Deconstructing children's expectations for psychotherapy: Understanding how parents prepare their children for mental health treatment

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Deconstructing Children’s Expectations for Psychotherapy:
Understanding How Parents Prepare Their Children
for Mental Health Treatment

by
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Dissertation

Submitted to the Department of Psychology
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Abstract

Little research has investigated the effects of stigma on child psychotherapy. Because parents are a primary factor in determining whether children receive psychotherapy and how therapy progresses, understanding how parental perceptions of psychopathology and psychotherapy are associated with children’s mental health treatment seems to be an important step in investigating how stigma impacts child psychotherapy. Researchers have not closely examined, however, how parents might influence children’s experiences of psychotherapy. To address this topic, the current study examined how parents’ views of psychotherapy were related to how they prepared their children for psychotherapy and how this preparation was related to children’s views of psychotherapy. Primary hypotheses were that parental views would be positively related to children’s views and that preparation would mediate the relationship between parental views and children’s views. Participants were 49 parent-child dyads with a child (aged 9-14 years) who was scheduled for his or her first therapy session. According to results, parent and child views of therapy were not significantly related in this sample, and parents’ views about therapy were not significantly related to the preparation that they provided to their children. Support was provided, however, for the idea that how parents prepare their children for therapy could be related to children’s views about therapy. Data also were useful in providing an idea of how parents prepare their children for therapy and how parents and children experience the first therapy session. The implications of these results, limitations of the present study, and directions for future research are discussed.
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Introduction

Little research has investigated the effects of stigma on child psychotherapy. Because parents typically seek mental health treatment for their children, are a primary factor in maintaining treatment adherence, and frequently participate in the treatment, understanding how parental perceptions of psychopathology and psychotherapy are associated with children’s mental health treatment seems to be an important step in investigating how stigma impacts child psychotherapy. Presumably, parents’ views could impact whether they seek mental health treatment for their children and how treatment progresses. Furthermore, parents could influence how children themselves experience treatment.

Researchers have not examined, however, how parents might influence children’s knowledge and attitudes regarding psychotherapy. To address this topic, the current study examined how parents’ views of psychotherapy were related to how they prepared their children for psychotherapy and how this preparation was related to children’s views of psychotherapy. Ultimately, better understanding this process could direct efforts to reduce barriers to families seeking, participating in, and benefiting from treatment. First, a review of empirical findings concerning knowledge and attitudes regarding mental illness and psychotherapy will be provided to illustrate the significance of this topic.
Views of Psychopathology

Various investigators have examined people’s views of mental illness and differences in those views depending on the disorder that is being studied, the developmental level of respondents, and respondents’ own experiences with mental illness. The literature often differentiates between knowledge of mental illness and attitudes toward mental illness. Studies investigating knowledge of mental illness typically address whether people know what mental illness is and what their explanations for mental illness are. Attitudinal studies examine how individuals perceive people with mental illness.

**Relationship between knowledge and attitudes.** Although knowledge and attitudes regarding mental illness are often studied separately, the two constructs are highly related. A person’s level of knowledge and, in particular, attributions about mental illness are related to his or her attitudes. Some studies have noted that the more correct knowledge that participants had of mental illness, the more positive their attitudes were toward mental illness (Bekle, 2004; Lopez, 1991). Additionally, efforts to improve attitudes by providing educational programs to increase knowledge about mental illness have been successful with adults (Cleary, Hunt, Malins, Matheson, & Escott, 2009; Corrigan & Gelb, 2006; Crisp, Cowan, & Hart, 2004; Lucksted et al., 2011; Ritterfeld & Jin, 2006) and children (Sakellari, Leino-Kilpi, & Kalokerinou-Anagnostopoulou, 2011; Watson, Otey, Westbrook, & Gardner, 2004). In 2008, Kerby, Calton, Dimambro, Flood, and Glazebrook found that medical students’ attitudes toward mental illness improved immediately after viewing two anti-stigma films but that the benefits had decreased eight weeks after viewing the films. Similarly, in another study, a single education session did
not impact undergraduate students’ attitudes toward mental illness (Roberts, Wiskin, & Roalfe, 2008). These two studies suggest a possible need for ongoing education to develop and/or maintain changes in attitude.

The bulk of the literature examining the impact of knowledge on attitudes has supported an attribution theory of attitudes toward mental illness (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Weiner, 1985); people’s attributions with regard to mental illness are seen as a critical factor in determining their attitudes (Corrigan et al., 2003; Phelan, Cruz-Rojas, & Reiff, 2002; Read & Law, 1999; Rusch, Todd, Bodenhausen, & Corrigan, 2009; Walker & Read, 2002). The majority of these studies suggest that a belief in biological causes or internal causes (e.g., lack of motivation) of mental illness is related to negative attitudes. The expressed emotion (EE) literature has consistently demonstrated that family members with high levels of criticality and hostility toward the identified patient tend to attribute symptoms to causes internal to and controllable by the patient (Barrowclough & Hooley, 2003; Barrowclough, Johnston, & Tarrier, 1994; Hooley & Campbell, 2002; Hooley & Licht, 1997; Weisman, Lopez, Karno, & Jenkins, 1993).

Although knowledge and attitudes are often investigated separately and are presented separately in the current paper, their close relationship both conceptually and empirically should be remembered when examining research on views of mental illness.

**Knowledge and attitudes of the general population.** Most commonly, research investigating people’s views of mental illness has been conducted with people from the general population. Several studies are available to provide insight into what the public knows about mental illness and what their attitudes are toward people with mental illness.
Knowledge of adults in the general population. Studies of adults’ knowledge of mental illness suggest that most adults have some knowledge of mental illness but also hold some misperceptions. The majority of studies of adults’ knowledge of mental illness have focused on knowledge of specific disorders, but the General Social Survey (a large representative survey of adults from the general population) examines adults’ knowledge of mental illness more broadly. When adults were asked to define mental illness for the 1996 survey, 34.9% of responses included a reference to psychosis, 34.3% of responses included anxiety and/or mood problems, 15.5% of responses referred to social deviance, 13.8% of responses mentioned cognitive impairment, and 20.1% of responses included a reference to non-specific psychological problems such as a “nervous breakdown” (Phelan, Link, Stueve, & Pescosolido, 2000). These results suggest that the public holds diverse ideas of what mental illness is and may be most likely to identify certain symptoms or disorders (e.g., psychotic, anxiety, and mood disorders) as mental illness.

As mentioned, the majority of studies of adults’ knowledge of mental illness have focused on specific disorders. In particular, schizophrenia has received considerable attention. Link, Phelan, Bresnahan, Stueve, and Pescosolido (1999) found that when the public was presented with a vignette describing a person with schizophrenia, 88% of respondents labeled the person in the vignette as having a mental illness, and 85% of the sample responded correctly when asked if the person was likely to have schizophrenia. Despite this indication that the public is familiar with the symptoms of schizophrenia, the most common belief that participants in another study had about schizophrenia was that it involves having a “split personality” (Furnham & Rees, 1988). Research also suggests that people do not expect symptoms of schizophrenia to change or improve over time.
(Corrigan et al., 2000; Furnham, 2009). Data indicate that the public attributes schizophrenia to a variety of causes, including biological causes (Furnham, 2009; Link et al., 1999; Martin, Pescosolido, & Tuch, 2000), psychosocial factors such as stress and family conflicts (Furnham & Rees, 1988; Link et al., 1999; Martin et al., 2000; Wahl, 1987), and personal characteristics of the patient (Corrigan et al., 2000). Participants in a study by Crisp, Gelder, Rix, Meltzer, and Rowlands (2000) believed that people with schizophrenia are not to blame for their disorder.

Studies also have investigated adults’ knowledge of depression. The Link et al. (1999) study revealed that 69% of people labeled a vignette character who met DSM-IV-TR (American Psychiatric Association, 2000) criteria for Major Depressive Disorder as having a mental illness, with 95% of the sample responding in the affirmative when asked if the person was likely to have depression. Studies also suggest that adults believe that people with depression are likely to recover from their disorder or experience remission (Corrigan et al., 2000; Furnham, 2009). The general population tends to regard depression, like schizophrenia, as having a variety of possible causes, with both biological causes and stress being commonly proposed etiologies (Furnham, 2009; Link et al., 1999; Martin et al., 2000).

Data also are available regarding people’s knowledge of substance-related disorders. In the Link et al. (1999) study, 49% of people labeled alcohol dependence as a mental illness, and 44% of the sample designated cocaine dependence as a mental illness. When asked whether vignette characters with DSM-IV-TR (2000) symptoms of Alcohol Dependence and Cocaine Dependence were likely to have these disorders, 98% of participants and 97% of participants, respectively, stated that the characters were likely to
have the disorders. Approximately one fifth of respondents to the 1996 General Social Survey cited biological causes as a possible source of drug dependence, but the majority of people linked alcohol and drug dependence to non-biological causes, especially stress (Martin et al., 2000). Another commonly proposed cause for alcohol dependence was how the person was raised, though cocaine dependence often was notably attributed to the person’s “bad character” (Link et al., 1999; Martin et al., 2000). Samples from other studies believed that substance problems are self-inflicted (Crisp et al., 2000) and controllable (Corrigan et al., 2000).

As described above, individuals’ knowledge of mental illness is directly related to their attitudes. Because some people have little understanding of mental illness and the symptoms of certain disorders, their attitudes would be expected to be correspondingly negative. Similarly, because some people attribute internal causes to disorders, attribution theory suggests that these people will have relatively negative attitudes toward these disorders (Corrigan et al., 2003; Phelan, Cruz-Rojas, & Reiff, 2002; Read & Law, 1999; Rusch, Todd, Bodenhausen, & Corrigan, 2009; Walker & Read, 2002). Of course, internal causes are likely to contribute to mental illness, but a focus on internal causes to the exclusion of other psychosocial factors could lead to negative attitudes. Accordingly, the data on attitudes toward mental illness suggest that people often do hold negative attitudes regarding mental illness.

Attitudes of adults in the general population. Hayward and Bright (1997) reviewed research from the 1950s and 1960s, concluding that at that time, studies supported the idea that the public “feared and disliked the mentally ill, and wished to avoid them at all costs” (p. 346). More recent research suggests that adults continue to
exhibit a variety of negative attitudes toward people with mental illness. While some of these beliefs might be formed upon some element of truth, they usually exaggerate and overgeneralize negative aspects of mental illness, and some are complete misperceptions (Crisp et al., 2004; Hayward & Bright, 1997). One of the most commonly demonstrated sets of beliefs is that people with mental illness are unpredictable, dangerous, and violent (Crisp et al., 2000; Link et al., 1999; Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999; Read & Law, 1999). Crisp et al. (2004; 2000) found that participants thought that talking to a person with mental illness is difficult. Studies also suggest that people prefer to maintain social distance from people with mental illness, as expressed through negative attitudes toward being romantically involved with, living next to, spending an evening socializing with, making friends with, or working closely with someone with a mental illness (Link et al., 1999; Read & Law, 1999). Pescosolido et al. found that adults believed that people with a mental illness are not as able to manage personal matters such as finances as are other people. In contrast to the majority of findings, Read and Law reported that their sample rated people with mental illness, on average, as caring and intelligent.

A few studies have investigated attitudes regarding mental illness over time. Schomerus et al. (2012) examined studies on mental illness-related beliefs and attitudes and found no changes, or even changes for the worse, over time regarding attitudes toward people with mental illness. When Mossakowski, Kaplan, and Hill (2012) compared data from the 1996 and 2006 General Social Surveys, they found small but significant changes indicating that the public’s preferences for social distance and perceptions that people with mental illness are dangerous to themselves and to others
diminished somewhat from 1996 to 2006. Also comparing the 1996 and 2006 General Social Surveys, Payton and Thoits (2011) did not find changes in the public’s attitudes over time with regard to depression and schizophrenia.

Adults’ attitudes toward mental illness do appear to vary by disorder. People with schizophrenia tend to be viewed more negatively (Crisp et al., 2000; Pescosolido et al., 1999) and as more violent, dangerous, and unpredictable (Furnham & Rees, 1988; Martin et al., 2000; Pescosolido et al., 1999; Phelan et al., 2000) than people with other disorders. Another related belief that people hold is that individuals with schizophrenia are dangerous to themselves (Pescosolido et al., 1999). Pescosolido et al. reported that the majority of adults believe that people with schizophrenia are unable to manage their own money or treatment decisions. Mossakowski et al. (2012) found that people believe that individuals with schizophrenia should be forced to take psychiatric medications by law more than they believe that individuals with other disorders should.

Attitudes toward people with alcohol or drug dependence also tend to be more negative than attitudes toward other disorders are (Corrigan, Kuwabara, & O’Shaughnessy, 2009; Crisp et al., 2000; Pescosolido et al., 1999). The public tends to believe that people with substance dependence are violent, dangerous, and prone to self-harm (Crisp et al., 2000; Martin et al., 2000; Pescosolido et al., 1999). According to Pescosolido et al., roughly half of adults think that people with alcohol dependence are competent to make decisions about their own money and treatment, and the majority of adults do not think that people with drug problems can handle decisions regarding their own treatment and money.
Data from Pescosolido et al. (1999) also provide information about people’s attitudes toward depression. The majority of participants did not think that people with depression are dangerous to others, but 33% of the sample did support this view. Additionally, 75% of respondents believed that someone with depression is likely to hurt himself/herself. Although participants had more faith in the ability of people with depression to handle treatment and financial decisions than in the ability of people with schizophrenia or substance dependence, one third of the sample still believed that people with depression are incapable in these areas.

As mentioned previously, some of the public’s negative attitudes regarding mental illness are based on some element of truth. Mental illness does impact people’s functioning and can influence abilities in areas such as managing treatment, money, and so on. Court-ordering someone to take psychotropic medication or determining that someone needs assistance making decisions may be appropriate in certain cases. Negative attitudes can neglect the fact, however, that the amount of impairment greatly varies by disorder and by individual and can vary throughout the course of a person’s life. Also, negative attitudes often overgeneralize negative aspects of mental illness. For example, a significant association between schizophrenia and violence is suggested by the literature. However, the association is small, people with schizophrenia are not usually violent, and less than 10% of violent crimes are committed by people with schizophrenia (Walsh, Buchanan, & Fahy, 2002).

**Knowledge of children in the general population.** A series of studies have been conducted that investigate children’s knowledge of mental illness, and unlike the adult literature, the majority of the child literature focuses on mental illness in general rather
than on specific diagnoses, as it is presumed that children may not be able to discern such differences. The studies suggest that children, like adults, have some knowledge of mental illness but also hold some misperceptions in certain areas.

Bailey (1999) found that children (ages 11-17 years) in their sample believed that anyone could have a mental illness. Hoffman, Marsden, and Kalter (1977) noted that fourth- and sixth-grade students in their study were able to recognize that the central figures in vignettes depicting various types of disorders were experiencing varying levels of symptom severity. Conant and Budoff (1983) found that children were less knowledgeable about mental illness than they were about physical illness and mental retardation, perhaps as a function of their likely exposure to these other types of impairments. Middle school students in a study by Watson et al. (2004) labeled mental illness as a problem in the brain but had limited knowledge of mental illness in general. Several researchers report that children tend to think of mental illness as a problem that males rather than females experience (Poster, Betz, McKenna, & Mossar, 1986; Roberts, Biedleman, & Wurtele, 1981; Roberts, Johnson, & Biedleman, 1984). Secker, Armstrong, and Hill (1999) concluded that the 12- and 14-year-olds in their study tended to label behavior as mental illness if they could not relate to the behavior but did not label behavior as mental illness if they knew the behavior from their own experiences. Similarly, Spitzer and Cameron (1995) found that first-, fourth-, and seventh-grade students saw deviant adults as having a mental illness whereas deviant children were viewed as just violating social norms.

Like adults, children offer a variety of explanations for the etiology of psychopathology, including biological and psychosocial explanations. In the study by
Bailey (1999), children hypothesized an average of three causes of mental illness. Predominant causes that have been cited by children include genetics, innate aggressive tendencies, stress, media exposure, and “bad childhood”/abuse (Bailey, 1999; Norman & Malla, 1983; Roberts et al., 1981). Children also have reported beliefs that mental illness can be avoided through self-control (Roberts et al., 1984) and that people with mental illness are able to change (Maas, Marecek, & Travers, 1978).

The majority of research examining children’s knowledge of mental illness has studied knowledge of mental illness in general, but Secker et al. (1999) examined knowledge of specific disorders. They presented children with vignettes of children who exhibited symptoms of a behavior problem, depression, anorexia, or schizophrenia. They found that the children viewed the child in the behavior problem vignette as “normal” and not exhibiting mental illness. Depression also was not seen as a mental illness, although children were able to identify the vignette as someone who had depression. Anorexia was also identified in the vignette, and the majority of children identified it as a “psychological” or “mental” problem but denied that it was mental illness. Schizophrenia, which children also were able to identify in the vignette, was the only clinical presentation labeled as a mental illness.

Wahl (2002) concluded in his literature review of children’s views of mental illness that age differences exist in children’s knowledge of mental illness. Specifically, young children do not have a clear understanding of mental illness, but understanding increases with age. For example, with age, children become more likely to differentiate mental illness from other illnesses (Weiss, 1985) and to see psychological problems as involving emotions and cognitions (Dollinger, Thelen, & Walsh, 1980). Maas et al.
(1978) found that as children aged, they increasingly attributed mental illness to psychosocial causes, listed more causes for mental illness, and became more capable of differentiating between different types of disorders. When Spitzer and Cameron (1995) interviewed first-, fourth-, and seventh-grade students, all first-grade students were unfamiliar with the term *mental illness* and could only describe it as being very physically sick. Fourth-grade students still tended to define mental illness as being physically sick but specified being sick in the head or brain. Seventh-grade students most often defined *mental illness* as thinking problems, mental retardation, and “craziness.” In another study in which first-, fourth-, seventh-, and eleventh-grade students were asked to talk about two vignette characters exhibiting psychological symptoms (Coie and Pennington, 1976), the eleventh-grade students were the only ones to use language referring to psychological disorders (e.g., “mental problems,” “emotional problems”). The first-grade students tended to normalize the behavior of the vignette characters, children in the middle recognized that the characters exhibited “different” behavior but reverted to normalizing the behavior, and the older children struggled with the irrationality of the characters’ behavior and tried to deal with it rather than normalizing it. One other finding by Coie and Pennington was that, with increasing age, children became more likely to see distortions of reality as deviant behavior. Note that the available studies in this area are dated and do not provide recent information about children’s knowledge of mental illness and how it relates to age.

Although children’s knowledge of mental illness may increase with age, children overall lack complete information regarding mental illness and sometimes over-attribute internal causes to disorders. Considering the relationship between knowledge and
attitudes concerning mental illness, findings suggest that children would be likely to have negative attitudes toward mental illness. Research on children’s attitudes toward mental illness supports this suggestion.

**Attitudes of children in the general population.** In his review of the literature, Wahl (2002) concluded that children of all ages exhibit negative attitudes toward individuals with mental illness. Several studies support this conclusion. For example, the finding that children and adolescents perceive people with mental illness more negatively than they perceive people with physical disabilities/illnesses or with no disabilities has been widely documented (Adler & Wahl, 1998; Corrigan et al., 2005; Weiss, 1994; Weiss, 1986; Wilkins & Velicer, 1980). Studies also suggest that children perceive other children with mental illness to be unattractive as potential friends (Roberts et al., 1984; Royal & Roberts, 1987). Studies by Poster et al. (1986) and Watson, Miller, and Lyons (2005) indicate that children and adolescents share the perception with adults that people with mental illness are potentially dangerous to themselves and others. Norman and Malla (1983) found that adolescents preferred more social distance from people whom they perceived to be mentally ill than from others.

A few studies offer some hope when considering children’s attitudes toward mental illness. For example, in her sample of high school students, Lopez (1991) found that the majority of adolescents were socially accepting of people with mental illness in situations in which little personal contact is required (e.g., having a neighbor with mental illness), although the level of social acceptance decreased as proposed level of personal involvement increased (e.g., being related by marriage to an individual with mental illness). Secker et al. (1999) discovered that when 12- and 14-year-olds could identify
with a person portrayed in a vignette, they felt sympathy for the person. In a study by Watson et al. (2004), middle school students did not have negative attitudes toward mental illness overall. For example, they believed that people with mental illness can learn and participate in normal activities.

Some of the literature also has examined children’s attitudes toward specific psychological disorders. A common finding among researchers is that children perceive other children with antisocial, aggressive behavior more negatively than they perceive children with problems like anxiety or depression (Marsden, Kalter, Plunkett, & Barr-Brossman, 1977; Roberts et al., 1981; Secker et al., 1999). Secker et al. and Marsden et al. found that children were more fearful of and were less socially accepting of people with schizophrenia than they were of people with other disorders. Secker et al. also reported that children had no fear of people with depression or anorexia.

Recall that the literature regarding children’s knowledge of mental illness, although dated, suggests that children become increasingly knowledgeable with age; such a trend is not clear regarding children’s attitudes regarding mental illness. Data on developmental trends in attitudes toward mental illness are inconclusive. For example, when Royal and Roberts (1987) examined the attitudes of students in 3rd, 6th, 9th, and 12th grades and the attitudes of college students, they found that 3rd-grade students were more socially accepting of people with mental illness than 9th-grade and college students were. Weiss (1985), on the other hand, found that 2nd grade students had less positive attitudes than 4th, 6th, and 8th grade students did. Other studies have found no change in attitudes with age (Lopez, 1991; Weiss, 1994; Wilkins & Velicer, 1980).
Knowledge and attitudes of people who have experienced their own mental illness. Given their direct experience with psychological disorders, do people with mental illness differ from the general population in terms of their knowledge and attitudes regarding mental illness? Findings indicate that the perceptions of people who have experienced their own mental illness are similar to the general population’s views in some regards but quite different in others.

Knowledge of mental illness in adults who have experienced their own mental illness. Concerning adults’ knowledge of their own mental illness, the literature focuses on the level of insight that people have. Although insight has several definitions, a definition that is widely accepted and is used here involves a patient’s awareness of symptoms, illness-related consequences, and need for treatment (Goldberg, Green-Paden, Lehman, & Gold, 2001). Some studies have shown that individuals with schizophrenia and bipolar disorder possess lower levels of insight than people with schizoaffective disorder or depression with psychotic features possess (Goldberg et al., 2001; Pini, Cassano, Dell’Osso, & Amador, 2001). Debate exists regarding whether insight is related to severity of symptoms (Goldberg et al., 2001; McEvoy, Apperson, Appelbaum, & Ortlip, 1989) and whether it is a reflection of the disorder itself or a product of social factors (Goldberg et al., 2001).

