

Motivation and Maternal Presence during Induction of Anesthesia

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Background: The authors developed a measure to determine whether maternal motivation to be present during induction (Motivation for Parental Presence during Induction of Anesthesia [MPPIA]) is related to children's anxiety during the induction process.

Methods: Mothers and children (aged 2–12 yr) undergoing outpatient, elective surgery and general anesthesia were enrolled in this study (n = 289 dyads). Items to assess motivation for parental presence during induction were selected by experts in anesthesiology, psychology, and child development; mothers completed the resulting 14-item measure as well as assessments of anxiety and coping style. Children's anxiety and compliance was assessed during induction of anesthesia. Factor analysis was performed, and maternal motivation was then examined against children's anxiety during induction of anesthesia.

Results: Factor analysis resulted in four scales with a total variance of 72.3%: MPPIA-Desire, MPPIA-Hesitancy, MPPIA-Anxiety, and MPPIA-Preparation. Analysis supported the reliability (0.89–0.94) and validity of the MPPIA. The authors found that mothers with high MPPIA-Desire and low MPPIA-Hesitancy had children with significantly higher anxiety ($P < 0.0001$) during induction of anesthesia, as compared with mothers with low MPPIA-Desire and MPPIA-Hesitancy. The authors also found that highly motivated mothers reported significantly higher levels of anxiety ($P = 0.007$).

Conclusion: Clinicians should be aware that many mothers who have a high desire to be present in the operating room are very anxious and that their children are likely to exhibit high anxiety levels during induction of anesthesia.

THE controversy surrounding parental presence during induction of anesthesia (PPIA) has not abated. Previous nonrandomized studies showed that PPIA could reduce children's anxiety during induction of anesthesia,^{1,2} whereas results from randomized controlled trials indicate that parental presence does not reliably reduce children's anxiety.^{3–7} The underlying concept of ran-

domized controlled trials, however, is that parents are randomly assigned to the appropriate study groups regardless of any parental and child preferences or input from the anesthesiologist. Many anesthesiologists indicate that although some children do not benefit from parental presence, other children do exhibit lower levels of anxiety during induction of anesthesia if their parents are present. Therefore, it is important to understand what makes some parents more effective than others in reducing their child's anxiety during induction of anesthesia.

In the course of our research into parental presence, many parents have commented to us regarding their perioperative experience. These comments reflect the tension parents experience as they weigh their anxiety about being in the operating room (OR), their desire to be with their child during induction of anesthesia, and their varying beliefs regarding how necessary or helpful PPIA might be. Based on these comments, we surmised that one dynamic that might explain why PPIA reduces anxiety in some children but not in others is the construct of parental motivation for PPIA. Motivation can be defined as the influence of needs and desires on the direction and intensity of behavior.⁸

We hypothesized that the type of motivation to be present during induction of anesthesia may play an important role in children's anxiety outcomes. That is, parents who are told to be present during induction of anesthesia but are hesitant to do so may be far less effective than those parents who are highly desirous to be with their child during induction of anesthesia. The first step in examining this hypothesis was to develop a valid, reliable measure to examine parental motivation to be present during induction of anesthesia. The next step was to use the newly created measure to determine whether parental motivation for PPIA plays any significant role in children's anxiety during induction of anesthesia.

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Materials and Methods

Phase I: Scale Development

Item Selection. In July 2002, a research team composed of two anesthesiologists and two psychologists began identifying various factors that are related to the construct of motivation for parental presence during induction of anesthesia. The process involved interviews with parents, anesthesiologists, surgeons, and nurses and examining the medical literature. The team further consulted with international experts in child develop-

ment and psychometrically valid techniques for scale development. After this procedure, the team concluded that a parental motivation assessment scale should include items in the areas of parental desire to be present, parents' self-assessed anxiety, parents' beliefs about the potential impact they could have during induction of anesthesia, and beliefs about the relative importance of their child's anxiety, coping skills, and preparation. The team next developed 14 items that reflected these areas.

Before the onset of this study, the team piloted these 14 items with 25 parents of children who underwent anesthesia and surgery. Based on the comments from these parents, the team further revised the 14 specific items. We did not include these 25 parents in any further analyses. We titled the scale Motivation for Parental Presence during Induction of Anesthesia (MPPIA) (appendix).

