USE OF SOCIAL SUPPORT IN THERAPY AS A FUNCTION OF CLINICIANS' THEORETICAL ORIENTATION, TREATMENT SETTING, AND SELF-PERCEIVED SOCIAL SUPPORT

A Dissertation

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ABSTRACT

Social support serves as a protective factor and a change agent in mental health. Research suggests that social support helps facilitate therapeutic change and reduce client symptomology across numerous presenting concerns. Despite the well-established nature of social support's usefulness in the therapeutic process, no research has explored the degree to which social support interventions are utilized in therapy. Little is known about psychologists' use of support or factors that may impact social support use.

To address this gap in the literature, the present study explored psychologists' use of social support in individual therapy, as well as the relationships among psychologists' use of social support, theoretical orientations, treatment settings, and self-perceived social support. 178 psychologists of various theoretical orientations, treatment settings, and levels of self-perceived support participated in the study. Social support use was measured with a self-report survey. Confirmatory factors analyses of the survey supported a two-factor structure for social support use, with one factor related to the use of interventions involving the teaching of skills/information and the second factor related to the use of interventions involving enacted behaviors and overall application of social support interventions. Descriptive statistics revealed normal distributions of social support use among psychologists for both factors of use, suggesting that social support interventions are not underutilized within the field. Two-way ANOVAs revealed that neither psychologists' theoretical orientation nor treatment setting had a significant

effect on use of social support for both factors. A significant interaction effect between theoretical orientation and primary treatment setting was found for use of enacted interventions and overall application of interventions. Results of simple linear regressions showed that psychologists' perceptions of their own social support did not significantly predict use of social support in individual therapy. However, results of multiple linear regressions showed that when controlling for perceived social support and treatment setting, theoretical orientation appeared to significantly predict use of enacted interventions and overall application of social support interventions. This study provides a valuable initial analysis of psychologists' use of social support in individual therapy. As such, it yields meaningful implications for psychologists, future research, and the field of psychology overall.

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CHAPTER I

INTRODUCTION

Since the 1970s, researchers within the fields of psychology and medical sciences have sought to explore the effects of social support on both physical and mental health. Research has established that social support is linked to a myriad of health benefits, including better immune function, lowered blood pressure, decreased risk for mortality, and increased health promotion behaviors (Hogan, Linden, & Najarian, 2002; Reblin & Uchino, 2008). Social support also serves as a protective factor and change agent in mental health. Numerous studies have cited social support's role as a buffer against stress and psychological responses to stress that are detrimental to well-being across populations, cultural groups, and sources of stress (Cohen & Wills, 1985; Mitchell, Evans, Rees, & Hardy, 2014; Peirce, Frone, Russell, & Cooper, 1996; Wilcox, 1981). Moreover, perception of social support is associated with self-esteem, which may in turn impact mental health and well-being (Brown, Andrews, Harris, Adler, & Bridge, 1986; Lakey & Cohen, 2000). Within the field of psychology, the use of social support in therapy through interventions aimed at enhancing support has been linked to benefits across presenting concerns such as loneliness, depression, substance abuse, eating disorders, low self-esteem, trauma-related stress and anxiety, personality disorders, and schizophrenia (Hogan, Linden, & Najarian, 2002).

Despite the large body of literature demonstrating the benefits of social support and despite its demonstrated value in the therapeutic process, there is limited research on

the use of social support in therapy. Additionally, limited formal training exists for the use of social support interventions. The lack of research on social support use in therapy may point to an area of growth for the field of psychology; it is possible that clinicians may not fully recognize the value and importance of incorporating social support in therapy. Consequently, clinicians may be missing opportunities to enhance their care or to more effectively facilitate therapeutic change. No research has explored the degree to which clinicians utilize interventions aimed at enhancing social support. Moreover, little is known about the ways in which clinician characteristics such as theoretical orientation, treatment setting, and self-perceived social support impact the use of social support in the therapeutic process.

Purpose Statement

The purpose of this study is to explore the relationships among clinicians' use of social support, theoretical orientations, treatment settings, and self-perceived social support. The results of this dissertation will allow for greater understanding of how clinicians utilize social support interventions to facilitate therapeutic change and will contribute to the limited psychological literature on social support use in therapy. Despite the well-established evidence of social support's value and the underpinning of counseling as a social support endeavor, the field has done little to demonstrate how therapists beneficially use social support interventions. The results of this dissertation will also provide insight on factors that impact the utilization of social support and may offer insight into an area of potential growth for the field of psychology.

Research Questions

This study will explore the following research questions:

Research Question 1: To what extent do clinicians employ social support interventions in psychotherapy?

- Hypothesis 1: Clinicians overall will report limited use of social support in psychotherapy.

Research Question 2: Is there a relationship between clinician theoretical orientation and use of social support interventions in therapy?

- Hypothesis 2: Clinicians of different theoretical orientations will differ in their use of social support in therapy.

Research Question 3: Is there a relationship between clinician primary treatment setting and use of social support interventions in therapy?

- Hypothesis 3: Clinicians of different treatment settings will differ in their use of social support in therapy.

Research Question 4: Is there a relationship between clinicians' self-perceived social support and use of social support interventions in therapy?

- Hypothesis 4: Clinicians who have higher self-perceived social support will report greater use of social support interventions in therapy than clinicians who have lower self-perceived social support.

CHAPTER II

LITERATURE REVIEW

Social Support

Researchers have noted that social support is a broad concept, and there does not seem to be a consensus definition of social support. However, since the emergence of social support research in the 1970's, there have been many proposed and interrelated definitions of social support found in the literature. Early definitions of social support present a relatively straightforward understanding of support. For example, Shumaker and Brownell (1984) describe social support as "an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient" (p. 13). Cohen and Syme (1985) define social support as "the resources provided by other persons" which can have a positive or negative effect (p. 4). More recent definitions reflect a more complex understanding of social support that has emerged through years of research, identifying the impact of social support as well as dimensions that may exist within the construct. For example, Saegert & Carpaino (2017) define social support as "the transference of salutary benefits via the presence and content of social relationships that respectively provide the structural and functions elements of social support" (p. 297). Recent literature has also sought to distinguish the construct of social support from related constructs. Gottlieb & Bergen (2010) highlight the differences that exist among social support, social networks, and social integration. They define social support as "the social resources that persons perceive to be available

or that are actually provided to them by nonprofessionals in the context of both formal support groups and informal helping relationships" (p. 512). This differs from social networks, which refer to "a unit of social structure composed of the individual's social ties and the ties among them," and from social integration, which refers to "the extent to which an individual participates in the private and public social interactions" (p. 512). In examining definitions of social support, it is clear that social support is more than merely the presence of relationships. Rather, social support inherently involves the exchange or reception of resources.

Types of Social Support

In general, there are three main types of social support interactions, or types of resources, that appear throughout social support literature: informational support, emotional support, and instrumental support (Barrera, 1986; Goldsmith, 2004; Hogan, Linden, & Najarian, 2002; Lopez & Cooper, 2011; Thoits, 2011). Informational support refers to given information or resources that help in defining, understanding or coping. Informational support may come in the form of advice, suggestions, or access to information (Hogan, Linden, & Najarian, 2002; Lopez & Cooper, 2011). Emotional support, which is sometimes called esteem support, refers to verbal and nonverbal communication of caring, concern, love, respect, approval, encouragement, acceptance, or empathy (Hogan, Linden, & Najarian, 2002). Instrumental support, which is also known as tangible support, refers to aid or assistance that comes in the form of needed services or materials (Hogan, Linden, & Najarian, 2002). Examples of instrumental support include financial support, material resources, assistance in skill acquisition, and

assistance in task completion (Goldsmith, 2004; Lopez & Cooper, 2011). In addition to these three types of support that appear consistently throughout the social support literature, some researchers propose a fourth type of social support known as appraisal support (House, 1981). Appraisal support refers to evaluative feedback given by others (Malecki & Demaray, 2003). Like informational support, appraisal support involves the transmission of information. However, appraisal support differs from informational support, as it involves information that is relevant to social comparison and self-evaluation (House, 1981). While appraisal support has been recognized within the literature, appraisal support is often difficult to define and distinguish from other forms of social support (House, 1981) and does not appear to be as widely accepted as the other three forms of support.

Conceptualizations of Social Support

Just as there is a lack of consensus among researchers about how to define social support, there are many perspectives on how to most appropriately conceptualize social support. Lopez & Cooper (2011) note that despite the lack of consensus, three broad conceptualizations of social support appear throughout the literature: enacted social support, perceived social support, and social connectedness. Recognizing these three conceptualizations is important for the measurement and understanding of social support.

Enacted. Enacted social support, which is also known as actual support or received support, refers to "actual behaviors that people (e.g. family, friends, acquaintances) enact to benefit an individual" (Saegert & Carpiano, 2017, p. 298). In

other words, enacted social support is the actual occurrence of support or supportive behaviors.

Perceived. Perceived social support is defined as "an individual's cognitive appraisal of support" and encompasses an individual's beliefs about the availability and/or the adequacy of social support (Lopez & Cooper, 2011, p. 8). The distinction between perceived social support and enacted social support is meaningful; supportive behaviors may be present even if individuals do not perceive them to be, and individuals may perceive social support that may not actually be present. Some research suggests that perceived support may be more important for health and well-being than enacted support (Hogan, Linden, & Najarian, 2002).

Social connectedness. Social connectedness, which is also known as social embeddedness, refers to:

> the quantity and quality of social ties or interpersonal connections that an individual has with others, including both informal and formal social relationships. Informal relationships often include family members, relatives, friends, neighbors, and others, whereas the more formal relationships may include mental health professionals, physicians, counselors, teachers, clergy members, among others (Lopez & Cooper, 2011, p. 8).

Aspects of Social Support

Social support is comprised of two main aspects or elements: structural aspects and functional aspects. Numerous studies have found that these aspects are different

phenomena; as such, the distinction between the two aspects is important for the investigation and understanding of social support (Thoits, 1995).

Structural. The structural aspects of social support refer to number and pattern or structure of social ties (Gottlieb & Bergen, 2010) and are defined as:

> the organization of people's ties to one another- in particular, to the number of relationships or social roles a person has, to the frequency of his/her contact with various network members, to the density and multiplexity of relationships among network members, and so forth (Thoits, 1995, p. 64).

Examples of structural aspects of social support include the size of an individual's social circle or the number of resources provided to an individual (Hogan, Linden, & Najarian, 2002). Because the structural aspect of social support provides information about the presence of potential sources of social support, it may provide insight into the role of social support in an individual's life.

Functional. Functional aspects of social support refer to the particular functions that interpersonal relationships serve (Cohen, 1988; Freeman, Rees, & Hardy, 2009). Social support can serve several functions and may play many different roles in individuals' lives. For example, social support may "cheer you up, encourage you, give you technical advice, or help you plan practice sessions" (Freeman, Rees, & Hardy, 2009, 187-188). The functional aspects of social support are linked closely to the conceptualizations of social support; the purposes/functions of social support may be intended by those who are offering/enacting support, or they may be perceived by an individual. Functional aspects of social support are also inherently tied to types of social

support, as the function of social support may depend on the type of support. For example, the function of social support may be to provide feelings of belonging and acceptance (emotional support), to provide material aid (instrumental aid) or to provide information (informational support) (Cohen & Syme, 1985).

Social Support Sources

As previously noted, social support can come from both informal and formal relationships. Informal sources of social support are often thought of as "natural support systems" (Hogan, Linden, & Najarian, 2002, p. 382), while formal sources of social support generally relate to professional or group support. In general, informal sources of support are family, friends, and significant others. Formal support networks include medical professionals, support groups, clubs, or religious groups (Hogan, Linden, & Najarian, 2002). Research notes that it is unclear whether one source of support is better than the other (Hogan, Linden, & Najarian, 2002). However, many existing measures of social support evaluate only informal social support.

Impacts of Social Support on Health

The impacts of social support on health have been of great interest to researchers, physicians, and psychologists throughout the past several decades. There are several existing theories for how social support relates to and influences health. As previously noted, social support can have positive or negative effects. Overwhelmingly, research reveals that social support influences both mental and physical health. The presence and perception of meaningful social support are associated with numerous health benefits across both domains.

Theoretical perspectives. Before exploring the benefits of social support, it is first necessary to understand the theoretical perspectives of social support's influence on health. In general, there are three main perspectives present within the literature that seek to explain the relationship between social support and health.

Stress and coping perspective. The stress and coping perspective emphasizes the role of social support as a protective factor against stress, positively influencing health (Lakey & Cohen, 2000). This perspective highlights what is known as the buffering hypothesis or buffering model, which suggests that support serves as a buffer against the adverse effects of stress. Social support impacts health either through the supportive actions of others, which promote coping, or through belief that social support is available, which promotes fewer negative appraisals of stress (Lakey & Cohen, 2000). In this way, the stress and coping perspective recognizes the role of both enacted and perceived social support.

Social constructionist perspective. The social constructionist perspective consists of theories of social cognition and symbolic interactionism. This perspective suggests that "support directly influences health by promoting self-esteem and self-regulation, regardless of the presence of stress" (Lakey & Cohen, 2000). The social cognitive element of the social constructionist perspective proposes that the perception of social support (i.e. perceived support) can lead directly to health benefits and that perceived support enhances self-esteem, which in turn impacts health. When individuals perceive emotional, instrumental, or informational support, they are likely to develop more positive self-evaluations and self-beliefs that contribute to their self-esteem.

