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Parent Perception of the Working Alliance, Parent Self-Efficacy, and Parent Locus of Control as Predictors of Child Therapy Outcome

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PARENT PERCEPTION OF THE WORKING ALLIANCE, PARENT SELF-EFFICACY, AND PARENT LOCUS OF CONTROL AS PREDICTORS OF CHILD THERAPY OUTCOME

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Christopher Chandler

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PARENT PERCEPTION OF THE WORKING ALLIANCE, PARENT SELF-EFFICACY, AND PARENT LOCUS OF CONTROL AS PREDICTORS OF CHILD THERAPY OUTCOME

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The purpose of this study is to examine the impact that parent-therapist working alliance, parent self-efficacy, and parent locus of control have on child therapy outcomes. Bordin’s model of the working alliance provides a framework for measuring the collaboration between the parents and therapists while Social Cognitive Theory informs the decision to assess parent self-efficacy and parent locus of control.

The research questions were as follows: 1) Does a strong parent and therapist working alliance, as perceived by the parent, predict improved outcomes in child counseling? 2) Does parent self-efficacy predict outcomes in child counseling? 3) Does parent locus of control predict improved outcomes in child counseling?

Stepwise multiple regression was used to determine the predictive power of the independent variables on treatment goal progress for children in therapy. Parents’ perception of their working alliance with the therapist, parent-self efficacy, and parent locus of control were the independent variables. Therapists’ assessments of child progress on their primary treatment plan goal was the dependent variable. The stepwise multiple regression analysis indicates that parents’ perception of the working alliance with the child’s therapist had an $R^2$ of .11 in relation to the children’s progress on their primary treatment plan goal. Parent self-efficacy and parent locus of control did not contribute
significantly to the model. However, parent self-efficacy and parent locus of control had a moderate correlation with parents’ perception of the working alliance ($r = .55$ and .48, respectively).

Developing a strong working alliance between parents of child clients and their therapists appears to be an important part of predicting children’s therapy outcomes. Furthermore, parent self-efficacy and parent locus of control appear to have a relationship with parent perception of the working alliance.
Introduction

According to a joint survey by the Centers for Disease Control, the National Institute for Mental Health, and the Substance Abuse and Mental Health Services Administration (2012), approximately 13 to 20% of children experience some form of mental disorder in any given year of their lives. The upper end of this range is equivalent to one in every five children. Understanding the factors that improve child therapy outcomes is crucial. Parental investment in their children’s therapy has been shown to be one of those factors (Friedburg & Gorman, 2007, Suveg, Kendall, Comer, & Robin, 2006).

An estimated 40-60% of parents end therapy for their child prematurely (Kazdin, 1996). These children experience fewer benefits from their time in counseling than those who finish the process, such a decrease in symptom behaviors (Prinz & Miller, 1994). While some of these termination issues revolve around transportation or childcare, Kazdin, Holland, and Crowley (1997) identified working alliance issues as contributing to why parents may choose to end therapy services for their children.

There are several studies identifying factors of adult and child clients that can predict better outcomes in their treatment. However, there appears to be less knowledge about what parent factors positively contribute to or predict better outcomes for child clients. Knowing what factors influence positive child therapy outcomes would allow therapists to assess and target those factors. The therapist can address these factors in either family or collateral sessions or with a referral to an appropriate service (family support, parenting classes, or individual therapy). Such studies would add another dimension to child therapy treatment planning.
Past research (Sanders & Wooley, 2005, Warren, Brown, Layne, & Nelson, 2011) has looked at the relationship between the client and the therapist and has explored what factors those individuals possess that can influence therapy outcomes. However, the role of legal guardians of children in therapy (hereafter referred to as “parents”) needs more analysis besides whether they are simply involved. What are the effects that a parent can have on the child-client’s therapy outcomes? Does a parent’s relationship with the therapist influence outcomes for the child-patient? Can personal factors in a parent predict how well the child-client does in treatment? Exploring these questions more thoroughly will help inform therapists and other practitioners about how to involve parents in their children’s therapy and how to individualize child-client treatment plans in a way that identifies strengths and addresses weaknesses in parents. In sum, better understanding the elements of positive parent investment in child therapy can help improve child therapy outcomes.

Taylor and Adelman (2001) suggest that parent investment involves 1) parents meeting with the therapist regularly; 2) parents giving feedback to the therapist regarding their children’s response to interventions; and 3) parents administering appropriate, therapist-informed interventions at home. While Taylor and Adelman’s (2001) research provides a strong theoretical basis for parental investment, it does not necessarily offer a directly measurable construct. There is a need to look at measurable traits within parents that could accurately reflect parental investment. Increasing our understanding of this means being able to measure something in parents that both reflects their relationship with the therapist and the traits that may increase parents’ likelihood of investing in their child’s therapy process.
There are at least two goals of research in this area. First, it will build upon existing research that supports parent investment in child therapy. Second, if parents’ investment and traits can predict positive outcomes in child therapy, that would offer another potential focus of treatment planning for child therapists. If, for example, a parent has some identifiable deficits in a trait that can be strengthened in therapy to help improve the outcome of the child-client, the therapist can include targeted interventions in the treatment plan for those parental deficits. Evidence that the parent-therapist relationship and parent traits act as contributors to child therapy success would encourage therapists to involve parents in the treatment of their children in therapy. This research could influence and inform treatment planning for child therapists in terms of both building and improving relationships with parents and helping parents address any deficits or perceived shortcomings in themselves that limit their investment. Before moving forward with research, it is important to review the research on parent investment in child therapy.

**Parent Investment in Children’s Counseling and Similar Environments**

Positive outcomes for children in counseling generally refers to symptom alleviation and improved psychosocial performance across environments (Borden, 1994). Measurement of outcomes can come from either what the child client reports in session or the parents’ and therapists’ perception of improved behaviors at home, school, and other relevant environments (Hudson et al., 2014). From a clinical record-keeping standpoint, these changes are typically captured in the patient’s master treatment plan which is the primary responsibility of the therapist to complete and update.
Parent investment in their children’s therapy typically plays out in family sessions or pre-treatment meetings between the therapist and the parent. Parent investment in counseling has demonstrated benefits in child therapy outcomes for treating anxiety (Suveg, Kendall, Comer, and Robin, 2006), trauma (Santiago, Lennon, Fuller, Brewer, & Katoako, 2014) and parents’ follow-through with environmental interventions recommended by the therapist (Kazdin & Whitley, 2006). Friedburg and Gorman (2007) are among the researchers who corroborate these findings, particularly regarding cognitive-behavioral therapy in children with anxiety. They noted that a strong parent-therapist working alliance helped identify, among other things, issues that the child was having in implementing cognitive behavioral therapy protocol either at home or in the office. Their study also supports the notion of the therapeutic alliance between child and therapist.

The benefit of parental investment has also been demonstrated across cultures (Pina, Zerr, Villalta, & Gonzalez, 2012). Pina and colleagues’ study was among the first to assess a sample of American Caucasian children and Mexican-origin Hispanic children (given the interventions in Spanish) and compare the effects of individual versus a “plus parent” condition of therapy (where one or both child’s parents were asked to participate in sessions). Statistically significant improvements in the “plus parent” groups were found in both the Caucasian and Mexican samples.

School psychologists have similarly noted the benefit of parents being involved in their children’s counseling (Sheridan, Ryoo, Garbacz, Kunz, & Chumney, 2013). They found positive outcomes in the classroom and at home, including a reduction in disruptive behavioral outbursts. They explored involvement in the form of parent-teacher
consultations with a behavioral specialist. In addition, the positive effects of parent investment have been found to be related to the parents’ own psychological characteristics, including parent role construct and self-efficacy (Semke, Garbcz, Kwon, Sherida, & Woods, 2010).