Studies also have examined adults’ explanations for their own mental illness. Like the general population, adults with mental illness attribute psychological problems to a variety of causes. Interviewees who had recently begun treatment at a Community Mental Health center provided various, multiple explanations for their current problems. Biological, social, internal, and external attributions were all given, although external
social explanations were most common (Williams & Healy, 2001). Nathan, Wylie, and Marsella (2001) found that people with severe mental illness listed stress as the main cause of their disorder, and Srinivisan, Cohen, and Parikh (2003) discovered that people with depression cited stress and negative life experiences as the most common causes of their depression.

**Attitudes toward mental illness in adults who have experienced their own mental illness.** The limited available data suggest that people who have experienced a mental illness themselves are more accepting of people with mental illness than the general public is. In a survey of adults who had received mental health treatment (Segal, Kotler, & Holschuh, 1991), participants exhibited high levels of social acceptance (i.e., willingness to be socially and personally close to someone with mental illness) than participants in 17 general population studies. Wolff, Pathare, Craig, and Leff (1996) found that people who had experienced a mental illness themselves were less in favor of social control of people with mental illness (e.g., hospitalization, exclusion from participating in public activities) than people who had not experienced a mental illness were. Laggari et al. (2006) found that people with chronic mental illness had a significantly more positive attitude toward mental illness while experiencing the mental illness than before experiencing it. In a sample of older adults, some from a clinical population and some from a non-clinical population, the clinical population reported more positive attitudes toward mental illness than non-clinical participants did (Quinn, Laidlaw, & Murray, 2009). Although adults with mental illness tend to hold more positive attitudes toward mental illness in general than adults without mental illness do, evidence does suggest that people with mental illness can internalize stigma from others,
which can negatively impact several domains in the lives of people with mental illness (West, Yanos, Smith, Roe, & Lysaker, 2011).

In summary, adults who have experienced their own mental illness possess varying levels of insight about their own symptoms and disorders and attribute mental illness to a variety of causes, although non-biological explanations are most common. In general, having experienced a mental illness oneself is related to relatively positive attitudes toward others with mental illness, although internalization of stigma from others is common. Not many studies have examined the knowledge and attitudes of children who have experienced mental health concerns, but the available studies will be discussed now.

*Knowledge of mental illness in children who have experienced their own mental illness.* Like children in the general population, children with mental illness have some accurate knowledge and some inaccurate information regarding mental illness. When Szajnberg and Weiner (1989) interviewed 22 children who were receiving inpatient mental health care, 14 of them could distinguish between physical and mental illness, 7 children gave ambiguous responses, and 1 child could not make the distinction. Kendall, Hatton, Beckett, and Leo (2003) examined the knowledge of children with attention-deficit/hyperactivity disorder (ADHD) with regard to their own ADHD. Describing the symptoms of their ADHD, the children listed problems with learning, thinking, behaving, and feeling and also described themselves as “hyper,” “bad,” and “weird.” Some children saw their ADHD as an illness, some viewed their behavior as normal, and some children thought that “ADHD” was the name of the medication that they took for their ADHD. When questioned about the cause of their ADHD, 9 of the children (almost half) did not
have an explanation for their ADHD. Most of the children who did have an explanation believed that a biological factor (e.g., heredity, being born with it) had led to their attention difficulties. When Kazdin, Griest, and Esveldt-Dawson (1984) provided vignettes of a child with a conduct disorder and a child with an anxiety disorder to 30 children who were receiving inpatient mental health services, the most commonly cited causes for the children’s problems were environmental stressors, namely parental yelling and harsh discipline.

**Attitudes toward mental illness in children who have experienced their own mental illness.** Research on attitudes toward mental illness in children who have experienced their own mental illness is sparse. Participants in the Kazdin et al. (1984) study, who had been given a variety of diagnoses, viewed characters in clinical vignettes as having a worse prognosis, being less likable, and being more dysfunctional than themselves. The children also saw themselves as less similar to the children in the vignettes detailing children with conduct and anxiety disorders than to a description of a child without a disorder. In other investigations, both children receiving outpatient mental health care and children receiving inpatient mental health care have been found to perceive themselves as having impaired individual and interpersonal functioning (Treiber & Mabe, 1987; Young & Childs, 1994). A 2010 study found that approximately 20% of adolescents who were receiving mental health services reported significant concerns related to self-stigmatization (Moses, 2010).

Overall, the sparse literature examining knowledge of mental illness in children with mental illness suggests that these children possess varying levels of knowledge regarding their symptoms. Some children are uncertain of the etiology of their symptoms,
and others cite biological or environmental factors that they believe to have caused their symptoms. The few studies addressing attitudes suggest that, like children in the public, children who have experienced their own mental illness hold negative attitudes toward mental illness.

**Knowledge and attitudes of people who know someone with a mental illness.**
Like people who have experienced their own mental illness, people who know someone who has experienced mental illness might be expected to have different perceptions of mental illness than the general public. Some researchers have found that the attitudes of participants who knew someone with a mental illness did not differ significantly from the attitudes of other participants (Crisp et al., 2000; Furnham & Rees, 1988; Lopez, 1991; McKechnie & Harper, 2011). Other studies, however, reveal that individuals who have had personal contact with people with mental illness have more positive attitudes than people who have not had personal contact (Corrigan & Gelb, 2006; Corrigan, Larson, Sells, Niessen, & Watson, 2007; Couture & Penn, 2006; Matteo & You, 2012; Roberts et al., 2008).

**Family members’ knowledge of mental illness.** A more focused method of studying views of people who know someone with mental illness has been to conduct studies with family members of individuals with mental illness. In a survey of adult family members of adults with schizophrenia (Gantt, Goldstein, & Pinsky, 1989), only 53% of family members knew the correct diagnosis of the person with schizophrenia. Regarding the early symptoms of schizophrenia, 29% of families had a good understanding of the early symptoms, 47% of families had some understanding of the early symptoms, and 24% of families had no knowledge of these symptoms. Regarding
the chronic nature of schizophrenia, 33% percent of families had a good understanding of its chronic nature, 16% of families had some understanding of the disorder’s chronicity, and 51% of families had no understanding of the chronicity. Gantt et al. reported that 68% of family members had no understanding of the etiology of their family member’s disorder, despite the fact that this particular disorder has clear genetic links. When adults have been asked to name specific causes for their adult family members’ mental illnesses, the causes have included biological factors (Marshall, Solomon, Steber, & Mannion, 2003) and psychosocial factors such as stress, trauma, and interpersonal problems (Magliano et al., 2004; Marshall et al., 2003; Nathan et al., 2001).

Research is lacking concerning family members’ knowledge of mental illness in children. One study by West, Taylor, Houghton, and Hudyma (2005) suggests that parents are relatively knowledgeable about ADHD. West et al. found that over 90% of parents of children with ADHD knew that poor concentration and inattention are symptoms of ADHD. About one third of the parents, however, were not aware that excessive talking and verbal aggression often occur in children with ADHD. Research on parental knowledge of other childhood disorders has not been conducted.

**Family members’ attitudes toward mental illness.** When Magliano et al. (2004) examined relatives’ attitudes toward people with schizophrenia, they found that 31% of relatives thought that people with schizophrenia should be punished if they commit an illegal act, 32% of relatives believed that their family members with schizophrenia should not vote, 71% of relatives believed that their family members with schizophrenia should not get married, and 49% of relatives reported that their family members with
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schizophrenia should not have children. Additionally, 35% of relatives stated that the person with schizophrenia was unpredictable.

Some studies have focused on parents’ attitudes toward their children with mental illness and the discrepancy between children’s and parents’ views. Young and Childs (1994) found that parents perceived their psychiatrically hospitalized adolescents as individually and interpersonally impaired and viewed them as more impaired than the adolescents viewed themselves. Treiber and Mabe (1987) cited a similar discrepancy for children who were receiving outpatient mental health services, although the discrepancy was smaller than in studies in inpatient settings. Young and Gunderson (1995) discovered that this parent-child discrepancy was larger for adolescents who had been diagnosed with borderline personality disorder than for adolescents with other diagnoses.

Considering these data, obtaining both child and parent reports of clinical phenomena appears to be critical to fully understanding the situation and appreciating the inherent conflicts that may occur as a result of discrepant conceptualizations with regard to disagreements about etiology, severity, and prognosis.

**Summary of views of psychopathology.** In summary, adults and older children in the general population seem able to correctly identify some symptoms of psychological disorders and differentiate between specific disorders. Children become more likely to view mental illness as a psychological problem rather than a physical one as they age. However, people also mistakenly attribute some symptoms to particular disorders (e.g., split personality as a symptom of schizophrenia). Certain disorders, especially schizophrenia, are more likely to be identified as mental illness by both adults and children than other problems such as substance-related disorders or behavior problems...
are. Research suggests that even people who have experienced their own or a family member’s mental illness lack some accurate information about mental illness. Like mental health professionals, both the general public and people who have had experiences with mental illness believe in a variety of causes of mental illness. Notably, a number of specific diagnoses and psychological problems have not received any research attention regarding people’s knowledge of them.

Children and adults in the general public exhibit a variety of negative attitudes toward people with mental illness. These attitudes are expressed in ideas such as that people with mental illness are dangerous and that they are not capable of managing their own lives. The nature and strength of these beliefs varies by disorder, but the majority of research findings have documented negative attitudes toward people with any type of mental illness. These attitudes either exaggerate and overgeneralize the negative aspects of mental illness or are completely inaccurate. For example, while psychological disorders can interfere with a person’s functioning, the amount of impairment greatly varies by disorder and by individual. Research suggests that adults who have experienced their own mental illness are more accepting of mental illness than the general public is. Conversely, the limited studies examining attitudes of children with mental illness toward mental illness suggest that such children hold negative attitudes toward their own and others’ mental illness. The literature addressing attitudes of family members of someone who has experienced a mental illness is sparse and inconclusive.

An area of particular interest to the current study is parental knowledge and attitudes regarding mental illness in children. Research in this area is sorely lacking. Only one known study has examined parental knowledge of psychopathology in children,
focusing on ADHD. A couple of studies have examined parents’ attitudes toward their children with mental illness, noting that parents tend to view their children as more impaired than the children view themselves. Overall, however, parental views of child mental illness have not received much empirical attention.

Understanding people’s knowledge and attitudes regarding mental illness is an important step in understanding stigma related to psychological disorders and treatment. Views of mental illness impact mental health treatment seeking, treatment adherence, and treatment outcomes. Views of psychotherapy itself also influence these processes.

**Views of Psychotherapy**

To obtain a complete picture of the impact of stigma on mental health treatment, one must have knowledge of people’s views of both mental illness and psychotherapy and how these views impact the treatment process. To achieve this purpose, the literature addressing people’s views of psychotherapy will now be discussed.

**Relationship between knowledge and attitudes.** This paper will refer to knowledge of psychotherapy and attitudes toward psychotherapy with the recognition that the two categories are highly related and represent the larger construct of views of psychotherapy. The distinction between knowledge and attitudes regarding psychotherapy is sometimes a difficult or artificial one to make. Some areas fit well into the category of knowledge (e.g., whether people are aware of the existence of therapy, what their expectations for the therapy process are), and others best describe people’s attitudes toward therapy (e.g., whether they would seek therapy for family members or themselves). Other issues, such as whether people think that therapy works, seem to represent a blend of knowledge and attitudes.
As knowledge of and attitudes toward mental illness are related to one another, so too are knowledge of and attitudes toward therapy related. Specifically, people who are well-informed about therapy seem to have more positive attitudes with regard to therapy than other people do. Moreover, efforts to improve the public’s attitudes by providing educational programs about mental health treatment have been successful at increasing accurate knowledge and improving attitudes toward treatment in adults (Buckley & Malouff, 2005; Gonzalez, Tinsley, & Kreuder, 2002) and children (Watson et al., 2004).

**Knowledge and attitudes of the general population.** First, views of psychotherapy will be considered from the standpoint of the general population. Such studies can provide an idea of what the general public knows about mental health treatment and what their attitudes are toward such treatment.

**Adults in the general population.** The majority of adults seem to know that mental health care facilities and therapy exist. In a survey of 3,057 residents of rural communities, approximately 80% of people were aware of mental health services (Flaskerud & Kviz, 1983). Furnham and Wardley (1990) found that adults generally expect therapists to teach clients how to achieve self-understanding and to encourage the expression of emotion. The majority of participants in the same study disagreed with the statements that “Very often psychotherapists prescribe drugs,” “Younger, more flexible clients are the only ones to benefit from psychotherapy,” and “Most psychotherapy clients lie on a couch.” Often, people seem to perceive therapy as a route to global self-improvement rather than a way to resolve a specific problem (Furnham & Wardley, 1990; Halgin & Weaver, 1986). For example, in the survey by Furnham and Wardley, adults thought that therapy helps people to be “in touch” with their feelings and to “feel more
hopeful and confident.” In 2009, Furnham found that adults believed that “talking it over” was highly relevant to therapy, especially for depression. When Richardson and Handal (1995) administered a questionnaire about perceptions of therapy to 173 adults, respondents believed that, on average, mental health treatment takes 8 months and that significant improvement occurs after 4 months of treatment.

One study indicates that parents who are seeking mental health treatment for their children do not possess all the information that they would like to have about child psychotherapy. Jensen, McNamara, and Gustafson (1991) asked parents what information they would most like to be given if their child were entering treatment. Parents felt that information regarding limits of confidentiality, therapeutic benefits and risks, and fees was critical. Parents in this sample rated the majority of topics as more important to discuss than a group of child clinical psychologists did, indicating that parents want more information about treatment than they may typically be given by their child’s therapist.

In the existing studies of adults’ attitudes toward therapy, participants have reported primarily positive attitudes. Flaskerud and Kviz (1983) found that the majority of adults had positive feelings about mental health care in general. When Jagdeo, Cox, Stein, and Sareen (2009) analyzed two large-scale population-based surveys, one from the United States and one from Canada, they concluded that 82% of respondents from Canada and 76% of respondents from the United States had positive attitudes toward seeking help for mental health concerns. Other studies have demonstrated that adults think that therapy is helpful in treating mental illness in general (Furnham, 2009; Narikiyo & Kameoka, 1992) and depression in particular (Hegerl, Althaus, & Stefanek, 2003). Critical to the present study, in general, adults believe that mental health treatment
is beneficial for children (Jensen et al., 1991; Thompson & Smith, 1993). Schomerus et al. (2012) examined trends over time and found that acceptance of professional help for mental health problems has increased over time.

Despite these various positive attitudes, the public identifies several factors that decrease their willingness and/or ability to actually utilize mental health care. Among these factors are time (Halgin & Weaver, 1986; Halgin, Weaver, & Donaldson, 1985), cost (Halgin & Weaver, 1986; Halgin et al., 1985; Jensen et al., 1991; Morano & DeForge, 2004), the complexity of entering the mental health system (Morano & DeForge, 2004), and stigma (Halgin et al., 1985; Morano & DeForge, 2004).

**Children in the general population.** Research addressing children’s views regarding psychotherapy is limited. Although adults typically initiate and maintain mental health treatment for children, obviously the identified patients are an integral part of the treatment process. Consequently, research on children’s views of psychotherapy seems relevant and important when studying the impact of stigma on child psychotherapy.

The available research indicates that not all children are aware of the existence of mental health care. When Roberts et al. (1981) asked 9- to 13-year-olds how children with psychological problems could “get better,” the most common methods that the children listed were self-help (e.g., reading books) and obtaining help from non-mental health professionals, such as teachers. Findings by Spitzer and Cameron (1995) suggest that awareness could increase with age. Consistent with the finding that young children tend to perceive mental illness as a physical problem, Spitzer and Cameron found that first-grade students most commonly believed that someone with a mental illness should
be treated by a general medical practitioner or at a general hospital. First-grade students also mentioned jail and “teaching the person how to behave” as possible interventions for mental illness, but none of them specifically mentioned mental health treatment. Like their younger peers, fourth-grade students in the same study most frequently cited general practitioners as a treatment option for mental illness but also mentioned psychological treatment. Seventh-grade students were aware of mental health care and listed mental health facilities most frequently as a treatment option. In a study involving 2nd-, 3rd-, 6th-, 7th-, and 10th-grade students, knowledge of therapist roles and therapy practices increased with age, and awareness of which types of problems therapy can address also increased with age (Sigelman & Mansfield, 1992). This developmental trend mirrors children’s increasing awareness of the existence of mental health care and could reflect increasing experiences with mental health treatment as children age.

Sigelman and Mansfield (1992) noted that children in their study were receptive to the idea of psychological treatment for a particular problem as long as the problem was viewed as a psychological one. For example, children were not receptive to treatment for a problem if it was regarded as an issue of nonconformity (rather than a psychological problem).

**Knowledge and attitudes of people who have received mental health treatment.** Like views of mental illness can be impacted by personal experience with mental illness, views concerning psychotherapy may be impacted by the amount of personal experience that a person has had with therapy. Studying the views of people who have sought therapy can help to explain how engaging in therapy impacts people’s views of therapy and is a reflection of how people experience treatment. Some studies
have examined views of individuals who are just entering treatment, while others have investigated the perceptions of people who have already been in treatment.

**Adults who have received mental health treatment.** Several studies have addressed adults’ treatment expectancies when entering psychotherapy. One interesting finding is that client and therapist expectations for treatment tend to differ from one another at the onset of treatment. For example, adults entering inpatient treatment for alcoholism often expect a medical approach to treatment rather than a biopsychosocial or purely psychological one (Potamianos, Gorman, & Peters, 1985; Verinis, 1993). Outpatient clients at a university counseling center also had different expectations for the first therapy session than their therapists did. Specifically, clients expected the therapist to give more advice and interpretations than the therapist expected to give (Benbenishty & Schul, 1987). Although this study has not heretofore been replicated, it stands to reason that over the course of the last two decades this finding may have become even more profound with the trend in psychotherapy to be toward less advice-giving and more empirically-supported techniques.

Other studies have examined treatment knowledge of people who have already engaged in therapy. In a survey of 200 adults, people who had been to a therapist were better able to differentiate between the terms psychiatrist, psychoanalyst, and psychologist than individuals who had never been to a therapist (Furnham & Wardley, 1990). Subich and Coursol (1985) found that undergraduate students who had received mental health treatment believed that treatment involves taking more responsibility and receiving less nurturing and empathy from the therapist than undergraduates who had never engaged in treatment did. When Zind (1991) interviewed 116 long-term outpatient
clients with schizophrenia, the clients exhibited a range of knowledge levels about mental health care, with patients who had had schizophrenia for the longest period of time possessing the highest levels of knowledge about treatment. Benbenishty and Schul (1987) assessed client and therapist treatment expectations during the course of treatment and found that patients expected less expression of feelings by therapists than therapists themselves expected. Patients also expected to be given a diagnosis and explanation of their condition more often than therapists expected to give them, which may well be different after enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Encouragingly, people who have participated in mental health treatment hold largely positive attitudes toward treatment. For example, college students who had received mental health treatment were more willing to seek treatment in the future than college students who had never sought treatment were in a study by Halgin, Weaver, Edell, and Spencer (1987). Jagdeo et al. (2009) found that people who had sought mental health treatment in the past had more positive attitudes about seeking help for mental illness than people who had not sought treatment in the past. In a survey of 204 outpatient clients with chronic mental illness, the majority of respondents reported that therapy was helpful and that they had good relationships with their therapists (Coursey, Farrell, & Zahniser, 1991). Similarly, in another study of 563 adults with serious mental illness, the majority of participants thought that the best treatments for their mental illness were medications and therapy (Nathan et al., 2001). Laggari et al. (2006) found that compliance with treatment was positively associated with years of experiencing mental illness in their sample of adults with chronic mental illness. Also, mothers who had prior
therapy experience had more positive attitudes toward therapy in general than other mothers had, according to a study by Jensen et al. (1991).

However, Fals-Stewart, Fincham, and Kelley (2004) found that less than half of parents who were receiving substance abuse treatment were willing to have their children participate in treatment. Similarly, in the Jagdeo et al. (2009) study, having substance abuse/dependence or antisocial personality disorder was associated with greater negative attitudes toward help-seeking. In addition, Furnham and Wardley (1990) noted that participants who had received therapy were less optimistic about progress in therapy than participants who had never engaged in therapy were.

**Children who have received mental health treatment.** In the only known study to examine knowledge of mental health treatment in children who have received such treatment, Szajnberg and Weiner (1989) investigated the views of 22 children (ages 7 to 13 years) regarding their psychiatric hospitalization. Twenty of these children (91%) were able to differentiate between a medical and a psychiatric hospital. When the children were asked why they were hospitalized, 10 of them (45%) stated that they were hospitalized as a punishment for something that they had done, 6 children (27%) understood the hospitalization as a type of treatment for their mental health problems, 4 children (18%) believed that they were there for physical problems, 4 children (18%) did not know why they were hospitalized, and 2 children (9%) thought that a misunderstanding had occurred and that they did not actually belong in the hospital.

Only one known study has addressed children’s attitudes toward psychiatric hospitalization. In this study, adolescents who had been hospitalized for a psychological disorder viewed psychiatric hospitalization as more beneficial and less stigmatizing than
adolescents who had never been hospitalized did (Pugh, Ackerman, McColgan, & de Mesquita, 1994).

**Knowledge and attitudes of family members.** Some data are available regarding the views toward therapy of family members who have a relative who has a mental illness and/or has received mental health treatment. Like people who have received treatment, family members might be expected to hold different views of psychotherapy than the general public does. Additionally, family members’ knowledge and attitudes are important to the extent that family members are involved in a person’s treatment. Some adults and most children rely on family members to initiate, maintain, and participate in treatment. Even when family members are not directly involved in treatment, their opinions could impact a person’s willingness and ability to engage in treatment.

**Family members of adult clients.** Only a couple studies have examined family members’ knowledge about mental health treatment. Gantt, Goldstein, and Pinsky (1989) discovered that family members of adults who had been hospitalized for schizophrenia were quite uninformed about therapy. Only 20% of the families had been given explanations about the therapy that their relatives would receive in the hospital. Similarly, in a study of 103 Mexican-American families of adults who had been hospitalized for schizophrenia or bipolar disorder, most families had no idea what kind of treatment their family member would receive. Most family members thought that the individual would receive only medication. The majority of families also stated that they overestimated how long the patient would be hospitalized, with many families believing that the patient would stay in the hospital until he or she was “cured” (Urdaneta, Saldana, & Winkler, 1995).
Not many studies have addressed family members’ attitudes toward their adult relatives’ mental health treatment. In their sample of family members of adults with severe mental illness, Nathan et al. (2001) noted that family members rated medications and therapy as the best treatments for their relatives. In another study of family members of adult inpatients, about three-fourths of the families were satisfied with their relatives’ treatment program, although a minority of families were dissatisfied with any intervention other than medication (Urdaneta et al., 1995). Notably, all known studies examining the views of family members of adult patients have involved patients with severe mental illness. The results, consequently, reflect the knowledge and attitudes of a specific group of family members whose perceptions could differ from the perceptions of other groups.