Enhanced self-esteem can lead to several health benefits, including reduced emotional distress and reduced negative emotion (Lakey & Cohen, 2000). According to the symbolic interactionism element of the social constructionist perspective, regular social support promotes health directly through regular social interaction. An individual's social interactions and social roles allow for the development of a sense of identity and self-concept. This may include personal identity, identity as a member of a group, identity as a relational partner, or identity within certain roles. One's sense of identity may enhance one's self-regulation and behavior. Moreover, social interactions themselves may influence self-regulation and behavior as individuals compare their behaviors to those of their interaction partners or groups. In this way, social support may enhance health promoting behaviors. For example, if individuals perceive themselves as healthy people, they may be more likely to engage in behaviors that reflect this identity, such as exercise or mindfulness. Moreover, individuals may be likely to engage in health promoting behaviors that are similar to those of other individuals, such as scheduling doctor visits (Lakey & Cohen, 2000).

One of the most important differences between the social constructionist perspective and the stress and coping perspective is that the social constructionist perspective emphasizes the main-effect model of support instead of the buffering model. The main-effect model proposes that social support has directly beneficial impacts on health. The main-effect model differs from the buffering model, as it claims that social support is helpful "irrespective of whether persons are under stress" (Cohen & Wills, 1985).

Relationship perspective. In the relationship perspective, which also emphasizes the main-effect model, social support enhances health through a variety of relational processes or relationship qualities. Qualities such as companionship, relationship satisfaction, low conflict, and attachment have positive implications for health, although there are several hypotheses for why these qualities may be beneficial. One such hypothesis is that these relationship qualities fulfill the basic psychological human need for connectedness and the basic biological need for survival (Lakey & Cohen, 2000).

Health benefits. The benefits of social support for health have been well-documented throughout social support literature. Social support enhances physical health across a variety of illnesses or health concerns, aids in rehabilitation after illness or injury, and serves as a physical health protective factor. Social support also has strong benefits for mental health, well-being, and coping. Contrastingly, negative relationships or lack of social support are often associated with negative physical and mental health outcomes. Due to the vast amount of research on the effects of social support on health, a brief overview of both physical and mental health benefits is provided.

Physical health benefits. Social support has a myriad of physical health benefits. For example, strong social support has been associated with superior overall health in populations of college students, unemployed workers, new mothers, widows, and parents of children with serious medical issues (Ozbay et al., 2007). Social support is also associated with life expectancy. In fact, research posits that "the effect of social support on life expectancy appears to be as strong as the effects of obesity, cigarette smoking, hypertension, or level of physical activity" (Ozbay et al., 2007, p. 38). Whereas the

presence of social support increases life expectancy, lack of social support has been associated with higher morbidity and mortality rates in individuals with ischemic heart disease, cerebral vascular disease, cancer, and numerous other diseases (Ozbay et al., 2007). Social support is linked to lower blood pressure, better immune function, and enhanced recovery from illness or injury. Moreover, social support enhances health maintenance behaviors and promotes healthy behaviors such as compliance with prescription medication and smoking cessation (Brownell & Shumaker, 1984; Zimet et al., 1988).

Mental health benefits. Social support yields many mental health benefits. One of the primary benefits of social support is its impact on stress. Social support reduces stress, serves as a buffer against stress, and improves coping and resiliency (McCormack et al., 2015). Social support also reduces psychological distress and decreases functional impairment in individuals with depression (Thoits, 2011). Poor social support or lack of support is associated with the onset of depression and with comorbidity of depression in individuals with physical illnesses (Ozbay et al., 2007). The presence and perception of social support reduces burnout and enhances engagement (McCormack et al., 2015). Additionally, social support enhances mattering, self-esteem, mastering, feelings of control, and belongingness. Through these enhancements, social support has been associated with increased life satisfaction and happiness and with lower symptoms of anxiety, depression, and distress (Thoits, 2011). Overall, social support serves as a protective factor and change agent in mental health and is beneficial to psychological well-being.

Social Support Measurement

Social support can be measured and explored in a variety of ways because there are many types, aspects, conceptualizations, and sources of support. Even early research on social support recognized that

> instruments differ on multiple dimensions, including whether they asses (1) structure or function, (2) subjective or objective support, (3) availability or adequacy of support, (4) individual structures or functions global indices, (5) several individual structures or functions versus simply one, (6) the role of persons providing support or simply whether support is available, and (7) the number of persons available to provide support or simply the availability of support irrespective of the number of people (Cohen & Syme, 1985, p. 15).

Barrera (1986) further identified that social support measures may vary depending upon the sources of support, types of support, and perception of support. As social support research has expanded, even more complexities and aspects of support have been included in social support assessment. For example, Gottlieb & Bergen (2010) identify that research methods differ based upon whether a researcher is seeking to explore the quantitative or quantitative adequacy of support. Quantitative adequacy refers to the amount of support received while qualitative adequacy refers to aspects about the quality of support, such as "manner and covert message associated with its delivery" (Gottlieb & Bergen, 2010, p. 512). Research measures may also differ based upon bidirectionality or unidirectionality of support (Gottlieb & Bergen, 2010).

Throughout the past several decades, researchers have developed numerous instruments to assess social support. Measures exist to assess support for different populations, relationships, cultural and age groups, health concerns, and research questions. Due to the exceedingly large number of psychometrically sound instruments for assessing social support, it would be beyond the scope of this literature review to explore all instruments or even to create an exhaustive list of social support scales and surveys. However, it is important to highlight commonalities that exist among many social support measures. For example, the vast majority of social support measures are self-report scales, surveys, or interviews (Gottlieb & Bergen, 2010). Social support measures tend to explore either received support or perceived support, and many assess both the functional and structural sources of support. While most social support measures consist of self-report scales or questionnaires, researchers may also assess social support through alternative measures, such as observational coding or daily dairy methodology (Gottlieb & Bergen, 2010).

Social Support Use in Therapy

Within the field of psychology, evidence suggests that the use of social support in therapy can help to facilitate therapeutic change and to reduce client symptomology (Hogan, Linden, & Najarian, 2002; Pearson, 1986). Social support has been associated with benefits across presenting concerns, and it can prove to be a useful tool in therapy. There are many types of social support interventions that psychologists can utilize in therapy. In general, social support interventions can be categorized in the following ways: (a) treatment format, (b) targeted source and (c) focus of intervention.

Treatment format. Social support interventions can be employed in a group or individual treatment format. In other words, social support interventions are useful in both individual counseling and group counseling. Research indicates that it is unclear whether one treatment format is more effective than the other (Hogan, Linden, & Najarian, 2002).

Targeted source. While all social support interventions seek to enhance the well-being of the client and to facilitate therapeutic change, the target of social support interventions may vary. For example, interventions may target clients' naturally occurring support systems, such as the client's family, friends, or significant others (Hogan, Linden, & Najarian, 2002). Support interventions may also target groups, peers, or individuals outside of clients' natural support systems. Finally, social support interventions may target the clients themselves.

Focus of intervention. Social support interventions can be further categorized by their foci. The focus of an intervention is closely tied to the categorizations of social support (Hogan, Linden, & Najarian, 2002); interventions can focus on enhancing enacted support, perceived support, or social connectedness.

Enacted support. Interventions aimed at enhancing enacted support seek to increase the emotional, instrumental, and informational support that a client receives. Psychologists can aim to enhance enacted support in a variety of ways. For example, psychologists can seek to enhance enacted support by including family members, friends, and significant others in therapy. Psychologists can also increase enacted support through behavioral training of family, friends, or significant others (Hogan,

Linden, & Najarian, 2002). Psychologists can refer clients to groups (such as support groups, therapy groups, and social groups) or encourage involvement in groups to increase enacted support from their peers. Additionally, psychologists may employ social skills training, including the teaching and rehearsal of social skills, assertiveness training, or training in conflict resolution (Hogan, Linden, & Najarian, 2002); these types of interventions may lead to the development and enhancement of relationships in a way that increases enacted support.

Perceived support. Interventions aimed at enhancing perceived social support seek to increase clients' awareness or appraisal of support. Examples of interventions aimed at enhancing perceived support include cognitive reframing, activities such as reflective journaling, and psychoeducation on about the importance and benefits of social support (Hogan, Linden, & Najarian, 2002).

Social connectedness. Interventions aimed at enhancing social support through social connectedness seek to produce changes in the quantity and quality of a client's social ties or interpersonal connections. In many cases, these interventions target an individual's naturally occurring support system (Hogan, Linden, & Najarian, 2002). However, interventions may also focus on helping clients to build new social ties. Social support interventions that seek to enhance social connectedness include social skills training, assertiveness training, and training in conflict resolution. Additionally, psychologists may enhance social connectedness by encouraging clients to build new social relationships through community involvement; online groups, forums, or chats; church or religious groups; or special interest groups.

Impact of social support interventions. The use of social support in therapy has been associated with benefits across presenting concerns such as loneliness, depression, substance abuse, eating disorders, low self-esteem, trauma-related stress and anxiety, personality disorders, and schizophrenia (Hogan, Linden, & Najarian, 2002). In a meta-analysis of 92 studies, 73 studies (or 83% of studies) reported benefits of social support interventions when compared to no-treatment or control treatment conditions (Hogan, Linden, & Najarian, 2002). While one type of social support intervention was not found to be most effective across presenting concerns and while many studies included in the meta-analysis had a small sample size, researchers concluded that "different forms of support interventions generally produced encouraging results" (p. 425).

Question of Use

It is clear that social support has many benefits for health. Use of social support in therapy has proven to be effective in enhancing client well-being across a variety of presenting concerns. However, there is a limited amount of research on the use of social support interventions in therapy, and little formal training on use of social support exists for psychologists. Moreover, there is currently no research exploring the degree to which clinicians utilize social support interventions aimed at enhancing support in therapy. This gap in the literature is important to address, as it may point to an area of growth for the field of psychology. It is possible that psychologists may be underutilizing this resource for enhancing care and facilitating therapeutic change. Exploring the degree to which social support interventions are used in therapy could lead to greater

understanding of psychologists' awareness and perception of this tool for change, and it could also lead to advancements in the field of psychology.

CHAPTER III

METHODS

Study Variables

Variables for the present study include psychologists' theoretical orientation, treatment setting, self-perceived social support, and use of social support in individual therapy. Each of the aforementioned variables are defined below.

Theoretical orientation. A psychologist's theoretical orientation can be defined as the "conceptual framework used by a counselor to understand client therapeutic needs" (Poznanski & McLennan, 1995, p. 412). In general, theoretical orientation can be thought of as a psychologist's way of understanding human behavior, therapeutic change, and the therapeutic process. Theoretical orientations guide clinicians in understanding their clients' concerns, in identifying how to assist clients, and in determining how to best relate to clients to bring about change (Jones-Smith, 2012). Theoretical orientations inform case conceptualization, evaluation of the therapeutic process, treatment goals, and therapeutic interventions and techniques (Ogunfowora & Drapeau, 2008; Prochaska & Norcross, 1983; Poznanski & McLennan, 1995). Theoretical orientations also guide psychologists in determining which human capacities and experiences will be explored in therapy and which will be reduced in importance (Jones-Smith, 2012). A psychologist's theoretical orientation can greatly impact practice. Consequently, it is possible that use of social support in therapy may be impacted by clinician theoretical orientation.

Many types of theoretical orientations have been identified and explored throughout the literature. Researchers estimate that there are over 250 theoretical orientations or therapy models (Jones-Smith, 2012). Examples of theoretical orientations include Cognitive-Behavioral, Psychodynamic/Psychoanalytic, Feminist, Multicultural, Existential, Humanistic, Person-Centered/Rogerian, Systems, Gestalt, Interpersonal, and Eclectic/Integrative. Each theoretical orientation carries its own set of defining features and unique philosophies about human nature, development, change, and the therapeutic process.

Research has identified that Cognitive-Behavioral, Psychodynamic/Psychoanalytic, and Eclectic/Integrative are three of the most common theoretical orientations among clinical and counseling psychologists (Prochaska & Norcross, 2013). As the present study compares social support use among clinicians of these common orientations, it is meaningful to understand the defining features of these orientations. Thus, a brief overview of each orientation is provided.

Cognitive-Behavioral. Cognitive-Behavioral theory is one of the most widely used and strongly empirically supported theoretical orientations. Cognitive-Behavioral theory is rooted in elements of both behavior therapy and cognitive therapy and is often viewed as a merging of the two (Hupp, Reitman, & Jewell, 2008). Cognitive-Behavioral theory is based upon the belief that a person's cognitions (including meanings, judgments, appraisals, and assumptions) contribute markedly to the development and maintenance of emotional and behavioral responses (González-Prendes & Resko, 2012). Research suggests that there are three primary assumptions of Cognitive-Behavioral

theory: (a) clients are able to become aware of their thoughts and thought processes; (b) the way that clients think impacts the way that they respond to their environments; and (c) clients' thoughts can be intentionally identified and changed (Dobson & Dobson, 2009; Dobson & Dozois, 2001; González-Prendes & Resko, 2012). Psychopathology is viewed as the result of deficits, excesses, or inappropriateness in cognitions (Prochaska & Norcross, 2013). In Cognitive-Behavioral therapy, psychologists work with their clients to develop more rational and realistic cognitions to achieve therapeutic change (González-Prendes & Resko, 2012).

