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Parent Expectancies for Child Therapy: Assessment and Relation to Participation in Treatment

Matthew K. Nock, M.Phil.[1] **and Alan E. Kazdin, Ph.D.**[2,3]

Two studies examined parents' pre-treatment expectancies for their child's psychotherapy among children (N = 405, ages 2–15) referred for oppositional, aggressive, and antisocial behavior. Study I focused on the development of a measure to assess expectancies. The results indicated that the measure was internally consistent. Moreover, socioeconomic disadvantage and ethnic minority status, severity of child dysfunction, child age, and parental stress and depression were significant predictors of lower parent expectancies for child therapy. Study II examined the relation of parent expectancies and participation in therapy. The results indicated that parent expectancies predicted subsequent barriers to treatment participation, treatment attendance, and premature termination from therapy. Overall, these findings have implications for the study of expectancies for therapy, for identifying families at risk for premature termination from treatment, and for the development of interventions designed to increase parent participation in child therapy.

KEY WORDS: parent expectancies; expectations; child psychotherapy; premature termination; participation.

Expectancies about psychotherapy refer to anticipatory beliefs that clients bring to treatment and can encompass beliefs about the procedures, outcomes, therapists, or any other facet of the intervention and its delivery. Client expectancies play a significant role in participation in treatment (e.g., attendance and treatment completion) as well as in therapeutic change. Clients with treatment expectancies that are consistent with characteristics of treatment delivery (e.g., treatment requirements and duration) and who believe that treatment is worthwhile are more likely to remain in treatment and to achieve greater therapeutic change than clients

[1]Doctoral Student, Department of Psychology, Yale University, New Haven, CT.
[2]John M. Musser Professor, Department of Psychology, Yale University, New Haven, CT.
[3]Correspondence should be directed to Alan E. Kazdin, Department of Psychology, Yale University, Box 208205, New Haven, CT 06520.

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who do not begin treatment with these expectancies (see Frank & Frank, 1991; Garfield, 1994 for reviews). Beyond the confines of psychotherapy, research on placebo effects, hypnosis, and suggestibility also suggest the power of expectancies and belief as potent sources of change in mental and physical health (Fisher & Greenberg, 1989; Kirsch, 1997; Shapiro & Shapiro, 1998).

Research on the effects of expectancies has focused almost exclusively on therapy for adults. Child therapy fundamentally differs from adult therapy in ways that may make key findings from adult treatment inapplicable. For example, in adult therapy, it is the expectancies of the client that predict therapeutic outcome and attendance at psychotherapy. In child therapy expectancies of the child may influence therapeutic change. However, typically *parents* decide to initiate and continue psychotherapy for the child. Thus, *parent expectancies* about the effectiveness and structure of psychotherapy may be of primary importance regarding whether the child will attend psychotherapy.

Child attendance and participation in treatment are significant issues in the delivery of treatment. Only 33% of children and families in need of mental health services receive such treatment (U.S. Congress Office of Technology Assessment, 1991). Moreover, among families who do attend, 40–60% terminate treatment prematurely (Gould, Shaffer, & Kaplan, 1985; Wierzbicki & Pekarik, 1993). Consequently, the identification of factors that might be useful in predicting, understanding, and ultimately preventing premature termination from child therapy, such as parent expectancies for therapy, is of great interest.

Previous research on parent expectancies for child therapy has focused primarily on the congruence between parent expectancies about the focus and structure of therapy (e.g., number of sessions needed, level of parental involvement) and the actual focus and structure of therapy that is provided. Discrepancies between parent expectancies and actual therapy predict premature termination from treatment (Burck, 1975; Day & Reznikoff, 1980; Furey & Basili, 1988; Plunkett, 1984). While demonstrating the usefulness of evaluating parent expectancies about the focus and structure of child therapy, this research has generally ignored the role of parent expectancies about the *effectiveness* of therapy—the primary focus of most research with adults. Because beliefs about effectiveness play a role in participation and outcome in psychosocial and medical interventions, this facet of expectancies is particularly important.

In keeping with the adult literature, one would expect that premature termination from treatment would be associated with low or inaccurate expectations at the inception of treatment. Although few studies have examined parent expectancies and treatment participation in child therapy, a burgeoning body of research has examined treatment participation and termination. Several family, parent, and child characteristics are known to predict participation in and premature termination from treatment. For example, family socioeconomic disadvantage, parental stress and depression, and severity of child dysfunction predict not attending treatment sessions and terminating treatment early (Furey & Basili, 1988;

Kazdin, Mazurick, & Bass, 1993; Kazdin, Stolar, & Marciano, 1995; Novick, Benson, & Rembar, 1981). In short, there already is literature on family, parent, and child factors that predict participation in treatment. Expectancies may or may not add to these other influences on treatment participation.

We report two studies designed to evaluate a new measure of parent expectancies for child therapy and to examine predictors and outcomes of such expectancies. From the perspective of test validity, it is essential to ensure that a new measure it not merely another way to assess other variables that are more well established, and more easily assessed, in predicting participation in treatment (e.g., socioeconomic status, parent and child dysfunction) (e.g., Campbell, 1960; Campbell & Fiske, 1959). Consequently, two foci of validation in this study were to examine whether parent expectancies predict participation in treatment, and are not merely a proxy for other variables already known to predict participation. Study I reports on the development and evaluation of the psychometric properties of the new measure and examines pre-treatment predictors of parent expectancies. Study II examines the validity of this new measure via its ability to predict subsequent barriers to participating in treatment, treatment attendance, and premature termination from therapy. Development of the scale and evaluation of the prediction were conducted in the context of outpatient treatment of children and their families referred for oppositional, aggressive, and antisocial behavior. These problems serve as the most frequent basis of clinical referrals for outpatient treatment (see Kazdin, 1995).

STUDY I: DEVELOPMENT AND EVALUATION OF THE MEASURE

Despite the importance of expectancies for therapy, there is currently no measure available to assess a broad range of pre-treatment parent expectancies. Study I reports on the development of a new measure of parent expectancies for therapeutic change and provides evidence to begin the process of validation. The overall goal was to provide a measure to permit systematic research on the topic. There were two objectives. First, the study provides psychometric data on a new measure of expectancies. Second and related, the study examined the relations between parent expectancies and family, parent, and child characteristics hypothesized to be associated with such expectancies.

