; Renshaw et al., 2005) and the logistics around  
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39 therapy (e.g., practical obstacles like time and money; Kazdin, Holland, & Crowley, 1997).  
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41 Additionally, close others may share concerns that clients themselves hold about therapy, such as  
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43 worries about treatment failing or resulting in worsened symptoms (see the Treatment  
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45 Ambivalence Questionnaire; Rowa et al., 2014). However, to date there has been no systematic  
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47 study of treatment concerns in the close others of adults with anxiety and related disorders, nor is  
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49 there a validated measure of loved ones' concerns. Development of such a measure would allow  
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51 us to explore the impact of treatment ambivalence of close others on their loved ones' pursuit of  
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53 and success in therapy. Additionally, given the recent clinical trend towards systemic  
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4 interventions, including the involvement of important others in anxiety treatments (Chambless,  
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7 2012; Thompson-Hollands, Edson, Tompson, & Comer, 2014; and for a review see Carr, 2014),  
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9 such a measure would be of use to clinicians when considering such involvement.

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11 The purposes of the current studies are to develop and validate a measure of treatment  
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13 ambivalence for close others of those with anxiety and related disorders, drawing from the  
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15 methods used by Rowa et al. (2014). Rowa and colleagues surveyed those with anxiety- and  
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17 related disorders with an open-ended form eliciting treatment fears and concerns. They coded  
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19 these responses to understand themes and used these themes to develop items for the Treatment  
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21 Ambivalence Questionnaire, which they administered to a large sample and explored its factor  
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23 structure, reliability, and validity. The current series of studies aimed to conduct a similar  
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25 procedure to explore the treatment concerns of close others to those with anxiety. The first study  
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27 sought to determine the nature and range of the concerns close others have about cognitive-  
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29 behavioural therapy for their loved one with anxiety. Because attitudes are culturally influenced  
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31 (Kushner & Sher, 1989, 1991) and there are different beliefs about family roles, mental illness,  
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33 and therapy in different cultures, it is important to note that this sample is drawn from a  
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35 Canadian population and may not reflect treatment concerns globally. Using the inductive  
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37 method for item generation (Boateng, Neilands, Frongillo, Melgar-Quiñonez, & Young, 2018),  
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39 the qualitative data collected in study 1 was used to develop the Treatment Concerns  
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41 Questionnaire-Close Others (TCQ-C). The second study examined the psychometric properties  
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43 of the TCQ-C, including factor structure, internal consistency, and convergent and divergent  
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45 validity.  
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### Study 1: Measure Development

Many people will experience an anxiety or related disorder in their lifetime, but a minority will seek treatment. Close others can influence not only the course of a mental health difficulty, but also the person's treatment-seeking efforts. Close others may be supportive of entering treatment, but they may also have concerns about treatment that can influence their loved ones' decisions with respect to treatment seeking and drop out. Despite research suggesting that family members can influence therapy success, to date no research has directly surveyed the concerns loved ones of those with anxiety and related disorders have about their loved ones starting therapy. The purposes of the current study were to: i) obtain qualitative data on the concerns people have about their loved one receiving CBT; ii) identify the general themes following the principles of grounded theory, in which the conceptualization of an idea is conducted in a bottom-up manner (from data to theory; Chun Tie, Birks, & Francis, 2019); and, iii) use this data to develop a quantitative measure of close other treatment ambivalence.

### Methods

#### Procedure

Participants were loved ones of people seeking treatment at an outpatient adult anxiety clinic in Ontario, Canada. We defined "loved one" broadly and included anyone who considers themselves to be a "close other" to the person with anxiety (e.g., family members, romantic partners). The study was advertised through posters in the clinic, at family education sessions, and posters given to clients to pass onto loved ones if they wished. People who were over 18 years of age and whose loved ones had not yet begun treatment or were in the first month of treatment were invited to participate in the online survey. Those who participated were able to

enter a draw to win a gift card. The survey began with a brief overview of CBT to ensure that all participants had a basic understanding of this form of therapy. This overview was presented as 10 slides that, in lay terms, (a) introduced the idea that CBT is an evidence-based treatment, (b) provided an example of how thoughts and behaviours impact each other and levels of anxiety, (c) provided basic information about how CBT might address these maintaining factors in anxiety, and (d) provided resources for additional information. The survey also included demographic questions, a questionnaire about treatment expectations, and open-ended forms on which participants could report expected benefits of and concerns about treatment. Participants were asked to rate each the intensity of each concern from 1 (“minor concern”) to 10 (“major concern”). For the purposes of this study, we report only on respondents’ concerns and how those were used to create the measure.

### Participants

Participants (that is, those reporting on their concerns about their loved one starting treatment) (n=33) ranged from 18-65 years of age and were 43.15 years of age on average (SD=12.03). About half (52.6%) of the participants were female (2.6% trans or non-binary). The majority (73.7%) of participants were White (5.3% East Asian, 2.6% Aboriginal, 2.6% Latin American, 2.6% South Asian). The education background of the sample was varied, with 24.2% having completed university or college, 21.1% having completed some university or college, 15.8% having completed a graduate level degree, and 10.5% having completed high school.

Most participants were a parent (39.5%) or a romantic partner (34.2%) of a client with anxiety; on average, participants knew the client for 18.77 years (SD=10.34). Many (60.5%) were currently living with them, and were in frequent direct (i.e., face-to-face;  $\mu = 35.07$  hours



per week,  $SD=23.07$ , range=0-80) and indirect (i.e., text, call, etc.;  $\mu=8.17$  hours per week,  $SD=20.51$ , range=0-112) contact with the client.