There are some cautions regarding encouraging parent investment in their children’s therapy. Overbearing parent investment may have a zero or negative effect on child therapy outcomes for anxiety, for example (Peterman, Read, Wei, & Kendall, 2015). Over-investment or inappropriate investment often includes such factors as restrictive behaviors by the parents, over-regulation of the children’s behaviors, intrusiveness, lack of age appropriate autonomy for the children, and the parent informing the children of what their emotional state “should be” (Drake & Ginsburg, 2012). As Khanna and Kendall (2009) suggest, these potential issues can be assessed prior to starting counseling and appropriately dealt with during the children’s therapy sessions.

**Child Development Level**

The role of child development level must be taken into consideration. Suveg and colleagues (2006) illustrate the difference between children and adolescents in taking cues from their parents. They noted the differences between children and adolescents in how they imitate their peers versus their parents, for example. Among their findings was the observation that pre-adolescent children would be more likely to take cues from their parents if they were involved in therapy versus adolescents who were less likely to do so. Their research found that younger children tend to benefit more from the direct physical presence of parents in counseling due to the parents being able to give detailed examples. This included negative child behaviors, effective and ineffective examples of limit setting.
at home, and accounts from parents about whether or not they rescued their children from natural consequences. This suggests that different levels of parental investment and presence in therapy should be considered depending on the age and developmental level of the child client. Both over-investment and under-investment may negatively impact the working alliance and the child’s outcome in counseling (Hudson, Kendall, Chu, Gosch, Martin, & Taylor, 2014). Under-investment, relative to the child’s development, can affect the therapist’s view of the child client due to having to rely primarily on child self-report. Over-investment can restrict development of autonomy and active participation in counseling, particularly for adolescents.

Knowing that parent investment in child therapy makes a difference in outcomes offers incentive to better understand and more tangibly define what investment consists of and how to measure it. Existing research and theory offers some direction for exploring and potentially identifying those factors.

**The Working Alliance**

The working alliance, from the parents’ point of view, offers a potential estimate for how invested parents are in working with their children’s therapist, including goal setting, goal attainment, and positive relationship building with the therapist (Bordin, 1994). As such, the working alliance between the parent and therapist, as recorded by the parent, may serve as part of a dependable construct for assessing parent investment in their child’s therapy.

**Bordin and the Working Alliance**

The working alliance is a concept explored by Bordin (1979). The fundamental components of the working alliance, according to Bordin, are goals, tasks, and bonds
between the therapist and client. Goals are defined as what the client wishes to achieve while in therapy while tasks are the exercises that the therapist and client agree are necessary to complete to reach those goals. Bonds, in this case, are the relationship elements such as trust that develop between the client and therapist during therapy. Bordin’s model of the working alliance offers a model that suggests how engaged the parents are and how effective and meaningful they believe they can be in their children’s therapy.

Bordin (1994) identified several client factors that could affect the formation of the working alliance. These include 1) the extent and nature of treatment goals, 2) negative expectations of success, and 3) difficulty maintaining social relationships. In this instance, treatment goal refer to the client’s perceived attainability of those goals and how effectively the therapist communicates the goals. Negative expectations of success refers to one’s belief that therapy will likely fail before actually starting sessions. Finally, social relationship difficulty refers to the client’s ability to connect with the therapist on a personal level (similar to relationships in the client’s personal life). Addressing these concerns would conceivably improve the working alliance.

Bordin’s (1979) model of the working alliance is a three-factor construct that offers a measurable model of how parents view their relationships with their children’s therapists. Goals and tasks are both tangible in that they appear in both discussions with parents during therapy and in the treatment plan. Bonds are reflective of how well the client (in this case, the parent) is communicating and sharing thoughts and concerns with the therapist and vice versa.
Horvath and Greenberg (1989) conducted a content analysis of Bordin’s descriptions of goals, tasks, and bonds from his research (Bordin, 1979; Bordin, 1980) and created a measure, The Working Alliance Inventory (WAI). They began with 91 items based on their analysis (35 bond items, 33 goal items, and 23 task items) and had seven working alliance researchers evaluate the items via a Likert-type scale for relevance. The final version consists of 36 items that differentiate between each of Bordin’s three factors and measures working alliance strength as perceived by the client. It also provides an overall score. Items include “We agree on what is important to work on,” “I believe the way we are working on my problem is correct,” and “[therapist’s name] and I respect each other.” These examples come from the goals, tasks, and bonds factors respectively. The WAI utilizes a Likert-type scale for responses ranging from 1 (seldom) to 5 (always). Horvath and Greenberg (1989) reported a coefficient alpha of .93.

To evaluate whether Horvath and Greenburg’s (1989) measure assessed Bordin’s working alliance construct, Munder, Wilmers, Leonhart, Linster, and Barth (2010) conducted a factor analysis of the WAI to identify the items most closely reflecting Bordin’s concept of tasks, bonds, and goals. They found that the positively-worded items more accurately reflected the three factors more closely than the negatively-worded ones. Using the highest loading items, they constructed the Working Alliance Inventory-Short Revised (WAI-SR). Coefficient alpha for the three subscales ranged from .85 to .90 while total score coefficient alpha was .91. This research provided a measure for Bordin’s working alliance construct with a tool that synthesizes goals, tasks, and bonds into a single working alliance score.
Common Factors Theory and the Working Alliance

Lambert and Barely (2001) stress the importance of the working alliance in their models of successful therapy. They have examined the working alliance as an integral part of a bigger system of common factors that interact within the framework of therapy outcomes. Common Factors Theory states that certain factors, including the working alliance, underlie all successful therapy encounters regardless of theoretical orientation being utilized. (Rosenzweig, 1936; Wampold, 2015). Goldfried (1982) studied the commonality of certain practices in successful counseling regardless of theoretical orientation and found that working alliance was a common factor in improved therapy outcomes. Weinberger and Rasco (2007) identified the working alliance as one of five crucial common factors that influence therapy outcome regardless of theoretical orientation. The other factors they identified were expectations of treatment effectiveness, confronting or facing the problem (exposure), mastery or control experiences, and patients' attributions of successful outcome to internal or external causes.

The nature of the working alliance shows some variations across theoretical orientations due to the ways that therapists of different orientations interact with their clients, but the strength of the alliance is what affects the potential for change (Bedi, 2006, Horvath, 2006). This emphasis on the strength of the working alliance regardless of therapy modality has also been demonstrated in treating specific disorders such as Major Depressive Disorder (Lorenzo-Luances, DeRubeis, & Webb, 2012; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996), Obsessive-Compulsive Disorder (Simpson, Maher, Wang, Bao, Foa, & Franklin, 2011), and Bulimia Nervosa (Accurso, Fitzsimmons-Craft, Ciao, Cao, Crosby, Smith, & Peterson, 2015). Accurso and
colleagues’ (2015) study also supported the concept of the working alliance being influential in outcomes regardless of specific therapy model. Their study followed 209 children with disruptive behaviors and their parents for 16 months while they participated in therapy at a rural mental health clinic. High working alliance scores were reported by parents across the various therapy orientations practiced by each of the participating therapists.

Evidence shows that the working alliance is also an indicator of symptom alleviation during sessions. Falkenstrom, Granstrom, and Holmqvist (2013) noted that early working alliance strength predicted client progress in treatment. A reciprocal relationship between working alliance and symptom alleviation is also found in other studies (Xu & Tracy, 2015), suggesting that, as each improves, the other benefits. These findings suggest that the working alliance may develop over the course of therapy but that its initial strength also affects how successful the client will be.

MacFarlane, Anderson, and McClintock (2015) specifically focused on the client’s perspective when examining the working alliance and categorized early alliance formation for clients into four areas. They include 1) addressing initial misgivings about therapy, 2) organization and meaning-making of therapy, 3) psychotherapy support activities, and 4) appreciation of the therapy technique.

In MacFarlane and colleagues’ (2015) study, addressing misgivings about therapy referred to helping clients process through and address common stigmas associated with therapy whereas organization and meaning-making of therapy referred to helping clients understand their own motivation for coming to therapy. Psychotherapy support activities involved developing specific treatment plan goals with input from the client while
appreciation of the therapy technique involved therapists describing how they perform therapy and how they plan on having clients contribute to the process.