Ultimately, an explanation of the processes involved in participation in treatment will need to identify multiple characteristics that clients bring to treatment, the interrelations of these characteristics, and how the characteristics influence treatment processes and outcomes. In relation to the present study, we examined characteristics of the family, parent, and child hypothesized to be associated with low or inaccurate expectations for therapy. Characteristics such as socioeconomic disadvantage, parental stress and psychopathology, and child dysfunction have a pervasive role in child therapy insofar as they predict who is likely to drop out of treatment prematurely, to show fewer gains in treatment among those who remain, and to maintain changes over the course of follow-up (see Kazdin, 1995). Apart

from considerations of test validation, we were interested in identifying the relation of family, parent, and child characteristics to expectations for treatment outcome. The relations among these variables and expectations may have implications for understanding processes related to expectations and therapeutic change. For example, depression and stress predict attendance to child therapy, as noted previously. Depressed and highly stressed parents may be much more pessimistic and hopeless about the effectiveness of therapy and therefore have lowered expectations. More generally, it would be important to integrate the concept of expectancies with other characteristics that families bring to treatment.

We expected that family, parent, and child characteristics would have small-to-moderate correlations with parent expectancies, indicating that they are related, but not overlapping (i.e., redundant); and that these characteristics would be statistical predictors of parent expectancies. More specifically, in keeping with prior research, we expected low socioeconomic status, ethnic minority status, more severe child dysfunction, and high parental stress and psychopathology would be predictive of lower parent expectancies for child therapy. This latter objective is important because many characteristics clients bring to treatment (e.g., socioeconomic disadvantage, clinical dysfunction), other than expectancies, are likely to influence participation in treatment. It would be important to integrate these influences in a model of treatment participation and as guide for clinical work in identifying who is at-risk for poor participation and early termination from treatment.

METHOD

Participants

The study was conducted at the Yale Child Conduct Clinic, an outpatient treatment service for child oppositional, aggressive, and antisocial behavior. Attendance was initiated by families, who contacted the clinic directly, or by a triage center at a child psychiatry service that referred families to the clinic. After referral, all children and families participated in an assessment of family, parent, and child functioning, and then began treatment.

The study included 405 children (313 boys, 92 girls) and their parents. Children ranged in age from 2–15 years ($M = 8.17$, $SD = 2.83$). Two hundred sixty-four (65.2%) of the children were European American, 98 (24.2%) were African American, 23 (5.7%) were Hispanic American, and 20 (4.9%) were of other groups or of mixed ethnic backgrounds based on parent identification. Full-scale Weschler Intelligence Scale for Children (WISC-R; Weschler, 1974) intelligence quotients ranged from 56 to 144 ($M = 98.23$, $SD = 17.08$). To obtain diagnoses of the children, parents were interviewed using the Research Diagnostic Interview (Kazdin, Siegel, & Bass, 1992), a structured interview used to assess the presence and

duration of symptoms based on the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R; American Psychiatric Association, 1987). Reliability of Axis I diagnosis is assessed in an ongoing basis for randomly selected cases for 15–20% of the sample. The assessment is based on evaluation of the diagnostic interview by an independent observer and has yielded high agreement (kappa $\geq$ .90 across all diagnoses). Principal Axis I diagnoses included conduct disorder (40.8%), oppositional defiant disorder (30.7%), attention deficit/hyperactivity disorder (6.9%), major depressive disorder (5.9%), various other disorders (9.7%), or no diagnosable Axis I disorder (5.9%). Most children (74.3%) met criteria for more than one disorder ($M = 2.27$, $SD = 1.22$).

The primary caretaker of the child included biological mothers (91.4%), step or adoptive mothers (4.5%), or other relatives (4.1%). Mothers ranged in age from 20 to 61 ($M = 34.58$, $SD = 6.28$); 47.9% of the children came from single-parent families. Family socioeconomic status class (Hollingshead, 1975) included (from lower to higher): Class I: 11.6%, II: 16.6%, III: 28.0%, IV: 28.5%, and V: 15.3%. Median monthly family income was \$1,500–\$2,000 (range from 0–\$500 to >\$5,000); 27.5% of the families received public assistance.

Assessment

The purposes of assessment were to measure parent expectancies for therapy and pretreatment family, parent, and child characteristics, all assessed prior to the first therapy session. The measures were completed by the parents of referred children and drew on varied assessment formats (interviews and questionnaires).

Parent Expectancies for Therapy

The main goal was to evaluate parent expectancies for their child's psychotherapy. A scale was developed to assess a broad range of areas related to parents' expectancies about the credibility of therapy, the magnitude and rate of change that are likely to occur as a result of treatment, and the structure and amount of parental involvement in treatment. Questions were generated via focus-group discussions with therapists who were asked to draw on their clinical experience in dealing with parents involved in child therapy. The item pool generated from these discussions went through several iterations prior to administration of the scale to participants. The result was a 29-item pool used to create the *Parent Expectancies for Therapy Scale* (*PETS*; Kazdin & Holland, 1991).

In an assessment session prior to treatment, the *PETS* items were read aloud to the parent by the therapist, who indicated the parent's choices of responses on a 5-point scale. The wording of the response items varied insofar as whether the first or last response option (point on the scale) reflected low or high expectancies. However, for scoring the measure, the lowest score (i.e., 1) always indicated lower

expectancies about treatment (e.g., this treatment will not work, my child will not improve, I will not have to be involved in treatment), and the highest score (i.e., 5) always indicated higher expectancies about treatment (e.g., this treatment will be very effective, my child will improve quickly, I will have to be very involved in treatment).

Family, Parent, and Child Characteristics

Several family, parent, and child characteristics were assessed at intake because of their previously demonstrated relation with premature termination from therapy and their hypothesized relations with parent expectancies. Family characteristics (e.g., subject and demographic variables) were assessed using a *General Information Sheet* completed by all parents during the initial evaluation. From this measure, five indices were used to assess socioeconomic disadvantage, including: Hollingshead (1975) level of educational and occupational attainment of the family, monthly income of the family (9-point scale where 1 = 0–$500/month; 9 = >$5,000/month;), whether the family received public assistance (yes, no), ethnic minority group membership (yes, no), and single-parent family status (yes, no). Ethnic minority group was measured in this way because prior research with this clinic population showed that it is closely associated with socioeconomic disadvantage (Kazdin et al., 1995).

Parental stress and psychopathology were expected to relate to parent expectancies for child therapy and assessed using three measures of parent dysfunction. The *Parenting Stress Index* (*PSI*; Abidin, 1990) was used to evaluate the overall level of parental stress. The *PSI* consists of 120-items (rated on a 5-point scale) that assess parenting stress related to child (e.g., demandingness, mood) and parent functioning (e.g., restrictions of role, social isolation). The items yield a total perceived stress score that was used in this study. The total score on the 120-item *PSI* was used in the study. The psychometric properties of the *PSI* have been reported previously (e.g., Abidin, 1990; Lloyd & Abidin, 1985). The *Beck Depression Inventory* (*BDI*; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) is a 21-item scale for which the parent selects 1 of 3 statements that differ in the presence and severity of parental depression. To sample a broad range of symptoms, parents completed the *Symptom Checklist* (*SCL-90*; Derogatis & Cleary, 1977). The *SCL-90* includes 90 items rated on a 5-point scale that reflect the degree of discomfort across several symptom areas. The total score was used as an overall index of psychological dysfunction. The psychometric properties of the *BDI* and *SCL-90* have been studied extensively.