Clients were 31.91 years of age on average ( $SD=9.98$ , range=18-54), 34.2% female (2.6% trans or non-binary), and 50% White (5.3% Asian, 44.7% information was not in clinical file). Diagnostic information (obtained through formal clinical assessments) was collected from the clinic with respondent and client permission. Diagnoses varied, with 15.8% of the sufferers having a primary diagnosis of OCD, 7.9% SAD, 7.9% GAD, 7.9% panic disorder, 5.3% depression, 2.6% PTSD; the remainder of the diagnoses were not retrievable from the client files (e.g., assessment was not yet complete or client had not consented to their data being used for research). Note that many of the clients had additional diagnoses, and all were seeking treatment for an anxiety or related (e.g., obsessive-compulsive or traumatic-stress) concern. Participants reported that 50% of those with anxiety had never received CBT, and for 87%, it was their first time seeking any kind of therapy for their anxiety. Participants reported that the clients had been experiencing anxiety for 16.37 years on average ( $SD=10.40$ ).

## Results

Of the 33 participants, 23 (69.7%) reported having one or more treatment concerns. The modal number of concerns reported was 2 (range=0-6). The average intensity of the concerns was 6.67 ( $SD=1.95$ ) on a 10-point scale, with no concern being rated lower than 3. In total, there were 55 unique concerns. The list of concerns was initially reviewed to gain an understanding of the range of responses. Then, stage 1 coding was completed, whereby each response was given a label that reflected the themes of that concern (“lower-order” or “conceptual coding”; Charmaz, 2006). In accordance with grounded theory, lower-order codes were collapsed into categories or

“higher-order” codes, which allow an understanding of larger themes in the data (Charmaz, 2006; Chun Tie, Birks, & Francis, 2019). After reviewing concerns and codes, all three authors agreed that the qualitative data had reached saturation, as data was beginning to repeat, and no additional insights were identified. This number of participants is within the typical range for reaching saturation on qualitative data collection (Hennick, Kaiser, & Marconi, 2017; Marshall, Cardon, Poddar, & Fontenot, 2013). See the discussion for a comment on coder reflexivity.

Category coding resulted in seven main themes (see Table 1). All authors reviewed the coding, and no conflicts arose. In the interest of creating a quantitative measure based on this qualitative information, conceptual codes were used to create items that captured the main concerns from our dataset (both broad themes as well as individual concerns). This resulted in a pool of 24 items. Then, all authors reviewed the items, eliminating or combining those that were redundant, and ensuring all remaining items showed face and content validity. The remaining measure consisted of 19 items (2-4 from each thematic category).

*Table 1. Qualitative Themes: Close Others’ Concerns about Treatment*

Theme	Frequency of Endorsement: n (%)	Example Response <sup>2</sup>
Treatment will not work	16 (24.24%)	“Therapy ... won't work. We have tried many things that [haven't]”
Treatment failure will result in client hopelessness, depression, self-criticism	6 (9.09%)	“... He will feel even lower than he does now if it doesn't work because he sees no better life for himself”
Treatment will result in an unwanted change in family relationship(s)	8 (12.12%)	“... The treatment will put stress on our relationship”
Treatment will lead to unwanted changes in client’s personality	2 (3.03%)	“He changes the person he is...”

Client will take on others' anxieties	5 (7.57%)	"She will pick up other problems or symptoms from peers"
Client will not fully engage with therapy	11 (16.67%)	"... My loved one will not practice elements introduced in the treatment."
Treatment will lead to increased anxiety, stress, depression, and/or self-criticism	18 (27.27%)	"Treatment will cause him stress by having to face his anxiety."

<sup>1</sup>Although there were 55 unique concerns, some concerns contained content that spanned several categorical codes, resulting in them having more than one categorical code applied. There were 66 categorical codes in total.

<sup>2</sup> Respondents provided permission for the use of anonymous quotations.

### Discussion

Many participants reported treatment concerns and rated these concerns as important, with moderate to high intensity ratings. Seven main themes arose, with categories reflecting concerns about therapy not working, treatment failure leading the client to feel worse, therapy resulting in increased stress or new fears, therapy changing the loved one and the family relationships, and the loved one not fully committing to treatment. Participants reported that their loved ones had been experiencing anxiety for more than 15 years on average, which is consistent with previous research showing that treatment seeking is often delayed by a decade or more (Wang, Berglund, & Olfson, 2005). Future research may explore whether the attitudes of close others are related to treatment seeking efforts and delays.

Interestingly, approximately one-third of participants did not report any concerns about treatment. This is consistent with previous research showing that family members are typically supportive of their loved one entering therapy (e.g., Chavira, Stein, Bailey, & Stein, 2003; Tarnowski, Simonian, Bekeny, & Park, 1992). However, this study sampled close others of people who were already seeking treatment; it is likely that there would be greater ambivalence,

