ABSTRACT

Title of Thesis: THE EFFECT OF PERCEIVED SOCIAL SUPPORT ON
                        CLIENT ATTENDANCE IN INDIVIDUAL THEAPY

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There is an abundance of research that seeks to understand what affects client attendance in therapy. Many of the most recent studies have begun to look at how relationship factors, such as the client and therapist bond affect client retention in therapy. This study aimed to understand how perceived social support from friends and family might make an impact on client attendance. Additionally the effect of gender was observed to look at how it might moderate the effect of perceived social support on client attendance. No significant results were found to indicate that perceived social support from friends or from family has an effect on client attendance. Gender, as well, did not have a significant impact on client attendance. Future research is proposed to better understand patterns of client attendance in therapy as well as the role of social support in therapy.

THE EFFECT OF PERCIEVED SOCIAL SUPPORT ON CLIENT ATTENDANCE IN
INDIVIDUAL THERAPY

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Chapter I Introduction

Statement of the Problem

The process of therapy for mental health issues is as complex as the persons involved and requires a strong commitment to the challenge of change. In addition to the functional requirements of therapy, which include a significant amount of time, money, and strategy, therapy also requires a high level of personal and emotional vulnerability, openness to differing attitudes and perceptions, personal commitment, and trust in the ability of the therapist and his or her methods to support positive growth. Considering the challenges posed by psychotherapy, it is not surprising that many clients who initiate therapy drop out prematurely.

Client attendance in psychotherapy, also termed as retention, attrition, or dropout, has long been of interest for mental health researchers and practitioners, with studies addressing the issue first emerging in the 1950s (Baekeland & Lundwall, 1975; Sharf, 2007). Research on client retention in therapy has followed the evolution of the mental health field, which began with a more narrow view of psychotherapy, primarily looking at individual processes. Studies at this time focused on patient variables such as demographics, psychological diagnosis, and personal attitudes (Baekeland & Lundwall, 1975). As researchers and practitioners expanded their outlook to include a more systemic perspective, viewing how relational processes affect individual functioning, they began to assess the impact of relational factors on client retention (Fearing, 2002; Longo, Lent, & Brown, 1992; Sharf 2007).

Client retention is key to the success of therapy because it affects both the efficacy of therapy for the clients, and the efficacy of the agency and practitioner. It is

important to note that the effectiveness of therapy depends on participants' investment of time and consistent attendance. The most recent research to determine the effective "dose" of therapy found that between 13 and 18 sessions were required for at least 57.6% - 67.2% of clients to make significant progress (Hansen, Lambert, & Forman, 2002). The authors did not identify the modalities used in the reviewed studies (e.g., individual, group); however, the results of this study strongly suggest psychotherapy requires more than a few sessions to significantly help clients in distress, and therefore client retention is essential. Additional problems that result from client dropout include inability to meet treatment goals, wasted time that might have otherwise accommodated clients in need, fiscal consequences for the agencies and practitioners, as well as a lowered sense of morale and confidence for practitioners (Barret, Chua, & Crits-Christoph, & Gibbons, 2009; Fearing, 2002; Hansen, et al. 2002; Sharf, 2007; Wierzbicki & Pekarik,1993).

Client attendance in therapy is a complex issue to study, not only due to the complexities of factors that affect the issue in practice, but due to the various ways it can be examined in research. Due to the variance in the way it is defined, measured, and analyzed, it is often difficult to synthesize the results of studies that look at client attendance. To begin with, researchers have used a variety of terms to refer to how long clients attend therapy after their initial intake and/or how long clients stay in therapy before dropping out. Studies that measure client retention, client "attendance," (Hampton-Robb, Qualls, & Compton, 2003), "early withdrawal," (Barret et al., 2009), client "attrition," (Aubuchon-Endsley & Callahan, 2009; Longo et al., 1992), and client "dropout" (Fearing, 2002; Sharf, 2007; Wierzbicki & Pekarik, 1993) from therapy are all

essentially studying the same thing, but subtle definitional differences may affect how the concept is viewed and measured.

Studies also differ in the way they measure client attendance, or failure to attend. For example, some studies begin to count dropouts as clients who fail to attend their first appointment after a phone intake (Hampton-Robb et al., 2003), whereas other studies begin counting dropouts as clients who fail to return after their first session (Longo et al., 1992). Other studies classify dropouts at various levels, depending on the point at which they drop out of therapy. For example, Fearing (2002) classified clients who dropped out before five sessions as "early dropouts," clients who dropped out between five and 19 sessions as "late dropouts," and clients who stayed in therapy for 20 or more sessions as "completers." Furthermore, we must consider how therapists' opinions as to when it is acceptable to terminate therapy may differ from both other therapists and from their clients, which may also confound our analysis of which clients can be seen as "dropouts" in therapy and why (Barret et al., 2009).

Additionally, not all studies and meta-analyses of client attendance specify what type of therapy they are observing: individual, relational or group therapy. For example, Sharf (2007) distinctly stated that all studies included in a meta-analysis observed attendance trends in individual therapy, whereas a literature review by Barret et al. (2009) did not specify whether trends were observed in the context of group, relational or individual therapy. Similarly, Hansen et al.'s (2002) review of therapeutic dose did not specify the modality of individual, relational or group therapy as a criterion for inclusion in their analysis.

Identifying risk factors that contribute to attrition is an additionally complex endeavor, as there are so many variables that may influence client attendance. Therefore, in addition to identifying the variables that influence client attendance, we must also identify the vast number of ways they can interact with one another to produce different outcomes. To give an example of the range of variables that relate to client attendance, Barret et al., (2009) observed six broad categories termed as "patient characteristics," "enabling factors or barriers," "need factors," "environmental factors," "perceptions of mental health and mental illness," and "beliefs and assumptions about mental health." Barret et al., (2009) noted that the aids and "obstacles to engagement and retention reflect a complex array of cultural, attitudinal, and experiential differences" (p. 250), which may mean that these factors have different impacts, depending on the specific population of mental health consumers and how they experience their therapeutic treatment. In drawing conclusions about client retention we must be careful when considering the generalizability of our claims. Since so many variables can interact to influence client attendance in therapy, it is difficult to make generalizable conclusions about how specific variables influence client retention across a variety of populations.

In spite of the obstacles to studying client attendance, several factors have emerged as influential across meta-analyses. In a recent meta-analysis, Sharf (2007) was able to identify 24 variables to have small to moderate significant correlations with client dropout in individual psychotherapy, including gender, marital status, symptom severity, interpersonal functioning, patient-therapist alliance, and treatment type. In past research on client attendance, minority status, lower level of education, and lower socioeconomic status emerged as the strongest predictors of dropout (Garfield, 1994; Wierzbicki &

Pekarik,1993). More recent studies have identified that the initial relationship between therapist and client as a measure of their "alliance" with one another is a key predictor of client attendance (Fearing, 2002; Sharf 2007).

Reexamining previously studied influences on client attendance continues to be an important mission for researchers who need to clarify their conclusions. A more pressing agenda in this area of research however is identifying new factors, particularly those that consider a more complex interaction of influential factors such as those viewed from a systemic and relational perspective (Weirzbicki & Pekarik, 1993). As previously discussed, more recent studies on client retention have looked at how relational factors, such as the client-therapist alliance contribute, to attendance in psychotherapy. If positive relationships between client and therapist predict client attendance, then perhaps other positive relationships in the client's life predict client attendance as well. It should be noted that as all studies on client and therapist alliance have been observed in individual therapy (Fearing, 2002; Sharf, 2007), a basic expansion on this finding should begin with individual therapy as well.

Researchers have asserted that some of the most influential predictors of therapeutic outcomes are four common factors; client/extratherapeutic factors, factors attributed to the client/therapist relationship, theoretical perspectives and therapeutic techniques, and expectancy factors (Asay & Lambert, 1999; Blow & Sprenkle, 2001). Of the four factors, client variables and the client/therapist relationship have been cited as the most influential (Asay & Lambert, 1999; Blow & Sprenkle, 2001). As much as 40% of favorable therapeutic outcomes can be attributed to client variables and other extratherapeutic factors which include demographic characteristics like gender,

personality characteristics like motivation, and relationship contexts such as social support (Asay & Lambert, 1999). The second most influential category of common factors includes aspects of the relationship between client and therapist, which may account for around 26% of successful therapeutic outcomes (Asay & Lambert, 1999).

