What Happens in Therapy?

Adolescents' Expectations and Perceptions of Psychotherapy

By

Peter K. Stewart, M.A.

University of Kansas

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_____
Michael C. Roberts, Ph.D.
Committee Chair

_____
Julie Boydston, Ph.D.
Committee Member

_____
Bruce B. Frey, Ph.D.
Committee Member

_____
Yo K. Jackson, Ph.D.
Committee Member

_____
Ric G. Steele, Ph.D.
Committee Member

Date Submitted:_____

The Dissertation Committee for Peter K. Stewart certifies that this is the approved version of the following dissertation:

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_____
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Committee Member

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Abstract

An empirically based measure of adolescent pre-treatment expectations and perceptions of psychotherapy is provided with supporting literature from service-use models, common factors research, evidence-based practice principles, and expectancies. The development of the Psychotherapy Expectations and Perceptions Inventory (PEPI) is described with initial psychometric properties reported based on data from 546 adolescents (age 14-18). Results indicate adequate internal consistency and a 3 factor structure measuring negative expectancies, process/outcome expectancies, and expectancies for a positive therapeutic relationship. Boys reported greater negative expectancies, but also greater expectancies for a positive therapeutic relationship. Girls reported greater therapy process/outcome expectancies. Level of contact with mental illness was not a significant predictor for any factors. An item response report is provided. Clinical and educational implications are discussed. Clinicians might be advised assess adolescent expectancies in treatment to facilitate greater rapport and engagement in the therapeutic process in order to foster more therapeutic change.

What Happens in Therapy?

Adolescents' Expectations and Perceptions of Psychotherapy

Recent estimates state that approximately 20% of adolescents have symptoms of a mental disorder, but only 4% of those receive services from a mental health professional (Costello, Pescosolido, Angold, & Burns, 1998; Logan & King, 2001). There exists a service gap between those who might seek services and those who actually receive them. The underutilization of needed services was a catalyst for the Surgeon General, David Satcher, to issue *Mental Health: A Report of the Surgeon General* (Satcher, 2000). He called for further research to assess the needs and preferences of service users (Satcher, 2000). Within the context of service use, preferences include pre-treatment client expectancies. These are defined as the beliefs and expectations that a client brings with them to their first therapy session and can influence their decision to even seek services (Dew & Bickman, 2005). Likewise, perceptions of services have been identified as the most commonly reported barrier to beginning mental health services (Owens et al., 2002). In addition, many researchers report that across ages, negative attitudes and expectancies about treatment contribute to the underutilization of services (Gonzalez, Alegria, & Prihoda, 2005). Thus, an increased understanding of pre-treatment client expectancies may help enhance therapist understanding of adolescent clients and influence the services provided, in addition to the creation of interventions to alter inappropriate and/or negative expectancies which may lead to an increase in service use.

Why Adolescents?

Adolescent service use is influenced by the fact that adolescence is a sensitive period for the development of a vast array of life expectations and perceptions, mental health and psychotherapy being just a few of these expectancies (Weisz & Hawley, 2002). There are several explanations as to why adolescence is a period of development that appears to spawn a general unwillingness to seek services. Cognitively, during adolescence, most develop abstract thought. Although abstract thought is adaptive, it can also lead to a false belief that others are always watching and making judgments of the adolescent (i.e., imaginary audience). Combined with mental health stigma reported to pervade adolescent attitudes, these beliefs can influence willingness to seek treatment and foster negative therapeutic expectancies (Corrigan et al., 2005). Within the emotional domain, adolescence is a time for the development of increased autonomy that is characterized by amplified conflict with caregivers and authority figures (Furman & Buhrmester, 1992). An adolescent may place a therapist in a category of an authority figure similar to a teacher or parent, which may influence an adolescent to view therapy as punitive or aversive in nature because of the contrast to his or her development of autonomy (Garland & Besinger, 1996). Potential adolescent unwillingness to seek services is further reported to be based on negative attributions of therapy and lack of choice in the decision to participate in services (Taylor, Adelman, & Kaser-Boyd, 1985). All of these issues provide support for the need to assess reasons or causes for this apparent "service gap" among adolescents and specifically their expectancies about psychotherapy. In

addition to the "service gap" present in adolescent treatment, the need for research into pre-treatment expectancies is supported by the literature in three allied fields: service use models, common factors research, and evidence-based practice. Consequently, support from and applications to each of these fields of research are subsequently presented.

Service Use Models

There have been several models of mental health service utilization developed for adult populations, but few for children or adolescents (Costello et al., 1998). Adult models are often less complex because they are focused on the characteristics of the adult client who is often the initiator of therapy (Anderson, 1995). Downward extrapolations of adult models to child populations are untenable because of the tremendous differences in the amount of autonomy of the identified client. In contrast, the child models of service use are focused on the parents as the "gate-keeper" into the children receiving services and entering other systems (i.e., school) (Costello et al., 1998; Logan & King, 2001).

Adolescent service use is particularly challenging to conceptualize as a result of the transition between childhood and adulthood. Adolescents are typically more independent in their behaviors in comparison to children, but they are often not the sole service seekers, in contrast to adult clients, nor are they legally able to independently consent to treatment in most jurisdictions. The present paucity of research on adolescent service use is emphasized by Cauce et al. (2002) who stated: "Research on the pathways that adolescents take into mental health treatment is vastly

underdeveloped, and we know very little about how this multilayered process unfolds for young people" (p. 51).

In an attempt to conceptualize the underdeveloped field of adolescent mental health use both Logan and King (2001) and Cauce et al. (2002) have identified models of service use. The model developed by Logan and King (2001) relies on the parent as the service initiator, but takes into account the adolescent's characteristics (e.g., expectancies and perceptions of therapy). The adolescent plays a significant role in the transition from the parent's attempt to secure services and the adolescent actually receiving the services. In contrast, the Cauce et al. model identifies adolescent involvement in all three phases of their model: problem recognition, decision to seek help, and service selection. A hallmark of the Cauce et al. model is the inclusion of cultural and contextual issues in the help-seeking model. These contextual issues can include adolescent therapy expectancies, among others. Thus, adolescent expectancies and perception of therapy are important characteristic variables within both models of service use and require further investigation to better understand adolescent mental health service use.

Common Factors

Expectancies and perceptions of an adolescent can also be examined through a common factors perspective. "Common factors of psychotherapy approaches" is an overarching term that incorporates several topics including client characteristics, therapist qualities, change processes, treatment structure, and the therapeutic relationship (Grencavage & Norcross, 1990). In their review of the literature, Dew

and Bickman (2005) outlined the role of client expectancies. Client expectancies are encapsulated under the term "client characteristics," and can be divided further into "role expectations" and "outcome expectations." Role expectations refer to the behaviors that are expected of both the client and therapist (e.g., the therapist will give orders, listen, or judge, and the client lies on a couch and complies), whereas outcome expectancies are the perceptions that therapy will bring about change (Dew & Bickman, 2005).

Nock and Kazdin (2001) provided a slightly broader definition of expectancies: "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" (p. 155). Furthermore, expectancies of therapy are one of the most frequently identified constructs of common factors, but they are also one of the most neglected areas of research, particularly among children and adolescents (Dew & Bickman, 2005). The present study will adopt the broader definition of expectancies as provided by Nock and Kazdin (2001), which essentially states that expectancies are all of the pre-treatment client beliefs that are brought to therapy.

Evidence-Based Practice

The assessment of expectancies of psychotherapy is also one part of the evidence-based practice concepts that include empirical evidence, clinical expertise, and patient values/characteristics. Client expectancies and perceptions of psychotherapy fit within the domain of patient values/characteristics (APA

Presidential Task Force on Evidence-Based Practice, 2006). The APA task force (2006) reported that "…psychological services are most likely to be effective when they are responsive to the patient's specific problems, strengths, personality, sociocultural context, and preferences" (p. 278). Client preferences are further defined to include goals, beliefs, worldviews, and treatment expectations. Consequently, a call was issued for further research to identify successful treatments in terms of patient preferences (APA Presidential Task Force on Evidence-Based Practice, 2006). Identification of treatment expectancies is a critical step toward the goal of identifying successful treatments. Additionally, Hoagwood and colleagues (2001), in an assessment of the current state of evidence-based practice, called for further research into the identification and reduction of barriers to seeking mental health services. These barriers include client values and the inaccurate expectations they have of psychotherapy.

Term Clarification

A comprehensive and exhaustive search was conducted to find relevant studies measuring child or adolescent pre-treatment expectancies which resulted in little research in regard to expectations of therapy among child and adolescent populations. Thus, a review of appropriate literature from related topics will be presented as well. Before the results of the literature review can be presented, however, some clarification of terms is appropriate.

Several terms within the literature relate to client expectancies such as health beliefs, client perceptions, help-seeking, and mental health knowledge. As noted

earlier, client expectancies and perceptions are used interchangeably within the literature. Health beliefs are "attitudes, values, and knowledge that people have about health and health services that might influence their subsequent perceptions of need and use of health services" (Anderson, 1995, p. 2). Accordingly, health beliefs is the larger overarching term under which client expectancies and the other terms may be included. Help-seeking is often defined as the willingness to seek help for problems or obstacles in life and is conceptualized as an appropriate coping behavior (Boldero & Fallon, 1996; Garland & Zigler, 1994). This is a general term incorporating a broad definition of individuals who can provide help ranging from a parent or friend to a teacher or therapist. Thus, client expectancies would be only one factor associated with help-seeking. Finally, mental health knowledge is an individual's knowledge of mental health which includes both an awareness of symptoms and when professional help should be utilized, but does not specifically target expectations of therapy.

Expectancies Literature

There have been two recent examinations of client expectancies within child therapy; however, both studies assessed parent's expectations, and not the child's (Nock & Kazdin, 2001; Shuman & Shapiro, 2002). These studies suggest that parental expectations of therapy are malleable to interventions, but identified an inconsistent relationship between expectancies and session attendance (Shuman & Shapiro, 2002). Nock and Kazdin (2001) reported more consistent findings, namely a curvilinear relationship between accuracy of parental expectations with attendance and premature termination; parents with very high or very low expectancies had

better attendance and were less likely to terminate prematurely. However, in one of the first studies of child expectations of therapy, Day and Reznikoff (1980) found that parents and children (age 7 to 12 years) held few expectations of therapy in common. They also reported that inappropriate expectations were significant disruptions to therapy and lead to premature termination. Consequently, knowledge of parental expectations may be helpful to understand their possible service utilization but does not provide understanding about child or adolescent expectations.