**Parents of child clients.** Investigations of parents’ knowledge of child therapy have focused on therapy for ADHD. West et al. (2005) found that parents whose children had been diagnosed with ADHD were less knowledgeable about treatment for ADHD than they were about the causes and characteristics of the disorder. Over half of parents did not know whether electroconvulsive therapy is an effective treatment for ADHD. The majority of parents did know that medication can be helpful for children with ADHD, however.

Parents seem to have generally positive attitudes toward therapy for their children, although certain variables can impact these attitudes. Nevas and Farber (2001) interviewed 51 parents of 5- to 11-year-old children who had attended at least six outpatient treatment sessions to assess the parents’ attitudes toward their children’s treatment. Overall, the parents in this sample had positive attitudes toward treatment and
their children’s therapists. They supported and respected the therapist, viewed the therapist as understanding and dependable, had positive feelings toward the therapist, and felt that the therapist provided them with adequate consultation. They also saw the treatment as valuable and believed that it was decreasing their children’s problems. Parents whose child was experiencing depression were more likely than other parents were to have negative feelings toward the therapist, and parents who perceived their children as most in need of treatment were most likely to have positive feelings toward the therapist.

**Summary of views of psychotherapy.** In conclusion, the general public appears to be well aware of mental health services. People often perceive therapy as a way to achieve global self-improvement or improve insight (e.g., learning to express emotions, increasing self-understanding), rather than a way to resolve a specific psychological problem. Client and therapist expectations frequently differ at the beginning of treatment; whether expectations become more accurate as treatment progresses is unclear. Furthermore, having a family member who has received mental health treatment does not necessarily lead to increased knowledge about therapy. Both the general public and people who have experience with their own or a family member’s psychotherapy typically believe that the process of therapy can help adults and children, but several factors (e.g., time, cost, stigma) deter people from actually engaging in therapy.

Little research has examined children’s views of psychotherapy. The limited available data suggest that children lack information about mental health care but possibly become increasingly knowledgeable about it as they age and that previous experience with therapy could improve attitudes toward therapy.
Studies investigating parents’ views regarding psychotherapy for their children are particularly relevant to the current study. Like research on parental views of mental illness in children, research on parental views of child psychotherapy is sparse. Of the few available studies on the topic, one study suggests that parents do not possess all the information that they would like to have about child psychotherapy, one indicates that parents have generally positive attitudes toward therapy for their children, and the other found that parents whose children had ADHD were not always knowledgeable about treatment for ADHD.

**Influence of Knowledge and Attitudes on Psychotherapy**

As described above, the literature suggests that, in general, people are aware of mental health services and hold positive attitudes regarding them. Yet most people with mental health problems do not seek treatment, and many people who do pursue treatment do not stay in treatment or do not adhere to treatment plans (Corrigan, 2004). Why? As mentioned, people have concerns about issues such as the cost of treatment, the complexity of entering the mental health system, and stigma. In particular, research suggests that negative and/or inaccurate views of mental illness correspond with negative attitudes toward psychotherapy, as measured by treatment utilization and adherence. Additionally, some studies have demonstrated that inaccurate expectations of treatment can influence child psychotherapy outcomes.

**Influence of views of psychopathology on adult psychotherapy.** In a literature review of the effects of stigma on mental health treatment seeking, Corrigan and Rusch (2002) concluded that people’s own negative attitudes toward mental illness or concerns about stigma can decrease rates at which they enter psychotherapy. Similarly, positive or
neutral attitudes toward mental illness have been associated with willingness to use mental health services (Lehtinen & Vaisanen, 1978). Alvidrez (1999) also found that attributing mental illness to internal causes was associated with decreased use of mental health services.

When someone does initiate psychotherapy, beliefs and views regarding psychopathology could impact treatment adherence. Sirey et al. (2001) found that senior citizens were more likely to terminate treatment prematurely if they believed that others devalue people with mental illness. Schwartz (1998) reviewed studies of insight in schizophrenia and concluded that although results are inconsistent, generally a greater amount of insight is correlated with better treatment adherence.

**Influence of views of psychopathology and psychotherapy on child psychotherapy.** Because adults seek treatment for their children, adults’ knowledge and attitudes could impact child therapy in much the same way that they impact adult therapy outcomes, with incomplete information or negative parental attitudes decreasing participation in and adherence to child therapy. A few studies have examined the impact of parental knowledge about mental illness and mental health care on child psychotherapy. One study examined the impact of parental knowledge of ADHD on treatment utilization. Parental level of knowledge about ADHD was positively related to the likelihood of enrolling children with ADHD in pharmacological and non-pharmacological treatments but was not related to treatment adherence (Corkum, Rimer, & Schachar, 1999). Other studies examined treatment expectations concerning issues such as the type of treatment that children receive, the length of treatment, and the activities that occur in treatment. Similarity between client (parent or child) and therapist
expectations was associated with parental acceptance of the services and treatment continuation (Day & Reznikoff, 1980; Plunkett, 1984).

The effect of parental attitudes regarding mental illness and mental health care on child psychotherapy has not been empirically documented. In a survey by Richardson (2001), parents did express concerns about other people discovering that they took their children to a mental health care provider, but whether this concern actually impacted treatment seeking and/or adherence was not investigated. One known study did examine the influence of parents’ attitudes regarding mental health care on their college-aged children’s attitudes. The college students’ attitudes toward therapy were linked to their parents’ attitudes toward therapy. In turn, the college students’ attitudes toward therapy influenced their intentions to seek therapy for their problems (Vogel, Michaels, & Gruss, 2009).

**Influence of Formal Preparation for Treatment on Mental Health Treatment**

For both children and adults, research is available examining the impact of patient preparation programs on mental health treatment. Preparation programs aim to change patient views of mental illness and/or treatment and, thereby, to positively influence the treatment process.

The primary methods of preparing adults for psychotherapy have involved providing new clients with information about psychotherapy (e.g., Deane, Spicer, & Leathem, 1992; France & Dugo, 1985; Graham, 2003; Wilson, 1985) and showing new clients videotapes that model psychotherapeutic behavior (e.g., France & Dugo, 1985; Wilson, 1985). Studies investigating preparation for adult psychotherapy have demonstrated that both information and modeling can positively impact the treatment
process. Some of these studies have investigated the influence of preparation on the client’s experience of therapy, finding that preparation can help to increase accuracy of expectations for treatment (Bowman & DeLucia, 1993; Deane et al., 1992; Lambert & Lambert, 1984) and decrease anxiety about the first session (Deane et al., 1992). Preparation also can impact treatment outcomes in ways such as decreasing dependence on the therapist, decreasing attrition, increasing attendance, increasing treatment satisfaction, and increasing self-rated client change (France & Dugo, 1985; Lambert & Lambert, 1984; Wilson, 1985). All known studies of preparation for adult psychotherapy have been conducted in outpatient settings and have not investigated the effects of preparation on those with specific diagnoses.

Preparation programs for child psychotherapy also have focused on providing information about therapy (e.g., Bonner & Everett, 1986; Coleman & Kaplan, 1990; Corder, Haizlip, Whiteside, & Vogel, 1980; Shuman & Shapiro, 2002) and showing videotapes that model psychotherapeutic behavior (e.g., Coleman & Kaplan, 1990; Day & Reznikoff, 1980; Weinstein, 1988). Preparation programs sometimes have involved only children (e.g., Corder et al., 1980; Weinstein, 1988), other times only parents (e.g., Shuman & Shapiro, 2002), and sometimes both children and parents (e.g., Bonner & Everett, 1986; Coleman & Kaplan, 1990; Day & Reznikoff, 1980). The differential effectiveness of involving children and/or parents in preparation has not been investigated, but overall, preparation efforts seem to positively impact treatment.

For example, preparation for child therapy has been shown to increase the accuracy of expectations regarding therapy, receptivity to treatment and the therapist, and expectations for therapy outcomes for both children and parents (Bonner & Everett,
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1986; Coleman & Kaplan, 1990; Day & Reznikoff, 1980; Shuman & Shapiro, 2002; Weinstein, 1988). Additionally, preparation programs have improved outcome variables such as treatment attendance and mothers’ ratings of child problem behaviors (Coleman & Kaplan, 1990; Day & Reznikoff, 1980). As with adults, the known studies addressing preparation for child therapy have been conducted in outpatient settings and have not focused on specific diagnoses.

In reality, patients typically do not receive formal preparation for psychotherapy. Little is known about steps people take to prepare themselves for psychotherapy. Presumably, when formal preparation programs are not available, any informal preparation that occurs would influence similar variables as formal preparation. In the case of children, parents are a likely source of preparation for therapy. However, no studies have investigated if and how parents prepare their children for therapy.

**Influence of Parents’ Views of Mental Illness and Psychotherapy on Children’s Experience of Psychotherapy**

Assuming that parents typically initiate their child’s mental health treatment, are responsible for treatment attendance, and often participate in their child’s treatment, they are a crucial factor in determining how treatment progresses. As already discussed, some research exists to suggest that parents’ views of mental illness and psychotherapy can impact their child’s treatment directly. In particular, parental knowledge of mental illness and psychotherapy appears to affect whether or not parents seek and participate in treatment for their child (Corkum et al., 1999; Day & Reznikoff, 1980; Plunkett, 1984).

Parents’ knowledge and attitudes regarding psychotherapy could also have an effect on the information that they give their children regarding psychotherapy. If parents
have insufficient or inaccurate knowledge, presumably they then are unable to provide their children with a complete and accurate understanding of therapy. For example, Day and Reznikoff (1980) found that the number of correct expectations about the process of treatment that were held by children before their first therapy session was related to the number of correct expectations that their parents held. Parents and children also tend to hold similar attitudes to one another, in general (Glass, Bengtson, & Dunham, 1986). Although debate exists regarding the extent to which parents directly determine their children’s attitudes, direct teaching is believed to be influential in the process of attitude transmission (Glass et al., 1986). Of course, children’s views can be affected by other sources such as the media, school, and peers (Starrels, 1992), but parents are the primary influence on children’s views (Glass et al., 1986). In a previously mentioned study by Vogel et al. (2009), college students’ attitudes toward therapy were linked to their parents’ attitudes toward therapy. Given that college students are typically largely autonomous at that developmental stage, it is reasonable to posit that the correlation between these variables in younger children or teenagers and their parents may be even stronger.

Although preparation programs for child psychotherapy are generally effective, most treatment facilities do not formally prepare children or parents for treatment. In the absence of formal preparation programs, parents typically are responsible for informally preparing their children for psychotherapy. Any preparation (or lack of preparation) that a parent provides for a child could influence the same factors (e.g., expectations for treatment processes and outcomes, receptivity to treatment) that formal preparation programs have been demonstrated to alter. Thus far, existing research has not attempted
to build a model examining the relationship between parents’ views and children’s views at the beginning of therapy and how informal preparation may play a role in the formation of these views. The empirical findings described previously form a base on which to postulate such a model.

**Current Study**

Children’s experiences of psychotherapy and the impact of stigma on child psychotherapy have received little research attention. The aim of the present study was to determine the extent to which parents’ views of psychotherapy were related to how they prepared their child for psychotherapy and how this preparation was related to their child’s views regarding the first therapy session. Preparation was hypothesized to be a mediator between parents’ views and children’s views. More specifically, parents’ own knowledge of and attitudes toward psychotherapy were expected to be related to their children’s knowledge of and attitudes toward psychotherapy via the preparation for therapy that parents provided to their children. Although, as previously discussed, parental views with regard to mental illness may also influence preparation, they are not thought to be directly linked to preparation for therapy. Therefore, views regarding mental illness were not examined in the current study. The current study also aimed to identify parental views that could negatively impact children’s therapy experiences in order to suggest ways to help parents effectively prepare their children for therapy.

Formal preparation programs for child therapy might not always be feasible (e.g., due to financial and time considerations). Through increased understanding of children’s expectations of their first therapy session, therapists can learn optimal ways to interact with children during the first session. Moreover, this knowledge makes a significant
contribution to the extant literature in that it will guide the development and implementation of formal preparation materials. The present study could also provide content for ongoing public health efforts to decrease stigmatization around mental illness and help-seeking by examining existing knowledge and attitudes.

**Hypotheses**

The hypotheses of the current study focus on parents’ and children’s knowledge and attitudes regarding psychotherapy. For the current study, knowledge of therapy was defined as expectations for the process of therapy, and attitudes toward therapy were defined as receptivity toward therapy and outcome expectations for therapy. Measures of knowledge (i.e., expectations for the process of therapy) focused on factual information about the structure of therapy; the purpose of therapy; confidentiality; and parent, child, and therapist roles for therapy. Measures of attitudes (i.e., receptivity toward therapy and outcome expectations for therapy) focused on relatively subjective information regarding how receptive participants were to the concept of therapy; how they thought the child would feel, act, think, and get along with others differently as a result of therapy; and the extent to which the child’s problems would change over the course of treatment. Several specific hypotheses were examined.

**Hypothesis 1.** In consideration of research suggesting that children’s knowledge regarding psychotherapy increases with age, the first hypothesis was that the older a child was, the more accurate his or her expectations about the process of therapy would be.

**Hypothesis 2.** On the basis of research examining discrepancies between parents’ and children’s reports of parent-child interactions (e.g., Bogels & van Melick, 2004; Jaccard, Dittus, & Gordon, 1998; Tein, Roosa, & Michaels, 1994), parents’ and
children’s reports of preparation for the initiation of psychotherapy were hypothesized to
differ from one another. In particular, parents were expected to provide a more favorable
account of preparation (i.e., were expected to describe the preparation that occurred as
more complete, more accurate, and more positive in valence) than children were.

**Hypothesis 3.** Because prior participation in therapy may impact knowledge
about therapy, families with children who had participated in therapy in the past were
expected to have more accurate expectations for the process of therapy than families with
children who had never participated in therapy.

**Hypothesis 4.** Fourth, parental knowledge and attitudes with regard to
psychotherapy were hypothesized to be significantly related to their child’s knowledge
and attitudes with regard to psychotherapy. Hypothesis 4 had three sub-hypotheses,
specifically that:

a. The accuracy of parental expectations for the process of therapy would be
   positively associated with the accuracy of child expectations for the process of
   therapy.

b. Receptivity of the parent toward therapy would be positively associated with
   receptivity of the child toward therapy.

c. The parent’s outcome expectancies for the child’s treatment would be positively
   associated with the child’s outcome expectancies for his or her treatment.

**Hypothesis 5.** Preparation was believed to be the variable that would account for
the hypothesized relationship between parents’ and children’s views. Preparation was
operationally defined as having three components: completeness, accuracy, and valence.
Consequently, a second hypothesis was that preparation would mediate the relationship
between parental knowledge and attitudes and child knowledge and attitudes regarding psychotherapy. Hypothesis 2 also had three sub-hypotheses, specifically that:

a. Preparation (i.e., completeness, accuracy, and valence of preparation) would mediate the relationship between parental expectations for the process of therapy and child expectations for the process of therapy.

b. Preparation (i.e., completeness, accuracy, and valence of preparation) would mediate the relationship between parental receptivity toward therapy and child receptivity toward therapy.

c. Preparation (i.e., completeness, accuracy, and valence of preparation) would mediate the relationship between parental outcome expectancies for the child’s treatment and child outcome expectancies for treatment.
Methods

Sample

Participants were 49 parent-child dyads, with each dyad composed of one parent and his or her child. For the purposes of this study, the term *parent* was used to describe any adult who was a primary caregiver for the child and did not imply that the adult must have been a biological parent. English-speaking families with a 9- to 14-year-old child who was scheduled for his or her first psychotherapy session were eligible to participate. This age range was selected because children of this age were deemed to be old enough to understand the content of the instruments that were administered but young enough that they would be likely to harbor some confusion with regard to the therapeutic process and their parents were likely to be involved in the therapy process. Thirty-six families were recruited through a home-based therapy program run by a Community Mental Health agency in Mid-Michigan, nine families were recruited through an outpatient therapy program run by the same Community Mental Health agency, three families were recruited through an outpatient therapy clinic in Mid-Michigan, and one family was recruited through a university psychology clinic in Southeastern Michigan. The Community Mental Health agency and outpatient clinic in Mid-Michigan both served a mix of patients from urban and rural areas, and the psychology clinic was located in a city with a university. None of these clinics had any formalized means of preparing families for therapy prior to the intake appointment.

Demographics. Of the 49 parents who participated in the study, all considered themselves to be a primary caregiver for the child who participated in the study. Forty-five caregivers were the biological parents of their children who participated in the study, two caregivers were grandparents, and two caregivers were stepparents. Forty-five of the
parents were female (92%), and four biological fathers (8%) participated in the study. Parents had a mean age of 36.02 years ($SD = 5.36$) and ranged from 29 to 44 years old. Regarding race, 46 parents reported being Caucasian (94%), 2 parents reported being Hispanic (4%), and 1 parent reported being African American (1%). Twenty parents were currently married, 15 parents were divorced, 6 parents had never been married, 4 parents were separated, 3 parents were living with a partner, and 1 parent was widowed. The mean number of children living in the household was 2.86 and ranged from 1 to 6.

This sample was diverse from a socioeconomic perspective. Regarding income, 35 parents (71%) reported that their household income was below $25,000 per year. Ten parents (20%) reported an annual income of $25,000 to $49,999, and three parents (6%) reported an income above $50,000. One parent chose not to report income level. Ten parents had not completed high school, 6 parents reported having a high school degree or equivalent as their highest level of education, 3 parents reported completing a two-year degree or certificate program, 19 parents had some college credits, 10 parents had a bachelor’s degree, and 1 parent had completed graduate school.

Although the data regarding education level indicate that 33 parents (67%) had some college credits or had obtained some type of post-high school degree, recall that 35 parents (71%) reported a household income below $25,000 per year. The data on employment status could provide some insight into this discrepancy. Regarding employment status, 9 parents were employed full-time; 12 parents were employed part-time; 4 parents were students; 7 parents were homemakers; 14 parents were receiving public assistance, disability, and/or supplemental social security income; and 3 parents fit more than one of these categories. These data indicate that a majority of these parents
were not employed full-time. Although many of them had received post-high school education, the employment data suggest that perhaps factors such as the parents’ own mental health or physical health problems—obligations such as attending college, raising children, or caring for other family members, and so on—could have impacted employment rates. The economic climate at the time also could have impacted employment rates.

The 49 children who participated in the study were 29 boys and 20 girls with a mean age of 11.82 (SD = 1.82), ranging in age from 9 to 14 years old. The median age was 12 years, and the modal age was 14 years. The mean age of the boys was 12.17 (SD = 1.81) and ranged from 9 to 14. The girls’ mean age was slightly younger, 11.30 (SD = 1.75), and also ranged from 9 to 14. Forty-three of the children identified as Caucasian (88%), one child identified as Hispanic, one child identified as African American, one child identified as Native American, and three children identified as multiracial.

When parents were asked why they were seeking therapy for their children, 26 parents (53%) reported that the primary reason for seeking therapy was a specific problem or concern regarding the child’s behavior, indicative of externalizing disorders. Five parents identified more internal factors, such as the child’s feelings of depression or anxiety, as the primary reason for seeking therapy. Four parents cited concerns about the child’s learning and/or academic performance as the primary reason to seek therapy, five parents cited life events such as divorce or abuse as the primary factor, and two parents reported seeking therapy because another adult had suggested that the parent seek therapy for the child, without indicating particular areas of concern. Note that seven parents did not respond to the question regarding reason for seeking treatment. See Figure 2 for a
representation of reasons that parents gave for seeking treatment for their children.

Independent samples $t$ tests were conducted to determine if these groups differed with regard to demographic characteristics. Results indicated that the reason for seeking therapy did not have a significant impact on any of the demographic variables.

Further $t$ tests explored whether the reason for seeking therapy had a significant relationship with any of the variables under investigation in the current study. These $t$ tests indicated that the reason for seeking therapy was not significantly related to any of the variables under investigation for the current study.

![Figure 1. Reasons cited by parents in the current sample for seeking therapy for their children.](image)

Regarding treatment history, 26 children had received therapy in the past (53%), and 23 children had not previously received therapy. Independent samples $t$ tests were conducted to determine if these two groups differed with regard to demographic characteristics, and treatment history did not have a significant impact on any of the
demographic variables. Further t tests explored whether treatment history had a
significant impact on any of the variables under investigation in the current study. Two
significant findings surfaced. First, children who had not previously received therapy had
significantly more positive outcome expectations for therapy than children who had
received therapy, $t(47) = 1.98, p = .05$. Mean scores on the Expectations of Therapy
Outcome Scale were 47.26 ($SD = 9.96$) for the group with no past treatment and 40.69
($SD = 12.81$) for the group with past treatment. Second, children who had not previously
received therapy reported more complete preparation for therapy than children who had
received therapy, $t(47) = 2.09, p < .05$. Mean completeness scores on the Preparation
Interview, according to child reports of preparation, were 2.57 ($SD = 1.04$) for the group
with no past treatment and 2.04 ($SD = 0.72$) for the group with past treatment. Because
these findings suggested that treatment history could possibly impact results, treatment
history was entered as a covariate in regression analyses for Hypotheses 4 and 5 during
hypothesis testing to control for the influence of having prior treatment vs. not having
prior treatment.

As mentioned, 36 children were scheduled for an intake for a home-based therapy
program, and 13 children were scheduled for an intake for outpatient therapy in a
therapist’s office. Independent samples t tests were conducted to determine if these two
groups differed with regard to any demographic characteristics, and two significant
differences did arise. First, the home-based group had a significantly higher mean number
of children living in the home than the outpatient group, $t(47) = 2.11, p < .05$. The second
finding was that the home-based group had a significantly lower mean income than the
outpatient group, $t(47) = 2.42, p < .05$. The home-based and outpatient groups did not
significantly differ with regard to any other demographic variables, including treatment history. Both groups included children who had received treatment in the past, with 61% of the children in the home-based group and 31% of the children in the outpatient group having received past therapy. Furthermore, additional independent samples $t$ tests indicated that type of treatment (i.e., home-based therapy or outpatient therapy) did not have a significant relationship with any of the variables under investigation for the current study.

**Measures**

**Demographic information.** A brief demographics questionnaire was created to assess basic demographic variables including age, sex, race, marital status, income, employment status, education, number of children living in the home, parent’s relationship to child, and the parent’s reason for seeking treatment for the child. Parents completed the demographics questionnaire.

**Parent and child views of psychotherapy.** Parents’ and children’s expectations for the process of therapy, receptivity to therapy, and outcome expectations for therapy were assessed to measure parent and child knowledge and attitudes regarding psychotherapy.