Expanding on findings that clients' alliance with their therapist correlates with client attendance (Fearing, 2002; Sharf, 2007), and that client variables, such as the nature of their social networks predict therapeutic outcomes (Asay & Lambert, 1999), we might look at how a client's alliance with their friends and families, might predict their likelihood of continuing therapy. Alliance with friends and families is most easily measured through self-report measures of perceived social support from friends and perceived social support from family. Indeed, levels of perceived social support may relate with the two most influential categories of common factors associated with successful client outcomes in therapy: client variables and the client/therapist relationship.

Several researchers have observed that the nature of social support in an individual's relationships with family and friends is similar to the nature of the relationship with a therapist (Barker & Pistrang, 2002; Roehrle & Strouse, 2008). The formal helping relationship with the therapist and the informal type of helping relationship experienced with friends and families, are both characterized by intimate disclosures from the person being helped. Both formal and informal helpers convey positive intentions, empathy, and caring (Barker & Pistrang, 2002). Furthermore, both formal and informal relationships have the potential to create new meaning for problems and encourage new ways of coping with them (Barker & Pistrang, 2002).

Researchers have also asserted that social networks may help to perpetuate positive therapeutic outcomes because "they develop social skills as important prerequisites for therapy," (Roehrle & Stouse, 2008). Roehrle and Strouse (2008) stated that social networks "strengthen the attachment by sustaining the therapeutic relationship;" suggesting that ample social support primes clients to make a strong bonds with their therapists and stay dedicated to continuing their work together. Therefore, alliances with friends and family and may predict client attendance either as a trend that parallels the positive correlation between client/therapist alliance and client attendance, or as an additional factor that enhances the bond between client and therapist which then increases client attendance (Fearing, 2002).

Social support has already been found to be a predictor of client compliance with non-psychiatric medical recommendations (DiMatteo, 2004). An extensive meta-analysis of patients' compliance with non-psychiatric medical recommendations found that patients with higher levels of social support from both family and nonfamily members indeed showed more cooperation with doctors and obedience in following doctors' orders (DiMatteo, 2004). Perhaps social support similarly influences client cooperation in treating mental health issues, as exhibited by their commitment to attending therapy.

Furthermore, although no research has looked at behaviors that demonstrate how social support influences client compliance with psychotherapy, there are ample data from self-report measures that have linked higher levels of social support to more positive attitudes towards seeking psychotherapeutic help. (Koydemir-Özden, 2010; Morgan, Ness & Robinson, 2003). As attitudes have been found to predict behavior

(Fazio & Roskos-Ewoldsen, 2005), we might assume that a positive attitude toward therapy, as predicted by social support, might also predict client attendance.

An important consideration in research examining social support and how it relates to seeking help in psychotherapy is how gender affects each construct and influences the interaction (Koydemir-Özden, 2010; Morgan, et al., 2003). Since men and women are socialized differently both in how they experience relationships and how they seek help, we must consider that men and women may have differing levels of social support, different types of social support, and different help-seeking attitudes. Therefore, the relationships between these variables may be significantly different. Overall, women have been found to have more robust social networks, and higher ratings of perceived social support that correlate with their more positive attitudes towards seeking psychotherapeutic help (Koydemir-Özden, 2010; Morgan, et al., 2003). So far, looking at gender differences simply suggests that overall, women trend higher than men in measures of these constructs. No evidence has suggested that social support has a different impact on attitudes towards seeking psychotherapeutic help for men than for women. It may be important, however, to explore this possibility when measuring how social support correlates with behavioral expression of these attitudes though attendance.

Although some studies have found slight gender differences in client attendance (Sharf, 2007), more research is needed to determine if client behavior related to gender and social support will align with the self-report attitudes towards therapy expressed in previous findings (Koydemir-Özden, 2010; Morgan, et al., 2003). Furthermore, a positive attitude toward help-seeking may make one more likely to begin therapy, but other factors may influence whether or not one continues. Beyond help-seeking attitudes,

gender differences in expectations and motivation to attend therapy may also influence

client attendance (Longo et al., 1992). For example, Longo et al. (1992) found that

women tend to report stronger expectations and motivation for therapy than men. It may

be important to note, however that this study found no significant evidence to suggest

that gender alone influences client attendance. In general, findings demonstrating

whether or not gender alone correlates with client attendance are inconclusive, (Barret et

al., 2008; Sharf, 2007; Weirzbicki & Pekarik, 1993).   Sharf's (2007) meta-analysis found

few studies that produced significant relationships between gender and client attendance;

those that did found that women were slightly more likely to drop out of therapy.

Theoretical Foundation for the Study

The bioecological perspective of human development provides a theoretical basis

from which to explain how one's level of social support might predict one's attendance in

psychotherapy. The bioloecological perspective of human development assumes that

humans are social in nature and that social relationships can be viewed as systems of

interaction (White & Klien, 2008). This perspective views systems at multiple levels of

complexity, the *microsystem*, the *mesosystem,* the *exosystem,* and the *macrosystem,* and

assumes all systems have an impact on one another (Brofenbrenner, 1979 as cited in

White & Klien, 2008). The *microsystem* is the smallest system, which involves the

developing person and the individual's other significant relationships. In this study, the

client and therapist relationship would be seen as a microsystem. The *mesosystem* is the

combination of two or more microsystems, such as family relationships and professional

relationships. In this study, the individual's network of perceived family and social

support would be seen as the mesosystem. The *exosystem* does not directly impact the

developing individual, but surrounds and influences micro and mesosystems, and therefore makes an indirect impact. The exosystem might be the surrounding system of the therapeutic organization when clients are seen, which would include systems of interactions with the therapist and coworkers, and the therapeutic environment. The *macrosystem* is the larger system that includes micro meso, and exosystems, therefore creating a cultural and environmental context for these smaller systems of interaction.

The bioecological perspective assumes that various personal relationships (microsystems), or several relationships of a social network (mesosystem) can have an impact on the relationship between the client and therapist (another microsystem). Likewise, micro and mesosystems outside of therapy may impact a client's motivation and/or ability to continue this therapeutic relationship. For example, an encouraging friend, or system of several encouraging friends may increase one's self-efficacy and motivation for self-improvement and therefore encourage the client to stay in therapy until he or she has met his or her goals. Additionally positive relationships at the micro and meso level may help to increase social skills that create and maintain a therapeutic alliance and continued dedication to therapeutic growth.

The concept of *proximal process* explains how systems influence each other through enduring interaction (Brofenbrenner & Evans, 2000). Brofenbrenner and Evans (2000) explain that, "to be [an] effective [influence] the interaction must occur on a fairly regular basis over extended periods of time," (p.117). *Proximal process* asserts that for a process to develop, such as a person's ability to bond with others, that person must be able to regularly practice this skill be repeated process (Brofenbrenner & Evans, 2000). We might assume that people who report high levels of social support have greater

opportunity to practice positive social interactions are therefore more likely to be better

skilled at bonding and maintaining enduring relationships, which may help them stay in

therapy.

Purpose

As discussed previously, an ample amount of research suggests that the initial

alliance between client and therapist is an important relationship that is associated with

client retention in therapy (Fearing, 2002; Sharf, 2007). However, there is a gap in the

research on client retention regarding information about how other relationships may

similarly influence client attendance. In order to better understand relationships that

predict client attendance in therapy, the current study will examine the degree to which

perceived support from friends prior to individual therapy predicts client propensity to

stay in therapy. Additionally, because gender may be an important variable influencing

the relationship between social support and client retention, this study examined whether

or not gender moderates the relationship between social support and client therapy

attendance.

Chapter II Review of Literature

Previous Studies on Client Retention

Studies on client attendance have looked at a range of factors influencing whether or not clients stay in therapy. A literature review by Barret et al. (2009) explained that methodological differences in how researchers operationally define client dropout has additionally complicated the comparison of the early withdrawal phenomena across studies. The range of definitions for client attrition includes: failure to return after intake, missing two consecutive sessions, failure to attend last scheduled session, terminating therapy sooner than therapist's recommendation, and termination of therapy before 9 months. Barret et al. (2009) additionally highlighted that therapists and clients often differ in their explanations for clients' early termination, especially if reasons for attrition reflect negatively on the therapist.