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4 on average, among close others of those who have not yet sought treatment (or do not intend to  
5 do so). Our sampling technique may have missed out on those who are not seeking treatment  
6 because close others' treatment concerns have interfered with their doing so; that is, our survey  
7 may have not captured the most serious concerns about treatment. Since we sampled from an  
8 adult anxiety clinic and the majority of clients were seeking therapy for the first time, it is also  
9 possible that some of the clients may be seeking treatment now that they can consent on their  
10 own, after previously avoiding treatment due to loved one's treatment concerns. Additionally,  
11 the majority of respondents in this sample were White; given research showing that culture can  
12 be an important variable in help-seeking attitudes (e.g., Mojaverian, Hashimoto, & Kim, 2013;  
13 Sun, Hoyt, Brockberg, Lam & Tiwari, 2016), it is important not to assume that these themes are  
14 reflective of those in other racial or ethnic groups. This may be particularly true for cultures in  
15 which beliefs about family, mental health, and/or therapy differ significantly from traditional  
16 Western beliefs. Future research may explore cross-cultural differences in the treatment attitudes  
17 of close others. In recognition of this limitation for the current study, the TCQ-C includes an  
18 open-ended question where respondents can report any additional concerns they have about  
19 treatment (see Appendix).  
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43         Several participants shared concerns about clients taking on others' anxieties. The  
44 outpatient clinic from which loved ones were recruited offers both individual and group therapy  
45 services, and loved ones may have been referring to their loved one hearing others' concerns in a  
46 group therapy format. Research is needed to explore how prevalent this concern is among  
47 patients and whether this feared "contagion" effect actually occurs in group therapy formats.  
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4 generate useful information about loved ones' ambivalence regardless of the therapy format the  
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6 sufferer is considering/entering.  
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9         Given that qualitative coding was involved in this study, reflection upon the potential role  
10 of the researchers in the research process is warranted. As a statement of reflexivity, the primary  
11 coder (first author) was a graduate student with a clinical training background and the two  
12 additional coders (second and third authors) were practicing psychologists and academic  
13 professors. All coders were White females, living in Canada, who use CBT as part of their  
14 clinical practice. These backgrounds likely played into the research design, collection, and  
15 interpretation. The purposes of the study are aligned with researcher beliefs that therapy is a  
16 valuable and worthwhile venture for many individuals, and the drive to understand and overcome  
17 barriers to treatment success. The work is also influenced by an assumption that families tend to  
18 want to support their loved ones, even if they find symptoms challenging. The authors' prior  
19 experiences with clients and their families contributed to the assumption that family members  
20 can be ambivalent and have concerns about treatment. This assumption was incorporated into the  
21 open-ended form that was used to collect respondent treatment concerns; however, participants  
22 were also asked about perceived benefits of the treatment in an attempt to minimize demand  
23 characteristics. Prior experience with clients and the research literature on clients' concerns  
24 about therapy may have been a source of influence on the coding of data and generation of  
25 themes. We attempted to minimize the effect of this prior knowledge by collecting qualitative  
26 information from close others rather than creating items of our own. We were agnostic about the  
27 concerns and themes that would arise. We attempted to create items that reflected both general  
28 trends in the data as well as individuals' concerns in order to ensure that multiple perspectives  
29 were incorporated into the items that were created.  
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Loved ones reported significant worries about treatment. This warrants the development of a quantitative measure of close others' concerns. Such a measure could fill an important gap in our understanding of the underutilization of anxiety treatment and could be used by researchers to study the relationship between ambivalence in close others, client ambivalence, and treatment success. Additionally, when working with clients with anxiety and related disorders, clinicians could use such a measure to understand the treatment attitudes of close others, address their concerns, and/or determine their level of involvement in therapy.

### Study 2: Measure Validation

The purpose of the current study was to evaluate the psychometric properties of the TCQ-C through examining its factor structure, internal reliability, and construct validity. As such, we performed an exploratory factor analysis and examined the internal reliability of each subscale through calculating Cronbach's alpha coefficients. In addition, we examined construct validity through evaluating the measure's relationship to a theoretically related construct (convergent validity with treatment expectations) and a theoretically unrelated construct (discriminant validity) that may have an indirect effect on responses (i.e., distress).

To explore convergent validity, a pre-existing measure of treatment expectations was selected. Theoretically, one's treatment expectations should be related to one's treatment attitudes, such that the more negative one's attitudes about treatment, the more one feels treatment will not work. For example, Gonzalez, Tinsley, Howard, and Kreuder (2002) found that students' attitudes and expectations both saw a positive shift after a psychoeducational intervention. Given that treatment expectations and treatment ambivalence are not redundant concepts, we expected them to have a significant but modest correlation to each other.

Discriminant validity was examined through evaluating the relationship between the TCQ-C and a pre-existing measure of respondent distress. As in the psychometric assessment of the Treatment Ambivalence Questionnaire (Rowa et al., 2014), it was important to determine that one's beliefs about treatment were not solely a representation of their current levels of distress. Based on the findings from that study, small correlations were expected between these constructs.

## Methods

### Procedure

People who had a loved one with significant symptoms of an anxiety or related disorder were recruited from a number of sources: an outpatient anxiety clinic, a student population, a research database, posters in the community, and Amazon Mechanical Turk (“MTurk”). All participants confirmed that they had a loved one with significant, problematic, and/or excessive anxiety that has been present for six months or more. People who were over 18 years of age and who could read and understand English were eligible to participate; there were no age restrictions specified for the person with anxiety that participants reported on. Remuneration varied based on the recruitment method: students ( $n=71$ ) received course credit, MTurk participants ( $n=225$ ) received a small monetary compensation, and all others ( $n=61$ ) were entered into a draw to win a gift card. After consenting to participate, participants reviewed a brief description of CBT (the same that was used in Study 1) and completed demographic questions and the other measures (see *Measures*). Additionally, participants completed measures about their relationship with their loved one’s anxiety (e.g., criticism, accommodation) and about their own distress tolerance and fear of compassion; for the purposes of this study, we report only on those measures that are relevant to the psychometric properties of the TCQ-C.