Psychodynamic/Psychoanalytic. Psychodynamic and Psychoanalytic theories are rooted in the work of psychologist Sigmund Freud. While there are some basic differences between these two theories (Jones-Smith, 2014), they share many important common elements. For this reason, these two theories are often grouped together (Jones-Smith, 2014). These theories posit that human behavior is predominantly due to unconscious contents, beliefs, and processes (Barber & Solomonov, 2016; Jones-Smith, 2012). Psychodynamic and Psychoanalytic theories emphasize the roles of a personality structure consisting of the id, ego, and superego. Psychopathology can be thought of as the result of conflicting desires, wishes, or thoughts among these elements of personality (Barber & Solomonov, 2016). Moreover, these theories emphasize the roles of needs and of early childhood experiences and relationships in personality development. One of the main goals of Psychodynamic and Psychoanalytic therapies is to help clients gain awareness and understanding of their behaviors, emotions, and thoughts through the context of their pasts (Barber & Solomonov, 2016). To this end, psychologists of

Psychodynamic/Psychoanalytic theory may employ treatment techniques originally established by Freud, including free association and interpretation, analysis of transference, analysis of resistance, or dream therapy (Jones-Smith, 2014). It is meaningful to note that many of these interventions have a strong focus on the individual, emphasizing and exploring the client herself.

Eclectic/Integrative. Psychologists who identify primarily with an Eclectic/Integrative theoretical orientation combine elements of many theories and counseling techniques to form their own unique approaches to counseling. Eclectic/Integrative theoretical orientation is rooted in the belief that no one theoretical orientation is appropriate and accurate for all clients (Jones-Smith, 2012). Consequently, psychologists of this approach work to understand the principles of numerous theories and to identify elements of these theories that are relevant to their understanding of change. Research suggests that Eclectic/Integrative theoretical orientation is also based on the notion that the therapeutic alliance and clients' beliefs are more important than specific interventions or theoretical techniques (Jones-Smith, 2012). Thus, in therapy, an Eclectic/Integrative psychologist applies interventions from a variety of theories to most effectively meet a clients' needs while working to develop a strong therapeutic alliance with her clients.

Treatment setting. Treatment setting refers to the type of agency in which a psychologist works. Psychologists can work in numerous different settings, and many psychologists are employed by more than one agency. The American Psychological Association (APA) Center for Workforce Studies identifies common treatment settings

in which psychologists serve including universities/college counseling clinics, schools, hospitals, Veterans Affairs medical centers, community mental health clinics, jails/criminal justice systems, medical clinics, private practices, intensive outpatient programs, and rehabilitation facilities (Michalski, Kohout, Wicherski, & Hart, 2011). Within certain treatment settings, the use of social support in therapy may be emphasized, and it is possible that the use of social support may vary across treatment settings. For example, the use and impact of social support in therapy within rehabilitation facilities, hospitals, and medical clinics has been well-documented throughout the literature. However, literature exploring social support use in other treatment settings is fairly limited.

Clinician self-perceived social support. Clinician self-perceived social support refers to clinicians' perceptions of the social support that they receive. It is possible that perception of one's own social support may impact the degree to which social support interventions are utilized in therapy. If clinicians perceive high levels of personal social support, they may have a heightened awareness of social support itself and, consequently, may be more likely to utilize social support in therapy. Moreover, if clinicians perceive higher levels of social support, they may be more aware of the impact and benefits of social support. This may, in turn, influence their use of social support interventions.

Use of social support. For the purposes of this study, use of social support refers to clinicians' self-reported utilization of social support interventions in individual therapy. As previously noted, social support interventions are those seek to enhance

social support. They may seek to enhance enacted support, perceived support, or social connectedness. While research has demonstrated the benefits of the use of social support interventions in therapy, no research explores the degree to which social support interventions are employed in therapy. Moreover, few training program or resources for psychologists explore how to effectively implement social support interventions or how to use social support in therapy. It is possible that the overall use of social support interventions is low and that social support may be underutilized within psychotherapy.

Procedure

To be considered for participation in this study, potential participants must have a doctoral degree in a psychology-related field and must currently practice individual psychotherapy. Participants were recruited from membership databases of the American Psychological Association (APA), Texas Psychological Association (TPA), and Brazos Valley Psychological Association, as well as through the electronic mailing lists for APA Division 17 (Society of Counseling Psychology), Division 22 (Division of Rehabilitation Psychology), Division 35 (Society for the Psychology of Women), Division 36 (Society for the Psychology of Religion and Spirituality), Division 43 (Society for Couple and Family Psychology), and Division 50 (Addiction Psychology). These divisions were selected because they have electronic listservs that allow for the solicitation of research participants. Participants were also recruited from several community mental health centers, hospitals, medical centers, university counseling clinics, and jails/correctional facilities across the United States. A total of 205 agencies

were contacted. Of the 205 agencies, 80 agencies agreed to participate. A list of participating sites can be found in Appendix A.

Following approval from the Institutional Review Board at Texas A&M University (IRB Number: IRB2017-0557M), emails were utilized to recruit participants. The recruitment email utilized for this study can be found in Appendix B. Recruitment emails included information about the purpose of the study and the informed consent process. The recruitment emails noted that participation was voluntary and that all participants would remain anonymous. Potential participants were notified that in exchange for their participation, they had the opportunity to be entered into a random drawing for one $50 donation to the charity of their choice. Emails contained a link to an informed consent document, which can be found in Appendix C, and to a self-administered questionnaire containing all measures for the study, including a demographic questionnaire, a survey for social support use, and the multidimensional scale for perceived social support. Questionnaires were facilitated via Qualtrics, a web-based data collection tool. Data collection lasted for approximately 10 weeks.

Participants

A total of 199 responses were recorded. Of the 199 responses, 21 responses were incomplete and did not contain ample information for analysis, as participants did not provide information on social support use in therapy. Because social support use in therapy was the construct of interest for this study, these responses were not used in analysis. Therefore, 178 participants were included in the study. Participants ranged in age from 26 to 83 (M= 41.04; SD=12.139). Most participants were Female (66.3%),

with a smaller portion of participants identifying as Male (33.1%) or Other (0.6%). The sample consisted primarily of White/European psychologists (80.3%), followed by African American/Black/African (5.6%), Latino/a (5.6%), Asian American/Asian/Pacific Islander (3.4%), Other (2.9%), and Biracial/Multicultural (2.2%) psychologists. Most participants obtained a doctoral degree in clinical psychology (65.2%), followed by counseling psychology (25.5%), other psychology-related fields such as forensic psychology, neuropsychology, and rehabilitation psychology (5.1%), and school psychology (4.5%).

The sample consisted largely of psychologists who identify primarily with an Eclectic/Integrative theoretical orientation (42.7%), followed by Cognitive-Behavioral theoretical orientation (38.8%) and Psychodynamic/Psychoanalytic theoretical orientation (10.6%). The remaining participants (7.9%) identified primarily with "Other" theoretical orientations, including Feminist-Multicultural, Humanistic, Person-Centered, Interpersonal, Emotion-Focused, and Existential. The sample represented a variety of treatment settings including Hospitals/Medical Facilities (24.2%), Jail/Criminal Justice Systems (22.5%), University/College Counseling Centers (22.5%), and Community Mental Health Facilities (13.5%). The remaining participants (17.4%) endorsed that they worked primarily in "Other" treatment settings, including private practices, a forensic hospital, an air force intelligence agency, and an inpatient treatment setting. Most participants of "Other" treatment settings worked in private practices (80.65%).

A summary of participants' demographic information can be found in Table 1. Because the interaction effects between theoretical orientation and treatment setting on

use of social support were explored in several analyses of the study, it is meaningful to consider the number of psychologists of each theoretical orientation in each treatment setting. A summary of this information can be found in Table 2.

Demographic Variable	N	%
Age		
26 – 30	34	19.1
31 – 40	72	40.5
41 – 50	32	17.9
51 – 60	26	14.6
≥ 61	14	7.9
Race/Ethnicity		
African American/Black/African	10	5.6
Asian American/Asian/Pacific Islander	6	3.4
Latino/a	10	5.6
White/European	143	80.3
Biracial/Multiracial	4	2.2
Other	5	2.9
Field of Study		
Clinical	116	65.2
Counseling	45	25.2
School	8	4.5
Other	9	5.1

Table 1. Participant Demographics

Demographic Variable	N	%
Theoretical Orientation		
Cognitive-Behavioral	69	38.8
Psychodynamic/ Psychoanalytic	19	10.6
Eclectic/Integrative	76	42.7
Other	14	7.9
Treatment Setting		
Community Mental Health	24	13.5
Hospital/Medical Facility	43	24.2
Jail/Criminal Justice System	40	22.5
University/College Counseling Center	40	22.5
Other	31	17.4

Table 1. Continued

	N	% of Total Sample
Cognitive Behavioral		
Community Mental Health	6	3.37
Hospital/Medical Facility	24	13.48
Jail/Criminal Justice System	22	12.36
University/College Counseling Center	8	4.49
Other	9	5.06
Psychodynamic/Psychoanalytic		
Community Mental Health	2	1.12
Hospital/Medical Facility	2	1.12
Jail/Criminal Justice System	3	1.69
University/College Counseling Center	3	1.69
Other	9	5.06
Eclectic/Integrative		
Community Mental Health	13	7.3
Hospital/Medical Facility	16	8.99
Jail/Criminal Justice System	14	7.87
University/College Counseling Center	22	12.36
Other	11	6.18

Table 2. Theoretical Orientation by Treatment Setting

	N	% of Total Sample
Other		
Community Mental Health	3	1.69
Hospital/Medical Facility	1	0.56
Jail/Criminal Justice System	1	0.56
University/College Counseling Center	7	3.93
Other	2	1.12

Table 2. Continued

Measures

Demographic questionnaire. Participants were asked to complete a brief demographic questionnaire in which they identified their age, gender, race, field of study, theoretical orientation with which they most identify, and primary treatment setting. Choice options for theoretical orientation and primary treatment setting reflected the main orientations and settings identified throughout the literature (Michalski, Kohout, Wicherski, & Hart, 2011; Prochaska & Norcross, 2013). A copy of the demographic questionnaire can be found in Appendix D.

Survey for use of social support. A thorough review of the literature on social support, use of social support, and social support interventions revealed that prior to this study, there were no instruments to measure the use of social support/social support

interventions in therapy. Throughout psychology literature, in the absence of psychometrically validated instruments, surveys are frequently utilized to assess constructs of interest. It is meaningful to note that surveys are distinct from scales, which require validation and psychometric studies for use. To evaluate the use of social support in individual therapy, a survey instrument was created. This survey can be found in Appendix E.

Items were developed to reflect existing literature on the use of social support interventions and to account for the many ways that social support may be used in therapy. For example, items reflected the multiple targeted sources of social support interventions such as the clients themselves and clients' naturally occurring support systems. Items also reflected the use of interventions aimed at enhancing enacted support, perceived support, and social connectedness. Survey structure was modeled after existing surveys that measure the use of specific interventions in therapy (e.g. Becker, Zayfert, & Anderson, 2004; McGovern et al., 2004).

An initial group of 30 items was developed. These 30 items were reviewed by Dr. Charles Ridley and by Dr. Eunkyeng Baek of Texas A&M University for content and understandability. Based upon feedback from Dr. Ridley and Dr. Baek, survey items were revised, and several items were deleted. The final survey consisted of 12 items to most effectively address social support use in therapy without redundancy. The number of items was also selected in an effort to maintain high response rate throughout the survey.

Items were rated via self-report using a 5-point Likert scale with the following anchors: 1 (rarely or never), 2 (sometimes but not often), 3 (often but not most of the time), 4 (most of the time), 5 (almost always or always).

Multidimensional scale of perceived social support. Psychologists' perception of their own social support was assessed using the Multidimensional Scale of Perceived Social Support (MSPSS), which can be found in Appendix F. The MSPSS is a 12 item, self-administered assessment designed to measure the perception of social support availability and adequacy from friends, family, and significant others. Items of the MSPSS utilize a 7-point Likert scale ranging from (1) very strongly disagree to (7) very strongly agree. The MSPSS yields a total score as the average of all responses. The instrument also yields a friends subscale score, a family subscale score, and a significant other subscale score (Zimet et al., 1988). Higher scores indicate higher levels of perceived support. For this study, the MSPSS total score was used.

The MSPSS has been found to be psychometrically sound and to have good reliability and validity (Zimet et al., 1988). Across studies with diverse samples, internal reliability of total scores and subscales was consistently >=0.85 (Lopez & Cooper, 2011). Test-retest reliabilities ranged from 0.72-0.85 at 2-3 months for the total scores and subscales (Zimet et al., 1988). Moreover, factor analyses support the 3-factor structure of the instrument (Lopez & Cooper, 2011). Construct validity has been established, as the total score has been significantly and negatively correlated with depression scores and a social support behavior scale (Kazarian & McCabe, 1991; Lopez & Cooper, 2011; Zimet et al., 1988). Concurrent validity has also been established in

respect to the Social Support Behaviors Scale, another measure of social support (Kazarian & McCabe, 1991; Lopez & Cooper, 2011).