Barret et al.'s (2009) review of over 50 years of research on early withdrawal from mental health treatment explored a vast assortment of variables by grouping factors that affect early withdrawal into six categories: "patient characteristics," "enabling factors or barriers," "factors related to [psychotherapeutic] need," "environmental factors," "perceptions of mental health," and "perceptions and assumptions about treatment." In Barret et al.'s (2009) examination of patient characteristics that may contribute to client attrition, the authors observed an overall trend of inconsistent findings in studies relating client attrition to demographic variables such as gender, age, socioeconomic status, and race. Although some studies found higher dropout rates for younger clients, minority clients, and clients at a lower socioeconomic status, they noted that we must consider the complex way in which different attitudes and experiences also

influence consumers of therapy. Barriers that contributed to client attrition, as reviewed by the authors, included difficulties finding mental health services, large travel distance, waitlist placement, extended wait-time between intake and treatment, and difficulties coordinating therapy with work schedule or child-care as factors that have consistently related to client early withdrawal from treatment. Additionally, they suggested social networks as a potential enabling factor that might make clients less likely to drop out of treatment early, referencing the finding that clients referred by religious groups were more likely to attend their first appointment than clients referred by more impersonal sources, such as crisis hotlines (Barret et al., 2009).

An assessment of factors related to patient need in therapy found that patients' ability to recognize their psychological distress, and therefore, their therapeutic needs in order to reduce distress related to their likelihood of staying in therapy (Barret et. al., 2009). Factors contributing to the therapeutic environment, such as staff attitudes towards the client during the intake and the aesthetic appearance of the clinic were found to have an impact on client engagement, especially early in the therapeutic process. The authors' review of patient perceptions of mental health and mental illness considered these perspectives to be largely culturally influenced, observing that many cultures may have negative perceptions about mental illness and that stigmas about seeking help from mental health issues might contribute to clients' reticence to continue therapy (Barret et al., 2009).

Finally, personal perceptions and assumptions about treatment such as negative expectations about therapeutic outcomes, negative perceptions about therapists' expertise, competence, trustworthiness, and even clients' perception of their therapist as less

attractive can lead to early withdrawal from therapy (Barret et al., 2009). The authors

provided a comprehensive overview of theories and findings to examine the problem of

attrition in therapy. They concluded that even after 50 years of research the problem of

client retention is so complex and multifaceted that more research is still needed to

adequately address the issue (Barret et al., 2009).

As researchers have continued to study client retention over the last half-century,

a series of summative projects have periodically synthesized studies on client retention

through meta-analysis in order to extract consistently significant variables that predict

client attendance (Baekeland & Lundwall, 1975; Garfield, 1986; Sharf, 2007; Wierzbicki

& Pekarik, 1993). Weirzbicki and Pekarik (1993), and more recently Sharf (2007),

synthesized the abundance of research on variables that predict client dropout through

meta-analyses. Weirzbicki and Pekarik's (1993) meta-analysis of 125 studies conducted

from 1974 to 1990 used Cohen's d (effect size) as a way to compare standardized mean

differences in variables between clients who stayed in therapy and clients who did not.

Despite the volume of studies that were reviewed, they only found a few demographic

variables to be significantly associated with client dropout. Risk for dropping out of

therapy was associated with minority racial identity, lower levels of education, and low

socioeconomic status (Wierzbicki & Pekarik, 1993). In their discussion, the authors

observed that studies looking at how demographic variables relate to client attendance

were becoming exhausted and enjoined researchers to aim future projects at identifying

more complex psychological variables that might influence dropout in psychotherapy

(Wierzbicki & Pekarik, 1993).

Many of the studies that followed, as reviewed by Sharf (2007), seem to respond to Weirzbicki and Pakarik's (1993) charge. Sharf's (2007) meta-analysis of 73 studies conducted from 1990 to 2006 followed the methods of its predecessor. Through these methods Sharf (2007) amplified the number of variables linked with client retention, including patient characteristics beyond demographics. The author identified 24 variables as having a small to moderately significant relationship (in varying directions) with psychotherapy dropout: age, gender, education, marital status, anxiety symptom severity, depression symptom severity, eating disorder symptom severity, general symptom severity, duration of illness, diagnosis, borderline personality disorder, personality disorder, interpersonal functioning, self-efficacy, self-esteem, hostility, impulsivity, motivation, expectations for treatment, patient-rated alliance, therapist-related alliance, therapist training, treatment length and treatment type (Sharf, 2007). Some of the strongest predictors of client dropout were variables related to the quality of the relationship between client and therapist. The author found that patients who were able to form a stronger alliance with the therapist, as both perceived by the therapists' assessment and the patients' assessment, were less likely to drop out of therapy. Additionally, results of this study highlighted that patients' level of interpersonal functioning, as measured prior to therapy, predicted client attendance (Sharf, 2007).

An acknowledged limitation of Sharf's (2007) study was that due to the wide array of variables analyzed in this study, only a few articles were devoted to each meta-analysis category; therefore an inclusion of additional studies, past or future, in each category might reveal different results, especially for weaker correlations. Adding the studies used by Wierzbicki and Pekarik (1993) to Sharf's (2007) analyses would mostly

serve to clarify the relationship between demographic variables and client dropout, however. The research synthesized by Wierzbicki and Pekarik (1993) may have been greater in volume, as they were able to include more studies, but the research synthesized by Sharf (2007) shows a broader range of variables in the study of client dropout.

How Relationships Affect Client Retention

In some of the most recent and pioneering studies on client attendance, the role of "relational factors," such as clients' interpersonal style and level of interpersonal functioning prior to therapy, has emerged as a focus of study (Fearing, 2002). As the author highlights in his study, the relationship between the client and the therapist is of particular interest to researchers looking to predict client dropout. Fearing's study of 76 adults (50 female, 26 male) seeking psychotherapeutic services at a university mental health center measured how the initial quality of the working alliance between therapist and client affected client dropout. Overall, 22 participants were classified as early dropouts (those who dropped out prior to the 5th sessions), 32 as late dropouts (those who stayed between 5 and 19 sessions before dropping out), and 22 as completers (those who continued therapy for 20 to 21 sessions). Fearing (2002) found that early dropouts begin treatment with a weaker therapeutic alliance than later-dropouts and completers. Although the study's largely correlational design limited its ability to identify mediators and allow causal conclusions from the data, the significant results of this study (at *p*-level <.01) support the general consensus that positive relational factors relate to positive therapy outcomes and increased client attendance (Fearing, 2002).

A study by Hampton-Robb et al. (2003) additionally suggests the potential for social influence to predict client retention, as its findings supported a prediction of first

session attendance based on referral source. A sample of 397 consecutive referrals to a nonprofit, religiously affiliated, mental health clinic over an 18-month period found that, consistent with most studies of client failure to attend therapy, 37% of their phone intakes failed to attend their first session (Hampton-Robb et al., 2003). Of these clients, those referred by either religious groups or physicians were significantly more likely to attend than those referred by crisis lines and other agencies. Clients referred by friends, relatives and their insurance agencies were also slightly more likely to attend than referral sources less personally related to the clients, though this difference was not highly significant (Hampton-Robb et al., 2003).

The greatest strength of this study is that it indeed found a significant relationship between attendance and referral source, suggesting that the clients in their sample might have been influenced by a personal relationship with source of referral (Hampton-Robb et al., 2003). Unfortunately, this study is rife with limitations. The relationship between religious affiliation and client attendance was likely strengthened by the religious affiliation of the mental health clinic, and though this detail is not reported, the religious affiliations of the referrals' organization and the mental health clinic is likely similar, making the results of this study very difficult to generalize to other clinics, especially nonreligious organizations (Hampton-Robb, et al., 2003).

The Impact of Social Support on Therapy

Although some research has suggested a link between social relationships and attendance in therapy (Fearing, 2002; Sharf, 2007), the mechanism of that link is not clear. To begin examining this mechanism it may be necessary to look at the general research on therapeutic outcomes. One social variable that seems to generally affect

therapeutic outcomes is social support (Pernice-Duca, 2010; Roehrle & Strouse, 2008). Thus, it may make sense to examine this literature to so that we may better understand and make predictions about the link between one's social relationship and continuance in therapy.