Specific to adolescents, other studies have identified that older children and adolescents have more accurate perceptions of therapy than younger children, but adolescents are more resistant to therapy than younger children (Garland & Zigler, 1994; Sigelman & Mansfield, 1992). In comparison to an adult population, adolescents (age 15-17) and young adults (age 18-25) had the lowest attitudes toward willingness to seek treatment for mental health issues among individuals aged 15 to 54 years old (Gonzalez et al., 2005). However, during the adolescent period there are differing results within the literature; some studies suggest that later adolescents are more willing to seek treatment, yet others suggest the opposite trend (Zwaanswijk, Verhaak, Bensing, van der Ende, & Verhulst, 2003). Furthermore, individual differences still exist as evidenced by another study reporting that many adolescents (43% of the sample) initiated therapy on their own (Garland & Besinger, 1996). Additionally, even if adolescents were not involved in the choice to receive services, some still report high satisfaction with treatment received (Garland & Besinger, 1996). Therefore, there appears to be a period of general unwillingness to seek

treatment which peaks during adolescence, and improves with age, nevertheless, there are individual differences.

These findings, however, are based primarily on clinical samples of adolescents who have received mental health services which do not provide a generalizable extension to a non-clinical adolescent population. A clinical sample is already receiving services, and while maintaining provision of those services is critical, this population is not solely responsible for the "service gap." These results do not add direct assistance to understanding adolescents more generally, as well as those who are in need of services yet fail to seek or receive them. Only an assessment of a non-clinical sample can provide direct information on the cohort of non-service users.

In addition to information on the expectancies of clients, there is some research on the malleability of pre-treatment client expectancies. As noted earlier, both Nock and Kazdin (2001) and Shuman and Shapiro (2002) found that parent treatment expectancies were malleable to intervention. Specifically, education via video presentation was the most effective intervention method (Shuman & Shapiro, 2002). These findings are congruent with a review of expectancy manipulation studies that were primarily adult samples, but included some child samples. Video interventions were found to be the most effective method to modify inaccurate expectancies of psychotherapy and counseling interviews (Tinsley, Bowman, & Ray, 1988). Specifically, they reported more receptivity to change in child samples: 86% change, in comparison to approximately 50% change in adult samples. However, the

effectiveness of interventions with children should be subjected to further investigation because there have been only 3 studies completed with small sample sizes. Consequently, expectancies appear malleable and normative data on the expectancies of adolescents can provide specific areas to target for programs designed to manipulate expectancies of adolescents seeking services.

Measurement of Expectancies

The expectancies literature is hindered by not having validated measures to assess psychotherapy expectancies of adolescents. Several studies have measured expectancies based on interview responses (Garland & Besinger, 1996; Sigelman & Mansfield, 1992). This methodology may be useful for initial data gathering on a participant, however, the results are more subjective in nature and difficult to replicate. Incidentally, the aforementioned studies based their findings on responses to eight or less questions. Other researchers have utilized a Q-sort methodology to understand what the adolescent desires in a therapist-adolescent relationship (Randall, 2003). This represents a more sophisticated methodology in comparison with open-ended interviews, but the psychometric information is lacking.

Several measures have been utilized in past studies. Within the adult literature, the *Expectations About Counseling—Brief Form* appears to be the most commonly used measure to assess therapy expectancies (Tinsley, 1982). This is a shorter form of the original *Expectancies About Counseling* scale which has several studies examining its psychometric properties (Tinsley, 1982; Tinsley, Workman, & Kass, 1980). Yet, a recent assessment of the instrument utilizing a confirmatory factor

analysis did not uphold the 4 factor structure that has been previously reported through exploratory factor analyses (Aegisdottir, Gerstein, & Gridley, 2000). Moreover, this measure was designed for an adult population and focuses on treatment in a counseling interview modality which may not be applicable to adolescent psychotherapy interventions. Nevertheless, it provides a model or framework for measure development.

Nock and Kazdin (2001) developed and provided initial validation of the *Parent Expectancies for Therapy Scale*, a measure they created to examine parent expectancies, yet this measure does not assess child or adolescent expectancies. The same limitation exists for the *Therapy Expectancies Questionnaire* in that it was developed to measure parent expectancies with few psychometric properties reported (Shuman & Shapiro, 2002). To measure child expectancies, Day and Reznikoff (1980) developed and utilized the *Therapy Scale* to measure both child and parent expectancies of therapy. Internal reliability and test-retest reliability were reported for the measure, but many questions are specific to the type of therapy being performed (i.e., play therapy) that would most likely not be applicable to therapy with an adolescent population. *The Help-Seeking Scale* was developed to measure help-seeking behaviors of adolescents (Garland & Zigler, 1994). Whereas this measure has direct applicability to adolescents with some questions that measure therapy expectancies specifically, as reported earlier help-seeking behavior encompasses a broader set of behaviors than therapy expectancies. Therefore, there does not appear to be a psychometrically sound measure to assess therapy expectancies of

adolescents. This conclusion is further supported by the findings of Dew and Bickman (2005). They concluded after reviewing the adult, child, and adolescent expectancies literatures that there was not a "gold standard" for the measurement of expectancies with few measures or instruments extant that report any psychometric characteristics. Thus, in order to empirically measure adolescent therapy expectancies a measure must be created for this population.

Psychotherapy Expectations and Perceptions Inventory (PEPI)

In order to measure the adolescents' expectation and perceptions of psychotherapy, the Psychotherapy Expectations and Perceptions Inventory (PEPI) was developed (see Appendix A). The PEPI was developed from a review of various instruments that measured help-seeking, attitudes toward therapy, and expectancies with appropriate questions adapted for use in the PEPI (Day & Reznikoff, 1980; Garland & Zigler, 1994; Mackenzie, Knox, Gekoski, & Macaulay, 2004; Randall, 2003; Shuman & Shapiro, 2002; Sigelman & Mansfield, 1992; Tinsley, 1982). Measure development also included consultation with child and adolescent therapists and items developed by the author to measure five areas of therapy expectancies: client's feelings, therapeutic process, therapeutic relationship, therapeutic outcome, and logistics. Resulting from this process was a 71-item pool to be used for instrument validation. On the measure, the participant is directed to complete statements about therapy expectations that finish the sentence stem "I expect…" (Tinsley, 1982). Item responses are based on a five-point Likert scale (Not True = 1, Definitely True = 5; Nock & Kazdin, 2001).

Purpose of the Current Study

With supporting literature from service-use models, common factors research, evidence-based practice principles, and the expectancies literature, the present investigation has a primary goal to provide a current empirically based description of adolescent pre-treatment expectancies of psychotherapy in the general population. A study of this nature does not appear to exist within the psychology literature. The present study attempts to answer a call by several researchers to provide more empirical data into the expectations and perceptions of adolescents about psychotherapeutic services available to them (Garland & Besinger, 1996; Garland & Zigler, 1994; Logan & King, 2001). Before this can be accomplished, a measure to assess adolescent therapy expectancies had to be created. Hence, the current study has two parts. First, a pilot study (Study 1) was conducted to develop and perform initial validation of an adolescent therapy expectancies measure, namely the *Psychotherapy Expectations and Perceptions Inventory* (PEPI). Second, adolescent expectancies of psychotherapy in the general population were assessed resulting in an empirically based description (Study 2).

It is hypothesized that there will be 5 factors on the PEPI that align with the 5 areas being measured on the instrument (i.e., client's feelings, therapeutic process, therapeutic relationship, therapeutic outcome, and logistics). The universal accuracy of expectancies may not be determined because of the many therapeutic styles and orientations, but there are dimensions that can be assessed (e.g., positive vs. negative feelings, directive vs. client-centered, strong vs. weak therapeutic relationship). These

dimensions are areas where a score can be reported and be useful in understanding and conceptualizing the expectancies. However, a conservative approach to subscale development is taken in which the subscales, if any, are determined through the factor analyses and not author subjectivity. Thus, this allows any number of factors to result. Items not loading onto factors will have been removed from the measure in the subsequent analyses of the PEPI. Additionally, the internal consistency is measured though Cronbach's Alpha. Internal consistency of the entire measure and subscales as identified though the factor analysis is assessed with poorly loading items removed. Following the establishment of subscales, if any, through the factor analysis and internal consistency estimates, the content analysis of the measures was conducted using the same sample that was used to perform the factor analysis. This methodology is consistent with other studies of measure development and assessment of therapeutic expectancies (Nock & Kazdin, 2001).

The subscales which are substantiated through the factor analysis will be scored by calculating the mean score for the subscale. Thus, a summation score is not calculated, but rather a mean score is presented to allow for clearer comparison and interpretation with the instrument response scales. Consequently, a total score is not calculated, but subscale interpretations are reported. Reverse scoring for certain items was performed for each subscale so that a score is reflective of one end of the dimensions of the subscale. For example, if a "feelings about therapy" subscale would be identified, then the subscale has been scored so that a higher score would reflect a more positive feeling about therapy and items would be reverse scored respectively to

allow for this scoring procedure. Regardless of the subscale scores, item responses are reported with percentage agreement for each item. This item report is important to identify specific areas for change in educational programs or for an individual clinician to identify the most meaning responses for their therapeutic style. Subscale scores are intended to help increase understanding of the item report and data contained therein.

Additional comparisons are made in order to better understand the normative data resulting from the present investigation and assess the relationship between therapeutic expectancies and the following predictor variables: level of exposure to mental illness, previous experience in therapy, age, and gender. Within this later purpose is the examination of 4 hypotheses. The first is a test of the relationship between adolescent expectancies and both (1) level of exposure to mental illness and (2) previous therapy experience. It is hypothesized that the expectancies of adolescents who have experienced therapy in the past or have close association with an individual with a mental illness will have different expectancies then individuals without close contact or past therapeutic experience.

Two demographic variables are examined for their relationship to adolescent therapy expectancies, (3) age and (4) gender. Zwaanswijk et al. (2003) reported inconsistent findings in the literature about the willingness to seek treatment and adolescent age. However, due to factors such as life experiences and previous course completion, the third hypothesis are based on the relationship between age and expectancies with older adolescent having different expectancies than younger

adolescents. Finally, the fourth hypothesis measures the relationship between gender and therapeutic perceptions and expectations of therapy. Gender was selected based on consistent findings that females report more positive help-seeking attitudes and behaviors (e.g., willingness to talk with adults about problems, belief that talking about problems is helpful, advising a friend to talk with an adult about a problem, etc.) than males (Garland & Zigler, 1994; Schonert-Reich & Muller, 1996). Thus, it is anticipated that females will have different expectancies than males.

Study 1

Methods

Participants

Participants consisted of 10 adolescents (50% female) recruited from local churches and community centers with a mean age of 17 years (SD = 1.42, range 14-19). The group was primarily European American (90%; Pacific Islander 10%) with 50% of their parents having a college degree. Also, 50% of the participants had attended therapy in the past.