MacFarlane and colleagues (2015) study emphasized the importance of mindfulness regarding the client’s perspective of the therapy process and building the alliance from client and therapist observations. These observations inform therapists on how to address alliance concerns. This study will measure the working alliance according to Bordin’s model and use it to represent the child therapy environment.

**Social Cognitive Theory and Measurable Traits**

Identifying specific traits within parents that may predict positive outcomes in child therapy may provide more options in treatment goal collaboration and goal setting. Social Cognitive Theory offers some direction on traits that may potentially affect a parent’s willingness and enthusiasm to actively invest in their children’s therapy.

**Social Cognitive Theory.** The way that people respond to their environments and learn effective behaviors is explored in Social Cognitive Theory. Social Cognitive Theory began as a theory stating that people learn through imitating the observable actions of others (Holt & Brown, 1931). Miller and Dollard (1941) expanded on this theory and stated that drives, cues, responses, and rewards were the components of learning. They argued that motivation to act led to observation of that act in their environment followed by imitation of the act. They stated that, if positive reinforcement occurs after the act, then the act will be continuously performed. Social cognitive theory suggests that motivation to act, ability to observe, ability to imitate, and positive reinforcement shape how people learn in environments. This theory offers some possible explanations of how people may learn new skills in therapy based upon their motivation and willingness to
invest in the process. A parent’s motivation and desire to invest in their children’s therapy, for example, could influence a parent’s willingness to learn from their children’s therapists and practice recommended interventions. Positive progress in the form of their children’s achieving treatment plan goals could reinforce parents’ continued investment in therapy.

Following Miller and Dollard (1941), researchers continued to explore the role of Social Cognitive Theory in how people learn and interact in their environments. Rotter (1954) postulated that personality is an expression of the individual’s responses to his or her environment. He discussed how a person expressing him or herself can change based upon the influence of the surrounding environment. Cognitive processing, according to Bandura (1969), plays an important role in social behavior (i.e. how people respond to various social and relational situations). Rather than believing in strict environmental control over personality, Bandura (1990) insisted that a process of reciprocal determinism occurred in which thoughts, behaviors, and contexts continuously interact and shape how people respond to their environments and how their environments respond back.

Bandura (1989) discussed the relationship between behaviors and environment as triadic reciprocal determinism. He described personal traits, environmental influences, and behaviors interacting and influencing one another in a bidirectional manner. Bandura noted that these three factors are not necessarily equal in strength. In any particular situation, one factor may outweigh the others. Figure 1 illustrates Bandura’s model.
Fig. 1

Representation of Bandura’s Social Cognitive Model

Social Cognitive Theory emphasizes one’s motivation level and one’s interactions in his or her environment as important parts of learning. If we look at therapy as an environment where participants (in this case, parents) observe and learn new skills, it is possible to apply concepts of Social Cognitive Theory to the study of parent traits that may affect their investment in their children’s therapy.

Social Cognitive Theory discusses traits people have that may influence perception, motivation, and behaviors of parents with children in therapy. Two of the most studied traits are self-efficacy and locus of control.

Self-Efficacy. Self-efficacy is an important trait from Bandura’s (1977) study of Social Cognitive Theory to consider when discussing parents’ investment in their children’s therapy. Bandura referred to self-efficacy as one’s belief in one’s ability to succeed in specific situations or accomplish tasks. Bandura argued that higher levels of self-efficacy are associated with people who view difficult tasks as things to master as opposed to things to avoid. While there are some existing scales that measure the
construct of general self-efficacy, Bandura (2006) argued that self-efficacy is best measured in terms of specific tasks rather than as a generalized trait across all tasks.

Child therapy outcomes for children served in mental health clinics, as measured by symptom alleviation, have been shown to be more positive when parents score high on several factors of self-efficacy. For example, Warren, Brown, Layne, and Nelson (2011) worked with 217 child clients and their parents at a community mental health center. They noted that as the children’s therapy outcomes improved, parent self-efficacy increased which was then followed by continued improving outcomes. They showed support for the idea that parental self-efficacy is something that can be addressed in therapy and that it also influences outcomes.

Positive outcomes for children in academic settings, including homework adherence, have also been linked to stronger scores of parental self-efficacy. Clarke and colleagues (2015) studied 92 parents of children with Attention-Deficit Hyperactivity Disorder and found, among other conclusions, that higher levels of homework adherence and school attendance for the children were predictors of higher parent self-efficacy. While this particular study showed that children’s homework adherence influenced parent self-efficacy, it raises the question of whether parent self-efficacy may have a similar effect on child performance on a task such as therapy.

Sanders and Wooley (2005) found that lower levels of maternal parent self-efficacy had a significant correlation with problem behaviors in children and maternal distress (worrying about one’s ability to perform effectively as a mother). They looked at a sample of 45 mothers of children with conduct problems and 79 mothers of children with no identified conduct problems. They found that mothers of children with conduct
problems scored lower on maternal self-efficacy than mothers of children with no conduct issues. They also noted that mothers with lower scores on task-specific self-efficacy, which indicated that parents had less confidence in their abilities, predicted how permissive or inconsistent mothers were when addressing their child’s conduct problems.

Self-efficacy has been found to relate to a client’s ability to make progress with specific treatment goals. Task-specific self-efficacy has been shown to increase the likelihood of substance abuse clients following through successfully with their treatment plan goals and remaining in treatment (Kadden & Litt., 2011). Ilgen, McKellar, and Tiet (2005) found that maximum scores on self-efficacy for abstinence from illegal drugs for one year predicted nearly twice as many actual cases of abstinence as participants whose abstinence self-efficacy measurement scores were anywhere below maximum. This research suggests that self-efficacy is related to investment in therapy.

Based on the existing research, it is reasonable to hypothesize that parent self-efficacy influences both parental investment in the child’s therapy and therapy outcomes for the children. Greater progress on a child’s treatment plan goals would also suggest greater investment by the parent. Past research has shown that levels of self-efficacy can influence outcomes in interventions, whether it is in relation to the child receiving the service or a parent of the child receiving the service.

**Locus of Control.** Another important factor to consider in Social Cognitive Theory is locus of control. Locus of control, also referred to as control of reinforcement, is a construct that Rotter (1966) developed after examining Bandura and Walter’s (1959) concept of reciprocal determinism as it applied to child aggression. Rotter examined how people responded to events and outcomes in their environment. He examined whether
people believed they could influence outcomes or if outcomes were due primarily to things outside of their control (for example, chance). This may apply to parents of children in therapy. The parents’ locus of control may determine whether they believe they can influence their child’s progress in therapy or if they believe progress is due to factors outside of their control. For example, in the latter situation, a parent may believe, “It’s all in the therapist’s hands.”

Locus of control can be considered to be internal or external. Internal locus of control refers to people’s belief that they can influence outcomes whereas external locus of control refers to the belief that outcomes are due more to chance or fate (Rotter, 1990). Rotter (1966) also theorized that internal or external locus of control affects the strength of a reinforcer. A positive or negative reinforcer is more likely to influence one’s future behaviors if locus of control is internal as opposed to external.

Phares (1957) found that, in a controlled experimental setting, participants responded more to reinforcement on tasks when emphasis was placed on listening and applying skilled instruction as opposed to being told outcomes were determined by chance. In a study of 77 participants, he noted that positive and negative reinforcers were more likely to keep participants investing in tasks if they believed their skills were influencing the outcomes. Conversely, reinforcement was less effective at increasing task completion behaviors if participants believed that the outcomes were driven by chance. It may be possible that parents would respond more to reinforcement from a therapist if they believed that their use of therapist-recommended interventions for their children was influenced by their skills as a parent. This could suggest that internal locus of control leads to more investment from the parents in their child’s therapy. This would also allow
a therapist to have a greater impact via praise and reinforcing positive, therapeutic behaviors from a parent while working with a child in therapy.

