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ORIGINAL PAPER

Does Failure Help or Harm? Linking Parents' Treatment Histories, Views of Failure, and Expectancies for Child Psychotherapy

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Abstract

Background Parents' personal psychotherapy experiences can shape their expectancies of mental health treatment for themselves and offspring. For instance, parents with negative psychotherapy experiences may view mental health treatment as less likely to be helpful—and seek treatment at lower rates—for themselves and their children. However, these associations are not absolute. One potential moderator may be parents' *beliefs about failure* as debilitating versus enhancing.

Objective We tested whether beliefs about failure moderated links between parents' own past psychotherapy experiences and their expectancies for future psychotherapy, both for themselves and offspring.

Method One-hundred and forty-three parents with a history of receiving psychotherapy reported on beliefs about failure, past psychotherapy experiences, and future psychotherapy expectancies and preferences, for themselves and their offspring. All measures were completed through mTurk, an online method of collecting survey data.

Results Parents perceiving their own past psychotherapy as ineffective held significantly lower expectancies that psychotherapy would benefit their offspring and were more likely to decline hypothetical treatment for offspring. These relations were significantly stronger among parents holding "failure-is-debilitating" beliefs, versus those with "failure-is-enhancing" beliefs. Parents' reporting negative past therapy experiences had lower expectancies for their own future therapy regardless of failure beliefs.

Conclusions "Failure-is-enhancing" beliefs may strengthen parents' confidence that psychotherapy can benefit their children, especially in parents with negative treatment experiences themselves.

Keywords Parent beliefs · Parental treatment expectancies · Parenting · Youth · Psychotherapy · Treatment · Child mental health

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Introduction

Adults with positive expectancies for the effectiveness of mental health treatment show increased treatment-seeking behavior, greater treatment engagement, and larger symptom reductions following psychotherapy (Callahan et al. 2009; Joyce et al. 2003; Snippe et al. 2015). Likewise, parents' mental health treatment expectancies can shape beliefs about whether treatment will yield benefits, for both themselves and their offspring (Schleider and Weisz 2018). Parents' positive treatment expectancies have predicted improved psychotherapy outcomes for offspring with disruptive behavior, obsessive–compulsive disorder, and depression (Lewin et al. 2011; Stevens et al. 2009) potentially by helping to increase parental engagement in treatment and reducing premature dropout from child psychotherapy (Nock and Kazdin 2001; Schleider and Weisz 2018). Indeed, parents' attitudes towards psychotherapy have predicted whether or not youths with mental health needs accessed treatment at all (Ingoldsby 2010; Reardon et al. 2017). Some of the parent-level factors identified in extant literature include parental perception of their children's mental health issues and parent perceived efficacy, with parents who view mental health challenges as stemming from internal, fixed causes and who report lower self-efficacy having lower treatment attendance compared to parents with high self-efficacy and who view their children's struggles as being due to an external cause (Chacko et al. 2017; Yeh et al. 2005). Additionally, the literature indicates that parents who perceive many barriers to treatment, such as logistics of attending sessions or relevance of the treatment plan, have lower treatment expectancies, lower session attendance, and higher treatment dropout (Chacko et al. 2017; Nock and Kazdin 2001; Yeh et al. 2005). Other demographic factors, such as older child age, higher parent and child psychopathology, socioeconomic disadvantage, and nonwhite racial identity have also been found to be associated with lower treatment utilization and expectancies (Nock and Kazdin 2001; Yeh et al. 2005).

Given the impact of parental treatment expectancies on therapy access, engagement, retention, and clinical outcomes, both for parents themselves and their children, there is a need to identify modifiable, parent-level factors linked to pessimistic treatment expectancies for themselves and their children. Identifying such factors may target efforts to increase parents' confidence in psychotherapy, potentially improving treatment engagement and effectiveness for parents and offspring alike. Towards this goal, we examined two factors that might interactively shape parents' expectancies regarding psychotherapy, both for themselves and their children: parents' *own past psychotherapy experiences*; and parents' *views of failure* as enhancing versus debilitating by nature.

Parents' Past Psychotherapy Experiences and Beliefs About Treatment Effectiveness

Parents' own past psychotherapy experiences may shape their expectancies of future mental health treatment for themselves and their children. People tend to reference personal experiences to forecast the odds of future outcomes, leading them to over-estimate the odds of past personal experiences re-occurring (Tversky and Kahneman 1973, 1974). Accordingly, research suggests that adults who view their past psychotherapy as unhelpful are less likely to seek psychotherapy in the future; likewise, they are more likely to view therapy as unlikely to alleviate their symptoms (Dew and Bickman 2005; Greenberg et al. 2006; Nock et al. 2007; Raue et al. 2009). Conversely, adults reporting high satisfaction with previous psychotherapy have shown a greater likelihood of electing to receive subsequent therapy

(Delsignore 2008). Given these findings, and people's global tendencies to overgeneralize based on salient life experiences (Epstein 1992), it is possible that parents with negative personal experiences with therapy—that is, parents who view their own past therapy as ineffective—may be less likely to seek treatment and more likely to view psychotherapy as unhelpful, both for themselves *and* for their offspring. However, to our knowledge, the possibility that parents' prior treatment experiences might influence their views of treatment for their children has not been tested empirically.