As previously noted, the MSPSS has been found to be psychometrically sound across populations. This instrument is free to use, and researchers have utilized the instrument to assess the social support of helping professions in several studies. For example, Ben-Zur & Michael (2007) utilized the MSPSS to assess the social support of psychologists, social workers, and nurses. Therefore, the MSPSS is an appropriate tool for assessing social support for the sample of this study.

Data Analysis

The survey of social support use was initially examined. A confirmatory factor analysis (CFA) was conducted in Mplus 8.1 to analyze the dimensionality of the survey items with a hypothesis of a unidimensional factor structure. Poorly loaded items were removed. Given adequate fit of the data, a total score for social support use in therapy was obtained by summing the score of all remaining items.

To explore Hypothesis 1, which stated that clinicians overall would report limited use of social support in psychotherapy, descriptive statistics were used to examine the distribution of social support use total scores, along with a histogram to visually analyze the distribution. Descriptive statistics were found utilizing SPSS 21. A limited use of social support would result in a positively skewed distribution of total scores; thus, the researcher expected to obtain a skewness statistic of <0.5.

Hypotheses 2 and 3 addressed the impact of theoretical orientation and treatment setting on use of social support in therapy. As noted, Hypothesis 2 proposed that

clinicians with different theoretical orientations would differ in their social support use in therapy. Hypothesis 3 stated that clinicians of different primary treatment settings would differ in their use of social support in therapy. To address Hypothesis 2 and Hypothesis 3, two-way ANOVAs were conducted utilizing SPSS 21.

Hypothesis 4 postulated that clinicians who have higher self-perceived social support would report greater use of social support interventions in therapy than clinicians who have lower self-perceived social support. To address Hypothesis 4, simple linear regressions were conducted with perceived social support as the predictor. Multiple linear regressions were then conducted with perceived social support, theoretical orientation, and treatment setting as predictors. Dummy coding was utilized in the multiple linear regressions for both theoretical orientation and treatment setting, as these are categorical variables. For the variable of theoretical orientation, Psychodynamic/Psychoanalytic theoretical orientation was coded as 1 with all remaining theoretical orientations coded as 0. Similarly, for the variable of treatment setting, University/College Counseling Center was coded as 1 with all remaining treatment settings coded as 0. Figure 1 displays a conceptual diagram of the relationships tested through Hypotheses 2, 3, and 4.

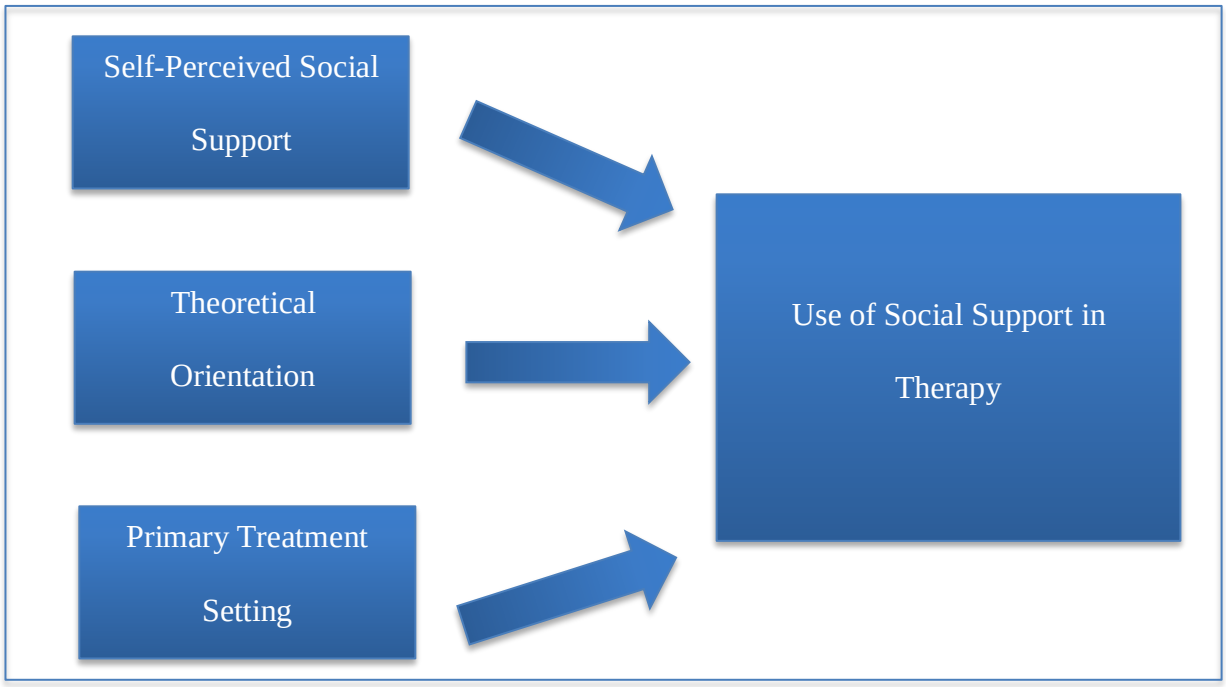

Figure 1. Conceptual diagram of relationships tested by Hypotheses 2, 3, and 4.

CHAPTER IV

RESULTS

The 12-item survey for use of social support was initially examined. Inter-item correlations, presented in Table 3, revealed that all 12 items correlated with at least one other item. However, while Items 1 and 2 strongly correlated with one another, these two items did not correlate strongly with other items. In reviewing the items, the researcher observed that these two items likely did not correlate well with other items because they relate to a different target of social support inventions than do the others 10 items of the survey. As noted in the literature review of this study, social support interventions may target clients' support systems or the clients themselves. While Items 3-12 evaluated the use of social support interventions targeted at the client, Items 1 and 2 evaluated the use of social support interventions targeted at the client's naturally occurring support system. Consequently, these two items were removed.

A confirmatory factor analysis (CFA) was conducted using the remaining 10 items to determine if the proposed one factor solution for the survey was adequate. The determination of model fit was based on a comparison of Chi-Square (χ^2), Comparative Fit Index (CFI), Root Mean Square Error of Approximation (RMSEA), and Standardized Root Mean Square Residual (SRMR) fit indices. The initial one factor solution did not obtain good fit [$\chi^2(35) = 164.056$, $p < .001$, CFI = .84, RMSEA = .14, SRMR = .06]. Items were reviewed, and a two-factor structure of social support use was proposed, as the researcher noted that Items 7, 8, 9, and 10 related to social support interventions in

which skills or information is taught to the client, while Items 3, 4, 5, 6, 11, and 12 related to enacted interventions and the application of social support interventions. A CFA indicated adequate item fit with a two-factor structure [$\chi^2(34) = 102.08$, $p < .001$, CFI = .920, RMSEA = .106, SRMR = .050] with Items 7, 8, 9, and 10 as factor 1 and Items 3, 4, 5, 6, 11, and 12 as factor 2. To obtain better item fit, suggested modifications were observed. In reviewing modifications, the researcher noted that allowing Item 9 to load on factor 2 would produce changes that may improve model fit (M.I.=15.048). This inspired the researcher to more thoroughly examine Item 9 to determine whether allowing the item to load on factor 2 would be appropriate. However, in reviewing the item, the researcher concluded that Item 9 may actually be appropriate to remove, as this item related to interventions targeted toward support that the client is already receiving; all other items of the survey related to the use of interventions targeted toward support that clients may receive in the future or to the overall application of social support interventions across presenting concerns and psychopathology. Consequently, Item 9 did not seem to measure use of social support in the same way as the other items. Additionally, recommended modifications included correlating the errors of Items 11 and 12. The researcher noted that it would be appropriate to correlate the errors of Items 11 and 12 due to similarities between the items. Specifically, Item 11 states, "I use social support interventions in my treatment of many different presenting problems/concerns," and Item 12 states, "Social support interventions are important in my treatment of psychopathology." These items relate to one another in that they both refer to presenting problems/psychopathology. Another CFA for the two-factor structure was run without

Item 9 and correlating the errors of Items 11 and 12. This CFA revealed good, but not perfect, model fit for the two-factor model [$\chi^2(25) = 45.98$, $p = .0064$, CFI = .967, RMSEA = .069, SRMR = .045]. Therefore, subsequent analyses were conducted using a two-factor model of social support intervention use. Factor 1 (which included Items 7, 8, and 10) was named Use_Teaching, as items related to social support interventions in which skills or information is taught to the client. Factor 2 (which included Items 3, 4, 5, 6, 11, and 12) was named Use_Application, as items related to interventions that involved behaviors that can be enacted by clients and the overall application of social support interventions. A copy of the survey items used for subsequent analyses can be found in Appendix G.

Descriptive statistics were used to examine the distribution of social support use total scores for both factors, along with a histogram to visually analyze the distribution. Results indicated a normal distribution of both Use_Teaching (Skewness= -0.222, Kurtosis= -0.533) and Use_Application (Skewness= -0.259, Kurtosis= -0.150). Figure 2 shows the histogram for Use_Teaching total scores. Figure 3 shows the histogram for Use_Application total scores.

Two-way ANOVAs were conducted to examine the relationships among theoretical orientation, primary treatment setting, and use of social support using both Use_Teaching and Use_Application total scores. Results of the ANOVAs revealed no significant differences among theoretical orientations for Use_Teaching and Use_Application. This means that clinicians of different theoretical orientations did not significantly differ in their use of social support interventions in which skills or

information was taught to the client ($F(3, 158) = 0.827$, $p = .481$) or in their use of enacted interventions and the overall application of social support interventions ($F(3, 158) = 1.162$, $p = .326$). Similarly, results indicated no significant differences among primary treatment settings in Use_Teaching or Use_Application, i.e. clinicians of different treatment settings did not significantly differ in their use of social support interventions related to the teaching of skills or information ($F(4, 158) = 0.165$, $p = .956$) or in use of enacted interventions and application of interventions ($F(4, 158) = 0.943$, $p = .441$). Results also indicated no significant interaction effect between theoretical orientation and primary treatment setting for Use_Teaching ($F(12, 158) = 1.198$, $p = .289$). However, results showed a significant interaction effect between theoretical orientation and primary treatment setting for Use_Application ($F(12, 158) = 2.092$, $p < .05$). Post-hoc analyses indicated that Psychodynamic/Psychoanalytic theoretical orientation with varied treatment settings ($F(4,158) = 4.219$, $p < .05$) had an effect on the Use_Application total score. Treatment setting had no significant effect for all remaining theoretical orientations. Univariate tests also showed that for "Other" treatment settings, varying theoretical orientations had a significant effect on the Use_Application total score ($F(3,158) = 4.689$, $p < .05$). Additionally, for the Jail/Criminal Justice System treatment setting, varying theoretical orientations had a significant effect on total scores for Use_Application ($F(3,158) = 3.617$, $p < .05$).

Specifically, pairwise comparisons indicated that of clinicians who identify with a Psychodynamic/Psychoanalytic theoretical orientation, those who work in "Other" treatment settings reported significantly lower use of enacted interventions and overall

application of interventions when compared to psychologists of University/College Counseling Center treatment settings (mean difference= -9.778, $p < .05$). In the "Other" treatment setting, which consisted primarily of clinicians in private practice, clinicians who identify with Psychodynamic/Psychoanalytic theoretical orientation reported significantly lower use of enacted interventions and application of interventions than clinicians of other theoretical orientations including Cognitive-Behavioral (mean difference = -5.556, $p < .05$), Eclectic/Integrative (mean difference = -5.717, $p < .05$), and Other (mean difference = -8.944, $p < .05$). Additionally, in the Jail/Criminal Justice System treatment setting, clinicians who identify with a Cognitive-Behavioral theoretical orientation reported significantly lower use of enacted or applied social support interventions than clinicians of Eclectic/Integrative theoretical orientation (mean difference = -4.545, $p < .05$). A plot of estimated marginal means for Use_Application, which can be seen in Figure 4, provides a visual representation of these differences.

Simple linear regressions were conducted to explore the impact of clinicians' self-perceived social support on use of social support in therapy. Regressions were examined for both Use_Teaching and Use_Application with perceived social support as the predictor. Regressions indicated that perceived social support did not significantly predict use of social support in therapy for Use_Teaching ($F(1, 175) = 0.870$, $p = .352$) or Use_Application ($F(1, 175) = 2.676$, $p = .104$). Multiple linear regressions were conducted to further explore the relationships among theoretical orientation, treatment setting, self-perceived social support, and use of social support in therapy. In the multiple regressions, perceived social support was used as a predictor, along with

theoretical orientation and treatment setting. Regressions were examined for both Use_Teaching and Use_Application. Results of the regressions indicated that perceived social support, theoretical orientation, and treatment setting did not significantly predict use of social support in therapy for Use_Teaching ($F(8, 168) = 1.547$, $p = .144$). However, these variables significantly predicted use of social support in therapy for Use_Application ($F(8, 168) = 2.209$, $p = .029$). Results indicated that when perceived social support and treatment setting were held constant, Other theoretical orientation significantly predicted use of enacted interventions and application of interventions ($\beta = .229$, $p = .018$) when compared to Psychodynamic/Psychoanalytic theoretical orientation.