Severity, breadth, and duration of child dysfunction also were examined, given their relation to participation of children and families in treatment. Child functioning encompassed multiple domains and assessment drew on three different measures. First, as a measure of scope of child impairment, the total number of

symptoms evident in the child was obtained from the diagnostic interview (*RDI*), mentioned previously. The total number of symptoms has been used as a psychometrically more sensitive measure of comorbidity and scope of dysfunction than merely counting comorbid diagnoses (e.g., Kazdin & Wassell, 2000). Second, the *Interview for Antisocial Behavior* (*IAB*; Kazdin & Esveldt-Dawson, 1986) was completed by all parents. The *IAB* is a 30-item measure that assesses the severity (5-point scale) and duration (3-point scale) of a range of overt and covert aggressive and antisocial behaviors in the child. The total antisocial behavior score is obtained by adding the severity and duration subscores. The psychometric properties of the *IAB* have been reported previously. Third, overall child dysfunction was measured using parent-report on the *Child Behavior Checklist* (*CBCL*; Achenbach, 1991). The *CBCL* is a 118-item, 3-point measure that assesses multiple problem areas. For the present investigation, the total problem score was evaluated to assess severity of child dysfunction across a broad range of behaviors.

Treatment

After intake assessment, children and families began treatment. Cognitive problem-solving skills training (PSST) for the child and parent management training (PMT) were provided alone or in combination (see Kazdin, 1996a). In PSST, children were seen individually for approximately 20–25 sessions and learned problem-solving skills (e.g., generating alternative solutions, means-ends thinking) to manage interpersonal situations (e.g., with parents, teachers, siblings, and peers). Within the sessions, problem-solving skills were developed through practice, modeling, role-playing, corrective feedback, and social and token reinforcement. Outside of the sessions, the children applied problem-solving steps to interpersonal situations in everyday life. For PMT, parents were seen individually for approximately 16 sessions to develop adaptive parenting practices and child-parent interaction patterns and to alter child behavior at home and at school. Practice, feedback, and shaping were used to develop parental skills in the sessions and specific behavior-change programs for use outside of the session. For school-age children, child functioning at school was incorporated into treatment through contact with the teacher and home-based reinforcement programs. Over the course of therapy, the child or parent(s) were brought into each other's sessions to review, discuss, and practice aspects of treatment.

The treatments included a core set of sessions to convey content, themes, and skills. Within the core sessions, child dysfunction at home and at school and special family circumstances (e.g., living conditions, job schedules, custody issues, use of extended family members) were individualized. Occasionally, additional sessions were provided to address specific problems or a theme that was not sufficiently well conveyed in the core session. For children ages 7 and older (63.0% of the

cases), PSST, PMT, or both were provided. For children ages 6 and younger, PMT alone was provided. The mean duration of treatment was 16.31 weeks ($SD = 8.42$).

Eleven clinicians (2 male, 9 female, ages 23–56 all European American, 9 Masters Degree and 2 Ph.D. level) served as therapists. Therapists had experience and supervised training in PSST and PMT. To maintain integrity of treatment: a) therapists followed a treatment manual; b) all treatment sessions were videotaped, some of which were reviewed weekly to provide feedback to the therapists; c) all cases were reviewed weekly; and d) ongoing clinical supervision was provided through direct observation of live treatment sessions via a TV monitor connected to cameras in the treatment rooms.

RESULTS

Characteristics of the Measure

Principal Component Analysis

Several initial analyses were completed to examine the structure and internal consistency of the measure. A principal component analysis was completed to examine the internal structure of the scale. An oblique (direct oblimin) rotation was used because we had no a priori reason to assume that different components of expectancies (i.e., factors) were orthogonal. In fact, we expected that different components of expectancies might be intercorrelated. Interpretation of the resulting eigenvalues, scree plot, pattern matrix, and residual correlation matrix suggested the presence of three intercorrelated components, which together accounted for 39.12% of the variance in scores. Four of the original 29 items were excluded from the scale and subsequent analyses because they failed to load on any factor (i.e., $<.35$) and because inclusion of that item on the component reduced the interpretability. All of the items and their component loadings (and the four deleted items) are listed in Table I.

The first component, Credibility (eigenvalue = 6.22; variance explained = 24.87), was comprised of 13 items ($M = 56.98$, $SD = 5.53$). The second component, Child Improvement (eigenvalue = 1.93; variance explained = 7.70), was comprised of 6 items ($M = 22.93$, $SD = 3.67$). The third component, Parent Involvement (eigenvalue = 1.64; variance explained = 6.55), was comprised of 6 items ($M = 23.40$, $SD = 3.25$). There were moderate, positive, statistically significant correlations among the subscale scores on the components. Specifically, the correlation between Credibility and Child Improvement was $r = .40$, between Credibility and Parent Involvement was $r = .37$, and between Child Improvement and Parent Involvement was $r = .24$ (all Ns = 405 and ps $> .001$). These moderate correlations suggest that the components represented related, but readily distinguishable measures of parent expectancies.

Table I. Principal Component Analysis of Parent Expectancies for Therapy Scale

Items	Component 1	Component 2	Component 3
16) I believe that this treatment sounds reasonable for the problems that I have been experiencing with my child.	.60		
29) How would this treatment compare in effectiveness with your own attempts at dealing with the problem?	.58		
23) To what extent do you think the therapy described is worthwhile?	.54		
18) I believe I will be motivated to work in this type of treatment with a therapist.	.54		
27) How will this treatment compare in effectiveness with having the child talk over the problem with a counselor at school?	.54		
19) I believe this treatment will be valuable in treating my child's problems.	.50	−.48	
17) I believe this form of treatment will help me better understand my child's problem behaviors.	.47	−.38	
11) I believe sessions will be once a week.	.46		
13) I believe that my child will mostly be talking about his/ her feelings in therapy, rather than learning how to behave differently.	.46		
8) I believe that only my child will be seen in treatment.	.42		
28) How would this treatment compare in effectiveness with medical treatment (e.g., medication) for the problem?	.40		
10) I believe that all the information that I give out will be confidential.	.39		
21) I believe that this treatment will make my child's problem worse.	.37		
12) Once therapy begins, I believe that my child's problems will improve.		−.76	
7) I believe that my child will improve quickly.		−.75	
9) I believe that it will take a long time for my child to improve.		−.69	−.40
20) I believe this treatment will improve my child's adjustment at home or at school.		−.64	
1) How much do you believe that the treatment at the clinic will help your child to better control his or her behavior?		−.59	
2) How much do you believe the treatment will help you in being a parent?		−.42	
3) How much time do you think you will have to spend outside the sessions on assigned tasks or activities related to treatment?			.63
24) I believe I will have to do a lot of work outside of the sessions in order for my child to improve.			.61
6) I believe that the school will have to be involved in the therapy.			.55
26) I believe these outside phone calls will help improve my child's behavior.			.49
5) How much of a role do you believe that you will have in your child's treatment?			.40
25) I believe that the therapist will call me during the week.			.37
Deleted items			
4) How many months do you believe this treatment will last?			
14) I believe I will be able to find out everything that happens to my child in therapy sessions.			
15) I believe it is important for my child to come in each week for treatment.			
22) Would this treatment be more helpful than just letting the problem go with no treatment?			