Scale Validation and Reliability Analysis. The population to which the MPPIA was administered was drawn only from mothers of children who were aged 2-12 yr and were undergoing outpatient, elective surgery and general anesthesia. All mothers in this sample were invited to be present with their child during induction of anesthesia, and no child received sedative premedication. Mothers whose children had developmental delays or who did not speak English were excluded from this study. This study was approved by the Yale University Human Investigation Committee (New Haven, Connecticut).

Mothers were recruited to this study in the preoperative waiting area on the day of surgery. After informed consent, mothers who were enrolled in the study completed a demographic questionnaire, the MPPIA, and the following measures, all of which took approximately 10-15 min to complete.

- The *State-Trait Anxiety Inventory* is a 40-item self-report scale aimed at measuring anxiety in adults. The scale consists of two separate measures, one aimed at measuring situational anxiety and one aimed at measuring baseline anxiety. Total scores for the scale range from 20 to 80; higher scores denote higher levels of anxiety.⁹ The State-Trait Anxiety Inventory has excellent reliability and validity and is considered the accepted standard for state anxiety assessment in adults.⁹
- The *Miller Behavioral Style Scale* assesses parental coping style through scenarios of stressful situations. This measure has excellent reliability and validity.¹⁰
- The *Modified Yale Preoperative Anxiety Scale* is an observation measure of anxiety previously developed by our laboratory. This measure has good reliability and validity when compared with both the State-Trait Anxiety Inventory-Child's version and with cortisol levels.^{11,12} Scores range from 22 to 100; higher scores indicate higher levels of anxiety. This scale was applied to the children at three time points, in the holding area, at arrival in the OR, and at the time of mask induction.

- For the *Visual Analog Scale of Desire to Enter the OR (Desire VAS)*, each mother made a mark across a 10-mm line indicating how much she wanted to enter the OR with her child. The line was anchored by the poles "not at all" and "very much."

Next, mothers and children were brought into the OR. None of the children received sedative premedication. Children were placed on the table, an oxygen saturation probe was placed on the child's hand, and a scented anesthesia mask was introduced. Anesthesia was induced using an oxygen-nitrous oxide-sevoflurane technique. The child's state anxiety (modified Yale Preoperative Anxiety Scale) was evaluated by trained observers after entering the OR and again after introduction of the anesthesia mask. After anesthesia was induced, researchers escorted mothers to a waiting area.

Factor Structure, Reliability, and Validity Analyses. As a first step to examine the MPPIA, we performed principal components factor analysis using SPSS 11.0 (SPSS, Inc., Chicago, IL). This statistical procedure examines correlations between the various scale items and summarizes the various items into meaningful conceptual groups (factors). Thus, the process results in identification of a number of scales, each with a number of the original 14 items. We have calculated each resulting factor's internal consistency, determining overall α levels for the scale as a whole, as well as resulting α levels if any item were removed from the scale.

We next administered the scale at two different time periods to additional mothers ($n = 30$) to calculate test-retest reliability using the Pearson r . Mothers completed the MPPIA after arrival to the hospital for their child's surgery and again approximately 30-45 min later, before their child's induction.

Next, we examined the validity of the MPPIA by correlating MPPIA subscale scores to the Desire VAS. To further examine construct validity, we used t tests to compare mothers who declined PPIA to a matched sample of mothers who did not decline PPIA and examined resulting differences in their MPPIA scale scores, baseline characteristics, and anxiety.

Phase II: The MPPIA as a Predictor of Child's Anxiety

We next examined changes in children's anxiety from the holding room to the OR by repeated-measures analysis of variance (ANOVA) and then examined the impact of differing facets of maternal motivation for PPIA by analyzing MPPIA subscale values and children's state anxiety scores (modified Yale Preoperative Anxiety Scale) as follows. Independent samples t tests were performed on the continuous variables of children's state anxiety, mother's state anxiety (State-Trait Anxiety Inventory), and mother's coping styles (monitoring factor, Miller Behavioral Style Scale) using group factors desire, hesitancy, and belief in preparation and coping skills (in

each case, the group factor was determined by defining the upper and lower 25% of scores on the relevant MPPIA subscale as high and low, respectively). Mothers who were defined as high in desire and low in hesitancy were those who were members of both high-desire and low-hesitancy groups as defined above.