Studies on locus of control have found connections between internal or external attribution and how one responds to symptoms. Research on anxiety and locus of control by Chorpita and Barlow (1998), for example, found a correlation between locus of control and levels of manifest anxiety. They noted that people with external locus of control reported higher levels of anxiety-related symptoms than those who reported internal locus of control. Locus of control has also been found to relate to better outcomes for children with depressive symptoms (McCauley, Mitchell, Burke, & Moss, 1988) and adults (Hoehm-Saric & McCloud, 1985) with anxiety. These examples may indicate that internal locus of control contributes to more positive outcomes in therapy. This may be due to the belief that people can have an impact on their mental health and attribute progress in treatment to their own actions.

Perhaps parents’ locus of control may have some impact on their participation in therapy and/or their child’s outcome in therapy. If a parent, for example, believes that their actions can influence outcomes, they may be more inclined to invest in their child’s therapy as they believe their actions can bring about change in their child’s symptoms. These changes would presumably be reflected on treatment plan goal progress.

There is evidence suggesting that locus of control impacts outcomes for clients. Given that research also supports the idea that parent investment in child therapy has positive outcomes, it seems reasonable that parents’ locus of control may impact their investment in their children’s therapy and, therefore, the outcomes. Additionally, this line
of reasoning gives the opportunity to study the effects of one person’s locus of control on the therapy outcomes of another individual.

**The Current Study**

The existing research suggests that appropriate parent investment in child therapy is likely to lead to better outcomes. These findings occur across different diagnoses (Wampold, 2015) and severity levels (Ilgen, McKeller, & Tiet, 2005) of child psychopathology. The existing research also gives suggestions as to what factors may increase parents’ investment in their children’s therapy.

Bordin’s working alliance construct offers us an effective model for measuring how strong each participant in the therapy process feels about the relationship with each other (client, participant, and in this case the parents or guardians of the client). Goals and tasks are compatible with modern treatment plans and reflect their content. Bonds are less tangible in terms of record keeping and progress monitoring. However, the researcher believes that parent attendance and feedback on the therapy process form adequately measured bonds.

Social Cognitive Theory discusses two constructs relating to how people perform tasks and respond to the environment. From Bandura’s (1969) model of Social Learning, self-efficacy emerges as a factor that could influence how effective parents believe they would be in engaging in the therapy process for their children. The current research suggests that believing one is effective at parenting would measure that parent’s likelihood of participating in the therapy environment. It also suggests that believing one is effective at parenting increases positive outcomes for their children in counseling.
From Rotter’s model of Social Cognition, Locus of Control emerges as a factor that the current research suggests would influence parents’ belief that they can actively impact the therapy process. Locus of control research suggests that parents or guardians would believe that they could make a positive difference in therapy, whereas external locus of control indicates that parents or guardians believe they have no control over therapy and that therapy outcomes are due to the therapist (or chance) or other external factors.

For example, a parent with a higher locus of control might think, “I can do these things on my child’s treatment plan that relate to me and I can have an impact on how well this process goes.” A parent with a high sense of parent self-efficacy might think, “I am a capable parent and I can help my child be successful in his treatment. I can guide him in this just as I guide him in all other things.” A parent who perceives a strong working alliance might believe, “I have a good relationship with my child’s therapist. We share a belief that these goals for my daughter are good and the steps needed to meet those goals are the right ones.”

**Research Questions.** The researcher asked three questions regarding parent investment and parent traits in child therapy outcomes for children. First, does a strong working alliance, as perceived by the parent, predict improved outcomes in child counseling? Second, does parent self-efficacy predict improved outcomes in child counseling? Third, does parent locus of control predict improved outcomes in child counseling?

From these research questions, the researcher developed three hypotheses. They are as follows:
1. High parent scores on the Working Alliance Inventory, Short Revised (Hatcher & Gillaspy, 2006) will predict positive progress on the child’s treatment plan;

2. High parent scores on the Parent Self-Efficacy Scale (Layne & Barber, 2003) will predict positive treatment goal progress on the child’s treatment plan; and

3. High parent scores on the Rotter’s Locus of Control Scale (Rotter, 1966) will predict positive treatment goal progress on the child’s treatment plan.
Method

Participants

Parents and legal guardians of 45 outpatient psychotherapy child-clients between the ages of 4 and 12 were surveyed for this study. Power analysis utilizing G*power 3.1 (Faul, Erdfelder, Lang, & Buchner, 2007) indicated that at least 54 participants were needed for ideal statistical power. The researcher had problems with soliciting enough clinics to participate and was unable to obtain the ideal number of participants. In total, six clinics were solicited and one agreed to participate in data collection. Reasons that clinics refused to participate included not wanting to give their clientele additional paperwork to complete and not wanting to add additional workload to their clinicians. The limitations of this are reviewed in the Discussion Section.

The researcher obtained the sample from a regional mental health clinic that accepts child clients. The researcher met individually with the clinic proprietor to answer all questions and concerns prior to collecting any data. The researcher obtained appropriate approval and consent from the clinic owner, therapists, and parents. Assent was obtained from the child clients. Twelve out of 15 solicited therapists from a private mental health clinic in southern Kentucky agreed to participate. Nine therapists had their educational background in clinical social work, two had their backgrounds in clinical counseling, and one had a background in clinical psychology. All participating therapists were licensed at the master’s level. The participating therapists did not indicate the rate of refusal of parents to participate. There were no instances of clients prematurely ending therapy services before having an opportunity to finish completing questionnaires.
There were 33 unique parents of child clients who answered the questionnaires. The majority of parents had one child in therapy. Two parents had three children in therapy while three parents had two children in therapy. In these five multiple-child cases, the child clients were siblings. These cases were included with the remaining cases in the analysis. Thirty-two parents identified as Caucasian and one identified as Hispanic. Table 1 compares educational attainment and marital status between this study’s sample and the most recent American census data (U.S. Census Bureau, 2017).

*Table 1*

*Education Level and Marital Status Comparison Between Study Sample of Parents and National Average*

<table>
<thead>
<tr>
<th>Parent Education</th>
<th>Study Sample</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some High School</td>
<td>18%</td>
<td>21%</td>
</tr>
<tr>
<td>High School</td>
<td>36%</td>
<td>29%</td>
</tr>
<tr>
<td>Some College</td>
<td>24%</td>
<td>16%</td>
</tr>
<tr>
<td>College</td>
<td>21%</td>
<td>21%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Study Sample</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>61%</td>
<td>54%</td>
</tr>
<tr>
<td>Divorced</td>
<td>39%</td>
<td>9%</td>
</tr>
</tbody>
</table>

*Note: N = 33. No study participants in the sample reported earning beyond a four-year degree. According to U.S. Census data, 35% of respondents were “never married” while 2% were widowed. No study participants fell into either of these categories.*
Table 2 shows income levels among participating parents.

Table 2  

Income Comparison Among Participating Parents

<table>
<thead>
<tr>
<th>Income</th>
<th>Study Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$15,000</td>
<td>23%</td>
</tr>
<tr>
<td>$15,000 - $24,999</td>
<td>23%</td>
</tr>
<tr>
<td>$25,000 - $34,999</td>
<td>10%</td>
</tr>
<tr>
<td>$35,000 - $44,999</td>
<td>13%</td>
</tr>
<tr>
<td>&gt;$45,000</td>
<td>31%</td>
</tr>
</tbody>
</table>

Note: N = 33

There were no dropouts or incomplete data packets with this sample. There were no instances of missing data on any of the predictor variable instruments. There were also no instances of clients prematurely terminating therapy services while participating therapists collected data.

Measures

Demographics. Participants completed a brief demographic survey before completing the other instruments. It included data on age, ethnicity, education level, marital status, income, reliability of transportation, and employment level (including full or part-time status). Gender data was not collected. These data points were collected, as they could potentially affect child therapy outcomes, regardless of scores on the predictor variables. See Appendix A.