Note. Based on the loadings and content of the items, we refer to Components 1, 2, and 3 as Credibility, Child Improvement, and Parent Involvement, respectively. $N = 405$. Factor loadings $< .35$ are not displayed.

In order to verify the three-component structure of the initial principal component analysis, we divided the sample in half, as determined randomly (using the random case selection procedure in SPSS®, Version 10.0). While the eigenvalues and variance explained varied slightly in each solution, the component structure and loadings were consistent among all three principal component analyses.

Reliability Analyses

The 25-item *PETS* ($M = 103.31$, $SD = 9.48$, *range* = 57 to 124) demonstrated adequate internal consistency reliability, with an alpha coefficient of .79 and Spearman-Brown coefficient of .84. Individual item-total scale score correlations were computed, in each case removing that item from the total score. The item-total score correlations were positive and ranged from .04 to .65 ($Mdn = .35$, $p < .001$). In addition, each of the three components demonstrated an adequate level of internal consistency, as evidenced by alpha coefficients of .72, .75, and .56 for Credibility, Child Improvement, and Parent Involvement, respectively.

The overall level of expectancies was our primary interest in relation to test validation and predictions. Because the total *PETS* demonstrated high internal consistency, we used the total score as a measure of a broad range of parent expectancies in subsequent analyses. Subscale scores were examined as well to explore specific facets that might elaborate the nature of expectancies.

Predictors of Parent Expectancies

One of the main goals of Study I was to demonstrate that parent expectancies for therapy are a distinct construct, and to identify pre-treatment factors that would be useful in the prediction of parent expectancies for therapy. As stated previously, we expected that the family, parent, and child characteristics would be related with parent expectancies for therapy, but that they would not be so highly correlated as to be redundant. To examine the relations between these characteristics and parent expectancies and to test the hypotheses that parents with low expectancies for therapy would be characterized by socioeconomic disadvantage, having children with more severe and chronic psychological dysfunction, and more parental stress and psychopathology, we first examined the zero-order correlations between each pre-treatment characteristic and parent expectancies for therapy (presented along with the *M* and *SD* of each family, parent, and child characteristic in Table II). Measures were regarded as redundant if their correlation was $\geq .85$ (indicating a shared variance of $\geq 75\%$). As presented in Table II, the absolute value of the correlations ranged from .02 to .18, indicating significant relations between these constructs, but reflecting very little shared variance ($\leq 3\%$). Consistent with the hypotheses, the significant correlations presented in Table II indicate that lower

Table II. Means, Standard Deviations (or Proportions) of Family, Parent, and Child Characteristics and Correlations with Parent Expectancies

Domains/measures	*M* (%)	*SD*	Parent expectancies
Family characteristics			
Socioeconomic status	37.54	14.21	.16***
Income level	4.74	2.55	.17***
Public assistance (%)	27.50	—	−.10*
Ethnic minority group status (%)	33.10	—	−.18***
Single-parent family (%)	47.90	—	−.14**
Parent characteristics			
Parenting stress index	264.50	45.46	−.13*
Beck depression inventory	8.93	7.80	−.11*
Symptom checklist-90	53.99	47.05	−.09
Child characteristics			
Child age	8.17	2.80	−.15**
Child behavior checklist	67.51	9.83	−.10*
Child total DSM symptoms	27.91	9.23	−.09
Interview for antisocial behavior	96.56	25.16	−.04

*$p < .05$,**$p < .01$,***$p < .001$.

parent expectancies for child therapy were associated with lower socioeconomic status and income, ethnic minority and single-parent family status, more overall child dysfunction (as rated on the *CBCL*, but not on the *IAB* or total number of DSM symptoms), and higher parental stress and depression (but not overall dysfunction as rated on the *SCL-90*). Lower parent expectancies were also associated with older child age.

Because the family, parent, and child characteristics examined were significantly associated with parent expectancies for therapy, we next examined the ability of these characteristics to predict parent expectancies. Given that some these characteristics are known to be intercorrelated, we examined which characteristics were related to parent expectancies controlling for other factors in each domain (family, parent, and child). We performed three separate simultaneous regression analyses using those family (socioeconomic status, income level, receipt of public assistance, minority group status, and single-parent family status), child (age and overall dysfunction), and parent (depression and parenting stress) characteristics that had a significant univariate relation with parent expectancies, entered together in each regression analysis, to statistically predict pre-treatment parent expectancies. In separate regression analyses, the five family characteristics (F [5, 370] = 4.14, $p < .001$, $R^2 = .05$), child age and overall child dysfunction (F [2, 402] = 5.24, $p < .01$, $R^2 = .03$), and parent stress and depression (F [2, 400] = 3.68, $p < .05$, $R^2 = .02$) were all significant statistical predictors of parent expectancies. There was considerable overlap among the characteristics entered in each of the three simultaneous regression analyses, and after controlling for the other variables in each analysis, socioeconomic status ($\beta = .15$, $p < .05$), ethnic minority status

($\beta = -.13$, $p < .05$), and child age ($\beta = -.13$, $p < .05$) were the only variables to contribute significant, unique variance to parent expectancies.

Subscale Analyses

In order to better understand how the family, parent, and child characteristics are associated with the different domains of parent expectancies identified in the principal component analysis, we examined the relations between these predictors and scores on each of the three *PETS* subscales. Based on our prior hypotheses, we expected that low socioeconomic status and ethnic minority status would be most highly correlated with Credibility; higher levels of child dysfunction and older child age would be most highly correlated with low expectancies about Child Improvement; and that higher levels of parenting stress, depression, and psychopathology would be significantly correlated with low expectancies on each of the three factors, since the pessimism and hopeless associated with stress and depression were expected to be pervasive and not limited to one area of parent expectancies for therapy.