**Expectations for the process of therapy.** Parent expectations for the process of therapy were measured with the 25-item Therapy Survey (see Appendix A), which was initially created by Day and Reznikoff (1980) and modified by Bonner and Everett (1986). Day and Reznikoff used the survey with a sample of 42 boys, ages 7 to 23, and their parents. Modifications made by Bonner and Everett included rewording of the questions to avoid sex-biased language, to make the questions appropriate to a more
general model of child psychotherapy, and to include a *don’t know* response category. The Bonner and Everett sample consisted of 38 children, age 6 to 12 years, with one of their parents. The questionnaire addresses expectations for the structure of therapy; the purpose of therapy; confidentiality; and parent, child, and therapist roles for therapy. Items are written in a question format with response options of *yes, no,* and *don’t know.* Respondents earn a total score ranging from 0 to 25, with higher scores indicating increasing accuracy regarding expectations for the process of therapy. No instrument assessing parent or child expectations for child therapy has been subjected to rigorous psychometric evaluation, but in the Bonner and Everett study, the Therapy Survey did discriminate between children and parents who had participated in a therapy preparation program and children and parents who had not participated in a preparation program \[F(1, 34) = 60.36, p < .001\].

At the request of the Eastern Michigan University Human Subjects Review Committee (HSRC), children were administered a slightly altered version of the Therapy Survey for the current study (see Appendix B). The Therapy Survey-Child Form (Revised) consists of the same 25 items as the Therapy Survey but rephrases the items into statements rather than questions. Children can indicate that they *completely disagree,* *disagree a little,* *agree a little,* or *completely agree* with each statement. The HSRC required that the questions be rephrased into statements and that children indicate their level of agreement (rather than replying *yes, no,* or *don’t know*) so the items would seem less intimidating to children. A final requirement by the HSRC was that the following statement be added to the end of the survey: “It’s important for you and your therapist to have a good relationship. If you have any concerns about the questions above, please talk
to your therapist about them.” Otherwise, no changes were made from the original version of the Therapy Survey. Like the original version of the Therapy Survey, children are assigned a score from 0 to 25, with higher scores indicating increasingly accurate expectations for the process of therapy. For scoring purposes, the response options completely disagree and disagree a little both receive the same score that a response of no would receive on the original Therapy Survey, and the response options of agree a little and completely agree both receive the same score that a response of yes would receive on the original Therapy Survey.

**Receptivity to therapy.** Children’s and parents’ receptivity to engaging in child psychotherapy was measured using the Attraction-Receptivity Questionnaire (see Appendices C and D) developed by Bonner and Everett (1986). Bonner and Everett modeled the questionnaire after the Client’s Personal Reaction Questionnaire (Ashby, Ford, Guerney, & Guerney, 1957), and Bonner and Everett used a similar version in their study in 1982. The 1982 study was conducted with 72 children ages 6 to 12 years old, and the sample for the 1986 study was 38 children ages 6 to 12 years. The questionnaire consists of 20 items describing positive and negative aspects of therapy and therapists to which the respondent answers yes, no, or don’t know. The questionnaire has a parent form and a child form, with the only difference between the two forms being the wording of the directions so the directions are worded in a developmentally appropriate way for children. Respondents receive a total score ranging from 0 to 20, with higher scores indicating greater receptivity to engaging in therapy. Like the Therapy Survey, the Attraction-Receptivity Questionnaire has not undergone extensive psychometric evaluation but did distinguish children and parents who had received formal preparation.
for therapy from children and parents who had not received such preparation in Bonner and Everett’s (1986) study \( F(1, 34) = 4.75, p < .05 \).

**Outcome expectancies.** Child and parent outcome expectations for therapy also were assessed with an instrument developed by Bonner and Everett (1986), the Expectations of Therapy Outcome Scale (see Appendices E and F). Bonner and Everett used a similar version in their study in 1982. As mentioned, the 1982 study was conducted with 72 children ages 6 to 12, and the sample for the 1986 study was 38 children ages 6 to 12 years. The Expectations of Therapy Outcome Scale is a 7-item questionnaire measuring expectations for how the child will feel, act, think, and get along with others differently as a result of therapy and the extent to which the child’s problems will change over the course of treatment. Items are phrased in the form of a question. Participants respond to each question on a 9-point Likert scale, and the sum of the item ratings yields a total score, with higher scores indicating more positive outcome expectations for therapy. The questionnaire has parent and child forms. The directions are phrased differently on the two forms so the directions for children are developmentally appropriate. Also, wording of questions is slightly altered between the two forms to reflect whether parents or children are answering the items (e.g., “How do you expect your child to feel when therapy is over?” on the parent form versus “How do you expect to feel when therapy is over?” on the child form). Otherwise, the two forms are the same. Like the other measures in the study, the Expectations of Therapy Outcome Scale differentiated between children and parents who had received preparation for therapy and children and parents who had not received preparation in the Bonner and Everett (1986)
study \[F(1, 34) = 6.09, p < .02\], though no additional psychometrics have been gathered to date.

**Total parent and child views of therapy.** Hypotheses 1 and 2 involve parent and child views of therapy, which include expectations for the process of therapy, receptivity to therapy, and outcome expectations for therapy. Total scores for parent and child views were used in testing these hypotheses. Total scores for parent views were created by totaling the parent’s scores (using z scores) on the Therapy Survey, Attraction-Receptivity Questionnaire, and Expectations of Therapy Outcome Scale. Similarly, total scores for child views were created by totaling the child’s scores (using z scores) on the Therapy Survey-Child Version (Revised), Attraction-Receptivity Questionnaire, and Expectations of Therapy Outcome Scale. These total scores, as well as scores on each of the three individual measures, were utilized in hypothesis testing.

**Preparation of child for therapy.** The amount, accuracy, and valence of preparation of children by parents were assessed with a semi-structured Preparation Interview that was created for the current study. The parent and child versions of the interview investigate whether the parent prepared the child for treatment, the extent to which the parent prepared the child, the content of the preparation, and feelings that the parent had while preparing the child (see Appendices G and H). The interview was created for the purpose of the study because no established instruments existed for gathering these data.

Questions assessing the content of the preparation were formulated on the basis of previous research on expectations for the process of therapy. Past research was examined to determine factors that other researchers deemed to be important in assessing
expectations for the process of therapy. This research included the Bonner and Everett (1986) study and also studies by Coleman and Kaplan (1990), Day and Reznikoff (1980), Shuman and Shapiro (2002), and Weinstein (1988). All these studies involved formal therapy preparation programs and demonstrated that the preparation programs increased the accuracy of expectations regarding such areas of therapy.

The Preparation Interview has parent and child versions, with the primary difference between the two versions being wording geared toward whether the respondent is a parent or child (e.g., “your child” vs. “you”). The interview begins with two broad, open-ended questions about whether the parent talked to the child at all about the child’s first therapy appointment and, if so, what the parent discussed. Then, 11 more specific questions are asked to determine whether the parent discussed specific information about therapy, including why the child is seeing the therapist; what the child, parent, and therapist will do in therapy; how helpful therapy will be for the child; what kinds of things the child can talk about with the therapist; whether therapy will be easy or hard for the child; whether therapy will be fun or boring for the child; how long the intake appointment will be; how often the child will see the therapist; and how many times the child will see the therapist. If the parent or child indicates that the parent did discuss a particular topic with the child, then the interviewer queries what was discussed in relation to that topic. Following the 11 specific questions, the parent is asked who started any preparation conversations that occurred, and parents and children are asked whether the child made any comments or asked any questions during the conversation(s). The child then is asked what he or she thinks will happen at his or her intake appointment. Finally, parents and children are provided with a list of feelings and asked
to indicate which feelings that they have regarding the intake appointment and which feelings that they think the other person has regarding the intake appointment. The parent and child interviews are administered separately rather than concurrently and typically take about 5 minutes each to administer.

Interviewers follow this general format but are free to make additional inquiries if further clarification is needed. For example, a parent may respond, “He knows about that,” and the interviewer may ask a question to clarify whether the parent assumes that the child knows about the topic or whether the topic was actually discussed. As another example, a participant may provide a response that does not actually answer the question, and then the interviewer would ask the question again, perhaps providing clarification of the question’s meaning.

Because the Preparation Interview was created for the current study, the first five participants in the study were used to pilot test the interview to ensure that the questions were understandable and appropriate for parents and children. The interview did not undergo any changes as a result of the pilot testing. Because no changes were made to the interview and because exactly the same procedures were used for these five participants as were used for all participants, these five participants were included in the actual sample for the study.

Data from the current study were utilized to gain some initial psychometric data for the Preparation Interview. Cronbach’s alpha was computed to determine internal consistency among Preparation Interview items. Internal consistency was computed using completeness scores for the 11 main items of the interview (each item receives a score of 0 points for completeness if an item was not discussed and 1 point for completeness if an
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Completeness scores were utilized because those were believed to best represent the content of the Preparation Interview, whereas accuracy and valence scores are descriptions of how the items were answered and are dependent on whether an item was discussed (i.e., a topic cannot be discussed accurately or positively/negatively if it was not discussed at all). Cronbach’s alpha was 0.71 for the parent version of the interview and 0.75 for the child version. These results suggest that the Preparation Interview has an acceptable level of internal consistency.

An exploratory factor analysis also was performed to gain further psychometric information regarding the Preparation Interview. The factor analysis was conducted using principal component analysis with Quartimax rotation. Again, completeness scores for the 11 main items of the interview were used to conduct the analysis.

For the parent version of the Preparation Interview, results initially produced four factors with eigenvalues greater than 1. Based on the scree plot of this variance and theoretical understanding of the scale items, factors were restricted and reviewed. This process resulted in a proposed 3-factor model, which explains 53.94% of the variance in the parent version of the Preparation Interview. The first factor includes 5 items and is defined as Basic Child Information. The items composing this factor contain information that would be essential for a child to receive if he or she were to have an understanding of why he or she is going to therapy, what will happen when he or she is there, and what the impact will be. Factor 2 contains 3 items and is defined as Peripheral Child Information. These items include information that would help the child to have a better understanding of therapy but do not seem crucial to having a basic understanding of therapy. Finally, Factor 3 includes 3 items and is defined as Therapy Logistics. The 3 items in this factor
describe how long the child’s intake appointment will be, how often the child will see the therapist, and how many times the child will see the therapist. Factor 1 explains 26.75% of variance in the parent version of the Preparation Interview, Factor 2 explains 15.64% of the variance, and Factor 3 explains 11.55% of the variance. See Table 1 for the eigenvalue and factor loading for each item. Only item loadings 0.40 and above were considered. Item loadings were in the expected direction, and no items cross-loaded.
Table 1

*Factor Loadings for Preparation Interview-Parent Version*

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor (eigenvalue)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item loading</td>
<td></td>
</tr>
<tr>
<td>1 (2.94)</td>
<td></td>
</tr>
<tr>
<td>2 (1.72)</td>
<td></td>
</tr>
<tr>
<td>3 (1.08)</td>
<td></td>
</tr>
<tr>
<td>Why the child is coming to therapy</td>
<td>0.74</td>
</tr>
<tr>
<td>What the child will do with the therapist</td>
<td>0.65</td>
</tr>
<tr>
<td>What the therapist will do</td>
<td>0.59</td>
</tr>
<tr>
<td>How helpful it will be for the child to see the therapist</td>
<td>0.77</td>
</tr>
<tr>
<td>What kinds of things the child can talk about with the therapist</td>
<td>0.54</td>
</tr>
<tr>
<td>What the parent will do with the therapist</td>
<td>0.65</td>
</tr>
<tr>
<td>If therapy will be easy or hard for the child</td>
<td>0.76</td>
</tr>
<tr>
<td>If therapy will be fun or boring for the child</td>
<td>0.78</td>
</tr>
<tr>
<td>How long the intake appointment will take</td>
<td>0.59</td>
</tr>
<tr>
<td>How often the child will have therapy appointments</td>
<td>0.87</td>
</tr>
<tr>
<td>How many times the child will see the therapist</td>
<td>0.61</td>
</tr>
</tbody>
</table>

For the child version of the Preparation Interview, results initially produced four factors with eigenvalues greater than 1. Factors were restricted and reviewed based on the scree plot of this variance and theoretical understanding of the scale items. This process suggested only one interpretable factor, with an eigenvalue of 3.33 and accounting for
30.26% of the variance in the child version of the Preparation Interview. Eight of the eleven main interview topics had factor loadings above 0.40 on this factor, and two more of the topics had factor loadings of 0.35 and 0.38. See Table 2 for the factor loadings for each item. Item loadings were in the expected direction. Overall, these results suggest that further research may be needed to determine whether the child version of the Preparation Interview is a valid instrument.

Table 2

*Factor Loadings for Preparation Interview-Child Version*

<table>
<thead>
<tr>
<th>Item</th>
<th>Item loading</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why the child is coming to therapy</td>
<td>0.41</td>
</tr>
<tr>
<td>What the child will do with the therapist</td>
<td>0.72</td>
</tr>
<tr>
<td>What the parent will do with the therapist</td>
<td>0.02</td>
</tr>
<tr>
<td>What the therapist will do</td>
<td>0.64</td>
</tr>
<tr>
<td>How helpful it will be for the child to see the therapist</td>
<td>0.59</td>
</tr>
<tr>
<td>What kinds of things the child can talk about with the therapist</td>
<td>0.73</td>
</tr>
<tr>
<td>If therapy will be easy or hard for the child</td>
<td>0.50</td>
</tr>
<tr>
<td>If therapy will be fun or boring for the child</td>
<td>0.52</td>
</tr>
<tr>
<td>How long the intake appointment will take</td>
<td>0.35</td>
</tr>
<tr>
<td>How often the child will have therapy appointments</td>
<td>0.74</td>
</tr>
<tr>
<td>How many times the child will see the therapist</td>
<td>0.38</td>
</tr>
</tbody>
</table>
Procedures

All procedures were approved by the Eastern Michigan University HSRC prior to data collection.

Families were recruited from a Community Mental Health agency in Mid-Michigan, an outpatient therapy clinic in Mid-Michigan, and a university psychology clinic in Southeastern Michigan. If a family fit the criteria for the study, then at the time that the first therapy session was scheduled, the person who was scheduling the appointment (i.e., a therapist or clinic staff person) provided some very brief information about the study’s purpose, what the parent and child would need to do to participate, and how the family would be compensated for participating. Then the child’s parent was asked if he or she would be willing to be called about the project (see Appendix I for the script for schedulers). As a result of this process, 63 parents indicated that they would be interested in being contacted regarding the study.

Either the primary researcher or a graduate student research assistant called interested parents to provide the details of participating in the study (see Appendix J for the script for researchers). Fifty-four of the interested parents were able to be reached; the others were not reached before the child’s first session due to unanswered phone calls and disconnected phone numbers. When the researcher called, if a parent indicated a desire to participate in the project, then the parent and child were scheduled to participate any time the day before or day of the child’s first therapy session (as long as the research appointment occurred before the first therapy session). Fifty-one families scheduled a session to participate, and 49 families attended their scheduled session. (Three of these families had rescheduled their intake sessions but did eventually attend a research
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session.) All families who attended their research session willingly completed the informed consent and assent documents and all measures for the study. Data collection occurred either in a private office at the data collection site or in the family’s home. When the session occurred in the family’s home, data were collected in quiet, private rooms to the extent possible. Each family that participated was compensated with $10 cash, with the exception of the family from the university psychology clinic, who was compensated with one free treatment session. See Figure 1 for a flowchart of procedures.

Person scheduling the child’s intake appointment provided parent with brief information about the study, and parent indicated that he or she would be willing to be called about the project (N = 63).

Researcher reached parent by phone and provided details of participating in the study (N = 54). Research session was scheduled if parent indicated desire to participate (N = 51).

Parent and child attended scheduled session, signed informed consent and assent forms, and completed all measures (N = 49)

Figure 2. Flowchart of procedures.

The Eastern Michigan University HSRC required that parents and children complete two versions of the informed consent and assent forms, completing the first version while in the same room and the second version while separated. The purpose of having two versions was to ensure that participation was voluntary, especially in the case of children because they are a vulnerable population, according to human subjects
protection standards. The HSRC felt that obtaining this second assent, in the absence of the child’s parents, would help to ensure that children wanted to participate and were not feeling pressured by their parents to complete the study. Therefore, Version A and Version B of the informed consent and assent forms were created. The Version A forms are traditional, full-length informed consent forms. The Version B forms are brief and remind participants that participation is voluntary and that their responses are confidential. See Appendices K and L for copies of all consent and assent forms.

Either the primary investigator or a graduate student research assistant conducted the research sessions. At the beginning of the research session, parents completed the first informed consent statement, and children signed a statement to indicate their assent. Parents and children then completed the remainder of the study separately; either the child or parent waited in a separate room and then completed the study once the other person had finished. When separated, parents and children completed Version B of the Informed Consent and Assent forms to ensure that participation was voluntary.

Once that consent was obtained, parents and children were administered the demographics questionnaire (parents only), the Preparation Interview, the Therapy Survey or Therapy Survey-Child Form (Revised), the Attraction-Receptivity Questionnaire, and the Expectations of Therapy Outcome Scale. Children were read the instruments by the person conducting the session if they were unable to read them due to reading ability; approximately two to three children were read the instruments. The discussion during the Preparation Interview was audiotaped, and the person administering the interview (i.e., the person who was conducting the session) took notes during the interview. The parent and child sessions lasted approximately 15 minutes each.
All instruments other than the Preparation Interview had existing scoring procedures that allowed participants to receive a total score on a continuous scale. Because the Preparation Interview was a new instrument, a coding system was developed to score it based on the elements of the interview. Interviews were transcribed from audiotape before they were coded. Detailed, specific written instructions for the coding system were developed (see Appendix M), and interrater reliability was established between the primary investigator and a trained coder using the kappa statistic for 20% of the sample (10 child and 10 parent interviews). Interviews used to calculate interrater reliability were selected using a random number generator. Interrater reliability was 0.85 overall, with kappa coefficients of 0.91 for the child interviews and 0.79 for the parent interviews.

Total scores of 3 to 15 are possible on the Preparation Interview. For each preparation component (i.e., completeness, accuracy, and valence of preparation), each parent interview and each child interview received a score from 1 to 5. In other words, each participant received a completeness of preparation score ranging from 1 to 5, with higher scores indicating increased completeness of preparation information; an accuracy score ranging from 1 to 5, with higher scores indicating increased accuracy of preparation information; and a valence score ranging from 1 to 5, with higher scores symbolizing increasingly positive valence.

The completeness score describes the extent to which the parent prepared the child for the first therapy session. Scores are determined on the basis of the number of the 11 main interview topics that the participant reports were discussed. A score of 1 reflects that no information was discussed. A score of 2 indicates that the participant reported that
1-3 of the 11 topics were discussed or that information about therapy was discussed but did not relate to any of the 11 topics. A score of 3 is assigned if the participant reported that 4-6 of the 11 topics were discussed, a score of 4 is assigned if the participant reported that 7-9 of the topics were discussed, and a score of 5 indicates that the participant reported that 10-11 of the topics were discussed.

The accuracy score on the Preparation Interview reflects the degree to which the preparation information provided by the parent to the child correctly describes the therapy situation. The score is determined on the basis of the number accurately discussed of the 9 main interview topics that are pertinent to accuracy. Full preparation in the area of accuracy would mean that all 9 of these topics were discussed in an accurate manner. A score of 1 is assigned if the participant reports that no information was discussed or that no accurate information was provided. Increasing scores indicate that an increasing number of interview topics were discussed in an accurate manner, with a score of 5 indicating that 8-9 of the 9 topics were discussed in an accurate manner.

The valence score on the Preparation Interview reflects the overall tone of the preparation information that was provided by the parent to the child. Scores are determined on the basis of whether preparation information was positive, negative, or neutral in valence. Information considered in determining the valence score includes all statements that are made during the interview as well as the feelings that the parent or child circles at the bottom of the page regarding the parent’s feelings about the intake appointment.

Examples of positive information include the parent commenting to the child that therapy will be helpful, stating that therapy will be fun or easy, stating that therapy will
be hard but worth the effort, stating that the child will like therapy and/or the therapist, stating that the parent is happy that the child is coming to therapy, circling that the parent is happy about the intake appointment, and so on. Negative information includes statements such as that therapy will not be helpful, that therapy will be hard with no reassurance to the child that therapy will be worth the effort, that therapy will be boring with no reassurance to the child that some aspects of therapy will be more fun than others, that the child will not like therapy and/or the therapist, that the parent is upset that the child is coming to therapy, and so on. If any negative feelings (e.g., mad, sad) are circled at the bottom of the page regarding the parent’s feelings about therapy, then that information is considered negative in valence also. Preparation information is considered neutral if a parent makes an information-giving statement (e.g., “I told her that the appointment would be an hour”), if a parent tells the child that he/she does not know about a particular topic, or if a neutral feeling (e.g., uncertain) is circled to describe the parent’s feelings about therapy. Failure to discuss a topic is also considered neutral in valence.

Scores of 1 for valence indicate that all preparation information was negative or neutral in valence. (Note: If all information was neutral, then the valence score is a 3). A score of 2 is assigned if preparation information contained both information with a negative valence and information with a positive valence, but information with a negative valence outnumbered information with a positive valence. A score of 3 is appropriate when all preparation information was neutral in valence or preparation information contained both information with a negative valence and information with a positive valence, and the coder is unable to determine whether information with a positive valence
or information with a negative valence is more prevalent. Scores of 4 are assigned when preparation information contained both information with a negative valence and information with a positive valence, but information with a positive valence outnumbered information with a negative valence. Finally, a score of 5 indicates that all preparation information was positive or neutral in valence.

**Anomalies in Data Collection Procedures**

Some procedures that have been described to this point represent changes that occurred prior to or during data collection. These changes were all made in relation to difficulties that occurred in locating data collection sites and obtaining participants. The original intent was that participants would complete the research session immediately before the first therapy session, that families would be recruited from outpatient clinics and complete research sessions at the clinic, and that only families whose child had no previous therapy experience would be eligible to participate. Because some potential data collection sites expressed concerns that conducting the research session immediately before the intake could interfere with their own pre-intake procedures, a change was made that participants could complete the research session any time the day before or day of the intake session, as long as the research session occurred before the intake session.