Measures

Psychotherapy Expectations. The beta version of the Psychotherapy Expectations and Perceptions Inventory (PEPI) was administered. A Flesch-Kincaid Grade Level of 6.1 is reported for the item-pool and consequently should be at an appropriate reading level for high school students. The adolescent is directed to imagine that they were to start therapy this week with a psychologist. The measure is composed of an item-pool of 71 statements about expectations that complete the

sentence stem “I expect….” (e.g., “to feel uncomfortable in therapy,” “to be in therapy with my parents,” “the therapist to be on my side,” etc.). Item responses are based on a five-point Likert scale (Not True = 1, Definitely True = 5; see Appendix A).

Exposure to Mental Illness. Because individuals with close contact with others that have a mental illness may have more exposure to therapeutic practices, their expectancies may be different. Thus, a revised version of the Level-of-Contact report was administered (Corrigan et al., 2005). This measure was adapted for an adolescent population by Corrigan and colleagues (2005) from the original Level-of-Contact report which had been created for an adult population by Holmes, Corrigan, Williams, Canar, and Kubiak (1999). The original measure presented 12 situations ranging in level of contact and varied from least intimate (“I have never observed a person with mental illness”) to most intimate (“I have a mental illness”) (Holmes et al., 1999). Interrater reliability correlations between 3 clinicians who ranked the responses on levels of intimacy were 0.83 (Holmes et al., 1999). Further psychometric characteristics of either version are not available. The revised version did not include 4 contact levels because they were not appropriate for adolescents, resulting in a measure with 8 questions. Scores range from 0 to 7, with higher scores showing higher contact with mental illness. Participants are instructed to check all the situations that apply to them; the response representing the highest level of contact is the participant’s score (see Appendix B).

Demographic Characteristics. A short demographic measure was designed for the current study to gather background information including age, grade level, gender, ethnicity, parents' education level, and past involvement in therapy (see Appendix C).

Semi-Structured Interview. A short semi-structured interview was administered to each group of participants after the completion of the measures (see Appendix D). Questions assessed their understanding of the directions and items on the PEPI. Additional information was requested in order to gain knowledge about expectancies that were not addressed in the measure, clarify item wording, and any additional suggestions provided.

Procedure

IRB approval to conduct the pilot study was requested, but was not required due to the preliminary nature of the pilot study. The measures were administered individually in small groups of 5, 3, and 2 individuals, followed by group administrations of the semi-structured interview. Following completion of the measures, refreshments were provided to aid in a relaxed and open environment conducive to the sharing of thoughts, ideas, and opinions. The structured interviews were conducted to gather information about the participants' experiences during the administration and suggestions for improvement of the measures. After the first group, the suggestions and comments from the previous groups were shared with the subsequent group for feedback and comments. Data gathering for the pilot study was stopped at the point of redundancy.

Results

The participants reported that the measures were straightforward and understandable with clear directions. Multiple suggestions indicated that repeating the phrase "I Expect…" more often on a page would add clarity to the PEPI. There were no further expectations or perceptions suggested to add to the PEPI item pool which were not already included. Suggestions about the demographic page included correcting a typographical error so that 2 items were not numbered "5." There were also two suggestions for the question about parent education level on the demographic questionnaire: (1) bold the word "parent" and (2) add an additional answer choice "I do not know." All of these suggestions were adopted on the measures that were administered in Study 2.

Study 2

Methods

Participants

Participants included 566 adolescents attending 7 different public and private high schools (grades 9-12) from several Western and Midwestern states. The participants consisted of 60% females, mean age of 15.93 years (SD = 1.33), and 84% European Americans (5 % African American, 5 % Hispanic, Latino(a), 3% Asian, and 3% other). Data were gathered from all grades across the high school setting including: 9^{th} (40%), 10^{th} (5%), 11^{th} (31%), and 12^{th} (24%) grades. A range of parent educational attainment was represented in the sample including those with graduate degrees (37%), some graduate school (5%), an undergraduate degree (16%), an

associates or technical degree (5%), some college (16%), a high school degree or GED (7%), did not complete high school (2%), and some did not know their parents' educational attainment (12%). Additionally, 73% of the sample had never attended therapy in the past.

Measures

Psychotherapy Expectations. The Psychotherapy Expectations and Perceptions Inventory (PEPI) version 1.0 was administered (see Appendix E). A Flesch-Kincaid Grade Level of 6.1 is reported for the item-pool and consequently should be at an appropriate reading level for high school students. The adolescent was directed to imagine that they were to start therapy this week with a psychologist and answer the items accordingly. The measure was the same as used in Study 1 with the exception of the previously mentioned changes.

Exposure to Mental Illness. Because individuals with close contact with others that have a mental illness may have more exposure to therapeutic practices, their expectancies may be different. Thus, a revised version of the Level-of-Contact report was administered (Corrigan et al., 2005). This measure was adapted for an adolescent population by Corrigan and colleagues (2005) from the original Level-of-Contact report which had been created for an adult population by Holmes et al. (1999). The original measure presented 12 situations ranging in level of intimate contact and varied from least intimate ("I have never observed a person with mental illness") to most intimate ("I have a mental illness") (Holmes et al., 1999). Interrater reliability correlations between 3 clinicians who ranked the responses on levels of intimacy

were 0.83 (Holmes et al., 1999). Further psychometric characteristics of either version are not available. The revised version did not include 4 contact levels because they were not appropriate for adolescents, resulting in a measure with 8 questions. Scores range from 0 to 7, with higher scores showing higher contact with mental illness. Participants were instructed to check all the situations that apply to them; the response representing the highest level of contact is the participant's score (see Appendix B).

Demographic Characteristics. A short demographic measure was designed for the proposed study to gather background information including age, grade level, gender, ethnicity, parents' education level, and past involvement in therapy (see Appendix F).

Procedure

Approval to conduct the present study was obtained from the University of Kansas Institutional Review Board (IRB). Following approval of the IRB, the present study consisted of 2 different procedures. First, participation was solicited through high schools via an email message to parents of the students from the school principal. In the email the study procedures were explained and parental consent was obtained by a reply email from the parent. Following parental consent, the measures were administered via electronic or paper versions following participant assent. By this procedure a total of 48 schools were contacted for participation in the study with 3 responding in the affirmative, 17 denied participation, and 29 did not respond. Of the 3 schools that responded with a willingness to participate, 2,360 parents were

contacted via email and 67 (2.8%) provided consent out of which 43 (64.32%) participants provided assent. Thus, 43 participants were recruited from method 1.

Second, parental consent was waived by the IRB because the study was deemed as a curriculum based assessment for some of the participants. The measures were administered to health and psychology classes as a part of a presentation on mental health therapy. The measures were administered to classes at the beginning of the presentation followed by a presentation on mental health therapy. A total of 35 schools were contacted for participation in the study by this latter method with 4 responding in the affirmative, 8 denied participation, and 23 did not respond. A high assent rate was attained (99.8%) in which 523 out of 524 participants agreed to complete the measures. Of the 523 participants, those enrolled in the 9^{th} or 10^{th} grade participated during their health class and those in the 11^{th} and 12^{th} grades participated in their psychology course. These data were gathered at the beginning of the term to ensure that none of the current classes had conducted a unit on mental health therapy, although the psychology students had already completed the health class curriculum.

In summary, a total of 43 participants were collected via the first method and 523 participants via the second for a total of 566 participants. The measures were administered in the same order throughout both procedures (i.e., demographic characteristics, PEPI, and Level of Contact measure). There was no compensation for participation in the study, and participation was voluntary.

Results

Out of the 566 participants, 3 were not included in subsequent analyses as a result of missing greater than 10% of the items, 4 additional participants were excluded from analyses due to missing demographic information, and 1 participant was beyond the age range of the study (19 years old) resulting in a sample size of 558 participants. In order to verify the reliability of the data entry, 25% of the sample were entered twice and compared to identify errors. There was a discrepancy of 0.4% between the two data entry sets. These errors were corrected and this was an acceptable level of agreement, thus the entire data set was not entered again.

Preliminary analyses.

An ANOVA was performed to assess for potential differences between the samples from the different schools. A PEPI total score was computed in order to provide a score for comparison across groups because the subscales had yet to be determined. The resulting omnibus F-test was significant $F(6,551) = 3.037$, $p < .01$. A post-hoc analysis identified the mean score of one school as significantly lower from the other schools; therefore, the school (n = 12) was removed from a subsequent ANOVA. The resulting second omnibus F-test was not significant $F(5,540) = 2.184$, $p > .05$ and all remaining participants (n = 546) were pooled together for subsequent analyses.

Exploratory factor analysis

Before the results of the measures could be interpreted, the initial psychometrics of the PEPI had to be established. This was accomplished through

assessments of construct validity and internal consistency. Construct validity was assessed by an exploratory maximum likelihood factor analysis. An initial maximum likelihood analysis yielded 19 factors with eigenvalues greater than 1.0, accounting for 57.25% of the variance. The Kaiser-Meyer-Olkin measure of sampling adequacy (which ranges from 0 to 1, with values greater than .06 being recommended; Compton, Bercu, Bollini, & Walker, 2006) was .83. In order to determine the number of relevant factors an examination of the eigenvalues and a scree plot analysis revealed these data were best explained in a 3 factor extraction (with initial eigenvalues of 8.1, 6.0, and 3.3). Hence, the maximum likelihood analysis was performed again truncating these data into 3 factors which alone accounted for 24% of the total variance. An oblique, promax rotation was utilized for the present analyses based on the assumption that the factors are not independent, orthogonal factors, but rather share some variance. Poorly loading items (i.e., < .32) were removed and the factor analysis was performed for subsequent iterations until a stable factor pattern emerged (Costello & Osborne, 2005). The resulting rotated factor loadings are presented in Table 1.

Table 1: Rotated (oblique) factor loadings.