Parents' Failure Beliefs and Expectancies of Mental Health Treatment

In addition to parents' past psychotherapy experiences, another parent-level factor that may influence youth mental health treatment is parents' *beliefs about failure* as being enhancing versus debilitating. Core beliefs about the meaning of failure have been conceptualized as a type of "lay theory": a guiding, common-sense belief about social phenomena that guides one's perceptions of life events, expectations, and behavior (Furnham 1988). Even if inaccurate, lay theories can shape how individuals interpret everyday experiences and respond to perceived setbacks (e.g., Rydstedt et al. 2004; Schleider and Schroder 2018). To our knowledge, parents' lay theories regarding the value of failure have been investigated in only two studies to date, and results from both suggest the relevance of parents' failure beliefs to their children's emotional and motivational outcomes. In one study, parents who viewed failure as more *enhancing* (e.g., as opportunities for learning), compared to parents who viewed failure as more *debilitating* (e.g., as inhibiting learning), were more likely to have children who viewed their own intelligence as malleable through personal effort (instead of fixed and immutable; Haimovitz and Dweck 2016). That is, children of parents holding positive failure beliefs held a stronger "growth mindset" of intelligence: a type of belief that has predicted greater resilience following emotional and academic setbacks (Burnette et al. 2013; Haimovitz and Dweck 2016; Schleider and Weisz 2016; Yeager et al. 2014). Thus, parents' beliefs about failure may shape youths' self-views, including their beliefs about their potential to grow and change. In another study, parents who viewed failure as debilitating reported significantly lower optimism about the effectiveness of psychotherapy, both for themselves and their children (Schleider and Weisz 2018). These parents were also more likely to decline treatment for their children, when presented with a hypothetical treatment-selection task, compared to parents who viewed failure as more enhancing. This finding suggests that beliefs about failure may shape the attributions parents make for treatment's potential for success. It is possible that parents who view failure as debilitating may avoid seeking treatment for their child due to concerns about possible "treatment failure"—and what such failures might imply about their parenting or their child's capacity to recover. In contrast, parents who view failure as enhancing may be more likely to pursue mental health treatment, viewing possible setbacks in psychotherapy as opportunities for growth rather than signs of personal deficiency.

Parents' Past Therapy Experiences and Expectancies for Future Treatment: Moderation Through Failure Beliefs?

Parents' beliefs about failure may hold relevance for the association between their past psychotherapy experiences and expectations for mental health treatment in the future. As one example, parents with negative personal therapy experiences may be less likely than those with positive therapy experiences to pursue future treatment—and this likelihood may be

especially low for parents who view failures are shameful or harmful. Such parents may interpret negative past experiences in psychotherapy as a *personal* failure—a sign of internal deficiency, or an inability to improve—which may further reduce their odds of seeking treatment in the future. By contrast, parents with negative past therapy experiences may remain open to seeking future treatment if they hold "failure-is-enhancing" beliefs. These parents might view a past therapy experience as a "failure" of sorts, but their optimistic lay theories regarding failure may equip them to engage with and learn from this negative experience, and perhaps re-engage in treatment in the future, either for their own difficulties or their children's (Schleider and Weisz 2018). Notably, lay theories, such as failure beliefs, are often activated in the face of distress (Rydstedt et al. 2004). For parents with failure-is-debilitating beliefs, a negative personal experience with psychotherapy experience could serve as a personally-relevant setback that activates their failure belief system, increasing that belief system's likelihood of shaping their expectancies for and intentions with regard to future treatment.

Present Study

Given the possibilities outlined above, we examined the relations between parents' past psychotherapy experiences, their beliefs about failure, and their expectancies, both for themselves and their offspring. Specifically, we tested whether parents' failure beliefs moderated the relation between their past psychotherapy experiences and future psychotherapy expectancies for themselves and their offspring. We also tested whether failure beliefs moderated the link between parents' past therapy experiences and their intentions to pursue future mental health treatment for themselves and their offspring. We had four primary hypotheses: (1) parents with negative past psychotherapy experiences would view psychotherapy as *less likely* to be effective for both themselves and their offspring; (2) parents with negative past psychotherapy experiences would be *more likely* to decline psychotherapy for both themselves and their offspring, in the context of a hypothetical treatment-selection task; (3) parents' failure beliefs would moderate the association between their negative past psychotherapy experiences and lower psychotherapy expectancies, both for themselves and their offspring, such that these links would be stronger for parents who viewed failure as more *debilitating* than *enhancing*; and (4) parents' failure beliefs would moderate the association between negative past psychotherapy experiences and likelihood of declining future mental health treatment, both for themselves and their offspring, such that parents with more negative therapy experiences would be more likely to decline future therapy if they viewed failure as more *debilitating* than *enhancing*. Given our questions of interest, we focused on a sample of parents who reported a history of receiving personal psychotherapy (excluding medication-only psychiatric treatment), regardless of their reasons for seeking services, intervention modality, or treatment duration, and who had at least one child between 7 and 17 years of age.