Similarly, concerns about the research being conducted in the clinic resulted in a change that allowed research sessions to be conducted in family homes. Difficulties continued in locating a site or sites to collect data. The university psychology clinic participated from the beginning but had very low numbers of children who met criteria for the study. The outpatient clinic in Mid-Michigan also agreed to participate but did not have any children who fit criteria for the study. Finally, the Community Mental Health
center was identified as a source of participants, although the majority of participants would be receiving home-based therapy. The decision was made to include the families who would be receiving home-based therapy so data collection could be completed in a timely manner. Adding participants from the Community Mental Health center helped with obtaining participants, but finding families who fit the study’s criteria continued to be a very slow process. Therefore, a final change was made to include families whose child had received therapy previously. These changes allowed for the completion of data collection.
Results

Missing Data and Multiple Responses

Several participants in the study left blank responses to single questions. In other cases, some respondents indicated two response choices for one question. No particular trends emerged regarding specific items that were likely to be left blank or answered with multiple responses. To perform the analyses, these missing data and multiple responses needed to be addressed. Therefore, if a participant left an item blank, then the mean score for that item on the version of the form that was being used (i.e., parent or child version) was substituted for the missing data. In the case of participants who provided two responses for the same question, the response that was the more common of the two responses (as determined by counting the number of participants who gave each of the two responses on the version of the form being used) was entered as the participant’s answer.

Descriptive Statistics

Descriptive analyses were utilized to gain an initial picture of how parents and children responded to the various measures. Examination of the parent and child data sets revealed some interesting information. Differences and similarities between parents and children were evident for the measures utilized in the study.

Expectations for the process of therapy. The mean score for parents on the Therapy Survey was 20.10 ($SD = 2.87$), and scores ranged from 11 to 24. Both the median and modal scores for parents were 21. On the Therapy Survey-Child Version (Revised), children’s mean score was 16.41 ($SD = 2.89$), with scores ranging from 10-22. The median and modal scores for children were both 17. These results indicate that in
general, parents had more accurate expectations about the process of therapy than children did. The item that caused the most difficulty for parents and children in this area pertained to the therapist’s role in keeping children from becoming angry. Only 31% of parents ($n = 15$) and 10% of children ($n = 5$) answered correctly that therapists do not try to keep children from getting angry. Conversely, 98% of parents ($n = 48$) and 96% of children ($n = 47$) correctly responded that both the child and the therapist work on the child’s problem in therapy. On several other items of the Therapy Survey, every parent or nearly every parent answered correctly, indicating that most or all parents knew that children in therapy usually require more than one or two sessions, that children can talk about secrets in their therapy sessions, and that a therapist will not tell other people everything that a child says or does in a therapy session.

**Receptivity to engaging in child psychotherapy.** Parents had a mean score of 14.82 ($SD = 4.62$) on the Attraction-Receptivity Questionnaire, and scores ranged from 0-20. The median score for parents was 16, and the modal score was 18. Children had a mean score of 9.29 ($SD = 5.93$), and their scores also ranged from 0-20. Children’s median score was 9. Interestingly, the modal score for children was 2. These results indicate that in general, parents reported higher receptivity to therapy than children did. The item that parents were least likely to endorse in a receptive manner was “I think that a therapist will like me,” with 47% of parents believing that a therapist would like them. Children were least likely to endorse the item “I have a very warm feeling toward therapists” in a receptive manner; only 29% of children endorsed the item. For parents and children, the item most likely to be endorsed in a receptive manner was “A therapist is a person who would really like to help me,” with 96% of parents and 63% of children
endorsing the item. See Appendix N for a listing of all items on the Attraction-Receptivity questionnaire and percentages of parents and children endorsing each item.

**Outcome expectations for therapy.** On the Expectations of Therapy Outcome Scale, the average score for parents was 50.67 \((SD = 6.66)\), with scores ranging from 37-63. Parents had a median score of 51 and a modal score of 49. The average score for children was 43.78 \((SD = 11.91)\), and children’s scores ranged from 17-63. The median score for children was 45, and the modal score for children was 51. In general, parents had more positive expectations about the outcome of therapy than children did. The outcome about which children had the lowest expectations was how helpful they expected therapy to be. Children’s average rating for this item was 5.92 \((SD = 2.69)\) on a Likert scale from 1 to 9, with 1 indicating “Not at all helpful” and 9 indicating “Very helpful.” The outcome about which children were most optimistic was the change that they expected to see in their problems by the end of therapy. The average rating for children on that item was 6.76 \((SD = 1.84)\), again using a 9-point Likert scale, with 1 indicating “Problems will be much worse” and 9 indicating “Problems will be much better.” Although these two items were the one that children rated most lowly and the one that children rated most highly, not much variance existed between the item ratings. Both ratings were in the moderate range of outcome expectations. For parents, the outcome viewed most negatively was how clearly they expected their child to think when therapy was over, with average parent ratings of 7.04 \((SD = 1.08)\) on a 9-point Likert scale. A rating of 1 indicated “Will think much less clearly,” and a rating of 9 indicated “Will think much more clearly.” Note that the item rated lowest by parents had a higher average rating than the item rated highest by children. Parents had the most positive expectations
with regard to how they expected their child to feel when therapy was over and how satisfied they expected to be at the end of the child’s therapy. Both items had an average rating of 7.35 on a 9-point Likert scale. Note that average item ratings for parents had even less variance than children’s average item ratings did, with the lowest-rated item by parents receiving an average score of 7.04 and the highest-rated items receiving scores of 7.35.

**Preparation of child for therapy.** On the Preparation Interview, parents had an average total score of 9.94 ($SD = 1.85$), and scores ranged from 5-14. The median score for parents was 10, with a modal score of 11. Children’s accounts of how their parents prepared them for therapy resulted in an average total score of 8.71 ($SD = 1.94$), with scores ranging from 5-13. Children’s median score was 9, and their modal score was 7. These results indicate that parents, on average, had higher preparation scores than children did. In fact, only seven parents had lower preparation scores than their children.

Parents’ scores on the three components that compose the total preparation score also were higher than children’s scores. Average completeness scores were 2.80 ($SD = 0.87$) for parents and 2.29 ($SD = 0.91$) for children, average accuracy scores were 2.53 ($SD = 0.82$) for parents and 2.06 ($SD = 0.80$) for children, and average valence scores were 4.61 ($SD = 0.70$) for parents and 4.37 ($SD = 0.95$) for children.

See Tables 3 and 4 for information regarding the percentages of parents and children who reported that each of the main Preparation Interview topics was discussed and was discussed accurately by the parent. That an item was discussed completely means that the parent discussed that item with his or her child, regardless of whether the provided information was correct. If the child was provided with correct information
about a topic, then that topic was discussed accurately. Further clarification of complete and accurate information is provided in the Instructions for Coding the Preparation Interview (Appendix M). A noteworthy finding is that three parents (6%) and nine children (18%) reported that parents did not discuss any of the preparation information explored in the interview.
Table 3

*Percentage of Parents Reporting That Each of the Main Preparation Interview Topics Was Discussed Completely and Accurately With Their Children*

<table>
<thead>
<tr>
<th>Interview Topic</th>
<th>Percentage of Parents Reporting That Topic Was Discussed</th>
<th>Percentage of Parents Reporting That Topic Was Discussed Accurately</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why the child is coming to therapy</td>
<td>80% (n = 39)</td>
<td>80% (n = 39)</td>
</tr>
<tr>
<td>What the child will do with the therapist</td>
<td>43% (n = 21)</td>
<td>43% (n = 21)</td>
</tr>
<tr>
<td>What the parent will do with the therapist</td>
<td>31% (n = 15)</td>
<td>29% (n = 14)</td>
</tr>
<tr>
<td>What the therapist will do</td>
<td>55% (n = 27)</td>
<td>55% (n = 27)</td>
</tr>
<tr>
<td>How helpful it will be for the child to see the therapist</td>
<td>82% (n = 49)</td>
<td>not applicable</td>
</tr>
<tr>
<td>What kinds of things the child can talk about with the therapist</td>
<td>55% (n = 27)</td>
<td>55% (n = 27)</td>
</tr>
<tr>
<td>If therapy will be easy or hard for the child</td>
<td>27% (n = 13)</td>
<td>16% (n = 8)</td>
</tr>
<tr>
<td>If therapy will be fun or boring for the child</td>
<td>16% (n = 8)</td>
<td>not applicable</td>
</tr>
<tr>
<td>How long the intake appointment will take</td>
<td>55% (n = 27)</td>
<td>47% (n = 23)</td>
</tr>
<tr>
<td>How often the child will have therapy appointments</td>
<td>29% (n = 14)</td>
<td>24% (n = 12)</td>
</tr>
<tr>
<td>How many times the child will see the therapist</td>
<td>4% (n = 2)</td>
<td>2% (n = 1)</td>
</tr>
</tbody>
</table>
Table 4

*Percentage of Children Reporting That Each of the Main Preparation Interview Topics Was Discussed Completely and Accurately by Their Parents*

<table>
<thead>
<tr>
<th>Interview Topic</th>
<th>Percentage of Children Reporting That Topic Was Discussed</th>
<th>Percentage of Children Reporting That Topic Was Discussed Accurately</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why the child is coming to therapy</td>
<td>57% ((n = 28))</td>
<td>53% ((n = 26))</td>
</tr>
<tr>
<td>What the child will do with the therapist</td>
<td>45% ((n = 22))</td>
<td>41% ((n = 20))</td>
</tr>
<tr>
<td>What the parent will do with the therapist</td>
<td>4% ((n = 2))</td>
<td>4% ((n = 2))</td>
</tr>
<tr>
<td>What the therapist will do</td>
<td>43% ((n = 21))</td>
<td>39% ((n = 19))</td>
</tr>
<tr>
<td>How helpful it will be for the child to see the therapist</td>
<td>41% ((n = 20))</td>
<td>not applicable</td>
</tr>
<tr>
<td>What kinds of things the child can talk about with the therapist</td>
<td>35% ((n = 17))</td>
<td>33% ((n = 16))</td>
</tr>
<tr>
<td>If therapy will be easy or hard for the child</td>
<td>14% ((n = 7))</td>
<td>2% ((n = 1))</td>
</tr>
<tr>
<td>If therapy will be fun or boring for the child</td>
<td>14% ((n = 7))</td>
<td>not applicable</td>
</tr>
<tr>
<td>How long the intake appointment will take</td>
<td>22% ((n = 11))</td>
<td>14% ((n = 7))</td>
</tr>
<tr>
<td>How often the child will have therapy appointments</td>
<td>24% ((n = 12))</td>
<td>18% ((n = 9))</td>
</tr>
<tr>
<td>How many times the child will see the therapist</td>
<td>10% ((n = 5))</td>
<td>6% ((n = 3))</td>
</tr>
</tbody>
</table>
Regarding the valence of the interviews, 36 parents reported that a mix of positive and neutral preparation information had been provided to the child, 12 parents reported a mix of positive and negative preparation information, and 1 parent reported a mix of negative and neutral preparation information. In the child interviews, 31 children reported a mix of positive and neutral preparation information, 16 children reported a mix of positive and negative preparation information, 1 child reported a mix of negative and neutral information, and 1 child reported only neutral preparation information.

In addition, the Preparation Interview included a few questions that were not part of formal hypothesis testing but do provide some insight into the preparation of children for therapy. Parents were asked who had started the conversation(s) that they had with their children about therapy. The majority of parents responded that they began the conversations, although several parents noted that both they and their children began conversations. Two children reportedly initiated a conversation about therapy with their parents.

During the Preparation Interview, parents and children also were asked what the child said (if anything) about the upcoming intake appointment. The most common responses were that the child said nothing or that the child did not want to attend the appointment/did not think that he or she needed therapy. Twenty-four children (49%) and 12 parents (24%) reported that the child had said nothing, and seven children (14%) and 12 parents (24%) reported that the child did not want to attend/did not think that he or she needed therapy. Eight parents (16%) reported that their children asked questions about practical information such as when they would see the therapist, who the therapist would be, why they were experiencing their symptoms, and so on. Five children (6%) and two
parents (4%) stated that the child was open to receiving help, with two of those children even expressing excitement about the upcoming appointment. Two children had expressed to their parents that they were nervous about the appointment.

At the end of the Preparation Interview, children were queried about what they thought would occur during their upcoming intake appointment. The two most common responses were that the child did not know what was going to happen (47%) or that the child expected to talk (35%). Some children just stated that they would be talking during the appointment, and other children specified that they would be talking about problems or symptoms that they were experiencing. One child stated that she was going to “get checked out.” A couple of children expressed positive expectations for the appointment, with one child predicting that he/she would have fun during the appointment and another child stating that he/she would feel better after the appointment.

**Comparison of parent scores to child scores.** Because parent scores on all measures in the current study were higher than child scores were, paired samples t tests were conducted to examine whether parents’ scores were significantly higher than children’s scores. These analyses indicated that parents’ scores on all four measures in the current study (the Therapy Survey, Attraction-Receptivity Questionnaire, Expectations of Outcome Scale, and Preparation Interview) were significantly higher than children’s scores were. See Table 5 for results of paired samples t tests examining relationships between parents’ and children’s scores. See results for Hypothesis 2 for further information regarding the relationship between parent and child scores on the Preparation Interview.
Table 5

Summary of Paired Samples t-tests Results for the Relationship Between Parent and Child Scores (N = 49)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Parent Mean (SD)</th>
<th>Child Mean (SD)</th>
<th>t test results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy Survey/Therapy Survey-Child Version (Revised)</td>
<td>20.10 (2.87)</td>
<td>16.41 (2.89)</td>
<td>( t(48) = 6.12^{**} )</td>
</tr>
<tr>
<td>Attraction-Receptivity Questionnaire</td>
<td>14.82 (4.62)</td>
<td>9.29 (5.93)</td>
<td>( t(48) = 5.20^{**} )</td>
</tr>
<tr>
<td>Expectations of Outcome Questionnaire</td>
<td>50.67 (6.66)</td>
<td>43.78 (11.91)</td>
<td>( t(48) = 3.73^{*} )</td>
</tr>
<tr>
<td>Total Preparation Interview</td>
<td>9.94 (1.85)</td>
<td>8.71 (1.94)</td>
<td>( t(48) = 4.72^{**} )</td>
</tr>
<tr>
<td>Completeness of Preparation</td>
<td>2.80 (0.87)</td>
<td>2.29 (0.91)</td>
<td>( t(48) = 4.11^{**} )</td>
</tr>
<tr>
<td>Accuracy of Preparation</td>
<td>2.53 (0.82)</td>
<td>2.06 (0.80)</td>
<td>( t(48) = 4.29^{**} )</td>
</tr>
<tr>
<td>Valence of Preparation</td>
<td>4.61 (0.70)</td>
<td>4.37 (0.95)</td>
<td>ns</td>
</tr>
</tbody>
</table>

*\( p < .01 \). **\( p < .001 \).

Hypothesis Testing

**Hypothesis 1.** Hypothesis 1 speculated that children’s ages would be positively correlated with their expectations about the process of therapy. A Pearson product-moment correlation coefficient was computed to assess the relationship between children’s ages and children’s expectations about the process of therapy. A positive correlation was present between the two variables, but it was low and non-significant, \( r = .23, n.s. \) Therefore, results did not provide support for Hypothesis 1.

**Hypothesis 2.** Hypothesis 2 predicted that parents would provide a more favorable account of preparation than children would. A paired samples t test was
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cast to compare preparation scores of parents and children. A significant difference was found between parents’ total preparation scores \((M = 9.94, SD = 1.85)\) and children’s total preparation scores \((M = 8.71, SD = 1.94)\), \(t(48) = 4.72, p < .001\). Parents’ completeness of preparation scores \((M = 2.80, SD = 0.87)\) and children’s completeness of preparation scores \((M = 2.29, SD = 0.91)\) also were significantly different, \(t(48) = 4.11, p < .001\). Additionally, a significant difference was found between parents’ accuracy of preparation scores \((M = 2.53, SD = 0.82)\) and children’s accuracy of preparation scores \((M = 2.06, SD = 0.80)\), \(t(48) = 4.29, p < .001\). The difference between parents’ and children’s valence of preparation scores did not reach statistical significance. Overall, the results support Hypothesis 4.

Hypothesis 3. Hypothesis 3 of the present study was that parents and children who had prior child therapy experience would have more accurate expectations about the process of therapy than parents and children who did not have such experience. Independent samples \(t\) tests were conducted to examine the relationship of past treatment status with expectations about the process of therapy for parents and children. This relationship was not significant in the case of parents or children. Scores on the Therapy Survey for parents whose child had no past treatment \((M = 19.61, SD = 3.46)\) and parents whose child did have past treatment \((M = 20.54, SD = 2.20)\) did not significantly differ from one another, \(t(47) = 1.14, n.s.\) Additionally, scores on the Therapy Survey-Child Form (Revised) for children with no past treatment \((M = 16.26, SD = 2.78)\) and children with past treatment \((M = 16.54, SD = 3.04)\) did not significantly differ from one another, \(t(47) = 0.33, n.s.\) Therefore, Hypothesis 3 was not supported.
**Hypothesis 4.** A linear regression analysis was conducted to test the fourth hypothesis, which was that parents’ views regarding psychotherapy would be positively related to children’s views regarding psychotherapy. Because findings using independent samples t tests had suggested that treatment history could possibly impact results, treatment history was entered as a covariate in regression analyses for Hypothesis 4 to control for the influence of having prior treatment vs. not having prior treatment.

Hypothesis 4 initially was examined using the total score for parent views (i.e., the total of the parent’s scores on the Therapy Survey, Attraction-Receptivity Questionnaire, and Expectations of Therapy Outcome Scale) and a total score for child views (i.e., the total of the child’s scores on the Therapy Survey-Child Version [Revised], Attraction-Receptivity Questionnaire, and Expectations of Therapy Outcome Scale). Parent and child views were not significantly related when using total scores to represent parent and child views. See Table 6 for results.

Hypothesis 4 was investigated further using individual measures of parent and child views rather than total parent and child scores. Analyses examined the relationships between 1) the Therapy Survey and Therapy Survey-Child Version (Revised), 2) the parent and child forms of the Attraction-Receptivity Questionnaire, and 3) the parent and child forms of the Expectations of Therapy Outcome Scale. For all regression analyses, treatment history (i.e., whether or not the child had received prior psychotherapy) was included as a covariate. These analyses also did not produce any statistically significant results regarding the relationship between parent and child views of therapy. See Table 6 for results.
Table 6

Summary of Regression Analyses for Parent Views of Psychotherapy as Predictors of Children’s Views of Psychotherapy, Controlling for Treatment History (N = 49)

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Dependent variable</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total score for parent views</td>
<td>Total score for child views</td>
<td>.09</td>
</tr>
<tr>
<td>Parent expectations for the process of therapy</td>
<td>Child expectations for the process of therapy</td>
<td>-.09</td>
</tr>
<tr>
<td>Parent receptivity to therapy</td>
<td>Child receptivity to therapy</td>
<td>.03</td>
</tr>
<tr>
<td>Parent outcome expectations for therapy</td>
<td>Child outcome expectations for therapy</td>
<td>.14</td>
</tr>
</tbody>
</table>

Summary of Hypothesis 4. Contrary to expectations, parent and child views were not significantly related when using total scores or individual measures to represent parent and child views. Therefore, no support was provided for Hypothesis 4.

Hypothesis 5

Review of requirements for tests of mediation. Hypothesis 5, that preparation would mediate the relationship between parents’ and children’s views, was a mediation hypothesis. One popular method of testing for possible mediation, the causal steps method outlined by Baron and Kenny (1986), involves four steps: 1) establishing that a relationship exists between the independent variable and the dependent variable, 2) establishing that a relationship exists between the independent variable and the possible mediator, 3) establishing that a relationship exists between the possible mediator and the dependent variable, and 4) conducting a multiple regression analysis with the independent variable and possible mediator predicting the dependent variable. If one or
more of the relationships in steps 1-3 are nonsignificant, then researchers usually conclude that mediation is not possible or not likely. Some concerns have been raised regarding this approach, including concerns about low power and relatively high rates of Type II errors. Additionally, in some cases, significant mediation can exist when the requirement of a significant relation of the independent variable to the dependent variable is not obtained (MacKinnon, Fairchild, & Fritz, 2007). Some other approaches to test for mediation, including the difference in coefficients approach and the product of coefficients approach, calculate the indirect effect and test it for significance (MacKinnon et al., 2007). Some researchers have recommended that the most effective approach to determining whether mediation could exist is to assess the significance of the relationship of the independent variable to the possible mediator and then the relationship of the possible mediator to the dependent variable; if both are statistically significant, then evidence of mediation exists (MacKinnon et al., 2007). Such an approach controls Type I error adequately, is relatively powerful, is fairly easy to compute, and is versatile in use (Krause et al., 2010). The current study took into account this approach and also the popular Baron and Kenny approach in determining whether possible mediation existed for Hypothesis 5.

When considering typical approaches toward mediation, a significant relationship between the independent variable and dependent variable and/or a significant relationship between the independent variable and the possible mediator and the possible mediator and the dependent variable must be present to consider that possible mediation exists. Analyses for Hypothesis 4 had already indicated no significant association between the independent variable (parents’ views of therapy) and dependent variable (children’s
views of therapy). Thus, mediation was not possible according to the methods recommended by Baron and Kenny (1986).

Further regression analyses were conducted to examine the relationship between the independent variable (parental views of therapy) and the possible mediator (preparation), as well as the relationship between the possible mediator (preparation) and the dependent variable (children’s views of therapy). Initial analyses examined these relationships using total scores for parent views, total preparation scores, and total scores for child views. Subsequent analyses examined relationships using individual measures of parent and child views and using the three components of preparation (i.e., completeness, accuracy, and valence). Analyses were conducted using parents’ accounts of preparation and children’s accounts of preparation separately. Treatment history was included as a covariate in all analyses.

**Relationship between parent views of therapy and preparation of child for therapy.** The regression analyses using total scores for parent views and preparation did not suggest significant relationships between parents’ total scores and parent or child accounts of preparation (see Tables 7 and 8). This finding indicates that overall, parental views were not related to how parents prepared their children for therapy.