Items	Negative	Therapeutic Process & Outcome	Positive Therapeutic Relationship
53. to feel like a failure in therapy.	**0.636**		
6. the therapist to be on my parents' side.	**0.584**		
21. peers to make fun of me if they found out I was in therapy.	**0.564**		
70. my friends to think less of me if I go to therapy.	**0.510**		

	Items	Negative	Therapeutic Process & Outcome	Positive Therapeutic Relationship
56.	if I am sad or upset after a therapy session, that shows that therapy is not working.	**0.498**		
8.	the therapist to reveal my secrets to my parents.	**0.489**		
33.	the therapist to make me talk about things I don't want to talk about.	**0.487**		
39.	if I go to therapy, then I will be in therapy the rest of my life.	**0.477**		
58.	the therapist to try to manipulate or trick me.	**0.446**		
62.	to be nervous about therapy.	**0.408**		
9.	the therapist to judge me and tell me what I am doing is wrong.	**0.390**		
55.	my therapist will tell me what to do.	**0.381**		
36.	the therapist will make me obey orders.	**0.366**		
27.	that a goal of therapy is to make me uncomfortable.	**0.362**		
5.	that most therapists give clients medication for their problems.	**0.361**		
15.	that if I don't want to go to therapy, then there is no way therapy can help.	**0.344**		
		(α = .78)		
24.	to have regularly scheduled therapy appointments.		**0.593**	
44.	the therapist to write down notes during therapy sessions.		**0.540**	
67.	for therapy to be different depending on the problems I am working on.		**0.532**	
37.	my parents will be asked to try new things at home between sessions to help me.		**0.507**	
57.	to have assignments between sessions.		**0.479**	
25.	to practice things I need to learn in the therapy session.		**0.474**	
19.	the therapist will help me figure things out.		**0.472**	
40	therapy to help me gain a better understanding of myself and others.		**0.460**	
68.	therapy to be helpful.		**0.387**	
60.	to change as a result of therapy.		**0.384**	
17.	to talk a lot about my past in therapy.		**0.384**	

	Items	Negative	Therapeutic Process & Outcome	Positive Therapeutic Relationship
46.	to have a say in my therapy goals.		**0.374**	
14.	therapy to usually occur in the therapist's office.		**0.366**	
			(α = .78)	
41.	to get better in a few weeks after I start therapy.			**0.574**
18.	the therapist to understand my position and help my parents change.			**0.460**
71.	to enjoy going to therapy.	-0.335		**0.430**
43.	the therapist to tell me about themselves.			**0.417**
59.	the therapist will understand what I am feeling.			**0.412**
50.	the therapist to know how I feel even when I cannot say quite what I mean.			**0.412**
54.	to feel comfortable talking with a therapist.	-0.352		**0.409**
48.	to do things with the therapist outside of their office.			**0.404**
13.	to be able to call my therapist by their first name.			**0.367**
42.	the only responsibility my parents have in therapy is to make sure I get to my appointments.			**0.366**
10.	to be able to bring my friends to therapy if I wanted to.			**0.356**
				(α = .70)

Deleted Items

1. to feel uncomfortable in therapy.
2. that I shouldn't have to go to therapy if I didn't have any problems during the previous week.
3. to work with the same therapist every therapy session.
4. to be able to ask the therapist when I have questions.
7. the therapist to praise me when I show improvement.
11. to be in therapy with my parents.
12. the therapist to be the same gender as me.
16. that if I don't want to go to therapy, then there is no way therapy can help.

Items	Negative	Therapeutic Process & Outcome	Positive Therapeutic Relationship
20. to draw during therapy.			
22. the therapist to give me their opinion about things.			
23. to be able to talk about anything I want in therapy.			
26. therapy sessions to last 1 hour.			
28. to have a choice about attending therapy.			
29. the therapist to allow me to stop therapy at any time.			
30. to be able to call the therapist for help whenever I want.			
31. a therapist to be more understanding of my problems than other adults.			
32. to lie down on a couch during therapy.			
34. the therapist to joke around with me and have a sense of humor.			
35. therapy sessions to be once a week.			
38. to cry during therapy sessions			
45. the therapist to analyze everything I say or do in therapy.			
47. to be able to say things how I want to in therapy.			
49. that anyone (lawyers, neighbors, etc.) can find out if I am in therapy by calling my therapist's office.			
51. the therapist to have a plan for each therapy session.			
52. to be alone with the therapist during therapy.			
61. to do most of the talking during therapy.			
63. for the therapist to have all the answers.			
64. to play with toys during therapy.			
65. I will be in therapy with my family.			
66. to take personality or intelligence tests in therapy.			
69. the therapist to like me in spite of the bad things they know about me.			

Note: Loadings less than .32 are not shown.

A final maximum likelihood analysis yielded 3 factors with eigenvalues of 5.6, 4.1, and 2.5, accounting for 30.5% of the variance. The Kaiser-Meyer-Olkin measure of sampling adequacy was .83 indicating that the sample is suitable for factor extraction. The results from the present analyses indicate a 3 factor structure, thus identifying 3 subscales retaining 40 items from the original item pool of 71 items. The factors retained include 16, 13, and 11 items respectively. Factor labels are also provided based on commonality of the items within a subscale. Factor 1 appears to measure adolescents' negative expectations and perceptions of therapy. Therapeutic process and outcome expectations and perceptions are measured in Factor 2, and Factor 3 measures expectations and perceptions for a positive therapeutic relationship.

Intercorrelations of the factors

An intercorrelation factor matrix is presented in Table 2. This table displays the relationship between the subscales of the PEPI for the present sample of adolescents. Factor 1 had nonsignificant negative correlations with Factors 2 and 3 (-.26 and -.22 respectively). Factor 2 and 3 had a nonsignificant moderate correlation of .41.

Additionally, Table 3 reports the correlation between factor scores. The only significant correlation was between Factors 2 and 3. Factors 1 and 3 were not significantly correlated, suggesting that they are measuring independent variables and not just opposite ends of the same variable (i.e., strong negative correlation and factor

loadings would have resulted if these factors were measuring opposite ends of the same variables).

Table 2: Factor correlations of the PEPI.

	Negative (1)	Therapeutic Process and Outcome (2)	Positive Therapeutic Relationship (3)
Negative (1)	1.00	-0.26	-0.22
Therapeutic Process and Outcome (2)		1.00	0.41
Positive Therapeutic Relationship (3)			1.00

Note: Factor numbers in parentheses. All are nonsignificant correlations.

Table 3: Intercorrelations for subscale scores of the PEPI.

	Negative (1)	Therapeutic Process and Outcome (2)	Positive Therapeutic Relationship (3)
Negative (1)	1.00	-0.04	-0.01
Therapeutic Process and Outcome (2)		1.00	0.33*
Positive Therapeutic Relationship (3)			1.00

Note: * $p < .01$

Internal Consistency

In order to assess the internal consistency of the PEPI, Cronbach's alpha coefficients were computed for the various domain subscales. The alpha coefficients are displayed in Table 1 at the bottom of the respective factor loadings. A common cut-off point for acceptable internal reliability is .80. By this standard, all the subscales are below this standard, but demonstrate moderately acceptable internal reliability with scores ranging from .78 to .70.

Item Report

As mentioned in the introduction, the item responses are provided to establish a normative base for further examination for the development of educational interventions. See Table 4 for a complete list of items retained and collective responses by percentage. Items retained in the factor analysis as well as deleted items are presented in the table (i.e., all 71 items from the original PEPI item pool are presented). In addition to the item responses, the mean item score and standard deviation are also provided. The mean scores provide comparison back to the item response values (i.e., 1 = Not True, 2 = Somewhat True, etc.) for interpretation. For example, item 6 has a mean score of 2.05 suggesting that the average item response was "Somewhat True" and a standard deviation of approximately 1 suggests that about 66% of the responses were in the "Not True" to the "Fairly True" range.

Table 4: PEPI item responses

Fac	Item	NT (1)	ST (2)	FT (3)	VT (4)	DT (5)	M	SD
1	5. that most therapists give clients medication for their problems.	22.6	**37.2**	27.9	9.5	2.8	2.33	1.01
1	6. the therapist to be on my parents' side.	**38.5**	32.6	18.2	7.0	3.7	2.05	1.09
1	8. the therapist to reveal my secrets to my parents.	**71.0**	16.3	7.5	2.6	2.6	1.49	0.93
1	9. the therapist to judge me and tell me what I am doing is wrong.	**34.9**	29.7	17.1	11.9	6.4	2.25	1.23
1	15. that if I don't want to go to therapy, then there is no way therapy can help.	**32.2**	24.6	19.9	11.4	11.9	2.46	1.36
1	21. peers to make fun of me if they found out I was in therapy.	**36.1**	26.4	16.9	12.5	8.1	2.30	1.29
1	27. that a goal of therapy is to make me uncomfortable.	**83.5**	11.2	2.4	1.6	1.3	1.26	0.70

Fac	Item	NT (1)	ST (2)	FT (3)	VT (4)	DT (5)	M	SD
1	33. the therapist to make me talk about things I don't want to talk about.	23.3	26.1	**27.3**	15.2	8.1	2.59	1.23
1	36. the therapist will make me obey orders.	**40.3**	33.9	17.4	6.2	2.2	1.96	1.01
1	39. if I go to therapy, then I will be in therapy the rest of my life.	**80.2**	12.3	4.6	1.8	1.1	1.31	0.74
1	53. to feel like a failure in therapy.	**72.5**	18.2	6.2	1.5	1.6	1.42	0.81
1	55. my therapist will tell me what to do.	14.1	**35.4**	31.1	13.0	6.4	2.62	1.08
1	56. if I am sad or upset after a therapy session, that shows that therapy is not working.	**59.9**	24.8	9.2	3.1	3.0	1.64	0.98
1	58. the therapist to try to manipulate or trick me.	**75.6**	15.6	4.6	3.1	1.1	1.39	0.81
1	62. to be nervous about therapy.	12.9	21.8	**24.4**	20.7	20.2	3.14	1.32
1	70. my friends to think less of me if I go to therapy.	**49.7**	23.5	12.8	8.1	5.9	1.97	1.22
2	14. therapy to usually occur in the therapist's office.	3.9	13.7	23.7	**33.7**	25.0	3.62	1.12
2	17. to talk a lot about my past in therapy.	2.7	14.1	31.1	**32.1**	20.0	3.52	1.05
2	19. the therapist will help me figure things out.	1.5	3.9	14.0	36.2	**44.4**	4.18	0.92
2	24. to have regularly scheduled therapy appointments.	4.2	9.3	25.9	**33.8**	26.8	3.70	1.09
2	25. to practice things I need to learn in the therapy session.	4.1	15.6	**30.9**	28.6	20.8	3.46	1.11
2	37. my parents will be asked to try new things at home between sessions to help me.	3.3	14.7	32.3	**35.4**	14.3	3.43	1.01
2	40. therapy to help me gain a better understanding of myself and others.	0.9	4.4	21.2	32.7	**40.8**	4.08	0.94
2	44. the therapist to write down notes during therapy sessions.	4.2	13.2	22.9	**32.6**	27.1	3.65	1.14
2	46. to have a say in my therapy goals.	3.1	7.7	22.5	**36.7**	30.0	3.83	1.04
2	57. to have assignments between sessions.	14.3	28.9	**34.4**	17.8	4.6	2.69	1.07