We used independent *t* tests to analyze the relation between MPPIA subscale scores on patient factors such as attendance at the preparation program (group = yes or no), sex (group = male or female), and age (group = younger [aged 2–6.9 yr] or older [aged 7–12 yr]). We used univariate ANOVA to examine the impact of previous surgery on MPPIA subscale scores, controlling for age. We used one-way ANOVA to examine the impact of MPPIA subscale scores on maternal education (groups = 12 yr or fewer, some college, or 16 yr or more). Data are reported as mean \pm SD. Examination of descriptive statistics indicated that MPPIA items were skewed. We therefore normalized the items by subtracting the mean from each individual item and then dividing the difference by the SD. The resulting normalized scores were used in all subsequent analyses. Significance was accepted at $P < 0.05$. Data were analyzed using SPSS 11.0.

Results

A total of 289 mother–child dyads were enrolled in the study, plus an additional 25 mothers who participated in the pilot portion of the study to help create the MPPIA but were not included in any other analyses. Although 281 of the 289 mothers agreed to be present during the induction process and 8 mothers declined to be present during their child's induction of anesthesia, all 289 mother–child dyads completed all questionnaires and measures. Data from mothers who declined to be present during their child's induction of anesthesia were compared to other mothers as part of the concurrent validity analysis. Baseline characteristics of all mother–child dyads are listed in table 1.

Factor Structure

After principal components factor analysis of the original 14 items, one redundant item was deleted. Factor analysis of the resulting 13 items yielded four principal components explaining 72.3% of the total variance. Table 2 shows internal consistency estimates (α) for each of these four components. (See the appendix for a copy of the MPPIA questions.)

Factor I described overall desire to be present during PPIA and accounted for 35% of the total variance. The factor includes items 2, 4, 9, 10, 12, and 13, and was named the MPPIA-Desire subscale.

Factor II described mothers' assessment of the relative importance of anxiety (maternal anxiety and child anxiety) accounted for an additional 16% of the variance. The

Table 1. Baseline Characteristics (n = 289)

Parents	
Age, yr	36.97 \pm 5.3
Sex, F/M, %	100/0
Trait Anxiety (STAI)	39.3 \pm 6.3
State Anxiety-Holding (STAI)	42.5 \pm 10.4
Coping style (MBSS)	8.3 \pm 3.3
Children	
Age, yr	5 \pm 3.3
Ethnicity, % white	77
Sex, F/M, %	37/63
Previous surgery, yes/no, %	33/67
Temperament (EASI)	
Emotionality	11.0 \pm 3.9
Activity	16.3 \pm 4.2
Sociability	18.5 \pm 2.6
Impulsivity	13.0 \pm 3.8
Previous medical experiences (VAS)	81.4 \pm 20.8
State Anxiety-Holding (mYPAS)	38.9 \pm 18.3
State Anxiety-Induction2 (mYPAS)	58.9 \pm 28.7
Voluntary preparation program, yes/no, %	25/75

Data are presented as mean \pm SD.

EASI = EASI Temperament scale; Holding = mYPAS measurement taken in the preoperative holding area; Induction2 = mYPAS measurement taken upon introduction of the anesthesia mask; MBSS = Miller Behavioral Style Scale (score indicates monitoring value; higher scores indicate a monitoring coping style as opposed to blunting); mYPAS = Modified Yale Preoperative Anxiety Scale; STAI = Spielberger State-Trait Anxiety Inventory; VAS = visual analog scale measuring how well child handled previous medical visits.

factor includes items 1, 6, and 7 and was named the MPPIA-Anxiety Impact subscale.

Factor III described parental hesitancy regarding PPIA and accounted for a further 12% of the variance. The factor includes items 8 and 11 and was named the MPPIA-Hesitancy subscale.

Factor IV described mothers' assessment of the relative importance of their children's preparation for induction of anesthesia and accounted for an additional 9% of the variance. The factor includes items 3 and 5 and was named the MPPIA-Preparation Impact subscale.

Reliability Analysis

The MPPIA showed excellent test-retest reliability estimates (Pearson *r*) for each of the MMPIA subscales:

Table 2. Psychometric Properties of the MMPIA Subscales

	No. of Items	Variance*, %	α	Test–Retest (<i>r</i>)
Scale 1: MPPIA-Desire	6	35	0.90	0.94
Scale 2: MPPIA-Anxiety Impact	3	16	0.72	0.90
Scale 3: MPPIA-Hesitancy	2	12	0.69	0.92
Scale 4: MPPIA-Preparation	2	9	0.65	0.89

* Proportion of the overall variance accounted for by this scale.