	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Item 10	Item 11	Item 12
Item 1	1	0.753	0.296	-0.005	0.11	0.226	0.111	0.126	0.025	0.093	0.133	0.15
Item 2	0.753	1	0.256	-0.013	0.13	0.204	0.187	0.187	0.116	0.136	0.185	0.203
Item 3	0.296	0.256	1	0.485	0.423	0.281	0.195	0.415	0.345	0.404	0.453	0.471
Item 4	-0.005	-0.013	0.485	1	0.575	0.257	0.325	0.535	0.518	0.467	0.521	0.503
Item 5	0.11	0.13	0.423	0.575	1	0.38	0.294	0.478	0.47	0.459	0.455	0.436
Item 6	0.226	0.204	0.281	0.257	0.38	1	0.111	0.257	0.189	0.219	0.216	0.207
Item 7	0.111	0.187	0.195	0.325	0.294	0.111	1	0.506	0.53	0.525	0.481	0.412
Item 8	0.126	0.187	0.415	0.535	0.478	0.257	0.506	1	0.772	0.547	0.537	0.471
Item 9	0.025	0.116	0.345	0.518	0.47	0.189	0.53	0.772	1	0.694	0.518	0.467
Item 10	0.093	0.136	0.404	0.467	0.459	0.219	0.525	0.547	0.694	1	0.607	0.499
Item 11	0.133	0.185	0.453	0.521	0.455	0.216	0.481	0.537	0.518	0.607	1	0.725
Item 12	0.15	0.203	0.471	0.503	0.436	0.207	0.412	0.471	0.467	0.499	0.725	1

Table 3. Inter-item correlation matrix for 12 survey items of Survey for Use

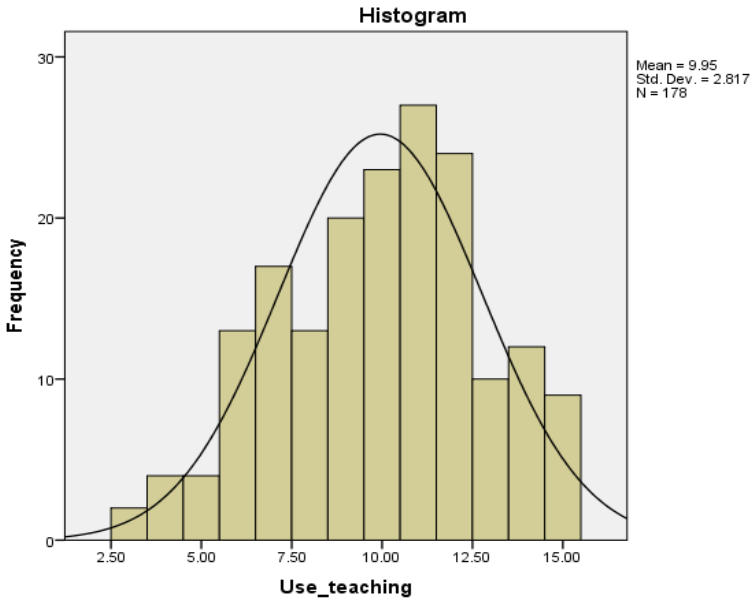

Figure 2. Histogram of Use_Teaching total scores

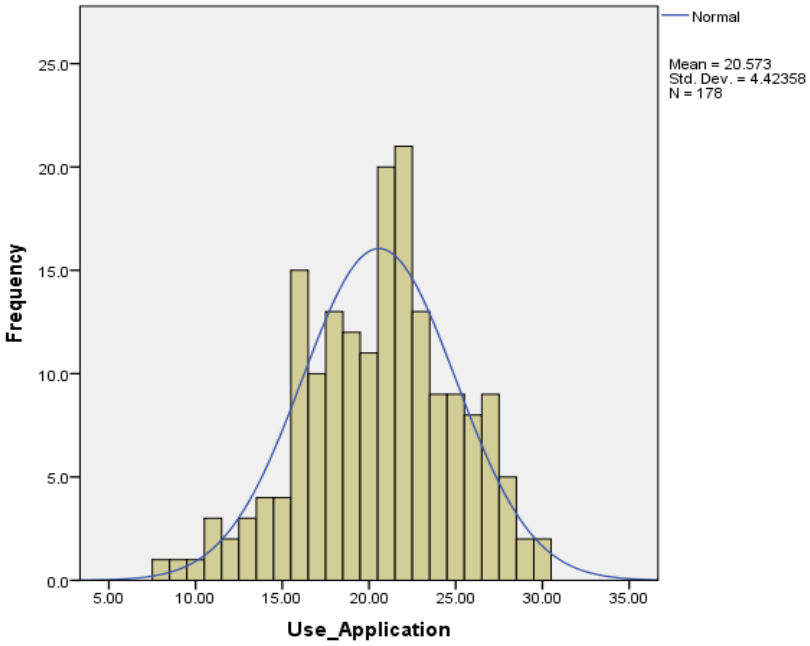

Figure 3. Histogram of Use_Application total scores

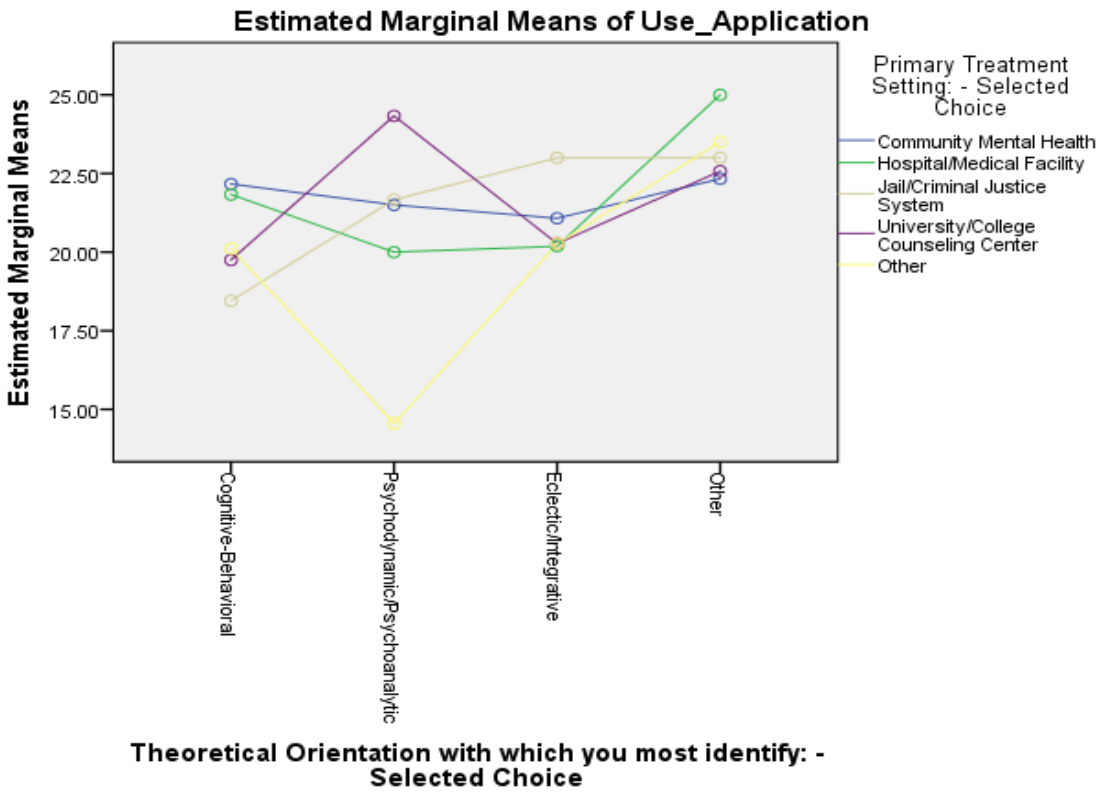

Figure 4. Estimated marginal means of Use_Application

CHAPTER V

SUMMARY AND DISCUSSION

Brief Summary of Findings

The present study explored psychologists' use of social support in individual therapy, as well as the relationships among psychologists' use of social support, theoretical orientation, treatment setting, and self-perceived social support. Clinician social support use was measured using a self-report survey, which evaluated use of interventions involving the teaching of skills/information, use of interventions related to enacted behaviors, and overall application of social support interventions. The results of the study revealed normal distributions of social support use among psychologists. While neither psychologists' theoretical orientation nor treatment setting had a significant effect on their use of social support, results showed a significant interaction effect between theoretical orientation and primary treatment setting for use of enacted interventions and overall application of interventions. Psychologists' perceptions of their own social support did not significantly predict their use of social support in therapy. However, when perceived social support and treatment setting were controlled, theoretical orientation had a significant impact on social support use for enacted interventions and overall application of social support interventions.

Interpretation of Findings

Survey for use of social support. In the absence of a validated instrument for measuring the use of social support in therapy, a 12-item survey was created. A

unidimensional factor structure was hypothesized for use of social support. Inter-item correlations and confirmatory factor analyses revealed that the construct of social support use is more complex than originally conceptualized.

Inter-item correlations highlighted the importance of the targeted source of social support interventions when evaluating psychologists' use of social support interventions. As previously noted, the 12-item survey was created to reflect the many ways that social support may be used in therapy. Consequently, items were written to reflect multiple targeted sources of social support interventions, including clients themselves and clients' naturally occurring support systems. Items 1 and 2 (which related to the use of social support interventions targeted at clients' naturally occurring support systems) correlated strongly with one another but did not correlate well with Items 3-12 (which related to the use of social support interventions targeted at the client). This suggests that the construct of social support use may be subdivided based on the target of the social support interventions. Said another way, use of social support interventions targeted at the client may be a construct distinct from use of social support interventions targeted at the client's support system. Consequently, Items 1 and 2 were removed, and all subsequent analyses were conducted using items that related to use of social support interventions targeted at the client.

Confirmatory factor analyses for Items 3, 4, 5, 6, 7, 8, 10, 11, and 12 showed evidence of a two-factor structure for use of social support. One factor of psychologists' social support use in individual therapy, labeled Use_Teaching, involves social support interventions in which psychologists teach skills or information to the client. A second

factor, labeled Use_Application, relates to enacted interventions and the application of social support interventions. This finding is supported by social support literature, which highlights that there are numerous types of social support interventions and several ways in which social support can be used in therapy to facilitate therapeutic change or to reduce client symptomology (Hogan, Linden, & Najarian, 2002). Exploring these two factors provides a deeper understanding of the construct of psychologists' social support use.

Factor 1: Use_Teaching. Items 7, 8, and 10 loaded on Factor 1 and are characterized by interventions in which psychologists teach information or provide instruction to their clients. Many social support interventions involve the teaching of information and skills; examples include psychoeducation, the teaching and rehearsal of social skills, assertiveness training, and training in conflict resolution (Hogan, Linden, & Najarian, 2002). Research indicates that psychologists can use interventions that involve teaching, training, or psychoeducation to enhance the three main foci of social support interventions: enacted support, perceived support, and social connectedness (Hogan, Linden, & Najarian, 2002). Consequently, interventions involving teaching are an important element of social support use. They are intended to teach information or skills that assist clients in engaging in and understanding their support systems in ways that enhance the benefits they receive from those systems. In this way, the factor of Use_Teaching can be thought of as psychologists helping clients to change themselves.

Clinical examples help to demonstrate and operationalize the factor of Use_Teaching. A few examples are noted below:

- ***Example A.*** A client who experiences anxiety in his workplace presents to individual counseling. The client has a difficult time connecting with his co-workers. He struggles to gauge the reactions of his peers, and he often wonders how others perceive him. The client's uncertainty leaves him feeling both disconnected and lonely. His difficulty understanding others' reactions also causes decreased confidence in his work performance, as he struggles to note if others are viewing his work as acceptable. For this client, it would be useful to employ a social support intervention in which skills or information is taught, such as social skills training. This intervention could include the teaching and rehearsal of social skills, such as reading body language, facial expressions, and vocal cues. This intervention could also include teaching the client how to effectively solicit feedback from his co-workers.
- ***Example B.*** A client has been participating in individual therapy for several sessions. The client feels that she has been making progress and is proud of her work. Despite this progress, she feels disappointed and frustrated because she has not received much positive feedback from her partner about her progress. The client believes that her partner is proud of her but at times questions her partner's support because she does not offer the affirmation that the client seeks. The client acknowledges that she has not shared her desire for affirmation with her partner, as she has a hard time expressing what she feels that she needs. A teaching social support

intervention, such as teaching the client to effectively articulate what she feels she needs from her partner and rehearsing how to assert that she would like messages of affirmation, may help the client to enhance the support that she is receiving.

- ***Example C.*** A client in individual therapy reports feeling unsupported, despite having many friends and family members in his life. The client is aware of his connections but does not to appear to have a strong understanding of the ways in which he receives support from these relationships. It could be useful for the psychologist to provide the client with information about the different types of social support, as well as the aspects of social support. In learning more about the numerous types of support and the ways in which others are able to contribute support, the client may be able to more readily see the ways in which his friends and family offer support moving forward. This may increase the client's perception of his support and reduce the dissonance the client is experiencing.