Fac	Item	NT (1)	ST (2)	FT (3)	VT (4)	DT (5)	M	SD
2	60. to change as a result of therapy.	2.8	8.5	30.4	**32.0**	26.3	3.71	1.04
2	67. for therapy to be different depending on the problems I am working on.	1.1	7.3	25.3	**34.3**	32.0	3.89	0.98
2	68. therapy to be helpful.	1.8	3.5	14.0	30.1	**50.6**	4.24	0.95
3	10. to be able to bring my friends to therapy if I wanted to.	**39.1**	22.4	20.0	9.9	8.6	2.27	1.30
3	13. to be able to call my therapist by their first name.	13.8	18.9	**25.3**	18.5	23.5	3.19	1.35
3	18. the therapist to understand my position and help my parents change.	15.1	**34.7**	31.1	12.5	6.6	2.61	1.09
3	41. to get better in a few weeks after I start therapy.	18.2	**35.4**	26.8	13.4	6.2	2.54	1.12
3	42. the only responsibility my parents have in therapy is to make sure I get to my appointments.	**40.3**	27.0	17.1	7.9	7.7	2.16	1.25
3	43. the therapist to tell me about themselves.	10.9	**26.5**	22.0	24.0	16.6	3.09	1.27
3	48. to do things with the therapist outside of their office.	**43.8**	31.1	13.4	7.5	4.2	1.97	1.12
3	50. the therapist to know how I feel even when I cannot say quite what I mean.	4.6	23.0	**28.3**	26.1	18.0	3.30	1.14
3	54. to feel comfortable talking with a therapist.	5.7	12.1	20.1	24.9	**37.2**	3.76	1.23
3	59. the therapist will understand what I am feeling.	1.8	11.7	25.9	**37.5**	23.1	3.68	1.01
3	71. to enjoy going to therapy.	12.1	23.1	**35.3**	15.0	14.5	2.97	1.20
n/a	1. to feel uncomfortable in therapy.	12.4	**32.8**	31.9	11.7	11.2	2.76	1.16
n/a	2. that I shouldn't have to go to therapy if I didn't have any problems during the previous week.	**43.8**	26.7	18.4	7.2	3.9	2.01	1.12
n/a	3. to work with the same therapist every therapy session.	1.3	2.5	8.3	26.3	**61.6**	4.44	0.85
n/a	4. to be able to ask the therapist when I have questions.	0.7	1.9	3.9	23.9	**69.6**	4.60	0.72

Fac	Item	NT (1)	ST (2)	FT (3)	VT (4)	DT (5)	M	SD
n/a	7. the therapist to praise me when I show improvement.	6.1	21.0	**27.3**	26.0	19.6	3.32	1.18
n/a	11. to be in therapy with my parents.	**35.1**	26.8	21.1	11.6	5.4	2.25	1.20
n/a	12. the therapist to be the same gender as me.	**37.7**	24.5	19.0	9.8	9.0	2.28	1.30
n/a	16. that if I don't want to go to therapy, then there is no way therapy can help.	12.8	28.2	**31.1**	14.1	13.8	2.88	1.21
n/a	20. to draw during therapy.	33.3	**34.9**	21.0	5.9	4.9	2.14	1.10
n/a	22. the therapist to give me their opinion about things.	0.9	7.9	20.1	32.4	**38.7**	4.00	0.99
n/a	23. to be able to talk about anything I want in therapy.	3.2	4.4	14.9	23.4	**54.1**	4.21	1.05
n/a	26. therapy sessions to last 1 hour.	12.5	22.8	**37.2**	17.0	10.5	2.90	1.15
n/a	28. to have a choice about attending therapy.	6.4	17.2	19.6	24.2	**32.6**	3.59	1.28
n/a	29. the therapist to allow me to stop therapy at any time.	9.3	18.0	22.8	21.3	**28.6**	3.42	1.32
n/a	30. to be able to call the therapist for help whenever I want.	4.0	13	24.7	24.7	**33.6**	3.71	1.18
n/a	31. a therapist to be more understanding of my problems than other adults.	6.8	9.3	22.9	**30.8**	30.2	3.68	1.19
n/a	32. to lie down on a couch during therapy.	19.3	**32.0**	26.8	11.6	10.3	2.62	1.21
n/a	34. the therapist to joke around with me and have a sense of humor.	4.6	14.5	22.7	**30.5**	27.7	3.62	1.17
n/a	35. therapy sessions to be once a week.	9.2	26.8	**37.7**	16.9	9.4	2.90	1.08
n/a	38. to cry during therapy sessions.	24.6	**29.1**	25.2	13.4	7.7	2.51	1.22
n/a	45. the therapist to analyze everything I say or do in therapy.	10.2	22.9	**29.7**	21.8	15.4	3.09	1.21
n/a	47. to be able to say things how I want to in therapy.	3.1	7.5	20.0	28.4	**41.0**	3.97	1.09
n/a	49. that anyone (lawyers, neighbors, etc.) can find out if I am in therapy by calling my therapist's office.	**75.8**	13.2	5.5	2.2	3.3	1.44	0.94

Fac	Item	NT (1)	ST (2)	FT (3)	VT (4)	DT (5)	M	SD
n/a	51. the therapist to have a plan for each therapy session.	5.7	18.7	**29.8**	28.9	16.9	3.33	1.13
n/a	52. to be alone with the therapist during therapy.	2.0	10.3	22	29.1	**36.6**	3.88	1.08
n/a	61. to do most of the talking during therapy.	4.8	21.4	**35.7**	25.4	12.7	3.20	1.06
n/a	63. for the therapist to have all the answers.	**40.7**	25.6	20.0	9.7	4.0	2.11	1.16
n/a	64. to play with toys during therapy.	**59.4**	24.9	9.2	3.8	2.7	1.66	0.99
n/a	65. I will be in therapy with my family.	**45.8**	33.5	15.7	3.5	1.5	1.81	0.92
n/a	66. to take personality or intelligence tests in therapy.	16.5	28.6	**32.4**	15.7	6.8	2.68	1.13
n/a	69. the therapist to like me in spite of the bad things they know about me.	2.4	8.7	19.3	30.3	**39.3**	3.96	1.07

Note: Fac = Factor loading; NT = Not True; ST = Somewhat True; FT = Fairly True; VT = Very True; DT = Definitely True; M = Mean; SD = Standard Deviation; Numbers are presented as percentages; bolded scores represent the highest percentage response per item.

Deleted Items

Although not included in subsequent versions of the PEPI, the deleted items do provide information about adolescent expectancies. These items were excluded because they either did not cluster together well with other items or were too highly correlated with too many items across multiple factors. Nevertheless, the results from 4 items are presented. Most adolescent do not expect or doubt that they would be in therapy with their family (item 65; 45.8% Not True, 33.5% Somewhat True). The majority of adolescents have an accurate understanding of confidentiality (item 49; 75.8% Not True) and the majority of adolescents are not expecting the therapist to "have all the answers" (item 63; 40.7% Not True, 25.6% Somewhat True). Yet, there

are still over 20% of adolescents who expect to lie down on a couch during therapy (item 32; 11.6% Very True, 10.3% Definitely True).

Subscale Score Analysis

Three separate multiple regression analyses were conducted to test hypotheses, one for each of the 3 PEPI subscales as the criterion variable. Each regression analysis is reported independently, but the same predictor variables were utilized in each regression: level of contact with mental illness, previous experience in therapy (coded 0 = previous therapy experience, 1 = no previous therapy experience), age, and gender (coded 0 = female, 1 = male). Negative expectations and perceptions (Factor 1) was significantly related to the predictor variables, $R^2 = .05$, adjusted $R^2 = .05$, $F(4, 541) = 7.36$, $p < .01$. Three out of the 4 predictor variables were also significant: age ($\beta = -.148$, t (540) = -3.54, $p < .001$), gender ($\beta = .142$, t (540) = -3.38, $p = .001$), and previous experience in therapy ($\beta = .100$, t (540) = 2.29, $p = .022$). Level of contact with mental illness was not a significant predictor ($\beta = .022$, t (540) = .50, $p = .615$).

Therapy process and outcome expectations and perceptions (Factor 2) was significantly related to the predictor variables as well, $R^2 = .02$, adjusted $R^2 = .01$, $F(4,541) = 2.43$, $p = .047$, yet there was only 1 significant predictor variable, gender ($\beta = -.115$, t (540) = -2.70, $p = .007$), suggesting that adolescent boys and girls have different expectations and perceptions about the therapy process and outcomes. Age, previous experience in therapy, and level of contact with mental illness were not significant predictors ($p = .56$, $p = .55$, and $p = .09$, respectively) in this model.

Finally, the expectations and perceptions for a positive therapist relationship (Factor 3) was also significant $R^2 = .05$, adjusted $R^2 = .04$, $F(4,541) = 6.67$, $p < .01$. Similarly to Factor 2, gender was the only significant predictor variable ($\beta = .190$, $t(540) = 4.52$, $p < .01$). Age, previous experience in therapy, and level of contact with mental illness were all not significant predictors ($p = .09$, $p = .11$, and $p = .61$, respectively) for this model. The results from the current model suggest that adolescent boys in this sample have more optimistic expectations and perceptions for a positive relationship with their therapist than adolescent girls.

Discussion

An essential first step to increase professionals' understanding and knowledge of adolescent expectations and perceptions of therapy has been accomplished through the present study. Specifically, the initial development and standardization of an empirically based measure of the aforementioned latent construct for an adolescent population has been provided. A measure of this type has not previously existed in the literature and historically has limited advancement in this vital area. Resulting from the present study is the PEPI, a 40 item measure with adequate initial psychometric properties including internal reliability and construct validity. The final version of the PEPI also retained a Flesch-Kincaid Grade Level of 6.1 and should be appropriate for most junior high and high school students. Three subscales were identified through exploratory factor analyses which measured related metrics under the broader construct of adolescent therapy expectations and perceptions. Areas measured in the subscales include: negative exceptions and perceptions, therapeutic

process and outcome expectations and perceptions, and expectations and perceptions for a positive therapeutic relationship. The subscales contain 16, 13 and 11 items, respectively (see Appendix G for a final version of the PEPI).

The 3 factor model for the PEPI is inconsistent with the proposed hypothesis of a 5 factor model measuring client's feelings, therapeutic process, therapeutic relationship, therapeutic outcome, and logistics utilized in the development of the item pool. However, portions of all 5 areas are included within the 3 factor model. For example, the therapy process and outcome subscale includes questions that were categorized during item development under headings of logistics, outcome, feelings, and process. However, when the items are examined collectively, they all relate to therapeutic process and outcome, as indicated by the factor analyses and face validity. Similarly, the other factors examine a cohesive metric. Thus, the reported 3 factor model provides the best description of the present data utilizing the chosen factor extraction and rotation model.

In addition to the development of an objective measure, a goal to provide an initial snapshot of normative data in a general adolescent population was accomplished. Information about adolescent expectancies and identified predictor variables were also reported. Significant findings include the strong relationship between gender and expectancies. Gender was the only predictor variable that was significantly related to all 3 subscales of the PEPI indicating that it is the best predictor among measured variables. Yet, the results appear inconsistent with previous gender trends identified in the help-seeking literature. The present findings

suggest that boys have greater negative expectations and perceptions of therapy, but they also display on average more optimistic expectations and perceptions for a positive therapeutic relationship. As stated earlier, the help seeking literature consistently reports that girls typically display more positive help seeking behaviors, however, present results do not support this assertion (Garland & Zigler, 1994). Yet, further examination of this commonly supported assertion suggests some gender similarities (Saunders, Resnick, Hoberman, & Blum, 1994). Although, females generally are more wiling to seek help from professional sources, if the components of help-seeking behavior are further examined, then no gender differences are found when obtaining help after the need for services have been identified (Saunders, et al., 1994). In other words, once the need for services is established, adolescent boys and girls are just as likely to seek help. Similarly, Raviv and colleagues (2000) report that when compared to adolescent girls, boys are more likely to refer a friend with severe problems to formal sources of support (e.g., a psychologist).