Attendance. Therapists were asked to keep track of all scheduled appointments over the duration of treatment with the parents of the child clients (Appendix B).
researcher converted the data into a percentage for each child client’s parent (e.g.,
attending 6 out of 8 scheduled appointments equals an attendance rate of 75%).
Attendance was assessed for potential impact on treatment goal progress. Forty-one child
clients had parents attending 100% of all sessions, one had a parent attending 94% of all
scheduled sessions, one had a parent attending 75% of all scheduled sessions, and two
had parents attending 57% of all scheduled sessions. See Appendix B.

**Therapy Outcomes.** Child therapy outcomes were measured via progress on the
first treatment plan goal. Therapists answered a brief questionnaire that asked about child
client treatment goal progress. Therapists were asked to select from four options
indicating how much progress they believed their child-clients had made relative to their
primary treatment plan goal. The highest available option was scored as a 4 while each
descending option was scored one point lower. See Appendix B.

**Working Alliance Inventory, Short Form, Revised (WAI-SR).** Parents
completed the WAI-SR (Hatcher & Gillaspy, 2006) to assess their perception of working
alliance strength. As previously discussed, the WAI-SR is based on Bordin’s (1980)
construct of the working alliance as goals, bonds, and tasks between therapist and client.
It is a shortened, revised form of Horvath & Greenberg’s (1989) WAI and includes
stronger factor differentiation (Hatcher & Gillaspy, 2006; Munder et al., 2010). It consists
of 12 items that differentiate between each of Bordin’s three factors and measures
working alliance strength as perceived by the client. It also provides an overall score.
Items include “We agree on what is important to work on,” “I believe the way we are
working on my problem is correct,” and [therapist’s name] and I respect each other.”
These examples come from the goals, tasks, and bonds factors respectively. The WAI-SR
utilizes a Likert-type scale for responses from 1 (seldom) to 5 (always). Coefficient $\alpha$ for the three subscales ranges from .85 to .90 while total score Coefficient $\alpha$ is .91. See Appendix C.

**Parenting Self-Efficacy Scale (PSES).** Parents completed the PSES (Layne & Barber, 2003) to assess for parent self-efficacy. The Parenting Self-Efficacy Scale (PSES) is a 20-item self-report measure that utilizes a nine-point Likert-type scale from 0 (poorly) to 8 (exceptionally well). It was developed by Layne and Barber (2003) to assess caregiver’s perceived parenting abilities. All items share a common stem (“How well can you…” followed by individual statements. The PSES consists of three dimensions that include Parental Connection, Behavioral Influence, and Psychological Autonomy. Layne and Barber calculated Cronbach’s alpha for these dimensions as .91, .86, and .88 respectively. It has, according to Layne and Barber (2003), an overall Cronbach’s alpha of .95. Warren and colleagues (2011) have utilized the PSES in measuring parents’ self-efficacy and its relation to child outcomes in counseling. They found that, as PSES scores rose over the course of treatment, outcome scores for the children increased as well which indicates improvements in therapy. See Appendix D.

**Rotter’s Locus of Control Scale (RLOCS).** Parents completed the RLOCS (Rotter, 1966) to assess for locus of control. The Rotter’s Locus of Control Scale is a 29-item scale that measures an individual’s perceived locus of control. The higher people’s scores, the more they endorse an external locus of control. Each item comes in a pair of responses and participants endorse the response they believe more closely aligns with their beliefs. One such item gives people the choice between endorsing the statement “I have often found that what is going to happen will happen” and “Trusting to fate has
never turned out well for me as making a decision to take a definite course of action.”

Statements that endorse external locus of control are assigned one point while responses endorsing an internal locus of control are assigned zero points. Rotter (1966) found test-retest reliability estimates for the LOCS as high as .83 while internal consistency reliability estimates ranged from .65 to .79. Isik (2013) has used the RLOCS to measure locus of control and compare it to other variables such as predicted outcomes in vocational school for students. See Appendix E.

**Procedure**

**Institutional Review Board.** The researcher obtained permission from the university’s institutional review board prior to any data collection. The researcher addressed all concerns, including 1) protection of privacy, 2) proper consent, and 3) appropriate participant debriefing. See Appendix F.

**Data Collection.** Data collection took place at a private mental health clinic in a southern state. Therapists who agreed to participate in the study took as many data packets as they believed they could get completed by willing clients. To address the institutional review board’s concerns about privacy and protected health information, the researcher did not directly interact with participating parents. Instead, the researcher instructed participating therapists on how to explain and administer each measure to parents. Each therapist, per researcher instruction, reviewed the purpose of the study with the potential participants and had them sign the informed consent form upon agreement to participate (Appendix F). Participating therapists provided parents with a pencil/pen and a clipboard or a seat at a desk. Parents completed the measures in a designated private office while their children were in their therapy sessions. Upon completion,
parents gave the packets to participating therapists who then placed them in a secured box provided to the clinic by the researcher. The packets were collected by the researcher upon completion and placed in a secure office with at least two locked doors separating it from non-participating individuals, per IRB instruction. Data collection took approximately 16 months.

For each participant, therapists completed a two-page packet. The packet asked the therapists to indicate both how many parent-therapist appointments the participant attended and how many they missed. The therapists were asked to assess progress on the child client’s primary treatment plan goal. This information was kept in a HIPAA compliant location (per IRB instruction) in the clinic until the researcher collected it.
Results

There was no incomplete data for the dependent or independent variables although some demographic data was left blank. SPSS Version 25 was used to calculate all descriptive and inferential statistics. Correlation coefficients among the WAI, PSES, and RLOCS were obtained while assuming a one-tailed relationship between variables. A stepwise multiple regression analysis was used to determine the predictive value of each factor (working alliance strength, locus of control, and parent self-efficacy) for child treatment goal outcomes. Coefficient of determination (R squared) was calculated for the three predictor variables. See Table 3 for descriptive statistics for the independent variables.

Table 3

Descriptive Statistics for Independent Variables

<table>
<thead>
<tr>
<th>Instrument</th>
<th>M/sd</th>
<th>α</th>
<th>Range</th>
<th>Absolute Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAI-RS</td>
<td>50.42/6.07</td>
<td>.89</td>
<td>34 - 60</td>
<td>1-60</td>
</tr>
<tr>
<td>PSES</td>
<td>131.69/12.08</td>
<td>.88</td>
<td>114-160</td>
<td>0-160</td>
</tr>
<tr>
<td>RLOCS</td>
<td>9.78/3.75</td>
<td>.67</td>
<td>2 - 18</td>
<td>1-18</td>
</tr>
</tbody>
</table>

Note: N = 33

For treatment progress, participating therapists rated 4 child clients as “still at baseline,” 30 as making “some progress,” and 11 as “achieving primary goal.” No therapists rated their child clients as “regressing” relative to their treatment goal.

Correlation coefficients were also calculated between each of the three predictor variables. Refer to Table 4.
Table 4

Correlations Among Predictor Variables

<table>
<thead>
<tr>
<th></th>
<th>WAI-RS</th>
<th>PSES</th>
<th>RLOCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAI-R</td>
<td>_</td>
<td>.55**</td>
<td>-.47**</td>
</tr>
<tr>
<td>PSES</td>
<td>.000</td>
<td>_</td>
<td>-.38**</td>
</tr>
<tr>
<td>RLOCS</td>
<td>.001</td>
<td>.005</td>
<td>_</td>
</tr>
</tbody>
</table>

Note: ** Correlation significant at the .01 level (two tailed).

To test the hypothesis that a child’s progress in treatment is in part a function of three variables (parents’ working alliance with the therapist, parents’ parental self-efficacy, and parent’s locus of control), a stepwise multiple regression analysis was performed. The WAI-RS scores were entered first, followed by the PSES scores, and finishing with the RLOCS scores. Treatment plan goal progress scores were the dependent variable. The multiple regression model produced $R^2 = .11$, $F(1, 43) = 5.28, p < .05$ for WAI-RS scores. This indicates a small coefficient of determination.