Method

Participants

Parent participants were recruited through Amazon's Mechanical Turk (mTurk). MTurk is an online method of collecting survey and intervention data that has yielded valid, reliable

data from parent populations concerning family and parent-level factors, along with youth mental health, both cross-sectionally and over time (Chandler and Shapiro 2016; Schleider and Weisz 2015). Through the mTurk program, researchers can recruit individuals with a registered mTurk account (called "workers") to complete surveys or other small projects. Workers receive compensation for study participation only after submitting the task through the mTurk website. MTurk is used frequently for large-scale data collection across numerous social scientific fields, including linguistics, behavioral economics, and psychology (Chandler and Shapiro 2016). Within clinical psychology, studies have found that measures of mental health collected through mTurk have satisfactory reliability and criterion validity (Shapiro et al. 2013). Research studies conducted via mTurk have yielded samples that are similarly diverse (based on age, gender, ethnicity, and employment status) to community-based research studies in the United States (Berinsky et al. 2012).

The current study sample (N = 143) was drawn from a subset of parents recruited for a larger study conducted via mTurk on parental mental health treatment expectancies (total N = 630 for the original project; baseline data for all 630 parent participants are included in the Electronic Supplement). In the original study, workers were eligible to participate if they were located in the United States (as determined by mTurk's settings and Internet Protocol addresses), had at least a 95% task approval rate (rate of successful completion of other tasks on mTurk), and had at least one child between the ages of 7 and 17 years old. A 95% approval rate has been shown to produce acceptable data across a range of studies (Pe'er et al. 2014; MASKED). Parents selected for this study (22.70% of the original sample) were those who reported a history of receiving psychotherapy.[1] The full set of procedures and measures used in the larger study is available elsewhere (Schleider and Weisz 2018). Parents included in the present study were between the ages of 20 and 59 years (M_{age} = 36.10), were 35% male, and 74.80% Caucasian. Forty-two percent of the sample had a college degree and 38.50% identified as single parents. If parents had more than one child between 7 and 17 years old, they were asked to report on the child who they believed presented with the most challenging emotional and behavioral concerns at the time of the study. In total, 37.60% parents of those in the larger study sample reported receiving mental health treatment previously (either psychotherapy, medication, or both). Parents who received both psychotherapy and medication in the past were included in this study; parents who reported receiving medication only were excluded. Children were 54.50% female, had a mean age of 10.34 years, and 30.10% had received some form of mental health treatment previously, per parent report.

Procedures

Prior to beginning the study, all participants were asked to respond to three screening items in order to exclude those individuals who were not parents (this procedure for recruiting parents to participate in research on mTurk has been validated previously; Schleider and

[1] The decision to focus on psychotherapy-based treatments, rather than medication-based treatments alone, is twofold: (1) previous literature has not found any significant links between failure beliefs and medication-based treatment for themselves or offspring and preliminary evidence suggest that parent factors, such as beliefs, may not be relevant for attitudes towards medication (Schleider and Weisz 2018); and (2) examining parent treatment history in relation to medication remains an important and unexplored question, but would have required additional analyses leading to reduction of statistical power to detect effect and is beyond the scope of the current study.

Weisz 2015). In a Qualtrics-based survey, participants were asked if they, or any immediate family member, spoke another language in addition to English; if they had at least one child between the ages of 7 and 17 years; and if they had siblings more than 4 years older or younger than themselves. Of these three questions, only the second determined eligibility for study participation. The other questions were included as filler questions so that participants were unable to identify which screening question would determine study eligibility. Participants were only directed to begin the survey if they answered "yes" to question 2. Notably, the survey was programmed such it could only be initiated once from a given IP address.

Measures[2]

Demographic and Treatment History

Prior to questionnaire completion, all participants were provided with information from the National Institute of Mental Health about the definition of psychotherapy and psychological medications (NIMH 2019). Participants were then asked to report on basic demographic information (e.g., age, gender, socioeconomic status) and history of mental health services that they and their children had received. Parents who responded that they had received previous mental health treatment were asked two additional questions: (1) what type(s) of treatment had they received in the past (psychotherapy, medication, or both); and (2) how *helpful* did they find each treatment type, on a scale from 1 (not at all helpful) to 10 (extremely helpful). This yielded one effectiveness rating for each type of mental health treatment a given parent had received. In this study, each parents' rating of the effectiveness of their previous *psychotherapy* (not medication) was used in analyses, given our research questions of interest.

Failure Beliefs

Beliefs about failure being debilitating or enhancing were assessed through the Failure Beliefs Scale (Haimovitz and Dweck 2016). The Failure Beliefs Scale is a 6-item parent-report questionnaire in which parents are asked to respond to each item on a 6-point scale from 1 (*strongly disagree*) to 6 (*strongly agree*). The measure contains three items assessing debilitating beliefs (e.g., "experiencing failure inhibits my learning and growth") and three items assessing enhancing beliefs (e.g., "the effects of failure are positive and should be utilized"). Items addressing enhancing views of failure are reverse coded and all items are then summed to create a total score. Higher scores reflect more debilitating beliefs about failure. This measure has demonstrated good reliability and validity (Haimovitz and Dweck 2016). Internal reliability for the Failure Beliefs Scale in this study was $\alpha = .91$.