In attempting to understand the gender results from the present study, and the somewhat inconsistency with the majority of the help-seeking literature, it may be helpful to remember the questions that were posed to the participants in the present study. The directions of the PEPI state: “Imagine you were to start therapy with a psychologist this week.” The question of whether or not they wanted to attend therapy was not asked, but rather the directions indicate that a therapy session is imminent, and to answer the items accordingly. From this perspective, it is more understandable that the gender response was not in line with the overall help-seeking literature, but

closer with the results of Saunders et al. (2004) which reported that no gender differences were found after the need for services was identified. The situation presented on the PEPI suggests that therapy will start and indirectly assumes that a need has been established.

Another explanation of the current findings is based on sex-role stereotypes. As stated earlier, females typically endorse more willingness to seek help, often preferring more informal sources (i.e., friends, family, etc), and identifying more willingness to express their feelings. In contrast, males typically are less likely to share feelings, seek help, and are more likely to use denial and avoidance (Raviv, Sills, Raviv, & Wilansky, 2000). If males are less likely to seek and/or receive social support for problems from informal sources, then they may place more importance or expectancies on the confidential, therapeutic relationship with a professional because they are less likely to utilize other sources of support. The current results among adolescent boys of more optimistic expectancies for a positive therapeutic relationship are initially supported by this rationale.

Additional anecdotal support is also provided. During the presentation given on mental health therapy after data gathering, each class was asked to describe what they pictured as a psychologist. The majority of the responses were in line with a "Freud-like" description: namely, a balding, middle age, Caucasian male with glasses and facial hair. In fact, there was commonly reported surprise during the presentation when information was presented that currently, the majority of psychology graduates are female. The gender stereotype and possible view of a male dominated profession

represented within this participant group may have contributed to adolescent girls not reporting as high of an expectation for a positive therapeutic relationship, with the opposite being applied to the boys.

Regarding age, a hypothesis of differences in expectancies was partially supported. Age was a significant predictor of negative expectancies. Older adolescents had less negative expectancies than younger adolescents. Due to multiple variables that may also contribute to this finding (e.g., life experiences, curriculum completed, etc.), definitive interpretation cannot be made at present, but these findings support some previous research indicating that adolescent willingness to seek services increases with age (Garland & Besinger, 1996; Zwaanswijk et al., 2003).

An additional hypothesis was not supported about the level of contact with mental illness and an adolescent's expectations and perception of therapy. This was not a significant predictor on any of the subscales suggesting that regardless of level of contact with mental illness, one can still hold varying expectations and perceptions of therapy. In other words, just because an adolescent has close contact with an individual with a mental illness does not indicate that they had experience with the therapeutic process, or similar experiences with therapy.

Moreover, significant differences in expectances were only identified between those with previous therapy experience and negative expectancies. In other words, individuals with no previous experience in therapy reported more negative expectancies than adolescents who have previous experience in therapy. Thus, those who have been to therapy had less negative expectancies suggesting that on the

whole, they either began therapy with less negative expectancies or had experiences which subsequently, altered in a positive direction their initial negative expectancies. This result is also in contrast to the findings of Dollinger and Thelen (1978) who reported that children and adolescents (grades 5-12) who have previous experience with a psychologist did not report more favorable views toward a psychologist than peers without experience with a psychologist. Although, differences may be due to methodological changes and including younger participants, current results may provide evidence, over the last 30 years, of a positive shift in expectancies among adolescents, namely, adolescents with previous experience in therapy reporting less negative expectancies than their peers. Further studies can evaluate potential influences and moderating variables such as an increased focus on adolescents' experience in therapy, changes in societal beliefs, implementation of evidenced-based interventions, or other factors.

Another possible societal influence is presented in a recent article (Agrell, 2008, May 2) which reported that adolescent use of mental health professionals doubled in the years of 2006 and 2007, in comparison to the previous 2 year interval, as reported by the Ontario Student Drug Use and Health Survey. Researchers at the Centre for Addiction and Mental Health attribute this rise in service use partially to a decrease in stigma associated with mental illness as a result of celebrities such as Britney Spears, Owen Wilson, and Amy Winehouse for being more open with their struggles with mental health issues (Agrell, 2008, May 2).

Comparisons of the results of the present study with the adult expectancy literature are difficult as a result of the specific variables measured have not been assessed in a similar manner among adult populations (Dew & Bickman, 2005). However, some loose comparisons are tenable. Gender differences are consistently reported among the adult literature, with males much less likely to seek services, particularly if they identify a greater gender role conflict (Pederson & Vogel, 2007). Yet, the present finding of a greater expectancy for a positive therapeutic relationship among adolescent males does not appear to be comparable due to a lack of data on the specific factor. In regard to age differences, there appears to be greater negativity toward mental health professionals among adolescents and younger adults, which decreases with age suggesting adults on average, are more willing to seek services (Gonzalez, Alegria, & Prihoda, 2005).

Application to Clinical/Educational Settings

Results from the present study have direct application to clinical settings and educational programs. Admittedly, individual differences will exist; however, these general trends may be helpful to clinicians. First, adolescent boys, appear to have more extreme expectancies. Thus, an increased focus on education about a particular therapeutic modality or practice may be helpful, particularly education about relationship variables. On the other hand, adolescent girls have different expectancies about therapeutic process and outcome, thus more clarity about these areas may be helpful to maintain engagement in the therapeutic process and correct potential inaccuracies and misconceptions that may interfere. Overall, clinicians may find it

helpful to spend more time directly targeting the clarification of expectations and perceptions about the various aspects of psychotherapy. When an adolescent reports higher expectancies, then a possible interpretation is that they are more certain of what they expect to happen in therapy. Thus, their opinions are more set suggesting a higher need to match with a therapist that is in line with their expectancies, or at least be notified of the need to provide specific education to address inaccurate or incompatible expectancies. When expectancies are in line with a clinician's approach, then it creates a good match, but when the opposite occurs, there is a high potential for disengagement, conflict, or frustration leading to lower outcomes and/or early termination. When an adolescent reports lower expectancies it may indicate more openness or flexibility in expectancies and consequently, being more adaptable to different techniques or treatment styles.

The PEPI may be utilized as a tool to assist in this purpose. The PEPI can be administered before an intake session to provide a clinician with information on a specific client's expectancies. Then, accommodations or education can be provided with the goal to increase engagement in therapy in order to lead to better outcomes. Due to the vast differences that exist within therapeutic interventions, modalities, and orientations, a clinician may find it helpful to complete the PEPI based on their own expectancies and perceptions of therapy based on their "treatment as usual" approach. Consequently, a comparison of clinician PEPI scores with a new or current client can identify specific areas for modification by the therapist, or education given to the client. Expanding on this concept, application can be given to larger service settings.

The PEPI may be helpful in matching adolescent clients with a specific clinician in order to best match their expectancies and potential therapeutic compatibility. This match can be based on client PEPI results and therapist "treatment as usual" scores. Of course, future studies can assess the effectiveness and feasibility of this latter option.

Limitations

There are some limitations that must be acknowledged about the present study. First, the measures were all given in the same order and as a developing instrument the PEPI items were also all in the same order, thus possible order effects could be evident in the results. However, by administering measures in the same order, all participants were "primed" by the same information before and during the administration of the measures.

Furthermore, there are characteristics about the study population that might limit the generalization of the findings to other samples. The majority of these data (94%) were gathered in a single large Midwestern metropolitan area. The sample was predominantly, but not exclusively, European American and over half (58%) of the participants' parents had a college degree. As a result of the high level of parent educational attainment, the present sample of adolescents may have displayed different expectancies because adolescents from higher socioeconomic status (SES) are more likely to obtain mental health services (Saunders et al., 1994). Moreover, adolescents from ethnic minority backgrounds and lower SES groups are reported to have more barriers to receiving mental health services, suggesting possible

differences in expectancies (Saunders et al., 1994). Cauce and colleagues (2002) also report some cultural differences of parent willingness to seek help from a mental health professional based on comparisons of cultural groups including European Americans, African Americans, Latino(a), and Asian Americans. However, an extension to adolescents is unclear without further examination.

Consequently, due to the preliminary nature of the present study, additional studies are needed to fully understand these potential influences. Data from different regional, ethnic/cultural, and socioeconomic status (SES) groups will allow for a more accurate interpretation of the generalizability of the current findings or if adolescent expectancies are related to the aforementioned demographic grouping variables.

Furthermore, age interpretations could be influenced by the fact that most of the 11th and 12th grade participants were enrolled in psychology courses. While none of the psychology classes had completed a unit on psychotherapy, this was an elective course. It is anticipated that individuals that have higher academic aspirations would choose to take an elective course such as psychology or have potential interests and exposure to psychological issues. The participants enrolled in a health course are inherently more representative of the general population of a school because all students at the school are required to take health class. Thus, the older group of participants might be skewed in comparison to the younger group due to a self selection bias displayed through enrolling in an elective psychology course. Again, the extent to which this prospective limitation influenced the current results will

require a measure of a more “general” adolescent population (i.e., participants from entire schools or required courses such as English/Language Arts).

Finally, the current results are based on a factor loading model that accounts for a relatively small percentage of the total variance of the sample. Consequently, the present findings only represent a small proportion of the variance in the data and future investigations into other portions of the variance are encouraged (e.g., presenting clinical problems, symptom severity, expectancy preferences, etc.).

Future studies

The current evaluation is the beginning of a line of studies to assess adolescent expectations and perceptions of therapy by objective methods. In addition to the studies mentioned in previous sections, there are more studies that can be performed to help gain an even more comprehensive picture of this important topic. In order for this line of research to continue, further validation and standardization of the PEPI must take place. A confirmatory factor analysis is crucial to verify the 3 factor model of the measure with another large and ideally, more diverse sample of adolescents. An assessment of the stability of the measure through an additional measure of reliability via a test-retest method is also needed. Moreover, additional measures of validity are required. However, due to the lack of another validated measure of adolescent expectations and perceptions of therapy, convergent validity cannot be established by a comparison with an already established measure. Yet, the validity of the PEPI might be examined through experimental methodology in a clinical setting in which expectancies are measured before and after an intervention in

order to assess the sensitivity of the measure to change; in other words, to validate that the measure identifies change under conditions in which one would expect an adolescent's expectations and perceptions to change (see Tinsley, Bowman, & Ray, 1988). Moreover, examinations of adolescent expectancies across specific ethnic and cultural groups may provide information to allow for more culturally sensitive and applicable interventions and therapeutic applications.