Factor 2: Use_Application. Items that loaded on Factor 2 involve enacted interventions and psychologists' overall application of social support interventions. Specifically, Items 3, 4, 5, and 6 relate to the use of social support interventions that involve behaviors that clients can enact or execute. As previously discussed, social support interventions may aim to enhance the emotional, instrumental, and informational support that a client receives or to produce changes in the quantity or quality of a client's

social ties. To this end, many social support interventions involve helping clients to engage in behaviors, activities, or relationships to enhance their support. In this way, the factor of Use_Application encompasses interventions in which psychologists help clients to change their support systems and to more effectively intervene in their reception of support. Items 11 and 12 relate to psychologists' use of social support interventions across presenting concerns and to the importance of social support interventions in their work. In this way, these items and the factor of Use_Application encompass psychologists' overall use or application of social support interventions.

Clinical examples of the factor of Use_Application are below:

- ***Example A.*** A client presents to individual therapy after his brother is arrested for criminal drug charges. The client has been struggling with his brother's substance abuse and drug addiction for some time. The client has a difficult time coping with his brother's drug use and frequently feels sad, ashamed, and hopeless. It could be useful for the psychologist to utilize a social support intervention in which behavior is enacted by the client. For example, it could be useful for the psychologist to encourage the client to become involved with a support group for family members of individuals who struggle with addiction. Becoming involved in a group of this nature could enhance the client's social support.
- ***Example B.*** A client reports to individual therapy because she frequently experiences panic attacks when in crowded places. Due to her fear of crowded places and her fear of having a panic attack, the client avoids

crowded places as much as possible and flees situations in which she encounters crowds. This causes strain for the client, as it prevents her from accomplishing daily life tasks such as going to the grocery store, riding the bus, going to her classes, eating in restaurants, etc. The psychologist encourages the client to turn to her husband for support; the psychologist has the client train her husband to help the client stay in crowded environments despite her desire to run. By helping the client to stay in crowded places, the client's husband assists in the extinction of the client's phobic response. In this way, the psychologist utilizes a social support intervention in which behavior is enacted by the client.

- ***Example C.*** A psychologist is working with several clients of various presenting concerns. Although each client has unique problems and symptoms, the psychologist notes the value in applying social support interventions in his work with each client. Therefore, the psychologist utilizes social support interventions in his treatment of many different presenting problems.

Extent of use. Descriptive statistics indicated normal distributions for both Use_Teaching and Use_Application. This finding did not support Hypothesis 1, which predicted that psychologists would report limited use of social support. There are many possible explanations for this finding. Despite the paucity of literature related to the use of social support in therapy, the benefits of social support in mental health have been well documented. Consequently, using social support as a therapeutic intervention may

be more pervasive than originally hypothesized. Moreover, although limited formal training exists for psychologists on the use of social support interventions in therapy, the importance of social support overall may be instilled within psychologists in their early stages of training. For example, the role of social support in mental health is highlighted in a variety of entry-level graduate training materials, including guides for interviewing and building rapport (e.g., Jones, 2010; Machado, Beutler, Harwood, Mohr, & Lenore, 2011; Tahan & Sminkey, 2012) and literature on counseling techniques and theories (e.g. Ivey, Ivey, & Zalaquett, 2014; Jones-Smith, 2012; Scheel & Conoley, 2012). Additionally, psychologists' experiences with previous clients may influence their use of social support in therapy. Because individuals with poor or inadequate social support are more likely to experience salient mental health concerns (Harandi, Taghinasab, & Nayeri, 2017) that could prompt them to seek counseling services, it is likely that practicing clinicians have encountered clients lacking social support. Identifying the difficulties associated with lack of social support in existing or previous clients may prompt clinicians to incorporate social support interventions in their work. Furthermore, the evaluation of social support/social relationships is seen as an important factor across several models of case conceptualization (e.g., Campbell & Rohrbaugh, 2006; Eells, Kendjelic, & Lucas, 1998; Ellis, Hutman, & Deihl, 2013; McClain, O'Sullivan, & Clardy, 2004), which is a vital part of mental health treatment. Clinicians who evaluate clients' social support and consider its relation to clients' presenting concerns may be more inclined to utilize social support interventions. Lastly, this finding may be related to the relationships among lack of social support, loneliness, and mental health concerns.

Loneliness, which is often a result of limited or poor social support, is correlated with a number of mental health concerns such as depression (Weeks, Michela, Peplau, & Bragg, 1980), alcoholism (Akerlind & Hörnquist, 1992), borderline personality disorder (Richman & Sokolove, 1992), schizoid personality disorder (Martens, 2010), stress (West, Kellner, & Moore-West, 1986), and suicidal ideation (Mushtaq, Shoib, Shah, & Mushtaq, 2014). While clients may not aptly identify lack of social support as a contributing factor to their presenting concerns, clients may report loneliness as a symptom of their concerns. Consequently, psychologists may employ interventions to enhance social support as a way of reducing feelings of loneliness associated with many common presenting concerns of their clients.

Impact of theoretical orientation. Results of the study did not support Hypothesis 2, which predicted that psychologists of different theoretical orientations would differ in their use of social support in therapy; no significant differences in use were found among psychologists of different orientations. Several possibilities exist for this finding. In addition to the aforementioned possibilities related to the extent of social support use, this finding may be due to similarities that exist among theoretical orientations, the embedded nature of social elements in numerous theoretical orientations, or lack of unequivocal allegiance to only one therapeutic orientation in practice.

This finding may relate to similarities that exist among theoretical orientations. As previously noted, there are well-established differences among theoretical orientations that make them distinct from one another. However, despite these

differences, research suggests that there are also important commonalities that exist among theories. Stiles, Shapiro, and Elliott (1986) found that numerous theoretical orientations share common factors that may "underlie or override differences in therapists' treatment" (Jones-Smith, 2012). These similarities across theories may lead therapists of different theoretical orientations to enact similar interventions (Jones-Smith, 2012). Thus, it is possible that similarities across theoretical orientations could lead to similar social support use among clinicians of different theoretical orientations.

One such similarity among theoretical orientations is an emphasis on clients' social relationships. In fact, elements of social support are embedded in numerous theoretical orientations. For example, despite its strong focus on the unconscious and individual's needs and past experiences, some researchers propose that Psychodynamic theory can be thought of as a "theory of relationships" (Meehan & Levy, 2009, p. 1299). In Psychodynamic theory, psychologists seek to understand how relationships have contributed to a client's internal or unconscious world, "how interpersonal experiences come to be internalized as aspects of personality," and "how these internalized relationships color people's understanding of their interpersonal experiences" (Meehan & Levy, 2009, p. 1299). Similarly, in Cognitive-Behavioral theory, clinicians aim to identify the roles that social relationships play in clients' thoughts and behaviors. Psychologists of a Cognitive-Behavioral theoretical orientation work to understand the content of clients' beliefs, as well as the social relationships that contributed to the development of their beliefs. González-Prendes & Brisebois (2012) note in Cognitive-Behavioral theory, "the context of the individual's social environment is essential to gain

a full appreciation of factors that influenced the formation of a person's core beliefs and schemas" (p. 29). Because social support and consideration of clients' relationships is meaningful in numerous theoretical orientations, it is possible that clinicians of differing orientations are inclined to employ social support interventions similarly.

Another possible explanation for this finding may be that in actual practice, many psychologists do not have an unequivocal allegiance to only one theoretical orientation. Some research suggests that few psychologists work from a single theoretical approach to therapy (Jones-Smith, 2012; Norcross & Goldfried, 2005; Norcross, Hedges, & Prochaska, 2002). Even if psychologists predominantly or strongly identify with one theoretical orientation, they may utilize frameworks, techniques, and knowledge from multiple theories to best meet clients' diverse needs (Jones-Smith, 2012). Consequently, the practices of psychologists of different theoretical orientations may include similar techniques and interventions. Thus, the practical differences in intervention use among clinicians of different theoretical orientations may be less than assumed, including fewer differences in the use of social support interventions.

Impact of treatment setting. Results of the study did not support Hypothesis 3, which proposed that that psychologists of different treatment settings would differ in their use of social support. This may be due to the fact that mental health concerns related to social support are prevalent across numerous treatment settings, although research related to social support intervention use across treatment settings is sparse. As previously noted, the importance of social support has been well-documented within rehabilitation settings, hospitals, and medical facilities, in which mental health and

physical health concerns are frequently comorbid (Sartorious, 2013). However, literature exploring social support use in other treatment settings is fairly limited. Despite this, the link between social support and mental health has been effectively demonstrated in several different treatment settings. For example, social support has been linked to mental health concerns within university/college counseling centers. College is a time marked by unique changes in social environments, and research suggests that social pressures of college can significantly impact student well-being. Specifically, lower quality social support is related to poorer mental health outcomes among college students, including a six-fold risk of depressive symptoms compared to students with high quality social support (Hefner & Eisenberg, 2009). In jail/criminal justice settings, lack of social support is associated with mental health concerns such as high stress, depression, lower quality of life and increased rates of addiction (Nargiso et al., 2014; Wallace et al., 2016). Contrastingly, higher rates of social support are associated with higher quality of life, lower rates of depression, and lower rates of re-incarceration upon release from prison (Jacoby & Kozie-Peak, 1997; Nargiso et al., 2014). Regardless of the setting in which they are treated, inherent in the presenting problems of clients is the almost universal need for social support. Because social support concerns and the impact of social support are so prevalent among different treatment settings, psychologists may be likely to employ similar levels of social support use across treatment settings.

Interaction effects. In an effort to more deeply explore factors that may impact use of social support, the researcher observed the interaction effects between theoretical orientation and primary treatment setting on use of social support. No significant

interaction effect was found for the use of social support interventions related to the teaching of skills or information (Use_Teaching). However, results showed a significant interaction effect between theoretical orientation and primary treatment setting for use of social support interventions related to enacted behaviors and overall application of social support interventions (Use_Application). As previously noted, treatment setting had a significant effect for Psychodynamic/Psychoanalytic theoretical orientation. Of clinicians who identify with a Psychodynamic/Psychoanalytic theoretical orientation, those who work in "Other" treatment settings report significantly lower use of enacted interventions and application of interventions when compared with psychologists of University/College Counseling Centers. Theoretical orientation had a significant effect for both "Other" treatment setting and Jail/Criminal Justice System treatment setting. Specifically, in the "Other" treatment setting, clinicians of Psychodynamic/Psychoanalytic theoretical orientation reported significantly lower use of enacted interventions and application of interventions than clinicians of all other theoretical orientations. In the Jail/Criminal Justice System treatment setting, clinicians of Cognitive-Behavioral theoretical orientation reported significantly lower use of enacted interventions and application of interventions than clinicians of Eclectic/Integrative theoretical orientation. These findings highlight the complex interplay between treatment setting and theoretical orientation. These findings also raise questions about why these interaction effects may exist.

Treatment setting for theoretical orientation. The finding that Psychodynamic/Psychoanalytic psychologists in "Other" treatment settings report

significantly lower use of enacted interventions and overall application of social support interventions than Psychodynamic/Psychoanalytic psychologists in University/College Counseling Centers may relate to the interplay of principles of Psychodynamic/Psychoanalytic therapy and psychologist autonomy in treatment.

As previously explored, Psychodynamic/Psychoanalytic theory emphasizes the role of the unconscious with the goal of helping clients to understand their behaviors, emotions, and thoughts through the context of their past (Barber & Solomonov, 2016). To this end, psychologists may employ a number of interventions traditionally associated with Psychoanalytic theory including free association and interpretation, analysis of resistance and transference, or dream interpretation (Jones-Smith, 2014). These types of interventions can be used to explore a variety of factors that contribute to a client's internal world, including relationships and interpersonal experiences (Jones-Smith, 2014; Meehan & Levy, 2009). In this way, these techniques relate to social support interventions, although they do not intentionally target and enhance support in the same way that social support interventions do. Many of these traditional techniques can be time-consuming. In fact, some research suggests that the change process in Psychodynamic/Psychoanalytic therapy is primarily appropriate for long-term therapy (Jones-Smith, 2014) or even that lasting change "typically requires at least 2 years of sessions" (U.S. Department of Health and Human Services, 1999, p. 122).

Psychodynamic/Psychoanalytic psychologists who work in agencies emphasizing short-term treatment models may have to limit their use of these long-term techniques. They may also need to employ forms of brief Psychodynamic/Psychoanalytic therapy

(U.S. Department of Health and Human Services, 1999) or employ interventions that are more short-term in nature. However, with more time and autonomy in practice, Psychodynamic/Psychoanalytic psychologists may be able to more effectively employ long-term interventions, which may reduce their use of other, short-term interventions.

This may relate to Psychodynamic/Psychoanalytic psychologists' use of social support interventions. Psychologists with less autonomy may elect to explore, target, and enhance social relationships through use of social support interventions, as these interventions are not time-consuming or long-term in nature. Contrastingly, psychologists with more autonomy and fewer time restraints may elect to utilize more traditional Psychodynamic/Psychoanalytic interventions to explore or target social relationships.

Many University/College Counseling Centers employ short-term treatment models for their clients, thus limiting some flexibility in treatment planning. Consequently, Psychodynamic/Psychoanalytic psychologists of this treatment setting may be more inclined to utilize short-term treatments and interventions, such as social support interventions, in their work. Contrastingly, Psychodynamic/Psychoanalytic psychologists of the "Other" treatment setting may experience more flexibility in their work. It is of interest that in this study, most psychologists of the "Other" treatment setting were psychologists in private practice (80.65%). Psychologists within private practice may exercise more autonomy in treatment than psychologists of other treatment settings (Barry, 2005), as psychologists within private practice may operate with fewer time-constraints and may exercise more independence in treatment planning than

psychologists of different treatment settings. With this flexibility, psychologists of Psychodynamic/Psychoanalytic theoretical orientation may elect to employ more traditional techniques of Psychoanalytic theory that may require long-term treatment to explore or target social relationships. Thus, their use of enacted social support interventions and their overall application of social support interventions may be lower.