Roehrle and Strouse's (2008) meta-analytic review considers the potential impact of social support on therapy and the multifaceted way it may influence therapeutic efficacy. The authors proposed that in many ways social support and psychotherapy might serve similar purposes, as both provide cognitive and emotional support that can influence positive behaviors and secure attachment to others. Additionally, the authors proposed that social support systems might facilitate therapeutic efficacy as they can serve as motivators to get help, they can help lower patient stress, and they can extend therapeutic efforts to put change into place. Supportive social relationships may enhance personal growth in therapy as they often help people to better define themselves (Roehrle & Strouse, 2008). Finally, social skills, as developed through these social relationships are important as pre-requisites for an effective client-therapist relationship and effective therapy (Roehrle & Strouse, 2008).

Although Roehrle and Strouse (2008) were able to logically explain how social support might enhance therapeutic outcomes, they expressed mild skepticism about the significance of this relationship, positing the possibility that the efficacy of social support or social networks in therapy may be "overestimated" (p. 464). Their meta-analysis of 27 controlled clinical outcome studies aimed to go beyond quantitative measures of social support by standardizing a variety of reports on social relationships to look at how increased social support might increase positive therapeutic outcomes (Roehrle &

Strouse, 2008). Using a composite index of quantitative and qualitative measures, the authors found only a small correlation, which was not statistically significant. When isolating the quantitative measures of the relationship between social support and positive therapeutic outcomes, however, they found a small correlation that was significant (Roehrle & Strouse, 2008).

Roehrle and Strouse's (2008) research makes an important statement about the connection between social support and therapy; however, the conclusion of their study is confounded due to lack of specificity in their methods. The weak correlations between social support and therapeutic outcomes found by Roehrle and Strouse might be explained by the researchers' broad inclusion criteria for their meta-analysis both in their nature of the studies they used and in the criteria used to define social support. More specific research on this topic might find stronger connections between social support and therapy for certain populations and therapeutic conditions.

A more recent study by Pernice–Duca (2010) found a stronger connection between supportive social relationships and mental health outcomes. Pernice-Duca's study specifically looked at how family support influenced recovery. Additionally, the research examined how mutuality in social support influenced recovery. This study included 169 consumers in mental health treatment programs. Social support was quantified from interviews assessing the consumer's emotional, instrumental, and material forms of social support, as well as levels of reciprocity and satisfaction in these relationships. Additionally, consumers were interviewed about their family support. Recovery was assessed relative to the construct of recovery for the individual's mental illness. Interestingly, males reported greater satisfaction with family social support than

females. The researchers also found that family support and reciprocity had a significant positive relationship with mental health recovery in treatment programs (Pernice-Duca, 2010).

The Impact of Social Support on Compliance with Healthcare Recommendations

Social support has also been linked to increased cooperation with recommendations from health workers, at least in treating physical health. A meta-analysis of 122 studies on social support from 1948 to 2001 found that both practical and emotional social support, presumably from peers and/or nonfamily members, increased a patient's likelihood to comply with nonpsychiatric medical recommendations (DiMatteo, 2004). Researchers reviewed studies examining "patient compliance" and "patient adherence" to non-psychiatric medical recommendations as it correlated with several domains of social support. One domain, defined as "functional social support" included "practical" social support, as instrumental aid from others, "emotional" social support, as emotional support from others, and "unidimensional" social support, as a presumed combination of emotional and practical support.

DiMatteo's (2004) meta-analysis found that patients who received practical social support were 3.6 times more likely to adhere to medical recommendations, those with simply emotional support were 1.35 more likely to adhere, and those with unidimensional social support were 2.35 times more likely to adhere. One limitation of this study is that the authors failed to specify from whom the patients were receiving the three types of functional social support, which slightly limits the conclusions one can draw from the findings (DiMatteo, 2004). However, as another domain was specified as "family cohesiveness," we might assume the reviewed studies referred to either general social

support, including either nonfamily and family members, or just nonfamily members (DiMatteo, 2004).

The results of this study make an important contribution to our understanding of social support and healthcare outcomes, however, as it produced some significant results relating social support to cooperation with physical healthcare (DiMatteo, 2004). The researchers additionally posited that, "social support may improve patient adherence through improved cognitive functioning, self-efficacy, [and] intrinsic motivation" (DiMatteo, 2004). Such conclusions suggest that social support might be used to predict adherence to mental health recommendations as well.

Gender, Social Support, and Therapy

Two recent studies looking at how social support influences attitudes towards therapy drew from precedents in earlier research (Koydemir-Özden, 2010; Morgan et al., 2003). Each study also looked at how gender influenced this relationship (Koydemir-Özden, 2010; Morgan et al., 2003). A study by Morgan et al. (2003) aimed to measure how the demographic variables of gender, race, and student status (graduate or undergraduate) influenced attitudes toward seeking counseling, as well as intentions to seek counseling. The researchers pointed out that students, and possibly the general population, prefer seeking help from family and friends to seeking help from mental health professionals, (Dirks & Metts, 2010; Morgan et al., 2003). Understanding that personal forms of social support are the preferred sources of psychological help still begs the question of how one's perceived social support resources might decrease or augment one's propensity to seek help from a professional.

Morgan et al.'s (2003) study sampled 207 Canadian university students and measured levels of perceived social support, attitudes toward seeking professional psychological help, and intentions to seek counseling. The authors' review of previous literature synthesized previous findings on how gender factors into social support and counseling, observing that women tend to report higher levels of stress, but they also report high levels of social support (Morgan et al., 2003). Previous literature has also found that women have more positive attitudes towards counseling than men, which might relate to the finding that women are more likely to utilize mental health resources (Morgan et al., 2003). The authors of this study found strong correlations exactly in line with previous findings. They found that women reported more social support, higher levels of distress, and more positive attitudes towards counseling (Morgan, et al., 2003).

Koydemir-Özden's (2010) study had similar aims, as it explored how perceived social support, gender, and additionally the level at which one defined themselves in relation to others (termed the "relational self-aspect") correlated with help-seeking attitudes. The author synthesized research looking at differences in how men and women engage in social relationships, stating that women are more likely to maximize their social networks and have closer friends; therefore they may be more socialized toward help-seeking. Her research used self-report measures from 408 Turkish university students to analyze how perceived social support, gender, and self-concept related to help-seeking attitudes (Koydemir-Özden (2010). Results indicated that women showed a greater sense of relational self, with the tendency to view relationships more positively and a greater willingness to express emotions in an interpersonal context. Of note, Koydemir-Özden found that her female subjects perceived more social support from their

family than did men, which is in possible contrast with Pernice-Duca's (2010) finding that men tended to be more satisfied with social support from their family. Koydemir-Özden also observed that women had more positive attitudes toward seeking psychological help, which additionally supports the previous findings presented by Morgan et al., (2003). Koydemir-Özden found that, overall, both perceived support from family and perceived support from friends had a significant positive relationship with attitudes toward seeking psychological help.

Summary

Overall, the high frequency of client attrition in psychotherapy is a problem that has led to extensive studies on the issue. Due to the vast number of variables that complicate measures of client attendance in psychotherapy, we must carefully consider confounds in the research. Therefore we must carefully consider context when predicting client retention. In recent research, the alliance between client and therapist has emerged as a strong predictor of client retention in therapy (Fearing, 2002; Sharf, 2007), which suggests that other relational and social variables predicting client retention should be explored further.

Current studies on the impact of social support on therapeutic outcomes, like client retention, are complicated due to the multitude of variables that may influence outcomes. Social support's potential to enhance cooperation with healthcare has, however, been identified by findings from a meta-analysis examining the relationship between social support and compliance with non-psychiatric healthcare recommendations (DiMatteo, 2004). Additionally, self-report measures show a strong correlation between perceived social support and attitudes towards seeking help through psychotherapy

(Koydemir-Özden, 2010; Morgan et al., 2003). Finally, as we consider how client social support might be used to predict client attendance in therapy, we must consider how differences in the way men and women are socialized to experience social support and psychotherapy might mean that gender modifies the relationship between these variables.