MPPIA = Motivation for Parental Presence during Induction of Anesthesia; MPPIA-Anxiety Impact = parent's assessment of how important anxiety is in creating a calm induction; MPPIA-Desire = parent's expressed desire to be present during induction; MPPIA-Hesitancy = parent's expressed hesitancy to be present during induction; MPPIA-Preparation Impact = parent's assessment of how important the child's preparation and coping skills are in creating a calm induction.

MPPIA-Desire = 0.943, MPPIA-Anxiety Impact = 0.901, MPPIA-Hesitancy = 0.924, MPPIA-Preparation Impact = 0.894.

Validity Analysis

To assess validity, we compared the MPPIA-Desire subscale to the VAS assessment asking the mother how much she wanted to enter the OR (Desire VAS). Desire VAS scale scores correlated highly with MPPIA-Desire subscale ($r = 0.634$) and showed much lower correlations to the other subscales (MPPIA Anxiety, $r = 0.146$; MPPIA-Preparation Impact, $r = 0.025$; MPPIA-Hesitancy, $r = 0.189$), supporting concurrent validity with the MPPIA-Desire subscale and divergent validity with the other MPPIA subscales. We also found that mothers who declined being present at their child's induction also scored significantly lower on the MPPIA-Desire subscale ($P = 0.000$) and showed significantly higher levels of hesitancy on the MPPIA-Hesitancy subscale ($P = 0.033$); such results give strong support to convergent validity of these two subscales of the MPPIA.

Phase II: The MPPIA as a Predictor of Child's Anxiety

As expected, anxiety of the child increased significantly between preoperative holding area, entrance to the OR, and introduction of anesthesia mask ($F_{1,286} = 134.7, P = 0.0001$), and age significantly affected anxiety levels because younger children were more anxious when compared with older children ($F_{1,286} = 37.9, P = 0.0001$).

We first examined children's preoperative state anxiety as it related to mothers' MPPIA subscale scores. Independent t tests showed that children of mothers with higher desire to enter the OR (MPPIA-Desire subscale) were significantly *more* anxious during induction of anesthesia ($P = 0.006$), and children of mothers with higher hesitancy to enter the OR (MPPIA-Hesitancy subscale) were *less* anxious ($P = 0.034$). Children of mothers who reported high belief in the importance of preparation and coping skills (MPPIA-Preparation Impact subscale) were significantly less anxious not only during induction of anesthesia ($P = 0.0001$) but also in the preoperative waiting area ($P = 0.016$). Children of mothers who reported a strong belief that anxiety levels determine a calm induction (MPPIA-Anxiety Impact subscale) were no different in anxiety during induction of anesthesia than other children ($P = 0.479$) (table 3).

We next identified a group of mothers who had reported both high levels of desire to enter the OR and low hesitancy (group A) and compared their children to the children of a group of mothers who had reported low levels of desire to enter the OR and high hesitancy (group B). Independent t tests showed that the children of mothers in group B were significantly *less* anxious during induction of anesthesia than were children of mothers in group A (51.4 ± 28.8 vs. 64.8 ± 28.8 , re-

Table 3. Children's Anxiety Scores during Induction of Anesthesia as a Function of Whether Parental MPPIA Subscale Scores Were Low (Lowest 25%) or High (Upper 25%)

MPPIA Subscales	Child's Anxiety Score (mYPAS), MPPIA Subscale Grouping		P Value
	Low	High	
MPPIA-Desire	51.5 \pm 28.5*	64.5 \pm 28.4	0.006
MPPIA-Anxiety Impact	57.3 \pm 28.4	60.6 \pm 28.2	0.479
MPPIA-Hesitancy	62.8 \pm 30.9	51.8 \pm 27.3	0.034
MPPIA-Preparation Impact	69.2 \pm 28.9	51.5 \pm 26.2	0.000

* For example, this score represents the Modified Yale Preoperative Anxiety Scale (mYPAS; state anxiety during induction of anesthesia) score for children whose parents scored in the lowest 25% on the Motivation for Parental Presence during Induction of Anesthesia (MPPIA) Desire subscale (denoting parent's expressed desire to be present during induction).

MPPIA-Anxiety Impact = parent's assessment of how important anxiety is in creating a calm induction; MPPIA-Hesitancy = parent's expressed hesitancy to be present during induction; MPPIA-Preparation Impact = parent's assessment of how important the child's preparation and coping skills are in creating a calm induction.

spectively; $P = 0.02$). This relation held true for both older (aged 7-12 yr or older) and younger (aged 2-6.9 yr or younger) children.