As presented in Table III, and consistent with the hypotheses, socioeconomic disadvantage was significantly related with low Credibility (rs $= -.14$ to $-.30$, all ps $< .01$), higher levels of parent depression was significantly related with low Credibility and low expectancies about Child Improvement (rs $= -.10$ and $-.14$, respectively, ps $< .05$), higher levels of parenting stress was significantly related with lower expectancies about Child Improvement (rs $= -.19$, $p < .001$), and older child age and higher levels of child dysfunction were significantly related with lower parent expectancies about Child Improvement (rs $= -.20$ to $-.25$, all

Table III. Correlations of Family, Parent, and Child Characteristics with Parent Expectancies Subscales

Domains/measures	Component 1 (credibility)	Component 2 (child improvement)	Component 3 (parent involvement)
Family characteristics			
Socioeconomic status	.19***	.05	.08
Income level	.20***	.06	−.08
Public assistance	−.14**	.04	−.07
Ethnic minority group status	−.30***	.05	−.04
Single-parent family	−.19***	−.02	−.02
Parent characteristics			
Parenting stress index	−.06	−.19***	−.06
Beck depression inventory	−.10*	−.14**	.01
Symptom checklist-90	−.10	−.09	.01
Child characteristics			
Child age	−.06	−.21***	−.10
Child behavior checklist	−.06	−.25***	.10*
Child total DSM symptoms	−.08	−.20***	.10
Interview for antisocial behavior	.05	−.23***	.06

*$p < .05$, **$p < .01$, ***$p < .001$.

*p*s < .001). The relations between the family, parent, and child characteristics and each of the three *PETS* subscales support the construct validity of each of these subscales.

DISCUSSION

The purposes of Study I were to develop and evaluate a new measure of pre-treatment parent expectancies for child therapy, and to examine the relations between family, parent, and child characteristics and pre-treatment parent expectancies for child therapy. The main findings were that: (a) principal component and reliability analyses yielded a 25-item, internally consistent measure of parent expectancies with three interrelated, internally consistent components representing the domains of credibility of therapy, expectancies about child improvement, and expectancies about parent involvement in therapy; (b) parent expectancies were related to, but did not overlap with, family, parent, and child characteristics that relate to participation in treatment; (c) socioeconomic disadvantage, older child age and higher levels of child dysfunction, and higher levels of parenting stress and depression were all significantly related with lower parent expectancies for therapy and aided in the statistical prediction of parent expectancies; and (d) on closer examination, socioeconomic disadvantage was significantly related with low credibility only, higher parental stress and depression was significantly correlated with low credibility and low expectancies about child improvement, and older child age and higher child dysfunction was significantly related with low parent expectancies for child improvement only.

These findings extend existing research on client expectancies for therapy in several ways. First, this study provides a measure of pre-treatment parent expectancies for child therapy. Expectancies for therapy have proven to be an important predictor of treatment participation and outcome in the adult psychotherapy literature but have not been the focus of much research with children and families. The *PETS* may be useful in the identification of families at risk for premature termination, or those who are likely to benefit most from treatment. Second, several family, parent, and child characteristics were identified that statistically predicted low parent expectancies for therapy. Parents from families characterized by socioeconomic disadvantage, ethnic minority status, and single-parent family status had lower expectancies for their child's therapy. These characteristics were particularly associated with lower credibility of therapy. This finding is consistent with previous research suggesting that families of lower socioeconomic status and ethnic minority status believe therapy is less credible than do other families (e.g., Kazdin et al., 1995; Novick et al., 1981; Sue & Zane, 1987). Since such families are also at higher risk for attrition from child therapy (Armbruster & Kazdin, 1994), it is possible that lower parent beliefs about the credibility of therapy may represent one mechanism that helps explain this relationship.

Parents with children characterized by more severe psychological dysfunction and older age had lower expectancies for their child's therapy. These child characteristics were more specifically associated with lower parent expectancies for their child's improvement. These lower expectancies for therapy may be accurate, since previous research has demonstrated that such children are less likely to improve in child therapy (e.g., Kazdin & Crowley, 1997). Alternatively, it is possible that lower parent expectancies at pre-treatment somehow limit the efficacy of treatment. Indeed, adult psychotherapy research has demonstrated that expectancies about the effectiveness of therapy are positively correlated with therapeutic improvement (e.g., Borkovec & Costello, 1993); and negative expectancies about treatment are associated with a worsening of an individual's condition (Hahn, 1997). If parents' expectancies are shown to influence their child's improvement in therapy, such expectancies would be an important variable to examine in studies aimed at better understanding, and amplifying, the effectiveness of psychotherapy.

Parents who experienced higher levels of parenting stress and depression also had lower expectancies for their child's therapy. These lower expectancies were not specific to a single aspect of therapy, but took the form of low credibility and low expectancies about their child's improvement. Because stress and depression are associated with pessimism and hopelessness that may be pervasive (e.g., Beck, Weissman, Lester, & Trexler, 1974), it is likely that these characteristics played a role in parents' beliefs that therapy would not be effective. While these results require replication, this finding may help explain why forms of child therapy that include a component designed to increase parental adjustment factors lead to more favorable child outcomes (Miller & Prinz, 1990). That is, decreasing factors such as parental stress and depression may lead to improved outcome in part by increasing parent expectancies for change.

STUDY II: PARENT EXPECTANCIES AND PREMATURE TERMINATION FROM THERAPY

Premature termination from therapy (i.e., attrition) is one of the greatest obstacles to providing psychotherapy to children and families and raises problems in the quality of clinical care (e.g., inadequate dose of treatment), costs of delivering services (e.g., increased unfilled appointment hours of clinicians and services), and evaluation of treatment in research (e.g., small sample sizes, loss of random composition of groups). Therefore, identifying factors that might be useful in predicting, understanding, and ultimately preventing premature termination from child therapy could have broad implications for research and practice. Unfortunately, however, most studies of attrition from child therapy have focused on "variables of convenience" (typically family, parent, and child characteristics that appear on clinic intake forms) and have lacked any theoretical perspective. For example, socioeconomic disadvantage, higher levels of parenting stress, and more

severe child dysfunction have all been shown to predict premature termination from child therapy (see Armbruster & Kazdin, 1994 for a review).

More recently, theoretical models have attempted to understand how and why some factors influence attrition from child therapy. In our work, we have proposed a barriers-to-treatment model that describes multiple treatment-related difficulties experienced by families (Kazdin, 1996b; Kazdin, Holland, & Crowley, 1997). These difficulties or barriers include stressors or obstacles to coming to therapy, perceptions that treatment is not relevant or is too demanding, and poor relationship with the therapist and increase the risk of premature termination of treatment. While the barriers to treatment model provides important information about what factors increase the probability of attrition from child therapy, these barriers cannot be assessed until the family has already begun to participate in treatment, and have typically been assessed in previous studies after treatment has already ended. Thus, it would be instructive to identify pre-treatment factors that may predict which families will experience barriers to treatment participation later on in treatment, and ultimately which families will drop out of treatment altogether.