Analyses then examined the relationships between individual measures of parents’ views (i.e., parents’ scores on the Therapy Survey, Attraction-Receptivity Questionnaire, and Expectations of Therapy Outcome Scale) with parent and child total accounts of preparation. Again, no significant relationships surfaced between parents’ views of therapy and child or parent accounts of preparation (see Tables 7 and 8).
Finally, analyses examined total scores for parent views and individual scores on the Therapy Survey, Attraction-Receptivity Questionnaire, and Expectations of Therapy Outcome Scale in relation to the three components of preparation. These analyses also yielded no significant relationships between parent views and child or parent accounts of preparation (see Tables 7 and 8).
Table 7

*Summary of Regression Analyses for Parent Views of Psychotherapy as Predictors of Parent Reports of Preparation, Controlling for Treatment History (N = 49)*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Dependent variable</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total score for parent views</td>
<td>Total preparation score</td>
<td>.26</td>
</tr>
<tr>
<td>Parent expectations for process of therapy</td>
<td>Total preparation score</td>
<td>.12</td>
</tr>
<tr>
<td>Parent receptivity to therapy</td>
<td>Total preparation score</td>
<td>.24</td>
</tr>
<tr>
<td>Parent outcome expectations for therapy</td>
<td>Total preparation score</td>
<td>.20</td>
</tr>
<tr>
<td>Total score for parent views</td>
<td>Completeness of preparation</td>
<td>.24</td>
</tr>
<tr>
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<td>Completeness of preparation</td>
<td>.12</td>
</tr>
<tr>
<td>Parent receptivity to therapy</td>
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<td>.18</td>
</tr>
<tr>
<td>Parent outcome expectations for therapy</td>
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<td>.22</td>
</tr>
<tr>
<td>Total score for parent views</td>
<td>Accuracy of preparation</td>
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<tr>
<td>Parent expectations for process of therapy</td>
<td>Accuracy of preparation</td>
<td>.18</td>
</tr>
<tr>
<td>Parent receptivity to therapy</td>
<td>Accuracy of preparation</td>
<td>.21</td>
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<td>Accuracy of preparation</td>
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<tr>
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<tr>
<td>Parent outcome expectations for therapy</td>
<td>Valence of preparation</td>
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Table 8

*Summary of Regression Analyses for Parent Views of Psychotherapy as Predictors of Child Reports of Preparation, Controlling for Treatment History (N = 49)*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Dependent variable</th>
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<td>Total preparation score</td>
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<td>Total preparation score</td>
<td>.22</td>
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<td>Parent outcome expectations for therapy</td>
<td>Total preparation score</td>
<td>.15</td>
</tr>
<tr>
<td>Total score for parent views</td>
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<td>Parent expectations for process of therapy</td>
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<td>Parent outcome expectations for therapy</td>
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</tr>
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<td>Parent outcome expectations for therapy</td>
<td>Valence of preparation</td>
<td>.02</td>
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*Relationship between preparation of child for therapy and child views of therapy.* Regression analyses were conducted to examine the relationship between total preparation scores and total scores for child views of therapy. Children’s total accounts of
preparation were significantly related to total scores for child views of therapy, \( B = .29, t(46) = 1.99, p = .053 \). This result suggests that greater preparation for therapy was associated with more accurate and positive views of therapy. Parent total accounts of preparation were not significantly related to total scores for child views of therapy.

Analyses then examined the relationship between total accounts of preparation and individual measures of children’s views of therapy (i.e., the Therapy Survey-Child Version [Revised], the Attraction-Receptivity Questionnaire, and the Expectations of Therapy Outcome Scale). Parent and child total accounts of preparation were not significantly related to children’s expectations about the process of therapy, receptivity to therapy, or expectations for therapy outcome when examining relationships between total preparation scores and individual measures of child views.

Finally, analyses were conducted to examine the relationship between the three components of preparation (i.e., completeness, accuracy, and valence) and children’s views of therapy, using total scores for child views as well as the three individual measures of child views. A few of these relationships reached statistical significance. When using parent accounts of preparation in the analyses, completeness of preparation was a significant variable in predicting children’s expectations for the process of treatment, \( B = .31, t(46) = 2.13, p < .05 \), such that more complete preparation was related to more accurate expectations. When using child accounts of preparation in the analyses, valence of preparation was a significant variable in predicting total scores for child views, \( B = .35, t(46) = 2.62, p = .01 \). Child accounts of preparation valence also were significant in predicting children’s outcome expectations for therapy, \( B = .34, t(46) = 2.57, p = .01 \).
These results suggest that more positive preparation was related to more accurate and positive views of therapy. See Tables 9 and 10 for results.

Table 9

*Summary of Regression Analyses for Parent Reports of Preparation as Predictors of Children's Views of Therapy, Controlling for Treatment History (N = 49)*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Dependent variable</th>
<th>$B$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total preparation score</td>
<td>Total score for child views</td>
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<td>Total preparation score</td>
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<td>Child outcome expectations for therapy</td>
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<tr>
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<td>Child receptivity to therapy</td>
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<tr>
<td>Completeness of preparation</td>
<td>Child outcome expectations for therapy</td>
<td>.24</td>
</tr>
<tr>
<td>Accuracy of preparation</td>
<td>Total score for child views</td>
<td>.22</td>
</tr>
<tr>
<td>Accuracy of preparation</td>
<td>Child expectations for process of therapy</td>
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<td>Child receptivity to therapy</td>
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<td>Accuracy of preparation</td>
<td>Child outcome expectations for therapy</td>
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<tr>
<td>Valence of preparation</td>
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<td>Valence of preparation</td>
<td>Child expectations for process of therapy</td>
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<td>Valence of preparation</td>
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</tr>
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</tr>
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</table>

*p < .05.*
Table 10

Summary of Regression Analyses for Child Reports of Preparation as Predictors of Children's Views of Therapy, Controlling for Treatment History (N = 49)

<table>
<thead>
<tr>
<th>Predictor</th>
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</tr>
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<td>Total preparation score</td>
<td>Child outcome expectations for therapy</td>
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</tr>
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<td>Child outcome expectations for therapy</td>
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<td>Accuracy of preparation</td>
<td>Total score for child views</td>
<td>.13</td>
</tr>
<tr>
<td>Accuracy of preparation</td>
<td>Child expectations for process of therapy</td>
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<tr>
<td>Accuracy of preparation</td>
<td>Child receptivity to therapy</td>
<td>.19</td>
</tr>
<tr>
<td>Accuracy of preparation</td>
<td>Child outcome expectations for therapy</td>
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</tr>
<tr>
<td>Valence of preparation</td>
<td>Total score for child views</td>
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<td>Child receptivity to therapy</td>
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</tr>
<tr>
<td>Valence of preparation</td>
<td>Child outcome expectations for therapy</td>
<td>.34***</td>
</tr>
</tbody>
</table>

*p = .05. **p < .05. ***p = .01.

Summary of Hypothesis 5. Overall, the regression analyses did not meet the prerequisites for possible mediation and, therefore, did not provide any support for
possible mediation. In the absence of any significant relationships between parent and child views of therapy and between parental views and preparation, testing preparation as a mediator between parents’ and children’s views would not be appropriate. Consequently, the mediation proposed by Hypothesis 5 was not supported by the findings.

Analyses for Hypothesis 5 did provide support for one portion of the proposed model, however. Results indicated that how a child is prepared for therapy could be related to his or her views of therapy.

**Summary of Findings**

In conclusion, the results provided support for Hypothesis 2 and partial support for Hypothesis 5. Hypotheses 1, 3, and 4 were not supported by the results. These findings have both theoretical and clinical implications that will be discussed in the next section.
Discussion

Scores of the Current Sample in Relation to Previous Research

One previous study (Bonner & Everett, 1986) utilized the same instruments as the current study to assess expectations for the process of therapy, receptivity to therapy, and outcome expectations for therapy. To examine how the current sample of parents and children compared to other parents and children who have completed these instruments, one sample t-tests were conducted to compare the scores of the current sample to the mean scores of the Bonner and Everett sample on these measures as a comparator, as raw data from the previous study were not available.

The mean Therapy Survey score for parents in the current sample was significantly lower than the mean score for parents in the Bonner and Everett (1986) sample, $t(48) = 2.12, p = .04$. This result indicates that parents in the Bonner and Everett study had more accurate expectations for the process of therapy (i.e., were more knowledgeable about the process of therapy) than parents were in the current study. Perhaps this result could reflect that some of the parents in the Bonner and Everett study had received formal preparation for therapy, or perhaps the samples differed in some other way that impacted the results. Mean scores for children in the two samples did not differ significantly in this area. Recall that children in the current sample completed a slightly altered version of the Therapy Survey rather than the original Therapy Survey. The extent to which the changes impacted results is unknown.

The Bonner and Everett (1986) study did not report mean scores for parents and children separately on the Attraction-Receptivity Questionnaire. A mean score for the total sample (i.e., parents and children together) was reported. Comparing that mean
score to the mean score for the total current sample, the two samples did not significantly differ in their receptivity to therapy.

Finally, scores on the Expectations of Therapy Outcome scale were compared for the two samples. The two samples of parents did not differ significantly from one another. However, the scores of children in the current sample were significantly lower than the scores of children in the Bonner and Everett (1986) sample, $t(48) = 6.15, p < .001$. This result indicates that children in the current study had more negative outcome expectancies for therapy than children in the Bonner and Everett sample. Results from the present study suggest that this finding could be related to the current study’s inclusion of children with past therapy experience. Of course, further investigation would be necessary to clarify variables that are related to children’s outcome expectancies for therapy.

**Review of Current Results**

**Impact of treatment history.** Results suggested a couple of ways in which a child’s treatment history could be related to the variables under consideration. First, having past therapy experience could be associated with decreased adequacy, especially the completeness, of preparation that a parent provides to a child before the child’s intake appointment. This result does not seem surprising; parents know that the child already has some information about therapy so may assume that the child does not need much preparation. Maybe families who have had previous treatment differ in some way from families who have not had treatment (e.g., level of conflict, etc.), and such a difference could impact the preparation process.
A second finding related to treatment history was that children who had prior therapy experience tended to have more negative outcome expectations than children without past therapy. The reason for this finding can only be speculated. Factors such as poor prior experiences with therapy, a belief that therapy does not work because they have had to return to therapy, weariness about beginning to see a new therapist, chronic family problems, and so on, could be areas that influence children’s outcome expectations for repeat courses of therapy. Considering that children with past therapy experience also might have received inadequate preparation for therapy, another possibility is that children who have past therapy experience have negative outcome expectations because of the inadequate preparation that they received. Of course, these ideas would need to be investigated further to draw any valid conclusions.

**Descriptive statistics.** Descriptive statistics from the current study lend some tentative ideas about how parents and children experience the first session(s) of child therapy. Examination of parent and child scores on the measures of the present study suggests that parents, in general, have more accurate expectations about the process of therapy, are more receptive to therapy, and have more positive expectations about the outcome of therapy than children do. Scores on the Therapy Survey-Child Version (Revised), as well as information gathered from the Preparation Interview, indicate that children often do not know what to expect when they are beginning therapy. Child reports of preparation in the current study suggest that before a child begins psychotherapy, parents and children often fail to discuss information such as why the child is going to therapy; what the child, parent, and therapist will do; what will be discussed; whether therapy will be helpful for the child; whether therapy will be easy or
hard; whether therapy will be fun or boring; how long therapy appointments will be; how
often therapy appointments will occur; and how many sessions will occur. Parent reports
of preparation also indicate that parents and children often do not discuss these topics
(with the exception of why the child is going to therapy and whether therapy will be
helpful for the child) before the child begins therapy. Parent and child responses on the
Preparation Interview indicate that children frequently do not raise the topic of therapy on
their own or ask questions when their parents raise the topic. Results suggest that when
the child has prior therapy experience, preparation may be even less likely to occur or
may be less comprehensive.

Children’s scores on the Attraction-Receptivity Questionnaire, as well as
information provided during the Preparation Interview, indicate that children (at least in
the current sample) often come to therapy with low receptivity. Children may wonder
why they need to be in therapy, think that they do not need therapy, feel that they do not
want to be at the appointment, believe that they were forced by their parents to attend,
and so on. Not all parents are highly receptive to therapy, either, although in the current
sample, they were more likely to be receptive than children were.

Current results tentatively suggest that a common pattern in families could be one
in which the parent disengages from therapy and believes that the purpose of therapy is to
“fix” the child, even though the child’s problems often occur in the context of the parent-
child relationship. At the same time, the child may feel stigmatized by the family because
he or she is the identified patient. The child receives messages about the problem and
therapy through statements that are made or not made by the parent and by the manner in
which the problem and therapy are approached. Considering data from the Preparation
Interview, families were less likely to discuss what the parent would do in therapy than what the child and therapist would do. In fact, according to child reports of preparation, what the parent would do in therapy was the least discussed topic of the Preparation Interview, with only 4% of children reporting that the topic had been discussed. The low levels of preparation overall that occurred in the current sample also support the idea that parents were more focused on changing the child rather than supporting the child through the therapy process.

Considering the possibility of this pattern being a common one, the finding that parents in this sample had more knowledge and more positive attitudes about therapy than children does not seem surprising. Parents may be optimistic that the child will be “fixed” with little effort on their part. Children may feel unsupported and stigmatized by the family and uncertain of what therapy is going to involve. Current information from the Preparation Interview indicates that often children may be left wondering why they need to be in therapy, believing that they do not need therapy, feeling that they do not want to be at the appointment, thinking that they were forced by their parents to attend, and so on.

**Hypothesis 1.** Hypothesis 1 was not supported. Children’s age had only a small and not significant positive correlation with their expectations about the process of therapy. Reasons that this hypothesis was not supported are unclear. Perhaps age truly had little relationship with children’s expectations about the process of therapy in this sample. Perhaps other variables were present that interacted with age to influence children’s expectations. The somewhat limited age range of the present sample (ages 9-14 years) could explain the difference in current findings from previous studies, which
typically have included children younger than age 9. Maybe children younger than 9
years would have had significantly less knowledge about therapy than the children in the
current age group. Considering that a positive (although small) correlation was found,
another possibility is that sample size could have decreased the ability to detect a
relationship between child age and expectations about therapy process.

Recall from the literature review at the beginning of this paper that very little
research has been conducted about children’s views of psychotherapy. Some limited data
have suggested that children’s knowledge about therapy might increase with age
(Sigelman & Mansfield, 1993; Spitzer & Cameron, 1995). Therefore, the finding from
the present study that age did not have a strong correlation with children’s knowledge
about therapy does not stand in contrast to a large, well-documented body of research.
The current finding only adds some information to an area that is in the beginning stages
of being understood. If, in fact, children’s age does not have a significant relationship to
children’s knowledge about therapy, then this finding would suggest that adults (e.g.,
parents, therapists) should not assume that children of a certain age will or will not have a
certain level of knowledge about therapy.

**Hypothesis 2.** Overall, results supported Hypothesis 2; parents did have more
favorable accounts of preparation than children did. This finding was true for total
accounts of preparation, accounts of preparation completeness, and accounts of
preparation accuracy. Prior research has suggested that parent and child reports often
differ and that parents tend to give a more favorable impression about their child-rearing
practices than children do (Bogels & van Melick, 2004; Jaccard et al., 1998; Tein et al.,
1994). The results for Hypothesis 2 are generally consistent with these research findings.
The results suggest that parents are especially likely to report that more complete and accurate preparation occurred than children are likely to report. This finding indicates that further investigations of how parents prepare children for therapy would be wise to include reports from both parents and children. Both parent and child reports are likely to contain some biases and inconsistencies (Rapee, 1997), and obtaining both accounts rather than just one could help to obtain a clearer, more accurate picture of the actual preparation that occurred.

**Hypothesis 3.** Hypothesis 3 was not supported. Results did not support the idea that parents and children who had prior therapy experience had more accurate expectations about the process of therapy than parents and children who did not have prior child therapy experience. Previous research on the impact of prior therapy experience on knowledge about therapy is inconclusive. Whether expectations about therapy generally become more accurate as treatment progresses is unclear from the limited available research on the topic (e.g., Benbenishty & Schul, 1987; Furnham & Wardley, 1990; Subich & Coursol, 1985; Szajnberg & Weiner, 1989; Zind, 1991), so the results for Hypothesis 3 are not necessarily surprising. Perhaps the nature of therapy experience that someone has (such as amount of experience, what the therapy was like, etc.), as well as personal variables of the patient and therapist, could influence what knowledge is gained. The results do highlight the importance of not assuming that families with prior treatment experience have accurate knowledge about all areas of therapy. Additionally, this finding suggests that parents should not assume that their child with past therapy experience has complete, accurate knowledge about therapy.
**Hypotheses 4 and 5.** Results did not provide support for Hypothesis 4; no significant relationships existed between parents’ and children’s views of psychotherapy. The mediation proposed by Hypothesis 5 was not supported, although a portion of the proposed model (the association between preparation and children’s views of therapy) did receive some support. Examination of descriptive data and the regression analyses that were performed provides some suggestions about why Hypothesis 4 and the mediation portion of Hypothesis 5 were not supported. These results also shed further light onto the preparation processes of the families.

The finding that parents’ and children’s views of psychotherapy were not related to one another was unexpected. However, another interesting, unexpected finding was that parents’ views of therapy also had no relationship with how they prepared their child for therapy. If preparation is expected to be the vehicle that transmits parents’ views to children, but parents do not express their views through preparation, then finding no relationship between parent and child views is not surprising. Parents cannot use their own knowledge and attitudes to impact children’s knowledge and attitudes if they do not somehow share the knowledge and attitudes with the child.

The results are not suggesting that parents shared their knowledge and attitudes about therapy with children but that children’s knowledge and attitudes were not impacted; instead, the results are suggesting that parents did not share their knowledge and attitudes about therapy with children. The reason for this situation can only be speculated, but possible factors could be that many parents do not prepare their children for therapy or prepare them very little (which received some support from the current findings, especially for children who had received therapy in the past) or that parents
prepare their children for therapy but do so in a way that does not relay their knowledge
and attitudes regarding therapy.

If parents are not passing their knowledge and attitudes regarding therapy to their
children, then one must wonder what other factors are influencing children’s views of
therapy. Influences such as the media, school, and peers often play a role in forming
children’s attitudes (Starrels, 1992) and could impact children’s views of therapy. The
current study also suggests that children may have limited accurate information regarding
therapy, which could be due to receiving inaccurate information from various sources
and/or due to receiving limited information about therapy. Overall, children may not
receive accurate, realistic, and positive information about therapy unless someone takes
the time to give the child that information.

Examination of descriptive data suggests that some families had not discussed any
of the main Preparation Interview topics and that many families who did have discussion
shared only low levels of information. According to both parent and child reports of
preparation, a majority of topics covered by the Preparation Interview were discussed by
less than 50% of the sample (see Tables 1 and 2 for percentages of parents and children
who reported discussing each topic). Often, children were not active participants in the
preparation process.

Families whose child had prior therapy experience prepared their children less
adequately overall than families whose child did not have therapy experience. However,
even when treatment history was statistically controlled, still no significant relationships
surfaced between parents’ views and preparation. Parents’ knowledge and attitudes were
not associated with preparation above and beyond the effects of prior therapy experience.
Perhaps because of a lack of preparation, or perhaps because of other factors, parents did not share their knowledge and attitudes with their children. Parent views were not related to preparation, and parental and child views were not related. Preparation could not possibly have been a mediator, as was proposed, in the absence of both these relationships.

Despite this lack of evidence for mediation, one portion of the proposed model was partially supported by the results. Specifically, some evidence surfaced for the idea that preparation can be positively related to children’s views of therapy. A significant relationship between children’s total accounts of preparation and total child scores for views of psychotherapy was found. Parents’ reports of preparation completeness were positively associated with children’s expectations for the process of therapy. Additionally, children’s reports of the valence of preparation had significant relationships with total scores for child views and children’s outcome expectations for therapy.

Overall, these results suggest that preparation that occurred or did not occur could have been associated with children’s views of therapy. Although preparation did not convey parents’ views regarding psychotherapy, it still had some relation to children’s views.

Considering the insignificant relationship between parental views of therapy and preparation, concluding that preparation is inconsequential or ineffective is unwarranted. In fact, as discussed in the literature review, formal preparation programs have positively influenced children’s views of therapy (Bonner & Everett, 1986; Coleman & Kaplan, 1990; Day & Reznikoff, 1980; Shuman & Shapiro, 2002; Weinstein, 1988). In summary, the current study did not support a model where parental views of therapy were related to children’s views of therapy via the preparation that parents provided, but the results do
not disprove that parents could use preparation as a means to impact their children’s views about therapy in a positive way. Results provided some support for the idea that providing children with complete, accurate, and positive information regarding therapy may help children to increase their knowledge about the process and to have relatively positive attitudes about therapy and its outcomes. Further research with larger sample sizes could help determine whether such relationships exist.

**Clinical Implications**

This section of the paper will consider how the theoretical implications could be applied in actual clinical situations, with suggestions of actions that parents, therapists/clinics, and children could take prior to the beginning of child therapy and in the early stages of therapy.

As discussed in the theoretical implications, the idea that preparation could be associated with children’s views of psychotherapy seems to be a reasonable one. Studies have shown that formal preparation programs have influenced children’s views of therapy (Bonner & Everett, 1986; Coleman & Kaplan, 1990; Day & Reznikoff, 1980; Shuman & Shapiro, 2002; Weinstein, 1988), and children’s views were at least somewhat related to preparation in the current study. Current results indicate that children who are presenting for an initial therapy session (even those who have past experience with therapy) often do not know what to expect about the process of therapy and have negative attitudes regarding therapy. Although further research would be useful in understanding the role that preparation plays, parents and/or clinicians presumably are in a position to positively impact children’s knowledge and attitudes about therapy by providing information about therapy to the child.
Parents in the present study often had more knowledge and more positive attitudes regarding therapy than their children did. Research also has suggested that in general, adults believe that mental health treatment is beneficial for children (Jensen et al., 1991; Thompson & Smith, 1993). Children in the current sample were unlikely to raise the topic of therapy themselves. If parents could take time to talk with their child before the child’s first therapy appointment (even if the child had participated in therapy previously), conceivably they could increase the child’s knowledge about therapy and create more positive attitudes about therapy.

Current results suggest that parents often do not talk much with their children before therapy begins. Parents may need encouragement and guidance to engage in such discussion. One possible means of accomplishing this task could be for therapy clinics or therapists to send information prior to the child’s intake session encouraging parents to discuss the upcoming appointment with their child. In addition to encouraging parents to talk with their children, accurate information about therapy (such as general examples of why children come to therapy; examples of what children, parents, and therapists do in therapy; examples of topics that are discussed in therapy; information describing that some parts or therapy take work and other parts are easier; information about how long therapy appointments typically are, how often therapy appointments typically occur, and the typical length of time for the course of therapy, etc.) could be included so it could be referenced for the discussion and provide parents with any knowledge that they did not have. Positive, realistic information about therapy also could be incorporated, such as stating that therapy can be fun in addition to hard work or providing examples of benefits that therapy could provide (e.g., helping the child to feel better, reducing the child’s
problems, helping families to get along better, etc.). Clinics or therapists could consider presenting the information in a developmentally appropriate manner to catch and maintain children’s interest and to ensure that children understand the material.

Of course, not all parents are willing or able to effectively prepare their children for therapy even if preparation information is easily accessible, and some parents might not recognize the opportunity of preparing their child. Due to their own views about therapy, some parents could conceivably make the situation worse rather than better by discussing therapy with their child. Some families could have such a high level of conflict that having a beneficial discussion is not possible. Therapists need to realize that, in reality, parents might not have prepared their children for therapy or might have provided incomplete, inaccurate, or negative information to the child. Therapists often will need to fulfill or partially fulfill the role of providing the child with accurate, positive, and realistic information about therapy.