Treatment Expectancies and Preferences

Parents completed a 6-item measure to assess for hypothetical treatment expectancies and preferences for themselves and their children. This measure was adapted from a similar

[2] For a comprehensive listing of measures included in the original study, please see (Schleider and Weisz 2018).

measured created by Schroder et al. (2015) in which parents are asked about hypothetical mental health services. Four items on this scale asked parents about expectations and preferences for hypothetical mental health treatment for themselves and their offspring:

1. In the future, if you were to struggle with mental health problems (e.g., anxiety, depression) and had a choice between individual (one-on-one) psychotherapy, medication, or no treatment to help you with these problems, which would you choose?
2. On a scale from 1 (*not at all helpful*) to 10 (*extremely helpful*), how helpful do you think individual psychotherapy would be in reducing mental health problems, if you struggle/were to struggle with them?
3. In the future, if *your child* were to struggle with mental health problems (e.g., anxiety, depression) and you had a choice between seeking out individual, therapy, medication, or no treatment to help with his or her problems, which would you choose?
4. On a scale from 1 (*not at all helpful*) to 10 (*extremely helpful*), how helpful do you think individual psychotherapy would be in reducing mental health problems in your child, if he or she struggles or were to struggle with them?

Items 1 and 3 were recoded so that 0 = preference for any type of mental health treatment over no treatment, and 1 = preference for no treatment (consistent with recoding used in the original study; 4). Two additional items asked parents about beliefs and intentions about medication-related treatment for themselves and their offspring; these items were not used in the present study.

Strengths and Difficulties Questionnaire (SDQ)

The SDQ (Goodman 2001) was used to assess children's behavioral, emotional, and peer difficulties, per parent report. The SDQ is composed of five scales (Emotional Symptoms, Conduct Problems, Hyperactivity, Peer Problems, and Prosocial Behavior) and each scale contains five items. Items are rated on a 3-point scale. Items from the first four subscales are summed to create a Total Difficulties score with higher scores reflecting greater difficulties. In the present study, we included SDQ Total Difficulties score as a covariate in all study analyses. The SDQ has demonstrated adequate internal consistency and construct validity (Smedje et al. 1999). Internal reliability for the total SDQ score in this study was $\alpha = .79$.

Data Analytic Plan

Zero-order correlations (or point-biserial correlations, where indicated) among all study variables were first conducted in order to evaluate associations among primary variables of interest. We ran hierarchical linear regression models to examine associations between perceived effectiveness of past psychotherapy and (1) parents' expected psychotherapy effectiveness and (2) parents' treatment preferences (for pursuing vs. not pursuing mental health treatment), and to evaluate whether beliefs about failure moderated these associations. In Step 1, parents' expected psychotherapy effectiveness and parents' treatment preferences were each regressed on perceived effectiveness of past psychotherapy in order to determine unique effects of the predictors. In Step 2, an interaction term between perceived effectiveness of past psychotherapy and failure beliefs were added to determine whether

failure beliefs moderated the association between parents' perceived effectiveness of past psychotherapy and (1) parents' expected psychotherapy effectiveness and (2) parents' treatment preferences. Parent education and gender, child age and gender, ethnicity, SDQ Total Difficulties scores, and prior child mental health treatment were included in all models as covariates. All variables were standardized prior to analyses to aid in the interpretation of interaction effects. For significant interaction effects, we calculated the simple slopes at high (+1 SD above the mean) and low (−1 SD below the mean) values of failure beliefs using the PROCESS macro for SPSS version 25 to determine the nature of the interactions.[3] Additionally, because our moderator of interest (parent failure beliefs) was a continuously-scored construct, we used the Johnson-Neyman technique to identify the specific points along the moderator at which the link between the independent and dependent variables transitioned to being statistically significant (vs. nonsignificant). We conducted parallel models for parents' expected effectiveness of future psychotherapy with respect to themselves and their offspring, as well as parallel models for parents' treatment preference with respect to themselves and their offspring, resulting in a total of 4 models.

Results

Descriptive Statistics and Correlations

Correlations among study variables, along with means and standard deviations, are reported in Table 1. Stronger parental perceptions of past therapy effectiveness were associated with greater parental optimism that future therapy would be helpful, both for themselves and their children. Parents' optimism that future therapy would be helpful was linked with a preference for pursuing (vs. declining) future treatment, both for themselves and their offspring. Failure-is-debilitating beliefs were associated with lower expected future therapy effectiveness for offspring. Parents' positive expectancies for their own future psychotherapy were associated with more positive expectancies for the effectiveness of their children's future psychotherapy. No differences by parent gender emerged for failure beliefs, treatment expectancies, or preference for treatment.

Expected Psychotherapy Effectiveness: Moderation by Failure Beliefs

Expected Psychotherapy Effectiveness for Offspring

In the first model, parents' expected psychotherapy effectiveness for offspring was regressed on parents' perceived effectiveness of past psychotherapy and parents' failure-is-debilitating beliefs, along with pre-specified covariates (child psychopathology, parent education level, parent and child sex, child age, and parent race; see Table 2 for full regression results). In the first step, parents' perceptions of their own past therapy as effective were significantly associated with optimism that psychotherapy might benefit their children, adjusting for all covariates ($B = .50$, $SE = .07$, $p < .001$). In the second step, the

[3] The PROCESS macro is capable of running linear and binary logistic regressions depending on the type of dependent variable. We ran two linear regressions (for the outcome variable expected psychotherapy effectiveness) and two logistic regressions (for the binary outcome variable treatment preference).