Furthermore, the present study only measured the degree to which an adolescent agrees with specific expectancies. There was no measure of value placed on the expectancies. Consequently, an additional measure of value would add important information on adolescent expectancies. For example, the present study identified that the majority of adolescents do not expect a therapist to reveal their secrets to their parents. However, the importance of this expectation to an adolescent was not measured. By adding a measure of value/importance to a study of this nature a more comprehensive picture of adolescent expectancies can be attained. Thus, allowing for a prioritization of expectancies for the development or modification of clinical/educational interventions. Similarly, comparisons with other constructs which could influence adolescent expectancies (e.g., locus of control, hope, self esteem, etc.) would also provide more information to have a clearer picture of the adolescent beliefs.

Finally, an assumption is alluded to throughout the current study, that the accuracy of expectancies and perceptions of therapy is difficult to determine due to the variety of therapeutic modalities, orientations, and interventions, yet this may be

an untested assumption. A study measuring therapist expectancies and perceptions across a variety of service providers (i.e., psychologist, social worker) and orientations (cognitive-behavioral, dynamic, client-centered) may be helpful in affirming this assumption or not. It may be found that there are greater similarities than differences, thus allowing for more commonality toward any educational curriculum or programs created and administered.

Conclusion

Knowledge of therapy expectancies can serve two primary benefits. First, this knowledge can help clinicians know how to best make their clients feel more comfortable in therapy and to help minimize attrition of clients so that therapeutic effectiveness can be increased. These results from the current study can help psychologists create better therapeutic relationships with adolescent clients and foster greater therapeutic change. Clinicians might be encouraged to examine these findings and incorporate them into their own clinical practices. Second, these results about adolescent expectancies have identified some common misconceptions of psychotherapy that education programs on a local, regional, or national level can target to help with a more accurate depiction of therapy (e.g., Farberman, 1997). These programs can, in turn, lower the “service gap” by helping adolescents have more accurate expectations toward therapy, which may lead to a more positive view, and increased service use.

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Appendix A

Psychotherapy Expectations & Perceptions Inventory (PEPI)

(Study 1)

Psychotherapy Expectations & Perceptions Inventory (PEPI)

Imagine you were to start therapy with a psychologist this week. Answer the statements about what you expect to happen in therapy. For each statement, indicate how true the expectation is for you by circling "Not True" (1), "Somewhat True" (2), "Fairly True" (3), "Very True" (4), or "Definitely True" (5).

I expect…		**Not True**	**Some-what True**	**Fairly True**	**Very True**	**Definitely True**
1.	to feel uncomfortable in therapy.....	1	2	3	4	5
2.	that I shouldn't have to go to therapy if I didn't have any problems during the previous week	1	2	3	4	5
3.	to work with the same therapist every therapy session.	1	2	3	4	5
4.	to be able to ask the therapist when I have questions.	1	2	3	4	5
5.	that most therapists give clients medication for their problems.....	1	2	3	4	5
6.	the therapist to be on my parents' side.	1	2	3	4	5
7.	the therapist to praise me when I show improvement.....	1	2	3	4	5
8.	the therapist to reveal my secrets to my parents.	1	2	3	4	5
9.	the therapist to judge me and tell me what I am doing is wrong	1	2	3	4	5
10.	to be able to bring my friends to therapy if I wanted to.	1	2	3	4	5
11.	to be in therapy with my parents.....	1	2	3	4	5
12.	the therapist to be the same gender as me.	1	2	3	4	5
13.	to be able to call my therapist by their first name.	1	2	3	4	5

I expect…		**Not True**	**Some-what True**	**Fairly True**	**Very True**	**Definitely True**
14.	therapy to usually occur in the therapist's office.	1	2	3	4	5
15.	that if I don't want to go to therapy, then there is no way therapy can help.	1	2	3	4	5
16.	the therapist to be on my side.	1	2	3	4	5
17.	to talk a lot about my past in therapy.....	1	2	3	4	5
18.	the therapist to understand my position and help my parents change	1	2	3	4	5
19.	the therapist will help me figure things out.....	1	2	3	4	5
20.	to draw during therapy	1	2	3	4	5
21.	peers to make fun of me if they found out I was in therapy.....	1	2	3	4	5
22.	the therapist to give me their opinion about things.....	1	2	3	4	5
23.	to be able to talk about anything I want in therapy	1	2	3	4	5
24.	to have regularly scheduled therapy appointments.	1	2	3	4	5
25.	to practice things I need to learn in the therapy session	1	2	3	4	5
26.	therapy sessions to last 1 hour.	1	2	3	4	5
27.	that a goal of therapy is to make me uncomfortable.	1	2	3	4	5
28.	to have a choice about attending therapy.....	1	2	3	4	5
29.	the therapist to allow me to stop therapy at any time.....	1	2	3	4	5

I expect…	**Not True**	**Some-what True**	**Fairly True**	**Very True**	**Definitely True**
30. to be able to call the therapist for help whenever I want	1	2	3	4	5
31. a therapist to be more understanding of my problems than other adults.....	1	2	3	4	5
32. to lie down on a couch during therapy.	1	2	3	4	5
33. the therapist to make me talk about things I don't want to talk about.....	1	2	3	4	5
34. the therapist to joke around with me and have a sense of humor.....	1	2	3	4	5
35. therapy sessions to be once a week.	1	2	3	4	5
36. the therapist will make me obey orders.....	1	2	3	4	5
37. my parents will be asked to try new things at home between sessions to help me.....	1	2	3	4	5
38. to cry during therapy sessions.	1	2	3	4	5
39. if I go to therapy, then I will be in therapy the rest of my life.....	1	2	3	4	5
40. therapy to help me gain a better understanding of myself and others.....	1	2	3	4	5
41. to get better in a few weeks after I start therapy.	1	2	3	4	5
42. the only responsibility my parents have in therapy is to make sure I get to my appointments.	1	2	3	4	5
43. the therapist to tell me about themselves	1	2	3	4	5

I expect…	Not True	Some-what True	Fairly True	Very True	Definitely True
44. the therapist to write down notes during therapy sessions.	1	2	3	4	5
45. the therapist to analyze everything I say or do in therapy.	1	2	3	4	5
46. to have a say in my therapy goals. ...	1	2	3	4	5
47. to be able to say things how I want to in therapy.....	1	2	3	4	5
48. to do things with the therapist outside of their office.	1	2	3	4	5
49. that anyone (lawyers, neighbors, etc.) can find out if I am in therapy by calling my therapist's office.	1	2	3	4	5
50. the therapist to know how I feel even when I cannot say quite what I mean	1	2	3	4	5
51. the therapist to have a plan for each therapy session.....	1	2	3	4	5
52. to be alone with the therapist during therapy.....	1	2	3	4	5
53. to feel like a failure in therapy.....	1	2	3	4	5
54. to feel comfortable talking with a therapist.	1	2	3	4	5
55. my therapist will tell me what to do.....	1	2	3	4	5
56. if I am sad or upset after a therapy session, that shows that therapy is not working.....	1	2	3	4	5
57. to have assignments between sessions.....	1	2	3	4	5
58. the therapist to try to manipulate or trick me.....	1	2	3	4	5

I expect…		**Not True**	**Some-what True**	**Fairly True**	**Very True**	**Definitely True**
59.	the therapist will understand what I am feeling.	1	2	3	4	5
60.	to change as a result of therapy.	1	2	3	4	5
61.	to do most of the talking during therapy.	1	2	3	4	5
62.	to be nervous about therapy.	1	2	3	4	5
63.	for the therapist to have all the answers.	1	2	3	4	5
64.	to play with toys during therapy.	1	2	3	4	5
65.	I will be in therapy with my family.	1	2	3	4	5
66.	to take personality or intelligence tests in therapy.	1	2	3	4	5
67.	for therapy to be different depending on the problems I am working on.	1	2	3	4	5
68.	therapy to be helpful.	1	2	3	4	5
69.	the therapist to like me in spite of the bad things they know about me.	1	2	3	4	5
70.	my friends to think less of me if I go to therapy	1	2	3	4	5
71.	to enjoy going to therapy	1	2	3	4	5

Appendix B

Level of Familiarity with Mental Illness Scale

LEVEL OF FAMILIARITY WITH MENTAL ILLNESS

Please read each of the following statements carefully. After you have read all of the statements below, place a check by **EVERY** statement that represents your experience with persons with a severe mental illness.

_____ I have watched a television show that included a person with mental illness.

_____ I have been in a class with a person with mental illness.

_____ I have observed a person with a mental illness.

_____ I have a mental illness.

_____ I have never observed a person with mental illness.

_____ A friend of the family has a mental illness.

_____ I have a relative who has a mental illness.

_____ I live with a person who has a mental illness.

Appendix C

Demographic Measure

(Study 1)

Perceptions of psychotherapy

Enclosed in this packet is a survey about your expectations of psychotherapy. Before you complete the following survey please complete the following question to provide us with some background information about you. Please answer all the questions in this packet honestly and remember to *not* write your name on this packet so your answers will remain anonymous.

Please circle the answer(s) that describes you best.

1. How old are you?

   A. 14 years old B. 15 years old C. 16 years old

   D. 17 years old E. 18 years old F. 19 years old

2. What is your gender?

   A. Female B. Male

3. What grade are you in?

   A. 10^{th} B. 11^{th} C. 12^{th}

4. How do you describe yourself? (Select one or more responses)

   A. African American B. American Indian C. Asian

   D. Hispanic or Latino(a) E. Pacific Islander F. White

   G. Other: _____

5. What was the highest education level completed by a parent?

   A. not complete high school
   B. high school graduate or GED
   C. some college
   D. associate's or technical degree
   E. college undergraduate degree
   F. some graduate school
   G. graduate degree (master's or doctorate)

5. Have you ever had therapy with a psychologist in the past?

   A. Yes B. No

Appendix D

Semi-Structured Interview about the PEPI

(Study 1)

Semi-Structured Interview about the PEPI

1. How did you feel while you were taking this measure?

2. What was your understanding of the directions?

3. Were there any questions you felt were confusing or unclear? If so, which ones and why?

4. What recommendations would you have to make this measure more understandable for other adolescents your age?

5. Are there any expectations that you would have about attending therapy that were not asked on this measure?

6. Are there any suggestions for the demographic page or contact with mental illness measure?

Appendix E

Psychotherapy Expectations & Perceptions Inventory (PEPI)

(Study 2)

Psychotherapy Expectations & Perceptions Inventory (PEPI)

Imagine you were to start therapy with a therapist this week. Answer the statements about what you expect to happen in therapy. For each statement, indicate how true the expectation is for you by circling one of the following answer choices: "Not True" (1), "Somewhat True" (2), "Fairly True" (3), "Very True" (4), or "Definitely True" (5).