### Data Preparation

Given that the TCQ-C item means were similar across recruitment methods (multivariate GLM was significant,  $F(38,522)=2.386$ ,  $p<.001$ , Wilk's  $\Lambda=.725$ , but none of the post-hoc group differences were significant when correcting for multiple comparisons) and the items did not show significant skew or kurtosis, the combination of data into one sample was deemed appropriate (Guildford, 1952) and even advantageous, as it provides increased heterogeneity and



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4 generalizability (Gaskin, Lambert, Bowe, & Orellana, 2017), and data from these different  
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6 sources have been shown to be comparable in quality (Kees, Berry, Burton, & Sheehan, 2017).  
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8 Once combined, data quality was analyzed. Bot and duplicate responding detection resulted in  
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10 the deletion of 4 participants' data, failed attention checks resulted in the deletion of 18  
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12 participants' data (a smaller proportion than is often reported in MTurk samples; e.g., Kaufmann,  
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14 Schulze, & Veit, 2011 as cited by Bentley, 2021), and two participants were removed from  
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16 analyses due to reporting on themselves, rather than a loved one with anxiety. An additional 46  
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18 participants were removed from analyses due to having completed less than 50% of the items in  
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20 the study (a similar proportion to previously reported community and MTurk samples; e.g.,  
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22 Zhang & Gearhart, 2020).  
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29 The remaining participants' (n=287) data showed acceptable skew and kurtosis on all  
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31 measures (Kline, 1998). Outliers were examined through Z-score analysis and visual inspection  
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33 of box plots; values that were 3 or more standard deviations from the mean and that were  
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35 discontinuous from the distribution (n=9) were replaced with the respondent's subscale mean  
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37 value, provided that the respondent had completed 80% or more of the items on that subscale.  
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### 41 **Participants**

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43 See Table 2 for demographic information about the respondents and their loved ones with  
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45 anxiety. The majority of respondents were living in the United States of America (n=169, 58.9%)  
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47 or Canada (n=107, 37.3%) when they participated, with < 5 participants each living in Barbados,  
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49 China, Egypt, or India. The majority of their loved ones were also living in the United States of  
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51 America (n=171, 59.6%) or Canada (n=104, 36.2%), with < 6 each currently living in China,  
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53 Egypt, France, Germany, India, or South Korea.  
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Most respondents were a partner/spouse (n=79, 27.5%), parent (n=67, 23.3%), sibling (n=61, 21.3%) or adult child (n=45, 15.7%) of the person with anxiety. Other relationships (ns < 9) included grandparent, aunt/uncle, cousin, grandchild, close friend, and niece. The age of the sufferers was normally distributed, and the majority were adults: 9.9% were 6-17 years old, 33.4% were 18-29 years old, 26.4% were 30-45 years old, 22.2% were 46-64 years old, and 7% were 65-90 years old (1% did not report age). Most respondents (n=257, 89.5%) had lived with the sufferer at some point, and many (n=164, 57.1%) were living with them at the time of participation. On average, respondents knew the sufferer for 21.2 years (SD=12.9). Respondents were in frequent direct (i.e., face-to-face;  $\mu$ = 30.5 hours/week, SD=33.0, range=0-120) and indirect (i.e., text, call, etc.;  $\mu$ = 8.9 hours/week, SD=16.0, range=0-112) contact with the sufferer.

Respondents reported that their loved one had been experiencing anxiety for 15.8 years on average (SD=14.7). Most respondents reported that their loved one's anxiety was impairing to a small (n=112, 39%), moderate (n=110, 38.3%), or great (n=42, 14.6%) degree. Sixty-two percent of respondents (n=180) reported that their loved one had received a diagnosis for their anxiety and 55.1% (n=158) reported that their loved one had attended therapy for their anxiety. Twenty-two percent of respondents reported that the sufferer was in therapy at the time of the study.

*Table 2: Demographic Information*

	Participant (Close Other)	Person with Anxiety
Age (years)		
Mean	35.8	36.9
Standard Deviation	13.2	17.7
Gender, n (%)		
Male	94 (32.8%)	114 (39.7%)

Female	188 (65.5%)	164 (57.1%)
Gender non-binary, gender non-conforming	3 (1.0%)	7 (2.4%)
Declined to answer	1 (0.3%)	2 (0.7%)
<b>Ethnicity, n (%)</b>		
White	200 (69.7%)	195 (67.9%)
East Asian	21 (7.3%)	16 (5.6%)
South Asian	18 (6.3%)	20 (7.0%)
Black/African American	14 (4.9%)	15 (5.2%)
Other	34 (11.8%)	41 (14.3%)
<b>Highest level of education, n (%)</b>		
High school or less	39 (13.6%)	89 (31.0%)
Some or completed university/college degree	203 (70.7%)	144 (50.2%)
Some or completed graduate degree	41 (14.3%)	45 (15.7%)
Other or declined to answer	4 (1.4%)	9 (3.1%)

## Materials

*Treatment Concerns Questionnaire-Close Others (TCQ-C)*. Treatment concerns were measured using the TCQ-C, the development of which was described in Study 1. The TCQ-C lists 19 potential concerns based on those reported by close others of people with anxiety. For each item, respondents rate how much they agree or disagree that they are concerned on a 7-point scale from “strongly disagree” to “strongly agree”.

*Stanford Expectations for Treatment Scale, Family Modification (SETS-F)*. Treatment expectations were measured using a modified version of the SETS (Younger, Gandhi, Hubbard, & Mackey, 2012), which is a brief, 6-item scale, 3 items assessing for positive treatment expectations and 3 items for negative expectations. The measure shows acceptable internal consistency and predictive validity in health care settings (Younger, Gandhi, Hubbard, & Mackey, 2012). For the purposes of this study, two items were slightly modified to become

specific to a loved ones' anxiety treatment (e.g., original item "my condition will be completely resolved after this treatment" was modified to "my loved one's anxiety will be completely resolved after this treatment"). In this sample, the SETS-F showed acceptable internal consistency (positive expectations subscale: Cronbach's alpha ( $\alpha$ )= .75; Revelle's omega ( $\omega$ )=.76 ; negative expectations subscale:  $\alpha$ = .79;  $\omega$ =.81).