Table 1 Descriptive statistics and zero-order correlations of study variables

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
1. Failure beliefs	–										
2. Past therapy effectiveness (parent)	−.12	–									
3. Expected therapy effectiveness (parent)	−.12	.76**	–								
4. Expected therapy effectiveness (child)	−.17*	.48**	.67**	–							
5. Therapy preference (parent)	−.06	.21*	−.21*	−.11	–						
6. Therapy preference (child)	.14	.02	−.08	−.28**	.28**	–					
7. Parent gender	−.12	−.006	.03	.05	−.09	−.07	–				
8. Child gender	.26**	−.12	−.01	.04	−.03	−.09	.12	–			
9. Child age	−.04	−.01	.09	−.02	−.14	−.03	.01	−.01	–		
10. SDQ	.18*	−.12	−.09	−.28**	.01	.04	−.03	.05	−.04	–	
11. Child prior mental health treatment	−.15	−.02	−.06	.03	.15	.14	−.19*	−.05	−.27*	−.21*	–
Mean	17.05	6.30	6.80	7.18	–	–	–	–	10.34	13.29	–
Standard deviation	5.3	2.53	2.08	2.24	–	–	–	–	3.05	7.57	–
Range	6–36	0–10	0–10	0–10	0–1	0–1	0–1	0–1	7–17	0–35	1–2

SBQ, Strength and Difficulties Questionnaire

*$p < .05$; **$p < .01$

Table 2 Full regression results for past therapy experiences × failure beliefs interactions across treatment expectancies

	Model 1 outcome: expected therapy effectiveness offspring			Model 2 outcome: expected therapy effectiveness parent		
	B	*SE*	ΔR^2	*B*	*SE*	ΔR^2
Step 1			.39***			.62***
Child age	−.04	.07		.09	.06	
Child gender	.12	.07		.08	.06	
Parent gender	−.01	.07		.003	.06	
Parent education	−.25**	.07		−.12*	.06	
SDQ	−.18*	.07		.02	.06	
Ethnicity (White)	−.04	.12		−.07	.10	
Ethnicity (Black)	−.19	.11		−.12	.08	
Ethnicity (Asian)	−.03	.08		−.04	.06	
Ethnicity (Latino)	.004	.09		.02	.07	
Prior child mental health treatment	.03	.08		.01	.06	
Past therapy effectiveness	.50***	.07		.77***	.06	
Failure beliefs	−.12	.07		−.05	.06	
Step 2			.03**			.005
Past therapy effectiveness × failure beliefs	.18**	.07		.08	.06	

All variables were standardized prior to analyses; SE, standard error

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

interaction of failure beliefs and perceived effectiveness of past therapy was added to the model. A statistically significant effect emerged for this interaction ($B = .18$, $SE = .07$, $p = .01$, $\Delta R^2 = .03$). Simple slope analyses at 1 SD above and below the mean were then estimated using the PROCESS macro for SPSS (see Fig. 1). Lower perceived effectiveness of past psychotherapy was significantly associated with lower expected psychotherapy effectiveness for offspring, both when parents held stronger failure-is-debilitating beliefs ($B = .68$, SE = .10, $p < .001$) and when parents held stronger failure-is-enhancing beliefs ($B = .31$, $SE = .10$, $p = .002$). However, this association was two times stronger among parents who endorsed failure-is-debilitating beliefs, as compared to those who endorsed failure-is-enhancing beliefs (Bs = .68 and .31, respectively). We further probed this interaction using the Johnson-Neyman technique (Hayes and Rockwood 2018), which identified the range of failure belief scores at which there was a statistically significant effect ($\alpha = .05$ criterion) of the independent variable (parents' perceived past psychotherapy effectiveness) on the dependent variable (parents' optimism that psychotherapy would benefit their offspring). A score on the Failure Beliefs Scale of 9.57 emerged as the "transition point" (on a scale of 6–36, with higher scores indexing stronger failure-is-debilitating beliefs). When scores on the Failure Beliefs Scale were ≥ 9.57, parents' lower perceived effectiveness of past psychotherapy was significantly associated with lower future psychotherapy expectancies for offspring. There were no differences in responses for failure beliefs scores below 9.54. In the present sample, approximately 9% of parents reported failure-is-debilitating beliefs below this score and 91% were above it.

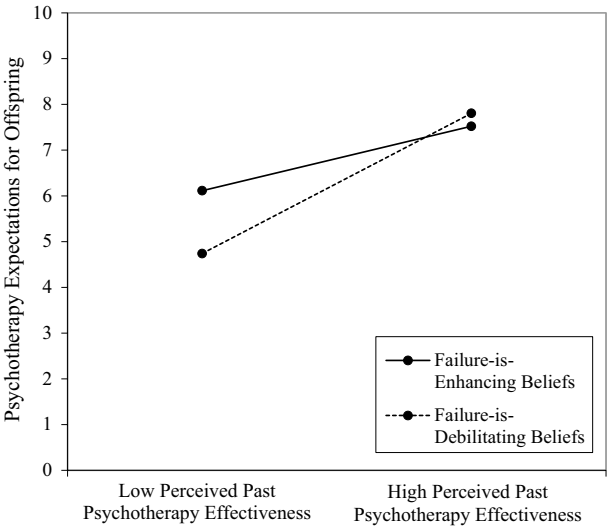

Fig. 1 Association between past psychotherapy effectiveness and future psychotherapy expectations for offspring at high and low levels of failure beliefs. NB: Graph reflects results of a linear regression

Expected Psychotherapy Effectiveness for Parents

In the second model, expected psychotherapy effectiveness for *parents themselves* was regressed on parents' perceived effectiveness of their own past psychotherapy and parents' failure-is-debilitating beliefs, along with all covariates (child psychopathology, parent education level, parent and child sex, child age, and parent race; see Table 2 for full regression results). In the first step, parents' perceptions of their own past therapy as effective were significantly associated with optimism that psychotherapy might benefit themselves, adjusting for all covariates ($B = .78$, $SE = .06$, $p < .001$). In the second step, the interaction of failure beliefs and perceived effectiveness of past therapy was added to the model. However, the interaction was not statistically significant ($B = .07$, $SE = .06$, $p = .25$).