We next examined the relation between mothers' state anxiety and coping style and the MPPIA subscales. We found that mothers with high desire for PPIA (MPPIA-Desire subscale) self-reported significantly more anxiety (State-Trait Anxiety Inventory) themselves as compared with mothers with lower desire for PPIA (44.4 ± 10.6 vs. 39.8 ± 9.7 ; $P = 0.007$). Similarly, mothers with lower hesitancy (MPPIA-Hesitancy subscale) reported more anxiety than mothers with higher hesitancy (46.2 ± 9.9 vs. 39.2 ± 9.7 ; $P = 0.0001$). Finally, mothers with predominately monitoring coping styles (Miller Behavioral Style Scale) showed significantly less hesitancy (MPPIA-Hesitancy subscale) to enter the OR ($P = 0.042$).

We wanted to determine whether MPPIA subscale scores were similar across patient-related factors such as attendance at the voluntary hospital preparation program, presence or absence of a previous surgery, sex, level of parental education, and child's age. Independent t tests showed that MPPIA subscale scores did not differ based on attendance at the voluntary hospital preparation program (P values ranged from 0.20 to 0.69 for all four subscales). Similarly, univariate ANOVA showed that MPPIA subscale scores of mothers with children who had undergone a previous surgery did not differ as compared with mothers of children who had not undergone a previous surgery, when controlling for age (P values range from 0.14 to 0.61). However, mothers of girls reported a significantly higher desire to enter the OR (MPPIA-Desire subscale) than did mothers of boys ($P = 0.036$). When education was entered as a variable, one-way ANOVA with *post hoc* analysis showed that the more years of education a mother had, the more likely the mother was to believe that the level of anxiety and

upset that a mother and child was experiencing was important in determining how calm and cooperative the child could be during induction of anesthesia (MPPIA-Anxiety Impact subscale; $P = 0.0001$). Mothers with older children reported significantly higher levels of belief in the value of preparation and coping skills ($P = 0.0001$) and significantly less desire for PPIA ($P = 0.028$), but age had no impact on maternal belief in the impact of anxiety (MPPIA-Anxiety Impact subscale; $P = 0.80$) or maternal hesitancy for PPIA (MPPIA-Hesitancy subscale; $P = 0.28$).

Discussion

After extensive statistical procedures, factor analysis resulted in four scales describing desire, hesitancy, assessment of the importance of anxiety, and assessment of the importance of children's preparation for induction of anesthesia. We found that children of mothers who are highly motivated (high desire and low hesitancy) to enter the OR were *more* anxious as compared with children whose mothers were less motivated to enter the OR. Also, the group of mothers who was highly desirous to enter the OR reported higher state anxiety. This finding surprised the investigative team because we initially hypothesized that children of parents who are highly desirous to enter the OR would be less anxious. Our findings can be explained by at least three mechanisms. First, some mothers who are anxious may have a high desire to enter the OR as a means of managing their own anxiety. However, anxiety felt by parents is also noted by their children, and children often respond to anxious parents by becoming more anxious themselves.¹³ Second, some mothers may have been less desirous for PPIA because they were more confident in their child's preparation and coping skills. In contrast, mothers who wanted to enter the OR did so because they knew their child needed help; however, in the OR, these mothers were unable to effectively decrease their child's anxiety (perhaps because of their own increased anxiety). Third, we also found that mothers of girls showed more desire for PPIA than mothers of boys, and that mothers of older children valued preparation and coping skills more than mothers of younger children. We surmise that mothers of younger children probably believe that preparation and coping skills are less relevant because of the young age and developmental status of their child.

Although it is clear from comments that many mothers very much want to be present during induction of anesthesia, it is also clear that maternal anxiety can affect not only the mother's motivation for PPIA but also the mother's ability to be an effective help to her child.¹³ It may also be that some mothers were more motivated to be present in the OR as primarily a means of managing their own anxiety or as a result of their own coping style. That is, mothers with predominately monitoring coping styles

and with high state anxiety showed less hesitancy and more desire for PPIA. Such mothers may be motivated for PPIA as a means of being present so that they could see that their child was all right and could thus better tolerate their own anxiety, rather than being present as a means of helping their child. It is also important to note that the relation between parental and child anxiety is not unidirectional. That is, the design of this study does not support a cause-effect attribution between maternal anxiety and child anxiety; highly anxious mothers may increase their children's anxiety, and highly anxious children may increase their mothers' anxiety.