*Depression, Anxiety, Stress Scales (DASS-21; Lovibond & Lovibond, 1995).* Respondent distress was measured through the DASS-21, a 21-item self-report scale that assesses for depression, anxiety, and stress. Each item is rated based on respondent's distress in the past week on a 4-point scale from "did not apply to me at all" to "applied to me very much, or most of the time". This widely used scale shows good reliability and validity (Antony, Bieling, Cox, Enns, & Swinson, 1998), and showed excellent internal reliability in this sample ( $\alpha$  =.96;  $\omega$ =.97). For the purposes of the current study, the DASS-21 was used as an indicator of respondent distress.

## Results

### Exploratory Factor Analysis

Two-hundred and eighty-one (n=281) participants completed the TCQ-C. Approximately 3% of those participants had 1 item missing from their response; missing items were treated with mean imputation. Items were within the recommended guidelines for skew and kurtosis (Watkins, 2018). Analyses were performed using SPSS version 24. Bartlett's test of sphericity (approximate Chi-Square(136)=2653.168,  $p$ <.001), and Kaiser-Myer-Olkin measure of sampling adequacy (.89) confirmed that the correlation matrix was factorable. Maximum likelihood estimation was used to identify a latent factor structure. Oblimin rotation was employed, as we assumed that factors would be intercorrelated rather than orthogonal. Eigenvalues, scree plot, theoretical convergence, and

percentage of variance accounted for by each factor were used to determine number of factors. Four factors showed eigenvalues over 1, accounted for a significant amount of variance, and represented the most parsimonious solution. A four-factor solution was robust across rotation methods and was also supported by the results of parallel analysis (conducted using RStudio, package “psych”, function “fa.parallel”): after 500 iterations, four eigenvalues from the observed correlations exceeded the eigenvalues from the simulated data correlations.

Item 1 (“treatment will change my loved one in unexpected ways”) showed discrepant loadings in the pattern matrix and the structure matrix, indicating that it is influenced by more than one factor; it was removed from analyses. Item 9 (“through treatment, my loved one may hear about others’ problems, and will think their own concerns are not valid”) loaded saliently on two factors (values within .10 of each other), so it was removed from analyses. The final four-factor solution accounted for 68.8% of the variance.

The first factor (“Adverse Reactions”, AR) was saliently loaded by six items, accounted for 41.89% of the variance, and showed good internal reliability ( $\alpha = .86$ ,  $\omega = .90$ ). The second factor (“Personal/Family Consequences”, PC) contained four items, accounted for 12.53% of the variance, and showed good internal reliability ( $\alpha = .80$ ,  $\omega = .95$ <sup>1</sup>). The third factor (“Lack of Commitment”, LC) was saliently loaded by four items, accounted for 7.62% of the variance, and good internal reliability ( $\alpha = .89$ ,  $\omega = .90$ ). The fourth and final factor (“Ineffectiveness”, IE) was saliently loaded by three items and accounted for 6.80% of the variance, with good internal reliability ( $\alpha = .82$ ,  $\omega = .82$ ). See Table 3 for descriptive statistics for each subscale and Table 4 for

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<sup>1</sup> Note that the initial report of Revelle’s omega for this subscale was .07. After investigation of multivariate outliers using R function “mahalanobis”, five were detected ( $p < .001$ ). This value reflects reliability once these outliers were omitted.

pattern coefficients and communalities of all items. When the 17 items are summed to make a total score, this total scale has excellent internal reliability ( $\alpha = .91$ ,  $\omega = .94$ ).

Table 3. Subscale Descriptive Statistics

	Descriptive Statistics			
	Mean	SD	Skew	Kurtosis
AR	22.13	8.42	-.022	-.657
PC	9.21	4.79	1.04	.722
LC	16.36	6.60	-.254	-.959
IE	10.98	4.54	.095	-.878

TCQ-C Subscales: AR=Adverse Reactions, PC= Personal/Family Consequences, LC= Lack of Commitment, IE= Ineffectiveness; SD=standard deviation.

Table 4. Factor Statistics

Item #	Item	Factor Loadings				
		Communalities	F1	F2	F3	F4
3	My loved one will feel like a 'failure' if they do not 'succeed' in treatment.	.41	<b>.53</b>	.00	-.08	.11
10	Treatment will be overwhelming for my loved one.	.60	<b>.75</b>	-.05	-.14	-.07
12	My loved one will feel hopeless or depressed if treatment does not help.	.41	<b>.61</b>	-.06	-.03	.08
14	Treatment will create too much pressure for my loved one.	.75	<b>.81</b>	.00	-.02	.08
15	Through treatment, my loved one may learn about symptoms or fears	.45	<b>.55</b>	.21	-.01	-.02

	others have, and will take on these fears or symptoms as their own.					
17	Treatment will lead to worsened symptoms.	.61	<b>.62</b>	.21	.03	.10
5	Treatment will negatively change the way my loved one sees me.	.71	.01	<b>.79</b>	-.06	.11
8	I will lose my relationship with my loved one because of this treatment.	.68	-.10	<b>.82</b>	-.10	.09
11	If my loved one's anxiety improves, other issues in our relationship/family will become more prominent.	.34	.09	<b>.56</b>	.00	-.14
13	Treatment will change my loved one in a negative way.	.57	.32	<b>.51</b>	.16	.18
7	My loved one will not use the coping tools that they learn in treatment.	.68	-.06	-.03	<b>-.73</b>	.23
16	My loved one will not be fully committed to improving.	.70	-.01	.08	<b>-.83</b>	-.04
18	My loved one will not complete all the required components of the treatment.	.67	.04	.03	<b>-.78</b>	.01
19	If treatment is difficult, my loved one will become discouraged and give up.	.74	.30	-.03	<b>-.70</b>	-.04
2	Treatment will not work.	.71	.19	-.11	.01	<b>.76</b>
4	Treatment will be a waste of time and/or money.	.54	-.03	.20	-.09	<b>.64</b>
6	Treatment will not be potent or comprehensive enough to help my loved one.	.60	.10	-.02	-.14	<b>.64</b>

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Extraction communalities are reported. Factor loadings are represented by pattern coefficients. F1= Adverse Reactions (AR); F2= Personal/Family Consequences (PC); F3= Lack of Commitment (LC); F4= Ineffectiveness (IE). See Appendix for final measure.