'Treatment' Versus 'No Treatment': Moderation by Failure Beliefs

Treatment Preferences for Offspring

In the third model, treatment (vs. no-treatment) preference for offspring was regressed on parents' perceived effectiveness of past psychotherapy and parents' failure-is-debilitating beliefs, along with pre-specified covariates (child psychopathology parent education level, parent and child sex, child age, and parent race; see Table 3 for full regression results). In the first step, parents' perception of their own therapy as effective was not significantly associated with treatment preference for offspring after adjusting for all covariates ($B = -.01$, $SE = .31$, OR = .001, $p = .97$). In the second step, the interaction of failure beliefs and treatment preference was added to the model. A statistically significant effect emerged for this interaction ($B = -.92$, $SE = .35$, $p = .01$, $\chi^2 = 7.93$) and simple slope analyses at 1

Table 3 Full regression results for past therapy experiences × failure beliefs interactions across treatment preference

	Model 1 outcome: preference for future therapy offspring			Model 2 outcome: preference for future therapy parent		
	B	*SE*	χ^2	*B*	*SE*	χ^2
Step 1			19.33			21.13*
Child age	.13	.31		−.58	.37	
Child gender	−.39	.32		−.09	.32	
Parent gender	.13	.31		−.32	.30	
Parent education	.46	.30		.13	.32	
SDQ	−.07	.32		.04	.30	
Ethnicity (White)	7.89	5318.70		−.13	.53	
Ethnicity (Black)	6.09	3755.03		.17	.43	
Ethnicity (Asian)	−.09	3753.16		−2.77	3259.95	
Ethnicity (Latino)	4.28	2816.27		.49	.33	
Prior child mental health treatment	.65	.43		.49	.44	
Past therapy effectiveness	−.01	.31		−.81**	.30	
Failure beliefs	.80*	.37		−.27	.36	
Step 2			7.93**			.16
Past therapy effectiveness × failure beliefs	−.92*	.35		.14	.34	

All variables were standardized prior to analyses; SE, standard error; χ^2, Chi square likelihood ratio test
*$p < .05$; **$p < .01$

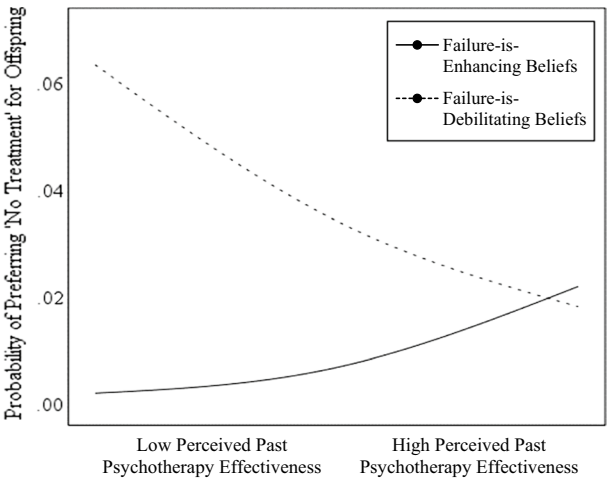

Fig. 2 Association between past psychotherapy effectiveness and future treatment preference for offspring at high and low levels of failure beliefs. NB: Graph reflects results of a logistic regression; although the range of probability values along the Y axis spans 0–1, the range in this graph has been truncated to enable visibility of the interaction effect

SD above and below the mean were then estimated using the PROCESS macro for SPSS version 25 (see Fig. 2). There was a trend level ($p = .05$) but positive effect between higher perceived effectiveness of past psychotherapy and preference for future treatment when parents viewed failure as more enhancing ($B = 1.18$., $SE = .61$, $p = .05$); this association was non-significant and negative among parents who viewed failure as debilitating ($B = -.65$,

SE = .43, *p* = .13). Because both variables in the interaction term were continuous, the Johnson-Neyman technique (Hayes and Rockwood 2018) is likely to provide more nuanced information than the simple slopes approach regarding the nature of the overall interaction effect observed. This approach identified scores on the Failure Beliefs Scale of 11.55 and 24.60 as the two "transition points" (on a scale of 6–36, with higher scores reflecting stronger failure-is-debilitating beliefs). More specifically, when scores on the Failure Beliefs Scale were less than 11.155 parents' higher perceived effectiveness of past psychotherapy was significantly associated with a greater likelihood of preferring treatment for their offspring. In contrast, when scores on the Failure Beliefs Scale were above 24.60, parents' lower perceived effectiveness of past psychotherapy was significantly associated with a greater likelihood of preferring 'no treatment' for their offspring. In our sample, approximately 12% of participants fell below a score of 11.55 and 8% of participants fell above 24.60.