Hypotheses

Based on the literature on perceived social support and therapeutic outcomes, the current study will examine the following hypothesis:

There is a positive association between social support from friends and family and client attendance in individual therapy.

Additionally, one research question is posed:

Does gender moderate the strength of the relationship between social support and client attendance?

Chapter III Methods

Participants

All clients voluntarily seen for individual therapy at the Center for Healthy Families (CHF) at the University of Maryland, College Park from 2003 to 2007 were included in this study. All clients that attended therapy at the CHF were residents of the Washington, DC metropolitan area. The sample included a diverse range of race, marital statuses, parental statuses, sexual orientations, and socioeconomic statuses. Nonetheless, there were a large number of clients at a lower socio-economic level due to nature of the clinic as a place that offered affordable relationship therapy as a teaching and research facility. The presenting problems were also diverse, and included issues such as depression, anger management, anxiety, and trauma. Clients whose symptoms were so severe that 24-hour on-call assistance must be available were excluded from this study, as the CHF, an out-patient-only facility, was not equipped to provide these services to clients. Additionally, the CHF did not provide therapy for substance users if they were not receiving additional professional help to deal specifically with substance issues. Nor did the CHF provide therapy for patients in need of psychiatric medications who did not allow therapists to communicate regularly with their psychiatrists. Therefore, clients who did not comply with these recommendations were not included in this study. Finally, clients who were court-ordered to therapy were not included in the sample as they are obligated to attend a specified number of sessions.

Of the clients seen as individuals at the CHF, 253 met the criteria for inclusion in this study; 166 were female (65.1%) and 87 were male (34%). The clients' average age was 32, and ages ranged from 14 – 75 years old. Of the clients included in this study,

37.6 % indicated "African American" as their race, 34.9 % indicated "White" as their race, 15.7% indicated "Hispanic" as their race, 3.5% indicated "Asian/Pacific Islander" as their race, .4% indicated "Native-American" as their race, and 7.1% indicated "Other or multiracial" as their race. Levels of education also varied in this population; 32.9% indicated "some college" as their highest level of education, 16.5% indicated "bachelors degree," 15.7% indicated "high school diploma," 9 % indicated "some high school," 8.6% indicated "masters degree," 5.1% indicated "doctoral degree," 4.7 indicated "associate degree," and 1.6 indicated "trade school." Clients' average annual income was $21, 290.50 and ranged from $0 to $90,000; 69.6 % of the population had incomes that fell below $29,000 a year, which was the lowest income bracket; 26.7 % had incomes between $30,000 and $59,000 a year, the mid-range income bracket, and only 2.8% had incomes over $60,000 a year, the highest income bracket.

Procedure

All clients initiated therapy by first calling the CHF. An intake worker gathered information about their presenting problem, demographic information, and income. Clients were quoted a fee based on a sliding scale. Clients were then assigned to a therapist intern or co-therapist team and contacted within the week that they call to set up their first appointment. Therapist interns were either first or second year masters students in the Couple and Family Therapy (CFT) program at the University of Maryland. Clients first attended an assessment session, which was free of charge. At the assessment session, clients met their therapists and briefly discussed the course of therapy. For the remainder of the session they completed packet of questionnaires, in which the measurement for perceived social support from friends (PSS-fr) and the measurement for

perceived social support from family (PSS-fa) were included.

All clients who wished to participate in therapy at the CHF signed an informed consent, allowing their assessment responses to be used in research. Responses to all questionnaires remained confidential, and each case was given a number in order to protect the client's personal identity. Once separated from personal identifiers client responses, along with their numeric identification, were entered into the CHF database.

This study involved a secondary analysis of data previously collected from clients who attended therapy at the CHF. All individual therapy cases were extracted from the CHF data file, which included all responses to the questionnaires given at the first appointment. The case ID number was used to identify each individual case. Within the sample, the variables of gender and scores on the PSS-fr and PSS-fa questionnaire were extracted for analysis. As client attendance records are kept in a separate data file in the clinic, case ID numbers were used to match attendance records with their corresponding data on gender and PSS-fr and PSS-fa. Client attendance was then assessed for its relationship with scores on the PSS-fr and PSS-fa and gender. In order to obtain these data it was necessary for the investigator to view case files to obtain their attendance records. This information is kept in a password-protected software file located within a limited access network. It is clinic policy that all personal information pertaining to clients is destroyed after a sever-year period.

Measures

Independent Variables

There were two independent variables for the current study, social support and gender. Social support was measured with the self-report Perceived Social Support

questionnaire for friends (PSS-fr) and for family (PSS-fa); (Procidano & Heller, 1983).

Both the PSS-fr and the PSS-fa were 20-item questionnaires assessing how clients

perceive the exchange of support between themselves and their friends or family

(Procidano & Heller, 1983). Items were rated using a five-point Likert response scale

(responses to each item range from "very much (5)" like one's friends or family to "not at

all (1)" like one's friends or family (Procidano & Heller, 1983). Scores ranged from 20 –

100 points. Higher scores indicated a greater level of support.

The PSS-fr and PSS-fa questionnaires had no subscales and assessed global

perception of social support. However, the scales assessed three types of social support;

perception of how close one is to one's friends or family (e.g., "Most people are closer to

their friends/family than I am."), perception of how supportive one's friends/family are

when one seeks help (e.g., "I rely on my friends/family for emotional support."), and

perception of how much one's friends/family seek one's help (e.g., "Certain

friends/family come to me when they have a problem or need advice.") (Procidano &

Heller, 1983). The PSS-fr and PSS-fa inventory was reduced from the original 35-item

inventory (Procidano & Heller, 1983). As 20-item scales they continued to show high

internal consistency (Cronbach alphas = .88 and .90, respectively) (Procidano & Heller,

1983). For the current study frequencies were run to determine "Low," "Medium," and

"High" groups for both the PSS-fr and PSS-fa for comparison in an ANOVA. The cut-

off scores for each group were based on distributuion, such that approximately a third of

the sample was in each group .

Gender was recorded as reported by client response to the demographic questionnaire

designed by researchers at the CHF.

Dependent Variable

Client retention was measured as the number of sessions the client attended before termination. Sessions were counted beginning with the first session of therapy after the initial assessment session in which clients met their therapists, signed the informed consent contract, and completed questionnaire packets. Clients who completed phone intakes, but failed to come to their appointment at the CHF were considered "No Contract" cases and not included in the study. Clients who only came to the first assessment session were included in the study and their attendance was counted as zero sessions. Clients who transferred to another therapist upon graduation were included in the sample, and the number of sessions in which they saw each therapist was added together as their total number of sessions. Number of sessions was capped at the span of two years from initial intake to minimize the number of times a client changes therapists. The two-year cap limited the number of times that a client could have changed therapists to no more than once.

Chapter IV: Results

The present study aimed to investigate how perceived social support from family and friends might relate to client attendance. The hypothesis proposed was: *There is a positive association between social support from friends and family and client attendance.* Additionally, a research question was proposed: *Does gender moderate the strength of the relationship between social support and client attendance?*

Primary Analysis

Hypothesis and Research Question:

To examine the hypothesis and the research question two separate, two-way univariate analysis of variance (ANOVA) tests were run for PSS-fr, and PSS-fa. The dependent variable was client attendance. For the first analysis the independent variables were perceived social support from friends (PSS-fr) and gender. The second analysis the independent variables were social support from family (PSS-fa) and gender.

The results of the first ANOVA indicated no main effect for either support from friends $F_{(2, 215)} = .42$ $p = .66$, or gender $F_{(1, 216)} = .00, p = .98$. Additionally, no interaction effect was found for support from friends and gender $F_{(5, 212)} = .57, p = .57$. In other words, perceived social support from friends did not have an impact on client attendance, gender had no impact on client attendance and gender did not significantly moderate the relationship between perceived social support from friends and client attendance. The results of the second ANOVA also indicated no main effect for either support from family $F_{(2, 225)} = .89, p = .41$, or gender, $F_{(1, 224)} = .00, p = .98$. As with the first ANOVA, no interaction effect was found for support for friends and gender, $F_{(5, 222)} = .01, p = .99$. Again, there was no significant relationship between

perceived social support from family and client attendance. Again, gender did not have an impact on client attendance, gender did not significantly moderate the relationship between perceived social support from family and client attendance.