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4 Respondents also had the option to complete an open-ended form with any additional  
5 concerns they had. Ninety-five respondents (33%) listed concerns here, many of which were more  
6 specific examples of items from the scale (e.g., reasons why the treatment may be distressing for  
7 their loved one in particular). Using the coding system from study 1, coding revealed that 22  
8 described concerns fell under the Adverse Reactions category (e.g., group therapy being difficult  
9 for someone with social anxiety), 6 additional concerns were about personal/family consequences  
10 (e.g., support network not being encouraging of therapy), 34 concerns were around the loved one's  
11 lack of commitment (e.g., they will not see therapy as applicable to them, will not co-operate, will  
12 stop therapy too early), and 12 concerns fell under the category of treatment being ineffective (e.g.,  
13 therapist being unskilled, therapy not being tailored to their needs). Lastly, close others also  
14 endorsed concerns about treatment being too costly (n=11), time-consuming (n=6), or stigmatizing  
15 (n=4).

### 33 **Convergent and Discriminant Validity**

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35 We examined convergent validity through performing correlations between the TCQ-C  
36 subscales and the SETS, a measure of treatment expectations. As predicted, the TCQ-C subscales  
37 showed negative correlations with the positive expectations subscale of the SETS, and positive  
38 correlations with the negative expectations subscale of the SETS (see Table 5). Although all but  
39 one of these correlations were significant, beliefs about the ineffectiveness of treatment (TCQ-C-  
40 IE) were more strongly negatively related to positive expectations for treatment, and beliefs about  
41 adverse reactions and personal consequences of treatment were more strongly positively related to  
42 negative expectations for treatment.

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44 Discriminant validity was explored through examining the correlations between the TCQ-  
45 C subscales and the respondent DASS scale scores. The correlations between these measures were  
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small to moderate (*r*s ranging from .08-.34; see Table 5), indicating that this measure is not just a reflection of one’s personal distress level.

*Table 5. Correlations: TCQ-C Subscales, General Distress, Treatment Expectations*

	TCQ-C- AR	TCQ-C- PC	TCQ-C- LC	TCQ-C- IE	DASS-S	DASS- A	DASS -D	SETS- POS	SET S- NEG
TCQ-C-AR	-								
TCQ-C-PC	.528**	-							
TCQ-C-LC	.560**	.270**	-						
TCQ-C-IE	.574**	.353**	.539**	-					
DASS-S	.286**	.083	.282**	.191*	-				
DASS-A	.264**	.157*	.244**	.111	.799**	-			
DASS-D	.291**	.151*	.335**	.192*	.745**	.699**	-		
SETS-POS	-.193*	-.011	-.323**	-.538**	-.137*	-.074	-.161*	-	
SETS-NEG	.539**	.486**	.242**	.307**	.037	.113	.065	-.046	-

TCQ-C= Treatment Concerns Questionnaire–Close Others; AR=Adverse Reactions, PC= Personal/Family Consequences, LC= Lack of Commitment, IE= Ineffectiveness; DASS= Depression, Anxiety, Stress Scales; DASS-S= Stress Scale, DASS-A= Anxiety Scale, DASS-D=Depression Scale; SETS-POS= Stanford Expectations for Treatment Scale, Positive Expectations Subscale, SETS-NEG = Stanford Expectations for Treatment Scale, Negative Expectations Subscale. \**p*<.05, \*\**p*<.001.

### Discussion

The current study examined the psychometric properties of the TCQ-C. Exploratory factor analysis showed that the most parsimonious solution was a four-factor solution, yielding 4 subscales with good internal reliability and with small to moderate intercorrelations. These