Previous research in the adult psychotherapy literature suggests that pre-treatment expectancies about the effectiveness and structure of therapy predict a range of outcomes, including premature termination from treatment (see Garfield, 1994; Walitzer, Dermen, & Connors, 1999 for reviews). Overall, clients with pre-treatment expectancies that treatment will be effective and those whose expectancies about the structure of therapy are congruent with the actual structure of treatment are less likely to terminate treatment prematurely. While these findings suggest a linear relation between expectancies and attendance, other research implies a more complex relation between client expectancies for treatment and therapy outcomes. For instance, in a study of the effects of client expectancies and therapeutic outcome, Park and Covi (1965) found that clients who improved most were those who were certain that they were receiving an active treatment *and* those who were certain they were receiving a placebo, while those who were unsure showed the least improvement, suggesting a curvilinear relation between expectancies and therapeutic outcome.

Based on findings in the adult psychotherapy literature, one might presume that parents who expect therapy to be effective and who expect to be very involved in treatment would experience fewer barriers to treatment (i.e., experience treatment as more relevant and not demanding), would attend more therapy sessions, and would be less likely to terminate treatment prematurely. Such a finding would suggest that beliefs about the effectiveness or relevance of therapy are relatively stable over time, and would be consistent with studies in the adult psychotherapy literature demonstrating a linear relation between expectancies about treatment efficacy and continuation in treatment. However, it is also possible that there is a curvilinear relation between parent expectancies and premature termination, as suggested by the data reported by Park and Covi (1965). In such a case, we would expect that parents with very high *and* very low expectancies for therapy to

attend the greatest number of sessions and be least likely to terminate prematurely, and for those with moderate expectancies to attend the fewest number of sessions and be most likely to terminate treatment prematurely. Regardless of the nature of the relation, the demonstration that parent expectancies predict barriers to treatment, treatment attendance, and premature termination from treatment would be significant. Expectancies represent an easily assessable, and probably malleable construct and thus a promising target for interventions developed to decrease premature termination from child therapy.

The purpose of this prospective study was to examine the ability of parent expectancies for child therapy to predict barriers to treatment participation, treatment attendance, and premature termination, and to do so above the effect of family, parent, and child characteristics that have previously been shown to predict these outcomes. Study II included three main hypotheses. First, we predicted that family, parent, and child characteristics assessed at pre-treatment would predict barriers to treatment, treatment attendance, and premature termination. This hypothesis is consistent with previous research and serves as a precondition for the next two hypotheses. Second, based on previous research demonstrating a positive relation between expectancies for therapy and treatment continuation, we predicted that parents with high expectancies for therapy would experience fewer barriers to treatment participation, would attend the most therapy sessions, and would be less likely to terminate treatment prematurely then those with lower expectancies. However, we also tested the alternative hypothesis based on research showing a curvilinear relation between expectancies and therapy outcomes that parents whose expectancies were either extremely high or extremely low would attend the most sessions and be least likely to terminate treatment prematurely. Third, and related, we predicted that parent expectancies would contribute incrementally to barriers to treatment, treatment attendance, and premature termination after controlling for family, parent, and child variables already shown to relate to barriers and participation. Evidence that parent expectancies make a significant and unique contribution to the explanation of these outcomes would support the incremental validity of this construct.

METHOD

Participants

Participants in Study II included the same 405 children and parents described in Study I.

Assessment

The purposes of assessment were to measure parent expectancies for therapy, pre-treatment family, parent, and child characteristics (all assessed prior to the

first therapy session); perceived barriers to treatment participation (assessed after the last therapy session); and actual attendance at therapy (assessed throughout the course of therapy). The measures were completed by the parents of referred children and drew on varied assessment formats (interviews and questionnaires). Several measures described in Study I provided information used in Study II. Specifically, we used the *General Information Sheet* (e.g., socioeconomic status, ethnic minority status, family income, etc.), and measures of parent (i.e., *BDI*, *PSI*, and *SCL-90*) and child characteristics (i.e., child age, total DSM symptoms, *CBCL*, and *IAB*). We also used the 25-item version of the *PETS* reported in Study I. Several additional measures were added to assess parents' experience of barriers to treatment participation and attendance at their child's therapy.

Barriers to Treatment Participation

The *Barriers to Treatment Participation Scale* (*BTPS*; Kazdin, Holland, Crowley, & Breton, 1997) was administered by a research assistant unfamiliar with the case to assess parents' experience of obstacles or barriers to participating in treatment. All parents (regardless of the number of sessions attended) completed the *BTPS*. The *BTPS* is comprised of a 44-item (1 = never a problem; 5 = very often a problem) section that assesses barriers related to stressors and obstacles that compete with treatment, treatment demands and issues, perceived relevance of treatment, and relationship with the therapist; and a 15-item (yes, no) section that assess the presence or absence of discrete critical events that might have interfered with treatment participation. We did not expect pretreatment expectancies to be related to the occurrence of critical events and hence used only the 44-item scale as a measure of barriers to treatment. Psychometric evaluation of the 44-item *BTPS* has demonstrated adequate internal consistency reliability (coefficient alpha = .86) and that it predicts attrition from child treatment (Kazdin, Holland, Crowley, & Breton, 1997).

Treatment Attendance and Premature Termination

Treatment attendance was a continuous variable defined as the number of sessions a family remained in treatment. Thus, the longer a family remained in treatment, the higher the score on this variable. Premature termination was a dichotomous variable and referred to any participant who began treatment (i.e., came to at least initial evaluation and one therapy session) but who did not finish the full treatment regimen. Premature termination was considered to have occurred if parents stated explicitly that they did not want to continue treatment or if they failed to appear for at least three consecutive weeks, and then failed to return after direct contact to schedule appointments. These two measures of treatment participation were highly correlated ($r\ [N = 405] = .84$, $p < .001$), however, they were

not completely redundant and both were used in the following analyses to demonstrate the relationship of each of these variables with the other constructs examined in this study. The method of defining and measuring participation in treatment using these two related, yet distinct, variables is consistent with that used in previous studies (e.g., Kazdin, Holland, & Crowley, 1997; Takeuchi, Sue, & Yeh, 1995).

RESULTS

Prediction of Barriers to Treatment and Premature Termination

Our initial hypothesis was that family, parent, and child characteristics assessed prior to treatment would predict subsequent barriers to treatment participation, treatment attendance and premature termination. To test this hypothesis, we entered all 12 of the parent, family, and child characteristics listed in Table II into three multiple regression analyses predicting total barriers score, treatment attendance, and premature termination. Entered together the 12 family, parent, and child characteristics significantly predicted barriers to treatment participation ($F\,[12, 364] = 5.20$, $p < .001$, $R^2 = .15$), treatment attendance ($F\,[12, 357] = 4.25$, $p < .001$, $R^2 = .13$), and premature termination ($F\,[12, 364] = 5.26$, $p < .001$, $R^2 = .15$). These findings are consistent with previous research on pre-treatment factors that predict barriers to treatment and actual participation in treatment.