Theoretical orientation for "Other" treatment settings. A similar explanation may account for significantly lower use of enacted interventions and overall application of social support interventions among psychologists of Psychodynamic/Psychoanalytic theoretical orientation when compared to clinicians of all other theoretical orientations in the "Other" treatment setting. Given the autonomy of private practice, psychologists may experience more flexibility in treatment planning and application of interventions. When compared to other theoretical orientations, Psychodynamic/Psychoanalytic theory and therapy generally emphasize more long-term treatment and use of interventions that focus more strongly on the individual, emphasizing the client herself (Jones-Smith, 2014). Consequently, psychologists of Psychodynamic/Psychoanalytic orientation may seek to address social relationships through more traditional interventions that emphasize focus on individual exploration and that are more long-term in nature. Because of this, Psychodynamic/Psychoanalytic psychologists in private practice may utilize social support interventions less than psychologists of other theoretical orientations.

Theoretical orientation for jail/criminal justice system. Results showed significantly lower use of enacted interventions and overall application of social support

interventions among psychologists of Cognitive-Behavioral theoretical orientation when compared to Eclectic/Integrative psychologists in the Jail/Criminal Justice System treatment setting. Research notes that Cognitive-Behavioral therapy in jails and prisons often emphasizes focus on the individual. Specifically, Cognitive-Behavioral therapy emphasizes individual accountability and self-monitoring (Lipsey, Landenberger, & Wilson, 2007). It also targets "criminal thinking" and its associated cognitive distortions, including displacement of blame, deficient moral reasoning, and schemas of dominance and entitlement (Lipsey, Landenberger, & Wilson, 2007). In this way, Cognitive-Behavioral therapy in jails/criminal justice systems may focus less on the role of social support systems in treatment than other forms of therapy. While social support interventions related to teaching may be employed, as these interventions may help in identifying cognitive distortions such as misinterpretation of social cues or antisocial thinking patterns (Lipsey, Landenberger, & Wilson, 2007), enacted interventions and overall application of interventions are less likely to occur. Because psychologists of Eclectic/Integrative theoretical orientation utilize interventions from a variety of different orientations, they may be more likely to incorporate social support, as they may have a greater focus on social relationships and systems when compared to Cognitive-Behavioral psychologists.

Impact of self-perceived social support. The results of the study did not support Hypothesis 4, which predicted that clinicians who have higher self-perceived social support would report greater use of social support interventions. Rather, results of the study showed that clinician self-perceived social support did not significantly predict use

of social support in therapy. Several possible explanations could account for these findings.

As previously noted, the benefits of social support in mental health have been well documented within the field of psychology. Although psychologists with higher self-perceived social support may be more aware of the impact of social support in their own lives, they may not necessarily be more aware of the benefits of support in mental health overall than psychologists of lower self-perceived support. Due to the widespread research on the benefits of social support, psychologists may be aware of the benefits and importance of social support regardless of the quantity or quality of support that they perceive in their own lives. Psychologists' knowledge of social support benefits may outweigh their personal perceptions of support in their use of social support in therapy.

Another possible explanation for this finding relates to the present-focused nature of self-perceived social support. For this study, clinician self-perceived social support was measured using the Multidimensional Scale of Perceived Social Support (MSPSS). All items of the MSPSS assess a person's perceptions of support that they currently receive in their lives (i.e., all items are present-focused). In this way, the MSPSS measured psychologists' perception of their social support at a particular point in time (Zimet et al., 1988). This may not account for support that psychologists have previously received. Psychologists may be more aware of the benefits of social support (and thus more inclined to use social support in therapy) if they received high levels of social support at any point in time, not just if they currently have higher self-perceived support.

Finally, while psychologists' perceptions of their own social support may influence their use of social support interventions to some degree, it is possible that use is better accounted for by other factors or a combination of perceived social support and other factors. For example, research posits that what psychologists do in therapy depends largely on psychologists' theoretical orientations, perceptions of clients' presenting concerns, conceptions of pathology, and therapeutic alliances with clients (Jones-Smith, 2012). Although personal experiences, values, and beliefs (such as psychologist's experiences of social support and beliefs about support) significantly influence psychologists' work (Ladany & Bradley, 2010), their use of social support may be more dependent upon other variables. Similarly, their use of social support may be due to a combination of these factors, limiting the impact of self-perceived social support on use of social support interventions.

Additional findings. Results showed that when controlling for perceived social support and treatment setting, "Other" theoretical orientation significantly predicted use of interventions related to enacted behaviors and overall application of social support interventions when compared to Psychodynamic/Psychoanalytic theoretical orientation. This finding speaks to the complex interplay of psychologists' characteristics in individual therapy and suggests that differing theoretical orientations account for differences in social support use when other clinician factors are held constant. These findings seem to relate to the aforementioned interaction effects found for this study, as use of interventions related to enacted behaviors and overall application of social support interventions was lower among psychologists of Psychodynamic/Psychoanalytic

psychologists when compared to psychologists of all other theoretical orientations in Other treatment settings. As previously mentioned, Psychodynamic/Psychoanalytic psychologists may employ more traditional interventions of Psychoanalytic theory, which have a strong focus on the individual. These traditional interventions may focus less on the role of social support systems and explore relationships through focus on the client. This may account for the finding that Other theoretical orientation significantly predicted use of interventions related to enacted behaviors and overall application of social support interventions when compared to Psychodynamic/Psychoanalytic theoretical orientation when treatment setting and perceived social support are held constant. It is also meaningful to note that in the study, "Other" theoretical orientation included many orientations that emphasize the roles of relationships and social support in case conceptualization and client change. For example, "Other" theoretical orientation included Interpersonal, Humanistic, Multicultural, and Existential theoretical orientation, each of which emphasizes relationships (Cooper & Joseph, 2016; Kaslow, Massey, & Massey, 2004; Sue & Sue, 2016; Teyber & McClure, 2010). It is possible that this emphasis on support may account for greater use of enacted interventions and overall application of social support interventions when compared to Psychodynamic/Psychoanalytic theoretical orientation when variables such as treatment setting and perceived social support are held constant.

Implications of Findings

This study provides valuable information about the use of social support in individual therapy and about the factors that influence social support use. As an initial

exploration into psychologists' use of social support, this study has several meaningful implications for psychologists and for the field of psychology overall.

Implications for practice. Results of the study suggest a normal distribution for use of social support interventions in which psychologists teach information or skills to the client, of interventions involving enacted behaviors, and of overall application of social support interventions. These results are promising, as they suggest that social support interventions are utilized by psychologists in individual therapy, more so than was predicted. However, these findings also suggest that for some psychologists, use of social support is relatively low. Moreover, findings of this study suggest that given certain interplays of psychologist characteristics (such as theoretical orientation, treatment setting, and self-perceived social support), use of social support may be low. While variation in social support use is to be expected, these findings points to opportunities for growth within the field of psychology. Given the myriad of physical and mental health benefits associated with social support, along with social support's role in contributing to therapeutic change, use of social support can be seen as an integral part of health and of the therapeutic process. For this reason, psychologists should work to employ social support interventions to augment client care and enhance well-being across presenting concerns. Therefore, it would be advantageous to expand the use of social support interventions in therapy.

There are a number of potential methods for increasing psychologists' use of social support in individual therapy. For example, the field could work to make explicit the ways in which social support can be utilized in therapy. As previously noted, there is

little literature on social support intervention use and limited formal training on the use of social support in therapy. The field may benefit from the development of manuals or models for use of social support in therapy, including a comprehensive exploration of types of social support, social support interventions, and assessment of social support. This could include a classification system of social support interventions. Moreover, more formal training on the use of social support interventions could be developed for both graduate trainees and licensed clinicians alike. Specifically, training programs for graduate students should emphasize the ways in which these interventions may be employed and the utility of social support interventions across theoretical orientations, treatment settings, and presenting concerns. Formal training on social support interventions, the benefits of use, and the implementation of interventions in therapy could also be developed for practicing psychologists. Finally, the incorporation of more intentional, thorough, or formal assessment of social support could expand the use of social support in individual therapy. Numerous measures of social support exist, and it would be beneficial for psychologists to conduct thorough assessments of support to determine how to best utilize support to augment client care. Deeper exploration of client relationships and support systems could be a gateway for increasing use of social support interventions.

Implications for future research. The present study provides an initial investigation into the use of social support in individual therapy. Future research could build upon this study by continuing to examine the use of social support interventions and factors contributing to use of social support. This could include investigations of

social support intervention use for specific presenting concerns and with specific client populations. Future research could also explore the impact of other clinician characteristics on use of social support. Findings of the present study suggest that clinician beliefs, experiences, or preferences impact their methods of treatment, including utilization of social support interventions. Previous research supports this finding, as clinician characteristics have been found to influence their client care or approach to treatment (Ladany & Bradley, 2010). It would be interesting to examine the relationships among social support use and other clinician characteristics such as clinicians' years of experience, race/ethnicity, religiousness, or gender. These investigations may allow for a more holistic understanding of psychologists' use of social support in individual therapy.

It may also be interesting to explore if differences in use of social support exist between Psychoanalytic and Psychodynamic psychologists. As previously noted, these two orientations share many similarities, which often leads to the grouping of the two orientations (Jones-Smith, 2014). However, in noting possible explanations for the results of the present study, the researcher identified that many possible explanations could be attributed to traditional Psychoanalytic theories or principles; some of these theories or principles may differ from principles of Psychodynamic theory. Therefore, it is possible that differences may exist between Psychoanalytic and Psychodynamic psychologists' use of social support.

The findings of this study speak to the complex interplay among psychologist characteristics in use of social support. Specifically, the findings show significant

interactions between treatment setting and theoretical orientation for enacted interventions and the overall application of social support interventions, as well as significant effects for theoretical orientation when holding perceived social support and treatment setting constant. While several possible explanations for these findings have been proposed, more research is needed to explore why these findings exist. For example, it would be meaningful to more deeply examine the use of social support among psychologists of Psychodynamic/Psychoanalytic theoretical orientation, as this theoretical orientation was found to be associated with lower use of enacted interventions and overall application of social support interventions across certain treatment settings and when clinician self-perceived social support and treatment setting are held constant. To this end, researchers could employ qualitative research methods such as focus groups or interviews to explore Psychodynamic/Psychoanalytic psychologists' use of social support and perspectives on social support interventions. Similar qualitative methods could be utilized to evaluate clinicians' perspectives on what influences their use of social support in therapy overall. Investigations of this nature could provide information that may be helpful in understanding the results of the present study.

Limitations of Current Study

There are some limitations of the present study that should be noted. One issue concerns the structure of the survey for use of social support, a newly generated survey. Although the confirmatory factor analysis revealed a good fit for the two-factor structure of Use_Application and Use_Teaching, the fit for this model was not perfect. Future

research should be conducted to refine survey items to achieve perfect model fit. While steps were taken to increase elements of validity such as content validity and structural validity, there is little information about discriminant validity for the survey. Additionally, to improve model fit and to increase content validity, items related to the use of social support interventions targeted at a client's support system were removed from the survey. To achieve a more holistic understanding of the use of social support in individual therapy, a survey could be developed to assess for the use of social support interventions targeted at individuals other than the client.

Another limitation of the present study relates to the generalizability of the results. The sample size for the study (N=178) is somewhat small. Particularly, the small sample size is meaningful to note when examining pairwise comparisons and the interactions between theoretical orientation and treatment setting. As can be seen in Table 2, for some theoretical orientations and treatment settings, there are very few psychologists. The sample also lacked in racial and ethnic diversity, as over 80% of participants were White/European. Moreover, the sample was predominantly Female (66.3%). Additional research could be conducted with larger, diverse populations of psychologists to determine if results are generalizable across populations.

Results of the study should also be evaluated with consideration of its procedural limitations. For example, the results of the present study rely strongly on psychologists' self-report of their use of social support interventions in therapy. It is possible that psychologists may not have accurately reported their social support use; psychologists' self-report may not reflect what they actually do in individual therapy with clients.

Secondly, the study utilized a web-based data collection tool. While utilizing a web-based data collection tool was useful for gathering responses and reaching psychologists from a variety of settings and orientations, there are a few disadvantages associated with this survey method. Because all measures were administered online, test takers could not access study measures without internet access and an internet-compatible device. This could limit accessibility for some potential participants. Moreover, given the online nature of the survey, accommodations may have been necessary for psychologists with physical or sensory impairments, which may have limited accessibility. Because all measures were administered in English, psychologists who do not speak/read English were not able to participate in the study without the use of an interpreter. Finally, the web-based nature of the study limited environmental and procedural standardization across study participants.

Overall, these limitations are meaningful to consider. However, despite its limitations, this study provides a valuable initial analysis of psychologists' use of social support in individual therapy. Results of the study shed light on factors impacting social support use and present several unique questions for future research. The present study ideally serves as a first step in the exploration of social support use in therapy with the hope of expanding use to augment therapy and enhance client well-being.