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4 subscales reflect fears about treatment being ineffective, loved ones not fully committing to  
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6 treatment, adverse reactions to treatment (e.g., increased symptoms) and personal consequences  
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8 of treatment (e.g., changes in family dynamics). These four factors correspond well to the main  
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10 themes that were derived in Study 1, with changes in personality and family relationships being  
11  
12 grouped together to make the ‘personal/family consequences’ subscale and concerns about  
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14 symptoms increasing, hopelessness, and taking on others’ symptoms being grouped together to  
15  
16 make the ‘adverse reactions’ subscale, the subscale that accounted for the most variance. Future  
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18 research could continue the validation of this factor structure by using confirmatory factor  
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20 analysis.  
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26 Many of these factors overlap with concerns clients themselves have about treatment as  
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28 measured by the Treatment Ambivalence Questionnaire (TAQ; Rowa et al., 2014), a measure of  
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30 client ambivalence for people with anxiety and related disorders. The TAQ contains subscales  
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32 that reflect concerns about personal consequences (such as change in personality or  
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34 relationships) and adverse reactions (such as an increase in anxiety or distress). Indeed, these  
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36 concerns may reflect some truth: therapy can be distressing in the short term (especially  
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38 exposure-based treatments; Thornton, 2017), treatment failure can lead to self-blame (Berk &  
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40 Parker, 2009), CBT for anxiety does not help everyone (Loerinc et al., 2015), and therapy  
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42 sometimes leads to negative outcomes for families (Szapocznik & Prado, 2007). The TCQ-C can  
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44 help assess when close others hold exaggerated or problematic treatment fears.  
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51 The TAQ and TCQ-C can be used together to understand where clients and/or close  
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53 others hold obvious misunderstandings about therapy. Depending on what is endorsed on these  
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55 measures, psychoeducation could include messages that CBT can be stressful in the short-term,  
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57 but it often leads to a decrease in anxiety symptoms in the long-term; treatment can involve the  
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4 development of coping strategies to help the client manage the additional stress that therapy can  
5 bring; and that therapists do not encourage clients to sever close, non-toxic relationships. Family  
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7 mental health awareness efforts are associated with better outcomes for clients (e.g., reduced  
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9 symptoms and relapse) and families (e.g., reduced family distress and friction) (Luckstead,  
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11 McFarlane, Downing, & Dixon, 2012). In their review, these authors emphasized the need for  
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13 family education efforts to be tailored; the TCQ-C could serve as an efficient and effective tool  
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15 for doing so. Researchers, too, could use the TAQ and TCQ-C conjointly to study whether there  
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17 is an association between specific concerns that close others endorse (on the TCQ-C) and those  
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19 that anxiety sufferers endorse (on the TAQ). This may shed light on the origin and maintenance  
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21 of beliefs/attitudes that impede treatment seeking behaviours.  
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29 Close others are worried about their loved ones' (lack of) commitment to treatment. Of  
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31 the four factors, this factor showed the highest endorsement (highest average item score),  
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33 whereas the personal consequences factor showed the lowest endorsement. At the same time,  
34  
35 close others are optimistic about treatment, showing higher average positive expectations scores  
36  
37 (mean=3.90, SD=1.23) than negative expectations scores (mean=3.07, SD=1.40) on the Stanford  
38  
39 Expectations for Treatment Scale ( $t(280)=9.94, p<.001$ ; not reported above). If close others  
40  
41 themselves are invested in the success of treatment, it is reasonable that they may be concerned  
42  
43 about whether their loved one is equally invested. Alternatively, endorsement of these items may  
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45 reflect disappointment in the failure of previous treatments; after all, CBT for anxiety has  
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47 clinically significant effects for about half of those who try it (Loerinc et al., 2015), and outside  
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49 observers may be in search of an explanation for why it hasn't worked for their loved one.  
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Attributing the negative outcomes in clients' lives to their own actions or characteristics is  
associated with criticism and hostility in relatives (Barrowclough & Hooley, 2003). Future

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4 research could explore whether the TCQ-C “Lack of Commitment” subscale is particularly  
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6 related to levels of criticism observed in the family or reported by the person with anxiety.  
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8 Should close others endorse these items, clinicians may want to explore the origins of these  
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10 concerns, and gently assess for criticism and client ambivalence about treatment.  
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14 The construct validity of the TCQ-C was also explored. Evidence for convergent validity  
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16 was seen in the TCQ-C subscales’ correlations with a measure of treatment expectations. As  
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18 expected, the strength of these correlations indicate that they are related, but not redundant  
19  
20 concepts. One exception was that positive expectations did not significantly correlate with  
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22 worries about the personal consequences of treatment. It appears that these concepts are  
23  
24 unrelated, such that close others’ beliefs that treatment will be effective are not related to how  
25  
26 concerned they are about treatment impacting family dynamics. In contrast, less worry about a  
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28 loved one’s commitment or about the ineffectiveness of treatment is associated with more  
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30 positive expectations for the outcomes of therapy. Given that hope and positive expectations are  
31  
32 an important component of treatment success (for a recent meta-analysis, see Constantino, Visla,  
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34 Coyne, & Boswell, 2018), the ineffectiveness subscale of the TCQ-C could be used to assess and  
35  
36 address beliefs about treatment ineffectiveness in the early stages of treatment.  
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43 Evidence for discriminant validity lies in the small correlations seen between respondent  
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45 distress and treatment ambivalence. Concerns about ineffectiveness of treatment and personal  
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47 consequences of treatment seem to be especially unrelated to respondent distress. In contrast,  
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49 concerns about adverse reactions to treatment and worries about lack of commitment showed a  
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51 small relationship to depression scores ( $r_s = .291$  and  $.335$ , respectively), perhaps indicating that  
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53 when one is more depressed, there is a general pessimism about their loved one’s ability to  
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55 handle treatment.  
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4 A strength of this study is the diverse sampling techniques that were used, resulting in  
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6 respondents from numerous countries, of different ages, and with a variety of relationships to the  
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8 individual with anxiety. A limitation of this sample is that the majority of respondents and people  
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10 with anxiety were White, limiting its generalizability to close others from other cultures and  
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12 ethnicities. Traditions around family involvement in mental health (Chadda & Deb, 2013),  
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14 stigma about mental illness (Papadopoulos, Foster, & Caldwell, 2013), and accessibility of  
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16 treatment (Snowden & Yamada, 2005), vary across cultures; future work would benefit from  
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18 conducting similar research in non-White samples. In addition, some respondents (17%) reported  
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20 having no direct contact with the person with anxiety; however, it should be noted that this study  
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22 was conducted from August 2020-November 2021, when many individuals were refraining from  
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24 in-person contact with those outside their household due to the COVID-19 pandemic. Lastly, this  
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26 sample represents people who believe their loved one has problematic, excessive, and/or  
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28 significant anxiety; however, a formal assessment was not conducted to determine diagnostic  
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30 information. Future research may aim to replicate the factor structure of this measure in samples  
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32 of those from different cultures and with a known clinical diagnosis. This measure may also be  
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34 used to explore whether the type and strength of concerns differs as a function of the relationship  
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36 to the client (e.g., parent versus romantic partner).  
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### 48 **General Discussion**