Participants’ treatment progress scores increased 1.67 points for each 0.03 increase in WAI-RS scores. It was found that parent perception of working alliance significantly predicted child treatment goal progress ($\beta = .33, t = 2.30, p < .05$). WAI-RS scores had positive regression weights, indicating parents with higher scores on this scale had children who progressed further on their primary treatment goal, after controlling for the other variables in the model. No other predictor or demographic variable loaded onto the stepwise regression model. Refer to Table 5.
Table 5

Summary of Multiple Regression Analysis

<table>
<thead>
<tr>
<th></th>
<th>$R^2$</th>
<th>$F$</th>
<th>$\beta$</th>
<th>Std. Error</th>
<th>$t$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAI-SR</td>
<td>.11</td>
<td>5.28</td>
<td>.33</td>
<td>.013</td>
<td>2.30</td>
<td>.03</td>
</tr>
</tbody>
</table>

Discussion

Prior research has failed to examine the impact of the parent traits on child therapy outcomes. In this study an effort was made to predict the effect of parent-therapist working alliance, parent self-efficacy, and parent locus of control on child therapy outcomes. A sample of 33 parents with 45 child-clients was gathered from a clinic located in a southern state. The parents completed a series of measures for working alliance, parent self-efficacy, and locus of control while 12 participating therapists completed a progress measure regarding child-client progress on their first treatment plan goal. A stepwise multiple regression analysis was performed with the three predictor variables and the dependent variable of treatment plan goal progress.

The results of the analysis supported hypothesis 1, which was that higher scores on the WAI would predict higher scores on a measure of treatment progress. Working alliance between the parent and the child’s therapist was found to have some predictive power regarding the child’s therapy outcome. While the coefficient of determination was small ($R^2 = .11$), it should be noted that this study was exploring the impact of one individual’s traits on the treatment progress of another individual in therapy. In this scenario, a small coefficient of determination should be considered worth exploring further.

The final multiple regression analysis excluded both parent self-efficacy and parent locus of control as these variables did not significantly contribute to the regression equation. This finding did not support hypothesis 2 or hypothesis 3 that stated high scores on the PSES and RLOCS would predict high scores on the treatment outcome measure. However, it is also important to consider that both PSES and RLOCS scores were
moderately correlated with WAI scores. One possible explanation for these correlations is that working alliance as a construct may be at least somewhat dependent on the levels of self-efficacy and the type of locus of control parents possess. It may be that higher levels of parent self-efficacy and internalized locus of control are associated with the ability to have a stronger, more positive working relationship with one’s child’s therapist. This finding may give therapists important information on how to better target parents’ needs in family and collateral sessions to address deficits and therefore strengthen the working alliance, which now has some evidence of predictive power regarding child therapy outcomes. However, it should also be noted that the reliability for the RLOCS was not as high as the other two measures, which limits the ability to discuss locus of control with as much confidence as working alliance and parent self-efficacy.

This study proposed a model in which working alliance and parent traits represented parent investment which, in turn, could predict treatment goal outcomes for child clients. The data suggests that parent-therapist working alliance alone has the greatest impact on treatment outcomes for the child client. However, parent self-efficacy and parent locus of control strongly correlated with working alliance, suggesting that they are an integral part of a successful alliance. Because this study used an instrument that focused on Borden’s (1979) model of working alliance, future researchers may wish to emphasize the goals, tasks, and bonds that therapists establish when working with parents/guardians on behalf of child clients. Treatment plans often encompass several of these factors and could serve as one possible point of reference. Future research may also want to look at the impact of parent traits on the elements of the working alliance. How confident, for example, are parents/guardians at working together with someone else to
set goals for their children and design relevant tasks to reach those goals? Whether a more specific form of parent self-efficacy relating to child therapy participation exists and is something that can be measured should be investigated. This more specific focus would fall in line with Bandura’s (2006) principle of very task-specific self-efficacy measures.

Borden’s (1979) concept of working alliance gives some insight into how these findings may inform clinical practice with children. Borden calls working alliance a series of goals, tasks, and bonds between the therapist and the client. These findings offer a few possibilities. One is that they may indicate that when parents feel more self-efficacious as parents and have a more internalized locus of control, they are better able to create a working alliance and participate in their children’s therapy. Alternately, it may be that, as parents participate in their children’s therapy process, their locus of control becomes more internalized and their reported parent self-efficacy increases. It may be that their confidence as a parent and perceived control of their environment allows for more meaningful input into their children’s treatment process. A longitudinal approach to data collection in future studies could possibly address this question and offer more insight.

Parents spend significantly more time with their children than a therapist ever will. They can share their unique perspective and knowledge of child clients to better inform the therapists. If parents believe that they 1) have the ability to be effective with their children and 2) can make an impact in the therapy process, then they would naturally be more likely to participate in the process. They would be more apt to help the therapist identify long term goals for children, identify individual tasks and milestones.
that gradually build to that goal, and believe that they could contribute in a meaningful therapeutic relationship with the therapist.

Working alliance was examined alongside parent self-efficacy and parent locus of control as predictors for child-client treatment goal outcomes. The correlations among working alliance, parent self-efficacy, and parent locus of control suggest considerable overlap among the constructs. Recalling Bandura and Walter’s (1959) reciprocal determinism, parent self-efficacy and parent locus of control might influence the alliance between the parents and the therapists working with the children. As the alliance grows stronger, it in turn strengthens self-efficacy and internalizes locus of control. This suggests the possibility that working with the parents and addressing their needs/deficits may be an important component of child therapy. When the therapist takes time to build a close, positive, and therapeutic relationship with the parent, the child client stands to benefit. Therapists could potentially assess and, if needed, address any concerns with parents/guardians and their sense of self-efficacy and locus of control. Short-term goals for the parents could appear alongside short-term goals for children on the treatment plan.

**Limitations and Future Research**

There are some limitations that must be considered. First and most obvious is the number of participants. The initial power analysis recommended 54 participants. Unfortunately, there were challenges in soliciting sufficient clinics. Some clinics were reluctant to give their clients additional paperwork to complete while others were concerned about giving their clinicians additional responsibilities outside of their regular clinical work. With limited access to clinics and limited time came a small sample size. This issue could potentially be addressed by having undergraduate or graduate students
assist in gathering the data from the parents/guardians to prevent the therapists from having to devote additional time doing so. This could increase the willingness of both clinic owners and therapists to participate in the study. Future researchers could also work more closely with their corresponding institutional review board to try to determine a way for the researcher to be more directly involved in data collection without having to fully depend on the participating therapists to gather the necessary information.

The number of participants needed for this study was based on child therapy clients rather than parents. This resulted in some sibling pairs being a part of the analysis. It is not uncommon for siblings to begin therapy around the same time, especially if an external event has affected an entire family. It is a reality in outpatient therapy and the data in this study reflects this likely scenario. It does, however, create an issue with clustered sampling, as multiple children were rated by the same parent and therapist. It is possible that this may have increased the likelihood of Type 1 error in the results and inflated the true significance of the statistical findings.