Therapists should be aware that children often do not know what to expect from therapy, even if they have had prior therapy. Parents do not always have complete, accurate information, either, so they may need preparation themselves. No matter how involved a parent is going to be in the actual therapy process, providing them with information could be helpful because parents often play a primary role in getting children to therapy sessions, continuing treatment, and supporting treatment efforts. Recall that some research suggests that parents are not always knowledgeable about mental health treatment for their children (West et al., 2005), that parents want more information about treatment than they may typically be given by their child’s therapist (Jensen et al., 1991), and that clients and therapists often have different expectations at the beginning of
therapy (Benbenishty & Schul, 1987; Potamianos et al., 1985; Verinis, 1993). Also recall that some research indicates that similarity between patient (parent or child) and therapist expectations could impact parental acceptance of the services and treatment continuation (Day & Reznikoff, 1980; Plunkett, 1984). Current and past findings highlight the importance of therapists providing information to parents and children.

Current results indicate that often children and sometimes parents have reservations about going to therapy. Children with past therapy experience may have especially negative expectations about the outcomes of therapy. Most (if not all) therapists likely are aware that some children and parents have resistance to therapy, and resistance often is approached as part of the therapy process. However, providing accurate and positive yet realistic preparation information early in treatment could be a means of influencing attitudes in a positive way and decreasing resistance based on misconceptions or fear of the unknown. Current results tentatively suggest that a common pattern in families could be one in which the parent is relatively receptive to therapy for the child and the child is not as receptive. Keeping this possibility in mind could assist the therapist as he or she prepares the family for treatment and as he or she works with the family throughout treatment.

If therapists or clinics are gathering information about what a particular parent has already discussed with his or her child, simply accepting the parent’s or child’s description could be risky. Past investigations and the current findings support that parents’ and children’s reports do not always match. Taking both reports into account is recommended.
Further research would be needed to determine the most effective and feasible ways for clinics/therapists to prepare children and parents for therapy. As discussed in the literature review section of this paper, formal therapy preparation programs have been beneficial for children and parents (Bonner & Everett, 1986; Coleman & Kaplan, 1990; Day & Reznikoff, 1980; Shuman & Shapiro, 2002; Weinstein, 1988) but could be associated with practical barriers such as the time and cost for development and implementation of such programs. A cost-benefit analysis of formal preparation programs could be useful. Other options for preparation could be providing written material (as described above) to families prior to the first session or at the first session, discussing information with families during the first session, or using a combination of these approaches.

Parents and therapists likely are the ones who have the most power to provide preparation information to children and positively impact children’s views about therapy. The child could play a role in the preparation process, however, by asking questions or raising concerns. During the current study, children were unlikely to contribute much to preparation conversations. During preparation discussions, parents and therapists should encourage and allow children to ask questions or make comments and be willing to provide fair, accurate feedback as they are able.

**Limitations of the Present Study**

The present study is the first known one to examine the relationships between parental knowledge of and attitudes toward psychotherapy and children’s knowledge of and attitudes toward psychotherapy. No other known studies have explored how parents prepare their children for therapy, whether parents communicate their views about
therapy through that preparation, or how that preparation is related to children’s views of psychotherapy. Despite these strengths, the current study does have limitations. Sample size was small, limiting statistical power. Additionally, the number of statistical analyses that were conducted with this sample size increases the chances of Type I and Type II error (Miller, 1981). Consequently, any conclusions drawn need to be made with caution, and further investigation would be needed to verify the results.

Some demographic groups (such as Caucasian individuals and families with low incomes) were overrepresented in the sample. Further research would be needed to clarify the relation (if any) of such demographic variables to the studied variables and hypotheses.

The sample was heterogeneous regarding type of treatment that the children would be receiving (i.e., home-based therapy vs. outpatient therapy), presenting problem, and treatment history. The study was not designed to systematically investigate whether and how these factors would influence the results. Depending on what type of treatment a child is scheduled to receive, parents could have differing levels of knowledge and varying attitudes or could prepare children in different ways. What the parent perceives the problem to be also could be related to knowledge, attitudes, and preparation. Past experiences with therapy, either for the identified child participating in the study or for anyone else in the family such as a parent or another child, obviously could be related to the child and parent’s knowledge and attitudes about therapy, as well as how the child is prepared for therapy. The present study statistically controlled for treatment history to an extent, but incorporating this variable and others (such as type of treatment and presenting problem) into the design of the study would be ideal.
Families participated in the study any time on the day before or day of their scheduled intake appointment, as long as participation occurred prior to the intake. The amount of preparation that had occurred could have been related to how near the intake session was. For example, families who completed the study the day before the intake session may have been less likely to have discussed the intake appointment already than families who were attending the intake immediately after their appointment with the researcher. However, allowing families to participate on the day before their session was necessary in order to recruit enough families for the study.

The children in the current sample represented a limited age range (age 9-14 years). Consequently, the study did not provide a picture of how the variables under investigation may look or be related to one another in samples with younger children or older adolescents.

A final limitation of the current study is that the instruments utilized were either created for the study, modified for the study, or used in previous studies but not subjected to rigorous psychometric evaluation. In the absence of more extensive psychometric evaluation of these instruments, conclusions drawn from the data must be considered tentative. The instrument that was created solely for the purpose of this study, the Preparation Interview, was created on the basis of previous research on expectations for the process of therapy so did have some roots in prior research. The Therapy Survey, the Attraction-Receptivity Questionnaire, and the Expectations of Therapy Outcome Scale did differentiate between children and parents who had received preparation for therapy and children and parents who had not received preparation in a previous study (Bonner & Everett, 1986). The Therapy Survey-Child Form (Revised) was a slight modification of
the Therapy Survey. No other instruments were available to measure the identified variables in the present study.

**Directions for Future Research**

Although the present study provided an initial look at the relationships that it investigated, the findings suggest several directions for future research. Most importantly, further research into the variables and relationships under investigation in this study is recommended. Whether relationships were supported or not supported in this study, it was only one study with one unique sample. Further research could help to clarify the relationships under question, especially if some of the limitations of the current study were taken into account. Ideally, further investigations in this area would involve larger sample sizes, and research design would provide better control of potentially relevant demographic variables and factors such as type of treatment, treatment histories, and reasons for entering treatment.

If further studies replicate the occurrence in the present study—that parents had more knowledge, were more receptive to therapy, and had more positive outcome expectations about therapy than children did—then exploring reasons for and implications of this finding could be useful. Conversely, understanding why children who are presenting to therapy often have relatively low levels of knowledge and negative attitudes about therapy could help identify ways to increase knowledge and improve attitudes. Research also could further examine the possibility that children who have had therapy in the past and are returning to therapy actually have more negative outcome expectancies for therapy than children with no therapy experience have. Understanding
reasons for this finding, if further supported, could provide direction on how to improve outcome expectancies.

Identifying barriers that keep parents from sharing their knowledge and (often more positive) attitudes about therapy with their children could be beneficial. For example, does this phenomenon occur because parents do not prepare their children for therapy or provide only limited preparation? If so, what prevents parents from providing more preparation? Factors such as limited time, discomfort with discussing therapy or the problem, negative feelings toward the child and/or the problem, uncertainty about how to prepare the child, lack of recognition that preparation could occur, a feeling that he or she does not know enough information about therapy, an assumption that the child already knows everything, and so on could all be explored as potential barriers to parents preparing their children for therapy.

Further investigation into the most effective methods of preparing children for therapy is recommended. Investigations would need to consider all factors such as the benefits and drawbacks of different methods, the time and cost associated with various methods, the practicality of different approaches, and so on. The current study suggests that what happens naturally between parents and children is probably not the best form of preparation that could occur, at least in the current sample, although further research would be needed to confirm this finding. Some approaches to investigate could include encouraging parents via mail or telephone to prepare their child, sending preparation information to parents to use with their children, providing families with written information about therapy at the first therapy session, talking with families about the process of therapy at the first session, providing formal preparation programs, or using a
combination of any of these approaches. Further research could also investigate the differential effectiveness of different forms of these preparation methods (e.g., providing information to parents vs. providing information to children, preparation programs involving information provision vs. preparation programs involving modeling, etc.). Additionally, research exploring specific elements of preparation that are effective could be useful.

The variables included in the present study do not have well-standardized instruments to measure them. Development of additional instruments and/or further standardization of the already existing instruments would help strengthen the conclusions drawn from investigations of these variables in future studies.

The age range of children in the current sample was restricted to 9-14 years. Future research examining the present study’s variables and hypotheses, in relation to younger children and older adolescents, could help to clarify the relationship of age to children’s views of therapy and the preparation of children for therapy.

Finally, the literature review that was completed for this paper identified several gaps in the literature regarding views of child psychotherapy. Little research has been conducted on the effects of stigma on child psychotherapy. Other areas that have received little to no research attention include the attitudes about mental health problems of children who have themselves been diagnosed with a psychological disorder, parental knowledge of and attitudes toward mental illness in children, children’s knowledge and attitudes regarding psychotherapy, and parents’ knowledge and attitudes regarding child psychotherapy. Additionally, of particular relevance to the variables under investigation in the present study, little research has examined the influence of parental views of
mental illness and therapy on child therapy. For example, little is known about how parental views impact factors such as initiating, continuing, and adhering to child therapy.

**Conclusion**

In conclusion, the current study sought to examine the relationship of parental views of psychotherapy to children’s views of therapy and how parents’ approaches to preparing their children for therapy play a role in this process. These relationships were examined with parents and children who had an upcoming first therapy appointment for the child. Overall, results indicated that parent and child views of therapy were not related in this sample. Moreover, parents’ views about therapy were not related to the preparation that they provided to their children. Some support was provided, however, for the idea that whether/how parents prepare their children for therapy could be associated with children’s views about therapy. Consequently, ideas were discussed regarding how parents and therapists can help prepare children for therapy.

One contribution of this study is that it provided an initial picture of whether and how parents prepare their children for psychotherapy. Left to their own devices, do parents prepare their children for therapy? If so, what does that preparation look like? The preliminary information provided by this study suggests that before a child begins therapy, parents and children often fail to discuss much significant information about therapy. If a child has received prior therapy, then he or she may be even less likely to receive adequate preparation. Children frequently do not raise the topic of therapy on their own or ask questions when their parents do raise the topic.
This study also provided data about how parents and children experience the first therapy session. Data indicated that children, even those with prior therapy experience, often do not know what to expect when they are beginning therapy and often present to therapy with low receptivity. Children with past therapy experience may have more negative outcome expectancies for therapy than children with no therapy experience. Not all parents have accurate expectations about the therapy process or are receptive to therapy, either; however, parents in this sample had more accurate expectations about the process of therapy, higher receptivity to therapy, and more positive outcome expectations about therapy than children did.

Understanding what parents and children know about therapy, how they feel about it, and how to increase knowledge and improve attitudes ultimately could assist with improving rates of children with mental health concerns who receive treatment, stay in treatment, and benefit from it. Although current results have been discussed from a perspective of helping families who are entering treatment, the larger social issue of stigma regarding mental illness and mental health treatment also is relevant to the current investigation. Continued anti-stigma efforts targeting society as a whole are likely warranted, as well as further research into variables creating the current zeitgeist of pejorative attitudes toward appropriate identification and treatment of mental health concerns in children.
References


APPENDICES
Appendix A: Therapy Survey-Parent Form

**Therapy Survey-Parent Form**

**Directions:** These are some questions about what therapy is like. Please answer the questions by encircling the appropriate answer.

1. Is it true that children in therapy usually need just about one or two sessions?  
   Yes  No  Don’t know

2. Is it true that children sometimes play in their therapy sessions?  
   Yes  No  Don’t know

3. Is it true that a child who has to go to a therapist is bad?  
   Yes  No  Don’t know

4. Is it true that children tell their therapist about a problem, and then the therapist tells them the answer?  
   Yes  No  Don’t know

5. Is it true that when a child is in therapy, it may be useful for the parents to have counseling, too?  
   Yes  No  Don’t know

6. Is it true that a child sometimes does difficult things in therapy?  
   Yes  No  Don’t know

7. Is it true that therapists try to keep children from getting angry?  
   Yes  No  Don’t know

8. Is it true that children must talk about their problems in therapy or they are wasting the time?  
   Yes  No  Don’t know

9. Is it true that most therapy sessions are about one hour long?  
   Yes  No  Don’t know

10. Is it true that when children are in therapy, they can feel sure that the therapist will make their problems go away?  
    Yes  No  Don’t know

11. Is it true that a child sometimes does things that are fun in therapy?  
    Yes  No  Don’t know

12. Is it true that it’s all right for children to talk about secrets in their therapy sessions?  
    Yes  No  Don’t know

13. Is it true that if a child’s mother comes for counseling, it is often helpful for the father to come, too?  
    Yes  No  Don’t know

14. Is it true that after children are in therapy, they never feel scared or worried?  
    Yes  No  Don’t know

15. Is it true that a child usually has therapy sessions once a week?  
    Yes  No  Don’t know

16. Is it true that if children don’t want to go to their therapy sessions, therapy isn’t helping them?  
    Yes  No  Don’t know
17. Is it true that if a teacher wants to know if a child is in therapy, the therapist will tell the teacher without the parent's permission? Yes No Don't know

18. Is it true that how long therapy will last depends on many things? Yes No Don't know

19. Is it true that a therapist will tell other people everything a child says or does in a therapy session? Yes No Don't know

20. Is it true that it is important for children to attend every one of their therapy sessions? Yes No Don't know

21. Is it true that in therapy both the child and the therapist work on the child's problem? Yes No Don't know

22. Is it true that when children behave badly, the therapist scolds them to get them to behave better? Yes No Don't know

23. Is it true that children may talk about whatever they want to in their therapy sessions? Yes No Don't know

24. Is it true that playing in therapy sessions is sometimes helpful? Yes No Don't know

25. Is it true that if some neighbors want to know if a child comes for therapy, the therapist will tell them without the parent's permission? Yes No Don't know
Appendix B: Therapy Survey-Child Form (Revised)

Therapy Survey- Child Form (Revised)

Directions read aloud to the child: These are some statements about what therapy is like. Please circle how much you agree or disagree with each statement.

1 = completely disagree
2 = disagree a little
3 = agree a little
4 = completely agree

1. Children in therapy usually need just about one or two sessions.
   
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<td>Completely disagree</td>
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2. Children sometimes play in their therapy sessions.

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3. A child who has to go to a therapist is bad.

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4. Children tell their therapist about a problem, and then the therapist tells them the answer.

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5. When a child is in therapy, it may be useful for the parents to have counseling, too.

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6. A child sometimes does difficult things in therapy.

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### Children’s Experiences 135

**7. Therapists try to keep children from getting angry.**

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**8. Children must talk about their problems in therapy or they are wasting the time.**

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**9. Most therapy sessions are about one hour long.**

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**10. When children are in therapy, they can feel sure that the therapist will make their problems go away.**

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**11. A child sometimes does things that are fun in therapy.**

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**12. It’s all right for children to talk about secrets in their therapy sessions.**

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**13. If a child’s mother comes for counseling, it is often helpful for the father to come, too.**

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**14. After children are in therapy, they never feel scared or worried.**

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**15. A child usually has therapy sessions once a week.**

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</table>
16. If children don’t want to go to their therapy sessions, therapy isn’t helping them.
1 2 3 4
Completely disagree a little disagree a little disagree agree

17. If a teacher wants to know if a child is in therapy, the therapist will tell the teacher without the parent’s permission.
1 2 3 4
Completely disagree a little disagree a little disagree agree

18. How long therapy will last depends on many things.
1 2 3 4
Completely disagree a little disagree a little disagree agree

19. A therapist will tell other people everything a child says or does in a therapy session.
1 2 3 4
Completely disagree a little disagree a little disagree agree

20. It is important for children to attend every one of their therapy sessions.
1 2 3 4
Completely disagree a little disagree a little disagree agree

21. In therapy both the child and the therapist work on the child’s problem.
1 2 3 4
Completely disagree a little disagree a little disagree agree

22. When children behave badly, the therapist scolds them to get them to behave better.
1 2 3 4
Completely disagree a little disagree a little disagree agree

23. Children may talk about whatever they want to in their therapy sessions.
1 2 3 4
Completely disagree a little disagree a little disagree agree
24. Playing in therapy sessions is sometimes helpful.

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25. If some neighbors want to know if a child comes for therapy, the therapist will tell them without the parent’s permission.

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<td>Completely disagree</td>
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It’s important for you and your therapist to have a good relationship. If you have any concerns about the questions above, please talk to your therapist about them.
Appendix C: Attraction-Receptivity Questionnaire-Parent Form

Attraction-Receptivity Questionnaire—Parent Form

Directions: These are some statements about your thoughts and feelings concerning working with a therapist. There are no right or wrong answers—we just want to know what your reactions are. Please encircle the answer that is most appropriate for you.

1. I think I will be pleased with a therapist's interest and attention.
   Yes  No  Don't know
2. It will be hard for me to talk about myself with a therapist.
   Yes  No  Don't know
3. I have a very warm feeling toward therapists.
   Yes  No  Don't know
4. I think only a few people can be helped by therapy.
   Yes  No  Don't know
5. I think that a therapist will like me.
   Yes  No  Don't know
6. If I get mad at a therapist, I think he or she would be angry with me.
   Yes  No  Don't know
7. I will feel nervous when I see a therapist.
   Yes  No  Don't know
8. I think that a therapist will know how to help me with my problems.
   Yes  No  Don't know
9. I think that a therapist will really like to spend a therapy session with me.
   Yes  No  Don't know
10. I would tell a friend who was having a problem to see a therapist.
    Yes  No  Don't know
11. I do not want to spend some time with a therapist.
    Yes  No  Don't know
12. A therapist is a warm and friendly person.
    Yes  No  Don't know
13. I will be afraid to show my real feelings to a therapist.
    Yes  No  Don't know
14. I have a feeling that a therapist is a person I can trust.
    Yes  No  Don't know
15. A session with a therapist will seem like a waste of time to me.
    Yes  No  Don't know
16. I think a therapist will misunderstand me.
    Yes  No  Don't know
17. A therapist is a person who would really like to help me.
    Yes  No  Don't know
18. I think a therapist will confuse me.
   Yes  No  Don't know

19. I will enjoy meeting with a therapist.
   Yes  No  Don't know

20. I can see where therapy can do a lot to help me solve my problems.
   Yes  No  Don't know
Appendix D: Attraction-Receptivity Questionnaire-Child Form

Attraction-Receptivity Questionnaire--Child Form

Directions read aloud to the child: Boys and girls have different thoughts and feelings about working with a therapist. I would like to know how you feel about it. On these questions, there are no right or wrong answers--I just want to know what you think or feel. Listen while I read each sentence. If you agree with what the sentence says or you think it's right, say "yes." If you do not agree or you think the sentence is wrong, say "no." If you are not sure about what you think, you can say "I don't know."

1. I think I will be pleased with a therapist's interest and attention.
   Yes No Don't know

2. It will be hard for me to talk about myself with a therapist.
   Yes No Don't know

3. I have a very warm feeling toward therapists.
   Yes No Don't know

4. I think only a few people can be helped by therapy.
   Yes No Don't know

5. I think that a therapist will like me.
   Yes No Don't know

6. If I get mad at a therapist, I think he or she would be angry with me.
   Yes No Don't know

7. I will feel nervous when I see a therapist.
   Yes No Don't know

8. I think that a therapist will know how to help me with my problems.
   Yes No Don't know

9. I think that a therapist will really like to spend a therapy session with me.
   Yes No Don't know

10. I would tell a friend who was having a problem to see a therapist.
    Yes No Don't know

11. I do not want to spend some time with a therapist.
    Yes No Don't know

12. A therapist is a warm and friendly person.
    Yes No Don't know

13. I will be afraid to show my real feelings to a therapist.
    Yes No Don't know

14. I have a feeling that a therapist is a person I can trust.
    Yes No Don't know

15. A session with a therapist will seem like a waste of time to me.
    Yes No Don't know

16. I think a therapist will misunderstand me.
    Yes No Don't know
17. A therapist is a person who would really like to help me.
   Yes   No   Don't know

18. I think a therapist will confuse me.
    Yes   No   Don't know

19. I will enjoy meeting with a therapist.
    Yes   No   Don't know

20. I can see where therapy can do a lot to help me solve my problems.
    Yes   No   Don't know
Appendix E: Expectations of Therapy Outcome Scale-Parent Form

Directions: On these questions, please encircle the appropriate number to indicate the change you expect your child to make by the end of therapy.

1. How do you expect your child to feel when therapy is over?

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2. How do you expect your child to behave or act at home or school when therapy is over?

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3. How clearly do you expect your child to think when therapy is over?

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4. How do you expect your child to get along with teachers, other children, and your family when therapy is over?

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5. What change do you expect in your child's problems by the end of therapy?

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6. How helpful do you expect that therapy will be for your child?

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7. How satisfied do you expect to be at the end of your child's therapy?

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### Appendix F: Expectations of Therapy Outcome Scale—Child Form

#### Directions read aloud to the child: On these questions, I want to know how you think things will be at the end of therapy. I will read each one and then you can tell me what you expect when therapy is over.

1. **How do you expect to feel when therapy is over?**
   - Will much feel worse feel much worse
   - Will feel feel the same feel much better
   - Will feel feel the same feel much better
   - Will feel feel the same feel much better

2. **How do you expect to behave or act at home or school when therapy is over?**
   - Will act much act worse act the same act much worse
   - Will act the same act worse act much worse
   - Will act the same act worse act much worse
   - Will act the same act worse act much worse

3. **How clearly do you expect to think when therapy is over?**
   - Will think much less think clearly think much more
   - Will think clearly think more think much more
   - Will think clearly think more think much more
   - Will think clearly think more think much more

4. **How do you expect to get along with your teachers, other children, and your family when therapy is over?**
   - Will get along much worse get along worse get along the same get along worse
   - Will get along worse get along the same get along worse get along worse
   - Will get along worse get along the same get along worse get along worse
   - Will get along worse get along the same get along worse get along worse

5. **What change do you expect in your problems by the end of therapy?**
   - Problems will be much worse worse worse worse
   - Problems will be worse worse worse worse
   - Problems will be worse worse worse worse
   - Problems will be worse worse worse worse

6. **How helpful do you expect that therapy will be?**
   - Not at all helpful Slightly helpful Moderately helpful Quite helpful Very helpful
   - Not at all helpful Slightly helpful Moderately helpful Quite helpful Very helpful
   - Not at all helpful Slightly helpful Moderately helpful Quite helpful Very helpful
   - Not at all helpful Slightly helpful Moderately helpful Quite helpful Very helpful

7. **How satisfied do you expect to be at the end of therapy?**
   - Not at all satisfied Slightly satisfied Moderately satisfied Quite satisfied Very satisfied
   - Not at all satisfied Slightly satisfied Moderately satisfied Quite satisfied Very satisfied
   - Not at all satisfied Slightly satisfied Moderately satisfied Quite satisfied Very satisfied
   - Not at all satisfied Slightly satisfied Moderately satisfied Quite satisfied Very satisfied

### Children's Experiences 143
Appendix G: Parent Version of Preparation Interview

Preparation Interview: Parent Version

Did you talk to your child at all about his/her appointment today?