Treatment Preferences for Parents

In the fourth model, treatment preference for *parents themselves* was regressed on parents' perceived effectiveness of past psychotherapy and parents' failure-is-debilitating beliefs, along with all covariates (child psychopathology, parent education level, parent and child sex, child age, and parent race; see Table 3 for full regression results). In the first step, parents' lower perceptions of their own past therapy as effective were significantly associated with a greater likelihood of preferring 'no treatment' for themselves, controlling for all covariates (*B* = −.82, *SE* = .30, *p* = .006). In step 2, the interaction of failure beliefs and perceived effectiveness of past therapy was added to the model. However, the interaction was not statistically significant (*B* = .14, *SE* = .34, *p* = .69), suggesting that failure beliefs did not moderate the association between parents' perceived effectiveness of past psychotherapy and preference for future treatment for themselves.

Discussion

This study examined associations between parents' personal experiences in psychotherapy, their beliefs about the value of failure, and their expectancies for and intentions to pursue future psychotherapy, both for themselves and their children. Specifically, we tested whether parents' beliefs about failure moderated the link between parents' own past therapy experiences and their expectancies and preferences regarding future mental health services. Consistent with prior literature (Delsignore 2008; Dew and Bickman 2005; Greenberg et al. 2006; Nock et al. 2007; Raue et al. 2009), parents reporting more negative past psychotherapy experiences endorsed less optimism about the potential effectiveness of psychotherapy, both for themselves and their children, and were more likely to decline mental health treatment for offspring in a hypothetical treatment-selection task. Further, parents' beliefs about failure moderated links between parents' past therapy experiences and expectancies and preferences for their children's future treatment. Specifically, the link between parents' negative past psychotherapy experiences and lower expectancies for children's psychotherapy was two times stronger among parents who viewed failure as more debilitating (vs. more enhancing). Further, parents who viewed failure as more debilitating (vs. more enhancing) were more likely to decline hypothetical mental health treatment for their children. However, parents reporting negative past psychotherapy experiences endorsed

lower expectancies for their own future psychotherapy, and were more likely to decline future mental health treatment for themselves, regardless of their failure beliefs.

These findings fit with prior work linking past therapy experiences to future therapy expectancies, treatment-seeking, and treatment retention (Greenberg et al. 2006; Nock and Kazdin 2001; Schleider and Weisz 2018). This study also extends this literature, suggesting that links between parents' past therapy experiences and future therapy expectancies *for their offspring* may depend on their beliefs about failure. Parents' beliefs about failure have rarely been examined in the context of youth mental health services, but present results suggest their potential role in promoting children's access to psychotherapy. For instance, viewing failure as a learning opportunity, instead of shameful or harmful, may help maintain parents' optimism about the utility of treatment for offspring. In turn, failure-is-enhancing beliefs may increase parents' odds of seeking-out services on behalf of their offspring, regardless of their personal experiences receiving similar treatment. Future studies may directly test this possibility, focusing—as in this study—on parents with a history of psychopathology (here indexed as a history of mental health treatment), as their offspring are at especially high-risk for developing mental health needs in the future (McLaughlin et al. 2012).

Further, our study suggests that viewing failure as *enhancing* may help retain parents' confidence in the potential for psychotherapy to reduce mental health problems in offspring, even among parents with negative experiences receiving therapy. This finding raises the possibility that shifting parental beliefs about failure may have the potential to bolster parents' optimism about their children's treatment, even if they have had poor psychotherapy experiences themselves. Because parents' expectancies regarding their children's mental health treatment has predicted children's treatment retention and clinical response (Dew and Bickman 2005; Greenberg et al. 2006; Nock et al. 2007; Raue et al. 2009), failure beliefs could serve as a parent-level target for improved treatment efficacy and warrants further longitudinal study, especially among parents with pessimistic views of failure.

Contrary to our hypotheses, parent failure beliefs did not moderate the relation between negative past parent psychotherapy and (1) low expected psychotherapy effectiveness and (2) preference of "no treatment" for parents themselves. A prior study found that parents' failure-is-enhancing beliefs were associated with higher expectancies of psychotherapy effectiveness and a lower likelihood of declining hypothetical mental health treatment for both themselves and their offspring (Schleider and Weisz 2018). Our findings suggest that this association may be weaker among parents with negative personal therapy experiences, who may be reluctant to engage in additional therapy regardless of their views of failure. Indeed, parents who viewed their previous psychotherapy as ineffective held lower optimism about future psychotherapy and were more likely to decline treatment for themselves, regardless of failure beliefs. This may reflect the fact that personal experiences in one's past, especially emotionally salient ones (e.g., participating in an "unsuccessful" course of psychotherapy), can influence one's expectancies for future personal outcomes (Wilson and Gilbert 2003). Accordingly, a parent's past therapy experience might be quite closely tied to forecasts about *their own* response to future treatment—and these forecasts may be difficult for other factors, such as failure beliefs, to influence. By contrast, past personal experience might be less strictly linked to their forecasts for *others'* future outcomes (Wilson and Gilbert 2003). In turn, among parents with negative past therapy experiences, predictions about whether their child might benefit from therapy might be easier to alter than predictions about whether *they* might benefit from therapy. Moreover, within this sample, parents' psychotherapy expectancies were generally more positive for their children than

for themselves, suggesting that parents may be more optimistic that children can improve (e.g., because they are younger and thus more "malleable").