It may be beneficial in the future to repeat this study and control for the possibility of parents providing data without giving thought as to whether or not they view their relationship with the therapist, their parent self-efficacy, or their locus of control differently depending on which of their children was in therapy at the moment they were providing data. Would a parent, for example, feel more efficacious with one of his or her children but less so with that child’s younger sibling? Would a parent also possibly shift opinion of his or her locus of control based on which of the children he or she was thinking about at the time of completing the measure? This study could also help address the potential problems with Type 1 error previously mentioned.
There was an additional issue within the instrument used to assess child therapy progress. Of the 45 responses, nearly two thirds of participating therapists identified their child clients as making “some progress.” This left little variability for the analysis on how the parent factors influenced child therapy. This issue could be addressed by adding additional responses for therapists to make regarding their child-client’s progress (see Appendix C). Perhaps between “no progress” and “some progress” there could be a “minimal progress” option. Similarly, there could be another option between “some progress” and “completed goal.” This would allow for a greater range of responses and potentially offer stronger predictive ability. It may also be worthwhile to consider a similar scale for the parent to complete regarding treatment goal progress. This could assess whether there was a significant difference in opinion between the therapists and the parent/guardians regarding the progress of the child client. This discrepancy between scores could also be examined with WAI-RS scores to see if there was any sort of relationship. For example, would a stronger working alliance predict smaller discrepancies between progress scores from parents/guardians and progress scores from therapists?

It should also be noted that the RLOCS presented with questionable internal consistency (Cronbach’s alpha of .67). While locus of control did not appear to influence the regression analysis, the RLOCS may not have been the most effective measure for this hypothesis. While the internal consistency for the RLOCS was not strong, the data may still be useful in understanding the limitations in either this study or the limitations in the application of the RLOCS in certain types of studies.
There may have also been an issue regarding parents’ state of mind at the time of therapy, particularly at the beginning stages. Sitting in a therapist’s office or waiting room may elicit feelings of dependence and desiring answers or control from an outsider. This could even be strengthened by a preconception of therapy as a process where someone else “fixes” the presenting problem for the child. If a parent believes, for example, that therapy is about ceding control of a problem over to another person (a therapist), then it may naturally predispose people to rate their locus of control as more external in that moment. Future studies may wish to both explore different measures for locus of control and a measure that assesses individual’s beliefs about psychotherapy.

This study looked exclusively at parents and guardians of child clients between the ages of 4 and 12. The decision to omit adolescents was based mostly on the distinctions previously mentioned by Suveg and colleagues (2006). Gender data was not collected in this study as well. Assuming that a researcher could secure a large enough sample, it may also be interesting to determine if gender differences in children affect how parent traits predict therapy outcomes. Gender differences may potentially affect how parents apply themselves in terms of therapy participation and working alliance formation, parental-self efficacy, and locus of control. A similar type of analysis may also be possible regarding the gender of the participating therapist. Would working alliances be perceived as stronger by parents if the therapist was male or female? Would parents perceive a stronger alliance with therapists if they were the same gender as the therapist, or perhaps even another gender? Would parents perceive working alliance differently if the therapists and children were the same or different genders?
Implications. There are several considerations for clinical practice when looking at the results of this study. Therapists could work closely with parents to first assess the parents’ perception of the working alliance and then attempt to further develop the relationship. Therapists could, for example, make sure to include parents in forming treatment plan goals for their children in therapy. Therapists could acknowledge the unique knowledge of that parents possess and utilize that knowledge in identifying baseline behaviors and creating reasonable goals. Therapists could also work to ensure that parents are given an opportunity to give regular updates and offer their opinions and feedback on the effectiveness of interventions. These updates could occur in person or, if scheduling regular face to face meetings with parents is difficult, via a secure email or texting application. Murdoch and Connor-Green (2000) offer some guidelines in utilizing electronic communication with clients effectively and therapeutically.

It may also be helpful for therapists to include treatment plan interventions for parents that help improve parent self-efficacy and internalize locus of control. For example, therapists may find it helpful to work with parents on any cognitive distortions that are lowering parents’ views of their efficacy. They could help parents challenge any cognitive distortions (i.e., “I’m a bad parent because my child is acting out.”) with other thoughts (i.e., “There are a variety of reasons why my child may be struggling and I can be part of the solution.”)

Another option to consider may be to direct parents to specific seminars or workshops on how to parent more effectively. Parenting classes, for example, may help parents address fundamental weaknesses in their parenting style and, in turn, help them grow more confident in their ability to effectively parent and apply therapist-
recommended interventions. It may be important, however, to address any potential stigma that parents may associate with parenting classes prior to making this recommendation to them.

Conclusions

This individual study suggests that parental factors can have an influence on children’s progress in therapy. Based on the results, it could be important for therapists to have strong relationships with parents/guardians when it comes to developing the goals for the child clients and the tasks that lead to goal attainment. This study also offers some initial support to the idea that social learning plays some role in children’s progress in therapy. This study appears to be in the interest of child therapy clients that parents work together with therapists to help formulate the treatment plan goals, identify tasks that lead to goal attainment, and create therapeutic bonds that allow healthy communication. This, in turn, creates a favorable therapy environment for the child to observe, interact with, and learn from.

The analysis supported one of the three hypotheses and the results show promise for the importance of parental factors in influencing child therapy outcomes. The influence of the working alliance and the strong correlations between working alliance, parent self-efficacy, and parent locus of control should not be overlooked by future researchers and therapists. It is especially encouraging to see data that can motivate therapists to include parents more actively in child therapy and also address the needs of parents in the treatment planning process. There is now evidence suggesting strong parent-therapist relationships are helpful in improving therapy outcomes for children.
Additionally, it also gives a closer look at what traits therapists can work on with clients (or their parents) to help make that alliance stronger.
References


APPENDIX A

Demographics

Age:

Ethnicity (please circle one)

Caucasian

African-American

Pacific East Islander

Asian

Hispanic American

Other ethnicity not listed ____________________

Education Level (circle one): Some High School

High School Graduate

Some College

College Graduate

Marital Status (circle one) Single Married Divorced Widowed Cohabitating

Yearly Income (circle one)

< $15,000

$15,000 - $24,999

$25,000 - $34,000

$35,000 - $45,000

> $45,000

Do you have reliable transportation?
Employment (Please circle one): Part time

Full time

Other (describe): __________

Unemployed (if yes, please select one)

- homemaker
- student
- on disability

If unemployed, are you looking for work?

- yes
- no
APPENDIX B

Treatment Goal Progress

Identify the primary treatment goal for this client:

With regard to this goal my client has (circle one)

1. Achieved the treatment goal in full
2. Made progress on the first treatment goal but did not achieve it fully
3. Remained at the same level relative to the first treatment goal
4. Gotten worse on the first treatment goal behavior.
5. Other (Describe):_________

Treatment Attendance

The client's primary caregiver is the person who has legal responsibility for the child and is present in a majority or plurality of sessions.

Make-up sessions that occur the same week as the cancellation do not count as a miss.

My client’s primary caregiver has attended ____ out of ____ scheduled family and/or collateral sessions

The client’s secondary caregiver has attended ____ out of ____ scheduled family and/or collateral sessions
APPENDIX C

Working Alliance Inventory – Short Revised (WAI-SR)

Instructions: Below is a list of statements and questions about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space – as you read the sentences, mentally insert the name of your therapist in place of in the text. Think about your experience in therapy, and decide which category best describes your own experience. Circle your answer.

IMPORTANT Please take your time to consider each question carefully.

1. As a result of these sessions I am clearer as to how I might be able to change.
   - Seldom
   - Sometimes
   - Fairly Often
   - Very Often
   - Always

2. What I am doing in therapy gives me new ways of looking at my problem.
   - Always
   - Very Often
   - Fairly Often
   - Sometimes
   - Seldom

3. I believe ______ likes me.
   - Seldom
   - Sometimes
   - Fairly Often
   - Very Often
   - Always

4. ______ and I collaborate on setting goals for my therapy.
   - Seldom
   - Sometimes
   - Fairly Often
   - Very Often
   - Always

5. ______ and I respect each other.
   - Always
   - Very Often
   - Fairly Often
   - Sometimes
   - Seldom

6. ______ and I are working towards mutually agreed upon goals.
   - Always
   - Very Often
   - Fairly Often
   - Sometimes
   - Seldom

7. I feel that ______ appreciates me.
   - Seldom
   - Sometimes
   - Fairly Often
   - Very Often
   - Always

8. ______ and I agree on what is important for me to work on.
   - Always
   - Very Often
   - Fairly Often
   - Sometimes
   - Seldom

9. I feel ______ cares about me even when I do things that he/she does not approve of.
<table>
<thead>
<tr>
<th>Seldom</th>
<th>Sometimes</th>
<th>Fairly Often</th>
<th>Very Often</th>
<th>Always</th>
</tr>
</thead>
</table>

10. I feel that the things I do in therapy will help me to accomplish the changes that I want.

Always   Very Often   Fairly Often   Sometimes   Seldom

11. _____ and I have established a good understanding of the kind of changes that would be good for me.