I expect…	**Not True**	**Some-what True**	**Fairly True**	**Very True**	**Definitely True**
1. to feel uncomfortable in therapy.....	1	2	3	4	5
2. that I shouldn't have to go to therapy if I didn't have any problems during the previous week	1	2	3	4	5
3. to work with the same therapist every therapy session.	1	2	3	4	5
4. to be able to ask the therapist when I have questions.	1	2	3	4	5
5. that most therapists give clients medication for their problems.	1	2	3	4	5
6. the therapist to be on my parents' side.	1	2	3	4	5
I expect…					
7. the therapist to praise me when I show improvement.....	1	2	3	4	5
8. the therapist to reveal my secrets to my parents.	1	2	3	4	5
9. the therapist to judge me and tell me what I am doing is wrong	1	2	3	4	5
10. to be able to bring my friends to therapy if I wanted to.	1	2	3	4	5
11. to be in therapy with my parents.....	1	2	3	4	5
12. the therapist to be the same gender as me.	1	2	3	4	5

I expect…	Not True	Some-what True	Fairly True	Very True	Definitely True
13. to be able to call my therapist by their first name.	1	2	3	4	5
14. therapy to usually occur in the therapist's office.	1	2	3	4	5
15. that if I don't want to go to therapy, then there is no way therapy can help.	1	2	3	4	5
16. the therapist to be on my side.	1	2	3	4	5
17. to talk a lot about my past in therapy	1	2	3	4	5
18. the therapist to understand my position and help my parents change	1	2	3	4	5
19. the therapist will help me figure things out	1	2	3	4	5
I expect…					
20. to draw during therapy	1	2	3	4	5
21. peers to make fun of me if they found out I was in therapy	1	2	3	4	5
22. the therapist to give me their opinion about things	1	2	3	4	5
23. to be able to talk about anything I want in therapy	1	2	3	4	5
24. to have regularly scheduled therapy appointments.	1	2	3	4	5
25. to practice things I need to learn in the therapy session	1	2	3	4	5
26. therapy sessions to last 1 hour.	1	2	3	4	5
27. that a goal of therapy is to make me uncomfortable.	1	2	3	4	5

I expect…	Not True	Some-what True	Fairly True	Very True	Definitely True
28. to have a choice about attending therapy.....	1	2	3	4	5
29. the therapist to allow me to stop therapy at any time.....	1	2	3	4	5
30. to be able to call the therapist for help whenever I want.....	1	2	3	4	5
31. a therapist to be more understanding of my problems than other adults.....	1	2	3	4	5
32. to lie down on a couch during therapy.....	1	2	3	4	5
33. the therapist to make me talk about things I don't want to talk about.....	1	2	3	4	5
34. the therapist to joke around with me and have a sense of humor.....	1	2	3	4	5
I expect…					
35. therapy sessions to be once a week.	1	2	3	4	5
36. the therapist will make me obey orders.....	1	2	3	4	5
37. my parents will be asked to try new things at home between sessions to help me.	1	2	3	4	5
38. to cry during therapy sessions.	1	2	3	4	5
39. if I go to therapy, then I will be in therapy the rest of my life.	1	2	3	4	5
40. therapy to help me gain a better understanding of myself and others.....	1	2	3	4	5
41. to get better in a few weeks after I start therapy.	1	2	3	4	5

I expect…	Not True	Some-what True	Fairly True	Very True	Definitely True
42. the only responsibility my parents have in therapy is to make sure I get to my appointments.	1	2	3	4	5
43. the therapist to tell me about themselves	1	2	3	4	5
44. the therapist to write down notes during therapy sessions.	1	2	3	4	5
45. the therapist to analyze everything I say or do in therapy.	1	2	3	4	5
46. to have a say in my therapy goals.	1	2	3	4	5
47. to be able to say things how I want to in therapy.	1	2	3	4	5
48. to do things with the therapist outside of their office.	1	2	3	4	5

I expect…

49. that anyone (lawyers, neighbors, etc.) can find out if I am in therapy by calling my therapist's office.	1	2	3	4	5
50. the therapist to know how I feel even when I cannot say quite what I mean	1	2	3	4	5
51. the therapist to have a plan for each therapy session.....	1	2	3	4	5
52. to be alone with the therapist during therapy.....	1	2	3	4	5
53. to feel like a failure in therapy.....	1	2	3	4	5
54. to feel comfortable talking with a therapist.	1	2	3	4	5
55. my therapist will tell me what to do.	1	2	3	4	5

I expect…	Not True	Some-what True	Fairly True	Very True	Definitely True
56. if I am sad or upset after a therapy session, that shows that therapy is not working.....	1	2	3	4	5
57. to have assignments between sessions.....	1	2	3	4	5
58. the therapist to try to manipulate or trick me.	1	2	3	4	5
59. the therapist will understand what I am feeling.....	1	2	3	4	5
60. to change as a result of therapy.	1	2	3	4	5
61. to do most of the talking during therapy.....	1	2	3	4	5
62. to be nervous about therapy.....	1	2	3	4	5
63. for the therapist to have all the answers.....	1	2	3	4	5
I expect…					
64. to play with toys during therapy.	1	2	3	4	5
65. I will be in therapy with my family.	1	2	3	4	5
66. to take personality or intelligence tests in therapy.	1	2	3	4	5
67. for therapy to be different depending on the problems I am working on.....	1	2	3	4	5
68. therapy to be helpful.	1	2	3	4	5
69. the therapist to like me in spite of the bad things they know about me.....	1	2	3	4	5
70. my friends to think less of me if I go to therapy.....	1	2	3	4	5
71. to enjoy going to therapy.....	1	2	3	4	5

Appendix F

Demographic Measure

(Study 2)

Perceptions of Psychotherapy

Enclosed in this packet is a survey about your expectations of therapy. Before you complete the following survey please complete the following questions to provide us with some background information about you. Please answer all the questions in this packet honestly and remember to ***not write your name*** on this packet so your answers will remain anonymous.

Please circle the response(s) that describes you best.

1. How old are you?

   A. 14 years old B. 15 years old C. 16 years old
   D. 17 years old E. 18 years old F. 19 years old

2. What is your gender?

   A. Female B. Male

3. What grade are you in?

   A. 9^{th} B. 10^{th} C. 11^{th} D. 12^{th}

4. How do you describe yourself? (Select one or more responses)

   A. African American B. Native American C. Asian

   D. Hispanic or Latino(a) E. Pacific Islander F. Caucasian

   G. Other: _____

5. What was the highest education level completed by a **parent**?

   A. not complete high school
   B. high school graduate or GED
   C. some college
   D. associate's or technical degree
   E. college undergraduate degree
   F. some graduate school
   G. graduate degree (master's or doctorate)
   H. I do not know

6. Have you ever attended therapy with a therapist in the past?

   A. Yes B. No

Appendix G

Psychotherapy Expectations & Perceptions Inventory (PEPI)

(Final)

Psychotherapy Expectations & Perceptions Inventory (PEPI)

Imagine you were to start therapy with a therapist this week. Answer the statements about what you expect to happen in therapy. For each statement, indicate how true each expectation is for you by circling one of the following answer choices: “Not True” (1), “Somewhat True” (2), “Fairly True” (3), “Very True” (4), or “Definitely True” (5).

I expect…	**Not True**	**Some-what True**	**Fairly True**	**Very True**	**Definitely True**
1. that most therapists give clients medication for their problems.	1	2	3	4	5
2. the therapist to be on my parents' side. ..	1	2	3	4	5
3. the therapist to reveal my secrets to my parents.	1	2	3	4	5
4. the therapist to judge me and tell me what I am doing is wrong	1	2	3	4	5
5. to be able to bring my friends to therapy if I wanted to.	1	2	3	4	5
6. to be able to call my therapist by their first name.	1	2	3	4	5
7. therapy to usually occur in the therapist’s office.	1	2	3	4	5
I expect…	**Not True**	**Somewh at True**	**Fairly True**	**Very True**	**Definitely True**
8. that if I don't want to go to therapy, then there is no way therapy can help....	1	2	3	4	5
9. to talk a lot about my past in therapy.....	1	2	3	4	5
10. the therapist to understand my position and help my parents change.....	1	2	3	4	5
11. the therapist will help me figure things out	1	2	3	4	5
12. peers to make fun of me if they found out I was in therapy	1	2	3	4	5
13. to have regularly scheduled therapy appointments	1	2	3	4	5
14. to practice things I need to learn in the therapy session.....	1	2	3	4	5

I expect…	Not True	Some-what True	Fairly True	Very True	Definitely True
15. that a goal of therapy is to make me uncomfortable	1	2	3	4	5
16. the therapist to make me talk about things I don't want to talk about.....	1	2	3	4	5
17. the therapist will make me obey orders	1	2	3	4	5
18. my parents will be asked to try new things at home between sessions to help me	1	2	3	4	5
19. if I go to therapy, then I will be in therapy the rest of my life	1	2	3	4	5
20. therapy to help me gain a better understanding of myself and others.....	1	2	3	4	5
21. to get better in a few weeks after I start therapy.....	1	2	3	4	5
22. the only responsibility my parents have in therapy is to make sure I get to my appointments	1	2	3	4	5

I expect…	Not True	Somewh at True	Fairly True	Very True	Definitely True
23. the therapist to tell me about themselves.....	1	2	3	4	5
24. the therapist to write down notes during therapy sessions.....	1	2	3	4	5
25. to have a say in my therapy goals.....	1	2	3	4	5
26. to do things with the therapist outside of their office.....	1	2	3	4	5
27. the therapist to know how I feel even when I cannot say quite what I mean.....	1	2	3	4	5
28. to feel like a failure in therapy	1	2	3	4	5
29. to feel comfortable talking with a therapist	1	2	3	4	5
30. my therapist will tell me what to do	1	2	3	4	5

I expect…	**Not True**	**Some-what True**	**Fairly True**	**Very True**	**Definitely True**
31. if I am sad or upset after a therapy session, that shows that therapy is not working.....	1	2	3	4	5
32. to have assignments between sessions...	1	2	3	4	5
33. the therapist to try to manipulate or trick me.....	1	2	3	4	5
34. the therapist will understand what I am feeling	1	2	3	4	5
35. to change as a result of therapy	1	2	3	4	5
36. to be nervous about therapy	1	2	3	4	5
37. for therapy to be different depending on the problems I am working on.....	1	2	3	4	5
38. therapy to be helpful	1	2	3	4	5
39. my friends to think less of me if I go to therapy	1	2	3	4	5
40. to enjoy going to therapy	1	2	3	4	5