Secondary Analysis

Given the lack of significance for the initial analyses, a secondary analysis was run to test the originally proposed hypothesis and research question. For theses analyses, the truncation of the support variables required to run ANOVA was dropped and the dependent variables were examined in their full range. Three multiple regression analyses were run to examine the effect of each type of support and gender, as well as the interaction between support and gender.

Three regression analyses were run to look at the relationship between the independent variables of social support (PSS-fr, PSS-fa, PSS-total) and gender, and the dependent variable of client attendance. The overall regression model for gender and social support from friends was not significant ($F = .34$, $p < .79$. Results indicated that there was no significant relationship between client attendance and perceived social support by friends, $\beta = .02$, $t (213) =. 30$ $p < .77$. There was also no significant effect of gender on client attendance $\beta = -.23$, $t (213) = -.65$, $p <. 51$. Finally, there was no significant interaction effect between gender and perceived social support from friends on $\beta = .23$, $t (213)= .670$, and $p < .50$.

Also, the overall regression model for gender and social support from family was not significant ($F = .10$, $p < .10$). Results indicated that there was no significant relationship between client attendance and perceived social support from family $\beta =. 02$ $t (223) = .21$ $p < .83$, or gender, $\beta = -.07$, $t (223) = -.28$, $p < .78$. Additionally, there was no

significant interaction effect for gender and perceived social support from family, β = .08, t (223) =. 30, p < .76 on client attendance.

Finally, the overall regression model for gender and total social support from friends and family was not significant (F = .37, p = .78). There was no significant relationship between client attendance and total perceived social support, β = .04, t (205) = .51, p < .61. Likewise, there was no significant relationship between client attendance and gender, β = -.17, t (205) = -.45, and p < .657, and there was no significant interaction effect between gender and total perceived social support, β = .18, t (205) = .48, p < .63.

Chapter V: Discussion

The present study was conducted to test the relationship between client attendance, social support and gender. Using client data from The Center for Healthy Families (CHF), the study failed to find significant results. Prior to discussing why there may not be a significant relationship between social support and retention in therapy for either males or females, it is important to consider the limitations of the present study, which may have contributed to the lack of significant findings. Finally, implications for further research are discussed.

Limitations of the Study

Characteristics of the Sample

It may be important to note that the sample observed in this study is skewed towards low-income clients, as 69.9% made less than $29,000 a year. Wierbicki and Pekarik's (1993) extensive metanalysis, which reflected on over 40 years of psychotherapy research, stated that the most consistent finding in the literature on client retention is that "there is a modest inverse relationship between dropout and social class." Therefore, with a high volume of low-income clients we might expect client attendance in this study to be lower than it would be with a wider range of socioeconomic levels. If client attendance was generally lower, it may have limited the capacity to effectively measure how social support and gender might have impacted client attendance.

Economic accommodations may be an important factor in determining whether or not a client stays in therapy. The economic constraints that low-income clients face make it difficult to consistently attend therapy. The CHF offers affordable rates on a sliding fee scale, however, some clients might find free or cheaper therapy elsewhere. In many

cases our $20 fee is still too steep for some clients, as is the cost of transportation and time. It is important to note that accommodations are often made for clients and fees can be lowered. Usually accommodations rely on additional client factors related to their individual situation and require that clients take the initiative to ask for a fee reduction. It is possible that less assertive clients may terminate therapy due to insufficient funds without expressing their financial constraints. It is also important to note that fee reductions are often attached to contracts for consistent attendance, and thus augment incentives for client attendance.

The population also included more females (65.1%), and more ethnic minorities (64.8%), which are also variables that have previously been studied for their impact on client retention. These characteristics are less important to consider, however, as findings on the impact of gender and minority status on client attendance have been largely inconsistent (Barret et al., 2008).

Therapist Characteristics

The CHF is a teaching and research facility staffed by advanced graduate students who are supervised by licensed therapists. The student status of the therapists may impact the length of time clients stay in therapy. Beginning therapists may not be as skilled at joining with clients as more experienced clinicians. Inadequate joining with clients may create a crucial problem for client retention, as research has shown the client retention often depends on the client's bond with their therapist (Asay & Lambert, 1999, Blow & Sprenkle, 2001; Fearing, 2002). Additionally, the range of skill levels may be highly varied depending on how long the therapist intern has been in the CFT program. Graduate students begin with very little experience and continue to develop their skills

throughout the two-year program. It is common for beginning therapist interns to lose many more clients in their first months of the program and to steadily retain more clients as their skills improve.

Despite their potential limitations for therapeutic outcomes, many other studies have utilized graduate student therapists in research and teaching centers as well, and found significant results related to client attendance (Aubuchon-Endsley & Callahan, 2009; Fearing, 2002). Although therapist inexperience might be seen as a limiting factor it has not been found totally limit any possibility for significant findings on in clinical outcome studies.

Characteristics of the Clinic

A few characteristics of the Center for Healthy Families as a therapeutic clinic may have limited the possibility of significant findings in the present study. Numerous factors go into the administering therapy that in some cases may influence attendance for some clients; clients may find the location and hours inconvenient, some clients may be accommodated on a case-by-case basis. There is only a slight chance, however, that these factors were unique to the CHF and influential enough to limit significant results.

Although the nature of a research and teaching therapeutic clinic involves a variety of factors that may create problems for consistently measuring client attendance, many studies have been conducted in clinics located on university campuses, which likely faced similar limitations (Barret, et al., 2008; Sharf, 2007). These studies indicate that finding significant results in clinical settings similar to the one featured in this study is possible, and that the lack of significant findings cannot solely be attributed the many variables that go into a clinical environment.

Two factors, however, were specific to the CHF. Therefore, their potential impact on client attendance should be considered. The schedule of operation for the CHF in accordance with the University of Maryland and Couple and Family Therapy program schedule interrupted therapeutic progress and may have discouraged clients from continuing therapy. Also, due to the CHF's specialization in relational therapy, preferential scheduling was given for couple and family cases which may have either discouraged individuals from continuing therapy altogether or encouraged individuals to opt for family therapy instead.

The CHF closes periodically throughout the year, in accordance with the program in which the CHF therapist interns are enrolled, Three summer breaks are observed for one week each; one in May, one in July, and one in August. A winter break is observed for two weeks at the end of the year, and a spring break is observed in either the end of March or beginning of April for a week. In some cases, these breaks may have affected the clients' progress in therapy, their continued relationship with the therapist, and/or motivation in therapy, and thus their continued attendance. It is not uncommon for therapist to lose more cases after a break.

Furthermore, as the emphasis of the CHF is on relational work with families and couples, relational cases are given the "prime" time slots after 5pm, and therapists are discouraged from seeing individuals during evening times. The privilege of being scheduled for evening therapy hours as a relational case may affect whether or not a client decides to be seen for individual or relational therapy, and thus bias the population of those we have to study as individuals. In some cases the option of being seen as a relational case at a more convenient time may be the reason a client terminates individual

therapy. It is hard to say how consistent adherence to this policy has been over the years of this study. Again, if individual clients were accommodated on a case-by-case basis, their decision to stay in individual therapy may have been differently influenced by factors other than perceived social support.

Therapy Characteristics

Another problematic issue that emerged in this study was the inability to distinguish clients who terminated individual therapy, yet continued in relational therapy, from individual clients who terminated therapy altogether. As individual data here reviewed, the connection between individual cases and relational cases became apparent. At the CHF it is common for clients to be seen as individuals prior to, in addition to, or after relational therapy. While individual therapy is different and may have different benefits and incentives to attend, it is highly possible that relational therapy affects attendance in individual therapy. Further, because relational therapy addresses issues with clients' social support, clients who participate in relational therapy may be differently affected by social support than clients who solely attend individual therapy.

Data Characteristics

Since attendance records for individuals were not originally considered for inclusion in research at the CHF they were not as closely monitored as other data and accurate attendance information was not easily accessible. A factor that may have hindered the efficacy of this study was that a notable amount of individual client attendance records were missing in the electronic database, and therefore those individual cases had to be thrown out. Most troubling for this study; many transfer cases were missing attendance information. Clients who transferred might have had some of the

higher attendance frequencies and therefore the data might be skewed because so many were thrown out.