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APPENDIX A

PARTICIPATING AGENCIES

Community Mental Health
AspenPointe Health Sciences
Behavioral Health Network, Inc.- Springfield, MA
California Pacific Medical Center
Children's Institute, Inc.
Clifford Beers Clinic
Community Health Center, Inc.- Hartford, CT
Community Healthlink Youth and Family Services
Eastern Health
Hamilton-Madison House, Inc.
Harris County Children's Assessment Center
Heritage Clinic
Hutchings Psychiatric Center
La Frontera Center, Inc.
LUK Crisis Center
Maimonides Medical Center
Middlesex Hospital
Mid-Ohio Psychological Services
Momentous Institute
Oakes Children's Center
Ohio Guidestone
Park Place Behavioral Health Care
Seasons Center for Behavioral Health
Sweetser Mental Health Services
The Carson Center
The Guidance Center
The Help Group
Tarzana Treatment Centers
UCLA TIES for Families
Wasatch Mental Health
Westchester Jewish Community Services
Will County Health Department

Hospital/Medical Facility
Bellevue Hospital Center
Elmhurst Hospital Center
Kings County Hospital Center
Milwaukee County Behavioral Health Division
Montefiore Medical Center

North Central Bronx Hospital
Patton State Hospital
Pilgrim Psychiatric Center
Saint Elizabeth's Hospital
State Operated Forensic Services
South Texas Veterans Health Care System
Utah State Hospital

Jail/Criminal Justice System
Bexar County Juvenile Probation Department
California Medical Facility- Vacaville Psychiatric Program
California State Prison-Sacramento
Colorado Department of Corrections
Division of Adult Corrections Behavioral Health Services- Greenville, NC
Federal Bureau of Prisons- Tallahassee, FL
Federal Correctional Complex Allenwood
Federal Correctional Institute- Terminal Island
Federal Medical Center Devens
Federal Medical Center- Rochester, MN
Harris County Juvenile Probation Department
Los Angeles County Department of Health Services
Metropolitan Detention Center Los Angeles
Rockdale Regional Juvenile Justice Center
Texas Juvenile Justice Department
U.S. Medical Center for Federal Prisoners
Wisconsin Department of Corrections

University/College Counseling Center
American University Counseling Center
Arizona State University Counseling Services and Health Services
Baylor University Counseling Services
Brigham Young University Counseling and Psychological Services
California State University Northridge University Counseling Services
Grand Valley State University
Indiana University Counseling and Psychological Services
Iowa State University Student Counseling Service
Pennsylvania State University Counseling and Psychological Services
Purdue University Counseling and Psychological Services
Stanford University Counseling and Psychological Services
The Chicago School of Professional Psychology Counseling Center
The Ohio State University Counseling and Consultation Service
University of California Davis Student Health and Counseling Services
University of California Irvine Counseling Center
University of California Los Angeles Counseling and Psychological Services

University of Delaware Center for Counseling and Student Development
University of Michigan Counseling and Psychological Services
University of New York at Buffalo Counseling Services
University of South Florida Counseling Center

APPENDIX B

RECRUITMENT EMAIL

Dear Prospective Participant:

I hope that this email finds you well. My name is Taylor Parks, and I am a doctoral candidate in the Counseling Psychology program at Texas A&M University. I am currently in the process of working on my doctoral dissertation, chaired by Dr. Charles Ridley. I am writing you today to ask for your participation in my research study, which aims to explore the use of social support in individual therapy. This study has been approved by IRB at Texas A&M University (IRB Number: IRB2017-0557M).

Your participation in this study is voluntary, and you may withdraw from the study at any time without penalty. Participation in this study will take approximately 5-10 minutes and will involve the completion of an online survey. All of your responses will be kept anonymous and will only be available to the researchers of this study. In appreciation for your participation, upon completion of the survey, you will have the option of submitting your email address to the researcher to be entered into a drawing for the chance to win one $50 donation to the charity of your choice.

If you would like to participate in this study, please visit the following website to access the survey:
https://tamucehd.qualtrics.com/jfe/form/SV_e2Pquao1P0sQUe1

If you have any questions or concerns about this study, please feel free to contact me by email at tmgparks@tamu.edu. You may also contact Dr. Charles Ridley by email at cridley@tamu.edu and Texas A&M University IRB at irb@tamu.edu.

Thank you so much for your time and consideration. We sincerely hope to have you as a part of our study.

Warmly,
Taylor Parks, M.Ed.

APPENDIX C

INFORMED CONSENT FORM

Project Title: Clinicians' Use of Social Support, Self-Perceived Social Support, Theoretical Orientation, and Treatment Setting

You are invited to participate in a research study being conducted by Taylor Parks, M.Ed., and Charles Ridley, Ph.D., researchers in the Department of Counseling Psychology at Texas A&M University. The information in this form is provided to help you decide whether or not to take part. If you decide to take part in the study, you will be asked to sign this consent form. If you decide you do not want to participate, there will be no penalty to you. You may choose to withdraw from the study at any time without penalty.

Why Is This Study Being Done?
The purpose of this study is to explore the relationship among clinicians' use of social support, self-perceived social support, theoretical orientation, and treatment setting.

Why Am I Being Asked To Be In This Study?
You are being asked to be in this study because you have a doctoral degree in a psychology-related field. Participants of this study must currently practice individual therapy. Your participation in this study will allow for greater understanding of how clinicians utilize social support interventions to facilitate therapeutic change and will contribute to the limited psychological literature on social support use in therapy.

How Many People Will Be Asked To Be In This Study?
Approximately 300-400 people (participants) will be invited to participate in this study.

What Are the Alternatives to being in this study?
The alternative to being in the study is not to participate.

What Will I Be Asked To Do In This Study?
This research will be conducted online. It will take you approximately 10 minutes to complete the study. You will first be asked to complete a short demographic questionnaire. You will then be asked to complete a survey regarding your use of social support interventions in individual therapy. Finally, you will be asked to complete a scale regarding your perceived social support.

Are There Any Risks To Me?
The things that you will be doing are no more/greater than risks than you would come across in everyday life. There is minimal risk in this study--some individuals may find participating in this study to be uncomfortable or boring and may stop at any time.

Will There Be Any Costs To Me?
Aside from your time, there are no costs for taking part in the study.

Will I Be Paid To Be In This Study?
While you will not be paid to participate in this study, in appreciation for your participation, one participant will be randomly selected and compensated with a $50 donation to the charity of his/her choice. If selected, you have the option to decline this, in which case, there will be no compensation for your participation.

Will Information From This Study Be Kept Private?
The records of this study will be kept private. No identifiers linking you to this study will be included in any sort of report that might be published. Research records will be stored securely and only Taylor Parks, M.Ed., and Charles Ridley, Ph.D., will have access to the records.

All information will be collected via the internet and will be stored in secure computer files protected with a password. This consent form will be filed securely in an official area.

People who have access to your information include the Principal Investigator and research study personnel. Representatives of regulatory agencies such as the Office of Human Research Protections (OHRP) and entities such as the Texas A&M University Human Research Protection Program may access your records to make sure the study is being run correctly and that information is collected properly.

Information about you and related to this study will be kept confidential to the extent permitted or required by law.

Who May I Contact For More Information?
You may contact the Principal Investigator, name of Principal Investigator Charles Ridley, Ph.D., to tell him about a concern or complaint about this research at (979)-862-6584 or cridley@tamu.edu

For questions about your rights as a research participant, to provide input regarding research, or if you have questions, complaints, or concerns about the research, you may call the Texas A&M University Human Research Protection Program (HRPP) by phone at 1-979-458-4067, toll free at 1-855-795-8636, or by email at irb@tamu.edu.

What If I Change My Mind About Participating?
Your participation in this research is voluntary, and you have the choice whether or not to be in this research study. You may decide to not begin or to stop participating at any time. If you choose not to be in this study or leave the study, there will be no effect on

your relationship with Texas A&M University; however, you will no longer be eligible to be selected to receive a $50 donation to the charity of your choice.

SIGNATURE AND ACKNOWLEDGMENT: By checking the box "agree to participate" you are electronically signing this form and agreeing to participate in this research study. You are also indicating that you have read the above information and agree to participate in the study until you decide otherwise.

APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE

What is your age? _____

How do you identify your gender?
Male
Female
Transgender
Non-Binary
Other: _____

How do you identify your race?
African American/Black/African
American Indian/Alaska Native
Asian American/Asian/Pacific Islander
Latino/a
White/European
Biracial/Multiracial
Other: _____

Primary Field of Study:
Clinical Psychology
Counseling
School Psychology
Other: _____

Theoretical Orientation with which you most identify:
Cognitive-Behavioral
Psychodynamic/Psychoanalytic
Eclectic/Integrative
Other: _____

Primary Treatment Setting:
Community Mental Health
Hospital/Medical Facility
Jail/Criminal Justice System
University/College Counseling Center
Other: ____

APPENDIX E

SURVEY FOR USE OF SOCIAL SUPPORT

Instructions:

The following statements relate to the use of social support and social support interventions in individual therapy. We are interested in the degree to which you feel the following statements describe your work with clients. Please use the following scale:

Circle the "1" for **Rarely or Never**
Circle the "2" for **Sometimes but Not Often**
Circle the "3" for **Often but Not Most of the Time**
Circle the "4" for **Most of the Time**
Circle the "5" for **Almost Always or Always**

Please provide responses that best describe what you really do in your work with clients in individual therapy.

1. I involve family members, friends, and significant others in the treatment process of my clients.	1 2 3 4 5
2. I teach behavioral skills and techniques to family members, friends, or significant others in order to enhance the support that my clients receive.	1 2 3 4 5
3. I encourage my clients to turn to their family members, friends, and significant others for support.	1 2 3 4 5
4. I encourage my clients to become involved in groups to increase support from their peers such as social groups, support groups, or therapy groups.	1 2 3 4 5
5. I encourage my clients to build new social relationships through community involvement.	1 2 3 4 5
6. I encourage my clients to seek support through online groups, forums, or chats.	1 2 3 4 5
7. I use social skills training, including the teaching and rehearsal of social skills, in my work with clients as a way to enhance social support.	1 2 3 4 5

8. I employ psychoeducation about the importance and benefits of social support in my work with clients.	1	2	3	4	5
9. I employ psychoeducation about social support to help my clients to recognize the support that they are receiving from others.	1	2	3	4	5
10. I employ interventions to enhance my client's perception of their social support.	1	2	3	4	5
11. I use social support interventions in my treatment of many different presenting problems/concerns.	1	2	3	4	5
12. Social support interventions are important in my treatment of psychopathology.	1	2	3	4	5

APPENDIX F

MULTIDIMENSIONAL SCALE OF PERCEIVED SOCIAL SUPPORT

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you **Very Strongly Disagree**
Circle the "2" if you **Strongly Disagree**
Circle the "3" if you **Mildly Disagree**
Circle the "4" if you are **Neutral**
Circle the "5" if you **Mildly Agree**
Circle the "6" if you **Strongly Agree**
Circle the "7" if you **Very Strongly Agree**

1. There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2. There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3. My family really tries to help me.	1	2	3	4	5	6	7
4. I get the emotional help & support I need from my family.	1	2	3	4	5	6	7
5. I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6. My friends really try to help me.	1	2	3	4	5	6	7
7. I can count of my friends when things go wrong.	1	2	3	4	5	6	7
8. I can talk about my problems with my family.	1	2	3	4	5	6	7
9. I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10. There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11. My family is willing to help me make decisions.	1	2	3	4	5	6	7
12. I can talk about my problems with my friends.	1	2	3	4	5	6	7

MSPSS SCORING INFORMATION

To calculate mean scores:

Total Scale: Sum across all 12 items, then divide by 12

Friends Subscale: Sum across items 6, 7, 9, & 12, then divide by 4

Family Subscale: Sum across items 3, 4, 8, & 11, then divide by 4

Significant Other Subscale: Sum across 1, 2, 5, & 10, then divide by 4

Scale Reference: Zimet GD, Dahlem NW, Zimet SG, Farley GK. The Multidimensional Scale of Perceived Social Support. *Journal of Personality Assessment* 1988; 52:30-4

APPENDIX G

ITEMS FOR TWO-FACTOR STRUCTURE OF SOCIAL SUPPORT USE

3. I encourage my clients to turn to their family members, friends, and significant others for support.	1 2 3 4 5
4. I encourage my clients to become involved in groups to increase support from their peers such as social groups, support groups, or therapy groups.	1 2 3 4 5
5. I encourage my clients to build new social relationships through community involvement.	1 2 3 4 5
6. I encourage my clients to seek support through online groups, forums, or chats.	1 2 3 4 5
7. I use social skills training, including the teaching and rehearsal of social skills, in my work with clients as a way to enhance social support.	1 2 3 4 5
8. I employ psychoeducation about the importance and benefits of social support in my work with clients.	1 2 3 4 5
10. I employ interventions to enhance my client's perception of their social support.	1 2 3 4 5
11. I use social support interventions in my treatment of many different presenting problems/concerns.	1 2 3 4 5
12. Social support interventions are important in my treatment of psychopathology.	1 2 3 4 5

Factor 1: Use_Teaching includes Items 7, 8, and 10.
Factor 2: Use_Application includes Items, 3, 4, 5, 6, 11, and 12.