Limitations and Future Directions

This study had limitations worth noting. First, data were cross-sectional, preventing us from exploring causal or predictive effects. The cross-sectional design also prevented us from examine potential changes in parents' perceptions of past psychotherapy, beliefs about failure, or future treatment preferences or expectations over time. In addition, all outcomes were assessed via parent-report, which creates the possibility of shared method variance. The study sample was also somewhat homogenous, consisting of mostly Caucasian (70.40%) and relatively well-educated (50% with college degree) parents, rendering generalizability to more diverse populations unclear. In addition, many parent-level, environmental, and family-level factors beyond failure beliefs may further shape parents' expectancies regarding mental health treatment—and in turn, treatment-seeking behavior. Alternative family-level factors include parents' own mental health histories (Lewin et al. 2011) and treatment history of offspring (Brown et al. 2007; Horwitz et al. 2012). Although we do not directly assess these parent-level factors in the current study, parental experiences with offspring's treatment do likely shape parents' expectancies regarding mental health treatment for their offspring and themselves. It is probable that if a parent had a poor past experience with their offspring's mental health treatment, that experience may, for example, impact their optimism about and willingness to engage in future mental health treatment. Future studies may investigate such factors in tandem with those addressed here.

Finally, it is possible that the specific type of mental health problem a given youth is experiencing may influence their parents' expectations about the utility of treatment. For example, the evidence base for youth externalizing problems includes parent training (e.g., Weisz and Kazdin 2010), which contains active involvement from parents. Thus, parent behaviors and involvement are especially essential to the success of parent training, relative to treatments for youth internalizing problems (which place the parent in a less central role). Overall, parents who expect to be involved in their child's treatment may also experience fewer barriers to treatment, including viewing their involvement in the treatment as more relevant and less burdensome. For example, prior research has found that psychoeducation about the treatment model and rationale was associated with subsequent parent involvement in treatment (Martinez et al. 2017). Parent expectations about their children psychotherapy has been linked to lower treatment attendance and premature termination for youth with oppositional and aggressive disorders (Nock and Kazdin 2001). Yet even in more child-centered treatments, parents play an essential role in treatment attendance, engagement, and outcomes (Dowell and Ogles 2010; Hoagwood et al. 2010). Parent treatment expectancies for specific youth mental health problem types are not examined in this study but may represent an important area for future research.

This study also has strengths that may inform future research. For instance, the present sample includes youths and caregivers of diverse ages (youths ages 7–17, parents ages 24–64), suggesting generalizability of effects to families with youth at diverse developmental stages (e.g., parent and child ages were not associated with outcomes of interest in this study). Additionally, 35% of parent participants were fathers, who are traditionally underrepresented in clinical child psychology research (Phares et al. 2005). However, parent gender was not associated with failure beliefs, treatment preferences, or psychotherapy expectancies, suggesting that results are generalizable to both male and female caregivers.

Finally, as noted above, results raise the possibility that parents' failure beliefs may be a promising intervention target—particularly among parents with negative therapy experiences themselves. Brief interventions targeting parent readiness have shown to be effective for treatment focusing on parent training. These interventions have included problem solving approaches for barriers to treatment, adaptive treatment expectancies, and motivation enhancement practices and have resulted in increased treatment retention, a stronger fit of expectancies for child improvement in treatment, and greater parental readiness/motivation for treatment (Chacko et al. 2012; Nock and Kazdin 2005). In addition, brief interventions targeting failure beliefs have shown positive effects on parents' perceptions of treatment for their children, yet no study has examined whether these interventions would retain their effects *specifically* among parents with a history of negative past treatment experiences. Teaching these parents that failures, adversities, and setbacks offer critical growth opportunities may help retain (or restore) their optimism that psychotherapy might benefit their child, improving future treatment-seeking for their offspring. For parents whose children are first entering therapy, it may be helpful for clinicians to assess parents' past therapy experiences and failure beliefs, along with parents' personal past experiences receiving psychotherapy themselves. This could help clinicians better understand the attitudes and expectancies of families coming into therapy, and administer brief, parent-directed interventions targeting optimistic failure beliefs when indicated, to support treatment retention and clinical response in children. Experimental research with treatment-seeking families is needed to test this potential treatment target.

Summary

Using a sample of parents with a history of receiving psychotherapy, we examined associations between parents' past psychotherapy experiences and their expectancies that future psychotherapy might be helpful, along with the moderating role of parent failure beliefs. Parents who viewed their own past psychotherapy as ineffective held significantly lower expectancies that psychotherapy would benefit their offspring; these parents were also more likely to decline treatment for offspring in a hypothetical treatment-selection task. Both of these relations were significantly stronger among parents holding "failure-is-debilitating" beliefs, as compared to parents with "failure-is-enhancing" beliefs. However, failure beliefs did not moderate these the link between past therapy experiences and future treatment expectancies or preference with reference to parents' *own* future treatment. That is, parents who reported negative past therapy experiences had lower expectancies for their own future therapy regardless of failure beliefs. Overall, results suggest that parents' beliefs about failure beliefs, in combination with negative personal experience with psychotherapy, may relate to expectancies for and likelihood of seeking mental health treatment for their children. By instilling failure-is-enhancing beliefs in parents—especially parents reporting negative personal psychotherapy experiences—interventions may improve parental optimism about the utility of psychotherapy for offspring.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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