The second hypothesis was that parent expectancies for child therapy would also be a significant predictor of subsequent barriers to treatment participation, treatment attendance, and premature termination. It was expected that lower parent expectancies would predict higher barriers to treatment participation, fewer sessions attended, and greater attrition from treatment. However, based on previous research demonstrating a curvilinear relation between expectancies for therapy and therapy outcomes, we also tested the alternative hypothesis that parents with expectancies for therapy that were either very high or very low would attend a greater number of sessions and be least likely to terminate prematurely. We tested these hypotheses using three hierarchical multiple regression analyses entering parent expectancy scores in the first step, and the quadratic term of parent expectancy scores in the second step, predicting barriers to treatment participation in the first regression analysis, treatment attendance in the second analysis, and premature termination in the third analysis.

The effect size (R) of the relation between parent expectancies and the criterion variables in the first step is an indication of the linear relation between these variables, and a significant increase in the variance explained in the second step indicates that the addition of the quadratic term makes a significant contribution to the equation, and that the relationship in the population is best explained as curvilinear in nature (Cohen & Cohen, 1983). As presented in Table IV, in the first step of the regression analyses pre-treatment parent expectancies significantly predicted

Table IV. Hierarchical Regression Analyses for Prediction of Barriers, Treatment Attendance, and Premature Termination

	Barriers to treatment			Treatment attendance			Premature termination		
	ΔF	R	R^2	ΔF	R	R^2	ΔF	R	R^2
Parent expectancies									
Step 1: Total score (linear)	16.71***	.20	.04	0.01	.01	.00	0.20	.02	.00
Step 2: Quadratic term (curvilinear)	0.03	.20	.04	7.64**	.14	.02	6.29*	.13	.02

*$p < .05$,**$p < .01$,***$p < .001$.

barriers to treatment participation, but not treatment attendance or premature termination. In the second step of the analyses, there was not a significant increase in the variance explained in barriers to treatment participation; however, there was a significant increase in the amount of variance explained in treatment attendance and premature termination by parent expectancies. The results of these analyses indicate that parents with lower expectancies for therapy experienced higher barriers to treatment (linear relation), and that parents with expectancies that were very high or very low attended the greatest number of sessions and were least likely to terminate treatment prematurely (curvilinear relation). Figure 1 illustrates the curvilinear relation (U-shaped function) between parent expectancies and number of treatment sessions attended.

Incremental Validity of Parent Expectancies for Therapy

The utility of assessing parent expectancies would be further supported if they contributed significantly to the prediction of barriers to treatment and actual participation, above and beyond (i.e., controlling for) family, parent, and child characteristics, which have previously been shown to predict these outcomes. Thus, the third hypothesis was that parent expectancies for therapy would predict barriers to treatment above and beyond the effects of family, parent, and child characteristics; and that parent expectancies would predict treatment attendance and premature termination above and beyond the effects of family, parent, and child characteristics and barriers to treatment. We tested these hypotheses using three hierarchical multiple regression analyses.

To test the first prediction, we entered the 12 family, parent, and child characteristics listed in Table II together in the first step, and the total parent expectancies scores in the second step, predicting barriers to treatment. We tested the second and third predictions by entering the 12 family, parent, and child characteristics together in the first step, the total barriers scores in the second step, and the total parent expectancies scores and the quadratic term for the total parent expectancies scores in the third step (to test for the presence of a curvilinear relation), with the number of

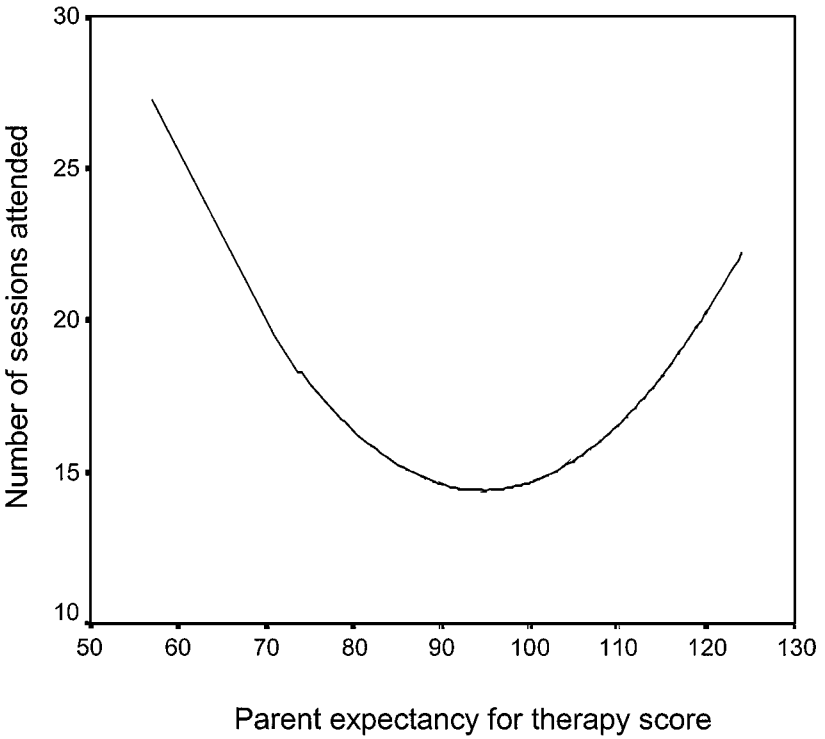

Fig. 1. Curvilinear relation between the number of sessions attended and parent expectancies for therapy. Lower parent (*PETS*) scores reflect lower expectations of the parents.

sessions attended and premature termination as the criterion variables. The parent expectancies score added significant variance to the explanation of barriers to treatment when family, parent, and child characteristics were controlled, (F [1, 363] = 6.29, $p < .05$, $\Delta R^2 = .02$). Similarly, the parent expectancies score added significant variance to the explanation of treatment attendance (F [2, 354] = 6.38, $p < .01$, $\Delta R^2 = .03$) and premature termination (F [2, 361] = 7.00, $p < .001$, $\Delta R^2 = .03$) when family, parent, and child characteristics, as well as barriers to treatment, were controlled. These results support the third hypothesis that parent expectancies for their child's therapy contribute in an incremental way to barriers to treatment participation, treatment attendance, and premature termination from child therapy.

DISCUSSION

Study II examined the ability of parent expectancies for child therapy to predict barriers to treatment participation, treatment attendance, and premature termination above the effect of family, parent, and child characteristics already

known to predict these outcomes. The main findings were that: (a) the family, parent, and child characteristics examined predicted barriers to treatment, treatment attendance, and premature termination; (b) parent expectancies for therapy were a linear predictor of barriers to treatment; lower expectancies were related to higher barriers; (c) parent expectancies were a curvilinear predictor of treatment attendance and premature termination from therapy; parents with expectancies that were very high or very low attended the greatest number of therapy sessions and were least likely to terminate treatment prematurely; and (d) parent expectancies for therapy contributed significant, unique variance to barriers to treatment, treatment attendance, and premature termination, supporting the incremental validity of this construct and measure.