We have recently demonstrated that when parents have a choice, the majority elect to remain with their child during induction of anesthesia, regardless of their previous experiences with other, more effective means of reducing their child's anxiety, such as sedative premedication.¹⁴ However, despite their relatively uniform decision to be present, parents vary in how comfortable they feel during PPIA and how hesitant they are about this technique. Therefore, as applied to parental presence in the OR, motivation is indeed a multifaceted and complex construct that goes beyond simple assessments of parental desire to be in the OR with their child, incorporating also the inconsistency in parents' feelings about PPIA and their varying beliefs about the meanings of their interactions with their child during PPIA.

It is also important to note that all parents in this study were mothers. Previous studies have established that women generally report higher levels of reactivity and anxiety to stressors than do men, and in the context of children with cancer, mothers report more anxiety than fathers.¹⁵⁻¹⁷ In a previous study, we found that mothers reported higher anxiety as measured by self-report but that there were no differences between fathers' and mothers' physiologic indicators of anxiety (*e.g.*, heart rate and skin conductance response).¹⁸ Future studies should examine differences in maternal and paternal MPPIA responses and children's anxiety.

Finally, interventions that prepare parents for PPIA may decrease parents' anxiety as well as help them to be more effective aids to their children. We are currently engaged in several projects that study this issue. The current study found that mothers who valued preparation and coping had children who were significantly less anxious during induction of anesthesia; in addition, these mothers were also significantly less anxious themselves, compared with mothers who did not value preparation and coping. Such results underscore the importance of educating parents about the value of preparation and coping skills as well as providing such preparation. Of note is that these data were collected on mother-child dyads only; therefore, the conclusions drawn in this manuscript apply to mothers.

In conclusion, we found that children of mothers who presented with high levels of motivation to be present

during induction of anesthesia were *more anxious* as compared with children whose mothers were less motivated to be in the OR. Clinicians should be aware that many mothers who have a high desire to be present in the OR are in fact quite anxious and that their children are likely to exhibit high anxiety levels during induction of anesthesia.

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Appendix: Motivation for Parental Presence during Induction of Anesthesia

Part I: How important do you think each of the following factors will be in determining how calm and cooperative your child will be during induction of anesthesia ("going to sleep")? For each item, circle the number that best represents how much you think these things will affect your child's cooperation and calmness during anesthesia induction.

1. Your child's level of fear or anxiety

0	1	2	3	4	5	6	7
No effect at all							Extremely important

2. Your presence during the induction

0	1	2	3	4	5	6	7
No effect at all							Extremely important

3. Your child's preparation and education about anesthesia

0	1	2	3	4	5	6	7
No effect at all							Extremely important

4. Your being able to hold and touch your child during induction

0	1	2	3	4	5	6	7
No effect at all							Extremely important

5. Your child's coping skills

0	1	2	3	4	5	6	7
No effect at all							Extremely important

6. The amount of anxiety that you feel

0	1	2	3	4	5	6	7
No effect at all							Extremely important

7. How upset you may become during anesthesia induction

0	1	2	3	4	5	6	7
No effect at all							Extremely important

Part II: Please rate the following items. For each item, circle the number that best represents how you feel.

8. How hesitant are you to be in the OR while your child goes to sleep?

0	1	2	3	4	5	6	7
Not hesitant at all							Extremely hesitant

9. How confident are you that your presence will be helpful to your child as he or she goes to sleep?

0	1	2	3	4	5	6	7
Not at all							Extremely confident

10. How strongly do you want to be in the OR while your child goes to sleep?

0	1	2	3	4	5	6	7
Not at all							Extremely strongly

11. How much uncontrollable anxiety do you think you will feel while in the OR?

0	1	2	3	4	5	6	7
None at all							Extreme amounts

12. How confident are you that you will be able to help your child stay calmer in the OR?

0	1	2	3	4	5	6	7
No effect at all							Extremely confident

13. How important is it to you to be in the OR while your child goes to sleep?

0	1	2	3	4	5	6	7
Not important at all							Extremely important

Deleted item (from part D):

14. Your not being present during the induction

0	1	2	3	4	5	6	7
No effect at all							Extremely important