Always   Very Often   Fairly Often   Sometimes   Seldom

12. I believe the way we are working with my problem is correct.

Seldom   Sometimes   Fairly Often   Very Often   Always
APPENDIX D

Parenting Self-Efficacy Scale

(Layne & Barber, 1999)

These questions ask about how well you believe you can carry out various parenting tasks:

*How well can you:*

1. Help your child to feel loved and cared for?

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2. Listen to your child with understanding and sympathy?

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3. Give your child good advice regarding the problems and choices he/she faces?

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4. Provide your child with friendship and companionship?

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5. Help your child feel needed and wanted?

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6. Help your child to build healthy feelings of self-esteem and self-confidence?

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7. Reassure your child that you will be there to help and sustain him or her if he/she needs you?

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8. Provide for the material needs of your child (food, shelter, clothes, etc.)?

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9. Help your child to do well in school (do homework, prepare for tests, encourage him/her, etc.)?

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10. Appropriately discipline your child when he/she does something foolish or wrong?

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11. Help your child to develop a healthy sense of independence and self-reliance?

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12. Protect your child from danger?

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13. Set a good example for him/her to follow?

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14. Help your child to find and keep good friends?

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15. Help your child to keep out of trouble (to not break the law, use illegal drugs, or hang out with the “wrong crowd”)?

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16. Avoid criticizing your child too much, or blaming him/her unfairly?

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<td>17. Respect your child’s ideas and feelings?</td>
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<th>18. Allow or encourage your child to express his/her own thoughts and feelings?</th>
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<th>19. Keep informed about your child’s life outside of the home (friends, activities, etc.)?</th>
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APPENDIX E

Rotter’s Locus of Control Scale

This is a questionnaire to find out the way in which certain important events in our society affect different people. Each item consists of a pair of alternatives lettered a or b. Please select the one statement of each pair (and only one) which you more strongly believe to be the case.

1. a. Children get into trouble because their parents punish them too much.
   b. The trouble with most children nowadays is that their parents are too easy with them.

2. a. Many of the unhappy things in people's lives are partly due to bad luck.
   b. People's misfortunes result from the mistakes they make.

3. a. One of the major reasons why we have wars is because people don't take enough interest in politics.
   b. There will always be wars, no matter how hard people try to prevent them.

4. a. In the long run people get the respect they deserve in this world.
   b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5. a. The idea that teachers are unfair to students is nonsense.
   b. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6. a. Without the right breaks one cannot be an effective leader.
   b. Capable people who fail to become leaders have not taken advantage of their opportunities.

7. a. No matter how hard you try some people just don't like you.
b. People who can't get others to like them don't understand how to get along with others.

8. a. Heredity plays the major role in determining one's personality.

b. It is one's experiences in life which determine what they're like.

9. a. I have often found that what is going to happen will happen.

b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

10. a. In the case of the well prepared student there is rarely if ever such a thing as an unfair test.

b. Many times exam questions tend to be so unrelated to course work that studying in really useless.

11. a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.

b. Getting a good job depends mainly on being in the right place at the right time.

12. a. The average citizen can have an influence in government decisions.

b. This world is run by the few people in power, and there is not much the little guy can do about it.

13. a. When I make plans, I am almost certain that I can make them work.

b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

14. a. There are certain people who are just no good.

b. There is some good in everybody.

15. a. In my case getting what I want has little or nothing to do with luck.

b. Many times we might just as well decide what to do by flipping a coin.
16. a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.

b. Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.

17. a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.

b. By taking an active part in political and social affairs the people can control world events.

18. a. Most people don't realize the extent to which their lives are controlled by accidental happenings.

b. There really is no such thing as "luck."

19. a. One should always be willing to admit mistakes.

b. It is usually best to cover up one's mistakes.

20. a. It is hard to know whether or not a person really likes you.  b. How many friends you have depends upon how nice a person you are.

21. a. In the long run the bad things that happen to us are balanced by the good ones.

b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22. a. With enough effort we can wipe out political corruption.  b. It is difficult for people to have much control over the things politicians do in office.

23. a. Sometimes I can't understand how teachers arrive at the grades they give.

b. There is a direct connection between how hard I study and the grades I get.

24. a. A good leader expects people to decide for themselves what they should do.
b. A good leader makes it clear to everybody what their jobs are.

25. a. Many times I feel that I have little influence over the things that happen to me.

b. It is impossible for me to believe that chance or luck plays an important role in my life.

26. a. People are lonely because they don't try to be friendly.

b. There's not much use in trying too hard to please people, if they like you, they like you.

27. a. There is too much emphasis on athletics in high school.

b. Team sports are an excellent way to build character.

28. a. What happens to me is my own doing.

b. Sometimes I feel that I don't have enough control over the direction my life is taking.

29. a. Most of the time I can't understand why politicians behave the way they do.

b. In the long run the people are responsible for bad government on a national as well as on a local level.
DATE: October 3, 2016
TO: Christopher Chandler
FROM: Western Kentucky University (WKU) IRB
PROJECT TITLE: [925301-3] Social Cognitive Theory as a Model for Parent Factors Influencing Child Therapy Outcomes
REFERENCE #: IRB 17-058
SUBMISSION TYPE: Amendment/Modification

ACTION: APPROVED
APPROVAL DATE: October 3, 2016
EXPIRATION DATE: October 3, 2017
REVIEW TYPE: Expedited Review

Thank you for your submission of Amendment/Modification materials for this project. The Western Kentucky University (WKU) IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the
researcher and research participant. Federal regulations require each participant receive a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a Minimal Risk project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of October 3, 2017.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Paul Mooney at (270) 745-2129 or irb@wku.edu. Please include your project title and reference number in all correspondence with this committee.
WESTERN KENTUCKY UNIVERSITY

Institutional Review Board
Continuing Review Report

If this is your third year for your Continuing Review Request, please complete a new application. Otherwise; DO NOT include the complete application in describing modifications and requests for additional time to collect data.

Name of Project: Social Cognitive Theory as a Model for Parent Factors Influencing Child Therapy Outcomes
Name of Researcher: Christopher Chandler
Department: Department of Psychology, Western Kentucky University

How many total subjects have participated in the study since its inception? 22

How many subjects have participated in the project since the last review? 22

Is your data collection with human subjects complete? ☒ Yes ☐ No

1. Has there been any change in the level of risks to human subjects? (If “Yes”, please explain changes on a separate page). ☐ Yes ☒ No

2. Have informed consent procedures changed so as to put subjects above minimal risk? (If “Yes”, please describe on a separate page). No

3. Have any subjects withdrawn from the research due to adverse events or any unanticipated risks/problems? (If “Yes”, please describe

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4. Have there been any changes to the source(s) of subjects and the Selection criteria? (If “Yes”, please describe on a separate page). No

5. Have there been any changes to your research design that were not specified in your application, including the frequency, duration and location of each procedure. (If “Yes”, please describe on a separate page). No

6. Has there been any change to the way in which confidentiality of the Data is maintained? (If “Yes”, please describe on a separate page). Yes

7. Is there desire to extend the time line of the project? No

On what date do you anticipate data collection with human subjects to be completed? January 1st, 2018

We are seeking additional time to collect data. We would like to request an additional six months for data collection and completion of the project. During this additional time frame, we would like to continue collecting data from the approved clinic while also reaching out to other clinics and providers to increase our number of participants.

Thank you for your consideration.