Discussion of the Findings

Based on previous findings, it was proposed that social support would impact client attendance similarly to how the client therapist relationship is related to increased client attendance (Fearing, 2002). It was also proposed that the impact of social support on client compliance with healthcare recommendations might be an additional basis for the hypothesis that social support predicts attendance in psychotherapy (DiMatteo, 2004). The evidence that people with higher levels of social support are more likely to report positive attitudes towards seeking psychotherapeutic help additionally supported the hypothesis of this study (Koydemir-Özden, 2010; Morgan, et al., 2003). Despite these previous findings, social support was not found to have any effect on client attendance in the present study.

It was suggested that higher levels of social support might be instrumental in creating the bond between client and therapist that assures greater client retention (Fearing, 2002). We must consider, however, that social skills might not be a prerequisite to bonding in therapy. Therapists are skilled in bonding with a number of personalities and therefore may be more responsible for establishing the bond than their clients. In this case, a clients' level of social competence may not be as important in predicting the strength of this bond.

It was suggested that social support's influence on client compliance in psychotherapy, as indicated through attendance, might be similar to client compliance with physical healthcare recommendations (DiMatteo, 2004). Physical healthcare may be

different enough from psychotherapy, however, that this parallel cannot be drawn. Physical healthcare regimens typically do not require as many meetings with the healthcare provider, such as with a mental health therapist. Physical healthcare regimens typically require more practical or physical effort, such as exercising, taking medications and sticking to a special diet – while these may require effort to continue they may not be as cognitively and emotionally taxing as psychotherapy. Furthermore, some people may view physical healthcare as more important than mental healthcare as the effects on one's physical body may be more salient than psychological effects.

Finally, it was suggested that if higher levels of perceived social support also correlate with more positive attitudes towards help-seeking in psychotherapy, perceived social support might also predict higher levels of attendance in therapy (Koydemir-Özden, 2010; Morgan, et al., 2003). It may be that these reported attitudes towards help-seeking in therapy are not consistent with actual behaviors because they are not strongly held enough to be influential (Ajzen,1991). It may be that people with higher levels of social support are more agreeable in general and are therefore likely to rate many interpersonal activities as more favorable than people with lower levels of social support. It is also possible that those who have higher levels of social support view therapy positively, but may have less of a need for it. Higher levels of social support have been found to correlate with lower levels of depression and lower levels of stress in both men and women (Gadalla, 2009). Lower levels of depression and stress may reduce the need to stay in therapy.

Given this discussion, it is possible that social support may have a slight influence on client attendance in therapy, but its subtle influence is overwhelmed by other factors,

which makes it difficult to detect. As reviewed in the introduction, client attendance often has multiple influences. As numerous studies on client attendance continue to emerge it is becoming clear that simply looking at a few factors at a time does not provide enough breadth and complexity of interaction to find significant results. It is possible that the impact of social support, if there is one, is contingent upon a host of other variables which may include personal characteristics of the client and therapists, the type of problem, and many other factors.

The bioecological model might consider that the complex system(s) of factors that influence client attendance occur within the "chaotic systems" of their lives (Broffenbrenner & Evans, 2000). "Chaotic systems" are defined as systems of interaction "characterized by frenetic energy, lack of structure, unpredictability in everyday activities, and high levels of ambient stimulation," (Brofenbrenner & Evans, 2000, p. 121). We must consider than many clients in therapy live within chaotic systems, therefore we might expect a certain degree of variance for factors that predict client attendance, if any can reliably do so. Factors that might motivate or hinder a client from attending therapy for one session may change by the next session.

Considering the chaos that may emerge out of the multiple systems that influence therapy, we might conclude that social support truly has no significant influence on client attendance. Or perhaps, the relationship between social support and retention is much more varied and nuanced than can be measured through a simple ANOVA or regression analysis. Many therapists anecdotally observe clients choosing to seek therapy because their friends and family encourage them. Therapists may observe social skills in these clients that allow them to be good consumers of therapy, such as willingness to work

collaboratively, conscientiousness, and reliability, are also related to higher levels of social support. While such cooperation may initially predict consistent attendance, this attitude may also be instrumental in producing more rapid therapeutic outcomes and therefore a more rapid termination from therapy. Other therapists observe opposite anecdotal trends and find that many clients stay on in therapy because they lack friends and family to support them. It may not be possible, therefore, to find a consistent pattern in the interaction between social support and client attendance.

On one hand social support increases both emotional resources that aid in therapy, such as motivation and sense of self-efficacy, and instrumental resources, such as transportation and childcare that may make it easier to attend therapy. Paradoxically, however, social support may help a person cope with their mental health issues and effectively decrease their need for psychotherapy. Individuals who enjoy supportive relationships with their friends and family may also prefer to receive informal help from friends rather than receive formal help.

Research indicates that social support from friends and family is actually preferred over therapy for help with stress. Dirks and Mett (2010) found that after traumatic or stressful events people prefer to turn to family and friends over any other type of support. If individuals have high social support it is easier for them to turn to the support that they prefer and the incentive to seek help from other sources may decrease.

Additionally, social support may be influential in different ways at different stages of therapy. If people prefer to turn to their friends when facing a problem (Dirks & Metts, 2010) then it is possible that people who do not have this support will be more likely to begin therapy. Lack of social skills that would allow the person to join with the

therapist may keep them from attending reliably. A person with high social support may be less likely to begin therapy if they have more resources to deal with their problems, but they may be more likely to stay in therapy if they have the social skills and resources for a secure and prolonged attachment with the therapist.

The effect of social support on therapy attendance may also be dependent on the culture of the client. Some cultures may praise therapy and friends and family may advocate for client to continue, Whereas some cultures may discourage it and therefore the more social influences a client has that instill this value, the more likely the client might be to terminate therapy as soon as possible or never pursue it at all. Some cultures may be underrepresented in therapy and may therefore find more comfort in social support to get therapeutic benefits.

Gender was also not found to have a significant influence on client attendance alone, or interaction with social support. The finding that gender does not moderate the influence of social support on client attendance is less surprising, as no research has been found to indicate that social support influences help-seeking and compliance in therapy differently for men and women.

Social support trends, in general, indicate that males report less social support than females and are less appreciated for their ability to provide support (Dirks & Mets, 2010; Koydemir-Özden, 2010; Morgan, et al., 2003). Females are seen as more effective in giving emotional support and therefore are preferred by both genders when seeking support (Dirks & Metts, 2010). Interestingly, the male capacity for providing emotional support has been viewed the opposite way. Researchers who studied subjects from a large Midwestern university found that a significant number of males disbelieve and

disapprove of scenarios where males offer highly sensitive emotional support (Burleson, et al., 2005).

Although, we might not expect gender to modify the relationship between social support and client attendance we should expect females to have higher levels of social support than males based on previous research (Koydemir-Özden, 2010; Morgan, et al., 2003). Data from the CHF was partially congruent with these findings. Two independent samples t-tests were run to assess the differences in means between males and females for PSS-fr and PSS-fa. There was, in fact a significant difference in the mean scores for PSS-fr in females (M = 74.97, SD= 15.79) and PSS-fr in males (M= 70.12, SD= 13.76); t (216)= 2.29, p = .03. In other words, female clients had higher perceived social support from friends than male clients. Perceived social support from family between males and females were not significant, however. There was no significant difference in the mean scores for PSS-fa in females (M=64.66, SD=19.05), and PSS-fa in males (M=65.72, SD=16.76); t (226)=-.42, $p=$. 674. Given the mixed findings for gender differences in social support the question of how gender may mediate the difference in the relationship between social support and client attendance is further complicated. These data seem to suggest that some differences in social support do seem to exist but they are not related to how long individuals stay in therapy. Clearly more research is needed to understand the possible nuances in the relationships among these variables.

Therapy consumption vs. Therapy outcomes

It is important to emphasize that this study attempted to observe patterns in therapy consumption and not therapy outcomes. In other words, this study did not aim to

determine whether high client attendance was beneficial to clients in therapy. In general, research on client retention is often conducted with the goal of increasing client retention due to the pervasive problem of client dropout from therapy before they have participated in enough sessions to show significant improvement. As previously referenced, the effective therapeutic "dose" for at least 57.6% - 67.2% of clients to make significant progress falls around 13 to18 sessions (Hansen et al., 2002). Barret et al., (2008) asserts that most clients drop out before eight sessions as many as 35% drop out before the third session. Brief therapy models, such as the MRI approach suggest that significant improvement can be achieved with even fewer sessions (Duncan, Miller, & Sparks, 2003).