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50 This series of studies represents the first attempt to systematically investigate the  
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52 concerns that close others have about their loved ones starting treatment for anxiety. Although  
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54 previous research has discussed the importance of family attitudes (e.g., Morrissey-Kane &  
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56 Prinz, 1999), a measure of close other ambivalence had not previously been developed. In  
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4 accordance with grounded theory principles (Chun Tie, Birks, & Francis, 2019), we elicited  
5 concerns by close others and used this qualitative information to develop a quantitative measure  
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7 of their treatment ambivalence. The final measure, with 17 items total, had strong internal  
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9 reliability, a stable four-factor structure, and evidence of construct validity.  
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14 Across studies, the majority of respondents were parents or romantic partners of  
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16 sufferers, indicating that these may be the close others that are most involved and/or invested in a  
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18 clients' mental health. Respondents in both studies had known the sufferer for many years (study  
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20 1 mean= 18.8 years, study 2 mean= 21.2 years) and the majority were living with the sufferer at  
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22 the time of the study, which may be indicative of the close relationships between the respondents  
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24 and the sufferers. Across studies, sufferers were mostly adults, with mean ages ranging from 32-  
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26 36 years. The concerns investigated in these studies therefore apply mainly to adult sufferers  
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28 with anxiety; future research may develop a similar measure for the close others of children with  
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30 anxiety who are entering treatment.  
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36 While the samples in the two studies were similar in many ways, they differed in that the  
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38 first study sampled loved ones of those who were treatment-seeking, while the second study  
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40 sampled close others of anyone with excessive anxiety (with varying treatment status).  
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42 Treatment concerns may be greater in a sample of those who are not awaiting treatment; on the  
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44 other hand, treatment ambivalence may increase as a treatment start date approaches and the  
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46 prospect of treatment becomes more "real" to close others. As Kushner and Sher (1991) write,  
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48 different treatment fears may be relevant at different times throughout the help-seeking process.  
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51 Some of the study two sufferers may be in different stages of therapy, while others may have no  
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53 therapy experience at all. Close others of those with no therapy experience may have increased  
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55 fears about lack of commitment. For example, on the open-ended item, some loved ones reported  
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worries about the sufferer not being open to therapy, not seeing it as applicable to them, or “not taking it seriously”. For close others to people who are in therapy (22% of the study two sample), concerns about personal consequences may be more relevant, and concerns about ineffectiveness and adverse consequences may vary depending on the close other’s perception of the sufferer’s progress. Future research may seek to compare the responses of close others whose loved ones are in different stages of treatment seeking.

Whether or not close others are involved in treatment, their attitudes could impact the client’s motivation and treatment outcomes. Thus, assessing for close others’ attitudes could be a useful part of the intake process or as a mid-therapy assessment should the expected progress not be observed. This information can then be used to discuss with the client the impact of their close others’ attitudes or to consider offering them a psychoeducation session before proceeding with treatment. Therapists can also use the TCQ-C as a tool to assess and address attitudes in preparation for joint therapy sessions with close others or when considering transitioning from individual to family therapy. Future research may explore whether close others’ concerns about treatment are related to rates of treatment-seeking in those with anxiety and whether TCQ-C scores predict treatment adherence, drop-out, or outcomes once the client has entered treatment.

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4 **TCQ-C**

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6  
7 It is common for the close others of those with anxiety to have concerns about their loved one  
8 starting treatment. On the one hand, people want their loved one to feel better, but at the same  
9 time they may be concerned that treatment could come at a cost. This questionnaire asks about  
10 your concerns about your loved one starting treatment.  
11

12 Please rate how much you agree or disagree with each of the following statements.  
13

14 I am concerned that...

15  
16  
17

	1	2	3	4	5	6	7
	strongly	moderately	slightly	neither	slightly	moderately	strongly
	disagree	disagree	disagree	agree nor	agree	agree	agree
				disagree			
18 1. Treatment will not	1	2	3	4	5	6	7
19 2. My loved one will be							
20 2. My loved one will be	1	2	3	4	5	6	7
21 2. My loved one will be							
22 2. My loved one will be							
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4	9.	If my loved one's						
5		anxiety improves, other	1	2	3	4	5	6
6		issues in our						7
7		relationship/family will						
8		become more						
9		prominent.						
10	10.	My loved one will feel	1	2	3	4	5	6
11		hopeless or depressed						7
12		if treatment does not						
13		help.						
14	11.	Treatment will change	1	2	3	4	5	6
15		my loved one in a						7
16		negative way.						
17	12.	Treatment will create	1	2	3	4	5	6
18		too much pressure for						7
19		my loved one.						
20	13.	Through treatment, my						
21		loved one may learn	1	2	3	4	5	6
22		about symptoms or						7
23		fears that others have						
24		and will take on these						
25		fears or symptoms as						
26		their own.						
27	14.	My loved one will not	1	2	3	4	5	6
28		be fully committed to						7
29		improving.						
30	15.	Treatment will lead to	1	2	3	4	5	6
31		worsened symptoms.						7
32	16.	My loved one will not	1	2	3	4	5	6
33		complete all the						7
34		required components of						
35		the treatment.						
36	17.	If treatment is difficult,	1	2	3	4	5	6
37		my loved one will						7
38		become discouraged						
39		and give up.						
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54		What other concern(s) do you have about your loved one starting treatment?						
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What other concern(s) do you have about your loved one starting treatment?

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