What kinds of things did you talk to him/her about?

Did you talk about [If answer is yes to any question, ask, What did you say about it?]
why your child is seeing the therapist?
what your child will do with the therapist?
what you will do with the therapist?
what the therapist will do?
how helpful it will be for your child to see the therapist?
what kinds of things your child can talk about with the therapist?
if it will be easy or hard for your child?
if it will be fun or boring for your child?
how long your child will see the therapist today?
how often your child will come see the therapist?
how many times your child will see the therapist?

Who started the conversation(s)? Did (child) ask any questions or say anything in response?

What are your feelings with regard to today’s appointment?
Which feelings do you think your child has?
mad    excited    disappointed    hopeful
sad    worried    uncertain    no feelings
happy    scared    embarrassed
Appendix H: Child Version of Preparation Interview

Preparation Interview: Child Version

After you talk to me today, you and your mom/dad will be going to an appointment. Did your mom or dad talk to you at all about your appointment today?

What did they tell you?

Did they talk about…. [If answer is yes to any question, ask, What did they say about it?] why you are coming here? what you will do while you are here? what they will do while you are here? what the person you are seeing will do? how helpful it will be to come here? what kinds of things you can talk about here? if it will be easy or hard? if it will be fun or boring? how long your appointment will be today? how often you will have appointments here? how many times you will come here?

Did you say anything to your mom or dad about coming here today?

What do you think is going to happen today?

How do you think that your mom/dad feels about your appointment today? How do you feel about coming here?

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Appendix I: Script for Scheduler

**Script for Scheduler**

[Child must be 9-14 years old for a family to participate in the study]

A researcher from Eastern Michigan University is conducting a research study at our clinic about children’s experiences with therapy. What you would need to do is meet with a researcher at your home or our clinic so you and your child could answer some questions. Then you would be paid $10 [or receive a free treatment session] for answering the questions. Would you be interested in having the researcher call you to give you more information?

[If interested, put name and phone number on list of interested people. Research will contact with more information.]
Appendix J: Script for Researchers

Script for Researchers

Hello, __________. My name is ________ from Eastern Michigan University, and I’m one of the researchers involved in the Children’s Therapy study. ________ from _______ gave me your name and said you might be interested in helping with the study. Is this a good time to talk? (if not, reschedule for a better time)

Okay, let me tell you a little about the study. We are doing the study to learn more about children’s experiences with therapy. Specifically, we are interested in what parents and children expect the child’s experience to be like. What you would need to do is meet with a researcher at your home or at our clinic so you and your child could answer some questions for the researchers and fill out some forms about your child’s therapy. Then you would receive $10 (for non-EMU clinic participants) / a free treatment session (for EMU clinic participants) for participating in the study. Do you have any questions?

[Have informed consent statement and project summary available for questions.]

[Once all questions are answered] Before we go any further, I’d like to ask you some questions to make sure that you and your child are eligible to participate in the study.

First, how old is your child? (if not 9-14 years old, then family is not eligible. Thank them for their time.)

Second, has your child attended his or her first therapy session yet? [If yes, then family is not eligible. Thank them for their time.]

[If eligible] Does this study sound like something you’d like to do?

[If no, thank for their time.]

[If yes, get information of where and when first appointment is. Schedule research appointment for some time the day before or day of the intake session, prior to the intake session.]

Someone from our research team will be at (clinic or home) on (date) at (time).

Do you have any other questions? [answer any further questions]

Thanks, see you then.
Appendix K: Informed Consent Statements for Parents

Informed Consent A

Thank you for volunteering to participate in this research project that is studying children’s experiences with therapy. During this session, you and your child will be asked some questions about your child’s therapy appointment today and also be asked to complete some forms about therapy. Overall, completing everything will take approximately 30-45 minutes. You and your child do not have to take part in this study. If you and your child do participate, either of you may withdraw at any time or refuse to answer any questions that make you feel uncomfortable.

Whether you and your child participate or not in this study will in no way affect your child’s treatment at this clinic, and your child’s therapist will not be informed of any information discussed during this study.

Part of the session will be audiotaped so the researchers can remember what you and your child have said. Please note that your name or your child’s name will never be attached to the tapes or the research. The tapes will be kept in a locked cabinet when they are not being used by the researchers, and only the researchers will have access to them.

The research in this study could be published in psychological journals or presented at conferences to other psychologists. If the research is published or presented, all identifying information will be excluded. The information will be presented in a confidential manner so individual identities cannot be determined.

There are no known risks for participating in the study. This study should not cause any discomfort, although talking about your child’s treatment could be emotional for you and/or your child.

Please be aware that the researchers will be required to report any suspected instance of a child being harmed.

For your participation, you will receive either $10 or a free treatment session, based on a previous agreement between the researchers and the clinic your child is attending. Otherwise, you and your child probably will not receive any direct benefits from the study, but the information that you provide could help to improve mental health care for children in the future.

--I have read or have had read to me all of the above information. Any questions I have about the study have been answered. I have been told of the risks and discomforts and possible benefits of the study. I understand my participation and my child’s participation are voluntary. I understand that my child and I do not have to take part in this study and that withdrawing at any time will not affect my child’s treatment at this clinic. I understand that our names will not appear on any materials other than this informed consent form.

--I understand my and my child’s rights as research participants, and I voluntarily agree for myself and my child to participate in this study. I understand what the study is about and why it is being done. I will receive a signed copy of this form.

____________________________________________
Child’s Name
Participant’s Signature ________________________ Date ________________________

Participant’s Name (Print) ________________________________________________

Signature of Researcher ________________________ Date ________________________

Researcher contact information:
Heather Nix Eastern Michigan University (989)860-9187
Michelle Byrd Eastern Michigan University (734)487-4919

This research protocol and informed consent document has been reviewed and approved by the Eastern Michigan University Human Subjects Review Committee for use from 4/26/11 to 4/25/12. If you have questions about the approval process, please contact Dr. Deb de Laski-Smith (734.487.0042, Interim Dean of the Graduate School and Administrative Co-chair of UHSRC, human.subjects@emich.edu).
Informed Consent B

Remember that you and your child do not have to take part in this study. If you and your child do participate, either of you may withdraw at any time or refuse to answer any questions that make you feel uncomfortable.

Whether you and your child participate or not in this study will in no way affect your child’s treatment at this clinic.

Neither your child nor your child’s therapist will be informed of any information that you provide during this study.

-- I voluntarily agree for myself and my child to participate in this study.

______________________________
Child’s Name

______________________________
Participant’s Signature Date

______________________________
Participant’s Name (Print)

______________________________
Signature of Researcher Date

Researcher contact information:
Heather Nix  Eastern Michigan University  (989)860-9187
Michelle Byrd  Eastern Michigan University  (734)487-4919

This research protocol and informed consent document has been reviewed and approved by the Eastern Michigan University Human Subjects Review Committee for use from 4/26/11 to 4/25/12. If you have questions about the approval process, please contact Dr. Deb de Laski-Smith (734.487.0042, Interim Dean of the Graduate School and Administrative Co-chair of UHSRC, human.subjects@emich.edu).
Appendix L: Assent Statements for Children

Assent Form A

We are doing a research study about children’s experiences with therapy. If you are willing, we will ask you some questions about your very first therapy appointment here. Answering all the questions will take about 30-45 minutes.

You do not have to do this study. If you do, you can stop at any time. You do not have to answer any questions that you do not want to answer.

We will not tell your parents or your therapist any of your answers to the questions. Some of your answers to the questions will be taped so we can remember what you have said. Your name will never be on the tapes.

There is nothing we will ask you to do that will hurt, but some of the questions could be hard to answer. If you decide to help, you and your parent will get $10 or a free therapy session. Also, this research could help other kids in the future.

--This paper has been read to me. Any questions I have about the research have been answered.

--I agree to do this study. I understand what the study is about. I will receive a signed copy of this form.

________________________________________________________________________
Minor’s Name

________________________________________________________________________
Minor’s Signature Date

________________________________________________________________________
Signature of Researcher Date

Researcher contact information:
Heather Nix Eastern Michigan University (989)860-9187
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This research protocol and informed consent document has been reviewed and approved by the Eastern Michigan University Human Subjects Review Committee for use from 4/26/11 to 4/25/12. If you have questions about the approval process, please contact Dr. Deb de Laski-Smith (734.487.0042, Interim Dean of the Graduate School and Administrative Co-chair of UHSRC, human.subjects@emich.edu).
Assent Form B

Remember that you do not have to do this study. If you do, you can stop at any time. You do not have to answer any questions that you do not want to answer.

If you do not do the study, we will not tell your parents. If you do the study, we will not tell your parents any of your answers to the questions.

--I agree to do this study.

____________________________________________
Minor’s Name
____________________________________________
Minor’s Signature  Date

Signature of Researcher  Date

Researcher contact information:
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Appendix M: Instructions for Coding the Preparation Interview

Instructions for Coding the Preparation Interview

Overview

The Preparation Interview assesses three preparation variables. These three variables are completeness of preparation (i.e., the extent to which the parent prepared the child for the first therapy session), accuracy of preparation (i.e., the degree to which the preparation information provided by the parent to the child correctly describes the therapy situation), and valence of preparation (i.e., the overall tone of the preparation information that was provided by the parent to the child). For each preparation variable (i.e., completeness of preparation, accuracy of preparation, and valence of preparation), each interview should receive a score from 1 to 5.

General Coding Instructions

Coders should take the following steps to code each interview:

1. On the Coding Worksheet, enter the participant number and indicate whether the interview is a child or parent interview.

2. **Read the interview** to become familiar with its content.

3. While reading the interview again, **complete the Completeness column on the Coding Worksheet**. Write either “yes” or “no” in each box of the column to indicate whether each of the 11 main interview topics was discussed. See below for more detailed information about coding completeness of preparation.

4. While reviewing the interview again, **complete the Accuracy column on the Coding Worksheet**. Write either “yes” or “no” in each box of the column to indicate whether each of 9 topics was discussed in an accurate manner. Note that 2 interview topics
(“how helpful it will be for the child to see the therapist” and “if therapy will be fun or boring for the child”) should not be evaluated for accuracy because these topics are subjective and cannot be accurately or inaccurately discussed. Note that if a topic is marked “no” in the Completeness column, then it does not need to be evaluated for accuracy; if a topic was not discussed, then it could not have been discussed in an accurate manner. The coder may automatically write “no” in the Accuracy column for any topic that has “no” written in the Completeness column. See below for more detailed information about coding accuracy of preparation.

5. While reviewing the interview further, complete the Valence column on the Coding Worksheet. Circle “positive,” “negative,” and/or “neutral” for each of the 11 main interview topics to indicate whether the preparation information provided by the parent regarding that topic was positive, negative, and/or neutral in valence. Also circle “positive,” “negative,” and/or “neutral” to indicate the valence of the parent’s feelings that were listed at the bottom of the interview page. The coder may circle more than one descriptive word (positive, negative, or neutral) for each topic. The coder also may list any preparation information provided by the parent that does not pertain to any of the other areas but is positive or negative in valence. A space for such additional information is provided in the bottom box of the Valence column. Remember that if a topic is marked “no” in the Completeness column, then it does not need to be evaluated for valence; if a topic was not discussed, then it could not have been discussed in a positive or negative manner.

6. Count the number of boxes marked “yes” in the Completeness column of the Coding Worksheet and write the total in the blank space provided below the column. See the section below titled “Coding Instructions for Completeness of Preparation” to determine
the Completeness Score of 1-5, and write that number in the box provided at the bottom of the Coding Worksheet.

7. Count the number of boxes marked “yes” in the Accuracy column of the Coding Worksheet and write the total in the blank space provided below the column. See the section below titled “Coding Instructions for Accuracy of Preparation” to determine the Accuracy Score of 1-5, and write that number in the box provided at the bottom of the Coding Worksheet.

8. Count the number of times the word “positive” was circled in the Valence column and write that total in the appropriate blank space provided below the column. Count the number of times the word “negative” was circled in the Valence column and write that total in the appropriate blank space provided below the column. Look at any additional positive or negative preparation information that is listed in the bottom box of the Valence column and add this information to the totals for positive and negative statements if applicable. See the section below titled “Coding Instructions for Valence of Preparation” to determine the Valence Score of 1-5, and write that number in the box provided at the bottom of the Coding Worksheet.

**Coding Instructions for Completeness of Preparation**

The following information should be kept in mind when coding completeness of preparation:

- The accuracy and valence of statements do not matter when coding completeness of preparation. The coder should determine only whether a topic was discussed, without regard to the accuracy or valence of that information.
• If a participant made a response such as, “I don’t know” or “I don’t remember” when asked if he/she discussed a certain topic, then that topic should be considered not discussed.

• If a parent said that he/she did not discuss a topic because he/she assumed that the child already knew the information, then that topic should be considered not discussed.

• If a parent or child says that a topic was discussed before a previous episode of therapy but not before the current episode of therapy, then that topic should be considered not discussed.

• Be aware that a participant could answer a question in response to another question. (For example, a participant may answer if the helpfulness of therapy was discussed after being asked if the reason for the child attending therapy was discussed). As long as a question is answered somewhere in the interview, then that response should be considered when coding.

• Finally, be aware that a participant could give a response but provide evidence elsewhere that contradicts that response. (For example, a participant may respond that a certain topic was not discussed but make a statement elsewhere in the interview about discussing that topic). Examination of all responses in each interview will be necessary to determine whether a topic was discussed.

Each interview will receive a completeness of preparation score ranging from 1 to 5, with higher scores indicating increased completeness of preparation information. Scores should be determined on the basis of the number of the 11 main interview topics that the participant reports were discussed. The 11 main topics discussed in the interview are:

why the child is coming to therapy
what the child will do with the therapist
what the parent will do with the therapist
what the therapist will do
how helpful it will be for the child to see the therapist
what kinds of things the child can talk about with the therapist
if therapy will be easy or hard for the child
if therapy will be fun or boring for the child
how long the intake appointment will be
how often the child will have therapy appointments
how many times the child will see the therapist

The following guide should be used to assign a completeness score to each interview:

- **Score of 1 for Completeness:** The participant reports that no information was discussed.
- **Score of 2 for Completeness:** The participant reports that 1-3 of the 11 topics were discussed OR information about therapy was discussed but did not relate to any of the 11 topics.
- **Score of 3 for Completeness:** The participant reports that 4-6 of the 11 topics were discussed.
- **Score of 4 for Completeness:** The participant reports that 7-9 of the topics were discussed.
- **Score of 5 for Completeness:** The participant reports that 10-11 of the topics were discussed.
Coding Instructions for Accuracy of Preparation

Each interview will receive an accuracy score ranging from 1 to 5, with higher scores indicating increased accuracy of preparation information. Scores should be determined on the basis of the number accurately discussed of the 9 interview topics that are pertinent to accuracy. The coder will need to determine whether the topic was discussed and if so, whether the information discussed was accurate. The 9 topics that are pertinent to accuracy and a description of information to be considered accurate follows:

why the child is coming to therapy- any response about child symptoms, life events, or family problems; any response about practical reasons to switch to a new therapist (e.g., a child is moving so is switching therapists)

what the child will do with the therapist- any response indicating child involvement in the therapeutic process, such as talking with the therapist, answering questions, playing, building skills, addressing symptoms or concerns, etc.

what the parent will do with the therapist- any response indicating parent involvement in the therapeutic process, such as talking with the therapist, answering questions, participating in therapy sessions, helping the child with therapeutic issues, building skills, addressing their own symptoms or concerns, etc.

what the therapist will do- any response indicating the therapist's involvement in the therapeutic process, such as talking with the child and/or parent, asking questions, playing with the child, providing skills to the child and/or parent, addressing symptoms or concerns, etc.

what kinds of things the child can talk about with the therapist – any response regarding symptoms, life events, family problems, feelings, concerns, etc. OR any response indicating that the child can feel free to discuss anything that he or she wants with the therapist

if therapy will be easy or hard for the child- any response acknowledging that children sometimes do difficult things in therapy, that therapy can require hard work, etc. OR acknowledging that therapy can be hard and easy

how long the intake appointment will be- any response indicating 1-2 hours for the length of the intake appointment or for therapy appointments in general

how often the child will have therapy appointments – any response indicating once a week for the frequency of therapy appointments
how many times the child will see the therapist—any response indicating that how many times the child will see the therapist will depend on unknown factors or could vary depending on therapeutic progress, therapeutic recommendations, etc.

The following guide should be used to assign an accuracy score to each interview:

- **Score of 1 for Accuracy**: The participant reports that no information was discussed OR no accurate information was provided.
- **Score of 2 for Accuracy**: The participant reports that 1-3 of the 9 topics were discussed in an accurate manner.
- **Score of 3 for Accuracy**: The participant reports that 4-5 of the 9 topics were discussed in an accurate manner.
- **Score of 4 for Accuracy**: The participant reports that 6-7 of the 9 topics were discussed in an accurate manner.
- **Score of 5 for Accuracy**: The participant reports that 8-9 of the 9 topics were discussed in an accurate manner.

**Coding Instructions for Valence of Preparation**

The following information should be kept in mind when coding valence:

- The valence being coded is the valence of the information provided to the child by the parent, not the child’s own feelings regarding the intake appointment, therapy, etc.
- The majority of preparation information provided to the child by the parent is normally neutral in valence.

Each interview will receive a valence score ranging from 1 to 5, with higher scores symbolizing increasingly positive valence. Scores should be determined on the basis of whether
preparation information was positive, negative, or neutral in valence. Examples of positive, negative, and neutral information include:

**Positive information**-

The feelings that the participant thought the parent had about the first therapy appointment, as indicated by the feelings listed at the bottom of the interview page, were positive in valence. Feelings considered to be positive in valence are: happy, excited, and hopeful.

The parent made a comment to the child that therapy would be helpful.

The parent said that therapy would be hard but provided reassurance to the child that therapy would be worth the effort or that some aspects of therapy would be easier than others OR the parent said that therapy would be easy.

The parent said that therapy would be boring but provided reassurance to the child that therapy would be worth the effort or that some aspects of therapy would be more fun than others OR the parent said that therapy would be fun.

The parent made any other positive statement such as that the child would like therapy and/or the therapist, that the parent was happy that the child was coming to therapy, etc.

**Negative statements**-

The feelings that the participant thought the parent had about the first therapy appointment, as indicated by the feelings listed at the bottom of the interview page, were negative in valence. Feelings considered to be negative in valence are: mad, sad, worried, scared, disappointed, and embarrassed.

The parent made a comment to the child that therapy would not be helpful.

The parent said that therapy would be hard but provided no reassurance to the child that therapy would be worth the effort or that some aspects of therapy would be easier than others.

The parent said that therapy would be boring but provided no reassurance to the child that therapy would be worth the effort or that some aspects of therapy would be more fun than others.

The parent made any other negative statement such as that the child would not like therapy and/or the therapist, that the parent was upset.
that the child was coming to therapy, that the parent was upset with the child for needing to come to therapy, etc.

Neutral statements-

The feelings that the participant thought the parent had about the first therapy appointment, as indicated by the feelings listed at the bottom of the interview page, were neutral. Feelings considered to be neutral in valence are: uncertain and no feelings.

The parent did not discuss a particular topic.

The parent discussed a particular topic but told the child that he/she did not know about the topic.

The parent made any other statement that would not be considered positive or negative in valence (e.g., “I told her that the appointment today would be about an hour,” “I told him that he was coming to therapy because of the problems he’s been having at school,” etc.).

The following guide should be used to assign a valence score to each interview:

- **Score of 1 for Valence**: All preparation information was negative or neutral in valence. (Note: If all information is neutral, then the valence score should be a 3).

- **Score of 2 for Valence**: Preparation information contained both information with a negative valence and information with a positive valence, but information with a negative valence outnumbers information with a positive valence when considering the definitions of positive and negative information above.

- **Score of 3 for Valence**: All preparation information was neutral in valence OR preparation information contained both information with a negative valence and information with a positive valence, and the coder is unable to determine whether information with a positive valence or information with a negative valence is more prevalent.
- **Score of 4 for Valence**: Preparation information contained both information with a negative valence and information with a positive valence, but information with a positive valence outnumbers information with a negative valence when considering the definitions of positive and negative information above.

- **Score of 5 for Valence**: All preparation information was positive or neutral in valence. (Note: If all information is neutral, then the valence score should be a 3).
Appendix N: Percentages of Parents and Children Endorsing Each Item of the Attraction-Receptivity Questionnaire

<table>
<thead>
<tr>
<th>Item</th>
<th>Percentage of Parents Relying Yes</th>
<th>Percentage of Children Relying Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think I will be pleased with a therapist’s interest and attention.</td>
<td>84%</td>
<td>35%</td>
</tr>
<tr>
<td>It will be hard for me to talk about myself with a therapist.</td>
<td>12%</td>
<td>31%</td>
</tr>
<tr>
<td>I have a very warm feeling toward therapists.</td>
<td>53%</td>
<td>29%</td>
</tr>
<tr>
<td>I think only a few people can be helped by therapy.</td>
<td>12%</td>
<td>31%</td>
</tr>
<tr>
<td>I think that a therapist will like me.</td>
<td>47%</td>
<td>47%</td>
</tr>
<tr>
<td>If I get mad at a therapist, I think he or she would be angry with me.</td>
<td>6%</td>
<td>14%</td>
</tr>
</tbody>
</table>
I will feel nervous when I see a therapist. 29% 31%

I think that a therapist will know how to help me with my problems. 67% 53%

I think that a therapist will really like to spend a therapy session with me. 51% 35%

I would tell a friend who was having a problem to see a therapist. 78% 43%

I do not want to spend some time with a therapist. 8% 22%

A therapist is a warm and friendly person. 71% 45%

I will be afraid to show my real feelings to a therapist. 10% 20%

I have a feeling that a therapist is a person I can trust. 80% 61%
A session with a therapist will seem like a waste of time to me. 0% 27%

I think a therapist will misunderstand me. 4% 20%

A therapist is a person who would really like to help me. 96% 63%

I think a therapist will confuse me. 0% 14%

I will enjoy meeting with a therapist. 82% 41%

I can see where therapy can do a lot to help me solve my problems. 84% 53%