It is possible, that the relationship between length of time in therapy and positive therapeutic outcomes is not constant. It may be that there is a curvilinear relationship between client improvement and client attendance in therapy in that its effectiveness peaks at some moderate point with prolonged attendance being of limited benefit or indicating that the therapy is stalled or ineffective. As with observing patterns in client attendance, determining how much therapy is effective for a client depends on a multiple factors, especially the clients' presenting problem. Other client factors, such as client compliance, motivation, and capacity for change may additionally decrease the need for prolonged therapy.

Future Research

Future research objectives related to this study include finding better ways to track differences in clients solely participating in individual therapy and clients participating in relationship therapy either before, simultaneously, or after individual therapy; assessing

multiple factors that interact to effect client retention; assessing different relationship factors; and distinguishing between the benefits of social support from friends and family and the benefits of the therapeutic relationship.

One of the most complicating factors in this study was that as a relationship oriented clinic, many of the individuals were also seen in relationship therapy. Participation in other therapy may be a strong factor in determining whether therapy is continued. Furthermore, clients who solely participate in individual therapy may share different characteristics than clients who participate in both individual and relational or those who solely participate in relational therapy. Future studies on this topic should more carefully distinguish clients who solely participate in individual therapy from clients who participate, have participated, or plan to participate in relational therapy.

Previous research on client attendance studying only a few factors of influence has been somewhat inconclusive, (Sharf, 2007). Meta-analyses are complicated by differences in definitions, measures, and contexts and therefore it is difficult to make effective comparisons from which to draw significant conclusions. It is also difficult to understand interactions between variables in studies that only look at a few factors and through the meta-analyses that compare these studies. In the future, large-scale studies, which include numerous variables, might benefit our understanding of client attendance because these studies allow for more standardization to decrease spurious variance. The CHF could make use of its large data set to run analyses to identify the numerous variables and interactions that predict client attendance.

Future research on client attendance and attrition might also benefit from a better understanding of the reasons clients give for terminating therapy. Clients who terminate

with the therapist agreement may have different characteristics from clients who dropout of therapy against the therapist's recommendation regardless of the number of sessions they attend. Therefore, in future studies it would be useful to have a more thorough record of clients' reasons for termination, and the therapists' recommendations at the time of termination.

Future research on how relationship factors influence client attendance should look at multiple ways of assessing social support and how the client receives it. Looking at other relationship factors such as attachment security might also help researchers understand how the client might connect with the therapist, and commit to therapy. Additionally, a greater understanding of the clients' social networks and social behavior, such the number of organizations they belong to and how many family members they keep in touch with, may help us better understand clients' actual social resources beyond their self-reported perceptions.

Finally, future research aimed to better understand the influence of social support in therapy should consider where the benefits of social support overlap with the benefits of therapy and where these benefits diverge. So far there has been very little research to compare and contrast formal and informal therapeutic relationships (Barker & Pistrang, 2002). Barker and Pistrang (2002) observed that individuals continue to seek informal support even when they have formal support from therapy. In fact, those who participated in therapy were more likely to seek informal therapy than those who were not (Barker & Pistrang, 2002). Informal therapy may supplement formal therapy, and vice versa. Asay and Lambert (1999) state that as many as 80 % of clients who participate in psychotherapy are better off than those who go untreated. Assuming that

the control group and the test group had equal distributions of social support, these findings suggest that formal therapy provides a special benefit that might not be found informally. Future studies might explore distinguishing characteristics of social support and formal therapy and the potentially unique therapeutic benefits of each.

Overall, the perspective of the CHF faculty supervisors and students is that relationships interact with individual issues. From this perceptive, relationships with others and social support are an essential point of assessment and intervention in therapy, even in individual cases. It is important to know how social support is affecting the individual in therapy in important areas such as their attendance, to their progress, and the implications for these effects. Understanding patterns in social support and client attendance better informs our outreach to clients in need.

If lack of social support deters clients from coming in to therapy or staying in therapy we, as therapists, may need to work to increase social ties with these clients. Therapy is based on the fact that relationships are healing; that interaction and support with others can helps those in need better cope with their struggles. The ultimate therapeutic goal is not be to create a lasting therapeutic relationship but to provide client with tools for lasting intrapersonal support and lasting social support.

SS(Assessment)

Gender: _____   Date of Birth: _____ Therapist Code: _____Family Code: _____

SOCIAL SUPPORT

Directions: The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with **FRIENDS**. When thinking about friends, please do not include family members. For each statement there are five possible answers (1 through 5) ranging from "Yes" to "No." Please check the answer you choose for each item.

<u>Yes</u>   <u>No</u>

1   2   3   4   5

__   __   __   __   __ 1.   My friends give me the moral support I need.

__   __   __   __   __ 2.   Most other people are closer to their friends than I am.

__   __   __   __   __ 3.   My friends enjoy hearing about what I think.

__   __   __   __   __ 4.   Certain friends come to me when they have problems or need advice.

__   __   __   __   __ 5.   I rely on my friends for emotional support.

__   __   __   __   __ 6.   If I felt that one or more of my friends were upset with me, I'd just keep it to myself.

__   __   __   __   __ 7.   I feel that I'm on the fringe in my circle of friends.

__   __   __   __   __ 8.   There is a friend I could go to if I were just feeling down, without feeling funny about it later.

__   __   __   __   __ 9.   My friends and I are very open about what we think about things.

__   __   __   __   __10. My friends are sensitive to my personal needs.

__   __   __   __   __11. My friends come to me for emotional support.

__   __   __   __   __12. My friends are good at helping me solve problems.

__   __   __   __   __13. I have a deep sharing relationship with a number of friends.

— — — — —   14.   My friends get good ideas about how to do things or make things from me.

— — — — —   15.   When I confide in friends, it makes me feel uncomfortable.

— — — — —   16.   My friends seek me out for companionship.

— — — — —   17.   I think that my friends feel that I'm good at helping them solve problems.

— — — — —   18.   I don't have a relationship with a friend that is as intimate as other people's relationships with friends.

— — — — —   19.   I've recently gotten a good idea about how to do something from a friend.

— — — — —   20.   I wish my friends were much different.

Directions: The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with **FAMILIES.** When thinking about family, please do not include friends. For each statement there are five possible answers (1 through 5) ranging from "Yes" to "No". Please check the answer you choose for each item.

<u>Yes</u>   <u>No</u>

1   2   3   4   5

— — — — —   1.   My family gives me the moral support I need.

— — — — —   2.   I get good ideas about how to do things or make things from my family.

— — — — —   3.   When I confide in the members of my family who are closest to me, I get the idea that it makes them uncomfortable.

— — — — —   4.   Most other people are closer to their families than I am.

— — — — —   5.   My family enjoys hearing about what I think.

— — — — —   6.   Members of my family share many of my interests.

— — — — —   7.   Certain members of my family come to me when they have problems or need advice.

— — — — —   8.   I rely on my family for emotional support.

__ __ __ __ __   9.   There is a member of my family I could go to if I were just feeling down, without feeling funny about it later.

__ __ __ __ __   10.   My family and I are very open about what we think about things.

__ __ __ __ __   11.   My family is sensitive to my personal needs.

__ __ __ __ __   12.   Members of my family come to me for emotional support.

__ __ __ __ __   13.   Members of my family are good at helping me solve problems.

__ __ __ __ __   14.   I have a deep sharing relationship with a number of members of my family.

__ __ __ __ __   15.   Members of my family get good ideas about how to do things or make things from me.

__ __ __ __ __   16.   When I confide in members of my family, it makes me uncomfortable.

__ __ __ __ __   17.   Members of my family seek me out for companionship.

__ __ __ __ __   18.   I think that my family feels that I'm good at helping them solve problems.

__ __ __ __ __   19.   I don't have a relationship with a member of my family that is as close as other people's relationships with family members.

__ __ __ __ __   20.   I wish my family were much different.

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