The finding that socioeconomic disadvantage, parent stress and psychopathology, and child severity predicted barriers to treatment, treatment attendance, and premature termination is consistent with previous research (Armbruster & Kazdin, 1994; Kazdin, Holland, & Crowley, 1997). While these factors are useful for the identification of families at risk for premature termination, they are difficult to change and therefore of relatively little use for potential intervention programs designed to decrease attrition from therapy, the ultimate goal of this research. Similarly, while barriers to treatment also predict treatment attendance and premature termination, this variable typically is assessed well after the treatment has begun, and is of limited use in identifying families at pre-treatment who are at risk of subsequent attrition, highlighting the need for the identification of more malleable, pre-treatment indicators of participation such as parent expectancies.

Parent expectancies emerged as a significant, prospective predictor of the experience of barriers to treatment participation in this study, even after controlling for family, parent, and child characteristics. Parents who did not expect therapy to be effective and who had inaccurate beliefs about the structure of therapy experienced greater barriers to treatment participation (i.e., subsequent beliefs that therapy is not relevant and is too demanding, more stressors and obstacles to coming to treatment, and a poorer relationship with their therapist). Those parents who begin treatment most skeptical of its effectiveness see therapy as less relevant, more work, and have a poorer relationship with the therapist. The stability of these parent attitudes from pre- to post-treatment is consistent with other research demonstrating that "parent resistance" to participating in child therapy is relatively stable over the course of child therapy (Patterson & Chamberlain, 1994). The findings suggest it is possible to detect families at pre-treatment who are at risk for experiencing subsequent barriers to treatment participation.

Parent expectancies for child therapy also were a significant, prospective predictor of treatment attendance and premature termination from treatment, even after controlling for family, parent, and child characteristics and barriers to treatment participation. Interestingly, those parents whose expectancies for therapy were very high and very low came to the greatest number of therapy sessions and

were least likely to terminate treatment prematurely, while those with moderate expectancies were most likely to terminate prematurely and came to the fewest number of sessions. This finding is consistent with previous reports in the clinical literature (e.g., Park & Covi, 1965), however, a theoretical model accounting for this finding has not been advanced or tested empirically. It is likely that two distinct processes are involved in the relations between those with high versus low expectancies and treatment attendance. For instance, those with high expectancies for therapy may be most likely to attribute any observed therapeutic changes to the therapy itself since this is most consistent with their belief system. Those with very low expectancies for therapy are least likely to expect any change to occur, and thus are most likely to increase their expectancies for therapy in the presence of any such change, causing them to continue attending sessions. In contrast, the observation of some level of therapeutic change is in keeping with the beliefs of those with moderate expectancies, thus this group is not as likely to experience any change in behavior or beliefs as a result of observed therapeutic change. Regardless of the processes underlying the relation between parent expectancies and treatment attendance, the results of Study II highlight the importance of this construct in predicting barriers to treatment participation and actual attendance at treatment, and provide researchers and clinicians with useful information about factors that can be used to identify and intervene with families at risk for premature termination from child therapy.

GENERAL DISCUSSION

Expectancies about the effectiveness of treatment have been well studied in the medical literature and less frequently in the adult psychotherapy literature; however, this construct has been largely ignored in research on child and family therapy. There has not been a measure for assessing parent expectancies about the effectiveness and structure of child therapy, and previous work has not identified factors that might predict this construct or examined whether such expectancies might be useful in the identification of families at risk for premature termination from therapy. The studies reported here extend previous psychotherapy research by providing a measure of parent expectancies for therapy. Reliability and validity are multifaceted and cumulative so any initial demonstration or set of demonstrations merely reflects a point of departure. Nevertheless, the present studies suggest the measure is internally consistent and has distinguishable subscales (factors) that relate meaningfully and predictably to family, parent, and child functioning. Preliminary validity evidence is suggested by expectancy scores ability to predict participation in treatment and the experience of barriers known to influence participation. Moreover, expectancies predict participation and premature termination over and above several family, parent, and child characteristics that relate to participation in treatment.

The studies reported in this article demonstrate that parents' expectancies for therapy predict subsequent participation in therapy and identify family, parent, and child characteristics that influence such expectancies. These findings have implications for theory, research, and practice. From the theoretical and research perspectives, expectancies represent the interface of characteristics that parents bring to treatment and connect with the actual procedures and interventions provided to them. There are multiple opportunities to conceptualize and to intervene in how treatment is provided that could favorably influence or indeed clash with these expectancies. During the treatment process, further contacts with the parents, whether central or ancillary to the treatment, could affect ongoing expectancies and such factors as patient adherence, attendance, and therapeutic change. Understanding the role of expectancies from inception through the course of therapy represents many rich lines of research.

From a clinical perspective, there are implications of the findings as well. The evaluation of family, parent, and child characteristics can provide the clinician with information about which parents may be at risk for low expectancies for therapy and may be useful targets in interventions designed to modify parent expectancies. Interventions can be tailored to individual parents or to profiles of characteristics depending on the nature of their pretreatment expectancies (e.g., which components of expectancies are low) and related characteristics (e.g., family and parent characteristics). For example, parents with low expectancies for their child's therapy who are characterized by socioeconomic disadvantage may benefit most from interventions describing the credibility of treatment, while those with children with more severe dysfunction may benefit most from interventions aimed at providing information about expected rate and magnitude of child improvement.

Important limitations of these studies deserve comment. First, the generality of the findings may be restricted, as these studies were completed among clinically referred youths identified because of conduct problems. Thus, the family, parent, and child characteristics examined may only apply to similar samples. Second, all measures were completed by the mother or maternal guardian of children referred for treatment. This may have increased correlations between measures because of shared method variance, and neglected the subjective experience of fathers and the children themselves, whose expectancies about therapy may also be important. Third, these studies did not report on the relation of parent expectancies with a range of other possible outcomes, such as parent adherence to treatment and child therapeutic change during the course of therapy. Based on research in the adult psychotherapy literature, it is expected that expectancies may influence such outcomes, however, these relations were not reported here and more complex models incorporating these outcomes await further testing.

Several potential lines of research follow directly from these studies. Future investigations might investigate the ability of parent expectancies for child therapy to predict premature termination from therapy, engagement in therapy, and therapeutic outcome. In addition, it may be instructive to examine parent expectancies

over the course of therapy, as well as the expectancies of significant others such as the father and the referred child. These additional measures of expectancies for therapy may provide useful information and may add to the predictive validity of the *Parent Expectancies for Therapy Scale*. Finally, whether expectancies play any causal role in treatment participation and therapeutic change are not known. Information gained from this and future studies could test whether interventions aimed at modifying parent expectancies for therapy reduce premature termination, improve treatment attendance and adherence, and ultimately increase the effectiveness of child therapy.

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